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February 2018

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Sam Clark, M.E. Khan, Catherine Kahabuka, Neema Matee, Rose Ernest, Mercy Joseph, Deodatus Mwingizi, and Edward Nkya.

Cover Photo: Women and children wait for service at a health center in Southern Tanzania.

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ABSTRACT

Led by EngenderHealth, the USAID Tanzania Responding to the Need for Family Planning through Expanded Contraceptive Choices and Program Services (RESPOND) Project was implemented as a five-year project, from November 2012 through October 2017, with a budget ceiling of US$ 42 million. Working in 110 districts in four regional areas (Mwanza, NW; Arusha, NE; Iringa, SW; and Coast, SE), the purpose of RESPOND was to increase the use of family planning (FP) and reproductive health services, with a focus on long-acting and reversible contraceptives/long-acting and permanent methods (LARCs/LAPMs) to meet the reproductive intentions of Tanzanian women, men, and adolescents.

The overall purpose of this evaluation was to review RESPOND's achievement of results related to: 1) increasing FP uptake in program-supported areas; 2) improving service delivery through integration; and 3) strengthening systems by applying a district-centered approach.

The evaluation was conducted between June 12 and July 26, 2017 by an eight-member Evaluation Team comprised of two expatriate and six host country evaluation and subject matter experts. The 12 districts, 17 facilities, and more than 200 key informants from which evaluation information was gathered (including 92 in-depth interviews, 55 trainees, and eight focus group discussions) were selected purposively by EngenderHealth based on criteria provided by USAID. Key RESPOND achievements included evidence of a significant uptake of contraceptive methods (especially for implants) with a three-fold increase in the Arusha Zonal area, improved contraceptive accessibility, and improved method choice.

Key recommendations included: continue capacity building until most facilities start providing LARCs/LAPMs and maternal and child health services as routine services; scale up integration of services within the context of the follow-on project, Boresha Afya, with a focus on better equipped and staffed facilities; and adapt the district-targeted approach by integrating key indicators under Boresha Afya.

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ACRONYMS

ANC	Antenatal care
ATP	ACQUIRE Tanzania Project
BCC	Behavior change and communication
BTL	Bilateral tubal ligation
CCHP	Comprehensive Council Health Plans
CCT	Christian Council of Tanzania
CDCS	Country Development Cooperation Strategy
CHCP	Community Health Care Provider
CHMT	Council Health Management Team
CHW	Community health worker
CPAC	Comprehensive post-abortion care
CPR	Contraceptive prevalence rate
CT	Care and treatment
CTC	Care and treatment center
CYP	Couple years of protection
DHIS	District health information system
DHS	Demographic and Health Survey
DO	Development objective
DQA	Data quality assessment
DQI	Data quality improvement
DRCHCO	District Reproductive and Child Health Coordinator
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EH	EngenderHealth
FGD	Focus group discussion
FP	Family planning
FP2020	Family Planning 2020
GBV	Gender-based violence
GOT	Government of Tanzania
HC	Health center
HCT	HIV care and treatment
HPT	Health Promotion Tanzania
HSSP	Health Services Support Project
IDI	In-depth interview
IEC	Information, education, and communication
IPC	Interpersonal communication

IPD	Inpatient department
IR	Intermediate Result
IUD (IUCD)	Intrauterine (contraceptive) device
KII	Key informant interview
LAPM	Long-acting and permanent method
LARC	Long-acting and reversible contraception
LGA	Local government authority
M&E	Monitoring and evaluation
MCH	Maternal and child health
MCPR	Modern contraceptive prevalence rate
MDGs	Millennium Development Goals
MIS	Management Information System
ML	Minilaparotomy
MNCH	Maternal, newborn, and child health
MOH	Ministry of Health
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly, and Children
MOHSW	Ministry of Health and Social Welfare
MSI	Marie Stopes International
NGO	Non-governmental organization
NOGI	National Operation Guidelines for Integration
NSV	No-scalpel vasectomy
OB/GYN	Obstetrics and gynecology
OJT	On-the-job training
OPD	Outpatient department
PAC	Post-abortion care
PITC	Provider-initiated testing and counseling
PMO-RALG	Prime Minister's Office – Regional Administration and Local Government
PMP	Performance Management Plan
PM	Permanent method
PMTCT	Prevention of mother-to-child transmission of HIV
PNC	Postnatal care
PPIUD (PPIUCD)	Postpartum intrauterine (contraceptive) device
PPP	Public-private partnership
PSI	Population Services International
QA	Quality assurance
RCH	Reproductive and child health
RCHCO	Reproductive and Child Health Coordinator

RCHS	Reproductive and Child Health Section
RESPOND	Responding to the Need for Family Planning through Expanded Contraceptive Choices and Program Services
RH	Reproductive health
RHMT	Regional Health Management Team
RMO	Regional medical officer
SAQ	Self-administered questionnaire
SOW	Scope of Work
SP	Service provider
SRH	Sexual and reproductive health
SS	Supportive supervision
STI	Sexually transmitted infection
TA	Technical and financial assistant
TEC	Tanzania Episcopal Council
TIP	Tanzania Interfaith Partnership
USG	United States Government
VEO	Village Executive Officer
WEO	Ward Executive Officer
WHO	World Health Organization
WRA	Women of reproductive age

EXECUTIVE SUMMARY

EVALUATION PURPOSE AND EVALUATION QUESTIONS

Led by EngenderHealth (EH), the United State Agency for International Development (USAID) *Responding to the Need for Family Planning through Expanded Contraceptive Choices and Program Services* (RESPOND) Tanzania Project was a five-year project (from November 2012 to October 2017) with a budget ceiling of US$ 42 million. It was implemented as part of the global RESPOND Project, which expands family planning (FP) services and improved reproductive health (RH) in 11 countries, including the United Republic of Tanzania.

RESPOND was positioned to support and closely collaborate with the Reproductive and Child Health Section (RCHS) of Tanzania's Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC) towards implementation of RH policy goals as outlined in the Health Services Support Project (HSSP) IV and One Plan II and their respective antecedents.

The purpose of RESPOND was to increase the use of FP and RH services, with a focus on long-acting and reversible contraceptives (LARCs)/long-acting and permanent methods (LAPMs), in order to meet the reproductive intentions of Tanzanian women, men, and adolescents. This was to be accomplished by achieving four results: (1) access to quality FP/LARC/LAPM and RH services; (2) quality FP/LARC/LAPM and RH-integrated services; (3) strengthened health systems; and (4) communities engaged in the promotion of FP/RH services.

The purpose of this evaluation was to review RESPOND's achievement of results specifically as relates to: 1) increasing FP uptake[1] in program-supported areas; 2) improving service delivery through integration; 3) strengthening systems by applying a district-centered approach; and 4) community engagement. The evaluation was designed to identify best practices and conclusions by exploring the different strategies and interventions employed. It also intended to help USAID identify facilitating and limiting factors faced while implementing a complex FP program. Finally, the evaluation was intended to enable more effective design, implementation, monitoring, and evaluation of FP programming in the future.

The evaluation focused on three themes: 1) achievement of results; 2) best practices; and 3) facilitating and limiting factors within each of the above mentioned four results. The Evaluation Team was tasked with answering the following questions:

1. What and how did specific enablers and constraints affect FP uptake in RESPOND regions?
2. How did RESPOND's model(s) of integration affect the uptake of FP services from various perspectives? Compare RESPOND sites with integration and without integration and assess which integration model is more effective.
3. How did RESPOND's district-centered approach result in strengthening the capacity of local government to manage and implement FP programs?

[1] "Uptake" refers to the action of taking up or making use of something that is available. For example, "Although the low uptake of health services has been seen as a measure of health, it has been reported that delays seeing a doctor are due to cultural reasons." Source: https://en.oxforddictionaries.com/definition/uptake

4. How has RESPOND contributed to community mobilization for increasing utilization of FP and RH services, including greater access to LARCs/LAPMs?

PROJECT BACKGROUND

Tanzania's current fertility rate of 5.2 children per women of reproductive age and growth rate of 2.7 percent place it among the world's fastest growing populations (Tanzania Demographic and Health Survey [TDHS]/MIS, 2015-16). In order for Tanzania to reach its goal of becoming a middle-income country by 2025, it must achieve a demographic transition that maximizes the potential for a demographic dividend. FP will be critical to achieving an accelerated reduction in fertility. Substantial investments in health, education, and employment—particularly for youth—will be required.

USAID/Tanzania seeks to help Tanzania increase demand for and use of FP by integrating it with other health services (e.g., HIV; maternal, newborn, and child health [MNCH]) and non-health activities (e.g., agriculture, nutrition, and natural resource management).

A renewed momentum for FP in Tanzania began in 2008, when the Government of Tanzania (GOT) launched several strategies aimed at making FP services accessible to and equitable for all Tanzanians. In 2012, as part of the Family Planning 2020 (FP2020) partnership, the GOT made several political commitments with the goal of doubling contraceptive users to 4.2 million towards attaining a national contraceptive prevalence rate (CPR) target of 60 percent. Unmet need has remained almost unchanged in Tanzania for more than a decade and, as of 2016, the CPR is just 38 percent. Much remains to be done to achieve this target.

EVALUATION DESIGN, METHODS, AND LIMITATIONS

The evaluation was conducted between June 12 and July 26, 2017 by an eight-member Evaluation Team comprised of two expatriate and six host country evaluation and subject matter experts. It covered the period from the project's inception in November 2012 through July 2017.

The evaluation methodology combined a desk review of pertinent documents with a review and analysis of quantitative data and application of qualitative techniques by conducting 92 in-depth interviews (IDI) of key informants. Key informants included USAID program officials, EH project staff, GOT Ministry officials, implementing partners, donor agencies, and other stakeholders. Observations were made of 17 health facilities using a structured observation sheet. Fifty-four trainees who had received clinical training in provision of LARCs/LAPMs were asked to complete a brief self-administered interview in Swahili, followed by informal group discussions. The quantitative analysis included data from EH's RESPOND monitoring and evaluation (M&E) database, TDHS 2010 and 2015-16, and recently released Track20 presentations on performance of Tanzania's FP program. Eight focus group discussions (FGDs) of women and men were also conducted to get a community perspective on the project and any benefits that may have reached the community. All data collection tools except the facility observation checklist were translated into the local language. The team obtained verbal consent from all participants of the IDIs and training follow-up self-dministered uestionnaires (SAQs), and FGD participants, according to USAID Evaluation Policy guidelines.

The evaluation used a mixed methods approach, collecting data from different sources pertinent to the project to help triangulate diverse data sets to get insights on the impact of the

RESPOND project and answer the key questions of the SOW. The evaluation model follows USAID Evaluation Policy and performance evaluation practices.

The districts, facilities, and key informants were selected purposively by EH based on criteria provided by USAID. Twelve districts were selected out of the 110 districts covered by RESPOND among the four zonal offices of the project: Mwanza NW, Arusha NE, Iringa SW, and Coast SE. Seven districts were purposively selected from four types of integration models implemented by RESPOND: comprehensive post-abortion care (CPAC) and FP; HIV and FP; gender-based violence (GBV) and FP; and Youth and FP. Five districts were selected from the non-integrated districts.

Limitations to the evaluation design: The evaluation cannot generate findings based on a sample that is statistically representative of the larger population from which they are drawn. Non-probability sampling methods were used for selecting districts, facilities, communities, key informants for IDI, and FGD participants. While the data are robust, the team largely depended on statistical information about EH activities maintained by EH in their database. IDIs with key informants constituted one of the primary sources of data and these interviews were subject to personal biases.

FINDINGS AND CONCLUSIONS

The body of this report responds to four main questions specified in the Evaluation Scope of Work. The findings and conclusions for each question are summarized below.

Evaluation Question 1: What and how did specific enablers and constraints affect FP uptake in RESPOND regions?

To answer these questions, the Evaluation Team first considered how the RESPOND project has affected the uptake of FP. For this, the team used data available from EH, complemented by other information, including 2012 census data for denominators, and observations made in the field. The key enabler and constraints were identified from IDIs. Regional variation and gender issues were assessed by using quantitative data drawn from available databases and the IDIs. Key RESPOND achievements included evidence of a significant uptake of contraceptive methods (especially for implants) with a three-fold increase in the Arusha Zonal area, improved contraceptive accessibility, a reduction of stock-outs, and improved method choice. Enabling factors included RESPOND support for capacity building of clinical staff (more than 4,800 trained) and improvements in quality and supervision of services provided. RESPOND-supported outreach activities, FP weeks, and special FP days were highly effective in generating new clients, especially for LARCs/LAPMs. Key constraints were limited availability of trained staff, arbitrary reassignment of trained staff, and inadequate infrastructure. The major conclusions were that building competency of providers and taking services closer to the community greatly enhances FP uptake, method mix, and reach to remote areas. Leveraging Ministry of Health (MOH) staff and infrastructure to expand access to FP services may be far less expensive and sustainable than separate and parallel non-governmental organization (NGO) service strategies. Limitations in the format and availability of certain data undermined the rigor of the impact analysis; youth and men were under-represented in FP uptake and mobilization outreach. Joint supportive supervisory visits help maintain quality of services, motivation, and self-efficacy of workers. A combination of FP and other MCH/health services increases uptake because availability of multiple services provides anonymity for women seeking FP services without their partners' knowledge.

Evaluation Question 2: How did RESPOND's model(s) of integration affect the uptake of FP services from various perspectives? Is uptake of FP at sites with integration model(s) better than sites without integration? Which integration model is more effective?

RESPOND implemented a client-oriented service model for integrating FP services into multiple service contexts. The RESPOND approach to integration permits health care providers to find opportunities to engage the client in addressing broader health and social needs other than those prompting the initial health encounter. Through this model, health facilities offer opportunities for integrating FP information and levels of service provision. RESPOND selected 114 service delivery sites for integration in 32 districts based on four criteria: availability of supportive infrastructure; volume of FP clients (high volume sites were preferred); availability of service providers who were eligible to be trained in FP/LARCs; and an adequate number of service providers in the facility (to avoid paralyzing services during offsite training).

Based on secondary data from EH, the evaluation found evidence of an increase in FP uptake by having additional service delivery points (SDPs) provide FP methods. Integration approaches increased FP uptake in RESPOND-supported service delivery sites from just 414 clients in 2012 to 83,996 in 2016. A majority of service providers interviewed were positive about the impact of integration on FP uptake by reducing missed opportunities. RESPOND secondary data demonstrated that districts with integration had more FP uptake than those without integration, particularly for shorter-term methods. Based on field interviews, most of the respondents mentioned FP integration with immunization as the best integration model in increasing client's uptake for FP methods. Other integration models that were considered effective include: labor and delivery for PPIUD, postnatal, and care and treatment centers (CTCs). These impressions were substantiated by quantitative data collected from RESPOND's 114 integration service delivery points. The average number of clients receiving FP services per site over five years was highest for immunization, followed by CTC and postnatal care. The main facilitating factors were the availability of multiple trained staff, required equipment, and counseling kits at the SDPs, as well as the MOH-approved integration manual—the *National Operation Guidelines for Integration (NOGI)*—to guide training, planning, and implementation of the program. It was essential to orient staff on integration at all levels. The process of integration was also facilitated by the fact that integration provides anonymity for FP services. The main conclusions were that integration helps in uptake of short-term FP methods (no significant increase in uptake of LARCs/LAPMs was observed). Not all facilities are a good fit for integration. Priority should be given to facilities with better infrastructure and adequate staffing to absorb the increased uptake of clients without affecting quality of services adversely. Integration needs systematic, comprehensive training in clinical skills, integration processes, administration, and M&E. Integration of PPIUD with labor and delivery and FP services in immunization clinics are promising best practices.

Evaluation Question 3: How did RESPOND's district-centered approach result in strengthening the capacity of local government to manage and implement FP programs?

The RESPOND district-targeted approach focuses RESPOND support on those districts with the highest unmet need and demand for FP as measured by district rates of FP uptake: districts were rated into three performance levels: 1 (low); 2 (medium); and 3 (high). Low-performing districts received higher intensity of integrated FP outreach (FP weeks) conducted on a quarterly basis, monthly outreach, and strengthening of special service days and routine FP

services. In addition, RESPOND conducted service provider (SP) training using central and on-the-job training (OJT) approaches and assisted districts to form commodity security committees to ensure that FP/RH commodities reached the last mile. RESPOND supported training for district managers in the use of district health information system 2 (DHIS2) data for Comprehensive Council Health Plan (CCHP) budgeting and also trained and supported regions and districts to conduct integrated supportive supervision, including joint visits with RESPOND and regional and district staff. RESPOND achievements through this approach included: an increased number of districts allocating resources for FP in their CCHPs; a significant transition of districts from low to medium and high performance; improved district capacity for supportive supervision; improved partner coordination; and improved data quality and usage. The major constraints included: competing demands for scarce funding; lack of follow-through to implement budget plans; high costs for joint supervisory visits; and occasional failure of implementing partners to share workplans. The main conclusions were that the district-targeted approach is an effective strategy to improve performance of less performing districts but support is required to sustain achieved targets. Improved allocation of funds for FP activities in CCHPs may facilitate sustainability of activities initiated under RESPOND. Strengthened HMIS and data use for decision-making is key.

Evaluation Question 4: How has RESPOND contributed to community mobilization for increasing utilization of FP and RH services, including greater access to LARCs/LAPMs?

According to RESPOND, community engagement can be effective in strengthening linkages between health facilities and communities. RESPOND has supported the use of diverse, locally appropriate approaches to sensitize the target population about the availability of FP services in their communities. RESPOND has supported the promotion of outreach clinics/FP weeks as a package of FP, antenatal care (ANC), postnatal care (PNC), and health care services through diverse methods. These include the use of loudspeakers, leaflets, and posters with information on FP methods; obtaining support from religious and community leaders for community sensitization; training and using community health workers (CHWs); and placing posters in public places, such as secondary schools, wards, and primary school announcement boards. These methods are employed one or two weeks prior to outreach services in order to achieve wide coverage of information on the availability of FP services in advance of outreach services. Best practices included presenting outreach and FP weeks as a package of integrated FP/MCH-health care services; community engagement through local leaders, religious leaders, and CHWs; and the use of satisfied clients during engagement activities. The main conclusions were that integrating MCH and other health services makes FP more attractive and acceptable. Timely and effective use of local media and community leaders/CHWs makes mobilization successful and attracts clients to outreach services. A package of locally adapted, culturally appropriate mobilization techniques succeeded in generating high levels of attendance at outreach events (i.e., FP days, FP weeks, and immunization days). RESPOND was asked to maintain a narrow focus on community engagement for access to services; as a result, behavior change and communication (BCC) was not fully employed as part of RESPOND. Effective community mobilization requires active engagement with CHWs and community and religious leaders.

RECOMMENDATIONS

The following are the Evaluation Team's recommendations, with an emphasis on adaptation of the findings and conclusions within the next cycle of USAID/Tanzania-funded programs.

Result 1: What and how did specific enablers and constraints affect FP uptake in RESPOND regions? Recommendations are made in the context of Boresha Afya. It is critical that Boresha Afya should build its Year Two approach based on conclusions from RESPOND and share /combine its resources with partners to:

1. Continue capacity building until most facilities routinely provide LARCs/LAPMs and MCH services. Task shifting could be considered and negotiated with MOHCDGEC to accelerate the process and overcome shortages of staff so as to provide some services at the dispensary level.
2. On-the-job training (rather than off-site training) with a built-in accreditation system to accredit trainees could reduce training costs substantially.
3. Continue outreach. Start gradual withdrawal when the majority of facilities have the capacity to provide all methods. Continue outreach efforts in difficult-to-reach areas.
4. Institutionalize supportive supervision, ensuring adequate allocation of funds for transport and per diem to mentor health care workers and monitor the quality of services as a key outcome.

Result 2: How did RESPOND's model(s) of integration affect the uptake of FP services?

1. Scale up integration of services within the context of Boresha Afya with greater focus on better equipped and staffed facilities.
2. Strengthen FP-immunization integration through immunization outreach and provision of required facilities at immunization service areas.
3. Strengthen FP-post natal/LND integration through staff trainings in LARCs (PPIUD and NXT implant).
4. Disseminate information about the availability of integrated services through different communication channels, including CHWs and community leaders.
5. Develop a suitable plan to integrate HMIS tools so as to reduce duplication of records, which poses a great challenge to quality data collection.
6. Develop a suitable plan for staff deployment, turnover management, and internal rotations so as to avoid paralyzing integrated services.

Result 3: How did RESPOND's model(s) of integration affect the uptake of FP services?

1. Adapt the district-targeted approach by integrating key indicators under the Boresha Afya project.
2. For continuous inclusion of FP activities in the CCHPs, systematic and sustained advocacy on the importance of FP is required at the RHMT, Council Health Management Team (CHMT), and national level.
3. The partners' practice of sharing their work plans with CHMTs before implementation should continue in order to support better coordination and collaboration at district level.
4. Efforts to strengthen and sustain data quality and utilization for decision-making should be made by advocating for allocation of funds for these activities in the CCHPs.

Result 4: How has RESPOND contributed to community mobilization for increasing utilization of FP and RH services, including greater access to LARCs/LAPMs?

1. Adapt and sustain a set of locally adapted, culturally appropriate mobilization techniques in Boresha Afya (e.g., in Lake Regions, find ways to combine FP mobilization with MCH and malaria eradication).
2. Strengthen focused mobilization efforts using local media techniques with an emphasis on low-cost and well-timed outreach that promotes integrated health messages/activities.
3. Develop and use strategic BCC campaigns covering all components of Boresha Afya with a focus on youth, men, women, and key community decision-makers.

INTRODUCTION

CONTEXT

The United Republic of Tanzania is the largest country in East Africa with almost 75 percent of its estimated population of 54.2 million (mid-2016) residing in rural areas (TSPAS, 2014-2015; NBS, 2014; PRB, 2017). Tanzania has a young population with 56 percent under the age of 19 years, implying a very high dependency ratio. Tanzania's current fertility rate of 5.2 children per women of reproductive age and growth rate of 2.7% place it among the world's fastest growing populations (TDHS/MIS, 2015-16). In order for Tanzania to reach its goal of becoming a middle-income country by 2025, it must achieve a demographic transition that maximizes the potential for a demographic dividend. Family planning (FP) will be critical to achieving an accelerated reduction in fertility and substantial investments in health, education, and employment—particularly for youth—will be required.

Driven by tourism, mining, trade, and communications, the private sector has grown considerably, with economic growth averaging 7 percent over the past ten years (World Bank, 2017). With these gains, the percentage of people living in poverty decreased from 53 percent in 2007 to 47 percent in 2011 (World Bank, 2017). Continued rapid population growth has increased the absolute number of Tanzanians living in poverty by more than one million, however, further taxing an already fragile social service system.

Tanzania relies heavily on foreign assistance, with roughly one-third of the national budget financed by donor-provided direct budget support. For the health sector, more than 50 percent of the country's budget is supported by bi-lateral and multi-lateral donors. Lack of basic healthcare, the impact of preventable diseases (e.g., HIV and malaria), low levels of education, low agricultural productivity, widespread corruption, and an urgent need for reform of a business-enabling environment persist as major challenges to development.

Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC) and the Prime Minister's Office-Regional Administration and Local Government. For administrative purposes, Tanzania is divided into 31 regions (26 on the mainland and five in Zanzibar). The regions are further sub-divided into 169 districts/councils (or local government units). The MOHCDGEC of Tanzania is responsible for policy formulation, training, supervision, and regulation of all health services throughout the country, as well as the management of tertiary health services.

The Government of Tanzania (GOT) operates a decentralized health system. The system is organized around three functional levels: council/district (primary level), regional (secondary level), and referral hospitals (tertiary level) (see Annex II.A). Local government authorities (LGAs) have full responsibility for delivering health services within their areas of jurisdiction and report administratively to the Prime Minister's Office-Regional Administration and Local Government (PMO-RALG). While health policy and regulations flow from the MOHCDGEC, delivery of health services is essentially (except for referral hospitals) under the oversight of the PMO-RALG.

Key Sexual and Reproductive Health Indicators. Tanzania has made some progress in improving its maternal, newborn, and child health (MNCH). Births attended by a skilled provider

are currently at 64 percent with 60 percent occurring in a health facility (TDHS/MIS, 2015-16). From approximately 1999 to 2015-16, the neonatal mortality rate dropped from 31 to 25 deaths; the infant mortality rate decreased from 67 to 43 deaths, and the under-five mortality rate declined from 107 to 67 deaths per 1,000 live births (TRCHS, 1999; TDHS/MIS, 2015-16). From 1999 to 2015, the maternal mortality ratio declined from 578 to 398 per 100,000 live births (TRCHS, 1999; World Bank, 2015). The national abortion rate is high at 36 per 1,000 women of reproductive age and it is estimated that each year 405,000 women have an abortion, almost all of which are clandestine; of these, 40 percent result in complications requiring medical treatment (Guttmacher Institute, 2016).

Family Planning Situation. Tanzania's total fertility rate has remained high for nearly 20 years, having only decreased from 5.8 births per woman in 1996 to 5.2 births per woman in 2015-16 (TDHS/MIS, 2015-16). Over the past decade and a half, the modern contraceptive prevalence rate (MCPR) among currently married women age 15-49 grew from 17 to 32 percent (TDHS/MIS, 2015-16). In the same period, the FP method mix has widened with an increase in use of long-acting and reversible contraceptives (LARCs), particularly implants. In 2015-16, the three most popular modern methods were injectables (accounting for 12.6 percent of MCPR), implants (6.7 percent), and OCPs (5.5 percent). Despite these improvements in contraceptive prevalence rate (CPR) and method mix, Tanzania's unmet need for FP has remained stationary at about 22 percent since 1999 (TDHS/MIS, 2015-16). The issue of adolescent fertility is of particular concern in Tanzania on both health and social grounds. The 2015-16 TDHS/MIS showed that more than one in four (27 percent) women age 15-19 have begun childbearing; this figure is higher than that reported in the 2010 TDHS (23 percent).

Family Planning as Reflected in National Policies. While Tanzania has a favorable policy environment for FP, the extent to which available policies and guidelines influence program performance is questionable. A renewed momentum for FP in Tanzania began in 2008, when the GOT launched several strategies aimed at making FP services accessible to and equitable for all Tanzanians. In 2012, as part of the Family Planning 2020 (FP2020) partnership, the GOT made several political commitments with the goal of doubling contraceptive users to 4.2 million towards attaining a national CPR target of 60 percent initially set in the One Plan Strategy of 2008. In early 2013, the MOHCDGEC, FP program implementers, and donors embarked on developing the FP2020 Action Plan (2013-2015) detailing strategic actions for implementing the FP2020 commitments. At the end of 2014, the GOT started developing—and subsequently launched—One Plan II: the National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child, and Adolescent (2016-2020) to pick up from where the One Plan I (2008-2015) and Sharpened One Plan (2014-2015) left off. The overall goal of One Plan II is to improve reproductive, maternal, newborn, child, and adolescent health in Tanzania in line with the *National Development Vision 2025* (see Annex II.B *Summary of GOT National FP Policies and Guidelines*, which summarizes and provides citations and URLs for 17 pertinent national FP policies and guidelines in Tanzania).

DEVELOPMENT PROBLEM AND USAID RESPONSE

Unmet Need for Family Planning. Unmet need for FP is defined as the percentage of women of reproductive age, either married or in a union, who want to stop or delay childbearing but are not using any method of contraception (UN DESA, 2014). Globally, there are more than 225 million women who have an unmet need for FP. According to one study (Sedgh G, et al., 2016), "[w]omen with unmet need for contraception rarely say that they are

unaware of contraception, that they do not have access to a source of supply, or that it costs too much." Their four most common reasons cited for non-use are: "concerns about contraceptive side effects and health risks (26 percent); have sex infrequently or not at all (24 percent); they or others close to them oppose contraception (23 percent); and they are breastfeeding and/or haven't resumed menstruation after a birth (20 percent)." In 2006, unmet need for FP was added to the fifth Millennium Development Goal (MDG) as an indicator for tracking progress on improving maternal health (Guttmacher Policy Review, 2006).

As of 2008, approximately one in four married women have an unmet need for FP in sub-Saharan Africa (MDG Report, 2008). Tanzania has a high unmet need for FP. Estimated at 25 percent among married women in 2010, it only decreased to 22 percent in 2015 (TDHS, 2015). Low contraceptive prevalence is a major contributor to maternal mortality and FP should be considered the primary intervention to prevent maternal mortality. A multivariate modeling study on the impact of eliminating unmet need using Demographic and Health Survey (DHS) data estimated that it could lead to a 43.9 percent reduction of the maternal mortality ratio in Tanzania (Ahmed S, et al., Lancet, 2012). In addition to its important role in reducing both maternal and neonatal mortality, reducing unmet need for FP is an effective strategy toward minimizing HIV infection rates, especially via reduction of mother-to-child transmission (Halperin DT, et al., AIDS, 2009; Ackerman ME, et al., 2012).

USAID's Response. As outlined in Annex I: Evaluation Scope of Work (SOW), Tanzania's high population growth rate must be addressed at both policy and practical levels in order to reduce poverty and achieve broad-based economic growth. Under the results framework for the USAID/Tanzania Country Development Cooperation Strategy (CDCS) (2015- 2019), the USAID/Tanzania Mission's goal is to help advance Tanzania's socio-economic transformation toward middle-income status by 2025. Under this CDCS, unmet need for FP is an intermediate result (IR, IR2.4) toward the CDCS Development Objective 2 for "sustained inclusive broad-based economic growth." Unmet need for FP is considered a valid indicator to gauge the effectiveness of Tanzania's national FP program because it focuses interventions on women who are at greatest risk of unintended pregnancy and are more likely to adopt a method of contraception compared to other nonusers. Unmet need also places women's personal reproductive health (RH) preferences and rights at the center of FP services.

The USAID/Tanzania response entails increasing demand for and use of FP by integrating it with other health services (e.g., HIV, MCH, and non-health activities such as those related to agriculture, nutrition, and natural resource management). It is recognized that integrating HIV and FP activities provides opportunities to simultaneously reduce the incidence of HIV and AIDS and the unmet need for FP. The strategic combination of FP and HIV services offers quality of care to people living with HIV through both HIV and FP settings. The USAID response assumes that when programs and services meet multiple client needs, satisfaction with the health system increases and scarce financial and human resources are better utilized.

Tanzania RESPOND Project. RESPOND was informed by more than a decade of extensive USAID-supported FP program activity in Tanzania. Between 2007 and 2012, EngenderHealth (EH) implemented the USAID-supported "ACQUIRE Tanzania Project" (ATP) that reached more than 4,700 health facilities throughout the mainland and Zanzibar. ATP encompassed FP, RH, post-abortion care, and HIV services for pregnant women. ATP's evidence-based results and lessons learned included the critical importance of using a district-based approach to achieve sustainable change in the Tanzanian national health system. This approach works within

the existing decentralized health structures of the MOHSW and aligns with Comprehensive County Health Plan (CCHP) development, budgeting, reporting, and implementation.

From 2008 to 2014, USAID supported the global Responding to the Need for Family Planning through Expanded Contraceptive Choices and Program Services (RESPOND) project, which expanded FP services and improved RH in 11 countries, including Tanzania. Building on the experience from ATP, USAID awarded EH with the contract for the RESPOND Project. RESPOND began on November 1, 2012 and ended on October 31, 2017 with a budget ceiling of US$ 42,357,285. It involved two global partners: (1) Meridian Group International, Inc. was responsible for building public-private partnerships (PPPs); and (2) Population Council was responsible for conducting operations research and special studies. RESPOND also worked with a wide range of local partners, including national and local government authorities, non-governmental organizations (NGOs) working in health and non-health areas, and the private sector. RESPOND has worked toward the goal of advancing the use of FP and sexual and reproductive health (SRH) services, with a focus on the informed and voluntary use of LARCs/LAPMs.

Integration of FP and HIV services began in Tanzania as part of the ACQUIRE Project in 2008 when the Ministry of Health and Social Welfare (MOHSW) created an FP/HIV Technical Working Group to coordinate national efforts toward integration of FP and HIV services. RESPOND has continued support to the MOHSW (now called the MOHCDGEC) for the integration of FP into provider-initiated HIV testing and counseling (PITC), HIV care and treatment (CT), comprehensive post-abortion care (CPAC), cervical cancer screening, prevention of mother-to-child HIV transmission (PMTCT) services, gender-based violence (GBV), and violence against children (VAC) services.

EVALUATION PURPOSE AND KEY QUESTIONS

The purpose of this evaluation is to review RESPOND's achievement of results specifically as they relate to: 1) increasing use of FP in program-supported areas; 2) improving service delivery through integration of FP with other health services, such as HIV, MCH, CPAC, and GBV services; and 3) strengthening health systems by applying a district-centered approach. The evaluation was designed to identify best practices by exploring the different strategies and interventions employed. It was also intended to help USAID identify facilitating and limiting factors faced while implementing a complex FP program. Finally, the evaluation was intended to enable more effective design, implementation, monitoring, and evaluation of FP programming in the future. The evaluation focused on three themes: a) achievement of results; b) best practices; and c) facilitating and limiting factors within each results area.

For this evaluation, the results framework employed by USAID and provided in the SOW is presented below in Table 1:

Table 1. RESPOND Results Framework

Purpose: Increased use of FP/RH services, with a focus on LARCs/LAPMs, to meet the reproductive intentions of Tanzanian women, men, and adolescents			
Sub-purpose 1: Access to quality FP-LARCs/LAPMs and RH services (HIV and GBV) increased	**Sub-purpose 2:** Quality FP-LARCs/LAPMs and RH integrated services demonstrated, evaluated, and scaled up	**Sub-purpose 3:** Health systems strengthened for integrated FP-LARCs/LAPMs and RH services	**Sub-purpose 4:** Communities engaged in the promotion of FP-LARCs/LAPMs and RH services
1.1 Improved capacity and performance of health service providers and facilities **1.2** Strengthened supervision and quality improvement support for service delivery **1.3** Improved contraceptive/commodity security at the "last mile"* *Reaching health facilities and end users in the remote communities they serve.	**2.1** FP-LARCs/LAPMs integrated into HIV prevention, care, and treatment services **2.2** FP-LARCs/LAPMs integrated into MCH health settings **2.3** Strengthened delivery of LARCs/LAPMs during CPAC services **2.4** FP-LARCs/LAPMs integrated into GBV services at facilities in targeted areas	**3.1** FP/RH resource allocation in CCHPs increased through advocacy and capacity building **3.2** Improved district coordination and partner collaboration **3.3** National, regional, and district level-capacity built to support integrated services **3.4** Strengthened integrated strategic information management (including research or demonstration activities to inform policy change)	**4.1** Increased community engagement and action for accessing tailored FP-LARCs/LAPMs services **4.2** Improved knowledge and acceptability of FP services among targeted populations (e.g., youth, males, urban) in selected areas

The key questions that will be addressed are shown below.

- Result 1: What and how did specific enablers and constraints affect the **increase of FP uptake** in RESPOND regions? The team looked at key factors (e.g., age, sex, geography, and marital status) as well as knowledge, attitudes, and practices of providers and clients; the team also examined GBV and PMTCT in districts where RESPOND works on these issues with FP.
- Result 2: How did RESPOND's model(s) of **integration** affect the uptake of FP services from various perspectives, e.g., Local Government Authorities (LGAs), service providers (SPs)/health facilities, and beneficiaries? The team compared RESPOND sites with and without integration. The team also identified the more effective integration models.
- Result 3: How did RESPOND's district-centered approach result in **strengthening the capacity** of local government to manage and implement FP programs? The team compared the different levels of support to Level 1, 2, and 3 districts and identified the successes/best practices that should be sustained in future programming, as well as challenges encountered, and provided recommendations on how to overcome them.
- Result 4: How has RESPOND contributed to community mobilization for increasing utilization of FP and RH services, including greater access to LARCs/LAPMs? Sub-questions: How has RESPOND increased community engagement and action for accessing tailored/adapted FP-LARC/LAPM services? To what extent has RESPOND improved knowledge and acceptability of FP services among targeted populations, such as youth, males, and urban populations in selected areas? Although Result 4 was not given as a question in the Evaluation SOW, it is embedded in the overall results framework. Given its importance, the Evaluation Team added it to the focus of the evaluation.

EVALUATION METHODS AND LIMITATIONS

Overall Approach. The evaluation methodology used a mixed methods approach consisting of quantitative and qualitative approaches. An interdisciplinary Evaluation Team representing different expertise and extensive experience in conducting such evaluations conducted the study. More information about the Evaluation Team members is provided in Annex VII.A.

The evaluation combined a desk review of pertinent documents with a review and analysis of quantitative data and application of qualitative techniques by conducting 92 in-depth interviews (IDI) with key informants. Key informants included USAID program officers and EH project staff, GOT Ministry officials, and representatives of implementing partners, donor agencies, and other stakeholders. Observations were made of 17 health facilities using a structured observation sheet. Fifty-four trainees who had received clinical training in provision of LARCs/LAPMs were asked to complete a brief self-administered interview in Swahili, followed by informal group discussions about the quality of training. Quantitative data assessed included data from EH's RESPOND M&E database, the 2010 and 2015-2016 Tanzania DHS (TDHS), and recently released Track20 presentations on performance of Tanzania's FP program (Track20 2017). Eight focus group discussions (FGDs) with women and men were also conducted to get a community perspective on the project and any benefits that may have reached the community. To comply with human subjects protection policies for evaluations in Tanzania, USAID/Tanzania requested that beneficiaries not be interviewed and that FGDs only include community members, that they only be asked to discuss issues related to FP and RH in general terms, and that they not be asked about their personal experiences. Table 2 presents the research questions, suggested data collection methodology, and possible challenges.

This mixed methods approach, including data from different sources pertinent to the project, helped triangulate diverse data sets to get insight on the impact of the RESPOND Project and answer the key questions of the Evaluation SOW. The evaluation model follows USAID Evaluation Policy and performance evaluation best practices (USAID Evaluation Policy, January 2011. https://www.usaid.gov/evaluation/policy.).

Table 2. Research questions with suggested source of information and possible challenges

Evaluation question	Data sources and data collection method used to produce evidence for answering this question	Sampling procedures and possible challenges
Q1. What and how did specific enablers and constraints affect the increase of FP uptake in RESPOND regions? - Team looked at key factors (e.g., age, sex, geography, marital status) as well as knowledge, attitudes, and practices of providers and clients. - Team looked at GBV and PMTCT in districts where RESPOND works on these issues with FP.	- Desk review - TDHS - Service statistics/MIS - RESPOND's M&E database - IDIs with different stakeholders - Integration-specific questions in all IDIs - FGDs with community members - Site visit checklist and observed integration of services (youth, CPAC, GBV, PMTCT) - Special RESPOND studies	- Desk review included review of RESPOND annual reports and different DHS reports to compare CPR over time and method mix. - Under the guidance of USAID/Tanzania, selection of experimental and control districts and facility was done by EH before the arrival of the Evaluation Team. - For IDIs, most of the key functionaries at the selected district level and facility level were selected purposively. - Care was taken at each stage to ensure all categories of staff were covered, including both men and women. - FGDs with staff may not always feasible with clinic hierarchy. - IDIs with clinic head and/or one or two doctors. - Focus on those who provide services. - Providers vs. supervisors. - IDIs conducted in local language. - Interviewing RESPOND staffs that were heavily involved in managing and coordinating the RESPOND program at different levels. - Program reports mentioning enablers of reported achievements and constraints. - Established which ones were the most crucial one to be prioritized in future programming by probing for some pre-identified enablers and constraints through desk review and in various interviews and FGDs.
Q2. How did RESPOND's model(s) of integration affect the uptake of FP services from various perspectives, e.g., LGAs, SPs, health facilities, beneficiaries? - Compared RESPOND sites with and without integration. - Identified which integration model is more effective.	- Desk review - Service statistics/MIS - RESPOND's M&E database - IDIs with different stakeholders from intervention and control districts - Integration-specific questions in all IDI - Observation at facilities whether integration has increased availability of providers and	- IDIs with most key staff at regional and district level. - Used quantitative data from all 110 sites from RESPOND and DHS by Level 1, 2, and 3. - RESPOND statistics on type of providers that provided training, quality, and duration of training and whether training enabled them to start providing services. - IDIs with district and regional health officials may be complimentary to quantitative data.

Evaluation question	Data sources and data collection method used to produce evidence for answering this question	Sampling procedures and possible challenges
	contraceptive methods in different facility units	
Q3. How did RESPOND's district-centered approach result in strengthening the capacity of local government to manage and implement FP programs? - The team compared the different levels of support to Level 1, 2, and 3 districts and identified the successes/best practices that should be sustained in future programming, as well as challenges encountered, and provided recommendations on how to overcome those. (See background documents for definitions of levels of support).	- Desk review - Service statistics/MIS - RESPOND's M&E database - IDIs with clinic staff and regional staff - Disaggregation of facility data by contraceptive uptake at Levels 1-3 - IDIs with regional and district health officials, i.e., Regional Medical Officers (RMOs), District Medical Officers (DMOs), District Reproductive and Child Health Coordinators (DRCHCOs) on district planning, MIS, contraceptive security, and so on	- IDIs with most key staff at regional and district level. - Used quantitative data from all 110 sites from RESPOND and DHS by Level 1, 2, and 3. - RESPOND statistics on type of providers that provided training, quality, and duration of training and whether training enabled them to start providing services. - Focused probing on contraceptive security and district level planning in IDIs. - IDIs with district and regional health officials may be complimentary to quantitative data.

Source: Adapted from framework provided in Evaluation SOW.

Selection of Districts and Health Facilities. The districts and health facilities were selected by EH based on overall guidance and criteria provided by USAID/Tanzania. The four selection criteria for districts were:

1. Convenience: Regions and districts that are easily reachable by air/tarmac road and health facilities not very far from district headquarters
2. Performance: Regional CPR as indicated by the 2010 TDHS, i.e., low CPR (Level 1=10-29 percent), medium CPR (Level 2=30-39 percent), and high CPR (Level 3=40-50 percent)
3. Program integration: Different integration models: FP, GBV, CPAC, and PMTCT
4. Rural and urban representation for a good balance for both urban and rural settings

For the RESPOND Project, district performance was measured in terms of modern contraceptive uptake per 10,000 women of reproductive age (WRA, 15-49 years old). For operational purposes, EH categorized FP uptake per 10,000 WRA by grouping districts into three categories based on current locally reported FP uptake at district level in each year: Category 1: Poor uptake (311 to 2,827); Category 2: Average uptake (1,686 to 4,310); and Category 3. Good uptake (2,671 to 11,131).

A total of 17 districts were chosen for the evaluation. Twelve districts were selected purposively out of the 110 districts covered by RESPOND among the four zonal offices of the project: Mwanza NW, Arusha NE, Iringa SW, and Coast SE. Of those 12, seven were purposively selected from four types of integration models implemented by RESPOND: CPAC&FP, HIV&FP, GBV&FP, and Youth&FP. The remaining five districts were selected from non-integrated districts.

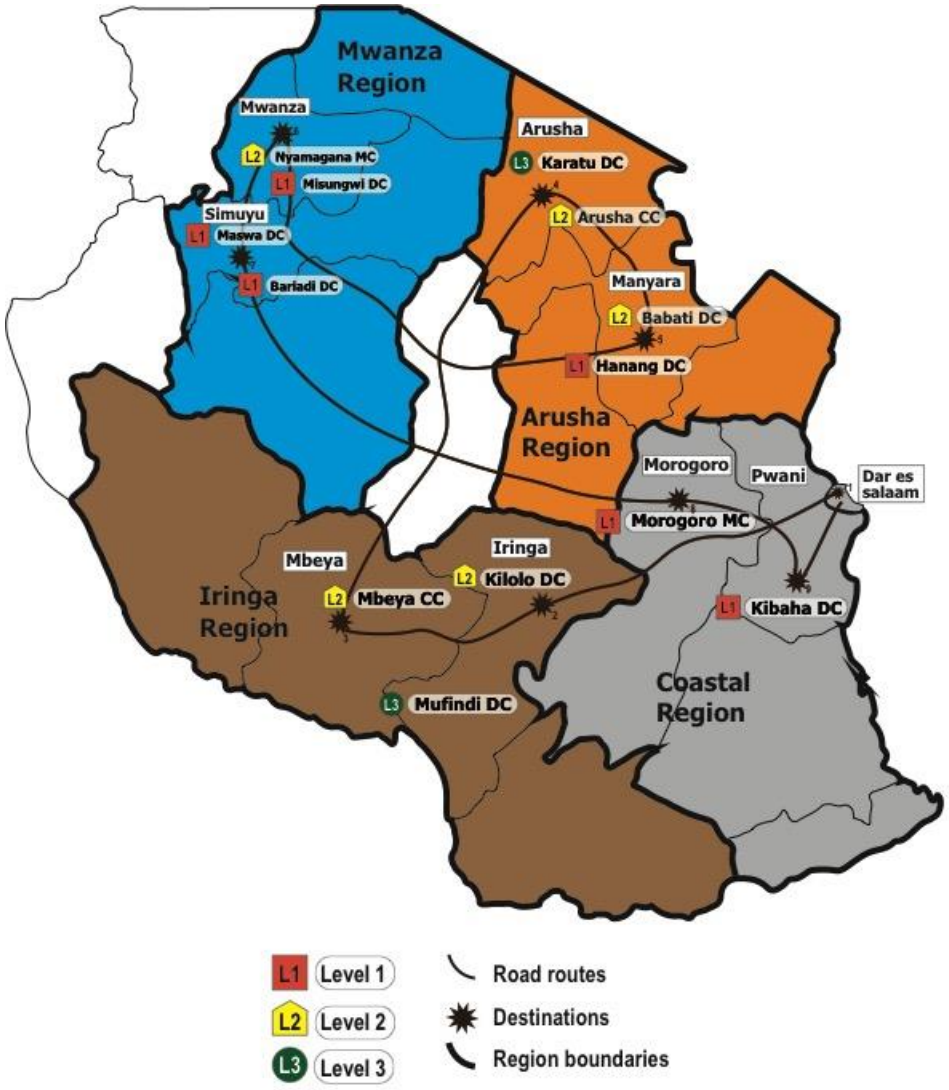
Among these 12 districts, 17 sites were visited: 10 sites in integration model districts and seven sites from non-integrated model districts. Following the above criteria, the districts selected by EH for the Evaluation Team are shown in Table 3. A map indicating the location of the selected districts in the four regions appears below (see Figure 1).

Table 3. Sampled districts from Zonal offices: integrated model districts versus non-integrated districts

Zonal Office	Integrated districts				Non-integrated districts			Total	
	Districts	Model	Site visits planned	Visits actual	Districts	Visits planned	Visits actual	Visits planned	Visits actual
Mwanza NW	Nyamagana Misungwi	CPAC&FP	4	2	Maswa	2	2	6	4
Arusha NE	Arusha City Karatu	HIV&FP	3	3	Babati Hanang	4	2	7	5
Iringa SW	Kilolo Mufindi	GBV&FP	4	4	Mbeya MC	2	1	6	5
Coast SE	Morogoro	Youth&FP	2	1	Kibaha	2	2	4	3
Total	7	----	13	10	5	10	7	23	17

Source: Evaluation Team.

Figure 1. RESPOND data collection regions and districts visited by performance level



Source: Evaluation Team.

KEY DATA SOURCES

Document and Data Review. Prior to arriving in the country, the Evaluation Team conducted a detailed desk review of the project documents as indicated in the Evaluation SOW. These included annual and quarterly reports of the RESPOND Project and data from sources provided by USAID/Tanzania, which were put on a shared drive created by GH Pro. Besides these documents, the Evaluation Team reviewed additional documents identified by USAID/Tanzania, such as TDHS 2010 and TDHS 2015 documents and several recent presentations made by Track20. A list of literature reviewed is presented in Annex IV.

IDIs with Key Informants. Semi-structured interviews with a wide range of stakeholders were conducted at all levels, from Dar es Salaam to regional, district, and facility levels. Although the selection of respondents for IDIs was purposive, care was taken to ensure that at each level all key categories of staff were interviewed. For example, at the district level office, Medical Officers in charge and Reproductive and Child Health (RCH) Coordinators and M&E staff in charge were given special focus as key informants. At times, these interviews involved more

than one person. For example, FP coordinators, M&E staff in charge, and pharmacists also participated with the medical officer (MO) in charge or RCH Coordinator during interviews.

These IDIs were designed to cover the four main RESPOND results and their sub-results and the themes specified by the Evaluation SOW, namely a) achievement of results, b) best practices, and c) facilitating and limiting factors, (A copy of the instrument is provided in Annex V). The interviews provided insights into the effectiveness of the RESPOND Project; activities implemented by the project to build the capacity of providers and management of the national FP program; approaches used in the implementation of various interventions; and gaps. Probing was also made on success stories related to different models of integration, including integration models that appeared to be more effective in increasing contraceptive use. Altogether, the team conducted 92 IDIs with a total of 129 key informants interviewed (76 women and 53 men). A list of persons contacted, including all key informants, is presented in Annex III.

Secondary Data Analysis. The objective of the secondary data analysis was to determine the trends and progress achieved in coverage, access, and utilization of LARC/LAPM services and how different interventions and models used have influenced the outcomes of the project in the 110 districts covered by RESPOND. In absence of any end-line survey, or special quantitative studies, the EH M&E database was the main source of data for secondary analysis to answer the questions raised in the Evaluation SOW. It also helped in comparing performance/outcomes from integrated model districts with non-integrated districts. The evaluation analyzed routine service data collected by RESPOND. These were complemented by DHS data from 2010 and 2015 surveys, as well as Track20 findings and the key informant interviews. Data from the 2012 national census were used for denominators down to the district level.

Focus Group Discussions. The team conducted eight FGDs with community members: three with men, four with women, and one mixed (See Annex II.G) with a total of 60 participants (27 women and 33 men). Participants in FGDs were chosen purposively from among clients who had either come to the health facility seeking services, were accompanying a client, or were community members from nearby areas. To get a better understanding of the process of community engagement, participants in the final two FGDs were chosen from among community members who were part of the mobilization for RESPOND outreach activities. The FGDs were organized to understand community perspectives on the FP needs of community members. The key topics that were covered in FGDs included: perceived FP needs; method choice and accessibility; observed changes over the last three years in method choice; the role of outreach services in increasing method mix and accessibility of LARCs/LAPMs; integration of FP with other health services; perceived quality of services; and community norms supporting, accelerating, or resisting acceptance of contraceptives.

A moderator and one or two note takers led the FGDs. The FGDs were conducted in the local language (Swahili). Both moderators and note takers were fluent in Swahili and fully conversant with FGD techniques. Male team members conducted male FGDs, while female team members conducted female FGDs. The FGD proceedings were digitally recorded; a transcript of each FGD was prepared and summarized. Findings from the eight FGDs are presented in Annex II.G and a copy of the *FGD Guide* is available in Annex V. All participants were at least 18 years old and participated in an informed consent process as outlined in the *FGD Guide*.

Facility Observations. During all 17 site visits, the team conducted structured observations using a checklist. The purpose of these observations was to determine the level of readiness of

facilities to provide quality FP services at different departments where FP had been integrated. The key points that were observed include availability of trained staff and contraceptives, including LARCs and LAPMs, and display of counseling materials. Records kept of patients registered were also examined to assess whether contraceptive services provided to clients were properly reported. Annex II.C provides a summary of findings from facility observations.

Follow-up with Providers that Received LARC/LAPM Training. Capacity building of providers is one of the key interventions of RESPOND for enhancing availability, accessibility, and quality of LARC/LAPM services in 110 districts. RESPOND has trained more than 4,833 providers in one or more LARC/LAPM techniques. To understand the trainees' perspective on training and whether they received practical training as per the country's standard practice, in each facility visited, the Evaluation Team asked all available providers trained by RESPOND to fill in a brief self-administered questionnaire (SAQ) in Swahili. A total of 54 staff (eight men and 45 women) trained in LARCs/LAPMs completed SAQs. A summary of the SAQ results is presented in Annex II.D. After completing the SAQs, where feasible, respondents were engaged in a brief discussion lasting approximately 20-30 minutes.

These discussions, while limited in number, provided qualitative data on staff feelings about the usefulness of the training. The information gathered was analyzed and discussed in the section on capacity building efforts. In many cases, health site clinical staff were in great demand from clients and it was not possible to have more than one staff member present fill in the SAQs at one time. In this situation, a group discussion following the SAQ was not feasible.

Data Collection Tools and Instruments. As indicated above, the team developed data collection tools and instruments for all data sources, including semi-structured IDI Guides, FGD Guides for specific groups, training follow-up interviews, and a facility observation checklist. All the tools except the facility observation checklist were translated into Swahili. All data collection tools were focused on relevant key evaluation questions and were pre-tested and revised prior to data collection. The Evaluation's data collection tools can be found in Annex V.

Data Analysis Methods. Well-established frameworks pertinent to FP were adapted for data collection and analysis and report writing (Bruce 1990. Rivero-Fuentes, Estela, et al. 2008. Pelto et al. 2014.). Each data collection method was carried out in its entirety and analyzed separately over the same period. The analysis considered how RESPOND had made a difference in ***access, quality, and management as well as monitoring*** of the program. Since this was a mixed-method evaluation, integrating both quantitative and qualitative data, the team triangulated the results from the different data sets and sources (Pelto et al. 2014; Schensul et al. 1999). The results from different methods were compared, contrasted, and validated. Overall, the findings from different methods were similar and reinforced one another; thus, the team has greater confidence in its findings.

Limitations of Evaluation Methods. The Evaluation Team acknowledges limitations to the evaluation design outlined here. First, because non-probability sampling methods were used for selecting districts, facilities, communities, and IDI key informants and FGD participants, the evaluation cannot generate findings that statistically represent the larger population from which they are drawn. As mentioned in the initial section of the methodology, EH selected districts, facilities, and key informants based on criteria provided by USAID. Second, the team largely depended on statistics maintained by EH about their activities in their database. However, the Evaluation Team found that their data sets were robust and have assumed that its analysis based

on these data represents the whole project area; hence, if the same analysis is repeated it would yield the same results. Furthermore, the Team acknowledges that IDIs of the key informants constituted one of the primary sources of data and it is subject to personal biases. The Team also observed that regional- and district-level officials were well briefed by the local RESPOND staff about the purpose of the evaluation and the types of questions that would be asked.

Gender Considerations. The approach incorporated a gender analysis throughout all levels of the evaluation and tried to assess whether certain individuals or populations are at a disadvantage because of their gender. Specific attention was given to gender considerations while collecting and analyzing data. The team endeavored to ensure that gender was incorporated in the evaluation design: both women and men were interviewed and participated in IDIs and FGDs. Where possible, results were differentiated by gender and care was taken in drawing conclusions. However, non-availability of quantitative data, both from the EH database and the government MIS, meant that results could not be differentiated by gender. Hence, there has been an important limitation of quantitative results with respect to gender analysis. The response pattern of men and women informants who participated in IDI did not show significant differences in their replies. The box below summaries the informants/respondents who participated in the qualitative data collection of this evaluation.

Box 1: Summary of the number of informants/respondents by gender who participated in different method of data collection

Approach used	Male	Female	Total
In-depth interview	53	76	129
Short structured interview of trainees	8	45	53
FGD	33	27	60

Ethical Considerations and Confidentiality. The team obtained verbal consent from all participants of the IDIs, training follow-up SAQs, and FGDs according to *USAID Evaluation Policy* guidelines. Interviewees were given the option to opt out of questions or the entire interview and they were assured personal confidentiality for the information provided. Informed consent was incorporated within the IDI tool, which was reviewed by USAID along with the tool itself.

FINDINGS AND CONCLUSIONS

EVALUATION QUESTION 1

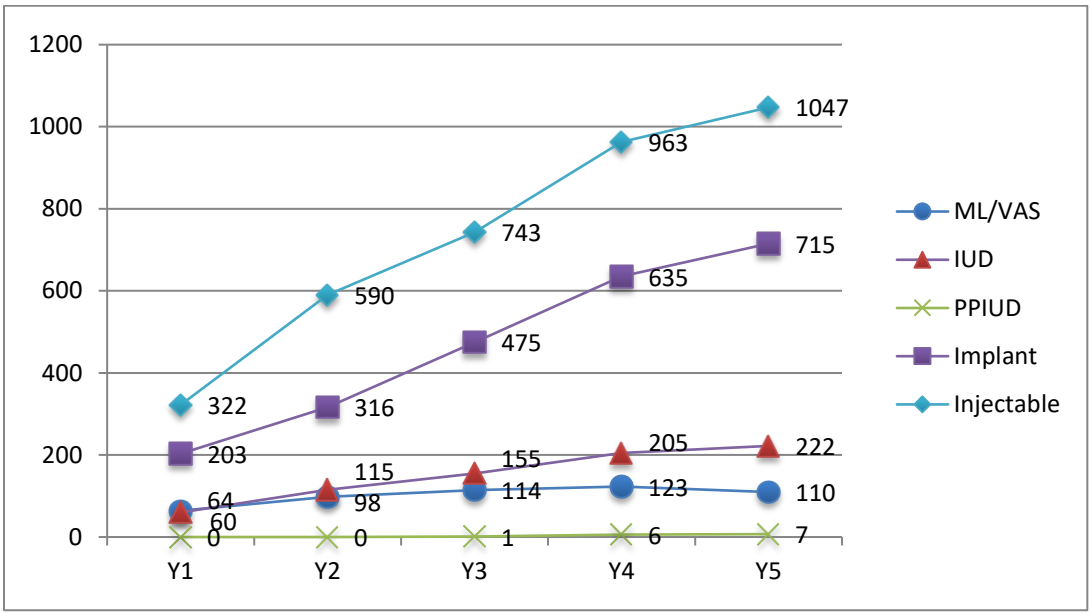
What and how did specific enablers and constraints affect FP uptake in RESPOND regions? Sub-questions: Were there differentials with respect to age, sex, geography, marital status, etc., as well as knowledge, attitudes, and practices of providers and clients?

To answer these questions, the Evaluation Team first considered how the RESPOND Project has affected the uptake of FP. For this the team used data available from EH, complemented by other information, including 2012 census data for denominators, presentations from Track 20, and observations made in the field. The key enablers and constraints were identified IDIs. Regional variation and gender issues were assessed using quantitative data drawn from available databases and the IDIs.

Figure 2 shows the uptake of LARCs/LAPMs over the five-year program period. To standardize the findings, the data are presented as the number of clients receiving a modern contraceptive method (uptake) per 10,000 WRA each year. To arrive at this figure, the reported number of clients provided with specific modern methods for all RESPOND districts was divided by 10,000 WRA. The data for Year 5 has been annualized based on the first two quarters of available data. It should be noted that this measure of uptake is not the same as a contraceptive prevalence rate, which typically measures current use of contraception among married WRA at the time of interview of a nationally representative sample.

The figure clearly shows that, since the first year of the RESPOND Project, LARCs (and to a lesser degree LAPMs) have shown an increasing trend of uptake. While implants have shown a steep increase, IUDs followed a moderate increase, but the minilaparotomy (ML)/no-scalpel vasectomy (NSV) uptake has stagnated around 11 per 10,000 WRA. Among the short-term methods, injectable contraceptives have also demonstrated a rapid increasing trend. A similar analysis of the couple years of protection (CYP) over the period shows that CYP has increased significantly during the RESPOND Project period, reflecting the increasing uptake of PM and LARCs (Table 4).

Figure 2. Uptake of injectable and different ML/NSV and LARCs per 10,000 WRA in 110 RESPOND districts from Year 1 (2012) to Year 5 (2016)



Source: RESPOND data for 110 RESPOND districts.

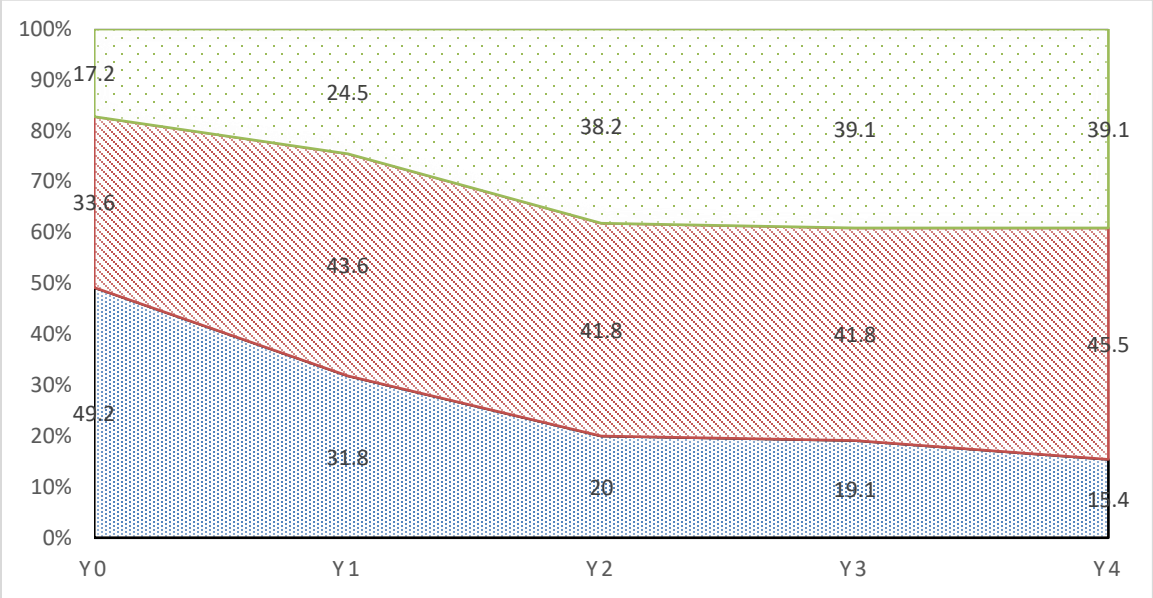
Table 4. CYP from PM, LARC and other short-term methods in 110 RESPOND Districts from Year 1 (2012) through Year 5 (2016)

	Couple years of protection					
Method	Y1 (2012)	Y2 (2013)	Y3 (2014)	Y4 (2015)	Y5 (2016)*	Total
PM (vas/LP)	477,712	745,216	893,160	991,672	919,744	3,567,632
LARCs	840,266	1,439,533	2,165,048	2,973,478	3,414,888	9,125,767
Other short-term methods	119,734	202,471	295,007	395,373	444,914	1,235,042
Total	1,437,712	2,387,219	3,353,215	4,360,522	2,389,773	13,928,441

*As the data for Y5 was available only for two quarters, multiplying by a factor of two has annualized it.
Source: RESPOND database.

A comparison of TDHS data for 2010 and 2015 also showed an increasing trend in the CPR. However, the pace of CPR increase between the two TDHSs was much slower as compared to the pace of increase among the RESPOND 110 districts (data not shown, available on request). This is with the caveat that these two indicators are not comparable: the former (CPR) represents current use of contraceptive on the day/period of survey, whereas the later represents **uptake** of contraceptives over the year. In addition, the district-focused approach adopted by RESPOND—whereby the low performing districts (Level 1=Year 2000 CPR of 10-29 percent) received additional efforts and attention than the average (Level 2=Year 2000 CPR of 30-39 percent) or good performing districts (Level 3=Year 2000 CPR of 40-50 percent)—has helped convert low and average performing districts into good performing districts (Figure 3). For example, the proportion of low performing districts reduced from 49.2 percent in Year 0 to 15.4 percent in Year 4. During the same period, percentage of good performing districts increased from 17 percent in Year 0 to 39.1 percent in Year 4.

Figure 3. Status of 110 RESPOND districts by uptake of modern contraceptives per 10,000 WRA in three categories (Low, Average, and Good) from Year 0 (2012) to Year 4 (2016)



Green (top) = Good range of uptake of modern contraception per 10,000 WRA: CPR greater than or equal to 40%.
Red (middle) = Middle range of uptake of modern contraception per 10,000 WRA: CPR ranged between 30-39%.
Blue (bottom) = Low range of uptake of modern contraception per 10,000 WRA: CPR less than 30%.
Source: RESPOND database.

These results demonstrate that uptake of contraceptive methods, particularly LARCs/LAPMs increased significantly during the RESPOND Project period. This transition from low level to higher level uptake was observed in all the regions. Further analysis, however, also shows that among the low performing districts, 12 districts were "resistant to change." Despite a district-focused approach, they remained low performing (Level 1=Year 2000 CPR of 10-29 percent) throughout the five-year project period. These districts are spread over five regions—three each fall in Mwanza, Dar, and Geita regions—indicating resistance to change was not associated with any specific region.

Further analysis revealed that most of these 12 stagnant Level 1 districts did not start from extremely low levels of uptake and then made good progress just up to but below the threshold to reach Level 2. Among the 12 resistant districts, two indeed started at a very low level of uptake (800-1000/10,000 WRA) and at the end of Year 4 both almost doubled their uptake to around 1800/10,000 WRA. However, among eight districts that started with an uptake between 1001-1500/10,000 WRA, five of them remained almost stationary; their percentage increase in uptake at the end of the fourth year was just around 5 percent. The two remaining districts, which started at a level of 1500-2000/10,000 WRA, did not improve their performance much; in one case, the percentage increase in uptake was only 3.5 percent while the second district increased its uptake only by 15 percent in four years. These "resistant to change" districts need special attention to improve their FP services.

Enablers and Constraints. In addition to observing the functioning of 17 service delivery sites, IDIs with government officials, USAID and EH staff, and providers at various levels of facilities helped in identifying the enablers and facilitating factors, as well as the constraints, associated with increasing uptake of contraceptive methods. Facilitating factors that were

repeatedly mentioned and/or expressed in different words were combined into the broad categories of *access, quality, and improved supervision/management of the program*. For example, access was repeatedly mentioned by almost all the informants (81 percent of the 92 IDI) in the form of the outreach approach, in which on a pre-announced date a team of skilled providers visits smaller facilities (HCs and dispensaries) and provides all FP methods as well as other MCH and health services. Similarly, access to FP services, particularly LAPMs and LARCs, was enhanced by organizing FP weeks. These special efforts supported by RESPOND were adopted because the majority of HCs and dispensaries serving rural communities lack trained providers for LAPMs/LARCs.

The outreach, FP weeks, and fixed day clinics contributed hugely in increasing the uptake of LAPMs/LARCs (Table 5). As the table shows, the majority (60 to 99 percent) of LAPM cases were performed in outreach/FP week settings, rather than routine clinic settings. However, the corresponding share is less for LARCs (35 to 73 percent). The trends in Table 5 suggest that as RESPOND trained providers in provision of clinical contraceptive services, access to these methods in routine clinic settings has increased. The increase in routine clinic availability of LAPMs/LARCs appears to have led to a decline in the share of outreach/FP weeks in the total uptake of the LAPM/LARC methods.

Table 5. Total LAPM/LARC cases performed and percentage share of outreach/FP weeks approach versus routine clinic settings

	Total number of cases performed				
Method	Y1 (2012)	Y2 (2013)	Y3 (2014)	Y4 (2015)	Y5 (2016)*
Total LAPM (vas/LP)	59,714	93,152	111,645	123,959	57,484
% share of outreach/FP weeks versus routine clinic settings	98.8	69.6	89.6	68.9	60.0
Total LARC	240,076	411,295	618,585	849,565	487,841
% share of outreach/FP weeks versus routine clinic settings	72.8	38.6	56.2	43.9	35.5

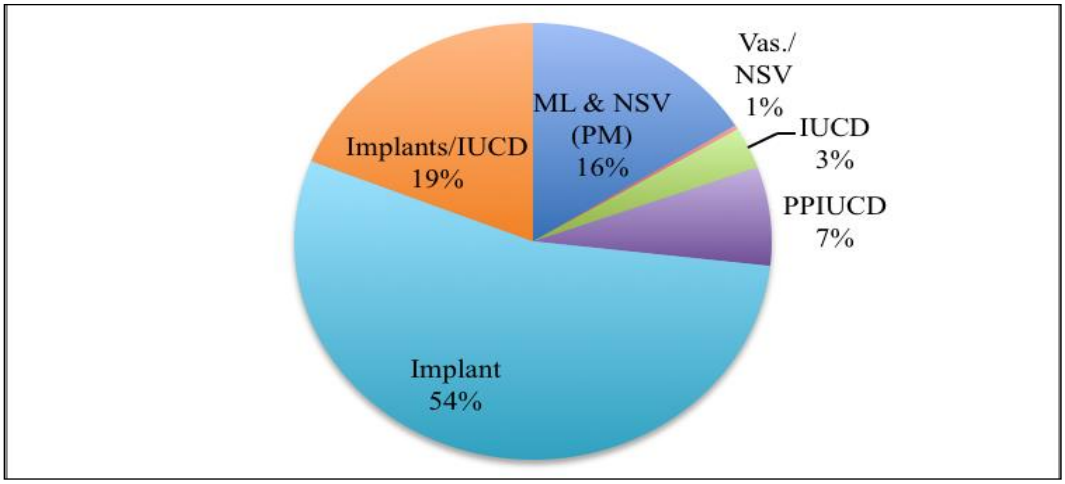
*Data for only two quarters were available.
Source: RESPOND database.

The *financial sustainability* of the RESPOND outreach approach was examined by calculating the cost per LAPM/LARC provided in the outreach/FP week. Over the years, the average cost varied between US$ 4.3 to US$ 6.7 per acceptor with an average of US$ 4.9 over the five-year period. The corresponding cost per CYP was estimated between US$ 0.95 to US$ 1.3 with a five-year average of US$ 1.10 per CYP. Considering the success of the approach in increasing contraceptive choice and higher uptake of FP, particularly LAPMs/LARCs, these costs could be considered extremely reasonable and worth continuing at least until a majority of the health facilities start providing these methods routinely. This suggestion gets further support when we consider the expenses per CYP of other similar programs. For example, Vance and Bratt assessed costs for Marie Stopes International (MSI) mobile outreach in Tanzania, including average cost per acceptor and cost per CYP for the MSI Outreach Expeditions. In total, over a five-month period, six MSI teams provided LAPMs to more than 14,000 women, producing an estimated 76,000 CYPs. The average cost per LAPM acceptor was US$ 22.37, ranging by expedition from US$ 14.40 to US$ 36.75. The average cost per CYP was US$ 4.28, ranging by

expedition from US$ 2.39 to US$ 6.80 (Vance and Bratt 2013). Further, a recent review published in PLoS shows that improving FP interventions in low- and middle-income countries appears to be cost-effective (Zakiyah N, et al., 2016).

Another facilitating factor mentioned by most (87 percent) of the informants interviewed was the RESPOND effort to build capacity of providers in providing clinical contraceptives; about half of them considered it as a best practice. RESPOND trained 4,833 providers through the second quarter of Year 5 (Figure 4).

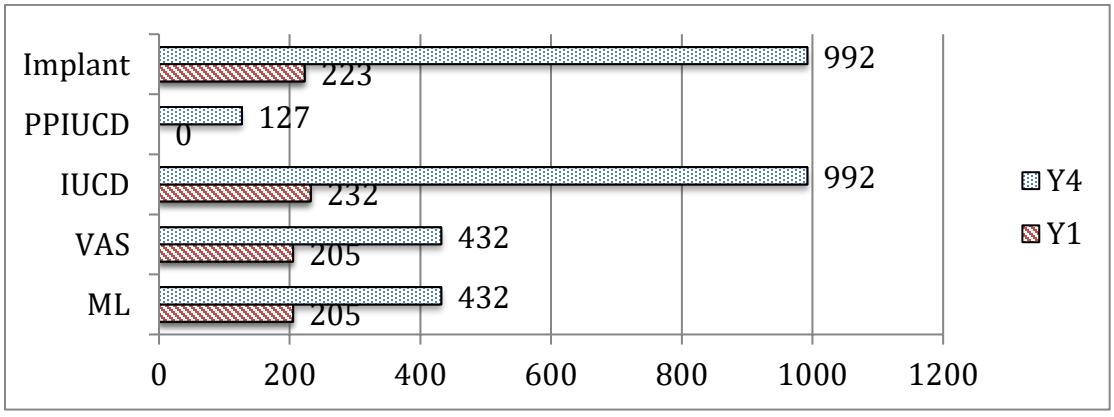
Figure 4. Distribution of providers trained by method (n=4,833) from Year 1 through second quarter of Year 5



Source: RESPOND database.

As the figure shows, the majority of providers were trained to insert implants. More than half (61 percent) of the 2,614 providers trained in implant were trained in Year 5 (data not shown, available on request). It is possible that increasing popularity of the NXT implant required more trained staff. The change in the number of facilities with at least one trained provider from Year 1 to Year 4 is shown in Figure 5. As the figure shows, there was a substantial increase in the number of facilities from Year 1 to Year 4 where specific contraceptive methods could be provided in routine clinic settings.

Figure 5. Number of facilities with at least one provider trained in an FP method by year and method from Year 1 (2012) to Year 4 (2015)

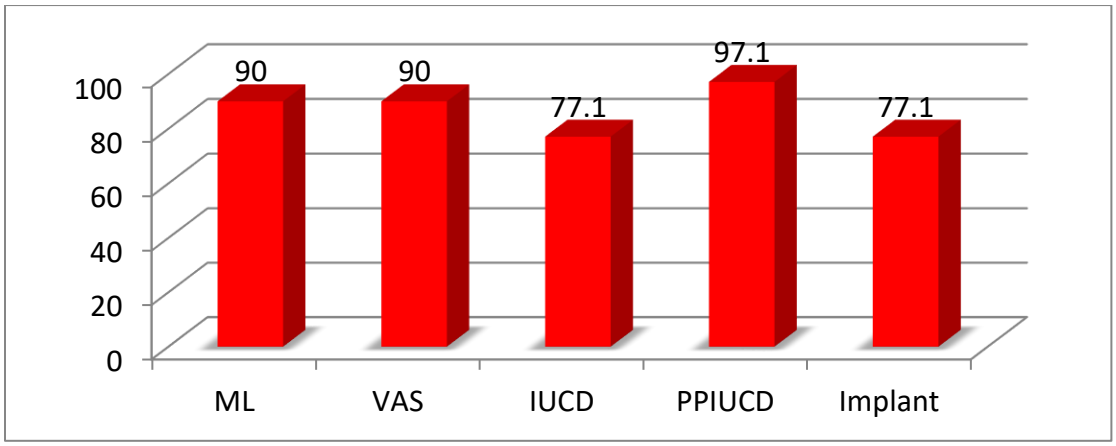


Source: RESPOND database.

The quality of training was assessed by collecting data through SAQs from 54 providers who were trained by RESPOND in clinical contraceptive methods and were available on the day of the Evaluation Team's visit to the facilities. The results show that most (90 percent or more) of the trainees interviewed had a positive view on the way training was implemented. As part of their training, most (77.8 percent) *observed* the performance of five or more procedures and the majority (57.4 percent) *performed* five or more procedures during training. There were striking differences by method. In the case of implants, more than two-thirds (68.7 percent) reported that they had performed only three cases during training, while all PPIUD (3/3) reported doing only two or three insertions. All of the trainees reported that they had received supportive supervision after training and 97 percent of the 54 trainees who answered this question stated they were currently providing the procedure independently.

Despite commendable work done by RESPOND in building the capacity of the health system to provide LAPMs/LARCs and to make the methods accessible as a routine service to expand contraceptive choice, the MOHCDGEC still has a long way to go. Analysis shows that a majority (77 to 90 percent) of the 4,323 facilities in the 110 districts covered under RESPOND do not have trained providers to provide LAPMs/LARCs (Figure 6).

Figure 6. Percentage of facilities in the 110 districts covered under RESPOND without at least one trained person to provide method-specific services



Source: RESPOND database.

This is not a criticism of RESPOND work, which has trained a large number of providers (4,833). Rather it points to the huge work ahead for capacity building. USAID's next project—*Boresha Afya (*USAID RFA-621-16-000012, April 2016)—needs to take this mission forward in collaboration with MOHCDGEC, DCs, and DMCs. Further, this finding should be taken with caution, as some of the facilities, like dispensaries, cannot have a skilled person in minilap as presently none of the staff posted in dispensaries are eligible for training or providing minilap. Dispensaries constitute almost 85 percent of the health facilities (Muganyizi, PS, Track20 presentation, 2017). Further, some of the staff trained by other agencies (presumed and expected to be only a few) might not have been included in the listing of skilled persons in the tracking of the facilities done by EH. Hence, the projected proportion of non-availability of skilled providers for some of the methods, like ML, could actually be more than shown above.

Other facilitating factors identified by many key informants included improved counseling by providers, easy access to counseling and services (because of integration of services), and no stock-outs or fewer stock-outs of contraceptive methods because of improved contraceptive security planning and close monitoring of services through supportive supervision. All these facilitating factors are components of quality of services and visualized by Judith Bruce (1990) as improved client-provider interaction, information given to the client, technical competence of providers, method choice, follow up, and appropriate constellation of services. During field visits and facility observations all of the above components were examined and to a great extent found to be in evidence. Annex II.C provides a summary of findings from the Evaluation's 17 site visits.

Box 2: Other Enablers

- Reaching remote/hard-to-reach areas
- More contraceptive choice
- Integration of services*
- Increased privacy for clients and less crowding
- Additional resources from RESPOND/allowances for outreach/equipment supply
- Training in supportive supervision*
- Training in CCHP/HMIS/data monitoring*
- More use of data for planning/decision-making*
- Technical asssistance in joint partners meeting/ planning*
- Increased fund support for FP in CCHP/MOH*
- Improved contraceptive security planning*
- Improved motivation/confidence of providers
- Increased behavior change and communication /information, education, and communication efforts
- Involvement of community leaders, CHW

*Enablers that were found important and mentioned by many.
Source: Analysis of IDIs.

Visits to these facilities and observations showed that LAPMs were largely available at district-level facilities or large health centers with operation theaters where skilled providers were available. Discussion with these providers revealed that all of them were independently providing good counseling and quality services. Improvement in quality of counseling and services was attributed to good training and continuous supportive supervision provided by district- and Council-level officials. For example, supportive supervision was repeatedly pointed out by about half of the informants who participated in the IDIs as a facilitating factor for contraceptive uptake by strengthening the technical competence of providers (47 percent), quality of the services (25 percent), and capability of district-level officials in monitoring and implementation of the program (22 percent).

Supportive supervision was consistently implemented throughout the RESPOND Project period. An analysis of the number of such supportive supervisions revealed that in the first four years, a total of 457 supportive supervision visits were made. Of these, 214 (46.8 percent) were jointly carried out by EH staff and district/regional authorities. During joint visits, facilities that were visited received guidance and support. The district/regional authorities were trained on how supportive supervision should be done in a systematic manner. In the remaining 243 (53.2 percent) visits, the supportive supervision was carried out by the health authorities of the district Council and/or regional officials. On average, a total of 110 to 115 supportive supervision visits were carried out every year.

Site visits at 17 hospitals and clinics confirmed that most of the contraceptive methods were available in the RCH/FP units as well as in other departments (e.g., HIV care and treatment

centers [CTCs], labor and delivery, PAC, immunization clinics, and GBV counseling and treatment units) where FP had been integrated with these services. At one HC, implants and IUDs were not available in the store, but all contraceptive methods were available at individual service delivery points within the same facility, confirming no stock-out of contraceptive methods.

Interviews at the district- and regional-level show that Council Health Management Team (CHMT) and other senior officials were confident that with the initial technical assistance from EH, contraceptive security planning is now well established and the R&R (request and receive) system is working smoothly. Overall, during the last year no major stock-outs were reported. This lack of stock-outs seems to be a more recent situation, as the recent (2017) Track20 presentation on the contraceptive stock-out in 2015 shows that at least 60 percent of the dispensaries reported stock-out of one of the five modern methods considered (Muganyizi 2017).

While some of the supportive factors were mentioned by many informants, we did not find any hard evidence to substantiate them. Examples include "improved motivation and efficiency of the providers because of capacity building" and "supportive supervision and their ability to serve many clients with multiple services (as in case of integration of services)." These were reported by only seven informants.

We did not find compelling evidence except for one operations research study supported by RESPOND and carried out by the Population Council (Francis, PI, personal communication, 2017) that appears to support the idea that supportive supervision improved motivation/self-esteem among the workers. The Population Council's study also considered the privacy issue for clients but did not find any significant differences. Similarly, as covered in the discussion of IR4 below, BCC efforts were at best anecdotal. Also, while many of the outreach sessions were organized at dispensaries and HCs that serve rural areas, there was no data to show what proportion of the FP acceptors came from "hard-to-reach" and "very remote villages" as repeatedly mentioned by informants. There were no data to determine what is the proportion of the rural population that could be considered hard-to-reach, except in the case of outreach clinics that made serious efforts to provide services to hard-to-reach populations.

Other Enablers. A content analysis of in-depth interviews identified many other facilitating factors that were reported by more than 10 percent of the informants (Box 2). Enablers that were found important and mentioned by many are discussed under Question IR2 and IR3 below. Our analysis also revealed some of the facilitating factors, including improved motivation/confidence of providers; increased behavior change and communication (BCC)/information, education, and communication (IEC) efforts; and involvement of community leaders. Community health workers (CHWs) were helpful in creating a more supportive environment in addition to playing a role in the uptake of contraceptives.

Constraints and Challenges to Uptake. The key barriers and challenges to contraceptive uptake, as identified by informants interviewed, are listed in Box 3 below. As can be seen from the listed barriers, there are many programmatic constraints and some social and cultural challenges that could adversely affect uptake of contraceptive methods, particularly LAPMs/LARCs. Some of the key constraints that were mentioned by more than 10 percent of the informants have been marked with an asterix (*).

Box 3: Constraints and Challenges	
Programmatic Barriers	**Social and Cultural Barriers**
• Resource/funding constraints to FP program* • Limited staff strength: many hold dual positions* • Facilities lack trained FP providers* • Poor and/or inadequate infrastructure* • Over-crowding at the service delivery point (SDP) with small rooms* • Increased work burden with increase in uptake of clients (more so in integrated districts) • Transfer of trained providers to unrelated positions* • Limited BCC campaign to address rumors and misconceptions about FP methods* • Limited effort to involve males or reach youths • Limited funding to sustain achieved RESPOND success and shifting emphasis to MCH and other health aspects in the current funding context*	• Lack of correct knowledge of FP methods • Misconception/fear of side effects of FP methods* • Adopting FP at young age reduces fecundability • Religious opposition* • Lack of support/opposition from men * • Sexuality/sexual problem after adopting FP • Believe more children gives prestige in community • Difficult access to facility particularly during rainy session* • Lack of transportation • Illiteracy, particularly among women
*Mentioned by more than 10% of informants. Source: Analysis of IDIs.	

Analysis of IDIs (as well as transcripts of FGDs) shows that the key constraints include resource constraints (34 percent), limited staff (29 percent), and shortage of providers trained in clinical contraceptive methods (16 percent). This is reflected in the following typical quote we received during IDIs:

> *"Shortage of health care providers is a serious constraint. We have less trained person and they lack skill. More staff need to be trained. Those who have been trained are often transferred, retired, EH try to replenish trained person, but the process takes time."*

Shortage of trained staff is also reflected in the quality of the services provided and is well reflected in the following quote:

> *"Quality of family planning at the facility level it's still a challenge. Due to shortage of staffs the services provided to clients are of poor quality. Providers are under pressure and they are in rush to attend all clients. This effect client provider's interaction adversely."*

Transfer of trained providers to position/facilities where s/he could not use learned FP skills (13 percent) was frequently mentioned during IDIs and again reflected in the following quote:

> *"Re-allocation of staff from one place to other makes it difficult because you may find staff have been trained this month and the next month they are shifted to another district for some other position."*

Limited BCC effort to remove misconceptions about FP methods (11 percent) was mentioned in in IDIs. The following quote reflected their observation:

"*Lack of awareness among community about FP, sensitization work has not been done. It needs strengthening.*"

Among the social and cultural barriers, a dominant issue was religious opposition (23 percent) of IDIs and it was mentioned both in IDIs and FGDs. A typical IDI quote reflecting this barrier was:

"*Religious barrier is strong, especially among Roman Catholics. They believe it is killing of unborn child. It will take time to remove such misconception and require serious motivational work (BCC) at the community.*"

Fear of side effects (21 percent), wide range of misconceptions and beliefs about FP methods (19 percent), male opposition (11 percent), and illiteracy—particularly among women (14 percent)—were again mentioned frequently as community level barriers to the uptake of contraceptive methods, both during the IDIs (as well as in FGDs). Quotes from IDIs reflecting these beliefs include:

"Education, it's still the barrier, community does not have the right information on contraceptive methods, wide ranging side effects and misconceptions about family planning methods discourage people to adopt some family planning methods. Men do not want to adopt vasectomy because it is feared among men that vasectomy affect erection ability and hence a man cannot do sex after vasectomy."

"In some places, most women prefer using injection, majority said if you use IUD you need to stick with one partner because it only fit to one partner while many women have multiple partners."

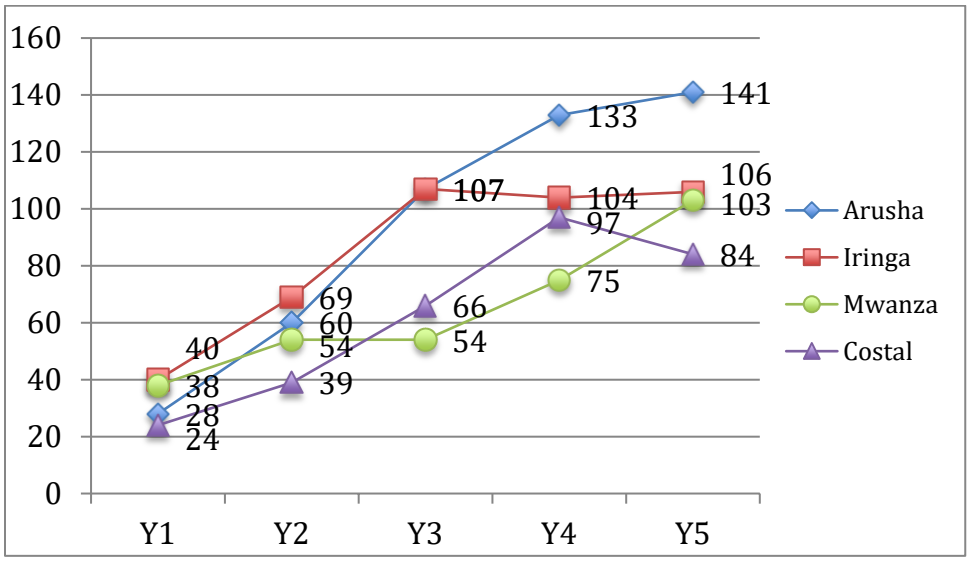
"Customs/traditions and cultural beliefs that having more children is a prestige is another challenge."

"Community believes that young women should not use FP as it may make them sterilize or they lose reproductive ability to produce any more child."

Differential Performance by Area, Gender, and Youth

Differential performance by area. An analysis of FP uptake by region and differentials in acceptance of contraceptive methods revealed a clear difference in uptake by region (Figure 7).

Figure 7. Uptake of LARCs/LAPMs per 1,000 WRA by RESPOND Administrative Zone, Year 1 (2012) through Year 5 (2016)



Source: Analyis of RESPOND database.

As Figure 7 shows, Arusha showed a steep increase in the uptake of contraceptive methods followed by Mwanza. Coastal zones showed a healthy increase but performance decreased in Year 5 (annualized). In Iringa, uptake plateaued after Y3. The reasons are not clear. An attempt was made to see whether the differential performance is due to a differential in capacity building effort. However, the results did not support this hypothesis (Table 6).

Table 6. Differential in capacity building effort by Administrative Zone

	Arusha	Coastal	Iringa	Mwanza	Total
No. trained	962	1376	952	1543	4833
No. of districts in the zone	27	26	17	40	110
No. providers trained / district	35.6	52.9	56.0	38.6	44.9

Source: Analysis of RESPOND database.

The average number of providers trained per district was significantly higher in the Coastal (53) and Iringa (56) zones but their performance was less than Arusha and Mwanza Zones.

Gender of Trained Providers and Acceptors of LAPM/LARC. Both the training of providers and number of clients served was heavily skewed towards women. Most (more than 90 percent) of the providers trained in provision of clinical contraceptives were female and almost all clients who accepted any LAPMs were females. For example, the total number of VSCs reported (2,566) accounted for less than one percent (0.7 percent) of the total 386,240 LAPMs from Year 2 through Year 5. LARCs are only intended for females and male condom use is low: 10 percent of total clients as of Year 5. A conscious effort is required both in training of NSV and motivational work to recruit male providers and clients.

Information on the age distribution of acceptors has not been maintained properly by RESPOND. All acceptors beyond age 25 have been merged into one category of 25 years or more. Available data, however, shows that because of various social and programmatic reasons,

only a relatively small proportion of sexually active adolescents and the younger population are availing of FP services (Table 7). The table also does not show that over time the proportion of adolescents and youth availing FP services is increasing. According to the TDHS, among women currently aged 20-24, 80 percent were sexually active by age 20. This shows the need for giving more attention to adolescents and young populations in motivational work and provision of services.

Table 7. Distribution of FP acceptors in Year 3 and Year 4 in RESPOND districts by age

	LAPM and LARC		Other short-term methods	
Age of acceptors	Y3	Y4	Y3	Y4
10-14	0.2	0.2	0.3	0.4
15-19	6.6	7.2	4.5	11.0
20-24	21.4	23.0	12.9	30.1
25+	71.8	69.6	82.3	58.5
Total number of acceptors	962,140	1,200,024	3,398,661	1,645,222

Limitations of the Data. In assessing the uptake of contraceptive methods and any differential by age, sex, or geographical distribution, we faced many challenges because of data limitations. The most serious limitation was the absence of a denominator. As most of the performance data were available primarily in the form of targets given in workplans and their achievement, assessing impact on the general population was challenging. Similarly, while information from service statistics was available on the number of clients who were counseled at integrated clinics who then adopted FP, no data were collected on how many clients had attended the clinic.

In addition, maintaining a truncated age structure of the contraceptive acceptors, by putting all acceptors aged 25 or above together, makes it almost impossible to assess the demographic impact of the contraceptive use, particularly the impact of LAPMs and LARCs. The number of births averted by sterilization is heavily dependent on the age at which the women get sterilized.

Outreach and FP weeks organized at HCs and dispensaries helps bring FP services closer to potential acceptors. Contraceptive services may not be easily accessible, but the absence of information on the villages where clients had come from to avail of FP services makes it difficult to assess to what extent these approaches helped in reaching remote and hard-to-reach areas. Slight modifications in maintaining the case register could make future evaluations much easier.

It should be also acknowledged that the nature of our sample of service delivery sites was biased toward favorable findings because all sites were chosen by EH based on USAID criteria. Generally, these facilities were close to district centers and easily accessible. All sites had been given several days advance notice that the team would be making a site visit.

Conclusions. The key conclusions are as follows:

- The analysis carried out to answer the first evaluation question (IR1) clearly demonstrates that the RESPOND Project has succeeded in increasing access to contraceptive services and enhancing contraceptive choice, thereby leading to the increased uptake of contraceptive methods, particularly LAPMs/LARCs.

- The evaluation shows that the key factors that contributed to uptake included: 1) capacity building of providers to provide LAPMs/LARCs and 2) organizing outreach and FP weeks to make all contraceptive available along with other MCH services closer to villages.
- RESPOND has improved the quality of services by strengthening monitoring and supervision and ensuring fewer (or no) stock-outs by systematic contraceptive security planning.
- Taking services closer to the community enhances uptake, method mix, and reach to remote areas.
- Building competency of providers and facilities helps enhance routine uptake of FP and method mix.
- Supportive supervision helps maintain quality of services, motivation, and self-efficacy of workers.
- A combination of FP and other MCH/health services provides anonymity for FP services.

EVALUATION QUESTION 2

How did RESPOND's model(s) of integration affect the uptake of FP services from various perspectives, e.g., Local Government Authorities, Service Providers/Health Facilities, and Beneficiaries? Sub-questions: a) Is uptake of FP at sites with integration model(s) better than sites without integration? b) Which integration model is more effective?

Defining Integration. EH defines integration as an approach in which health care providers seize the opportunity to engage the client in addressing broader health and social needs other than those prompting the initial health encounter (EH, Integration: A Key Approach to Health Systems Strengthening,2014). This definition builds on existing literature on integration, including technical guidance from the World Health Organization (WHO) that describes integration as an approach rather than an end in itself (Chan. 2007). WHO defines health services integration as the organization and management of health services so that people get the care when they need it, in ways that are user friendly, achieve the desired results, and provide value for money (WHO, May, 2008).

The Tanzania MOHCDGEC defines integration as provision of the combination of components of MNCH and HIV/AIDS services that are currently delivered and managed separately, with the goal of maximizing coverage and health outcomes for the clients and optimizing the use of scarce resources. In 2012, the Ministry of Health (MOH) released the *National Operational Guidelines for Integration (NOGI) of Maternal, Newborn, Child Health and HIV/AIDS Services in Tanzania*. The guidelines, which were developed in collaboration with EH during the ACQUIRE Project, call for all policy and program actions designed to achieve the integration of MNCH and HIV/AIDS services to be based on 11 guiding principles (MOHSW, 2012) (see Box 4 below).

Box 4: NOGI Guiding Principles of Integration

1. Do not compromise the reliability or quality of existing MNCH and HIV/AIDS services, but instead increase the demand for services and respond fully to clients' needs.
2. Emphasize a continuum of care. Ensure that no opportunities are missed in the delivery of services.
3. Base decisions regarding programmatic interventions on evidence.
4. Build on complementary services and avoid duplication.

5. Foster partnerships and participatory approaches that will address the needs and concerns of all stakeholders.
6. Phase and coordinate planning and implementation to ensure coherent responses to MNCH and HIV/AIDS.
7. Consider human rights, promote gender equity, and improve equity of access to services.
8. Foster community participation by involving young people, key populations, service providers, and the community at large as key partners in the delivery of integrated services.
9. Establish a functional referral system to follow up with patients and link them to MNCH and HIV/AIDS services.
10. Establish a functional commodity logistic system.
11. Ensure that models for integration strengthen systems rather than overburden or overstretch them.

Source: MOHSW. National Operational Guidelines for Integration of Maternal, Newborn, Child Health, and HIV/AIDS Services in Tanzania. 2012.

RESPOND Project Model of Integration. RESPOND implemented a client-oriented service model for integrating FP services into multiple service contexts. Through this model, health facilities offer opportunities for integrating FP information and some level of service provision in a gender-sensitive and respectful manner. As developed by EH, this model requires at least four levels to operationalize integration: the policy level, the program level, the service site level, and the client and community level (EH, Integrating FP and antiretroviral therapy: A client-oriented service model, New York, 2014).

The RESPOND Project employed EH's five-step approach (Farrell, 2015), which is considered fundamental to integration of FP services:

1. *Identifying the level of integration that can be adopted*. There are five levels (Level A to level E) of FP integration based on services provided. These range from providing FP information to clients accessing ART services to providing surgical contraception.
2. *Assessing the health facility's capacity to support integration*. This includes assessment of facility service delivery models, organization of work, work space, and staff functions.
3. *Building or strengthening that capacity to support integration*. This includes systems strengthening such as training of health care workers, supportive supervision, logistics, strengthening referrals, record keeping, and policy.
4. *Identifying the resources needed to support integration*. Resources include partnerships and networks with other stakeholders and capacity building needs.
5. *Phasing in FP methods* to expand the method mix based on the facility's capacity.

Context of Integration in RH. RESPOND has supported the MOH to introduce and implement service integration of FP services in the context of six health service areas: HIV/AIDS, RCH, CPAC, cervical cancer screening, GBV, and VAC care. Clients seeking HIV services and those seeking RCH services share many common needs and concerns; integrating services enables providers to efficiently and comprehensively address them. The integration of FP services into HIV prevention, treatment, and care services provides an opportunity to increase access to contraception among clients of HIV services who do not want to become pregnant and to ensure a safe and healthy pregnancy and birth for those who wish to have a child (WHO, 2009). Integration of FP into CPAC services helps women to limit and space their

pregnancies, prevents subsequent unsafe abortions, and reduces maternal morbidity and mortality (Post-abortion Care Consortium, July, 2017). Furthermore, integration of FP into GBV and VAC services is important in strengthening referral linkages to ensure that GBV and VAC survivors get the social and medical services they need, including their FP method of choice (Motta, et al, 2015).

Selection Criteria for RESPOND Integrated Service Delivery Sites. Starting in Year 1 (2012) RESPOND began the selection of 114 service delivery sites for integration in 32 districts.

The sites were selected based on the following criteria:

- Availability of supportive infrastructure
- Volume of FP clients (high volume sites were preferred)
- Availability of service providers who were eligible to be trained in FP-LARC
- Adequate number of service providers in the facility (to avoid paralyzing services during offsite training)

It is important to note that, compared to typical service delivery sites, these selection criteria are inherently biased towards integration sites with higher volumes of FP clients. Once selected, RESPOND M&E staff visited these sites on a quarterly basis to collect data on integration activities. These data included counts of number of clients who accepted FP from each type of health service area. Unfortunately, as data on client gender and method-specific information were not collected from the service delivery sites, these counts of clients are not disaggregated by gender or type of method adopted.

RESPOND Integration Activities

Examples of RESPOND support for integration of services include the following six areas:

1. **FP integration into HIV Care and Treatment (HCT) services**. This was done in collaboration with the MOHSW and AIDS Relief, whereby RESPOND trained service providers to offer FP within all 26 sites providing CTC services in Manyara Region.
2. **FP integration into RCH**. RESPOND supported access to quality PMTCT services in Manyara region, reaching all health facilities that provide RCH services in the region. A total of 58,467 HIV-positive women accessed FP services from 2012 to 2017. In the same service area, FP was also integrated into under-five immunization services; a total of 85,311 women who took their children for immunization received the FP method of their choice.
3. **Integration of PITC services into FP**. PITC is also taking place as part of regular FP services at 15 supported facilities in Manyara Region. From October 2012 to December 2013, 8,621 FP clients were tested for HIV and received their results. The number of FP clients tested for HIV has more than tripled since this integrated service was introduced in Manyara Region: from 843 in October–December 2012 to nearly 2,700 in October–December 2013.
4. **FP integration into CPAC services.** RESPOND supported the decentralization of CPAC services in 207 facilities in Mwanza and Shinyanga for women experiencing abortion-related complications, incorporating FP services. Of the 6,043 CPAC clients served at RCH facilities from October 2012 to December 2013, 85 percent (5,046)

were counselled on FP and 81 percent (4,090) of the women counselled were discharged with a FP method of their choice.

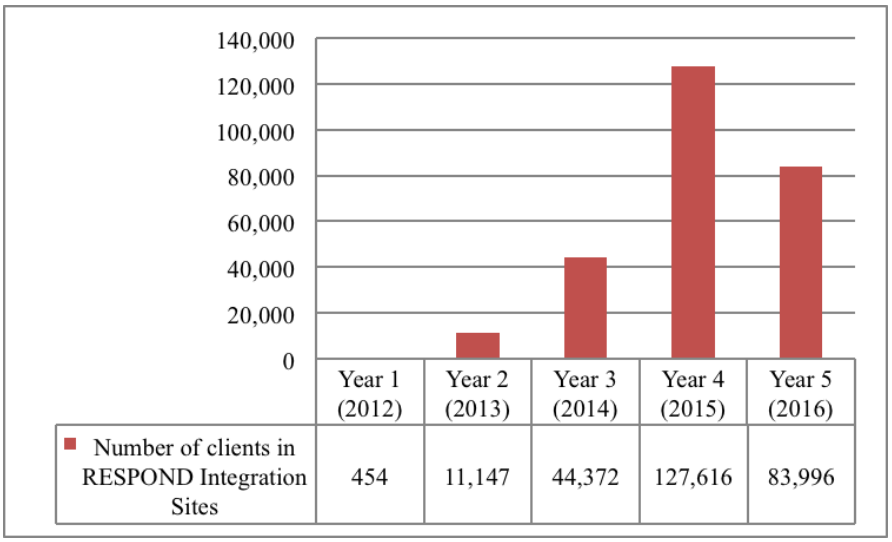
5. **Integration of cervical cancer screening into RCH.** RESPOND supported integration of cervical cancer screening into RCH and FP services at five hospitals in Manyara Region. A total of 3,268 women were screened and 43 were counselled and given FP methods.
6. **FP integration into GBV and VAC care.** RESPOND supported integration of FP into GBV and VAC services at facilities in a total of 48 target areas in Iringa and Njombe regions. A total of 2,647 GBV and VAC survivors were attended at 48 health facilities and were offered a comprehensive package of services, including counseling, PITC, screening for sexually transmitted infections (STIs), cervical cancer screening, FP (including emergency contraception), and male circumcision.

Key Findings

How did RESPOND's model(s) of integration affect the uptake of FP services from various perspectives? There is evidence of an increase in FP uptake by having several additional service delivery points within the same facility providing FP services. Before, RESPOND FP services were only being provided at RCH facilities in the FP clinic/room area. Since 2012, several other service units within the same facility started providing FP services, such as CTC, outpatient departments (OPDs)/STI clinics, tuberculosis (TB) centers, cervical cancer screening clinics, immunization, inpatient departments (IPDs) and postnatal units. The FP services provided include counseling and FP method provision.

Evaluation Team observations: 17 health facilities clearly demonstrated that the integration of FP services with different service delivery points within the same facility is working well. Their visits to the service delivery points in the facilities showed that different contraceptive methods and clinical instruments to provide the FP services were available in the respective clinics and at least one trained FP service provider was posted there. In three facilities however, they found that a trained FP provider was not available. In these cases, they had a good understanding with the FP unit and if a client wanted a clinical method, the FP provider from the FP unit came and provided the required services without any delay. In one clinic, they took the client to the FP clinic and she was provided the services on a priority basis. The impact of such integration is well reflected in the data supplied from RESPOND for the 114 integrated service delivery sites. As shown in Figure 8, over time this integration approach has increased FP uptake from just 454 clients in Year 1 (2012) to 83,996 in Year 5 (2016).

Figure 8. Number of clients received FP methods from service areas in 114 RESPOND integration sites by year



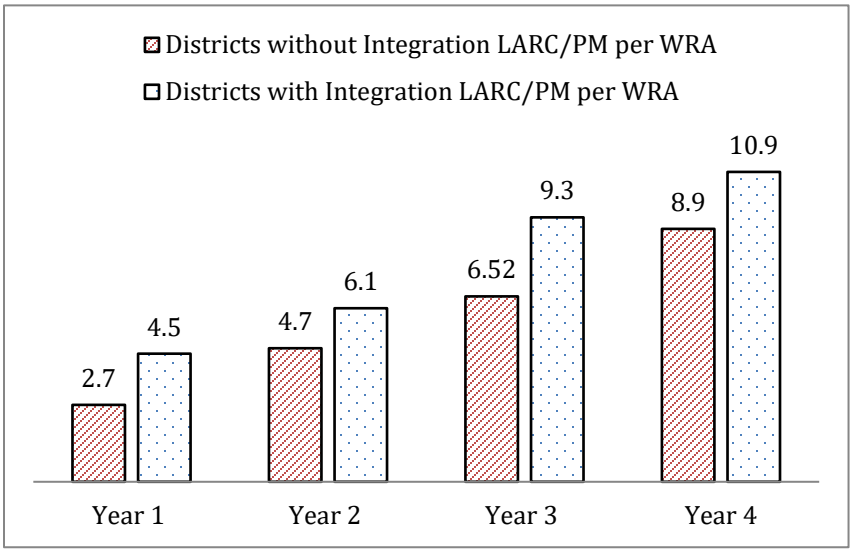
Source: RESPOND Database.

This finding from secondary data is substantiated by comments from the interviewees in the field. Most of the service providers and implementers (59 out of 76 IDIs) were positive on the impact of integration on FP uptake. They felt this approach has been very important in minimizing missed opportunities. The following is an example from an interview with a health official:

> *"Integration allows clients to receive FP services anywhere at the facility, which minimizes chance of missing a potential client. For example, we were missing several clients at our facility because they used to come, once they see FP clinic is full they go back home… simply because FP is not an emergency."* – Health Official, Manyara

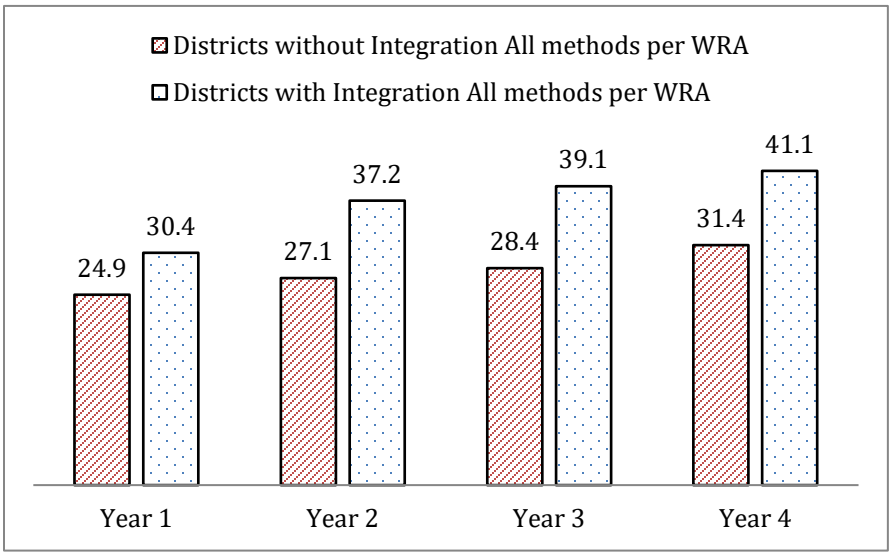
In addition, RESPOND secondary data demonstrates that districts with integration had more FP uptake than those without integration. See Figures 9 and 10 below.

Figure 9. Percentage of WRA accepting LARCs/LAPMs from Year 1 (2012) to Year 4 (2015)



Source: RESPOND monitoring data.

Figure 10. Percentage of all FP methods accepted by WRA from Year 1 (2012) to Year 4 (2015)



Source: RESPOND monitoring data.

Overall, from the above analysis it appears that districts with integration sites had higher FP uptake compared to those without integration. However, the difference of difference[2] for the

[2] The difference between the percentage of acceptors for LARCs/LAPMs in the first year for the sites with integration and those without integration in Figure 9, which is 4.5-2.7, equals to 1.8 and the difference of the same in the last year is 10.9-8.9, which equals to 2. Now, taking the difference of the difference of the percentage of acceptors for LARCs/LAPMs for the first and last years is 2-1.8 which equals to 0.2. This difference is statistically insignificant. The difference between the percentage of acceptors for all the methods in the first year for the sites with integration and those without integration in Figure 10 is 30.8-24.9, which equals to 5.9. The difference of the same in the last year is

uptake of LARCs/LAPMs (Figure 9) found no statistically significant difference between integrated and non-integrated districts. But when the uptake of all contraceptive methods taken together is considered (Figure 10), that same analysis shows a significant increase of FP uptake in the integrated districts. This implies that integration may increase uptake of short-term methods more than LARCs/LAPMs. Similar findings were noted in the RESPOND-funded Population Council operational study done in Mtwara (Population Council, personal communication, 2017).

Stakeholder Perspectives on Integration. Integration is perceived differently by different stakeholders. While most of the service providers see it as an important approach for the provision of FP services, some clinicians see it as something that adds to the workload. For example, clinicians at OPDs see this integration as something that adds burden for them. The following is an example of this sentiment.

> *"Integration reduces workload at RCH and adds at OPDs, OPD serves large number of patients and still clinicians have to counsel patients for FP methods, I think this is not working in that area."* – Health Official, Arusha

From the FGDs that were conducted with community members, the word integration was not well understood. But further probing found that participants were aware that now more services are provided at the same place/unit, like counseling on FP during antenatal care (ANC) clinics. This change was seen as something new and good.

Which Integration Models Accelerate FP Uptake Most? Based on field interviews, most of the respondents mentioned FP-Immunization as the best integration model for increasing client uptake of FP methods. Other integration models that were felt to be effective included labor and delivery for PPIUD, postnatal, and CTCs. Informants frequently mentioned that women do not want to miss immunization services. Even husbands who are not very supportive of FP usage may remind their wives to attend an immunization day. Immunization services offer several encounters between providers and women, creating an opportunity to provide them with FP information and services at a critical time (the 12 months following birth, HIP, 2014). A modeling exercise using data from five countries in sub-Saharan Africa demonstrated that reaching postpartum women through immunization contacts could decrease overall unmet need for FP by 3.8 to 8.9 percentage points (Kuhlmann, et al, 2010.) The period when a woman takes her child for immunization is very conducive for FP services. Although many informants who felt FP immunization integration is the most effective, they also mentioned that the immunization outreach program, which is provided monthly within the community, is the approach that increases FP uptake most, rather than immunization at the health facility. The following is an example of comments made on immunization clinics and FP:

> *"Women never miss immunization schedule for their children, they might miss or be reluctant to come for FP method when given a different date but for immunization of the child they always come."* – Health Official, Arusha

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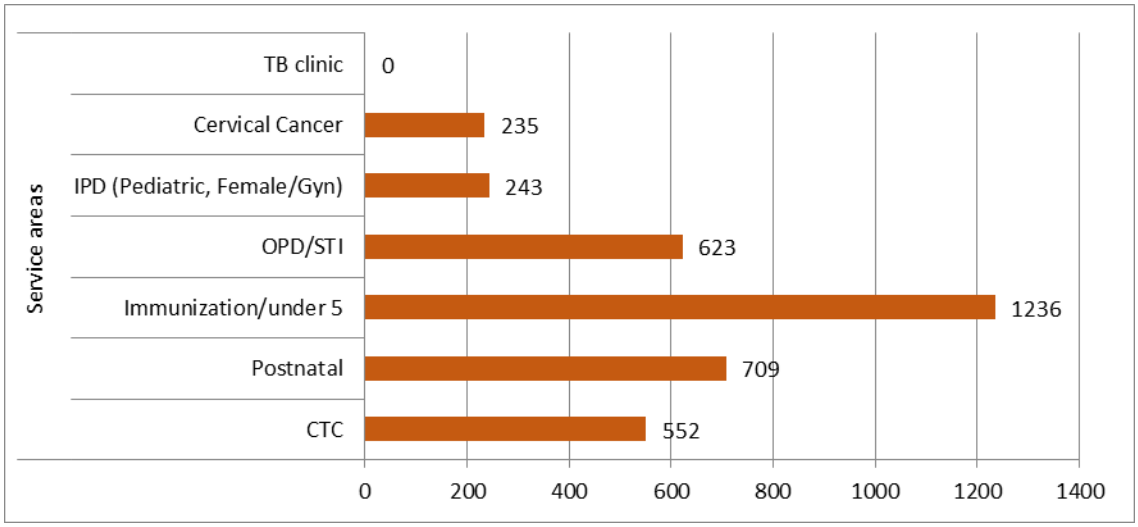
41.1-31.4, which equals to 9.7. Now taking difference of the difference of the percentage of acceptors for all the methods for the first and last years is 9.7-5.9, which equals to 3.8. This difference is statistically significant.

These findings from interviews reinforce findings from RESPOND secondary data analysis shown in Figure 11 below. It suggests that immunization services—followed by post-partum, OPD, and CTC—are the most effective area for increasing FP uptake.

Figure 11. Average number of clients who received FP services per clinic by type of service integration over five years



Source: RESPOND monitoring data.

Key Achievements

Development of the NOGI. As noted above, RESPOND provided support for the development of the national guidance document for the implementation of integration of MNCH and HIV/AIDs in Tanzania. This document was disseminated in September 2014 after it was piloted. Since then it has been crucial in providing guidance on the issues of training of service providers and orientation of Regional Health Management Teams (RHMTs) and Council Health Management Teams (CHMTs). The NOGI provides guidance for each type of facility to implement suitable types of integration. The NOGI also provides guidance to health care workers at all levels to provide integrated HIV and MNCH services and address issues of human resources, support, supervision, and functional referral systems, as well as M&E, which are essential components for integrated services. As indicated by a RESPOND staff member:

> *"No NOGI, no integration because it provides all the needed direction for the implementation of feasible and standard integration at all levels of health facilities..."* – RESPOND staff

Trainings for Service Providers and Orientation to RHMTs and CHMTs on Integration. Initially, in 2012, RESPOND supported a whole-site orientation to all staff in those facilities selected for implementing integration of services. This was a one-day orientation, done at the facility level, and involved all staff at the facility. In that year, some 500 staff were trained in facilities selected to provide integrated services.

From 2012 to 2014, RESPOND supported training of 270 health care providers from various service areas in order to provide integrated services in their health facilities. These trainings have provided or equipped these service providers with knowledge and understanding of the integration policy, how it has to be implemented, and how to collect data for integration. In addition, during the same time period, RESPOND supported integration orientation of 498 members of regional and council health management teams and FP/RH implementing partners

(e.g., MSI, PSI, JHPIEGO, AIDS Relief, CARE International, and Elizabeth Glaser Pediatric AIDS Foundation [EGPAF)]. This training intended to create awareness at the level of regional and district governance, which has a mandate to supervise and support health facilities at their respective areas. These orientations gave service providers the capacity to implement integration. The effectiveness of these orientations was commented on by both RESPOND staff and Tanzanian Health officials:

> *"In the past only nurses from RCH were talking about FP services, but now even clinicians at IPD know about FP services and this has been key in increasing FP uptake in those facilities because everywhere people are now talking about family planning…"* – RESPOND staff, Arusha

> *"We have so many challenges in the health system which makes implementation of integration sometimes difficult, one of them being staff deployments, orientation made me aware of the importance and impact of integration to my district was able to find ways to improve those challenges at the facilities…"* – Health Official, Manyara

Facilitating Factors. Based on IDIs, site visits, and document review, the most important facilitating factors for integration included:

- The availability of the NOGI, which provided clear guidance for implementation at multiple levels of service delivery.
- Orientation of staff at the regional and district level (i.e., RHMTs/CHMTs), which was essential to ensure proper orientation for essential staff.
- Availability of multiple trained staff, required equipment, and counseling kits in order to ensure a fully prepared staff and infrastructure and multiple levels.

Integration Provides Anonymity for Clients. Based on interviews with health care providers and RCH coordinators it emerged that a key facilitating factor from integration is its ability to provide anonymity for women seeking FP services. The existing reservations of males related to FP means that many women are unable to use FP methods or have to use them with high confidentiality because they are afraid of opposition from their partners. Having integration means women may be coming to the health facility and visiting service areas for different purposes and at the same time getting the FP method of their choice. Several informed staff, including an RMO, attested to this. A typical comment is reflected in the following quote:

> *"Integrated approach provides smoke to women to avail FP services, if husband is against contraceptive use…"* – RMO

Limiting Factors/Challenges. Based on IDIs, site visits, and document review, the most important limiting factors for integration included:

- Staff deployment and turnover remain constant ongoing problems that affect the feasibility of integration. Without additional trained staff adding their capacity to that of existing staff—particularly at MCH clinics, postnatal units, and OPDs—providers give less amount of time to each patient, reducing the quality of services.
- HMIS tools are not integrated. While significant improvement has been made in HMIS at the clinic level, service registers for FP clients have not been properly coordinated while adopting an integrated approach by adding FP services to various service units of the same facility. Hence, from HMIS it is not possible to assess the impact of integration on

provision of specific types of FP services. Presently FP service statistics are kept in a separate register and at the end of the month they is merged with the FP statistics of the RCH unit and that is forwarded to the district level. An effort to integrate the service statistics at each SDP within the facility could make the assessment of impact of integration much easier.

- Infrastructure not enough to support integration at all service locations within a given service delivery site. The small room size of clinics is mostly not sufficient to serve or even store FP clinical tools and supply.

Conclusions

- Integration needs systematic and comprehensive implementation: from region to district, training in clinical skills, integration process, administration, and M&E.
- Not all facilities are fit for integration. Priority should be given to facilities with a large volume of clients, adequate space, and proper staffing.
- Commodity security needs to be ensured at all facilities that are considered fit for integration, with special attention paid to providing commodities to all appropriate locations.
- Integration of PPIUD in labor and delivery and FP services within the immunization clinic and postnatal services are considered among the best practices and should be given special attention.
- HMIS tools need to be properly integrated in order to sustain quality data collection and data usage among all sites providing FP services.

EVALUATION QUESTION 3

How did RESPOND's district-centered approach result in strengthening the capacity of local government to manage and implement FP programs?

Based on the ACQUIRE Tanzania Project, EH recognized it was critical to use a district-targeted approach to maximize the impact of interventions to ensure good national coverage and regional equity (RESPOND, 2012). The district-targeted approach focuses on districts with the highest unmet need and demand for FP. As explained above (see *Evaluation Methods and Limitations*), EH conducted an analysis of mainland regions based on the 2010 regional CPR and grouped regions into three categories of CPR, i.e., low CPR (Level 1=10-29 percent), medium CPR (Level 2=30-39 percent), and high CPR (Level 3=40-50 percent). EH then selected 110 districts based on an analysis of FP uptake per 10,000 WRA that grouped districts into the three categories: FP uptake 1 (311 to 2,827), FP uptake 2 (1,686 to 4,310), and FP uptake 3 (2,671 to 11,131). FP uptake per 10,000 WRA is a tool that ATP developed to measure FP uptake and assess the performance of different districts in the absence of CPR data at the district level (RESPOND, District Approach, Undated). The initial selection appears in Annex II.E.

District-focus Activities

In Level 1 districts, RESPOND directly supported a full package of interventions which included, but were not be limited to, integrated FP outreach (i.e., FP weeks) that were conducted on a quarterly basis, monthly outreach, and strengthening special service days and routine FP services. In addition, RESPOND conducted service provider training using central and on-the-job training (OJT) approaches and assisted districts to form commodity security committees to

ensure that FP/RH commodities reach the last mile. Tables 8 and 9 provide examples of the distribution of modes of service delivery events by level of district. RESPOND conducted similar but much less intensive activities in Level 2 and 3 districts, with a lower emphasis on LARCs and LAPMs. As shown in Table 8, with each year, the proportion of activities in Level 1 districts with service delivery events decreased: from 50 percent in Y1 to 23.5 percent in Y4. This is due in part to the fact that over time districts graduated to Level 2 and 3; so there were fewer Level 1 districts available for service delivery events.

RESPOND also conducted trainings for members of the RHMTs/CHMTs to strengthen their skills and capacity in leadership and management. For example, in Year 3, RESPOND partnered with the WHO and the Center for Education Development in Health Arusha to train 121 newly appointed DRCHCOs and DMOs in leadership and governance. In the same year, RESPOND focused its efforts on district-level advocacy, with a special emphasis on building the capacity of districts for FP/RH planning and budgeting.

RESPOND continued its prior activities under the ACQUIRE Project to collaborate with the National FP Technical Working Group in 2017 to revise *the National Package of Essential Family Planning Interventions* for the CCHPs (after having led its initial development in 2010). This important document describes priority FP activities and their unit costs and is a practical tool to allocate resources for clearly defined FP initiatives within the CCHPs. The revisions were mainly due to government emphasis on service delivery to align with the 2011 CCHP development guidelines (RH staff personal communication, MOHCDGEC, January 2017).

Table 8. Distribution of modes of service delivery events by level of district, October 2012 to September 2016

Activities for all 110 Districts (2012-13)	**Level 1**	**Level 2**	**Level 3**	**Total**
Outreach	32	25	18	75
FP weeks	51	27	17	95
Service days	41	19	18	78
Sub-total for Year 2012-13	124	71	53	248
% of total events	50%	28.6%	21.4%	100%
Activities for all 110 Districts (2013-14)	**Level 1**	**Level 2**	**Level 3**	**Total**
Outreach	122	91	51	264
FP weeks	52	32	30	114
Service days	81	85	23	189
Sub-total for Year 2013-14	255	208	104	567
% of total events	45%	36.7%	18.3%	100%
Activities for all 110 Districts (2014-15)	**Level 1**	**Level 2**	**Level 3**	**Total**
Outreach	95	92	64	251
FP weeks	80	73	61	214
Service days	63	63	59	185
Sub-total for Year 2014-15	238	228	184	650
% of total events	36.6%	35.1%	28.3%	100%

Activities for all 110 Districts (2012-13)	Level 1	Level 2	Level 3	Total
Activities for all 110 Districts (2015-16)	**Level 1**	**Level 2**	**Level 3**	**Total**
Outreach	64	90	80	234
FP weeks	64	72	55	191
Service days	21	86	101	208
Sub-total for Year 2015-16	149	248	236	633
% of total events	23.5%	39.2%	37.3%	100%
Total for Years 2012-2016	**766**	**755**	**577**	**2,098**
Overall % of events	36.5%	36%	27.5%	100%

Source: RESPOND Annual Reports.

RESPOND mobilized district- and regional-level "champions" to advocate for inclusion and/or expansion of support for FP-LAPMs into CCHPs and trained district managers in using DHIS2 data for CCHP budgeting. According to EH staff these "champions" are people recruited at different levels to be change agents for FP. They include, for example, political/religious leaders, healthcare providers, and satisfied clients. Their influence depends on their status in the community. This approach follows a guide EH developed during the ACQUIRE program that was also used during the RESPOND Project (MOHSW, 2010).

EH also trained and supported regions and districts to conduct integrated supportive supervision, including joint visits with RESPOND and MOHCDGEC through the four RESPOND Field Offices. As part of this effort (see Table 9) Regional and District Health Managers were also given updates on what contraceptive methods should be available at each level. Interviewed members of RHMTs and CHMTs reported that RESPOND funded per diems and transport (fuel) for conducting supportive supervision. Lack of funds was reported as being a major challenge in the past that led to delay or skipping of supervisions.

Table 9. Training of service providers per level of districts

	Level 1	Level 2	Level 3	Total
Centralized training on LAPMs	60.0%	20.0%	20.0%	100%
Centralized training on LARCs	40.0%	30.0%	30.0%	100%
On-the-job training	25.0%	35.0%	40.0%	100%

Source: RESPOND Year 1 Workplan Narrative, 2012.

As part of data quality improvement efforts, RESPOND trained district-level supervisors on data quality assessment (DQA), which was conducted on a quarterly basis as part of supportive supervision. RESPOND trained district and facility health managers in data interpretation and use for decision-making, such as ordering of drugs and other commodities. To further facilitate data quality improvement, respondents reported that the last two days of every training to service providers were dedicated to data management at the facility level. To facilitate timely data entry at the district level, RESPOND provided computers (PCs) and modems to some districts as well as mobile phones and airtime to data clerks, Regional Reproductive and Child Health Coordinators (RRCHCOs), DRCHCOs, and HMIS focal persons to facilitate calling facilities to clarify any data quality issues. In some districts, RESPOND was reported to have trained staff on maintenance of computers and other electronic devices.

RESPOND was frequently reported by respondents as having supported some regions and districts to strengthen coordination of health services at the district level, including FP. In such regions and districts, RESPOND worked with RHMTs/CHMTs to organize partner coordination meetings where every partner shared their work plans.

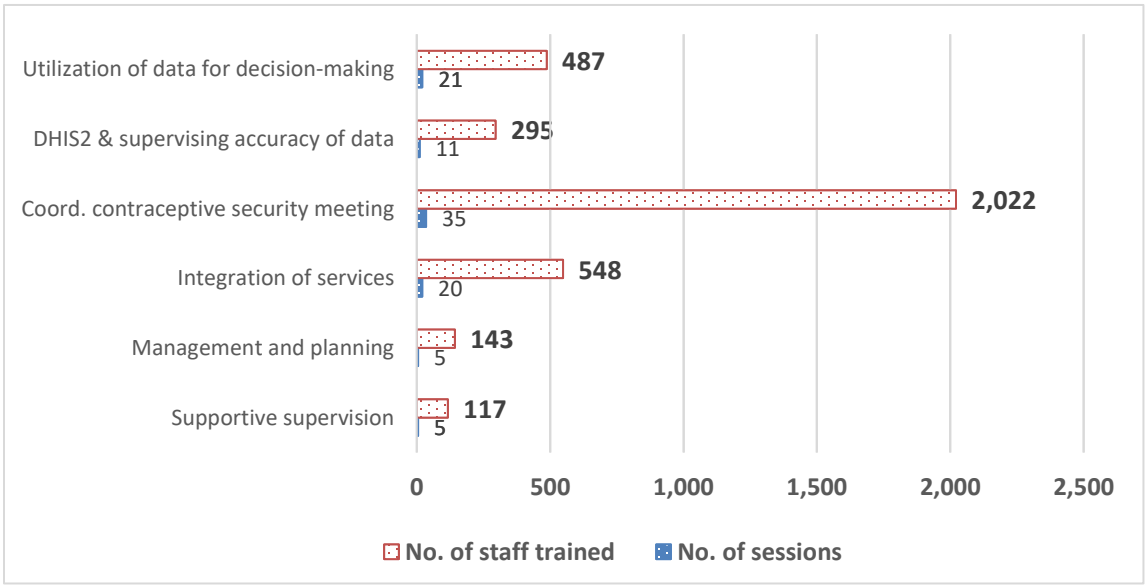
RESPOND had a plan to start phasing-out some of the technical and financial assistance by Year Four and transfer program ownership to respective CHMTs by Year 5 after having strengthened services and moved these districts to a certain level of sustainability (defined as having improved capacity to plan, implement, and support priority FP/RH activities). Based on interviews with USAID and EH, however, it was understood that this plan to phase out was not implemented out of an awareness that sustainability had not been achieved and out of concern that there would be a major drop off in uptake of methods.

Key Achievements

This section examines how the district-targeted approach affected: 1) the local government's capacity to manage and implement FP programs, including supervision and coordination of FP/RH activities at the region and district level; 2) FP/RH resource allocation in the CCHPs; and 3) implementation and roll-out of DHIS2, including data quality and use. This section also presents examples of key achievements of the district-targeted approach, including the facilitating and limiting factors and the key findings from implementing the approach.

Regional and District-level Capacity Built to Support Integrated Services. As shown in Figure 12, a large number of government staff were trained in various project leadership and management skills at the regional and district level. By Year 4 (2015), RESPOND had trained 3,612 RHMT/CHMT members. Of these, the majority (2,022) had received training in coordination of contraceptive security, while 548 had received training on integration of services, 487 had been trained on the use of data for decision-making, 143 received training in management and planning, and 117 received training in supportive supervision.

Figure 12. Number and type of trainings provided to RHMTs/CHMTs as of Year 4 (2015)



Source: RESPOND database.

Findings from in-depth interviews among members of RHMTs and CHMTs established that many had benefited from the various trainings that were offered by EH through the RESPOND project. A significant proportion of regional and district health managers (23 of 34) reported that they can better plan and manage the various program activities now after having received training as compared to before they received training. Members of RHMTs and CHMTs frequently voiced appreciation for RESPOND training on supportive supervision. They reported that, prior to the training, supervision was mainly managerial and RESPOND trained them to do mentoring and coaching of staff. Regional and district health managers reported that training gave them more confidence to assess facilities as compared to before, when they had limited knowledge on facility level issues. In line with the regional and district level managers' reports, the majority of facility staff interviewed reported a difference in the supportive supervision conducted during the RESPOND implementation as compared to before. RHMT and CHMT members are now more friendly and supportive during supervisory visits, as the quotes below illustrate:

> *"The other difference is that they now come in a friendly way, not like in the past when it was like a harassment. At times, they would shout at you in such a way that you would even fail to understand and repeat the same mistake when they come again…"* – RCH in-charge

> *"Compared to the past which were intimidating, now days supervisions are there to help us and they really make it possible for us to do what we have decided together during the supervision…"* – RCH in-charge

This is also illustrated by the following quote:

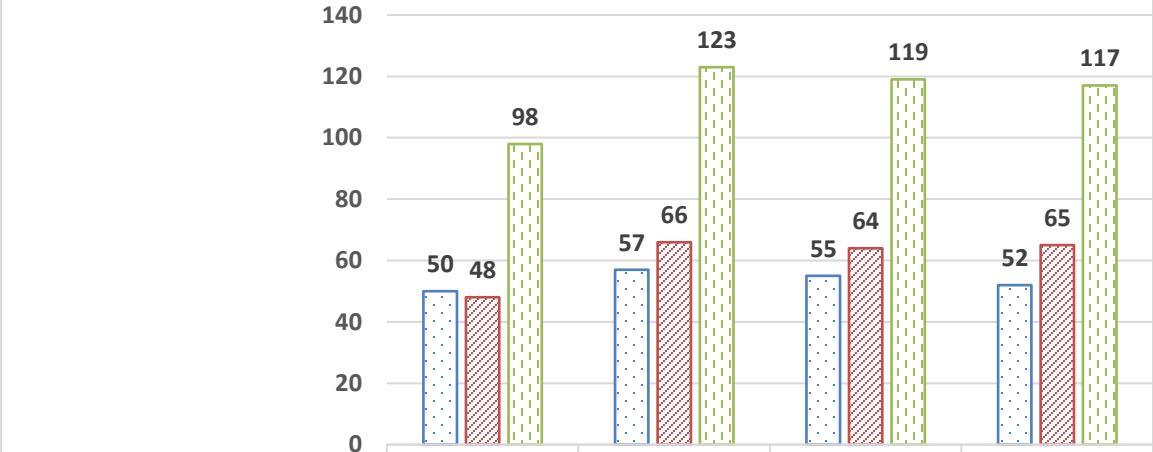
> *"Managers have been trained and can now do supervision confidently. Before managers were even afraid to ask questions to the providers as they themselves did not have sufficient knowledge…"* – RRCHCO

The improvement in supportive supervision was reported by almost all (31 of 34) key members of RHMTs and CHMTs and some of the facility staff (12 of 28) that were interviewed for this assessment. Moreover, the number of supervisions was reported to have increased while the supervision tool was also reported to being more comprehensive for FP. Based on in-depth interviews, it should be acknowledged that this comprehensiveness was also a result of RESPOND collaboration with other FP partners.

> *"In our previous tool, FP items were very few. In the new supervision tool, there is a lot on FP. Hence, we now do comprehensive supervision on FP…"* – DRCHCO

Figure 13 shows the number of both joint supportive and non-joint supportive supervisions that were conducted during the RESPOND period of activity. In line with qualitative findings, the figure shows a slight increase in the number of supportive supervisions between 2012 and 2015, which were distributed almost equally among joint and non-joint supportive supervisions. In general, each district planned to conduct supportive supervision on their own with a goal to visit each facility at least once every quarter. In each district, members from the CHMTs (where feasible accompanied by members of the RHMT) would visit two to three facilities in a day.

Figure 13. Number of supportive supervision activities (joint and non-joint) by year



	Y1(2012)	Y2(2013)	Y3(2014)	Y4(2015)
Joint supportive supervision	50	57	55	52
Non-joint supportive supervision	48	66	64	65
Total supportive supervision	98	123	119	117

Source: RESPOND database.

Improved District Coordination and Partners Collaboration. In regions and districts where RESPOND worked with RHMTs and CHMTs to organize partner coordination meetings, it was reported that these meetings were very instrumental in reducing duplication of efforts among partners. Respondents stated that many partners are now sharing their workplans, which facilitates the ability of CHMTs to coordinate and monitor their activities as the quotes below illustrate:

> *"EH also initiated the partners coordination meeting where each partner presented their plan and this was very helpful in avoiding duplication of efforts, in particular by these three partners (EH, MSI, and PSI) – at times all the three partners used to meet at one health facility, all wanting to do supportive supervision on just a single provider working there..."* – RRCHCO

> *"Before they used to go by themselves without involving us. Through the partner coordination meeting this challenge has been taken care of. Now, they share their plans and we tell them if where they plan to go there is already another partner..."* – DRCHCO

Increased Resource Allocation for FP in CCHPs. Through targeted advocacy, capacity building, and technical assistance in budgeting by RESPOND and other implementing partners, there was an increase in the proportion of the 110 districts allocating funds for FP in CCHPs. Advance Family Planning (AFP) provided leadership for national-level advocacy efforts that have been a factor in encouraging greater MOH funding at the national level (Advance Family Planning, January 2015).

Based on in-depth interviews and data received from EH, the type of activities funded from districts' own sources included community mobilization, outreach, staff attendance to key meetings, and purchase of commodities (e.g., jik and kerosene). These activities are clearly defined and budgeted in the above-mentioned document that RESPOND developed for CCHPs. This important work of RESPOND has clearly facilitated the CCHP budgeting and implementation process. There is also evidence that districts have increased allocation of local

sourced funds for FP in their CCHPs (Table 10). The increased proportion of CCHP allocations for FP funded by district or the MOH (up from 64 percent in Year 1 to 84 percent in Year 5) is demonstrated by EH data in Table 10. A significant proportion (42 or 84) of respondents reported an increase in funding for FP activities from district funds, as the quotes below illustrate:

> "*CCHPs are now including new budget items like FP days and community mobilization that were not budgeted for before… and some councils are already implementing activities using their own funds...*" – RRCHCO

> *"EH used to fund MOH staff attendance to these meetings but through sensitization and consideration for sustainability now CCHP pays for MOH staff to attend. This has, however, been a challenge when there wasn't a budget line in the CCHP to cover such costs, where the councils decided to give the money as loans to the staff so that they attend these meetings..."* – RRCHCO

As shown below in Table 10, the number of districts with CCHPs with FP allocations increased steadily from 51 districts in Year 1 to 91 districts in Year 5. Important findings from the key indicators in Table 10 include: a) the number of districts allocating funds for FP has almost doubled; b) with the caveat that some partner funding may not be reported, since more than 80 percent of CCHP FP budgets in Year 3 is sourced from MOHCDGEC or the districts; and c) the total value of CCHP funds for FP almost doubled from US$ 258,545 in Year 1 to US$ 465,222 in Year 5. These trends can be attributed, at least in part, to RESPOND advocacy and capacity building.

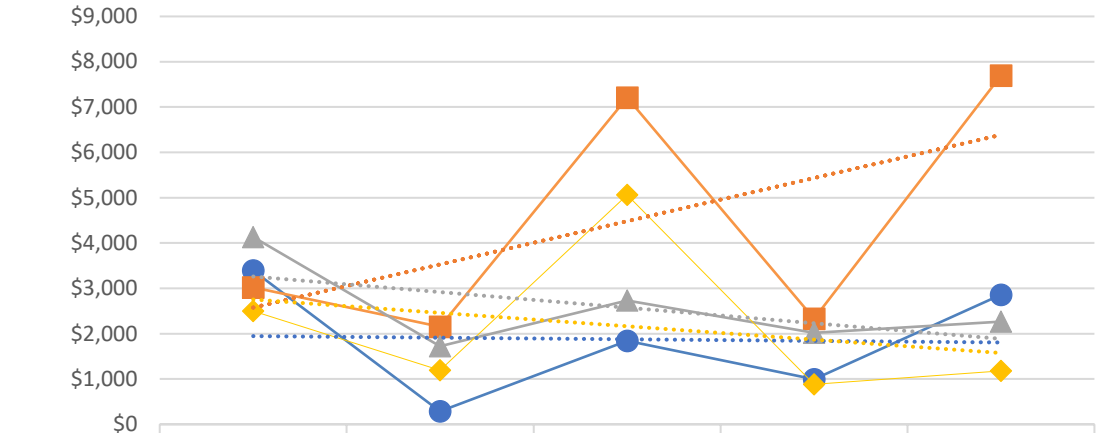
Table 10. Key indicators for CCHP funding of FP, Year 1 (2012) to Year 5 (2016)

	Year 1	Year 2	Year 3	Year 4	Year 5
Number of districts allocating CCHP funds for FP	51	53	60	89	91
% of districts allocating funds for FP in CCHPs	46%	48%	55%	81%	83%
% Total CCHP FP funds from district/MOHCDGEC	64%	70%	81%	92%	84%
Total US$ value of all CCHP funds for FP (all districts)	$258,545	$117,749	$378,947	$178,862	$465,222

Source: RESPOND database.

While the increase in total US$ value of CCHP funds from Year 1 to Year 5 is impressive, when adjusted for the number of districts allocating funds within each of the four RESPOND administrative regions, the trends in amounts allocated per district have not increased (except for Mwanza, see Figure 14). Trend lines are negative for three of the four RESPOND administrative regions. Average allocation per district declined from Year 1 to Year 5 in three of the four RESPOND administrative regions. Mwanza shows a very large increase from US$ 3,020 to US$ 7,695 per district (a very significant amount). The evaluation team was not able to determine why Mwanza increased by so much and requested an explanation from EH. EH staff did not have a clear answer for this trend in Mwanza but suggested it might be that advocacy was more systematic in the Lake zone (EH personal communication, 2017). It was also unclear why trends in per-district allocations vary by year with a surge in Year 3 and Year 5 and declines in Years 2 and 4.

Figure 14. Trends in per-district average FP funding allocations in CCHP from district MOHCDGEC sources by year for 110 districts, Year 1 to Year 5 in four RESPOND administration areas in US$



	Year 1	Year 2	Year 3	Year 4	Year 5
Arusha	$3,392	$286	$1,843	$997	$2,861
Mwanza	$3,020	$2,153	$7,211	$2,328	$7,695
Coast	$4,133	$1,723	$2,730	$2,016	$2,268
Iringa	$2,502	$1,193	$5,061	$883	$1,181

Note: Amounts are converted from TZS to US$ each year based on *Oanda.com* average annual exchange rates (https://www.oanda.com/currency/average): Year 1 (1 US$=1,628 TZS); Year 2 (1 US$=1,660 TZS); Year 3 (1 US$=1,844 TZS); Year 4 (1 US$=2,209 TZS); and Year 5 (1 US$=2,249 TZS).

Source: EH data, July 2017. The complete data set is presented in Annex II.F.

Improvement in Data Quality and Use for Decision-making. Data quality improvement (DQI) activities by RESPOND and other partners were reported to have improved the accuracy, completeness, and timely reporting of services data. For example, an improvement in FP reporting rate was reported: up from 80 percent (October-December 2013) to 97 percent (July-September 2016). During the same period, reporting timeliness improved from 33 percent to 94 percent (EH data). Several health managers (27 of 34) at the regional and district level reported they observed improvements in the quality of data submitted by facilities. However, most also admitted that data quality was still an issue that needed more effort. The improvement in data quality was reported as having resulted from detailed DQA activities that were initiated by RESPOND. Previously, DQA was superficial; it now involves detailed procedures, as explained by one of the respondents for this assessment in the quote below:

> *"We look at the registers, then we look at the tally sheets to see whether what is in the register is what is in the tally sheet. Then we compare with what was reported (in the monthly summary report) to see whether what was reported is what is in the register and tally sheets. We do not end there, we also go to the district person whom the data was sent to see whether the data was correctly entered in the DHIS2 system. This helped a lot in improving data quality..."* – RRCHCO

The increase in use of data for decision-making was also mentioned among RESPOND's achievements by the majority (22 of 34) of respondents at the district and regional level. Previously, health managers used to make decisions based on guesses and assumptions, which resulted in under-estimations of budgets and hence frequent stock-outs of commodities. The

improvement in data use, especially for commodities forecasting, was reported as having led to significant reduction in stock-outs of commodities at facilities in the project catchment area. Use of data was also reported as having facilitated several other management decisions as depicted in the quotes below:

> *"Before data was not being used for planning but now data is being used for planning, including ordering of various commodities and equipment. For example, currently, we have no stock-out of FP commodities because they request based on the demand established through data as compared to before when they just used to guess..."* – RRCHCO

> *"Districts are now ordering commodities based on actual data. Districts can now use the data to decide whether some dispensaries should be upgraded to health centers: based on the numbers of clients served. Data is also being used to inform managers on the various needs, e.g., need for theatres at some facilities and extra number of facilities in some districts..."* – Zonal RCHCO

Other Key Achievements of the RESPOND Project. In addition to the important CCHP budgeting document cited above, through RESPOND EH developed several program-guiding and supporting documents in collaboration with MOHCDGEC and other implementing partners. Key documents developed by EH during RESPOND in collaboration with partners include: NOGI (2012); trainee follow-up guidelines (2014); and OJT curriculum to ensure that OJT is structured and standardized (no date available).

RESPOND also reviewed and updated the FP and GBV/VAC training curricula and FP Procedure Manual in 2016.

Following successful development of a booklet on "Uislamu na Uzazi wa Mpangilio" ("FP in the Islamic Context") in 2010, RESPOND in collaboration with MOHCDGEC, Health Promotion Tanzania (HPT), Tanzania Interfaith Partnership (TIP), Tanzania Christian Council (CCT) and Tanzania Episcopal Council (TEC), developed a booklet in 2015 on "Family Planning in the Christian Context." Two years later, this document is still not circulated and is only now being pretested; the roll out for this document seems unduly slow (based on results from in-depth interviews).

The extent to which the above documents have been disseminated could not be established during this evaluation.

Best Practices

The district-targeted approach— i.e., allocating higher resources and efforts to less performing districts— was frequently cited by respondents as a best practice. Other best practices that were mentioned by respondents include:

- Orienting CHMTs, particularly District Health Secretaries, on the importance of FP: this facilitated inclusion of FP activities in the CCHPs.
- Partners sharing their work plans with CHMTs: this reduced duplication of efforts.
- Data sharing and review meetings: this facilitated discussion of data quality issues.
- Joint supportive supervision consisting of RHMTs, CHMT members, and EH staff, which increased awareness on the importance of FP services among regional and district health leaders and facilitated timely communication (and in some cases solutions) of identified challenges.

Limiting and Facilitating Factors

The following were frequently mentioned as limiting factors that reduced the successful implementation of the district-targeted approach:

- Competing demands on the limited financial resources available for CCHPs.
- Even after approval of FP budget at the district and regional level, some FP activities could be omitted from the CCHPs at a higher level.
- A few partners were still not sharing their workplans.
- Limited funds to conduct joint supportive supervision and key meetings on a regular basis.
- Many of the interviewed regional and district health managers, even those who were employed long-term during the time of the RESPOND program, had little or no understanding of the district-targeted approach. This low level of awareness was a surprise to the EvaluationTeam, which had assumed that it would be universally recognized and understood by regional and district-level managers.

The following facilitating factors that contributed to the successful implementation of the district-targeted approach were frequently mentioned by respondents:

- Well-oriented RHMTs/CHMTs on the importance of good FP coverage.
- Availability of sufficient resources for the CCHPs.
- Good program leadership and management skills among RHMTs/CHMTs.
- Data quality assessment and data interpretation skills among RHMT/CHMT members.

Conclusions

The key conclusions from implementing the district-targeted approach were that:

- The district-targeted approach is a highly effective strategy for identifying and improving the performance of poorly performing districts. However, sustaining the achieved targets was at times a challenge, especially after the regional and district management team, in consultation with RESPOND, reduced resources allocated to districts after they were designated a higher level.[3]
- Orientation of RHMT/CHMT members, particularly the Health Secretaries, on the importance of FP was key to inclusion of FP activities in CCHPs. However, limited resources for CCHPs remained a big limiting factor.
- The improved allocation of funds for FP activities in CCHPs in some districts may facilitate sustainability for the key activities that were initiated under RESPOND.

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[3]For example, findings from an interview with an RCH in-charge established that performance at that facility had dropped significantly in 2016 after EH removed some of their support: "Performance of health providers has decreased because now days EH doesn't come frequently, last time they visited us was early 2016. Implant uptake rate will fall down in 2017 because of the reduction of outreach in the communities EH has removed their help of providing transports" (RCH in-charge). Consistent with this respondent's claims, the facility's data showed a decline in the number of women accessing all methods between 2015-2016 (e.g., implant clients had fallen from 1,078 in 2015 to 706 in 2016, a 34% reduction in clients).

- Furthermore, partner coordination and collaboration may significantly increase impact of FP activities at the district level with the possibility of some partners taking roles that were performed by RESPOND.
- Strengthening of the HMIS and data use for decision-making remains a crucial factor for proper program planning and management at district and facility level.
- Setting targets (e.g., Levels 1, 2, and 3) in the district-targeted approach was reported as having facilitated proper resources allocation and improved performance of districts. It was evident that districts can be capacitated to plan and manage various program activities within their districts.

EVALUATION QUESTION 4

How has RESPOND contributed to community mobilization for increasing utilization of FP and RH services, including greater access to LARCs/LAPMs? Sub-questions: How has RESPOND increased community engagement and action for accessing tailored/adapted FP-LARCs/LAPMs services? To what extent has RESPOND improved knowledge and acceptability of FP services among targeted populations such as youth, males, and urban populations in selected areas?

How EH Defined Community Engagement and Mobilization. According to RESPOND, community engagement can be effective in strengthening linkages between health facilities and communities and in increasing the accountability of health staff to the clients they serve (RESPOND Community Engagement Manual, Undated). Community engagement is considered by RESPOND to be a capacity-building process through which individuals or groups plan, carry out, and evaluate activities on a participatory and sustained basis to improve their own health or meet other needs, on their own initiative or stimulated by others.

RESPOND Activities for Community Engagement. RESPOND has supported the use of diverse, locally appropriate approaches to sensitize the target population about the availability of FP services in their communities. RESPOND has supported the promotion of outreach clinics and FP weeks as a package of FP, ANC, postnatal care (PNC), and health care services through diverse methods. These include using loudspeakers, printing and providing leaflets and posters with information on FP methods, obtaining support from religious and community leaders for community sensitization, and training and use of CHWs. These also include the placing of posters in public places, such as secondary schools, wards, and primary school announcement boards.

RESPOND has used public address systems very effectively in demand creation prior to outreach services. For example, RESPOND supported use of loudspeakers in community and weekly markets to announce the date and facility of upcoming outreach clinics. These methods are employed one week or two weeks prior to outreach services to achieve wide coverage for information on availability of FP services during outreach services. Public announcements are often made using cars with loudspeakers and people are provided with leaflets to make them aware of the services, the date, and the area where the services will be provided.

As evidenced by the quotes below, based on IDIs with a wide range of zonal, regional and district-level stakeholders, there was a strong awareness and appreciation for RESPOND-supported community engagement activities:

"EH, they do community mobilization by using loudspeaker and local radio. They do this one week or two weeks before the exercise." – Zonal FP Coordinator

"Normally mobilization is done advertisement on car with loud microphone, banners, at ward offices and other get information at the OPD when they came for various services." – District FP Coordinator

"EH provide speaker and battery that used to announce to the community on the day of FP service will be provided, normally we go to the ward and village government then they give us a person who will move to the market area, at schools, at the churches and advertise on the FP day." – Health facility In-charge

"Ward and villages health committee these facilitated the mobilization of the communities on which day and when FP services will be provided. Those committee have been well trained by EH and other partner." – RMO and M&E Officer

Based on in-depth interviews there was consistent mention of RESPOND supporting outreach clinics/FP weeks as a package of FP, ANC, PNC and health care services. For example, a very compelling illustration is provided by a MO as follows:

"In the middle of village, I ring the bell and said 'Dear brother and sisters on such day a health outreach is being organized where all family planning methods and all health services will be provided. We will provide ML, implant, IUD, DMPA, and all other family methods. We will also provide all health services you may need. If you need ANC, post-partum check-up for child and women, TB testing, treatment of any disease that you want to get, sawflies all will be provided. Take advantage of outreach clinic and avail whatever services you want to take. It will be held at … HC and on … date.'" – MO in charge of a health clinic

Working with religious and community leaders for community sensitization.
RESPOND's community engagement initiatives focused on local leaders and influential individuals at the community level. Examples include ward and village leaders (Village Executive Officers, VEO), religious leaders, traditional authorities, as well as community level structures and institutions (e.g., health facility governing committees, ward and village development committees). Such local leaders and committees can be persuasive advocates for changing social norms and practices and they can be effective in addressing the myths and misconceptions that limit use of FP (RESPOND Annual Reports, Year 2 throughYear 5). RESPOND built capacity among these stakeholders in the community; they provided orientation for them on FP for five days so that they can go to their work and educate people on the importance of FP.

Religious leaders were encouraged to increase acceptability of FP among followers; RESPOND developed a booklet of FP for Muslims. A booklet for Christians is being pretested.

As demonstrated by the quotations in the box below, mobilizers were able to address religious concerns in community:

"There is a bible verse that goes, 'One who does not provide for his family is worse than the non-believers are.' So we are trying to educate the parents about their responsibilities and let them know about different challenges of daily life. We are trying to do away with different myths. God commanded us to give birth and multiply. This command was given to Adam and Eve. If we sometime act without wisdom, we create problems. Therefore, God can punish some of the people

who cannot go righteously. God resented adultery life, where people were casually bringing up children. He then erased that generation." – Mobilizers for a health clinic

"Ward, Village, and religious leaders, when comes for the outreach services we inform the [leaders] and they inform their communities." – Health facility In-charge

Training and Use of CHWs. CHWs are volunteers in the community who are selected in village meetings. RESPOND built capacity among this group in the community and provided them orientation trainings on FP for five days so they can educate people on the importance of FP. As shown below (see Table 11) over 400 CHWs were trained during eight sessions in Year 2 and Year 3. The CHWs work in the community during village meetings, where they are given the chance to educate people on FP. They also do home visits, going house-to-house and educating people on FP. At nearby health facilities, they work together with health providers and provide daily health talks on FP in different departments (mainly RCH). Also, during outreach services they work together with health providers before and during the outreach days and outreach weeks.

The following are comments of the role of CHWs from FGDs:

"CHW do come in the community and tell us about the date of outreach also they tell us when we come at health center they usually announce at OPD." – Women Ruanda Health Clinic

"EngenderHealth equipped us with FP education we do educate the community at the ward and village meetings; at the hoods, at the vikoba (loan groups) and we do visit house-by-house for FP education." – Community Mobilizers

"Going to visit people in their families has been more effective because talking to people publicly did not attract much response. There is also little time to educate people unlike when you visit them at their homes." – Mobilizers Malampaka Health Clinic

Efforts to Reach Selected Targeted Populations. RESPOND used different efforts to reach targeted populations (e.g., men and youth). One approach was to call upon satisfied clients, including satisfied male FP users, to address male involvement. As shown in Table 11 below, the number of these "expert clients" was relatively limited (ranging from just 18 in Year 2 to a maximum of 83 in Year 4). None were trained in Year 5. The participation of satisfied clients for male involvement on FP and RCH services engaged clients who used FP methods for a long time without complaint to speak positively about their experience with FP methods, especially LARCs/LAPMs. RESPOND supported orientations for these satisfied clients on how to promote FP in their communities. They were selected from different religious denominations. Apart from FP orientations, they were trained on public speaking so they could have confidence in speaking; this is because potential clients tend to believe testimonies from their fellow community members.

Use of Peer Educators for Universities and Colleges. RESPOND oriented a substantial number of peer educators on FP so that they could advocate for RH and FP among their classmates in universities and colleges (see Table 11 below). A total of 446 peer educatiors were trained from Year 2 through Year 5. In absolute number and impact measurement, compared to the community engagement activities to promote outreach and FP weeks, these efforts were largely anecdotal and—apart from quarterly and annual reports—were not well documented for impact. Based on IDIs, there was a limited awareness of work with youth:

"For Youth outreach days, the target audience is youth. We also do campaigns for higher learning institutions, colleges, and universities. We trained and oriented faculty and peer educators. We have some numbers, but they are relatively small." – RESPOND Senior Staff

Mobilizing the Community. RESPOND supported community engagement activities for FP outreach, especially for increased uptake of LARCs/LAPMs, by mobilizing the community during outreach and FP weeks. These outreach activities were responsible for a large portion of the increased uptake of LAPMs/LARCs, contributing almost 40 percent of the total uptake.

The strategy included:

- Start announcing about the date and facility two weeks before outreach at all different focal places within the community: e.g., at weekly markets and at the facility.
- Messages that skillfully integrated FP with MCH and general health care provided women an excuse to attend health sessions and avail multiple services.
- Health care providers and CHWs were encouraged through financial support and encouragement.

Table 11. Summary of key RESPOND-supported community mobilization activities, Year 1 (2012) through Year 5 (2016)

Activity	Year 1 (2012)	Year 2 (2013)	Year 3 (2014)	Year 4 (2015)	Year 5 (2016)	Total
Number of expert clients oriented	0	18	42	83	0	143
Number of clinic site walks	8	6	3	0	1	18
Number of community leader meetings	8 meetings 284 attended: 64 religious leaders; 224 VEO	8 meetings 513 leaders	2 meetings 76 leaders	4 sessions 91 religious leaders	0	22 meetings 964 attended
Number of CHW trainings organized	0	0	4 training sessions 94 CHWs	4 training sessions 338 CHWs	0	8 training sessions Total 434 CHWs attended
Number of youth peer educators trained	0	88	164	120	74	446

Source: RESPOND Annual Reports for Year 1 (2012) through Year 5 (2016).

Best practices

Based on IDIs and document review the following activities were deemed to be most effective for community engagement:

- Presenting outreach and FP weeks as a package of integrated FP-MCH-health care services.
- Using loudspeakers for community mobilization.
- Community engagement using local leaders, religious leaders, and CHWs.
- Using satisfied clients (especially for male involvement).
- IEC materials at the health centers and posters in executive ward boards, school advertisement boards, and local markets.

The above activities all have some potential for community sensitization, but efforts by RESPOND were limited mainly to linking the community to outreach services on a short-term basis, without any expectation of behavior change.

Challenges and barriers

- RESPOND was focused on short-term engagement, linking community to outreach services on a short-term basis, and therefore had a limited role in community mobilization.
- Limitations on the budgets to cover community and religious leaders meetings meant there was limited outreach at times.
- Male involvement is still a challenge—especially at the Lake Zone—and the number of male service providers remains quite low.
- FP myths and misconceptions persist at multiple levels (see Box 4).

Box 4: Voices from the Field

Negative misconceptions about FP methods in the community reduces uptake

- "Disruption in menstrual cycle, excess bleeding, spotting, and absence of menstrual bleeding are major concerns. Some side effects relate to sexuality and cause opposition from husband." – MO of a health clinic
- "In some religious groups, their leaders oppose modern method want their people to use natural methods only. Here at [our district) we have 3 health centers and three dispensaries managed by them and none provide modern family planning." – DRCHCO
- "Most of the men they don't want their wife to us FP methods because they think that will be engaged into sexual activities since they will not anymore scared with pregnancy." – Health facility In-charge
- "Lake Zone: Customs, value, and norms of lake zone communities, they do believe on having many children and big family, which they prefer as a big family is prestigious, so introduction of family planning methods it's a new thing for them." – FP Coordinator
- "Education it is still the barrier, community does not have the right information on family planning methods, some of the community still have negative myths and misconceptions of family planning methods, in Mtwara most of the women prefer using injection, majority said if you use IUD you need to stick with one partner because it only fit to one partner while many women have multiple partners." – Project Manager

Source: IDIs.

Facilitating Factors. Based on IDIs and document review, the factors that facilitated community engagement included:

- Resources provided from RESPOND to mobilize the community before outreach.

- Advocacy to allocate funds for community mobilization in CCHP, in clearly defined budget packages as outlined in the above mentioned national guidelines document, *National Package of Essential Family Planning Interventions for CCHPs.* This document was developed with RESPOND assistance.
- Effective and strategic short-term mobilization of community through outreach activities.
- FP orientation by CHWs, religious and community leaders, expert clients, and peer educators all contributed to community engagement:

  "Using community leaders such as VEO and WEO, and some religious leaders, facilitated in increasing community awareness and FP uptake." – RCHCCO, health clinic

Conclusions

- FP campaigns that integrate MCH and other health services with FP messages make the FP messages more attractive and acceptable to clients, especially to women.
- Timely and effective use of local media by community leaders/CHWs makes mobilization successful and attracts clients to outreach services.
- A package of locally adapted, culturally appropriate mobilization techniques (FP days, FP weeks, and Immunization days) succeeded in generating high levels of attendance at outreach events.
- Effective community mobilization requires active engagement with CHWs, community leaders, and religious leaders.
- In rural areas, community meetings and CHWs are important for effective community sensitization.

RECOMMENDATIONS

The following are the Evaluation Team's recommendations with emphasis on adaptation of the findings and conclusions within the next cycle of USAID/Tanzania-funded programs.

RESULT 1: WHAT AND HOW DID SPECIFIC ENABLERS AND CONSTRAINTS AFFECT FP UPTAKE IN RESPOND REGIONS?

Recommendations

Based on the above findings and conclusions, most of the evaluation recommendations are made in the context of **Boresha Afya.** ***It is critical that Boresha Afya build its approach based on conclusions from RESPOND and share/combine resources with partners*** to:

- Continue capacity building until most facilities start providing LARCs/LAPMs and MCH services as routine services. Task shifting could be considered and negotiated with MOHCDGEC to accelerate the process and overcome shortages of staff to provide some of the services at the dispensary level.
- OJT (rather than off-site training) with a built-in accreditation system to accredit trainees could reduce training costs substantially.
- Continue outreach. Start gradual withdrawal when the majority of facilities have the capacity to provide all methods. Continue outreach efforts in difficult-to-reach areas.
- Institutionalize supportive supervision, ensuring adequate allocation of funds for transport and per diem to mentor and monitor the quality of services as a key outcome.

RESULT 2: HOW DID RESPOND'S MODEL(S) OF INTEGRATION AFFECT THE UPTAKE OF FP SERVICES FROM VARIOUS PERSPECTIVES? IS UPTAKE OF FP AT SITES WITH INTEGRATION MODEL(S) BETTER THAN SITES WITHOUT INTEGRATION? WHICH INTEGRATION MODEL IS MORE EFFECTIVE?

Recommendations

- Develop a suitable plan for staff deployment, turnover, and internal rotations in order to avoid paralyzing integrated services.
- Strengthen community engagement on integration through training more CHWs and using influential people.
- Scale up integration of services with *Boresha Afya* partners with more focus on high-volume sites.
- Strengthen FP-immunization integration through immunization outreach and required facilities at immunization service areas.
- Strengthen FP-post natal/labor and delivery integration through trainings of staff for LARCs PPIUD.
- Develop a suitable plan to integrate HMIS tools so as to reduce duplication of records, which poses a great challenge to quality data collection.

RESULT 3: HOW DID RESPOND'S DISTRICT-CENTERED APPROACH RESULT IN STRENGTHENING THE CAPACITY OF LOCAL GOVERNMENT TO MANAGE AND IMPLEMENT FP PROGRAMS?

Recommendations

For better implementation of the district-targeted approach in future USAID-supported programs (e.g., Boresha Afya), the Evaluation Team recommends the following;

- For continuous inclusion of FP activities in the CCHPs, systematic and sustained advocacy on the importance of FP is required at the RHMT, CHMT, and national level.
- The partner's practice of sharing their work plans with CHMTs before implementation should continue in order to support better coordination and collaboration at district level.
- Efforts to strengthen and sustain data quality and utilization for decision-making should be made by advocating for allocation of funds for these activities in the CCHPs.
- Adapt the district targeted approach by integrating a limited number of key indicators (e.g. one key indicator for malaria, one for HIV, and one for FP) under *Boresha Afya* project.

RESULT 4: HOW HAS RESPOND CONTRIBUTED TO COMMUNITY MOBILIZATION FOR INCREASING UTILIZATION OF FP AND RH SERVICES, INCLUDING GREATER ACCESS TO LARCS/LAPMS?

Recommendations

- Strengthen focused mobilization efforts using local media techniques with emphasis on low-cost and well-timed outreach that promotes integrated health messages and activities that link FP with related MCH issues.
- Adapt and sustain a set of locally adapted, culturally appropriate mobilization techniques within *Boresha Afya* (e.g., In Lake Regions, find ways to combine FP mobilization with MCH and malaria eradication).
- Develop and implement a strategic BCC campaign covering all components of *Boresha* Afya with a focus on youth, men, women and key community decision-makers.

ANNEX I. EVALUATION SCOPE OF WORK

Assignment #: 400 [*assigned by GH Pro*]

Global Health Program Cycle Improvement Project (GH Pro)
Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)
Date of Submission: April 7, 2017
Last update: 5/11/2017

I. TITLE: Evaluation of Tanzania Responding to the Need for Family Planning (RESPOND) Project

II. Requester / Client
☐ USAID/Washington
Office/Division: /

■ USAID Country or Regional Mission
Mission/Division: Tanzania / Health Office

III. Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)

☐ 3.1.1 HIV	☐ 3.1.4 PIOET	■ 3.1.7 FP/RH
☐ 3.1.2 TB	☐ 3.1.5 Other public health	☐ 3.1.8 WSSH
☐ 3.1.3 Malaria	threats	☐ 3.1.9 Nutrition
	☐ 3.1.6 MCH	☐ 3.2.0 Other (specify):

IV. Cost Estimate: $500,000 (***Note**: GH Pro will provide a cost estimate based on this SOW*)

V. Performance Period
Expected Start Date (on or about): May 24, 2017
Anticipated End Date (on or about): October 20, 2017

VI. Location(s) of Assignment: (Indicate where work will be performed)

Tanzania

VII. Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:

■ **Performance Evaluation** (Check timing of data collection)

☐ Midterm■ Endline☐ Other (specify):

Performance evaluations encompass a broad range of evaluation methods. They often incorporate before–after comparisons but generally lack a rigorously defined counterfactual. Performance evaluations may address descriptive, normative, and/or cause-and-effect questions. They may focus on what a particular project or program has achieved (at any point during or after implementation); how it was implemented; how it was perceived and valued; and other questions that are pertinent to design, management, and operational decision making

☐ **Impact Evaluation** (*Check timing(s) of data collection*)

☐ Baseline☐ Midterm☐ Endline☐ Other (specify):

Impact evaluations measure the change in a development outcome that is attributable to a defined intervention. They are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

OTHER ANALYTIC ACTIVITIES

☐ Assessment

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

☐ Costing and/or Economic Analysis

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

☐ Other Analytic Activity (Specify)

PEPFAR EVALUATIONS *(PEPFAR Evaluation Standards of Practice 2014)*

Note: If PEPFA-funded, check the box for type of evaluation

☐ **Process Evaluation** *(Check timing of data collection)*

☐ Midterm☐ Endline☐ Other (specify):

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

☐ **Outcome Evaluation**

Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

☐ **Impact Evaluation** *(Check timing(s) of data collection)*

☐ Baseline ☐ Midterm ☐ Endline ☐ Other (specify):

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

☐ **Economic Evaluation** (PEPFAR)

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

VIII. BACKGROUND

If an evaluation, Project/Program being evaluated:

Project Title:	RESPOND Project in Tanzania
Award Number:	AID-621-LA-13-00001
Award/Contract Dates:	November 1, 2012 to October 31, 2017
Project/Activity Funding:	USD 42,357,285
Implementing Organization(s):	EngenderHealth
Project/Activity AOR/COR:	Selina Mathias, Family Planning/HIV Specialist

Background of project/program/intervention (*Provide a brief background on the country and/or sector context; specific problem or opportunity the intervention addresses; and the development hypothesis*)

COUNTRY CONTEXT

Tanzania has a population estimated at nearly 50 million, of which almost 75 percent live in rural areas. With a current fertility rate of 5.2 children per women of reproductive age and a population growth rate of 2.7 percent, it is among the world's fastest growing population (TDHS/MIS, 2015-16). Tanzania has a young population with 56 percent under the age of 19 years translating into a very high dependency ratio. Use of modern contraception among currently married women is 32 percent, and unmet need for family planning (FP) is high at 22 percent (TDHS/MIS, 2015-16).[4] Tanzania has made some progress in improving its maternal, newborn, and child health situation. From 1999 to 2015, the maternal mortality rate declined from 578 to 398 per 100,000 live births, respectively (TRCHS, 1999; World Bank, 2015). Births attended by a skilled provider are currently at 64% with 60% occurring in a health facility (TDHS/MIS, 2015-16). The national abortion rate is high at 36 per 1,000 women of reproductive age. It is estimated that each year, 405,000 women have an abortion, almost all

[4] Modern methods include female sterilization, male sterilization, oral contraceptive pills (OCPs), intrauterine devices (IUDs), injectables, implants, male condoms, female condoms, lactational amenorrhea method (LAM), and standard days method (SDM). Methods such as rhythm and withdrawal are defined as traditional.

of which are clandestine; of these, 40% result in complications requiring medical treatment (Guttmacher Institute, 2016). From approximately 1999 to 2015-16, the neonatal mortality rate dropped from 31 to 25 deaths per 1,000 live births, respectively. The infant mortality rate decreased from 67 to 43 deaths per 1,000 live births, respectively, and the under-five mortality rate declined from 107 to 67 deaths per 1,000 live births (TRCHS, 1999; TDHS/MIS, 2015-16).

Tanzania aims to become a middle income country by the year 2025. To reach this goal, the country must achieve a demographic transition that will assist it to maximize the demographic dividend it can potentially earn. Family planning will be critical to achieving an accelerated reduction in fertility, and significant investments in health, education and employment, particularly for youth, will be required. Driven by tourism, mining, trade, and communications, the private sector has grown considerably with economic growth averaging 7 percent over the past 10 years. With these gains, the percentage of people living in poverty has decreased from 53 to 47 percent from 2007 to 2011, respectively (World Bank). However, continued rapid population growth has increased the absolute number of Tanzanians living in poverty by more than one million, further overwhelming an already-fragile social service system. Tanzania relies heavily on foreign assistance with roughly one-third of the national budget financed by donor-provided direct budget support. For the Health sector, more than 50 percent of the country's budget is supported by bi-lateral and multi-lateral donors. Lack of basic healthcare and the impact of preventable diseases such as HIV and malaria, low levels of education and agricultural productivity, widespread corruption, and an urgent need for reform of a business-enabling environment persists as major challenges to development.

FAMILY PLANNING SITUATION

With the fastest growing population rate in East Africa, Tanzania's total fertility rate has been relatively stagnant for nearly 20 years, having only decreased from 5.8 births per woman in 1996 to 5.2 births per woman in 2015-16 (TDHS/MIS, 2015-16). Such high population growth is expected to limit industrialization, job creation, and poverty reduction. In addition, it will likely have harmful environmental effects and will lead to loss of biodiversity and endangered species. It will also further challenge the delivery of basic public services, particularly for health and education.

Over the past decade and a half, the modern contraceptive prevalence rate (mCPR) among currently married women age 15-49 grew from 17 to 32 percent (TDHS/MIS, 2015-16). However, Tanzania's unmet need for FP has remained stationary at about 22 percent since 1999 (TDHS/MIS, 2015-16). The issue of adolescent fertility is of particular concern in Tanzania on both health and social grounds. Children born to very young mothers are at increased risk of sickness and death, and teenage mothers are more likely to experience adverse pregnancy outcomes and are more constrained in their ability to pursue an education than young women who delay childbearing. The 2015-16 TDHS/MIS showed that more than one in four women age 15-19 have begun childbearing (27 percent); this figure is higher than that reported in the 2010 TDHS (23 percent). Further, the proportion of teenagers who have begun childbearing rises rapidly with age, from 4 percent at age 15 to 57 percent at age 19 (TDHS/MIS, 2015-16). Teenagers with no education and those in the lowest wealth quintile tend to start childbearing earlier than other teenagers, and the percentage of teenagers who have begun childbearing is higher among rural women (32 percent) than urban women (19 percent) (TDHS/MIS, 2015-16).

The FP method mix is slowly widening in Tanzania, with an increase in use of long-acting and reversible contraceptives (LARCs), particularly implants, over the past 10 years. In 2015-16, the three most popular modern methods were injectables (accounting for 12.6 percent of

mCPR), implants (6.7 percent), and OCPs (5.5 percent). These were followed by male condoms (accounting for 2.4 percent mCPR) and female sterilization (3.4 percent), with IUDs, LAM, and male sterilization coming last (all less than 1 percent).

The factors affecting high fertility and low mCPR in Tanzania comprise inadequate supply of commodities, including LARCs and permanent methods (PMs); poor quality of and access to FP services; lack of knowledge and persistent myths and misconceptions about modern contraception; lack of male involvement; and a shortage of skilled health workers. Further, gender inequity/inequality between the sexes profoundly influences women's access to and use of contraception. High rates of gender-based violence (GBV) in Tanzania also result in unintended pregnancies, miscarriages, and other reproductive health (RH) problems, including sexually transmitted infections (STIs), such as HIV.

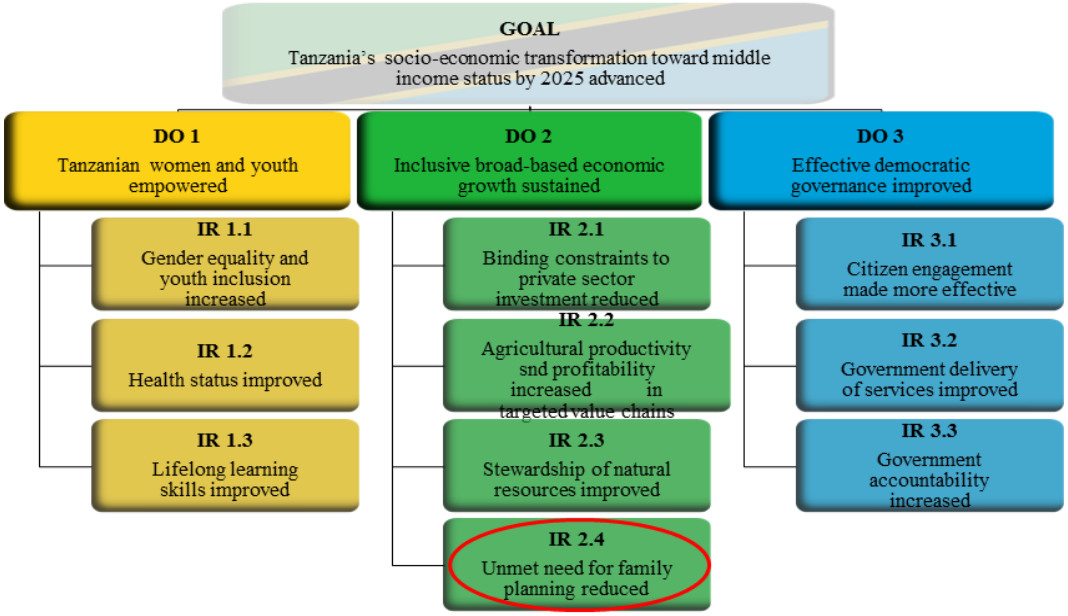
USAID/TANZANIA'S SUPPORT FOR FAMILY PLANNING

The Mission hypothesizes that Tanzania's high population growth rate must be addressed at both policy and practical levels in order to reduce poverty and achieve broad-based economic growth. The Government of Tanzania also recognizes the need to address this challenge in its national strategies for growth and reduction of poverty (2005-2010 and 2010-2015) and in its National Five-Year Development Plan (2016-2021). Furthermore, the country's National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child, and Adolescent Health in Tanzania (One Plan II) (2016-2020) prioritizes FP as a key intervention for saving women's lives and, thus, enabling them to be more active in the labor force, improve household income, and enhance the well-being of their children. The target for mCPR outlined in the One Plan II is 45 percent by 2020. However, with a current mCPR of 32 percent, Tanzania is unlikely to attain this target in the next five years unless focused and intensified measures are taken by all stakeholders.

Under the USAID/Tanzania Country Development Cooperation Strategy (CDCS) (2015-2019)

results framework, the Mission's goal is to advance Tanzania's socio-economic transformation toward middle income status by 2025. It will do this through three Development Objectives (DOs) and several related Intermediate Results (IRs), as depicted in the graph below:

In addition to fertility reduction, FP programs contribute to economic development by slowing population growth and allowing couples to plan and space children and shift resources to achieving other life goals. The positive outcomes from the reduction in the number of unintended and/or ill-timed births have been well documented across many developing and middle income countries. Specifically, research has shown a strong correlation between women's access to education and economic opportunities and increased demand for contraception. Effective FP programs have proven to substantially increase physical household assets and adult women's wages. They also lead to improvements in women's health, increases in women's productivity, and increases in the human capital of their children, as



reflected in their health, nutrition, and schooling. The Mission believes that unmet need for FP

is a valuable indicator for gauging the effectiveness of Tanzania's national FP program, because it points interventions towards those women who are at greatest risk of unintended pregnancy and are more likely to adopt a method of contraception than other nonusers. In addition, the concept of unmet need places women's personal RH preferences and rights at the center of FP services.

USAID/Tanzania's FP strategy aligns with the Government of Tanzania's Health Sector Strategic Plan IV (HSSP IV) (2016-2020) and the One Plan II, among other key Government of Tanzania documents. The Mission supports Tanzania's national FP program through financial and technical assistance to the Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC), the private sector, and civil society. This support focuses on the implementation of high impact practices in FP that promote voluntarism and informed choice in contraceptive use and meet the fertility intentions and lifestyle needs of women, men, and youth in both Tanzania Mainland and Zanzibar.

Specific areas of support for FP by USAID/Tanzania are briefly described below:

- Contraceptive security: This encompasses procurement of FP commodities, supply chain technical assistance, and the introduction of new contraceptive methods.
- Service delivery: This includes support for routine and mobile/outreach services and social marketing of condoms and OCPs, especially for underserved populations (e.g., postpartum women, post-abortion women, adolescent girls and young women [AGYW]) and disadvantaged areas (e.g., rural locations, densely populated urban areas). It also includes task shifting efforts that focus on developing a new cadre of MOHCDGEC community health workers and moving responsibility for bilateral tubal ligation from medical doctors to assistant medical officers and clinical officers.
- Capacity Building: This involves curriculum development together with pre-service education and in-service training for health providers, as well as supportive supervision and coaching/mentoring. A primary focus of the Mission's capacity building support for FP is on underutilized and new methods of contraception.
- Health Systems Strengthening: This covers government budgeting and resource tracking for FP; results-based financing; district planning, management, and accountability; civil society and private sector strengthening; workforce planning; and health information system streamlining, harmonization, and integration.
- Demand Creation: This comprises development and implementation of strategic behavior change communication (SBCC) interventions to increase awareness and knowledge of modern FP and amplify demand for contraception using mass media, community mobilization, and interpersonal communication channels.
- Policy and Advocacy: This includes garnering greater political and financial support for FP and advocating for FP as a tool for broad-based development.

In recent years, USAID/Tanzania supported the development, implementation, and monitoring of Tanzania's first National FP Costed Implementation Plan (NFPCIP) (2010-2015), and it is currently funding a review of the plan. It is expected that a second NFPCIP-like document will be developed in the coming year with support from the Mission among others.
USAID/Tanzania also seeks to increase demand for and use of FP by integrating it with other health services (e.g., HIV, maternal and child health [MCH]) and non-health activities (e.g., agriculture, nutrition, natural resource management).

OVERVIEW OF RESPOND

In 2011-12, as a follow-on to ACQUIRE Tanzania (an associate award made under the global ACQUIRE program led by EngenderHealth), USAID/Tanzania designed a Request for Application that aimed to increase the use of FP and RH services, with a focus on informed

and voluntary use of LARCs/PMs, provision of comprehensive post-abortion care (cPAC), integration of FP, and mitigation of GBV. The award aimed to support FP services at public hospitals, health centers, and dispensaries and through outreach services in all regions of Tanzania Mainland and parts of Zanzibar. Geographic coverage was increased from 90 districts under ACQUIRE to 110 districts under RESPOND. RESPOND was a modified continuation of the ACQUIRE activity which ended on March 31, 2013 (a five-month overlap occurred between ACQUIRE and RESPOND). The new activity, also an associate award (under the global RESPOND program led by EngenderHealth), was envisaged to last five years with a budget ceiling of USD 42,357,285.

Led by EngenderHealth, RESPOND began on November 1, 2012 and will end on October 31, 2017. It involves two global partners: (1) Meridian Group International, Inc. which is responsible for building public-private partnerships (PPPs) under the award; and (2) Population Council which is responsible for conducting operations research and special studies and assisting with program documentation. RESPOND also works with a wide range of local partners, including national and local government authorities, non-governmental organizations (NGOs) working in health and non-health areas, and the private sector.

A. Results Framework and Activities:

RESPOND is positioned to support the goals of the Reproductive and Child Health Section (RCHS) of the MOHCDGEC, including the HSSP IV and One Plan II and their respective antecedents. The purpose of the activity is to increase the use of FP and RH services, with a focus on LARCs/PMs in order to meet the reproductive intentions of Tanzanian women, men, and adolescents. As shown in the RESPOND results framework (see below), the project has four sub-purposes: (1) access to quality FP and RH services (prevention of mother-to-child transmission of HIV [PMTCT] and GBV) increased; (2) quality of FP and RH integrated services demonstrated, evaluated, and scaled up; (3) health system management, monitoring, and evaluation strengthened for integrated FP and RH services; and (4) communities mobilized to increase use of FP and RH services. RESPOND combines evidence-based strategies and innovative approaches to achieve its sub-purposes, as described below:

(1) Access to quality FP and RH services (PMTCT and GBV) increased

To increase access to quality FP and RH services, RESPOND implements interventions that improve the capacity and performance of health service providers and facilities in the public sector. In particular, it works to ensure a range of contraceptives are available at each service delivery point (SDP); strengthen routine services at SDPs; and increase and institutionalize different modes of service delivery that include FP outreach, FP weeks, and FP service days. RESPOND also implements interventions that improve contraceptive security at the "last mile," particularly for health facilities and clients located in remote underserved communities. As part of its capacity building work, RESPOND implements on-the-job training (OJT) and coaching/mentoring; strengthens pre-service training; builds the capacity of district leadership and management; and develops and implements PPPs with a variety of companies around the country.

(2) Quality of FP and RH integrated services demonstrated, evaluated, and scaled up

Since its inception, RESPOND has worked to improve the quality of FP and RH services by strengthening the integration of FP (LARCs/PMs, in particular) with other essential health services, including HIV prevention, care, and treatment (PMTCT, specifically), MCH, cPAC, and GBV. RESPOND's approach is based on a clear notion of the rights of clients to ensure informed and voluntary choice. It also responds to the needs of providers, assures the safety

of clinical techniques and procedures, and takes into account how gender norms impact the role of both provider and client within service delivery interactions.

(3) Health system management, monitoring, and evaluation strengthened for integrated FP and RH services

Work undertaken by RESPOND to strengthen health systems includes providing technical assistance and capacity building to Council/District Health Management Teams (C/DHMTs) to allocate resources for FP in their Comprehensive Council Health Plans (CCHPs) and to improve district coordination and partner collaboration. RESPOND also works at the national, regional, and district levels to strengthen government commitment to and operationalization of integrated services and to enhance integrated strategic information management.

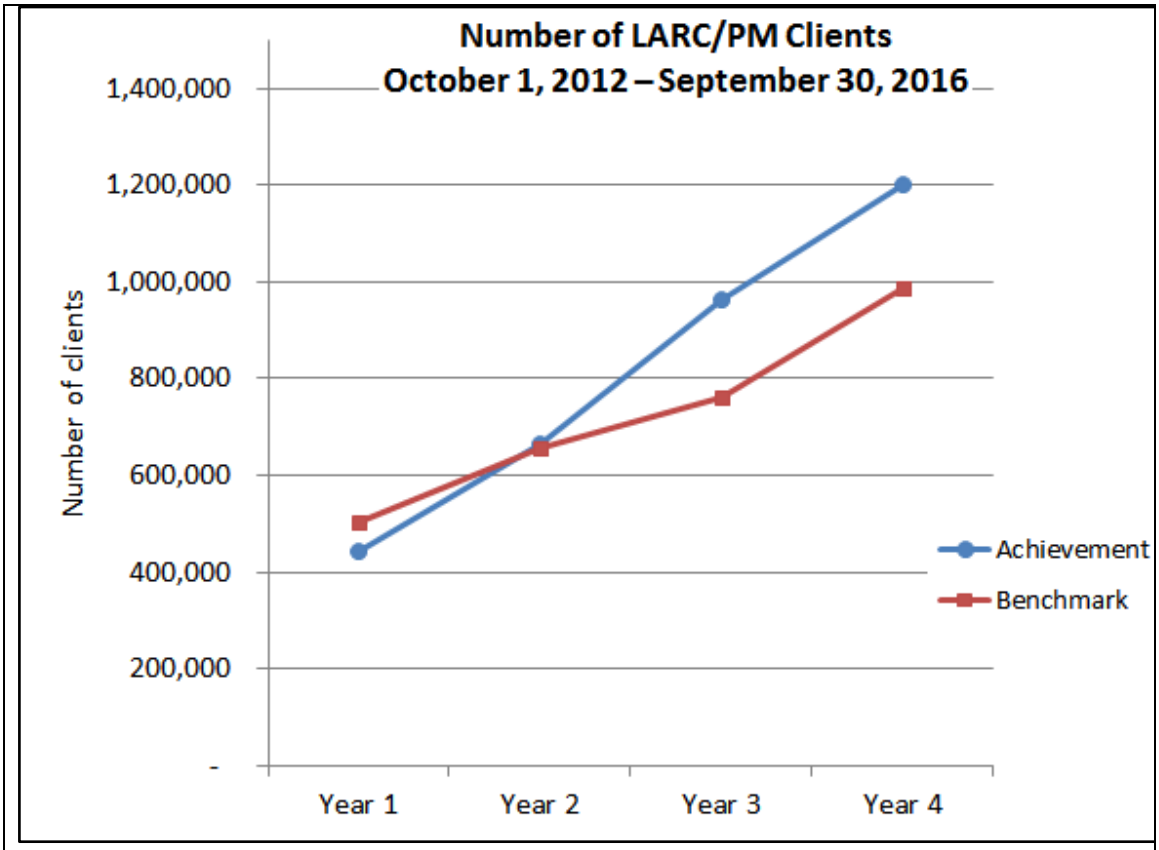
(4) Communities mobilized to increase use of FP and RH services

In partnership with the MOHCDGEC and other FP stakeholders, RESPOND promotes FP by focusing on the benefits of healthy timing and spacing of pregnancy and positioning contraception as a healthy choice for couples, families, communities, and the country as a whole. The program uses a number of innovative approaches to help providers and potential clients understand the benefits of FP, such as site walk-throughs at health facilities during FP weeks and FP services days, youth mobilization at universities, couple communication interventions, constructive male engagement activities, mHealth initiatives, and FP programming for people with disabilities.

RESPOND supports the Government of Tanzania to take ownership of and provide adequate resources for FP over time, particularly at the district level where it works within the existing decentralized health structures of the MOHCDGEC and aligns with CCHP development, budgeting, implementation, and reporting. Using a district-centered approach, RESPOND builds the capacity of districts to conduct simple cost and results analysis of activities; increase district budgets for FP in their CCHPs; improve cost efficiency of service delivery by changing staffing patterns through task sharing; and build partnerships with the private sector to complement public funding for FP activities.

B. Achievements to Date:

Over the first four years of the project, RESPOND achieved a number of key results related to the provision of LARCs/PMs, HIV testing and PMTCT, cPAC, and GBV/VAC services, as shown below.



Training

District work

Communities mobilized

C. Challenges Faced:

RESPOND faced a number of challenges over the first four years of the project, a number of which are briefly described below:

- Knowledge of FP among new District Reproductive and Child Health Coordinators (DRCHCos) was low which affected their ability to manage FP activities in the district, including proper management of data and contraceptive security. This was addressed through the addition of orientations and trainings for DRCHCos on FP program management and contraceptive security updates.
- In regions where RESPOND provided PMTCT services (Iringa and Manyara), districts and facilities faced a number of challenges. These included: limited monitoring of Option B+ drugs which led to stockouts; a shortage of M&E tools for Option B+; and a lack of CD4 machines. In collaboration with the MOHCDGEC, the project conducted training in commodity forecasting and stock monitoring and provided support for printing of M&E tools.

- A delay in receiving GBV/VAC incremental funding led to slowed implementation of clinical and prevention activities; however, upon receipt of funds, interventions were quickly brought to scale.
- As RESPOND worked to increase the integration of FP with HIV prevention, treatment, and care, GBV/VAC, cPAC, and MCH services, it found there were inadequate data collection tools available at the facility level which required them to assist in developing and printing these over the life of the project.
- In Manyara region, RESPOND consistently experienced low yield for known and new HIV cases resulting in low uptake of Option B+ and early infant diagnosis (EID). While this was due in part to the fact that Manyara had/has one of the lowest rates of HIV prevalence on the Mainland (1.5%), the project faced challenges in targeting women and infants and creating demand for PMTCT among them.

Strategic or Results Framework for the project/program/intervention (*paste framework below*)

RESPOND RESULTS FRAMEWORK ***Purpose*: Increased use of FP/RH services, with a focus on LARCs/PMs, to meet the reproductive intentions of Tanzanian women, men, and adolescents**			
Sub-Purpose 1: Access to quality FP-LARCs/PMs and RH services (HIV and GBV) increased	**Sub-Purpose 2:** Quality FP-LARCs/PMs and RH integrated services demonstrated, evaluated, and scaled up	**Sub-Purpose 3:** Health systems strengthened for integrated FP-LARCs/PMs and RH services	**Sub-Purpose 4:** Communities engaged in the promotion of FP-LARCs/PMs and RH services
1.1 Improved capacity and performance of health service providers and facilities **1.2** Strengthened supervision and quality improvement support for service delivery **1.3** Improved contraceptive/ commodity security at the "last mile"* * = Reaching health facilities and end users in the remote communities they serve	**2.1** FP-LARCs/PMs integrated into HIV prevention, care, and treatment services **2.2** FP-LARCs/PMs integrated into MCH health settings **2.3** Strengthened delivery of LARCs/PMs during cPAC services **2.4** FP-LARCs/PMs integrated into GBV services at facilities in targeted areas	**3.1** FP/RH resource allocation in CCHPs increased through advocacy and capacity building **3.2** Improved district coordination and partner collaboration **3.3** National, regional, and district level-capacity built to support integrated services **3.4** Strengthened integrated strategic information management (including research or demonstration activities to inform policy change)	**4.1** Increased community engagement and action for accessing tailored FP-LACs/PMs services **4.2** Improved knowledge and acceptability of FP services among targeted populations (e.g., youth, males, urban) in selected areas

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

National

IX. SCOPE OF WORK

A. **Purpose**: Why is this evaluation or analysis being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

The purpose of this performance evaluation is to review RESPOND's achievement of results specifically as relates to increasing FP uptake in program-supported areas, improving service delivery through integration, and strengthening systems by applying a district-centered approach. The evaluation will cover the award period from November 1, 2012 to December 31, 2016.

The evaluation will identify best practices and lessons learned during the implementation of RESPOND by exploring the different strategies and interventions employed under the award (as described in the program description of the Cooperative Agreement number AID-621-LA-13-00001).

B. **Audience:** Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

USAID/Tanzania and Government of Tanzania

C. **Applications and use**: How will the findings be used? What future decisions will be made based on these findings?

The evaluation is intended to provide USAID/Tanzania, the Government of Tanzania, and other key stakeholders with a greater understanding of the facilitating and limiting factors faced while implementing a complex FP program across 110 districts of all regions of Tanzania. It is anticipated that by answering the questions outlined below, the evaluation's findings and recommendations will enable the Mission, national and local government authorities, and other partners both within and outside the Health sector to more effectively design, implement, monitor, and evaluate FP programming in the future.

D. **Evaluation/Analytic Questions & Matrix**:

a) Questions should be: a) aligned with the evaluation/analytic purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation/analytic questions. **USAID Evaluation Policy recommends 1to 5 evaluation questions.**

b) List the recommended methods that will be used to collect data to be used to answer each question.

c) State the application or use of the data elements towards answering the evaluation questions; for example, i) ratings of quality of services, ii) magnitude of a problem, iii) number of events/occurrences, iv) gender differentiation, v) etc.

	Evaluation Question	**Suggested methods for answering this question** *What data sources and data collection and analysis methods will be used to produce the evidence for answering this question?*	**Sampling Frame** *Who is the best source for this information? What is the sampling criteria?*
1	What and how did specific enablers and constraints affect increases in FP uptake in RESPOND regions? - Team to look at factors related to age, sex, geography, marital status, etc, as well as knowledge, attitudes and practices of providers and clients. - Team should also look at GBV and PMTCP in districts where RESPOND works on these issues with FP.		
2	How did RESPOND's model(s) of integration affect the uptake of FP services from various perspectives, e.g Local Government Authorities, Service Providers/Health Facilities, Beneficiaries? - Team to compare RESPOND sites with integration and without integration.		
3	How did RESPOND's district-centered approach result in strengthening the capacity of local government to manage and implement FP programs? - The team should compare the different levels of support to Level 1, 2, and 3 districts and identify the successes/best practices that should be sustained in future programming as well as challenges encountered, and provide recommendations on how to overcome those. (See background documents		

	for definitions of levels of support)		

E. **Methods:** Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation/analytic questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

General Comments related to Methods:

The evaluation team will follow a participatory approach, working closely with USAID/Tanzania and RESPOND staff, as appropriate. Methodologies will combine a review of quantitative data and application of qualitative evaluation techniques to obtain information, opinions, and data from various stakeholders, including Mission and RESPOND staff, Government of Tanzania representatives, donors, and implementing partners.

The methods listed below are recommended by USAID/Tanzania and should serve as a guide for the evaluation team. The team should also consider other possible methods for collecting and analyzing the information that is required to answer the above evaluation questions with evidence. Final data collection methodologies will be discussed with and approved by the Mission during the initial team planning meeting.

The evaluation team will conduct site visits in regions/districts where RESPOND is being implemented. There are a limited number of days in the evaluation set aside for data collection, and because RESPOND is a national program, the evaluation team in consultation with the Mission will purposively select the regions/districts to be visited during the team planning meeting. A list of Field Offices and their respective regions and districts is included in Annex 1. It is intended that the evaluation team will visit RESPOND's four Field Offices, conducting site visits involving KIIs, small group interviews, and/or FGDs with regional and district ment authorities (i.e., RMOs, DMOs, RRCHCos, DRCHCos); ZHRC staff, where appropriate; implementing partners; health providers; and clients. The purpose of these site visits is to gain a better understanding of the technical competence of RESPOND's program implementation by public sector health staff and other partners, the constraints encountered in the various categories of activity implementation, and community and client perceptions of their needs in order to provide quality FP services.

Limitations: Because of limited sample size, the recommendations may not be generalizable. The Team will consult the project and USAID for the purposive sampling criteria, to better address this issue.

■ **Document and Data Review** (*list of documents and data recommended for review*)

Prior to arriving in Tanzania, the evaluation team will review background documents provided by USAID/Tanzania and EngenderHealth, as well as country data and national strategies on FP, maternal health, population, and development. All team members will review the following documents in preparation for the first team planning meeting in Dar es Salaam:

1) Tanzania RESPOND award documents
   - Technical proposal
   - Cost proposal
2) Tanzania RESPOND work plans for Years 1, 2, 3, 4, and 5
   - Narratives
   - Performance monitoring plans with indicators and targets
   - Annual budgets
3) Tanzania RESPOND quarterly progress reports

4) Tanzania RESPOND annual progress reports
5) HSSP IV (2015-2020)
6) One Plan II (2016-2020)
7) NFPCIP (2010-2015) (Updated July 2013)
8) Tanzania Elimination of Mother-to-Child Transmission of HIV Plan (2012-2015)
9) National Operational Guidelines for Integration of HIV/Maternal, Newborn, and Child Health Services in Tanzania
10) 2015-16 Tanzania Demographic and Health Survey/Malaria Indicator Survey (TDHS/MIS) [http://dhsprogram.com/Where-We-Work/Country-Main.cfm?ctry_id=39&c=Tanzania&Country=Tanzania&cn=&r=1]
11) 2014-15 Tanzania Service Provision Assessment (TSPA) [http://dhsprogram.com/Where-We-Work/Country-Main.cfm?ctry_id=39&c=Tanzania&Country=Tanzania&cn=&r=1]
12) 2011-12 Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS)
13) MOHCDGEC service delivery statistics.

■ **Secondary analysis of existing data** *(This is a re-analysis of existing data, beyond a review of data reports. List the data source and recommended analyses)*

As necessary, the evaluation team will conduct secondary analysis of existing data related to the three evaluation questions outlined above.

Data Source (existing dataset)	Description of data	Recommended analysis
Tanzania RESPOND performance indicator data	Routine project monitoring data used to report to USAID as part of their PMP	Priority indicators will be discussed with USAID at the in-brief.
Country survey data	TSPA data are health facility assessments conducted by DHS. TDHS/MIS is a household survey with data on reproductive health and malaria (http://dhsprogram.com/What-We-Do/survey-search.cfm?pgtype=main&SrvyTp=country&ctry_id=39)	Priority indicators will be discussed with USAID at the in-brief.
FP service delivery data	FP service data is available in Tanzania DHIS2, and is utilized by RESPOND to calculate their PMP data,	

■ **Key Informant Interviews** *(list categories of key informants, and purpose of inquiry)*

Evaluators will conduct key informant interviews (KIIs) with RESPOND staff, Government of Tanzania representatives, and other FP stakeholders and partners involved in the implementation of RESPOND activities. The evaluation team will conduct semi-structured one-on-one interviews. Suggested individuals to be interviewed are outlined below:

- RESPOND staff: Chief of Party; Deputy Chief of Party/Technical Director; Director of Finance and Operations; Director of Monitoring and Evaluation (M&E); Senior Technical Advisors; Technical Advisors; M&E Advisors; Field Office Managers; and Field Office staff.
- Government of Tanzania: MOHCDGEC-RCHS representatives; Regional Medical Officers (RMOs); District Medical Officers (DMOs); Regional Reproductive and Child Health Coordinators (RRCHCos); DRCHCos; and Zonal Health Resource Center (ZHRC) staff in Kigoma, Arusha, and Iringa. [Note: For each of the three ZHRCs, it is anticipated that evaluators will conduct an individual or small group

interview with one to four of those staff most closely involved with RESPOND in the implementation of the national FP program.]

- USAID/Tanzania Staff: To be identified in consultation with the AOR and other members of the Mission's Health Office senior management team.
- Donors: United Nations Population Fund (UNFPA); and United Kingdom Department for International Development (DFID)
- Implementing Partners: Jhpiego; Marie Stopes Tanzania; Johns Hopkins University-Center for Communication Programs (JHU-CCP); Chama Cha Uzazi na Malezi Bora Tanzania (UMATI); Wanawake na Maendeleo (WAMA) Foundation; Comprehensive Community-Based Rehabilitation in Tanzania (CCRBT); PSI; Abt Associates; Pathfinder International; FHI 360; PwC US; Tanzania Marketing and Communications (T-MARC); Mwanzo Bora Nutrition Project; NAFAKA Cereal Market Systems Development.

The RESPOND AOR and other USAID/Tanzania staff will provide contacts for these interviews and facilitate formal introductions, as appropriate and needed. The interviews will focus in large part on stakeholders' experiences participating in the implementation of RESPOND. Results will be aggregated by theme and presented anonymously to the greatest extent possible for purposes of documentation.

The list of key informants will be finalized in consultation with USAID during the Team Planning Meeting.

■ **Focus Group Discussions** *(list categories of groups, and purpose of inquiry)*

Focus groups discussions (FGDs) will be conducted with women and men of reproductive age (including adolescents 18 years and older) along with community leaders and members to obtain information from beneficiaries regarding demand for and use of FP services and perceived quality of care. The FGDs are meant to help the evaluation team to gain an in-depth understanding of project achievements and challenges at the local level.

■ **Group Interviews** *(list categories of groups, and purpose of inquiry)*

Where appropriate, KIIs can be clustered into small group interviews, provided there are no power differentials among respondents and all members feel comfortable voicing their opinions within the group. (See KII list above)

■ **Client/Participant Satisfaction or Exit Interviews** (*list who is to be interviewed, and purpose of inquiry*)

The Evaluation Team may consider Client Exit Interviews as needed to answer Evaluation Questions.

☐ **Survey** *(describe content of the survey and target responders, and purpose of inquiry)*

☐ **Facility or Service Assessment/Survey** *(list type of facility or service of interest, and purpose of inquiry)*

■ **Observations** *(list types of sites or activities to be observed, and purpose of inquiry)*

The Evaluation Team may consider Observations at health facilities and/or community activities as needed to answer Evaluation Questions.

X. HUMAN SUBJECT PROTECTION

The Evaluation Team must develop protocols to insure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent as part of this evaluation. **Minors cannot be respondents to any interview or survey, and cannot participate in a focus group discussion without going through an IRB**. The only time minors can be observed as part of this evaluation is as part of a large community-wide public event, when they are part of family and community in the public setting. During the process of this evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

An Informed Consent statement included in all data collection interactions must contain:

- Introduction of facilitator/note-taker
- Purpose of the evaluation/assessment
- Purpose of interview/discussion/survey
- Statement that all information provided is confidential and information provided will not be connected to the individual
- Right to refuse to answer questions or participate in interview/discussion/survey
- Request consent prior to initiating data collection (i.e., interview/discussion/survey)

XI. ANALYTIC PLAN

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data it to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

The evaluation will include both quantitative and qualitative analysis of achievements in relation to the objectives, targets, and output/outcome indicators for the RESPOND award. In the report, the evaluation team will describe any statistical tests that were used and how qualitative data were documented and analyzed. All information and data will be disaggregated by sex and age to show differential outcomes between men and women to meet USAID requirements. Data should also be disaggregated by geography, e.g. rural or urban and by level/type of facility services are being rendered. All analyses will be done for the purposes of answering the above evaluation questions only.

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age, and residence, whenever feasible. Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances, and homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist.

Use of multiple methods that are quantitative and qualitative, as well as analysis of existing data (e.g., data from project performance indicators, national survey, service delivery, TDHS,

TSPA, etc.) will allow the team to triangulate findings to produce more robust evaluation results. The evaluation team will explicitly identify and communicate any methodological strengths and limitations, such as potential for bias and language constraints, among others.

XII. ACTIVITIES

List the expected activities, such as Team Planning Meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

Background reading – Several documents are available for review for this analytic activity. These include the RESPOND proposal, annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data, as well as survey data reports (i.e., National survey, TDHS, TSPA and THMIS). This desk review will provide background information for the Evaluation Team, and will also be used as data input and evidence for the evaluation.

Team Planning Meeting (TPM) – A four-day team planning meeting (TPM) will be held in Dar es Salaam with the evaluation team and USAID/Tanzania staff at the start of the in-country assignment and before data collection begins. The evaluation team will be responsible for developing an agenda for this meeting. However, it is recommended that the meeting be divided into three parts:

OBJECTIVES	PARTICIPANTS
Part 1	
Review and clarify any questions or concerns related to the evaluation statement of work	Evaluation Team USAID/Tanzania
Describe USAID/Tanzania expectations and evaluation team members' roles and responsibilities	
Review evaluation questions	
Review sample and site selection methodology	
Review evaluation timeline	
Review and clarify any logistical and administrative procedures for the assignment	
Part 2	
Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion	Evaluation Team
Establish KII, small group interview, FGD, and site visit methodologies	
Develop data collection instruments, tools, and guidelines	

Develop and complete a data collection plan, including sample and site selection methodology discussed above	
Draft a preliminary outline of the evaluation report	
Assign drafting/writing responsibilities for the final report	
Part 3	
Finalize and present the draft evaluation work plan for the Mission's approval, including evaluation methodologies; data collection instruments, tools, and guidelines; data collection plan and sample and site selection methodology; draft outline of the evaluation report; timeline; logistics; etc.	Evaluation Team USAID/Tanzania

Briefing and Debriefing Meetings – Throughout the evaluation the Team Lead will provide briefings to USAID. The In-Brief and Debrief are likely to include the all Evaluation Team experts, but will be determined in consultation with the Mission. These briefings are:

- Evaluation **launch**, a call/meeting among the USAID, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.
- **In-brief with USAID**, as part of the TPM. At the beginning of the TPM, the Evaluation Team will meet with USAID to discuss expectations, review evaluation questions, and intended plans. The Team will also raise questions that they may have about the project/program and SOW resulting from their background document review. The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.
- **Workplan and methodology review briefing**. At the end of the TPM, the Evaluation Team will meet with USAID to present an outline of the methods/protocols, timeline and data collection tools. Also, the format and content of the Evaluation report(s) will be discussed.
- **In-brief with RESPOND/Tanzania** to review the evaluation plans and timeline, and for the project to give an overview of the project to the Evaluation Team.
- The Team Lead (TL) will brief the USAID **weekly** to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.
- A **final debrief** between the Evaluation Team and USAID will be held at the end of the evaluation to present preliminary findings to USAID. During this meeting a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. The evaluation team shall incorporate comments received from USAID during the debrief in the evaluation report. (***Note****: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.*)
- **IP and Stakeholders' debrief/workshop** will be held with the project staff and other stakeholders identified by USAID. This will occur following the final debrief with the Mission, and will not include any information that may be procurement deemed sensitive or not suitable by USAID. We anticipate a half-day meeting at the Mission with approximately 30 people including RESPOND staff, Government of Tanzania representatives, and other key stakeholders, such as Boresha Afya partners,

identified by the Mission will occur following the final debriefing with USAID/Tanzania to share and validate findings. During this workshop, no information deemed sensitive by the Mission will be shared.

- **Final meeting with USAID/Tanzania**: To be conducted via video or audio conference after the evaluation team has departed Tanzania. Mission staff will provide the evaluation team with final comments on the full draft report prior to its completion and official submission.

Fieldwork, Site Visits and Data Collection – The evaluation team will conduct site visits to for data collection, including KIIs, small group interviews, FGDs, and observations. Selection of sites to be visited will be finalized during TPM in consultation with USAID. The evaluation team, with assistance from the Mission and RESPOND (as necessary), will outline and schedule key meetings and site visits prior to departing to the field. Given the size of the geographic scope of the RESPOND activity and number of site visits to be done in a short period of time, it is recommended that the team split up into two or more groups for data collection.

Evaluation/Analytic Report – The Evaluation/Analytic Team under the leadership of the Team Lead will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team Lead will submit draft evaluation report to GH Pro for review and formatting (see full description of report and requirements below).
2. GH Pro will submit the draft report to USAID
3. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro
4. GH Pro will share USAID's comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro
5. GH Pro will review and reformat the final Evaluation/Analytic Report, as needed, and resubmit to USAID for approval.
6. Once Evaluation Report is approved, GH Pro will re-format it for 508 compliance and post it to the DEC.

The Evaluation Report **excludes** any **procurement-sensitive** and other sensitive but unclassified (**SBU**) information. This information will be submitted in a memo to USIAD separate from the Evaluation Report.

Data Submission – All quantitative data will be submitted to GH Pro in a machine-readable format (CSV or XML). The datasets containing quantitative data that were created as part of this evaluation must be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. It is essential that the datasets are stripped of all identifying information, as the data will be public once posted on USAID Development Data Library (DDL).

Where feasible, qualitative data that do not contain identifying information should also be submitted to GH Pro for archive purposes only.

XIII. DELIVERABLES AND PRODUCTS

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under "Other" in the table below. Provide timelines and deliverable deadlines for each.

Deliverable / Product	Timelines & Deadlines (estimated)
All data instruments, , presentations, and meeting notes for the evaluation will be provided electronically to USAID/Tanzania's POCs (contact information provided below).	
■ Launch briefing	May 24, 2017
■ In-brief with USAID	June 5, 2017
■ Workplan and methodology review briefing	June 9, 2017
■ Workplan (must include questions, methods, timeline, data analysis plan, and instruments)	June 10, 2017
■ In-brief with RESPOND	June 12, 2017
■ Routine briefings	Weekly
■ Out-brief with USAID with Power Point presentation	July 25, 2017
■ Findings review workshop with IP & stakeholders with Power Point presentation	July 26, 2017
■ Draft report	*Submit to GH Pro*: August 16, 2017 *GH Pro submits to USAID*: August 22, 2017
■ Final report	*Submit to GH Pro*: September 14, 2017 *GH Pro submits to USAID*: September 19, 2017
■ Final meeting with USAID/Tanzania (web-conference)	September 25, 2017
■ Raw data (cleaned datasets in CSV or XML with data dictionary)	September 14, 2017
■ Report Posted to the DEC	October 20, 2017
☐ Other (specify):	

Estimated USAID review time
Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? 10 Business days

XIV. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Evaluation/Analytic team: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations/analytics must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise.

- Note that **all team members will be required to provide a signed statement attesting that they have no conflict of interest (COI)**, or describing the conflict of interest if applicable.

Team Qualifications: Please list technical areas of expertise required for this activity:

- *List desired qualifications for the team as a whole*
- *List the key staff needed for this analytic activity and their roles.*
- *Sample position descriptions are posted on USAID/GH Pro webpage*
- *Edit as needed GH Pro provided position descriptions*

Overall Team requirements:

The composition and skill level of the team for the RESPOND evaluation will be critical to its overall success. Thus, it is imperative that the evaluation contractor form a balanced team made up of members with an appropriate mix of technical and subject matter expertise, including in evaluation and FP. The Mission recommends a four-person evaluation team that includes two international consultants and two local consultants.

Overall, the evaluation team will have collective expertise in public health M&E; FP service delivery for all contraceptive methods; health systems strengthening; health economics; capacity building; and FP integration. All team members will also have the following combined qualifications: (1) experience working in Africa, with Tanzania and/or East Africa experience strongly preferred; (2) an understanding of USAID contracting and reporting requirements, policies, and initiatives; (3) knowledge of performance monitoring plans and results frameworks; (4) advanced written and oral communications skills in English; and (5) strong quantitative and qualitative analysis skills.

USAID/Tanzania recommends four senior consultants on this evaluation team with the following background: Senior Evaluation Specialist, Senior Family Planning/Reproductive Health Expert, and Host Country National Health Experts.

Team Lead: This person will be selected from among the key staff, and will meet the requirements of both this and the other position. The team lead should have significant experience conducting project evaluations/analytics.
Roles & Responsibilities: The team leader will be responsible for (1) providing team leadership; (2) managing the team's activities, (3) ensuring that all deliverables are of good quality and are completed in a timely manner, (4) serving as a liaison between the USAID and the evaluation/analytic team, and (5) leading briefings and presentations.
Qualifications:

- Minimum of 10 years of senior level experience in public health, which includes experience in implementation of health activities and/or evaluations in developing countries
- Doctorate or master's degree, with related postgraduate training in public health program evaluation
- Demonstrated experience leading health sector project/program evaluation or research, utilizing both quantitative and qualitative methods
- Experience or familiarity with USAID-funded FP/RH programs and will have a solid understanding of health systems in Africa, preferably in Tanzania or East Africa.
- Excellent skills in planning, facilitation, and consensus building
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders

- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Experience working in the region, and experience in Tanzania is desirable
- Familiarity with USAID
- Familiarity with USAID policies and practices
  - Evaluation policy
  - Results frameworks
  - Performance monitoring plans

Key Staff 1 Title: **Evaluation Specialist**

Roles & Responsibilities: Serve as a member of the evaluation team, providing quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, insuring highest level of reliability and validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He will participate in all aspects of the evaluation, from planning, data collection, data analysis to report writing.

Qualifications:

- At least 10 years of experience in USAID M&E procedures and implementation
- At least 5 years managing M&E, including evaluations
- Doctorate or master's degree in public health or related field, or equivalent experience, particularly in evaluation and/or research
- Experience in design and implementation of evaluations
- Strong knowledge, skills, and experience in qualitative and quantitative evaluation tools
- Experience implementing and coordinating other to implements surveys, key informant interviews, focus groups, observations and other evaluation methods that assure reliability and validity of the data.
- Experience in data management
- Able to analyze quantitative, which will be primarily descriptive statistics
- Able to analyze qualitative data
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
- Able to review, interpret and reanalyze as needed existing data pertinent to the evaluation
- Strong data interpretation and presentation skills
- An advanced degree in public health, evaluation or research or related field
- Proficient in English
- Ability to speak and understand Swahili would be beneficial, but not required.
- Good writing skills, including extensive report writing experience
- Familiarity with USAID health programs/projects, primary health care or health systems strengthening preferred
- Familiarity with USAID M&E policies and practices
  - Evaluation policies
  - Results frameworks

- Performance monitoring plans

Key Staff 2 Title: **Senior FP/RH Expert** (International Consultant)

Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise in FP/RH. S/He will take the lead in assessing the ability of RESPOND to achieve its four major sub-purposes and to provide technical leadership in the area of FP/RH programming. S/He will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.

Qualifications:

- At least 10 years' experience with FP/RH projects; USAID project implementation experience preferred
- Doctorate or master's degree in public health or related field, or equivalent experience
- Expertise in supply and demand for FP services at the community and clinical level
- Proven background and experience in FP and maternal health and a strong understanding of the challenges Tanzania faces for increasing its modern contraceptive use
- Solid understanding of relevant national programs in FP in Africa, including in the public and private sectors.
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Proficient in English.
- Ability to speak and understand Swahili would be beneficial, but not required.
- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities

Key Staff 3 Title: **National Health Expert** (2 Host Country Consultants)

Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise Tanzania health systems, particularly FP/RH. S/He will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report. S/He will serve under the Team Lead.

Qualifications:

- At least 7 years' experience with FP/RH and/or maternal health projects; USAID project implementation experience preferred
- Master's degree in public health or related field, or equivalent experience
- Knowledge of Tanzania's public sector health system and national FP program
- Expertise in supply and demand for FP services at the community and clinical level

- Proven background and experience in FP and maternal health and a strong understanding of the challenges Tanzania faces for increasing its modern contraceptive use
- Experience facilitating and note taking of key informant interviews, group interviews and focus group discussions
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Proficient in English and Swahili
- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities

Other Staff Titles with Roles & Responsibilities (include number of individuals needed):

Local **Evaluation Logistics /Program Assistant** will support the Evaluation Team with all logistics and administration to allow them to carry out this evaluation. The Logistics/Program Assistant will have a good command of English and Swahili. S/He will have knowledge of key actors in the health sector and their locations including MOH, donors and other stakeholders. To support the Team, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and insure business center support, e.g. copying, internet, and printing. S/he will work under the guidance of the Team Leader to make preparations, arrange meetings and appointments. S/he will conduct programmatic administrative and support tasks as assigned and ensure the processes moves forward smoothly. S/He may also be asked to assist in translation of data collection tools and transcripts, if needed. [**Note**: in lieu of this position one of the National Health Experts, experienced in GH Pro evaluation logistic needs, will coordinate and oversee the logistics, with assistance from the Local Evaluators.]

Local Evaluators (2-4 local consultants) to assist the Evaluation Team with data collection, analysis and data interpretation. They will have basic familiarity with health topics, as well as experience conducting surveys interviews and focus group discussion, both facilitating and note taking. Furthermore, they will assist in translation of data collection tools and transcripts, as needed. The Local Evaluators will have a good command of English and Swahili. They will also assist the Team and the Logistics Coordinator, as needed. They will report to the Team Lead.

As needed, a local **Translator** (2-3) will work with each data collection team

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

☐ Yes – If yes, specify who:
☐ Significant Involvement anticipated – If yes, specify who:
■ No

Staffing Level of Effort (LOE) Matrix:
This LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

a) For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.
b) Immediately below each staff title enter the anticipated number of people for each titled position.
c) Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.
d) Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
e) At the bottom of the table total the LOE days for each consultant title in the 'Sub-Total' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

Level of Effort in **days** for each Evaluation/Analytic Team member
(The following is an Illustrative LOE Chart. Please edit to meet the requirements of this activity.)

Activity / Deliverable		Evaluation/Analytic Team				
		Team Lead / Eval Spec	P/RH Expert	Nat'l Health Expert / Field Coord	Nat'l Health Expert	Local Evals
Number of persons →		1	1	1	1	2-4
1	Launch Briefing	0.5				
2	HTSOS Training	1	1			
3	Desk review	5	5	5	5	2
4	Preparation for Team convening in-country	1		4		2
5	Travel to country	2	2			
6	In-brief with Mission	0.5	0.5	0.5	0.5	0.5
7	Team Planning Meeting	4	4	4	4	4
8	Workplan and methodology briefing with USAID	0.5	0.5	1	0.5	0.5
9	Eval planning deliverables: 1) workplan with timeline analytic protocol (methods, sampling & analytic plan); 2) data collection tools					
10	In-brief with project	0.5	0.5	1	0.5	0.5
11	Data Collection DQA Workshop (protocol orientation/training for all data collectors)	2	2	2	2	2
12	Prep / Logistics for Site Visits	0.5	0.5	2	0.5	1
13	Data collection / Site Visits (including travel to sites)	24	24	24	24	24
14	Data analysis	7	7	7	7	7
15	Debrief with Mission with prep	1	1	1	1	1
16	Stakeholder debrief workshop with prep	1	1	1	1	1

Activity / Deliverable		Evaluation/Analytic Team				
		Team Lead / Eval Spec	P/RH Expert	Nat'l Health Expert / Field Coord	Nat'l Health Expert	Local Evals
	Logistic Support and Closeout			2		
17	Depart country	2	2			
18	Draft report(s)	7	6	6	6	3
19	GH Pro Report QC Review & Formatting					
20	Submission of draft report(s) to Mission					
21	USAID Report Review					
22	USAID manages Stakeholder review (eg, IP(s), government partners, etc) and submits any Statement of Difference to GH Pro.					
23	Revise report(s) per USAID comments	3	2	1	1	
24	Finalize and submit report to USAID					
25	USAID approves report					
26	Final meeting with USAID/Tanzania (web-conference) with prep	1.5	1	1	1	
27	Final copy editing and formatting					
28	508 Compliance editing					
29	Eval Report(s) to the DEC					
	Total LOE per person	**64**	**60**	**63**	**54**	**49**
	Total LOE	**64**	**60**	**63**	**54**	**98-196**

If overseas, is a 6-day workweek permitted■ Yes☐ No

Travel anticipated: List international and local travel anticipated by what team members.

Purposive site selection will be among Districts located within Regions covered by the 4 RESPOND Field Offices: 1) Mwanza, 2) Arusha, 3) Iringa, 4) Coast (Dar es Salaam). See Annex 1 for complete list.

XV. LOGISTICS

Visa Requirements

List any specific Visa requirements or considerations for entry to countries that will be visited by consultant(s):

List recommended/required type of Visa for entry into counties where consultant(s) will work

Name of Country	Type of Visa

Tanzania	☐ Tourist	■ Business	☐ No preference
	☐ Tourist	☐ Business	☐ No preference
	☐ Tourist	☐ Business	☐ No preference
	☐ Tourist	☐ Business	☐ No preference

Clearances & Other Requirements

Note: Most Evaluation/Analytic Teams arrange their own work space, often in conference rooms at their hotels. However, if a Security Clearance or Facility Access is preferred, GH Pro can submit an application for it on the consultant's behalf.

GH Pro can obtain **Secret Security Clearances** and **Facility Access (FA)** for our consultants, but please note these requests processed through USAID/GH (Washington, DC) can take 4-6 months to be granted, with Security Clearance taking approximately 6 months to obtain. If you are in a Mission and the RSO is able to grant a temporary FA locally, this can expedite the process. If Security Clearance or FA is granted through Washington, DC, the consultant must pick up his/her badge in person at the Office of Security in Washington, DC, regardless of where the consultant resides or will work.

If **Electronic Country Clearance (eCC)** is required prior to the consultant's travel, the consultant is also required to complete the **High Threat Security Overseas Seminar (HTSOS).** HTSOS is an interactive e-Learning (online) course designed to provide participants with threat and situational awareness training against criminal and terrorist attacks while working in high threat regions. There is a small fee required to register for this course. [*Note: The course is not required for employees who have taken FACT training within the past five years or have taken HTSOS within the same calendar year.*]

If eCC is required, and the consultant is expected to work in country more than 45 consecutive days, the consultant may be required complete the one week **Foreign Affairs Counter Threat (FACT) course** offered by FSI in West Virginia. This course provides participants with the knowledge and skills to better prepare themselves for living and working in critical and high threat overseas environments. Registration for this course is complicated by high demand (consultants must register approximately 3-4 months in advance). Additionally, there will be the cost for additional lodging and M&IE to take this course.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

☐ USAID Facility Access (FA)
Specify who will require Facility Access:
■ Electronic County Clearance (ECC) (International travelers only)
■ High Threat Security Overseas Seminar (HTSOS) (*required in most countries with ECC*)
☐ Foreign Affairs Counter Threat (FACT) (for consultants working on country more than 45 consecutive days)
☐ GH Pro workspace
Specify who will require workspace at GH Pro:
☐ Travel -other than posting (specify):
☐ Other (specify):

XVI. GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation/analytic team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation/analytic team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production - If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

XVII. USAID ROLES AND RESPONSIBILITIES

Below is the standard list of USAID's roles and responsibilities. Add other roles and responsibilities as appropriate.

USAID Roles and Responsibilities

USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:

Before Field Work

- SOW.
  - Develop SOW.
  - Peer Review SOW
  - Respond to queries about the SOW and/or the assignment at large.
- Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.
- Documents. Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.
- Local Consultants. Assist with identification of potential local consultants, including contact information.
- Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.
- Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e.,, car rental companies and other means of transportation).

During Field Work

- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.
- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e., USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders.
- Facilitate Contact with Implementing Partners. Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After Field Work

- Timely Reviews. Provide timely review of draft/final reports and approval of deliverables.

XVIII. ANALYTIC REPORT

Provide any desired guidance or specifications for Final Report. (See *How-To Note: Preparing Evaluation Reports*)

The final performance evaluation report will be a comprehensive, analytical, evidence-based document. It will describe results, findings, constraints, and lessons learned; present recommendations; and identify key questions for future consideration, as appropriate. The report will follow USAID branding procedures. An acceptable report will:

- Represent a thoughtful, well-researched, and well-organized effort to objectively evaluate what worked under RESPOND, what did not work, and why
- Address all evaluation questions included in the statement of work
- Include the statement of work and any related modifications in an annex to the final report [Note: All modifications to the statement of work, whether in technical requirements, evaluation questions, evaluation team composition, methodology, and/or timeline shall be agreed upon in writing.]
- Explain in detail all tools used in conducting the performance evaluation such as questionnaires, checklists, and discussion guides, with samples of each included in an annex to the final report
- Present findings using sex- and age-disaggregated data, where appropriate
- Disclose limitations of the evaluation, with particular attention to the limitations associated with the methodology (e.g., selection bias, recall bias, unobservable differences between comparison groups)
- Present findings based on analyzed data, facts, and evidence; findings should not be based on anecdotes, hearsay, or evaluators' opinions
- Present findings that are specific, concise, and supported by strong quantitative and/or qualitative evidence
- Cite sources of information and properly identify and list as such in an annex to the final report, including a list of individuals interviewed [Note: If disclosure of an individual's name and location is a breach of confidentiality, s/he should be listed only by category of respondents, such as "rural female FP user."]
- Include recommendations supported by findings; recommendations should be action-oriented, practical, and specific, with defined responsibility for the action.

The **Evaluation Final Report** must follow USAID's Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the USAID Evaluation Policy).

- The report must not exceed 30 pages (excluding executive summary, table of contents, acronym list and annexes).
- The structure of the report should follow the Evaluation Report template, including branding found here or here.
- Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.
- For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found here.

USAID Criteria to Ensure the Quality of the Evaluation Report (USAID ADS 201):

- Evaluation reports should be readily understood and should identify key points

clearly, distinctly, and succinctly.

- The Executive Summary of an evaluation report should present a concise and accurate statement of the most critical elements of the report.
- Evaluation reports should adequately address all evaluation questions included in the SOW, or the evaluation questions subsequently revised and documented in consultation and agreement with USAID.
- Evaluation methodology should be explained in detail and sources of information properly identified.
- Limitations to the evaluation should be adequately disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Evaluation findings should be presented as analyzed facts, evidence, and data and not based on anecdotes, hearsay, or simply the compilation of people's opinions.
- Findings and conclusions should be specific, concise, and supported by strong quantitative or qualitative evidence.
- If evaluation findings assess person-level outcomes or impact, they should also be separately assessed for both males and females.
- If recommendations are included, they should be supported by a specific set of findings and should be action-oriented, practical, and specific.

Reporting Guidelines: The draft report should be a comprehensive analytical evidence-based evaluation/analytic report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. ***The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.***

The findings from the evaluation/analytic will be presented in a draft report at a full briefing with USAID and at a follow-up meeting with key stakeholders. The report should use the following format:

- Abstract: briefly describing what was evaluated, evaluation questions, methods, and key findings or conclusions (not more than 250 words)
- Executive Summary: summarizes key points, including the purpose, background, evaluation questions, methods, limitations, findings, conclusions, and most salient recommendations (2-5 pages)
- Table of Contents (1 page)
- Acronyms
- Evaluation/Analytic Purpose and Evaluation/Analytic Questions: state purpose of, audience for, and anticipated use(s) of the evaluation/assessment (1-2 pages)
- Project [or Program] Background: describe the project/program and the background , including country and sector context, and how the project/program addresses a problem or opportunity (1-3 pages)
- Evaluation/Analytic Methods and Limitations: data collection, sampling, data analysis and limitations (1-3 pages)

- Findings (organized by Evaluation/Analytic Questions): substantiate findings with evidence/data
- Conclusions
- Recommendations
- Annexes
- Annex I: Evaluation/Analytic Statement of Work
- Annex II: Evaluation/Analytic Methods and Limitations ((if not described in full in the main body of the evaluation report)
- Annex III: Data Collection Instruments
- Annex IV: Sources of Information
    - List of Persons Interviews
    - Bibliography of Documents Reviewed
    - Databases
    - [etc.]
- Annex V: Statement of Differences (if applicable)
- Annex VI: Disclosure of Any Conflicts of Interest
- Annex VII: Summary information about evaluation team members, including qualifications, experience, and role on the team.
- :

The Team will submit a memo to USAID/Tanzania with a Draft Dissemination and Use Plan (1-2 pages). [*This will provide the Mission ideas on what external and internal stakeholders the evaluators feel need to be reached for more targeted meetings to review the findings and recommendations and in what formats might work best.*]

The evaluation methodology and report will be compliant with the USAID Evaluation Policy and Checklist for Assessing USAID Evaluation Reports

The Evaluation Report should **exclude** any **potentially procurement-sensitive information**. As needed, any procurement sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USIAD separate from the Evaluation Report.

All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be submitted electronically to the GH Pro Program Manager. All datasets developed as part of this evaluation will be submitted to GH Pro in an unlocked machine-readable format (CSV or XML). The datasets must not include any identifying or confidential information. The datasets must also be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. Qualitative data included in this submission should not contain identifying or confidential information. Category of respondent is acceptable, but names, addresses and other confidential information that can easily lead to identifying the respondent should not be included in any quantitative or qualitative data submitted.

XIX. USAID CONTACTS

	Primary POC	Alternate POCs		
Name:	Jennifer Erie	Selina Mathias	Jane Schueller	Moses Busiga

Title:	Program Office MEL POC	FP/HIV Integration Specialist	Senior FP Advisor	M&E Specialist
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List other contacts who will be supporting the Requesting Team with technical support, such as reviewing SOW and Report (such as USAID/W GH Pro management team staff)

	Technical Support Contact 1	**Technical Support Contact 2**
Name:		
Title:		
USAID Office/Mission		
Email:		
Telephone:		
Cell Phone:		

XX. OTHER REFERENCE MATERIALS

Documents and materials needed and/or useful for consultant assignment, that are not listed above

XXI. ADJUSTMENTS MADE IN CARRYING OUT THIS SOW AFTER APPROVAL OF THE SOW (*To be completed after Assignment Implementation by GH Pro*)

The SOW initially had three Evaluation Questions. As work progressed, a fourth Evaluation Question was added. The final Evaluation Questions are:

1. What and how did specific enablers and constraints affect FP uptake in RESPOND regions?

2. How did RESPOND's model(s) of integration affect the uptake of FP services from various perspectives? Compare RESPOND sites with integration and without integration and assess which integration model is more effective.
3. How did RESPOND's district-centered approach result in strengthening the capacity of local government to manage and implement FP programs?
4. How has RESPOND contributed to community mobilization for increasing utilization of FP and RH services, including greater access to LARCs/PMs?

XXII. List of RESPOND Field Offices and their Respective Regions and Districts

Field Office	Region	Districts	Notes
MWANZA	Geita	Bukombe	cPAC and FP integration implemented in Geita region
		Chato	
		Geita	
	Kagera	Biharamulo	
		Bukoba District Council	
		Bukoba Municipal	
		Karagwe	
		Misenyi	
		Muleba	
		Ngara	
	Kigoma	Kasulu	
		Kibondo	
		Kigoma District Council	
		Kigoma Municipal	
	Mara	Bunda	
		Musoma District Council	
		Musoma Municipal	
		Rorya	
		Serengeti	
		Tarime	
	Mwanza	Ilemela	cPAC and FP integration implemented in Mwanza region
		Kwimba	
		Magu	
		Misungwi	
		Nyamagana	
		Sengerema	
		Ukerewe	
	Shinyanga	Kahama	cPAC and FP integration implemented in Shinyanga region
		Kishapu	
		Shinyanga District Council	
		Shinyanga Urban	
	Simiyu	Bariadi	
		Maswa	
		Meatu	
	Tabora	Igunga	
		Nzega	
		Sikonge	
		Tabora Urban	
		Urambo	
		Uyui	
ARUSHA	Arusha	Arusha Rural	
		Arusha Urban	

Field Office	Region	Districts	Notes
		Karatu	
		Longido	
		Monduli	
	Kilimanjaro	Hai	
		Moshi Rural	
		Moshi Urban	
		Rombo	
	Manyara	Babati Rural	FP and HIV integration implemented in Manyara region
		Hanang	
		Kiteto	
		Mbulu	
		Simanjiro	
	Tanga	Handeni DC	
		Kilindi	
		Korogwe	
		Muheza	
	Dodoma	Dodoma Urban	
		Kondoa	
		Kongwa	
		Mpwapwa	
	Singida	Iramba West	
		Manyoni	
		Mkalama	
		Singida Rural	
		Singida Urban	
IRINGA	Iringa	Iringa Rural	GBV and FP integration implemented in Iringa region
		Kilolo	
		Mufindi	
	Katavi	Mpanda Rural	
	Mbeya	Mbarali	
		Mbeya Rural	
		Mbeya Urban	
		Mbozi	
		Rungwe	
	Njombe	Njombe Rural	GBV and FP integration implemented in Njombe region
		Njombe Urban	
	Rukwa	Nkasi	
		Sumbawanga Rural	
	Ruvuma	Mbinga	
		Songea Rural	
		Songea Urban	
		Tunduru	
COAST	Dar es Salaam	Ilala	

Field Office	Region	Districts	Notes
		Kinondoni	
		Temeke	
	Morogoro	Kilombero	Youth FP services implemented in Morogoro region
		Kilosa	
		Morogoro Rural	
		Morogoro Urban	
		Mvomero	
		Ulanga	
	Lindi	Kilwa	
		Lindi Rural	
		Lindi Urban	
		Liwale	
		Nachingwea	
		Ruangwa	
	Mtwara	Masasi District Council	
		Mtwara Rural	
		Nanyumbu	
		Newala	
		Tandahimba	
	Pwani	Bagamoyo	
		Kibaha Rural	
		Kibaha Urban	
		Kisarawe	
		Mkuranga	
		Rufiji	

ANNEX II. DOCUMENT SUPPORT MATERIALS

ANNEX III.A ADMINISTRATIVE AND HEALTH SERVICE LEVELS IN TANZANIA

ANNEX II.B. TABLE 1. SUMMARY OF GOT NATIONAL FP POLICIES & GUIDELINES

Year	KEY SRH/FP Policies	Aim/Goal
2008	National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008–2015 (One Plan): http://www.who.int/pmnch/countries/tanzaniamapstrategic.pdf	One Plan Strategy had set a goal to increase the CPR from 20 percent to 60 percent by 2015.
2010	The National FP Costed Implementation Plan 2010-2015 (NFPCIP): https://www.fhi360.org/sites/default/files/media/documents/national-fp-costed-implementation-plan-tanzania-main-text.pdf	A strategic Framework detailing the program activities necessary to meet the One Plan CPR target of 60% and their cost estimates between 2010 and 2015.
2010	National Package of Essential FP Interventions (NPEFPI)" guidelines.	Presents priority FP activities and their unit costs that can be used to allocate resources for FP in the district plans.
2011	The National FP Procedure Manual (2011): http://www.afyatzsms.com/afyatzsms/pluginfile.php/74/mod_resource/content/1/National%20Family%20Planning%20Procedure%20Manual.pdf	States that "*All individuals have a right to receive services from FP programs, regardless of their socio-economic situation, religion, political belief, ethnic origin, age, marital status, geographic location or other characteristics which may place individuals in certain groups*."
2012	National Operational Guidelines for Integration (NOGI)	Provides guidelines for integrating FP (FP) into various SRH services.
2013	Amended National FP Costed Implementation Plan 2010-2015 (NFPCIP): http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/12/Tanzania-NFPCIP.pdf	Accommodate additional activities and new targets in response to the FP2020 commitments as well as the lessons learned from implementing the original NFPCIP.
2013	FP2020 Action Plan: http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/10/Tanzania-Action-Plan-2016-2017.pdf	Detailing strategic actions for implementing the FP2020 commitments
2014	2014-2015 National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths (Sharpened One Plan): http://www.mamaye.org/sites/default/files/evidence/RMNCH%20Plan%202014%20to%202015.pdf	Details four high-impact interventions (including FP) for the remaining 500 days towards reaching the Millennium Development Goals' (MDGs) deadline of 2015.
2014	National Road Map Strategic Plan to Improve Reproductive, Maternal, Newborn, Child, and Adolescent Health-One Plan II (2016-2020): http://ihi.eprints.org/3733/1/ONE%20PLAN%20CEEMI.pdf	A strategic document to pick up from where the Sharpened One Plan (2014-2015) ended.
2014D	National Guidelines for FP Outreach Services.	Standardize guidelines for implementation of FP Outreach services.
	Other Relevant Policies	
1971	1971 Marriage Act: http://www.rita.go.tz/eng/laws/History%20Laws/Marriage%20Ordinance,%20(cap%2029).pdf	Stipulates a legal minimum age of marriage of 15 years for females and 18 for males.

1972	Penal Code 1972: www.lrct.go.tz/?wpfb_dl=170	Requires parental consent for "minors" (children below 12 years) to receive medical and surgical services. Adolescents below the age of 16 need parental consent to receive FP services or an HIV test, unless they are married or have children.
1995	Tanzania Development Vision 2025: http://www.tzonline.org/pdf/theTanzaniadevelopmentvision.pdf	Realizes access to quality reproductive health services for all individuals of appropriate ages as among key strategies for achieving high quality livelihood for all Tanzanians.
2006	Tha National Population Policy (2006): http://www.africanchildforum.org/clr/policy%20per%20country/tanzania/tanzania_population_2006_en.pdf	Identifies low use of FP services as among underlying factors that contribute towards high fertility in Tanzania.
2010	National Strategy for Growth and Reduction of Poverty II (NSGRP II): www.tzonline.org/pdf/mkukutalldraft.pdf	Identifies provision of information, services and education on FP methods and options as important strategies for slowing down the total fertility rate and population growth.
2014	Third Health Sector HIV and AIDS Strategic Plan (HSHSP- III) 2013 – 2017: www.nacp.go.tz/site/download/hshsp3final2014.pdf	Identifies strengthening integration and linkages to RCH services specifically FP as one of the priority strategies
2015	Health Sector Strategic Plan IV (HSSP IV): http://www.tzdpg.or.tz/fileadmin/documents/dpg_internal/dpg_working_groups_clusters/cluster_2/health/#Key_Sector_Documents/Induction_Pack/Final_HSSP_IV_Vs1.0_260815.pdf	States that FP will continue to receive high priority in Tanzania and set a goal to reduce barriers to access of FP services. Set a goal to increase CPR (married women 15-49) to 60% and reduce Adolescent Fertility Rate (under 20) to less than 10% by 2020.
2016	Tanzania National Five Year Development Plan: http://www.mof.go.tz/mofdocs/msemaji/Five%202016_17_2020_21.pdf	Realizes FP as one of the interventions required to improve access and quality of basic social services and reduce communicable and non-communicable diseases.

ANNEX II.C. SUMMARY OF FINDINGS FROM HEALTH FACILITY SITE VISITS.

Five Summary Tables from 17 Site Observations

Table 1. Number of staff trained since 2012 versus number still present.

Table 2. Stock out for FP contraceptives and equipment in the past one year.

Table 3. Stock of IEC materials (Brochures) specific for each method available for distribution to clients.

Table 4. Presence of FP methods in the service area (LARC and/or Short-term).

Table 5. Gaps/Problems, Best Practices and Key Missed Opportunities

Table 1. Number of staff trained since 2012 versus number still present

	Type of contraceptive services provided:	Male Sterilization	Female Sterilization	IUD	Norplant	DMPA
1	Mafinga Hospital	NA	NA	NA	NA	NA
2	Kilolo Dispensary	NA	NA	NA	NA	NA
3	Kasanga Health Centre	NA	NA	2/0	4/4	NA
4	Ilula Hospital	NA	NA	NA	NA	NA
5	Iyunga Health Centre	NA	0/0	2/2	11/10	6/*
6	Ruanda Health Centre	NA	2/2	2/2	10/5	10/6
7	Kaloleni HC	0/0	2/*	5 /5	5 /5	6 /6
8	Ngarenaro HC	0/0	2/*	4/4	4 staff from central training and 2 through OJT/*	10 staff through central training/*
9	Karatu Health Centre	1/1	1/1	8/8	8/8	8/8
10	Galapo Health Centre	0	0	6 trained and 2 present	12 staff and 7 present	All providers
11	Tumaini Hospital	1 /1	1 /1	5/*	15 /15	15 /15
12	Misasi Health Centre	2/2	2/2	5/4	5/4	4/4
13	Nyamagana District Hospital	2/2	2/2	20/17	20/17	20/17
14	Malampaka Health Centre	NA	NA	2/*	5/*	5/*
15	Maswa District Hospital	3/3	6/6	18/18	15/15	16/16
16	Mlandizi Health Centre	5/5	5/5	5/5	5/5	5/5
17	Uhuru Health Centre	NA	NA	4/4	11/11	11/11

*Data not collected for number trained staff still present.

Table 2. Stock out for FP contraceptives and equipment in the past one year:

		Male Sterilization	Female Sterilization	IUD	Norplant	DMPA	Condom /OCP	Progestin Pills/ ECP
1	Mafinga Hospital	0	0	0	0	0	0	0
2	Kilolo Dispensary	0	0	0	0	0	0	0
3	Kasanga Health Centre	NA	0	NA	0	1	0	1
4	Ilula Hospital	0	0	0	0	0	0	0
5	Iyunga Health Centre	NA	NA	0	0	0	0	1
6	Ruanda Health Centre	NA	0	0	0	0	0	0
7	Kaloleni HC	0	0	0	0	0	0	1[5]
8	Ngarenaro HC	0	0	0	0	0	0	0
9	Karatu Health Centre	0	0	0	0	0	0	0
10	Galapo Health Centre	NA	NA	0	0	0	0	0
11	Tumaini Hospital	0	0	0	0	0	0	0
12	Misasi Health Centre	0	0	0	0	0	0	0
13	Nyamagana District Hospital	0	0	0	0	0	0	0
14	Malampaka Health Centre	NA	NA	0	0	0	0	0
15	Maswa District Hospital	0	0	0	0	0	0	0
16	Mlandizi Health Centre	0	0	0	0	0	0	0
17	Uhuru Health Centre	0	0	0	0	0	0	0

[5] This HC reported that they have never had PoPs in stock due to low demand. They have ECP in stock (Postinor2).

Table 3. Stock of IEC materials (Brochures) specific for each method available for distribution to clients

	Distribution material	**Male Sterilization**	**Female Sterilization**	**IUD**	**Norplant**	**DMPA**	**Condom /OCP**
1	Mafinga Hospital	No	No	Yes	Yes	No	Yes
2	Kilolo Dispensary	Yes	Yes	Yes	Yes	Yes	Yes
3	Kasanga Health Centre	No	No	Yes	No	No	No
4	Ilula Hospital	Yes	Yes	Yes	Yes	Yes	Yes
5	Iyunga Health Centre	No	No	No	Yes	No	No
6	Ruanda Health Centre	No (General for all methods only)	No (General for all methods only)	No (General for all methods only)	No (General for all methods only)	No (General for all methods only)	No (General for all methods only)
7	Kaloleni HC	Yes	No	Yes	Yes	No	No
8	Ngarenaro HC	Yes	Yes	Yes	Yes	Yes	No
9	Karatu Health Centre	Yes	Yes	Yes	Yes	Yes	Yes
10	Galapo Health Centre	Yes	Yes	Yes	Yes	Yes	Yes
11	Tumaini Hospital	Yes	Yes	Yes	Yes	No	No
12	Misasi Health Centre	Yes	Yes	Yes	Yes	No	No
13	Nyamagana District Hospital	Yes	Yes	Yes	Yes	Yes	Yes
14	Malampaka Health Centre	NA	NA	Yes	Yes	Yes	No
15	Maswa District Hospital	No	No	No	No	No	No
16	Mlandizi Health Centre	Yes	Yes	Yes	Yes	Yes	Yes
17	Uhuru Health Centre	No	No	No	Yes	No	No

Table 4. Presence of FP methods in the service area (LARC and/or Short-term)

	FP services integrated into:	CTC	Post-natal/LND	Immuniza-tion/ under 5	OPD/STI	IPD (Pediatric, Female/ Gyn)	Cervical Cancer	TB clinic	cPAC
1	**Mafinga Hospital**	No	Yes	No	No	No	No	No	NA
2	**Kilolo Dispensary**	Yes	Yes	Yes	Yes	No unit	Yes	No unit	NA
3	**Kasanga Health Centre**	Yes	No	No	No	No	No	No	NA
4	**Ilula Hospital**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA
5	**Iyunga Health Centre**	Yes	No	No	No	No	No	No	NA
6	**Ruanda Health Centre**	Yes	Yes	No	RCH only	L&D only	No	No	NA
7	**Kaloleni HC**	No	Yes but only counselling and referral to Mount Meru hospital	No	No	No	No	No	NA
8	**Ngarenaro HC**	Yes	No	No	No	No	No	No	NA
9	**Karatu Health Centre**	Yes	Yes	Yes	No	Ref to RCH	Yes	No	NA
10	**Galapo Health Centre**	Yes	Yes	Yes	Yes	Yes	NA	Yes	NA
11	**Tumaini Hospital**	Yes	Yes	Yes	No	Yes	Yes	No	NA
12	**Misasi Health Centre**	No	No	No	No	No	No	No	Yes
13	**Nyamagana District Hospital**	?	Yes	Yes	No	Ref to RCH	Yes	Yes	NA
14	**Malampaka Health Centre**	Yes	Yes	Yes	Yes	Yes	NA	NA	NA
15	**Maswa District Hospital**	No	Yes	No	No	No	No	No	NA
16	**Mlandizi Health Centre**	Yes	Yes	Yes	Yes	Yes	NA	Yes	NA
17	**Uhuru Health Centre**	No	No	No	No	No	No	No	NA

Table 5. Gaps/Problems, Best Practices and Key Missed Opportunities

	Location	Gaps/Problems	Best Practices	Key missed opportunities
1	**Mafinga Hospital**	There were only two places in the hospital where FP services were provided: The RCH and Labour and delivery. The RCH does not offer HIV testing/it offers HIV testing but only under PMTC platform. Some basic supplies were not sufficient: speculums. Storage area was not well maintained.		There were missed opportunities to give FP services greater visibility in many of the service delivery settings.
2	**Kilolo Dispensary**			
3	**Kasanga Health Centre**	Lack of FP IEC materials. Poor quality flip chart. Stock out of DMPA and Microlut, very low supply of ECP. Loss of two staff trained in IUD. Zero trained staff currently available for IUD. No lamp in operating theater.		Failure of EH to assist in stock out of DMPA. Failure to train staff in IUD and PP IUD. Need high quality flip chart for patient education. Need low-literacy materials for rural peasant clients.
4	**Ilula Hospital**			
	Lyunga HC	R1 Trainee: Only 3 IUD insertions as part of training. R2 Trainee: Implanon only 1 day of OJT experience. Not enough IUD kits (only 1)	Overall impression very favorable.	PP-IUD, Need method-specific IEC materials.
6	**Ruanda Health Centre**			
7	**Kaloleni HC**	• They need IEC materials specific for condoms, DMPA and Female Sterilization. • Not enough IUD kits (have only 3 kits) • Potential clients for PPIUD are available but they have to refer them to Regional hospital because there is no trained staff on PPIUD		• Potential clients for PPIUD are available but they have to refer them to Regional hospital because there is no trained staff on PPIUD
8	**Ngarenaro HC**	• They need IEC materials specific for condoms • Not enough IUD kits (have only 3 kits)		
9	**Karatu Health Centre**			
10	**Galapo Health Centre**		• This facility was among the best examples of integration. It had all methods, including LARCs in all departments that integrated FP (refer above table). • The facility also had a good stock of all contraceptives. The store room was well equipped with all contraceptives stored in	

	Location	Gaps/Problems	Best Practices	Key missed opportunities
			a very good arrangement in lockers that were reported having been donated by EH.	
11	**Tumaini Hospital**	• They need IEC materials specific for condoms and DMPA. • Not enough IUD kits (have only 5 kits)		
12	**Misasi Health Centre**	•They need IEC materials specific for condoms and DMPA. •Not enough IUD kits (have only 5 kits) •Provide FP planning methods during Immunization outreach but they don't have records (tools for integration) •Do not provide PPIUD though they deliver women (15-20 per day) and the reason being lack of trained staff •They have few trained staff for Integration (only 2 staff)		
13	**Nyamagana District Hospital**		• Labour and delivery not mentioned but they provide LARC/PM • All nurses at the Labour and delivery ward are trained with PPIUD and implant • 13 nurses are inserter while 4 are counsellor • At least every day 2 clients received LARC at the delivery ward	
14	**Malampaka Health Centre**			
15	**Maswa District Hospital**	• They need IEC materials specific for Male sterilization and DMPAs • No enough IUD kits (have only 5 kits) • Provide FP planning methods during Immunization outreach but they don't have records (tools for integration) they just write on the pieces of papers during outreach because of lack of enough FP tools • They have few trained staff for Integration (only 5 staff) • In some departments like CTC they provide methods there, counsel clients there but do not record because of lack of FP		

	Location	Gaps/Problems	Best Practices	Key missed opportunities
		registers enough to put in every service area. • CPAC Service is not provided since last year because two trained staff are now not available		
16	**Mlandizi Health Centre**			
17	**Uhuru Health Centre**	• They need IEC materials specific for all the methods except Implants • No enough IUD kits (have only 3 kits) • No enough MinLap kits (only one kit) • Shortage of progestin-only pills for the past six month • Lack of trained staff on LARCs and PMs although there are eligible staff for training • Need examination Lamp for procedure and a big autoclave for sterilization of equipments	• They are providing this service to young girls aged 14 years to 19 years (mostly secondary school girls) who come with either their mother's or alone. • Mostly they use IUD, although normally come for DMPA but after counseling from the trained provider (who seems to be well informed about FP, including the side effects and risk like when having STI) they normally change and decide to take IUD. Provider normally inserts the IUD and also counsels them on the use of condoms to avoid STI. • On average, they get 5-6 clients of that age per month (this number seen in the HMIS report book but also seen in the DHIS 2 printed report)	

ANNEX III.D. Summary of findings from training follow-up Self-Admininstered Questionnaires

Table 1. Age

Range	Frequency	Percent
>=30	5	10.6%
>=40	15	31.9%
>=50	17	36.2%
>=60	10	21.3%
Valid N	47	100.0%
Average	43.7	
Median	44	

Table 2. Sex

	Frequency	Valid Percent
MALE	8	15.1
FEMALE	45	84.9
Total Valid N	53	100.0

Table 3. Trainee Designation

	Frequency	Valid Percent
MO	1	1.9
ASS MO	7	13.0
CLINICAL OFFICER	4	7.4
NURSE	42	77.8
Total Valid N	54	100.0

Table 4. Educational Level

	Frequency	Valid Percent
Less than secondary	6	11.1
Secondary	34	63.0
Collages	14	25.9
Total Valid N	54	100.0

Table 5. Type of training received through RESPOND / EH project

Type of Procedure	Frequency	Valid Percent
Mini lap	4	7.4
PPIUD	3	5.6
IUD	9	16.7
IMPLANT	15	27.8
IUD, IMPLANT	19	35.2
NSV	4	7.4
Total Valid N	54	100.0

Table 6. Duration of training in days

Days in training	Frequency	Valid Percent
1	1	1.9
2	3	5.7
3	2	3.8
5	3	5.7
7	3	5.7
10 to 13	14	26.4
14+	27	50.8
Total Valid N	53	100.0

Table 7. (Q13) Number of procedures (IUD / PPIUD insertion / implant / mini Lap) observed during training

No procedures observed	Frequency	Valid Percent
2	2	3.8
3	9	17.3
4	1	1.9
5	14	26.9
6	3	5.8
7	2	3.8
Ten to 14	14	26.9
15+	7	13.6

Total Valid N	52	100.0
Average	10.2	
Median	10.5	
Mode	5	

Table 8. (Q14A) If Yes to Q13), how many procedures performed during training.

No procedures performed	Frequency	Valid Percent	Cumulative Percent
1	2	3.8	3.8
2	7	13.2	17
3	11	20.8	37.7
4	3	5.7	43.4
5	8	15.1	58.5
6	4	7.5	66
7	4	7.5	73.6
8	2	3.8	77.4
10+	12	22.6	100
Total	53	100.0	
Average	8.9		
Median	7.5		
Mode	3		

Table 9. Q15A How many such trained persons are there in your current facility.

	Frequency	Valid Percent	Cumulative Percent
1	1	2	2
2	4	8	10
3	6	12	22
4	4	8	30
5	9	18	48
6	4	8	56
7	1	2	58
8	6	12	70

9	2	4	74
10+	13	26	100
Total	50	100.0	

Table 10. (Q16) Are you now using your new acquired skills to provide family planning services?

	Frequency	Valid Percent
YES	52	96.3
NO	2	3.7
Total	54	100.0

Table 11. (Q17) How are you currently performing the procedure you were trained to do

	Frequency	Valid Percent
Able to do independently	52	96.3
Not able to do independently	1	1.9
Currently not providing	1	1.9
Total	54	100.0

Table 12 (Q18) How many procedures generally you do in a month?

	Frequency	Valid Percent	Cumulative Percent
<5	7	14.3	14.3
5-9	11	22.4	36.7
10-19	14	28.6	65.3
20+	17	34.7	100
Total	49	100.0	

Table 13. (Q19) Post-training support for this training program

	Frequency	Valid Percent
Yes	48	89.5
No	6	10.5
Total	54	100.0

Table 14. (Q19A) If yes, what did supportive supervision do or how did they help?

Among those reporting they received supportive supervision on various areas:

- Check availability of tools and commodities,
- Filling DHIS2, and DQA,
- Observing counseling procedures,
- Filling register,
- Referral procedures,
- R.R.,
- Performance assessment,
- Updates for IUD data.

CROSSTABULATIONS TABLES

Crosstab Table 1 (Q10B) Duration of training by methods

Duration	Type of training received through RESPOND / EH project						Total
	Mini lap	PPIUD	IUD	IMPLANT	IUD, IMPLANT	NSV	
1	0	0	0	1	0	0	1
2	0	0	1	2	0	0	3
3	0	0	0	2	0	0	2
5	0	0	1	1	1	0	3
7	0	0	1	2	0	0	3
10	0	1	1	4	4	0	10
12	1	0	1	0	1	0	3
13	0	0	0	0	1	0	1
14+	3	2	4	3	11	4	27
Total	4	3	9	15	18	4	53

Crosstab Table 2 (Q13) Number of cases observed during training by method

procedures observed	type of training received through RESPOND / EH project						Total
	Mini lap	PPIUD	IUD	IMPLANT	IUD, IMPLANT	NSV	
2	0	0	0	1	1	0	2
3	1	0	2	3	3	0	9
4	0	0	0	0	0	1	1
5	0	1	2	7	4	0	14
6	0	0	1	0	1	1	3
7	1	0	0	0	1	0	2
10+	2	2	3	4	8	2	21
Total	4	3	8	15	18	4	52

Crosstab Table 3 (Q14A) Number of cases actually performed during training

procedure performed	Type of training received through RESPOND / EH project						Total
	Mini lap	PPIUD	IUD	IMPLANT	IUD, IMPLANT	NSV	
1	0	0	0	2	0	0	2
2	0	1	0	4	1	1	7
3	1	2	1	4	3	0	11
4	0	0	0	1	2	0	3
5	2	0	4	0	2	0	8
6	0	0	1	1	1	1	4
7	0	0	2	0	2	0	4
8	0	0	1	0	0	1	2
10+	1	0	0	2	8	1	12
total	4	3	9	14	19	4	53

Crosstab Table 4 How many such trained persons are there in your current facility by type of training

Count								
		Type of training received through RESPOND / EH project						
		Mini lap	PPIUD	IUD	IMPLANT	IUD,IMPLANT	NSV	Total
How many such trained persons are there in your current facility	1	0	0	0	0	1	0	1
	2	1	1	1	1	0	0	4
	3	1	0	1	2	2	0	6
	4	0	0	1	2	1	0	4
	5	0	1	2	4	2	0	9
	6	1	0	0	2	1	0	4
	7	0	0	0	0	0	1	1
	8	0	0	0	1	4	1	6
	9	0	0	0	0	2	0	2
	10+	0	0	3	3	6	1	13
Total		3	2	8	15	19	3	50

Crosstab Table 5. (Q17) How are you currently performing the procedure you were trained to do?

	Type of training received through RESPOND / EH project						Total
	Mini lap	PPIUD	IUD	IMPLANT	IUD, IMPLANT	IUD, IMPLANT, NSV	
Able to do independently	4	3	8	14	19	4	55
Not able to do independently	0	0	0	1	0	0	1
Currently not providing	0	0	1	0	0	0	1
Total	4	3	9	15	19	4	55

Crosstab Table 6 (Q18) How many procedures generally you do in a month?

No of cases	type of training received through RESPOND / EH project						Total
	Mini lap	PPIUD	IUD	IMPLANT	IUD, IMPLANT	NSV	
2	0	2	0	0	0	0	2
3	0	0	1	0	1	0	2
4	2	0	1	0	0	0	3
5	0	1	2	3	2	0	8
6	0	0	0	0	0	1	1
7	0	0	0	0	1	0	1
8	0	0	1	0	0	0	1
10	0	0	0	2	4	1	7
12	0	0	0	2	1	0	3
15	1	0	0	1	0	1	3
18	0	0	0	0	1	0	1
20	0	0	0	2	0	0	2
23	0	0	0	0	1	0	1
26	0	0	0	1	0	0	1
27	0	0	1	1	0	0	2
28	0	0	1	0	0	0	1
30+	0	0	0	2	7	1	10
Total	3	3	7	14	18	4	49

ANNEX III.E SELECTION CRITERIA FOR THE 110 TARGETED DISTRICTS

Selection Criteria for the 110 Targeted Districts

Regions Grouped by CPR	FP Uptake per 10,000 WRA (All methods)	Level 1	Level 2	Level 3	Total
1 *CPR 10-29%*	No. of Districts	24	24	23	71
	FP Uptake	510 – 1,680	1,686 – 2,567	2,671 – 9,134	
2 *CPR 30-39%*	No. of Districts	15	14	15	44
	FP Uptake	311 – 2,428	2,653 – 4,219	4,392 – 11,191	
3 *CPR 40-50%*	No. of Districts	9	8	9	26
	FP Uptake	762 – 2,827	3,012 – 4,310	4,793 – 9,939	
	Total Number of Districts	**48**	**46**	**47**	**141**
	Targeted districts	40 (85%)	**38** (82%)	**32** (68%)	**110**

* Using regional CPR and FP (all methods) uptake per 10,000 WRA, districts are categorized into 3 levels: Level 1, 2 & 3

ANNEX II.F CCHP FP BUDGET DATA FOR Y1 TO Y5 BY RESPOND OFFICE ZONES.

	Funds allocated to FP activities - Data for Four Regional Offices for District Council CCHPs for FY 2011-2016						
Fiscal Year	2011	Year 1 2012	Year 2 2013	Year 3 2014	Year 4 2015	Year 5 2016	Total
Arusha Regional Office Districts							
Number of Districts		9	13	6	13	18	59
Total Funds Allocated for FP related activities (TS)		65,810,473	6,562,572	20,391,907	35,858,010	115,837,729	244,460,691
Total of above Funds from District/MoH Sources		49,697,473	6,172,572	20,391,907	28,617,480	115,837,729	220,717,161
Total of above Funds from external donors (EH, PSI, MSI etc.)		16,113,000	390,000		7,240,530		57
Number of Activities planned		9	13	6	13	18	59
Number of Activities not implemented		4	5	Data Missing	Data Missing	Data Missing	
Mwanza Regional Office Districts							
Fiscal Year	2011	2012	2013	2014	2015	2016	Total
Number of Districts		18	24	26	39	35	142
Total Funds Allocated for FP related activities (TS)		169,767,438	144,905,972	426,283,098	200,630,984	734,955,545	1,676,543,037
Total of above Funds from District/MoH Sources		88,488,992	85,786,756	345,737,098	200,570,184	605,737,350	1,326,320,380
Total of above Funds from external donors (EH, PSI, MSI etc.)		81,278,446	59,119,216	80,546,000	60,800	129,218,195	57
Number of Activities planned		18	24	26	39	35	142
Number of Activities not implemented		3	Data Missing	Data Missing	3	Data Missing	
Coastal Regional Office Districts							
Fiscal Year	2011	2012	2013	2014	2015	2016	Total
Number of Districts		13	14	15	24	24	90

	Funds allocated to FP activities - Data for Four Regional Offices for District Council CCHPs for FY 2011-2016						
Fiscal Year	2011	Year 1 2012	Year 2 2013	Year 3 2014	Year 4 2015	Year 5 2016	Total
Total Funds Allocated for FP related activities (TS)		136,034,890	40,033,219	108,556,313	124,165,464	158,303,076	567,092,962
Total of above Funds from District/MoH Sources		87,465,500	40,033,219	75,504,167	106,856,306	122,398,131	432,257,323
Total of above Funds from external donors (EH,PSI, MSI etc.)				33,052,146	17,309,158	35,904,945	57
Number of Activities planned		13	14	15	24	24	90
Number of Activities not implemented		3	9	Data Missing	6	Data Missing	
Iringa Regional Office Districts							
Fiscal Year	2011	2012	2013	2014	2015	2016	Total
Number of Districts		11	2	13	13	14	53
Total Funds Allocated for FP related activities (TS)		49,298,788	3,961,000	143,547,000	32,841,927	37,188,000	266,836,715
Total of above Funds from District/MoH Sources		44,798,788	3,961,000	121,313,000	25,351,927	37,188,000	232,612,715
Total of above Funds from external donors (EH, PSI, MSI etc.)		4,500,000		22,234,000	7,490,000		57
Number of Activities planned		11	2	13	13	14	53
Number of Activities not implemented		3	1	Data Missing	2	Data Missing	

ANNEX III.G SUMMARY OF RESULTS FROM FGD DISCUSSIONS

Summary of FGDs completed from 23 June through 17 July 2017

Name	Organization/ Implementing Partner	Region	Appointment Date	Interviewer	Note Taker	Notes available
Women Fgd (8)	Mafinga Hospital	Iringa	23/06/2017	Mercy	Deo & Neema	Yes
Men Fgd (7)	Ilula Hospital	Iringa	23/06/2017	Edward	Edward	Yes.
Women Fgd (6)	Ruanda Health Centre	Mbeya	27/06/2017	Catherine	Rose	Yes.
Male FGd (8)	Ngarenaro Hc	Arusha City	1/7/2017	Nkya	Deo	Yes.
Male Fgd Community (8)	Galapo Health Centre	Manyara	4/7/2017	Rose	Neema	Yes.
Female Fgd Community (7)	Nyamagana District Hospital	Mwanza	8/7/2017	Catherine	Mercy	Yes.
Community Mobilizer Fgd Male (8)	Malampaka Health Centre	Simiyu	12/7/2017	Rose	Edward	Yes.
Community Mobilizer Fgd M(2)F(6)	Mlandizi Health Centre	Coast Region	17/07/2017	Catherine	Rose	Yes.

Total Female FGD participants = 27

Total Male FGD participants = 33

I: Mafinga Hospital Female 23 06 2017
Focus Group Discussion Guide for Community Members

We are conducting a study to help health clinics improve the Family Planning services and care provided in your community. We are here today to talk about the services provided and to listen to your opinions about those services. This group discussion should not take more than 45-60 minutes and all answers will remain confidential; however, you may choose not to answer any questions if you are not comfortable. There is no right or wrong answer, please feel free to say what you think. We hope you will, as your responses will assist in improving these services. May be begin? Start with introducing yourself and the group.

Interviewer/s: ___MERCY JOSEPH_____ Date: 23/06/2017

District: MUFINDI TC Notetakers: DEO AND NEEMA

Community involved in this discussion: See sign up sheet.

The key themes that this FGD will cover include

- Perceived family planning needs, method choice and accessibility
- Observed changes over the last three years in method choice, use of FP, and accessibility including LARC/ PM
- Perception about out-reach services, its role in increasing method mix and accessibility of LARC/ PM
- Integration about FP with other health services
- Perceived quality of services received at health facilities
- Community norms supporting, accelerating or resisting acceptance of contraceptive, including decision making process to family planning

The guideline given bellow provides **examples of questions** that could be used to stimulate discussion and or steer the discussion. The information should be allowed to flow in its natural way as the discussion progress. Stimulate **a group dynamic** where **participants discuss among** themselves, with **moderators steering the discussion** and keeping focused on topics. As much as possible encourage **PARTICIPATION OF ALL** present in FGD. Questions given here per se and its order are **not important**. You need to watch that at the end, **you have covers most of the themes**. And there is a **general broad agreement** on the issues discussed. However, there could be always some diversion.

Given expected time allocation of one and half hours, **each topic could be allocated 10-12 min.**

Before starting the discussion, the introduction about the FGD given above should be mentioned. A list of the participants with some basic information should be collected as soon as the come on a sheet of paper with **name age, sex, education** and location where FGD is being conducted.

SIGN UP SHEET FOR FGDS

Location of FGD: MAFINGA HOSPITAL					
Date: 23/06/2017					
FGD Participant Information					
Number	Name	Female Or Male	Age	Education	
1	EM	F	25	STANDARD VII	
2	BM	F	24	STANDARD VII	
3	LM	F	18	FORM IV	
4	AM	F	30	STANDARD VII	
5	TM	F	25	DPLOMA	
6	CA	F	35	FORM IV	
7	EC	F	32	FORM IV	
8	GK	F	49	STANDARD VII	

1. **FP availability and needs**: In your opinion, are family planning services available in your community? Do FP services meet the needs of all community members? If they want a LARC/PM, where can these methods be easily obtained? Is there any family planning service that you need but not available when required? What are those services or methods that are not available when required?
    - Methods which are available at our community includes; condoms, implants, DMPAs, calendar, sterilization both male and female, IUDs
    - There is no any family planning method which is needed but not available
    - Family planning services are far easily available than other services here at the facility…there is no bureaucracy on family planning services, if you need them today you will get them today
2. **Quality of FP Services:** What do you think of the services provided by different facilities or at the outreach clinics? Are the FP services provided meet need of all community members – young, newly married, old? Are the services provided as you expect, or below or above expectation in terms of quality and behavior of providers? Do think your community members could get the method they want?
    - FP services are only available at the facility
    - Most of the family planning users are married couples for economic reasons, having too many children who are not well spaced is seen as burden now days because life is tough…the method which is mostly preferred by married couples are the long acting ones because they give enough space between children
    - Young people prefers short term methods because they still have to bear children
    - Service providers are now knowledgeable; they answer all the questions and concerns when you ask them.
    - Now days when we come at the facility we are first given education of FP, then each is counseled on different FP methods which enables one to choose her preferred method, service providers also give you time to choose the method you want
3. **Trends in past two years:** What changes have happened in the use of FP in your community in the past two years? Are some methods increasing or decreasing? Do you think there has been any change in the acceptance / use of some methods of FP? What about the use of LARCS/PMS methods in your community during the last two years? What changes? Why do you think these changes in use of LARCs/ PMs has happened? **Probe in detail irrespective whether answer is increase, decrease, or no change.**
    - Most people are now using FP and this has been possible because of the on going education which we are given, brochures which we normally receive and the posters which are many at RCH
    - Recently the method of FP are available compared to the past
    - *….'I have been getting services of FP here at this facility since 1993 and I have seen lots of changes compared to the past, now days people are free to talk about FP even the nurses here are willing to discuss with clients on FP which makes it easy for us to ask for them'*
    - All of these changes have been possible because we normally share informations during street talks (women's talk) which enables many of us to be aware of different methods and their effects, also there are lots of education at the facility, education

from IEC materials and some of us get information from the internet…you Google and make choice

4. **FP Method Choice:** How do people on community decide which method should be used? How do you think a person decides about a family planning method to use? Who in the family has maximum influence selecting a particular method? **Probe: How about n adopting a LARC / PM?**
    - We decide after conversation with health providers (after education and counseling), after we have all the necessary information to make choice then we make choice, sometimes it may happen one comes with her choice already in the mind (mostly from the education of other friends) but after education and counseling changes of methods do sometimes occur
    - For the long term and permanent methods normally we have to discuss with our partners and its normally one year after giving birth…you can come out of labour and start telling your partner that you need to use permanent method
    - Most of women use short term methods secretly because they will never be allowed by their partner since there is a misconception that the FP methods reduces sexual pleasure
    - Permanent methods are only used by women who are very old
5. **Outreach:** In these days government is organizing outreach clinics/ services to provide LARC/PM close to community. Are you aware of it? Has in the past such outreach clinic for providing LARC/PM organized in nearby health facility from where community members could easily obtained? How do you come to know the date when such outreach clinic for LARC/PM is being organized? What do you think of outreach / mobile clinic approach to provide LARC/ PM. Probe for whatever response they give
    - They heard about outreach from Marie stopes
    - Sometimes people use cars to announce about these events
    - Also health care providers sometimes tell them about these events before they occur
    - In the outreach activities most women are attending compared to men and this is because most of the family planning methods are used by women and not men
6. **Attitudes toward LARCs/PM.** Is there any opposition to its acceptance of LARC/PM in community or fear of side effect of the method? Has such opposition/ fear declined or increase over time? Ask to elaborate and give example and reason behind that.
    - LARCs misconception is that women are inserted aluminum in the vagina
    - Child may come out during delivery holding IUD
    - Women who are married culturally they are supposed to give birth to as many children as possible so if the woman decide to use permanent method the man will marry another women so that he can have children
    - Some people use LARCs and still get pregnant (not effective method)
    - These cultural beliefs/misconceptions/customs have decreased for the past years and this is again because of education sharing, most people are now aware though I cannot say all

II: Ilula Hospital Men	**Iringa**	**23/06/2017**

Focus Group Discussion Guide for Community Members

We are conducting a study to help health clinics improve the Family Planning services and care provided in your community. We are here today to talk about the services provided and to listen to your opinions about those services. This group discussion should not take more than 45-60 minutes and all answers will remain confidential; however, you may choose not to answer any questions if you are not comfortable. There is no right or wrong answer, please feel free to say what you think. We hope you will, as your responses will assist in improving these services. May be begin? Start with introducing yourself and the group.

Interviewer/s: ____EDWARD_____ Date: _____23/06/2017_____

District: _____KILOLO MALE FGD_____ Notetakers: _____NA_____

NUMBER	NAME	SEX	AGE	EDUCATION
1		M	29	FORM 4
2		M	32	STANDARD 7
3		M	38	FORM 4
4		M	27	STANDARD 7
5		M	36	STANDARD 7
6		M	37	FORM 4
7		M	28	FORM 4

Community involved in this discussion: See sign up sheet.

The key themes that this FGD will cover include

- Perceived family planning needs, method choice and accessibility
- Observed changes over the last three years in method choice, use of FP, and accessibility including LARC/ PM
- Perception about out-reach services, its role in increasing method mix and accessibility of LARC/ PM
- Integration about FP with other health services
- Perceived quality of services received at health facilities
- Community norms supporting, accelerating or resisting acceptance of contraceptive, including decision making process to family planning

The guideline given bellow provides **examples of questions** that could be used to stimulate discussion and or steer the discussion. The information should be allowed to flow in its natural way as the discussion progress. Stimulate **a group dynamic** where **participants discuss**

among themselves, with **moderators steering the discussion** and keeping focused on topics. As much as possible encourage **PARTICIPATION OF ALL** present in FGD. Questions given here per se and its order are **not important**. You need to watch that at the end, **you have covers most of the themes**. And there is a **general broad agreement** on the issues discussed. However, there could be always some diversion.

Given expected time allocation of one and half hours, **each topic could be allocated 10-12 min.**

Before starting the discussion, the introduction about the FGD given above should be mentioned. A list of the participants with some basic information should be collected as soon as the come on a sheet of paper with **name age, sex, education** and location where FGD is being conducted.

1. **FP availability and needs**: In your opinion, are family planning services available in your community? Do FP services meet the needs of all community members? If they want a LARC/PM, where can these methods be easily obtained? Is there any family planning service that you need but not available when required? What are those services or methods that are not available when required?
    - It was reported that that family planning methods are available in the community, "if you go in any dispensary looking for FP services no body we have heard saying didn't get FP services, we also hear the radio Furaha broadcasting FP services and where to get them"
    - "Fp services are also available at the district hospital, for the first time I heard FP services when I brought my son at the district hospital for circumcision, from there I remembered what my wife normally told me about FP methods then we decided to you use loop"
    - Most of women normally come at the district hospital to follow FP services because they are easily provided and on time, some of the clients said in their community dispensaries they only have short term methods
    - Family planning methods are available but the only issue to be addressed it's the time they use to stay at the community during outreach services, they only provide service for one day so if someone if busy that day and he/she couldn't hear the announcement it can be difficult to attend, therefore at least they should do continuous for two days a lot of people will attend especially men
2. **Quality of FP Services:** What do you think of the services provided by different facilities or at the outreach clinics? Are the FP services provided meet need of all community members – young, newly married, old? Are the services provided as you expect, or below or above expectation in terms of quality and behavior of providers? Do think your community members could get the method they want?
    - "The quality of FP services provided during outreach and at the facility it's the same because most of the face of people who come for outreach are the same with the one we normally find them at the hospitals and dispensaries, also the same instruments used and the same counseling, very few faces you might recognized , the only things changed is environment for services provision"
    - "I can say the one provided at the outreach it have more quality than the one provided at the facility especially for men because they feel shame at the facility there is no privacy, you have to stay to the line waiting for the FP services but at the outreach there is no queue, you just come and get your service and go"
    - Most of the respondents 4 out of six they have talked about the issue of privacy at the facility, most of the men they don't feel free to be seen that they are using FP methods because it's something for women
    - "The FP services and education provided it meet community demand this can observed even when men meet at venue/camps at evening you will see everybody has information of FP either from his wife or from media or from outreach"
    - "We have also learn that now days at the facilities health providers they do mix men and women when they provide general education of FP services, this is very good since it may reduce fear to women and more men will be involved."

3. **Trends in past two years:** What changes have happened in the use of FP in your community in the past two years? Are some methods increasing or decreasing? Do you think there has been any change in the acceptance / use of some methods of FP? What about the use of LARCS/PMS methods in your community during the last two years? What changes? Why do you think these changes in use of LARCs/ PMs has happened? **Probe in detail irrespective whether answer is increase, decrease, or no change.**
    - FP methods changes, "if you look in our community now and compare with the past year almost every house you will find a pregnancy women or pregnancy women carrying other little baby on her back, but now rate has decreased most of the people understand and are using FP methods"
    - Most said there is the reduction in unplanned pregnancies in the surrounding communities, "initially all the time when you meet with your friends you will find most of them blaming with their wife carrying unplanned pregnancies"
    - Cost of living facilitated most of the people to start thinking the use of FP methods and understand the importance of using FP methods
    - 3 out of 7 respondents said the use of FP methods facilitated health growth of mother and child
    - "FP awareness has increased for example if you take a women at the restaurant after you reach with her at the hotel she must ask for condom if you don't have it then will refuse to have sex"
    - LARC/PM methods are available in our community, now it's very rarely to find a young men having unplanned children
4. **FP Method Choice:** How do people on community decide which method should be used? How do you think a person decides about a family planning method to use? Who in the family has maximum influence selecting a particular method? **Probe: How about n adopting a LARC / PM?**

- It was reported that " there are at least three methods on how to decide FP method, the first one is when you go to the facilities and obtained FP counseling direct or indirect, the second one it's from the street groups/venues/camps you will find different people talking with variety of the FP methods and the last one it's from the brochures it explain various methods then you have to read and decide which one is favorable for you"
- It was reported that "During the past years women used to adopt FP method from each other, if she is heard her friend use pills then she will also go to the facility and look for pills, but now as the rate of awareness as increase most of the women use the method of their choice"
- In our communities women doesn't have decision to decide which method of FP to be used or to decide number children, Men are the final decision makers but women have influence on the use of FP methods, men are the final decision maker to use or not to use.

5. **Outreach:** In these days government is organizing outreach clinics/ services to provide LARC/PM close to community. Are you aware of it? Has in the past such outreach clinic for providing LARC/PM organized in nearby health facility from where community members could easily obtained? How do you come to know the date when such

outreach clinic for LARC/PM is being organized? What do you think of outreach / mobile clinic approach to provide LARC/ PM. Probe for whatever response they give**.**

- Most of the respond 6 out of 7 were aware of the outreach clinics
- Before if you to the remote area normally outreach used to came to provide services for women who delivered at homes only because they couldn't make to the facility due to long walking distances, but now the outreach as expanded to the provision of FP services, but now FP services are advertised on when and where will be provided and if you have other person needs during the outreach they normally give the clients referral to the facilities
- Initially before the outreach most of the beneficiaries were those who were living near the health facilities
- Most the responded 7 out of 7 said the information mostly they received from community health worker, local government leaders, village leaders, during vaccination, during public advertisement, some from their wife, at the health facilities, at the radio broadcasting,
- The outreach services should be increased at least 3 to four times per month
- The day for cancelling should be differentiated from the day of services delivery
- During outreach there is no privacy during services delivery sometimes they provide services even under the tree
- The brochures are not enough to the communities
- Outreach services should leave the free special number to the community if anybody have questions will call easily
- Outreach should prepare the community pear educators who live within that communities
- Service provider should be increased to meet community demand

6. **Attitudes toward LARCs/PM.** Is there any opposition to its acceptance of LARC/PM in community or fear of side effect of the method? Has such opposition/ fear declined or increase over time? Ask to elaborate and give example and reason behind that.
    - There is minor opposition from some of the churches like catholic and Muslim
    - Some of the community believe that if women use FP method and meet with that women the do believe that men can lose his fertilities
    - Women with big stomach some of the people said they are using DEPO
    - In overall the opposition and fear on use of FP keep decreasing because of the community awareness provided during outreach
    - FP methods now it's no longer a secret because even at the street people are talking and use, in summary out of 10 men 8 of them are using short term methods, while out of 10 women 9 of them are using long term methods, this can be even observed at the number of clients attending at the facilities for FP services

III: Mbeya City Health Center Women

Focus Group Discussion Guide for Community Members

Draft 0.3 26June2017

We are conducting a study to help health clinics improve the Family Planning services and care provided in your community. We are here today to talk about the services provided and to listen to your opinions about those services. This group discussion should not take more than 45-60 minutes and all answers will remain confidential; however, you may choose not to answer any questions if you are not comfortable. There is no right or wrong answer, please feel free to say what you think. We hope you will, as your responses will assist in improving these services. May be begin? Start with introducing yourself and the group.

Interviewer/s: _Catherine _____ Date:27-06-2017 _____

District: _Mbeya City_____ Notetakers: Rose Ernest

_____

Community involved in this discussion: See sign up sheet.

Age	Number of Children's	Marital Status	Education	Occupation
32	3	Married	STD VII	Business woman
28	1	Married	FORM 4	House wife
33	3	Married	STD VII	House wife
28	1	Married	FORM 4	Teacher
29	3	Married	FORM 4	House wife
37	5	Married	STD VII	Business woman

KEY

R1-R6= Respondent number one up to six

The key themes that this FGD will cover include

- Perceived family planning needs, method choice and accessibility
- Observed changes over the last three years in method choice, use of FP, and accessibility including LARC/ PM
- Perception about out-reach services, its role in increasing method mix and accessibility of LARC/ PM
- Integration about FP with other health services
- Perceived quality of services received at health facilities
- Community norms supporting, accelerating or resisting acceptance of contraceptive, including decision making process to family planning

The guideline given bellow provides **examples of questions** that could be used to stimulate discussion and or steer the discussion. The information should be allowed to flow in its natural way as the discussion progress. Stimulate **a group dynamic** where **participants discuss**

among themselves, with **moderators steering the discussion** and keeping focused on topics. As much as possible encourage **PARTICIPATION OF ALL** present in FGD. Questions given here per se and its order are **not important**. You need to watch that at the end, **you have covers most of the themes**. And there is a **general broad agreement** on the issues discussed. However, there could be always some diversion.

Given expected time allocation of one and half hours, **each topic could be allocated 10-12 min.**

Before starting the discussion, the introduction about the FGD given above should be mentioned. A list of the participants with some basic information should be collected as soon as the come on a sheet of paper with **name age, sex, education** and location where FGD is being conducted.

1.FP availability and needs: In your opinion, are family planning services available in your community? Do FP services meet the needs of all community members? If they want a LARC/PM, where can these methods be easily obtained? Is there any family planning service that you need but not available when required? What are those services or methods that are not available when required?

- FP availability

- ALL- Agreed that Family planning methods is available in the community and meet the need of community members, they mention family planning available in the community as follows
- RI-Injection ,pills, condoms
- R2: Implant
- R3: IUD
- R4: Calendar Method
- R2: Exclusive breast feedings

- If they want LARC/PM, where can these methods be easily obtained
  - ALL- LARC /PM is available at health centers and Hospitals
  - R2: They also get LARC/PM at the Outreach services at the dispensary where skilled health workers from government come and provide the services.
    ALL: Condom and pills available at health centers and at pharmacy

    ALL: Injection available at pharmacy and health centre but they prefer getting injectables at health centre.

- Is there any family planning service that you need but not available when required?
  ALL: All family planning methods is available

2. **Integration of FP with other health services:** In these days, government clinics are trying to provide many services at the same place/same clinic so that people can get services more easily, without spending too much time. Are you aware of this? Have you heard of women or men receiving FP counseling/services from clinics like OPD, or Immunization or HIV/AIDS clinics? How do people feel about obtaining FP services at a place that offers other services as well? Does it save time for them, do they receive the same services they expect? Are there problems when a clinic offers multiple services?

They spend less time or more time with the patient? Do they have more visits or fewer visits to clinics? How is the quality of FP services provided at clinics where many other services are provided? What about waiting time? More waiting or less waiting? Do they get more time to spend with the service provider or less time?

- ALL: They are aware of integration
  - How do people feel about obtaining FP services at a place that offers other services as well?
- R5: Women are very happy of integration because integration save waiting time of services, if you come for CTC visit you will get family planning service also, so there is no back and forth.
- R2: Women are very happy because when there is immunization outreach they provide family planning services also, integration of services save time and bus fair.
  ALL: There is no any challenges in integration.
  - Are there problems when a clinic offers multiple services
    R3: There is no problem because health providers they have skills on FP provision, so she will do the same whether it is at CTC or Family planning room.
    ALL; Time of receiving the services will be the same in integration because sometimes they do group cancelling. In integration you save time and queue of shifting from one department to other
    Note: They debate for sometimes they all agree that there is no problem when clinic offer multiple services

3. **Quality of FP Services:** What do you think of the services provided by different facilities or at the outreach clinics? Are the FP services provided meet need of all community members – young, newly married, old? Are the services provided as you expect, or below or above expectation in terms of quality and behavior of providers? Do think your community members could get the method they want?

ALL: Family planning meet the need of all community members because it is available for all groups of people in the community there is no any barriers for certain groups not to use family planning.

R2: Some parents they don't want their young children to use family planning because they fear effect but it is not very common.

4. **Trends in past two years:** What changes have happened in the use of FP in your community in the past two years? Are some methods increasing or decreasing? Do you think there has been any change in the acceptance / use of some methods of FP? What about the use of LARCS/PMS methods in your community during the last two years? What changes? Why do you think these changes in use of LARCs/ PMs has happened? **Probe in detail irrespective whether answer is increase, decrease, or no change.**
   - What changes have happened in the use of FP in your community in the past two years?
- R2: The changes I have noticed is now days people in the community talk freely about family planning and the methods they are using , we can talk in the community groups, funerals or anywhere, the reasons behind is sensitization of FP in the community through radio and brochures

- R2&R5&R6: Availabity of long term and short term family planning methods, Now days methods is available at health center, previous if you want long term methods you have to go up to META region hospital
    - Are some methods increasing or decreasing?
- R5&R1: Long term method increasing because now days it is available at the health centre
- R6: The reasons of increasing up take of all family planning methods is in earlier people they have fear of its effect after the education most people use family planning
- ALL: The usage of long term family planning has increase the reasons behind is availability of methods and it is long acting so it doesn't bother you to come at the health centre every time, also because it is long time you can space your children and have enough time to generate income.
- R6: Increase of Health providers who provide long term FP help in the usage.

5. **FP Method Choice:** How do people on community decide which method should be used? How do you think a person decides about a family planning method to use? Who in the family has maximum influence selecting a particular method? **Probe: How about n adopting a LARC / PM?**
    - How do people on community decide which method should be used
- R1: Education on Family planning from health providers influence my decision on methods use
- R1: Friends, if my friend use certain methods it can influence me to use the same
- R2&R3: Partner, I have to discuss with my husband about the methods before using it.
    - Who in the family has maximum influence selecting a particular method? **Probe: How about n adopting a LARC / PM**
- R5: Service providers
- R1:Partners
- ALL: Friends

6. **Outreach:** In these days government is organizing outreach clinics/ services to provide LARC/PM close to community. Are you aware of it? Has in the past such outreach clinic for providing LARC/PM organized in nearby health facility from where community members could easily obtained? How do you come to know the date when such outreach clinic for LARC/PM is being organized? What do you think of outreach / mobile clinic approach to provide LARC/ PM. Probe for whatever response they give**.**

    ALL: They are aware of outreach and it is used to be done in the community they come from, and it is for them to obtain LARC/PM at organized health facility.

    - How do you come to know the date when such outreach clinic for LARC/PM is being organized
        - R2: Village/street meetings where chairman announce the day
        - R2: Announcement at ward executive announcement board and brochures
        - R5: Announcement at the Health centers and burners
        - ALL: Speakers in the street

- ALL: CHW – CHW do come in the community and tell us about the date of outreach also they tell us when we come at Health centre, they usually announce at OPD**.**

➢ What do you think of outreach / mobile clinic approach to provide LARC/ PM. Probe for whatever response they give**.**

- ALL: Outreach is good practice because it serves family planning needs especially for the long methods.
- R4: The challenges I see here is when you get complications in any long term methods you have to come at health centre, if you are living at remote area it become hard for you because you have to have money for transport, my suggestion will be better government to build health centre in the area where there is needs instead of outreach. Also those health providers after the service they should provide mobile phone numbers so that if client face any complication she /he can call.

  Quote: "*I think they should improve the services that are brought to us (meaning outreach services), because it is a really challenge when someone gets a problem, because they have already provided the services and left, so who am I to go to if I get n problem? We wish they could come more frequently and may be also leave their phone numbers so that in case you get a problem you can call them".*

6. Attitudes toward LARCs/PM: Is there any opposition to its acceptance of LARC/PM in community or fear of side effect of the method? Has such opposition/ fear declined or increase over time? Ask to elaborate and give example and reason behind that.

ALL: There is no opposition to clients opposition is on region like catholic but still their followers use family planning
ALL: There is minor nuisances/disturbances but we do get education from health providers, there is no one who stop using family planning because of nuisances/disturbances they usually change the methods
ALL: Fear of using FP is minimized because of health education, now day's people talk openly about family planning

IV: Ngareno HC Male

Focus Group Discussion Guide for Community Members

We are conducting a study to help health clinics improve the Family Planning services and care provided in your community. We are here today to talk about the services provided and to listen to your opinions about those services. This group discussion should not take more than 45-60 minutes and all answers will remain confidential; however, you may choose not to answer any questions if you are not comfortable. There is no right or wrong answer, please feel free to say what you think. We hope you will, as your responses will assist in improving these services. May be begin? Start with introducing yourself and the group.

Interviewer/s: ____EDWARD_____ Date: _____1/07/2017_____

District: _____ARUSHA MALE FGD/ NGARENARO HC____ Note takers: _MERCY/DEO___

NUMBER	NAME	SEX	AGE	EDUCATION
1		M		MASTERS HOLDER
2		M		STANDARD 7
3		M		FORM 4
4		M		STANDARD 7
5		M		STANDARD 7
6		M		FORM 4
7		M		DIPLOMER
8		M		FORM 4

Community involved in this discussion: See sign up sheet.

The key themes that this FGD will cover include

- Perceived family planning needs, method choice and accessibility
- Observed changes over the last three years in method choice, use of FP, and accessibility including LARC/ PM
- Perception about out-reach services, its role in increasing method mix and accessibility of LARC/ PM
- Integration about FP with other health services
- Perceived quality of services received at health facilities
- Community norms supporting, accelerating or resisting acceptance of contraceptive, including decision making process to family planning

The guideline given bellow provides **examples of questions** that could be used to stimulate discussion and or steer the discussion. The information should be allowed to flow in its natural way as the discussion progress. Stimulate **a group dynamic** where **participants discuss among** themselves, with **moderators steering the discussion** and keeping focused on topics. As much as possible encourage **PARTICIPATION OF ALL** present in FGD. Questions given here per se and its order are **not important**. You need to watch that at the end, **you have covers most of the themes**. And there is a **general broad agreement** on the issues discussed. However, there could be always some diversion.

Given expected time allocation of one and half hours, **each topic could be allocated 10-12 min.**

Before starting the discussion, the introduction about the FGD given above should be mentioned. A list of the participants with some basic information should be collected as soon as the come on a sheet of paper with **name age, sex, education** and location where FGD is being conducted.

1.FP availability and needs: In your opinion, are family planning services available in your community? Do FP services meet the needs of all community members? If they want a LARC/PM, where can these methods be easily obtained? Is there any family planning service that you need but not available when required? What are those services or methods that are not available when required?

- 6 out of 8 participants reported that family planning methods are available in the community but have not meet the needs of all community members who are in need of the services., ("*FP services are only provided in facilities of like this one (pointing out Ngarenaro HC) But the facility is too far from other people, residents, others can not afford travelling from their home to this facility*(p 4))…*Services are available at this HC nut if you go outside the facility you cant get this services including FP education*(P7). *Also 3 participants added that services are available to some places other community members are not covered with this service. others are living in hard to reach areas, they also need FP services*.
- Most of women normally come at the district hospital to follow FP services because they are easily provided and on time, some of the clients said in their community dispensaries they only have short term methods while others do not provide FP services at all.
- Likewise some participants added that FP education is still needed to the community especially for dadapoa they don't have the FP education due to reasons that they noprmally do their bussing at midnight so efferts should be made to ensure that they also get this education.

2.Integration of FP with other health services: In these days, government clinics are trying to provide many services at the same place/same clinic so that people can get services more easily, without spending too much time. Are you aware of this? Have you heard of women or men receiving FP counseling/services from clinics like OPD, or Immunization or HIV/AIDS clinics? How do people feel about obtaining FP services at a place that offers other services as well? Does it save time for them, do they receive the same services they expect? Are there problems when a clinic offers multiple services? They spend less time or more time with the patient? Do they have more visits or fewer visits to clinics? How is the quality of FP services provided at clinics where many other services are provided? What about waiting time? More waiting or less waiting? Do they get more time to spend with the service provider or less time?

- While 3 participants reported that they once heard about integration and it is done at Ngarenaro HC, other 3 participants also reported that they had never heard of integration ***.(``I once heard about it during health education meeting at this place)***

- How do people feel about obtaining FP services at a place that offers other services as well?
  - One participant said that obtaining FP services at a place that offers other services as well **is very** important as it helps to ensure that families have good health all the time.
  - Participant no 1 said that intergration helps the patients to receive cervices including those which are not required. he also suggested that mobile phone companies should be used to remind their customers about FP services through short messages.
  - On the other hand one participant claimed that giving different cervices under one room will make the patients to waste more time waiting for services

putting into consideration that they are also sick. What he is thinking is that it is not fair to start to start counseling a malaria patient for example about FP.

3.Quality of FP Services: What do you think of the services provided by different facilities or at the outreach clinics? Are the FP services provided meet need of all community members – young, newly married, old? Are the services provided as you expect, or below or above expectation in terms of quality and behavior of providers? Do think your community members could get the method they want?

- The education provided is very important since it has helped many people in the community to wake up and start using FP services openly. Few years ago many people were not able to even to mention FP in front of others but now days they do.
- One participant said that he is not sure of the quality of FP methods as there are other commodities like condoms which are still supplied in the service areas while expired already. He also added that suppliers bare after money /profit they don't care about the users health.
- FP education is still needed to most of men as many of them force their wives to bear many children with ought considering their health.
- Participant no 6 also said that the only reliable method is the natural one where by people do use calendar days to plan for the number of children. other method like inject able depoprovera causes over bleeding to women and cervical problems.

4.Trends in past two years: What changes have happened in the use of FP in your community in the past two years? Are some methods increasing or decreasing? Do you think there has been any change in the acceptance / use of some methods of FP? What about the use of LARCS/PMS methods in your community during the last two years? What changes? Why do you think these changes in use of LARCs/ PMs has happened? **Probe in detail irrespective whether answer is increase, decrease, or no change.**

- 2 out of 8 participants said that for about 3 years now there has been an increase of long family planning methods up take in the community, and the complaints about FP services and local believed has been reduced to a big extent likely due to increased community awareness.
- One participant also commented that for the past 3 years ,there has been an increase in Short term methods uptake like condoms likely due to reasons that the community prefers condoms as they are the most easily accessible compared to other method which needs to be taken from health facilities.
- It is also noticed that the number of street children is decreasing overtime likely due to increased uptake in Long term FP services.

5.FP Method Choice: How do people on community decide which method should be used? How do you think a person decides about a family planning method to use? Who in the family has maximum influence selecting a particular method? **Probe: How about n adopting a LARC / PM?**

- 3 out of 8 participants reported that men do decide on the FP choice to be used.
- On the other hand 3 participants said that now days women are the one who decide on the methods to be used as they are the direct beneficiaries compared to men. This is due to reasons that men do not like to attend clinics for FP services likely due to mfumo dume, and also men do like many children so the women decide to use Long term FP methods without even discussing with their partners.

- 2 participants said that they don't know/are not aware of who decides on what methods to use between family members.

6.Outreach: In these days government is organizing outreach clinics/ services to provide LARC/PM close to community. Are you aware of it? Has in the past such outreach clinic for providing LARC/PM organized in nearby health facility from where community members could easily obtained? How do you come to know the date when such outreach clinic for LARC/PM is being organized? What do you think of outreach / mobile clinic approach to provide LARC/ PM. Probe for whatever response they give**.**

- 5 out of 8 participants said that they are aware of outreach services conducted in the community.
- Public Announcement is done using the cars with loud speakers, and also people are provided with leaf lets to make them aware of the services, the date and the area where it will be conducted..
- ***Outreach services were available even before 3 to 4 years back but the problem is it was not emphasized just like how it is currently done. It was not of high quality (p.1)***
- One participant recommended that religious leader should also be used to help influence their followers as far as Long term methods is concerned.
- Partricipant no.8 al;so added that education shoul be emphasized to the memberz of the community so as to increase the uptake of FP services.

7.Attitudes toward LARCs/PM: Is there any opposition to its acceptance of LARC/PM in community or fear of side effect of the method? Has such opposition/ fear declined or increase over time? Ask to elaborate and give example and reason behind that.

V: Galapo HC Female

Focus Group Discussion Guide for Community Members

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Interviewer/s: ____ROSE_____ Date: _____4/07/2017_____

District: _____GALAPO HC FEMALE FGD___ Note takers: _MERCY/NEEMA___

NO	NAME	SEX	AGE	EDUCATION
1		F	23	Std 7
2		F	33	-
3		F	28	Std 7
4		F	29	-
5		F	24	Form4
6		F	32	Std 7
7		F	33	Std 7
8		F	40	Std 7

Community involved in this discussion: See sign up sheet.

The key themes that this FGD will cover include

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- Observed changes over the last three years in method choice, use of FP, and accessibility including LARC/ PM
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Before starting the discussion, the introduction about the FGD given above should be mentioned. A list of the participants with some basic information should be collected as soon as the come on a sheet of paper with **name age, sex, education** and location where FGD is being conducted.

1.FP availability and needs: In your opinion, are family planning services available in your community? Do FP services meet the needs of all community members? If they want a LARC/PM, where can these methods be easily obtained? Is there any family planning service that you need but not available when required? What are those services or methods that are not available when required?

- All participants (8) participants reported that family planning methods are available in the community and they meet the needs of all community members.
- 3 participants mentioned the available methods are implants, pills, IUD, INJECTABLE DEPOPROVERA, and condoms.
- 1 Participant said that FP methods are available and helps to meet the needs as it helps them to space their children and help women to have enough time also to engage to economic activities.
- 2 participants also said that all FP services are available every time you need with exception of BTL and vasectomy which is arranged and are provided in a special day.

2. Integration of FP with other health services: In these days, government clinics are trying to provide many services at the same place/same clinic so that people can get services more easily, without spending too much time. Are you aware of this? Have you heard of women or men receiving FP counseling/services from clinics like OPD, or Immunization or HIV/AIDS clinics? How do people feel about obtaining FP services at a place that offers other services as well? Does it save time for them, do they receive the same services they expect? Are there problems when a clinic offers multiple services? They spend less time or more time with the patient? Do they have more visits or fewer visits to clinics? How is the quality of FP services provided at clinics where many other services are provided? What about waiting time? More waiting or less waiting? Do they get more time to spend with the service provider or less time?

- While 5 participants reported that they are not aware with integration of services 3 participants said that they are aware of it.
- ***``If you come to the hospital for any problem you will also being counseled for FP services(p.4)***
- ***``I once brought my child for immunization services after immunization I was advised of the FP services and I was referred to another room where I get implants services(p.7)***
- ***``My self I came to the facility just for FP services and I received the FP services only though I was also counseled to go for HIV testing before getting the FP services.(p.3).***

- How do people feel about obtaining FP services at a place that offers other services as well?
  - 5 participants said that obtaining FP services at a place that offers other services as well **is very** important as it will help to reduce waiting hours, as well as avoiding quing for FP services which will results to the wasting of time.
  - On the other hand 3 participants said that they don't see the importance of integration of services likely due to low awareness/understanding of integration. P.5 commented that ***``I don't think if provision of different services under one room can be a good strategy as I may forget what the doctors told me .So for me its better the services to be provided in different rooms."*** She also asked the question if integration of services could not bring difficulties in service provision or may have negative impacts to the clients.eg malaria testing,

IUD insertion, HIV testing in one room …she doughts if the clinicians wont mix up things.

3.Quality of FP Services: What do you think of the services provided by different facilities or at the outreach clinics? Are the FP services provided meet need of all community members – young, newly married, old? Are the services provided as you expect, or below or above expectation in terms of quality and behavior of providers? Do think your community members could get the method they want?

- Services are provided based on client`s choice and there is no any complaints that people in the community do not receive the services they want.
- To some extent FP services
- The education provided is very important since it has helped many people in the community to wake up and start using FP services openly. Few years ago many people were not able to even to mention FP in front of others but now days they do.
- One participant said that she is not sure of the quality of FP methods as there are other commodities like condoms which are still supplied in the service areas while expired already. SHe also added that suppliers bare after money /profit they don't care about the users health.
- FP education is still needed to most of men as many of them force their wives to bear many children withought considering their health.
- Participant no 6 also said that the only reliable method is the natural one where by people do use calendar days to plan for the number of children. other method like inject able depoprovera causes over bleeding to women and cervical problems.

4.Trends in past two years: What changes have happened in the use of FP in your community in the past two years? Are some methods increasing or decreasing? Do you think there has been any change in the acceptance / use of some methods of FP? What about the use of LARCS/PMS methods in your community during the last two years? What changes? Why do you think these changes in use of LARCs/ PMs has happened? **Probe in detail irrespective whether answer is increase, decrease, or no change.**

- 2 out of 8 participants said that for about 3 years now there has been an increase of long family planning methods up take in the community, and the complaints about FP services and local believed has been reduced to a big extent likely due to increased community awareness.
- One participant also commented that for the past 3 years ,there has been an increase in Short term methods uptake like condoms likely due to reasons that the community prefers condoms as they are the most easily accessible compared to other method which needs to be taken from health facilities.
- It is also noticed that the number of street children is decreasing overtime likely due to increased uptake in Long term FP services.

5.FP Method Choice: How do people on community decide which method should be used? How do you think a person decides about a family planning method to use? Who in the family has maximum influence selecting a particular method? **Probe: How about n adopting a LARC / PM?**

- 3 out of 8 participants reported that men do decide on the FP choice to be used.

- On the other hand 3 participants said that now days women are the one who decide on the methods to be used as they are the direct beneficiaries compared to men. This is due to reasons that men do not like to attend clinics for FP services likely due to mfumo dume, and also men do like many children so the women decide to use Long term FP methods without even discussing with their partners.
- 2 participants said that they don't know/are not aware of who decides on what methods to use between family members.
- 2 participants added that they think there has been discussions between men and their wives to other families which may also results not to agreement due to reasons that men are conservative, they don't like their wives to use FP method.

When the participants were asked why men doesnot like their wives to use FP services they replied that;

- ***Other women do not have FP education, they are not aware of how important FP is"(p 5)***
- ***Participant no 3 added that ``Men are opposes always,..but I think others afraid of diseases which are caused by FP such as cancer etc.***
- ***Participant no.8 reported that …``men are jealousy, they want us to deliver a big number of children so that we spend most of the time taking care of the children at home. They think that if a woman use FP she must be tempted to become a prostitute…they need education. YE ATOKE NA WENGINE AKUCHUUUUUUUUJE…."***

6. Outreach: In these days government is organizing outreach clinics/ services to provide LARC/PM close to community. Are you aware of it? Has in the past such outreach clinic for providing LARC/PM organized in nearby health facility from where community members could easily obtained? How do you come to know the date when such outreach clinic for LARC/PM is being organized? What do you think of outreach / mobile clinic approach to provide LARC/ PM. Probe for whatever response they give.

- ALL participants are not aware of outreach services.
- They are not aware of neither CHWs nor their activities in the community.
- They reported that they receive FP information when they reach at the health center and not somewhere else. They added that no FP information is given at either churches, mosques, or at Community/political meetings.

7. Attitudes toward LARCs/PM: Is there any opposition to its acceptance of LARC/PM in community or fear of side effect of the method? Has such opposition/ fear declined or increase over time? Ask to elaborate and give example and reason behind that.

- Data revealed that Men are still the challenge/ opposes as far as FP is concerned.
- 6 out of 8 participants reported that most of men do not support their wives from using FP services.
- P NO 4 said men do not like even to attend the clinic, women are just escorted to the clinic by their husbands during the first pregnancies only or if they are sick…they can't go to the health center just for FP services.
- Also data shows there is a belief that if a woman take FP /BTL while in young ages like 20,25, or 27 she will be continuous suffering from stomach pain, she will also be

prone to cancer. Other men also advise their wives to start using FP after delivering more that 7 or 8 children.

When they were asked about the response of men in doing vasectomy, they all laughed and murmuring to each other as if they were not aware that even men can undergo vasectomy.

- 4 out of 8 participants said that they never heard of men's vasectomy, they never heard that men also can take FP.
- One participant said that ``***if they can`t even escort their wives to the clinic is it possible for them to undergo vasectomy? it can't happen…"***

Six: Nyamagana District Hospital Mwanza 7 Female participants. 8/7/2017

Catherine led with Mercy taking notes

FGD SUMMARY: To follow

FGD NOTES

M: Okay. My first question is…May I ask you a question. The one who wishes to answer the question is to raise up her and for me to allow her. Right?

ALL: Yes.

M: Don't repeat what your fellow has said already. You can just add up to it if there is any, alright...So that we may save time. The first question is about availability and need for family planning services. We are going to talk more about family planning services in this conversation. In your opinion, I would like to know…are family planning services available in your localities. Yes or no?

ALL: Yes

M: I would like to know where they are available. Who is to speak first? Just raise up your hand…mention your number and speak out.

P7: These family planning services are available in District hospitals.

M: In district hospitals, ok. Is there any other place? What kind of service are provided at district hospitals?

P7: There are such services as injectables, implants, intrauterine devices and contraception by minor surgery.

M: Ok. What do the rest say? Where do they get family planning services? Welcome number 6.

P6: **I have ever joined at one of the centers when I was staying at Mukurani but I don't know the center name. Those services did not work well with me.**

M: To what hospital did you go or did you go to the pharmacy?

P6: No, at Mukurani

Px: Ibanda

P6: There is a small hospital where I went and joined for services. I was using contraceptive pills but they did not work well for me.

M: They did not work well with you

P6: I stopped using that brand. I went on buying the others from the pharmacy and stopped the medication I got form that hospital.

M: So you were buying the contraceptive pills from the pharmacy.

P6: Yes, I don't know how different they are because I was getting severe headache if I used those pills.

M: So you were buying the pills

P6: Yes.

M: We are coming to such issues later on, but it is good that you have talked about it. There is the section specific to such issues. As I got you, you bought these medications from the pharmacy, isn't it?

P6:**Yes.**

M: How many of you get these services from the pharmacies. Raise up your hands. Not only you but also your friends and other people you know. We are talking about all women being represented by you. So where the women in your localities get family planning services including yourselves? How many say that the women get these services from the pharmacies? How many of you? Only two?

Px: Three

M:Three including you. What kind of services are available in these pharmacies. Let's start with you who has introduced this issue.

P6: I may not know about other but I do use the pills

M: So the pills are available.

P6: Yes

M: Other family planning methods which are available?

P3: Even the injectables. I have ever escorted one of my friends to go for injection.

M: Mhmm

P3: But I did not know…

M: The contraceptive injectable from the pharmacy

P3:Mhmm

M: Ok. Another one? So, you have never heard about the injectables? Who else said it?

P2: I ever saw my friend taking and injectable at the pharmacy and he told me it was the contraceptive injectable.

M: Ok. Are you friends or you are coming from different places?

P2: Different places.

M: So, it seems the injectables are available at pharmacies. What about the other methods? Where do the rest get family planning methods? Where do they women say they get these services?

P6: At the health centers

M: So it is at the pharmacies, district hospitals and health centers. Is there any other place?

ALL: No

M: I will come to it again. Are there people who come over your streets to provide family planning services? Or is it necessary to get them form the centers?

ALL: It is at health facilities.

M: So not over the streets. I would like to know how you find these services or rather how your fellow women find these services that are available at the

hospitals, health centers and pharmacies. How do you find family planning services? Who wants to answer?

P4: We get family planning services but there are some differences. You can start with injections and they may not work well with you. You can then be advised to get implants or intrauterine device. There are some changes that occur in the body that can make you feel sick or lose some weight. You are always advised to go back for counseling but for now it think the injectables are not available. The majority are using the implants. The injections are said to have marked side effects. There are some side effects. You can feel sick when you use them or feel bad. You might even become unable to conceive later on.

M: How sick do these women who take injectables feel or what problems do they present with?

P4:**We don't know exactly.**

M: But they say they feel sick

P4: Yes. You can feel sick

M: Like one of us said that she used the medication and she…

P4: You can have stomachache, like pain below the umbilicus. If you have never experienced such a situation, you will think that it is because of the injectables or the implants, or the intrauterine devices.

M: There is one point you said that people say that the injectables are having marked side effects. What kind of side effects are they according to what they say?

P4: We do not exactly know the side effects they are talking about but these side effects are there.

M: So people in the community say that the injectables have side effects.

P4: Even here at the hospital

M: Have you ever been told here at the hospital that they have side effects?

P4: Yes

M: Who said so here at the hospital?

P4: The doctors.

M: So what were you told to use instead?

P4: The implants

M: So you were advised to use the implants. You said that you once escorted your friend and what happened?

P4: She is my sister in law and my friend. She came to get injectables. They told her that the injectables are not available because there are marked side effects that result from using these injectables. They said that the implants are good. I don't know how good are the implants and how harmful are the injectables.

M: Who raised up her hand? You had something to add up, let's start with this one here.

P2: As regards the side effects of these things…my younger sister went out for the implants. She came to have abdominal pain and swollen abdominal mass. I myself used these injectables. I injected once but I missed my periods. If I really had period it was as very

little dark blood. As such, I stopped using them up to now. My young sister is still having that abdominal swollen mass as a result of using implants.

P2: My I add up. When they come to say that these services have side effects, it is because when they get the services, they are advised to do some things as part of the directives. Some of them do not follow the instructions. Like for the injectables, you are advised to get them at the interval of three months. You might find someone adding on another extra moth. So, when you go beyond the advised time, you will definitely have marked side effects and such like things.

M: I don't say that there is right or wrong answer. My you go on. What did you wish to say?

P5: I wanted to say that these services have side effects to some extent. I have not used them for a long time but they have side effects because I have three children. I got the first born without using these services, likewise for the second and third born. Then I found that I had enough children and I wished to rest from getting pregnant. I was well before. Then after I shad just stopped bleeding post-delivery, I got back into my periodsas such early. Then I asked a nurse as to what is happening. I got back to my periods after one year following giving birth to my first born. So why getting back to my periods after a month.

M: Were you then already on family planning services or not

P5: I have already used them. I had not used these services at the time I was asking the nurse.

M: Mhmm

P5: I thought it might be because I have delivered the baby of different sex form the previous two. So, the nurse told me that it just happens. So, I found it better to get injectables. The next day I had severe abdominal pain, my legs felt hot, and all my body was aching. It went on for a long time. Up to now it is two months without getting my periods and I still feel such symptoms like abdominal pain and all the body is aching.

M: When have you taken this injectable?

P4: It was in April

M: It is when you started

P5: Yes. I was told to take the other one after three months, which is in July 26. I am supposed to get the other injection.

M: Will you go for injection?

P5: Yes, I will because if I don't take injection, I will become pregnant once again so long as I have a man. As such I won't be able to achieve the dreams ahead of me.

M: What did the nurse tell you? You definitely went to report that you had severe abdominal pain and the legs were aching, and you know still wish to use the injectables. What did the nurse tell you?

P5: She told me that my body was not used to such like things because I had never used these services. She told me that there are such changes like getting fat or losing weight. So, she encouraged me to continue using it.

M:Ok. These are good examples. We have like six questions and I would like to use not more than 10 minutes per question so that we may not delay and find the doctor already out. We already have your opinions. May I ask the other question? About the services you get at other facilities than the pharmacies,

let's talk about the health centers and hospitals like the district hospital as you said. How do you find the services? Are they good? Do you like them? Leave alone the methods, I need to know about the way you are attended. I would like to know how you are attended at the centers. Are you pleased with the availability of services? Are all the methods available? Who has ever gone for family planning services at the facility? Raise up your hands. One, two… you have ever gone to the health facility. 4 of you have ever done so. The rest have not. So, four of you have ever gone to the health facility for these methods and three of you have never.I would like to hear from those who have ever gone there. How did you find the services?

P6: The service we received was good because we had our own department and they cared for us. That's it.

M: You have your own department and you are cared for.

P6: Yes. There are some of the papers that were always given to us. They cared for us too much to an extent that I can't tell.

M: Another one

P1: When you are just beginning, you find the service good. But if you like have an implant or and intrauterine device and its time is over, you have to replace it. At that time, the doctor can demand some money before offering a service.

M: So as you are started on implant, it is free of charge, but to remove it, you have to pay some money.

P1: **Yes.**

M:How much

P1: Five thousand

M: Has it ever happened to you?

P1: It has happened to others.

M: Ok, we are also talking about the rest too. Another one?

P5: This has ever happened to my sister. She got and implant and has its time was over, she went to the hospital so as to remove it. She said that she went there several times without getting this service because they postponed this service many times for her. She went on suffering and later on she took the razor blade hoping that she would make an incision and take it out. So, as she incised, she could not find it. She then did nothing more. I don't know what side effects happened there after.

M: Mhmm

P5: They troubled her much as they postponed this service several times. Sometimes they were telling her to go back to the center where she got this service first. So as such, she decided to do it on her own.

M: So it seems taking this service is simple but removing them becomes a problem.

P5: It is a problem

M: It is so to all of you?

ALL: Yes.

M: Have you ever lacked some of family planning services, like you wish to have a certain method but you cannot find it? Or have you heard about people who have experienced such a situation?

ALL: No

M: Haven't you heard people complaining that some the methods are not available

ALL: **No, they are all available.**

M: There are three kinds of services. Do you mean that are the three types are available?

ALL: Yes.

M: Ok. Currently, there is an issue that the government is trying to do so as to improve availability of family planning services. They are trying to disseminate these services to the other departments. Like you go for vaccination or for having delivery, you find these services provided there too. For those who take ARVs, are able to access these services at their departments. Have you heard of such like a thing?

ALL: Mhmm

M: Raise up your hand s for those who have heard about it. Ok, three of you have heard about availability of these services at the other places. Four of you have not heard about it. Now for those who have heard, how do the people say about it? You all said that the services are good except when it comes to removing the implants or the intrauterine devices when their time is over.

Px: Yes.

M: So the services are good. Are they of the same quality even if they are provided at the other areas? Is there any challenge that you have ever heard about it?

ALL: No.

M: Mhmm

Px: Maybe you give as an example like about the service we came for as compared to what was offered on that same area.

M: Let us start with this one here.

P4: As I said, I escorted my friend who came for an injectable.She was told by the doctors that the injectables were not available and they would no more be available because they have side effects.

M: When was it?

P4: It was in April this year.

M: At what center

P4: This one.

M: Ok. So, she was told that the injectables are not available and they would not be available.

P4: Yes. She was advised that the implants are good too. She was like hesitating because you know each method has its own side effects. She was started on implants up to now.

M:Ok. She had come for such family planning services

P4: Yes, she was like forced to use implant because it is the method that she found available.

M: Ok. You said that you have ever heard about family planning services being provided at the other places.

Px: What we mean is like now I am having headache or as I have brought my child to the clinic, I can take the baby for clinical services and afterward I proceed to family planning services without even planning.

Px: On such a situation, you need to have arranged for it prior. Some of us have arrogant men. Some do not like these services. However, other do understand when you explain to them. You can like tell him that we already have enough children.

M: May reserve that point. Let's hear from those who have ever got this service.

P3: There is my young sister who came for delivery hear and she was counseled to take these services but she did not do so.

M: Do you know why she did not do so?

P3: I may not know.

M: So she had just come for delivery and then she was told about these services.

P3: Yes.

M: Another one with any incident?

P2: I have my friend who in the first place got pregnant and she came to have abortion here. She was the student by then. After abortion, the doctor advised her to use family planning methods. She was started on the injectables at the interval of three months. She was on boarding school and could not get time to come back at the scheduled time. She has been at home for vacation and got pregnant once again. The doctor advised her to use family planning after having the first abortion.

M: So, she got pregnant because she did not get time to go for the second injection because she was at school.

P2: Yes. She came back and had sex while the time for that injectable to work was over.

M: Did she come for abortion here or she had it right there in the streets and came here for further service?

P2: There is one of her friend who is knowledgeable about these issues, who advised her go somewhere for abortion.

M: So they came here directly.

P2: Yes.She was told that as long has she is a student and she is having sex casually, she is to use these services.

M: So she got abortion service right here.

P2: Yes.

M: Let us start with this one here before her point escapes her. Mhmm.

P5: I might have not understood the question as you said it at first.

M: I would like to know about the people who have come for other services and end up getting family planning services too.

Px: Like you can be having malaria, you go to see the doctor and after treating you, he goes on telling you about family planning services. This is good. Not to go to the other room for family planning services.

P5: I thought it like how it is for the pregnant mothers when they come for delivery, there are family planning options for them to opt. When you go for the clinic, they start telling you about family planning services for you to select the method earlier on such that as you give birth, they administer it right there.

M: Where you counseled about it when you were pregnant?

P5: Yes,

M: Why didn't you use the method as you gave birth?

P5: I like hesitated and felt to wait.

M: Why did you hesitate?

P5: I wanted to hear from those who have used them already because they are still new. I was to wait others to use and get the lesson from them. I asked one of the attendants at Buhongwa when I was staying at Mkuyuni. As the nurse told us about the loops, I asked her to tell us about the side effects of the loops. She said that there are minor side effects. I went further to ask her as what kind of side effect they were. She failed to answer me. So, as she could not answer, I was not convinced to use this method. She did not give clear explanation about the side effects. I was about to use these services but as she failed to answer me properly, I like said that let others use these methods and I will do so afterwards, if at all they are good.

M: Mhmm. Haven't you forgotten your point?

P7: I wanted to talk about the loop

M: Mhmm. May I remind you that we are now talking about people who got counseled about family planning as they came for other services is even if it is not you. Do you have such incident? If you don't have let's move to the other question. We will come back to your question. If we don't talk about it, remind me at the end.

P7:Ok. That's what I wanted to talk about.

M: I would like to hear about these services that are available at the other places. You said that they are of same quality as with the other places.

Px: Yes

M: Ok. For those who use these services, do they say that they wait for the same of duration of time or they have to wait for extra time? You know as you go for the clinic, you get services for clinics only. Likewise, with when you go for vaccination. Like if you go for vaccination and get family planning services right there, does make one wait for more time or what do they say about waiting or rather taking longer or shorter time as they wait for these services? Is anyone with something about this issue? If you have no experience with it, we can leave it alone because we don't like hypothetical things. We need to hear about the things that have ever happened and what you have witnessed or heard. There is no need to say what you have never witnessed or heard.

So, you have not heard if they spend a lot of time or if they save time due to the fact that the services are available at the same place.

Px: We have not heard about it.

M: Ok. You said that you have heard it that the services are about to come to the facilities that are very close to you apart from the district hospital.

ALL: Mhmm

M: Are there government dispensaries in your locality?

ALL: Yes.

M: Is there time when there are services available on such facilities that are unusually provide there? Have you heard of it? How many of you stay close to the dispensary? Raise up your hands. You all said there are dispensaries. So, the dispensaries are closer than this facility. How many of you have the dispensaries or health center closer to them than this district hospital?

Have you ever heard that family planning services will be available there? Have you heard some announcements that family planning services like permanent contraceptive methods that were not being provided before, are going to be administered by experts on such places? Have you heard of it?

ALL: Yes.

M: How many of you have heard and witnessed it? May you raise up your hands. Is it only two?

Px: Yes.

M: Ok. For you two who have heard about it, how do they people say about them? I would like to know who you have heard about them. Let's start with you who had another point

P7: As I saw, they did not say that they experienced any side effects. We had brought our children to the clinic, then the doctor came over and talked about family planning. He was providing implants, loops and providing permanent contraceptive methods.

M: Where did that doctor come from? Does he work there?

P7: No he just came over.

M: Was he alone form the other facility?

P7: They were many, but it was only one doctor who was explaining about the services.

M: Were there other people from different places?

P7: Yes, they were there. They came from other places and got the services right there.

M: Ok.

P7: I cannot tell what kind of side effects they got.

M: I just want to know if those services were provided. What kind of the service did they provide?

P7: Loops and implants and permanent contraception.

M: These are unusually available there.

P7: Yes.

M: Ok. Another one who said to have ever heard. What did you hear?

P5: I heard that…I took a child to a clinic where I found a man saying that for those who wish to use contraceptive methods, have to come over with their husbands for these services. This is what I say at Buhongwa hospital because we used to get usual services like injectables. I had not heard about this issue of getting there with your husband before. A lot of people went there but later on, the services were stopped.

M: Have you ever heard about family planning methods that have been newly introduced at the facility?

P5: I don't follow them up

M: For you who have heard about it,I would like to get your opinion about these service that are brought close to you, like permanent contraception, loops and implants. How did the people who used these services talk about them? Were there some shortcomings or challenges?

Px: May you come again?

M: **You have the health centers and the dispensaries that provide these short-term services like the injectables and pills. But you find the team has come over and announced to provide long term methods like injectables and loops. That's what I want to know as if you have heard about such things. Have you heard some people getting such services that were not normally provided there?**

M: Let's get back to you. What have you heard people talk about these methods? I mean these services that are provided unusually for a short time.

P5: At Buhongwa, I have not heard about any complaint and many people showed up for the services. So, I didn't hear about any problem.

M: You

P7: To me, I have not seen any one complaining about the side effects of family planning methods. To me personally, I did not get any side effects. I gave birth and as I went into the ward for the baby's clinic card, I met a male nurse who stared advising me to use family planning methods. I said ok. I was using the pills that were making me nauseated, and was aware of my heartbeat. I could not even take tea at 10 because the appetite was poor until 12 or 1 pm. I felt like I am pregnant. I stopped these medications and went on to use the injectables. These harmed me too such that I was bleeding daily. When I reported it to the health center they assured me that this would disappear.

M: So when you went to take the clinic card….

P7: I was still explaining to him on the side effects got before. So, I asked him about the method to use next and he told me to use the loop. She counseled me to use the loop that would last or ten years and get me more time to rest well. So, she told me that as I have recently given birth, it would convenient to use the loop. I then acceded. Then I got the loop and had it for about a year. The problem is that when I had sex, I experienced much pain.

M: That was not there before.

P7: Yes. I went to report it back to the health center and I would feel that this loop had already moved from the site I was inserted. So, they asked me if I wished to remove it, but I just told them that I wanted them to see what was wrong if any. They told me to

wait and observe. I stayed for like three months and such a condition was coming over again. So, I decided to go to Mwanza hoping to get better care.

M: So you came this way for this purpose

P7: I had just gone to Geita for getting delivered.

M: May you summarize please.

P7: Ok. I was forced to get back here whereby they told me to go for ultrasound to see if it had moved or not. It cost 5000 shillings. I wondered why I was to pay for it while these services are provided for free. Ok I explained it all to the other nurse. Then one who told me to go for ultrasound had gone away. Then there came another one who helped me to remove it.

M: When was it removed?

P7: Two months past.

M: Have you got the other services after it was removed?

P7: No.

M: Why?

P7: I wanted to explain more about the side effects I was getting

M: So you stopped them because of side effects

P7: Yes. I have used them all except the implants.

M: I am sorry to have made you rush. I don't like to delay you here that you might findadoctor no longer there. You can back again after you are attended. We like to hear about these stories but we care about time. We thank you for your experience.

M: I have the last question on this section. Did these people say get all the services when they are brought near the community? You spoke of implants, loops and permanent methods. So, whoever wanted each of these methods was able to get them?

ALL: Yes.

M: Isn't there one who complained to have missed the method of her preference?

ALL: No.

M: We would like to know about the changes that you have seen in your community within two to three past years up to now. What are the changes as regards family planning issues? I would like to hear anything else. Does it mean is no change?

Px: No

M: Who says no?

P1: Changes as regards family planning…first you no longer have birth at short intervals. You can use implants for like three years and remove them if you wish to have children.

M: So do you want to say that there are changes and women are having goo spaces for their children?

P1: Yes.

M: So this is one of the changes. Another one who has noticed the changes? I am going to ask you about what I need you to say.

P5: I wanted you to explain more about the changes, what kind of changes do you refer to? Did you mean the advantages that we get from…?

M: **This is a very nice question, I just wanted to hear from you first before I tell you what I need to share with you. Let is first hear from this one then I will come to your question. What do you have to say concerning the changes?**

P4: There are changes, and these are the changes; if you had the implants, after removing them, one takes even longer time before they can conceive.

M: Thank you, I have heard from you. Now I would like to tell you what I'm looking for. All that you said is good and right. If you do the comparison between the present and the past regarding false believes towards family planning, what do you think about the current situation, are there any improvements? Use of family planning methods and contraceptives; are many people using the contraceptives now when compared to the past? How about using different contraceptive methods; one of you spoke about use of injectables. Do you think people are now using different kinds of contraceptives when compared to the past? These are the changes that I would like to hear from you. Good, I can now see hands, who wants to be the fast?

P4: Currently, most of the people are using the injectables. Injectables are hard to find for the time being.

M: You are saying that there are no injections, how many of you are supporting this, that injections are very scarce nowadays?

ALL: No, this is not right. Injectables are available.

P4: They might be available, but they don't encourage their use.

M: Who else is saying that the use of injectables is not encouraged?

ALL: Only her.

M: There is no answer that is incorrect, and we love the fact that you people argue, this is the open discussion. So the rest are saying that the injectables are available. She might be having such experience or once being told that the injectables were not available. We are looking for personal experience too.

P4: I went and was told that they were not available.

M: It is therefore possible, there are many other people who were told the same thing, and they may not be around now, this will depend on the service providers you met at the health center. So don't hesitate saying what you have heard, you will differ at certain points by any means. Are there any other people saying that women are using the implants nowadays?

M: You are only two. What about others, what do you see as changes as far as contraceptive methods that are used now and in the past? What are the methods that were not used in the future and now they are in use?

P6: There are changes because in the past people used local methods. Through such use of local methods, things may not go well, and one may end up getting pregnancy. I have a

friend who advised me to use certain kinds of leaves, prepared and drinking the juice before meeting with a man believing that you will not conceive. The majority have changed from using such local methods to the modern family planning methods.

M: Good, so these are the changes, people have changed from local methods to modern methods. How many do support her that the use of local methods for contraception has declined and people use modern ones?

M: All of you?

ALL: Yes.

M: How about using the short and long-term methods? When I speak of short term methods, I mean the use of condoms, contraceptive pills and the injectables. Long term methods are intra uterine devices, implants and ligation. Are there any changes concerning this, that now people prefer using long term methods now more than it was in the past or they don't want to use them now. Who would like to contribute regarding this?

P6: For me, personally I wish to change because I am tired of taking the same medications every day before going to bed. If you forget to take the medication, you might find yourself returning to the wet periods. But for me, this has not happened to me any more since then. I wish to change the methods, but yet I do not know which is better?

M: When did you begin to think of changing the method?

P6: I have been wish so, but I was afraid.

M: Why have you not changed to this moment?

P6: I have not changed the method now because I am expecting to deliver in God's graces.

M: Okay, this is because you are pregnant, right

P6: Yes.

M: Who else wants to add up?

P5: Currently, the big percentage of people prefer to use the long-term methods. We are only worried about getting the side effects, just as my fellow said. A lot of people have now decided to use long term methods due to life difficulties and economic hardship, also planning on how to take care of their children. They no longer prefer to use the short-term methods.

M: For those who are not using family planning methods yet, what should they be told so that they can start using the method? And you said that, people are worried about certain side effects, what do you think needs to be communicated to you so that you can start using these long term methods.

P5: We need a lot of convincing power. Those who bring these medications, should make sure that the medications are trust worth and are free from side effects. Also, before we start using the medications; thorough research should be done and make sure that these medications do not cause any side effects. Because most of the people are afraid of taking these medications because of fear of side effects such as bleeding, general body pain, malaise, stomachache, having unstable menses, etc. So I think if there will be some improvements on these issues, because I believe we have the potential people, and if they give us a piece of advice and reliable information especially to us women, there will be no one who will refuse to use family planning methods.

M: Thank you very much. Just in brief, I am still asking; are there any changes regarding the use of long term methods or not? How many of you are saying that there have been any changes? I just wish to know only about the long term methods because I believe the short term methods such as contraceptive pills and the injectables have been widely used.

ALL: Yes.

M: We all know this. But do you think there are people who have changed from the use of contraceptive pills to the use of intrauterine devices, or implants and use of ligations? How many of you are saying yes? I am not forcing you to say yes, if you think there has been no changes, you just say no or if you don't know just say you don't know as well. Those who say yes, could you please tell us why you day so?

P2: Most of the people who were using contraceptive pills in the past, may decide to use the long-term method due to certain life challenges such as being divorced, and yet they still want to remain fertile and if they have children; they want to help them grow despite the economic challenges, they therefore opt to use the long term methods so as to achieve this. And if they think it is the right time to have a baby, they can remove the implants and then conceive again.

M: Okay. Specifically, what has made people change their minds, and start using the long term methods? For you who have said that there are changes, do you think it is because of the easy availability of these methods or these methods were available even in the past but only that people had no interest, or is it that there is an increase in the level of understanding about these methods, that people used to understand less about these matters in the past? I want to know if there are changes in the availability or the level of understanding or these are just personal decisions that in the past people had good understanding about the methods, they were available but they did not use them? Who wants to say something?

P1: I make the decisions on my own. Because I have heard from fellows that the use of implants and intra-uterine devices cause a lot of problems, the others say the implants do tend to shift from their original sites. But I said that rather than using these implants that shift from their original sites, it is far better for me to get the injection every after three months, then I will come back.

M: So you decided to get the injections because…

P1: I decided to use the injectables because I was told that the implants had a lot of side effects.

M: You were told that these implants do shift in position?

P1: Yes.

M: Where do they shift to?

P1: They go to the new location, if they are implanted at this site, by the time of removing them, they fetch them from a different site.

M: She has said that, a lot of people speak but she makes the decision on her own. How about others, you can speak for the other women in your localities, how

do most of the women in our communities make decisions regarding the use of family planning methods, on what method is to be used?

P4: The method to use will depend on what you have been told by other people, or depend on the life style you are living. Suppose I have a single child and I don't wish to get the other. You might be single or married, now suppose you are married and you have been advised to use the injectables, at this point you will have to consult your husband about this.

M: You have said that for the married couple, it is wise to involve the husband in decision making. How about others what do you think?

P4: One of the two things may happen when you have engaged the husband. He may agree with you, or he may refuse. If he refuses then, you will need to follow the right path. If the husband doesn't want you to use the contraceptives, them means he wants you to conceive and give birth, but if you think that the environment you are in is not conducive for conceiving again, you can decide on your own, you insert the implants secretly so that he doesn't know about, for if he does this becomes the other case then. For those who are not married, staying at home with a single child, it is wise to have the implants, so that you can have good time to bring up your child and prepare conducive environment for them. And when you have found a mate, you can decide to add up the number of children, may be two or three, according to your desire.

M: So it's upon you to decide. I will try to hasten so that you may go to be treated. This is for your good so that you may go to be attended. As you will be getting out of context I will be bringing you back so that we remain focused. The majority have said that it seems a large part of decision is upon the individual herself. How many of you say that the final decision as regards the use of the methods are upon the woman herself? All of you?

ALL: Yes.

M: How many of you say that the husbands are the ones with final say?

P4x: Others

M: So there are the other women with such husbands

Px: They are many.

M: How many of you say that they are convinced by their friends, as they use the methods because they find their friends doing the same? So it seems all the methods are available.

ALL: Yes.

M: So they are all alight depending on one's wish

ALL: Yes.

M: So if I got you well, there is no one with maximum influence. It just depends on the context.

ALL: Yes.

M: So let us talk about the outreach that we talked about earlier on. You have already answered many questions about this outreach, I don't know under which sections it falls. I would like to know how the people know about these services that are…so the outreaches have been there. I would like to know

about these services that are always brought nearby you. We can spend like ten minutes. Two of you have said that have ever heard about these long-term services that are always brought nearby you. How does one know that there are the new services available than the usual ones? How do they know that there are people providing such services like implants, the loops and others? How do they get information about these services that are not usually available?

P6: At one time I was staying at Mugurani in Mwanza. There is one female doctor who also works here. We used to go to his pharmacy and she was advising us to use these family planning services. She was telling us about different options that we can take according to our wishes.

M: So the health service provider can provide verbal information too.

ALL: Yes.

M: Number 1, what do you say about how people get to know about it?

P5: If you like go to the clinic, you can find a lot of people to ask about it and thus take time to read the posters. You can even ask the neighbors. A lot of people get to these places because they are open to all. As such all these will be sharing this information among themselves.

M: Before these services are introduced, is there information provided prior?

ALL: No

M: Do you all say no? Are they not making announcements along the streets so as to inform you on such issues?

Px: No, they can sometime ring the bell.

M: Mhmm

P6: It ever happened to us that they called the chair person and started blowing horns and saying that as a certain day there will be vaccination for children but not about family planning services.

M: Haven't you heard announcements even over the radios about family planning?

P6: We have heard them announce about the cancers but not about family planning services.

M: So you have to find these services at the centers or hear about it from the people

ALL: Yes.

M: Ok. I would like to have your opinions regardless of if you have ever heard or not heard about these services.As I have heard, there are not permanent methods at these small health centers. There are not services like implants, loops as well as permanent contraceptive methods. How do you find it, is it good for these services to be brought temporarily at these facilities? Is it good or bad or rather do you need to get them from these large centers?

Px: They should be brought here permanently.

M: I don't say they have to be permanent. I am talking about outreach activities. That is the health care providers get out of here to bring the services close to you. It is to be done temporarily for some days or moths

P6: So how are we going to know about it if at all they don't come back?

M: So those are your ideas that I wish to know. Like if they decide to come back after four months. How do you find it?

P6: That is not good. It will discourage us and pull us back.

M: Mhmm

P6: We will find it convenient to use these methods we used to although they are not good to us. So, in case of emergence it become a problem.

M: Ok. Another one who says that you do not wish people to come over, provide the service and disappear? The implant lasts for three months. Why should I come regularly here?

P4: You can come in case you experience side effects. I may have like stomachache and thus come to tell the doctor, for him so say if it is as a result of these services or other disease.

M: Ok. So you are worried about the side effects like they can occur and find yourself with nowhere to go to

ALL: Yes.

M: The last question. I would like to know if there has been any objection as regards the use of long term contraceptive methods. What do I mean by long term contraceptive methods?

ALL: Permanent contraception, implants and loops

M: Ok. Have you ever hear people objecting to these methods on account of any side effects? As compared to the methods that you are used to, the pills and injectables. I would like to hear vivid examples as to how people object on these three methods that you have mentioned.

P3: I once heard some women say that there was a woman with an implant whose husband wanted her to get pregnant. So it was difficult to remove that implant.

M: Why?

P3: It is because it disappeared into the body. So this interfered with the whole process and she did not get pregnant.

M: So that is the problem with this method. Ok, another one with something to say on these methods?

P1: There is one who used an implant. You know there are the conditions that one is to observe. She did not observe these conditions and ended to have ectopic pregnancy.

M: Another one who has heard that some are worrying about these methods because of the side effects they hear other people say?

P6: My sister was using one of the methods. I don't know if it was the implant or loop. She was then having severe abdominal and back pain. She decided to stop using them. I don't know what method she used afterwards but she was complaining of back and abdominal pain. She was well before using these services. So it is definitely these services that caused all this trouble.

M: Did such pain subside when she removed them

P6: Yes, it all disappeared.

M: What have the rest heard of it? How do the men say? How are our religious beliefs in this context?

Px: Our beliefs…

M: What kind of religious sects are you referring?

P1: There are some religious believes that do not support it?

M: What don't they support?

P1: They say that there are the methods that are written in their books?

M: Which religion?

P1: Our religion, Muslims.There are some methods that are available in the books but they require you to have read about it.

M: Like condoms, are they allowed?

P1: They are not allowed.

M: Mhmm

Px: They say that with condoms you are disposing the potentials into the pits. You find one basing very much on religious issues. So you have to make your own decision because it you how will get into problems. It might be considered sinful but God will forgive us.

M: How do the parents say about it? What about the other religion apart from Muslims? The condoms are not allowed. What is it that they can allow to use?

Px: They are allowed but you should have read the scriptures.

M: So for those who have not read scriptures are using any of the methods.

Px: We have read but….

M: Ok. What question did you ask then?

P6: The religious teaching instructs us to give birth because each baby comes with his or her own fortune. This should be in the wedlock. But you have to space these children.

M: Ok. The husbands are worried about the side effects of these methods, that's why they prevent you from using them.

ALL: Yes.

M: What else do they say that make them prevent you from using these methods?

P6: They are worrying of side effects like developing abdominal mass that might require surgical intervention. To some it may be unfortunate that they lose their lives out of it. Driven by such worry, they tell us not to use them but you have to.

M: If like my husband doesn't not want me to use these methods and my home community supports me to have many children. The man must have like 12 or 15 children as per our belief. Is it a case with your community? Have you heard such like a thing?

P6: Yes, my grandmother had 12 children. I cannot try to do the same because we are living in different area.

Px: Are there people who still have notions that women have giving birth as their primary role?

ALL: Yes, they are there.

Px: So it might be one among the reasons that make the men worry about it?

ALL: Yes

M: What about the men who think that if you use family planning methods, you will no longer be faithful because you can have sex without getting pregnant?

ALL: They are many of this type.

Px: They want you to give birth regularly so as to concentrate on raising up the children. You want have time to think about being unfaithful because you will be busy caring for your children.

Px: Some of the men do not provide enough for the family despite this large number of children. This is why we avoid such like things.

M: But there are men who allow their wives to use these methods.

ALL: Yes, they are there.

M: Are there some of the men who come to take these services or rather escort their wives or convince them to take these methods? Have you ever heard such like a thing?

Px: There are few. Some tell you to go but they don't escort you. Like with my husband, he can escort me the first day I go for the clinic but for the rest, I use to go alone.

M: I wish to end here so that you may not delay unless there is a marked issue to raise. Is there anything crucial that you cannot leave without letting me know?

ALL: No.

P5: I have something to talk about. The issue of family planning is for both of us be they males or females. Unfortunately, the husbands are not yet convinced about it. They leave all this issue to us.

M: What would you advise on this issue?

P5: I advise that the husbands should be provided with education and sensitized about family planning. They should also be undergoing procedures for family planning too (*vasectomy*).They should not leave all of it to us because if you get problems out of it, they abandon you and go on to have children elsewhere. So they should do undergo family planning procedures too.

M: Ok.

Px: I once heard that there are family planning service for men. I no longer hear about it anymore.

M: They are there.

Px: We would like you to improve it so that they may use it to large extent as we do

M: Ok.

Px: We thank you for taking your time to talk to us, thank you for your time and good contributions. We have indeed have got things that we have never thought of. So we hope that this is going to be helpful to the community.

END OF DISCUSSION

Seven: Focus Group Discussion Guide for 8 Male Community Mobilizers

Community Mobilizer Fgd Male (8)	Malampaka Health Centre	Simiyu	12/7/2017	Rose Leader	Edward Notetaker

Interviewer/s: _Rose Ernest _____ Date: 12-07-2017 _____

District: Maswa DC_____ Note takers: Edward Nkya

The focus group discussion consisted of 8 participants who were selected on a purposive basis by EH from members of the community who were mobilizing the community in the village and around Malampaka Health Centre in Maswa DC. Their ages ranged from 42 to 54. The number of children ranged from 1-9, all married. The composition of the participants was 2 religious leaders, 3 village executive leaders and 3 community health workers.

Selection of community mobilizes: They were selected through village meetings, and all have the experience of more than 5 years. They were oriented by EH/ RESPOND for a week.

Awareness of FP methods: Respondents agree that there are natural and modern family planning. They mentioned the long acting method and short-term methods. For the LARC the providers come with EH staff monthly from the regional or district hospital but all other methods are available at Malampaka HC.

P1: The other methods are the pills, loops, condoms and permanent methods by operation.

P3: Among these methods are the implants that the women can use. If they go to the health facilities, they can be asked about the method they opt to use. The implants are among the options.

Community mobilizes responsibility: Their responsibility is to bring awareness on FP in the community, reduce the misconceptions and myth about family planning and provide the information to the community on when the service will be available.

***"I** am the religious leader as I said. What I have done is preparing the preaching for my fellow Christians about the religious pillars. I do also prepare the seminars in the church and sometimes make preaching as usual. We base on educating the community because it is economic hardship, there are also deaths, and life becomes more expensive. Therefore, the parent should be aware that he/she lives with some people at home. If it is a man, he has a wife and children. If there arises a problem, it affects all family members. There is one bible verse that goes, "One who does not provide for his family is worse than the non-believers are" So we are trying to educate the parents about their responsibilities and let them know about different challenges of daily life. We are trying to do away with different myths. God commanded us to give birth and multiply. This was command was given to Adam and Eve. If we sometime act without wisdom, we create problems. Therefore, God can punish some of the people who cannot go righteously. God resented adultery life, where people were casually bringing up children. He then erased that generation*"

M: Do you have action plan after the trainings? If yes, is there some kind of feedback that you submit? Were there some follow-ups by your trainers to ensure that you are working? Has ENGENDER/ RESPOND done anything among these?

P5: Yes, we were trained and we submit our reports. They do come to fetch them here to compare them to see if they match with one another. We have action plan and we do submit our reports here.

P1: There is feedback that we submit. When you educate the clients, are times when you have to escort her for service. Despite escorting her, if you refer one, you have to make a follow up to ensure she has been attended. Furthermore, there are side effects that can result from that service. Therefore, you have to follow up the patient for these side effects and counsel her. If the side effects are because of the service, you facilitate communication with experts at a nearby center. These can also communicate with the project managers if the problem gets more severe.

How the mobilization is done: They have fliers that indicate the dates and place of family week or service day ten days before the day. They also go door to door.

P4: We use the microphones to make announcements two to three days before the event.

P4: In the church, we make announcements any day as soon as we receive them.

Most effective method for mobilization: The use of religious leaders and house-to-house visit seems as the best practice foe mobilization**.**

"Going to visit people in their families has been more effective because talking to people publicly did not attract much response. There is also little time to educate people unlike when you visit them at their homes."

P4: *Using pastors is a good idea because of their influence and people can go to consult them thereafter.*

Any support from Engender Health:

Community mobilizes got a small allowances during service day, which they call it Mkoba day. Other days is purely volunteering work.

Eight: Focus Group Discussion Guide for Community Mobilizer (2 male, 6 female)

Interviewer/s: _Rose Ernest _____ Date: 17-07-2017

District: Kibaha DC_ Note takers: Edward Nkya

The focus group discussion consisted of 8 participants who were selected on a purposive basis by EH from members of the community who were mobilizing the community in the village and around Mlandizi Health Centre in Kibaha DC. Their ages ranged from 38 to 59. The number of children ranged from 1-6, seven of them are married and one is a widow. Their position in the community is HBC's and Community based distributers.

Selection of community mobilizers: They were selected through village meetings, and all have the experience of six (6) years and more.

Awareness of Respond Project:

All respondents confirm to have the knowledge on RESPOND, as they are working with them closely. They were working with community even before Engender Health but the project orient them with the family planning knowledge.

R5: We are educating the community on family planning matters in the church, at the mosque.

R6: we were provided with material to work with so in the community we share the information with the community, members. *"We ask permission to the church leaders and if he agrees we talk to the people because if we won't do that we will end up with more street children"*

During the public meeting is when they also talk about FP.

Any training from Engender Health/ RESPOND:

- All types of family planning and how to counsel the clients and refer them to the health facility for more information and FP choices.
  R1: EH provide as with IUD and injection for demo during mobilization.

How outreach services is Conducted:

Their main role is to advertise and do the mobilization before the outreach but also during the outreach they are assisting in providing the short term methods. *"We normally go house to house to provide the children care services and immunization and at the same time we give them the information on outreach date and service that will be offered"*

Any support from RESPOND:

R2: This is a volunteering work but during seminars we get allowance of either 5000-10000 tsh.

R6: If I escort the client for FP services I get reward of up to 20000 tsh.

ALL: no standardized allowances and we are not sure even the small amount we get who provide it.

Achievements:

Clients for FP have been increased and the fear has been reduced for example few years back women tend to fear the use of IUD that cause cancer.

R2: Male are also aware, and they allow their wife to go for family planning.

R1: Infant and maternal mortality has gone down in this five years. Women have enough time to care for their children because of birth spacing, this means children are healthier.

R8: Couples works together to raise the family income even the women have time to participate in small income generation groups.

Challenges:

- Lack of transport to reach more people in the community.
- R3: It is still a challenge for Muslims to accept family planning and there are still barrier to reach at the Mosque.
- R6: need of refresher course, the last time we had orientation on FP is three years back.

ANNEX III. PERSONS INTERVIEWED

Total count of In-depth Interviews (IDIs)	Number of IDI participants	Female IDI participants	Male IDI participants
92	129	76	53

Name	Organization/ Implementing Partner	Title	Location/Region	Appointment Date
Richard Kilian	EngenderHealth	Former Chief Of Party	Washington DC	7/6/2017
Feddy Mwanga	EngenderHealth	Chief Of Party	Skype call/DAR ES SALAAM	8/6/2017
Annette Almeida and Edwin Earnest	EngenderHealth/ M& E	M&E Directorand M&E Assistant	Dar Es Salaam	15/06/2017
Joseph Kanama and Leopold Tibyehabwa	EngenderHealth/ M& E	SENIOR TECHNICAL ADVISER CLINICAL And Tech Director	Dar Es Salaam	15/06/2017
Dr. Koholeth Winami	MOHCDGEC	Acting Assistant Director, Rchs	Dar Es Salaam	16/06/2017
Clement Kihinga	MOHCDGEC	M&E Officer	Dar Es Salaam	16/06/2017
Zuhura Mbuguni	MOHCDGEC	Acting Fp Coordinator	Dar Es Salaam	16/06/2017
Jane Schueler	USAID	Senior Fp Advisor	Dar Es Salaam	17/06/2017
Eric Van Praag	FHI360	Senior Regional Technical Advisor	Dar Es Salaam	19/06/2017
Selina Mathias	USAID	Fp/Hiv Intergration Specialist	Dar Es Salaam	19/06/2017
Cindy Cisek	Meridian International	Former Staff Of Meridian International	US-Skype Call	19/06/2017
Michael Mushi	USAID	Former Respond Aor	Dar Es Salaam	20/06/2017
Francis Onyango	Pop Council	Pop Council Representative	Skype Call/Kenya	20/06/2017
Joseph Komwingangiro	Pathfinder	Senior Country Representatives Tanzania	Dar Es Salaam	20/06/2017
Isihaka Mwandalima	Pathfinder	Project Manager- Chaguo La Maisha	Dar Es Salaam	20/06/2017
Nelson Haule&Clement Matwanga	RESPOND	Zonal Manager&Gbv And Fp Program Officer	Iringa	21/06/2017
Dr. Hosea	RESPOND	Fp Program Manager& M&E	Iringa	21/06/2017
Frida Kingazi	RESPOND	Fp Zonal Coordinator	Iringa	21/06/2017
Dr. Robert Salumu	Iringa Regional Hospital	Rmo	Iringa	22/06/2017
Mathias Mahenge	Iringa Regional Hospital	Regional Mhis Focal Person	Iringa	22/06/2017
Roswita Msangi	Iringa Regional Hospital	Rrchco	Iringa	22/06/2017
EDA MPILUKA& Others 5 Ppl	Mafinga Town Council	CHMT -MAFINGA	Iringa	22/06/2017
Martida Ndijuye	Mafinga Hospital	Rch Incharge	Iringa	22/06/2017

Name	Organization/ Implementing Partner	Title	Location/Region	Appointment Date
Solomoni Husein	Kilolo Dispensary	Medical Officer Incharge	Iringa	22/06/2017
Rhoda Kumuzugala	Kilolo Dispensary	Drchco	Iringa	22/06/2017
Merciana Mwenda	Kilolo Dispensary	Rch Incharge	Iringa	22/06/2017
Mohamed Musa Mang'una	Kilolo Dispensary	Dmo	Iringa	22/06/2017
Facility Observation Checklist	Mafinga Hospital		Iringa	22/06/2017
Facility Observation Checklist	Kilolo Dispensary		Iringa	22/06/2017
2 Training Followup	Mafinga Hospital		Iringa	22/06/2017
Anjelista Chonya	Ilula Hospital	Rch Incharge	Iringa	23/06/2017
Yunfa Sovello	Ilula Hospital	Medical Officer Incharge	Iringa	23/06/2017
Dr.Yokobeth Nkonya& Ester Kibiki	Kasanga Health Centre	Hospital Incharge	Iringa	23/06/2017
Facility Observation Checklist	Kasanga Health Centre		Iringa	23/06/2017
Facility Observation Checklist	Ilula Hospital		Iringa	23/06/2017
WOMEN FGD (8) Participant	MAFINGA HOSPITAL		Iringa	23/06/2017
MEN FGD (7) Ppl	ILULA HOSPITAL		Iringa	23/06/2017
1 Traning Follow Up	Kasanga Health Centre/Iringa		Iringa	23/06/2017
6 Training Follow Up	Ilula Hospital/Iringa		Iringa	23/06/2017
Piales Mwamezi	Iyunga Health Centre	Facility Incharge	Mbeya	27/06/2017
Malisela Mkwenda	Iyinga Health Centre	Rch Incharge	Mbeya	27/06/2017
Dr. Agnes Bauchwa	Mbeya	Rmo	Mbeya	27/06/2017
Facility Observation Checklist	Iyunga Health Centre	Rch Incharge	Mbeya	27/06/2017
3 Training Follow Up	Iyunga Health Centre		Mbeya	27/06/2017
Elebia Mandarasi	Ruanda Health Centre	District&Facility Fp Coordinator	Mbeya	27/06/2017
Selina Amos Mlimba	Ruanda Health Centre	Rch Incharge	Mbeya	27/06/2017
Erioth John Sanga	Ruanda Health Centre	Asst. Mo	Mbeya	27/06/2017
3 Training Follow Up	Ruanda Health Centre		Mbeya	27/06/2017
WOMEN FGD (6) Ppl	Ruanda Health Centre		Mbeya	27/06/2017
Facility Observation Checklist	Ruanda Health Centre		Mbeya	27/06/2017
Jonas Eliot Lulandala	Mbeya City	Agg. City Medical Of Health	Mbeya	28/06/2017
Juliana Mawala, Petro Sungi	RHMT	Regional Health Secretary&Agg.Rpharmacist	Mbeya	28/06/2017
Anna J. Otaru	Regional Med Office, Mbeya	Reg RCH Assist	Mbeya	28/06/2017
REHEMA KYANDO And Dennis Swai	RESPOND	ZONAL FIELD Managerand Research M&E Officer	Arusha City	29/06/2017

Name	Organization/ Implementing Partner	Title	Location/Region	Appointment Date
LILIAN SHOO And Delphine Msele	RESPOND	Program Officers For Integration	Arusha City	29/06/2017
Belinda Mumboloi	Regional Office, Arusha	Zonal RCH Coordinator	Arusha City	29/06/2017
Catherine Jensen	CEDHA	Zonal Resources Centre	Arusha City	29/06/2017
Elipendo Shishi Ombayi	Karatu Health Centre	Acting Facility Incharge	Arusha City	30/06/2017
Lucia Nyando	Karatu Health Centre	Rch Incharge	Arusha City	30/06/2017
Francis Thomas	Karatu Health Centre	Dmo	Arusha City	30/06/2017
Hasina Sendewa, Daniel Mathias,Alex		Drchco, Dhmis Focal&Dhsecretyary	Arusha City	30/06/2017
Mary Leon	Ngarenaro Hc	Rch Incharge	Arusha City	30/06/2017
Mary Malya	Arusha Council	Hmis Focal	Arusha City	30/06/2017
Glory Mremi	Kaloleni Hc	Rch Incharge	Arusha City	30/06/2017
Anna Kimari	Kaloleni Hc	Facility Incharge	Arusha City	30/06/2017
Dr. Kivuyo	Ngarenaro Hc	Facility Incharge	Arusha City	30/06/2017
Facility Observation	Kaloleni Hc		Arusha City	30/06/2017
Facility Observation	Ngarenaro Hc		Arusha City	30/06/2017
Facility Observation	Karatu Health Centre		Arusha City	30/06/2017
Training Followup (2)	Ngarenaro Hc		Arusha City	30/06/2017
Training Followup (2)	Kaloleni Hc		Arusha City	30/06/2017
Training Followup (4)	Karatu Health Centre		Arusha City	30/06/2017
FGD MALE (8) Participants	NGARENARO HC		Arusha City	1/7/2017
Geraldine Matowo	Tumaini Hospital	Rch Incharge	Manyara	3/7/2017
Rose S. Slaa	Tumaini Hospital	Facility Incharge	Manyara	3/7/2017
Sarah Ngidile&	Tumaini Hospital	DRCHCO&MHIS Focal Person	Manyara	3/7/2017
Herieth Kimambo	Babati District	DRCHCO	Manyara	3/7/2017
Evance Simkoko	Manyara Region	Acting Rmo	Manyara	3/7/2017
Susan John	Galapo Health Centre	Rch Incharge	Manyara	3/7/2017
Namael Sanka	Galapo Health Centre	Facility Incharge	Manyara	3/7/2017
Magret Thadei Kiyabo&Emma Florine Ngatoluwa	RCHMT	Reg.RCHCO& Zonal Central Zone RCHCO	Manyara	3/7/2017
Facility Observation	Galapo Health Centre		Manyara	3/7/2017
Facility Observation	Tumaini Hospital		Manyara	3/7/2017
Training Followup (2)	Tumaini Hospital		Manyara	3/7/2017
Training Followup (4)	Galapo Health Centre		Manyara	3/7/2017
FGD COMMUNITY (8) Ppl	GALAPO HEALTH CENTRE		Manyara	4/7/2017

Name	Organization/ Implementing Partner	Title	Location/Region	Appointment Date
John Michel Nyorobi& Swaiba Ngulugulu	Misungwi District Council	Acting Dmo& Acting District Secretary	Mwanza	6/7/2017
Juliana Bantambya& Richard Masele	RESPOND Fo	Field Manager& Finance Operation Officer	Mwanza	6/7/2017
Laurencia Ngosso& Manase Nasania&Winlady Boniface	RESPOND Fo	Fp/Cpac Program Officer&Community Officer	Mwanza	6/7/2017
Dismas Kipondya&Musa Shipemba&Theresia Marombe	Chmt's Misungwi	Ass. DRCHCO, DHMIS Focal&Hospital Matron	Mwanza	6/7/2017
Alodia Festo&Bertha Yohana	Chmt's Nyamagana	DRCHCO&ASSIST. DRCHCO	Mwanza	6/7/2017
Charles Bundu& Cecilia Mrema	RCHM'S	Reg. HMIS FOCAL, RCHCO	Mwanza	6/7/2017
Melkiori Anselim	RESPOND FO	M&E Engender Health	Mwanza	6/7/2017
Agness Enock& Ruth Kanuki	Nyamagana District Hospital	DMO & DHMIS	Mwanza	6/7/2017
Suzan Poul	Misasi Health Centre	RCH Incharge	Mwanza	10/7/2017
Dr. Faustine Makayi	Misasi Health Centre	Facility Incharge	Mwanza	10/7/2017
Tumaini Kajila	Nyamagana District Hospital	Acting RCH Incharge	Mwanza	10/7/2017
Filbert Joseph	Nyamagana District Hospital	Acting DMO	Mwanza	10/7/2017
Facility Observation	Misasi Health Centre		Mwanza	10/7/2017
Facility Observation	Nyamagana District Hospital		Mwanza	10/7/2017
Training Followup (2)	Misasi Health Centre		Mwanza	10/7/2017
Training Followup	Nyamagana District Hospital		Mwanza	10/7/2017
FGD Female Community (7) Ppl	NYAMAGANA DISTRICT HOSPITAL		Mwanza	8/7/2017
Mary Makunja	Rchmt Simiyu	RRCHCO	Simiyu	11/7/2017
Mwigune Maheka	Rchmy Simiyu	Acting RMO	Simiyu	11/7/2017
Redenta John Kijuu& Kedia Rogers	Maswa District Council	DRCHCO& ASS. MHIS Focal	Simiyu	12/7/2017
Eric Kinyenje	Maswa District Council	Acting DMO	Simiyu	12/7/2017
Zawadi Pima	Maswa District Hospital	RCH Incharge	Simiyu	12/7/2017
Luguga Veddastus	Maswa District Hospital	Facility Incharge	Simiyu	12/7/2017
Victoria Njogolo	Malampaka Health Centre	RCH Incharge	Simiyu	12/7/2017
Ernest Joseph	Malampaka Health Centre	Facility Incharge	Simiyu	12/7/2017
Facility Observation	Malampaka Health Centre		Simiyu	12/7/2017

Name	Organization/ Implementing Partner	Title	Location/Region	Appointment Date
Facility Observation	Maswa District Hospital		Simiyu	12/7/2017
Training Followup (5)	Maswa District Hospital		Simiyu	12/7/2017
Training Followup (2)	Malampaka Health Centre		Simiyu	12/7/2017
Fgd Community Mobilizer Male(8)	Malampaka Health Centre		Simiyu	12/7/2017
Dr. Mpola Stanley Tamambele	Mlandizi Health Centre	Medical Officer Incharge	Coast Region	17/07/2017
Cosmas Alex Kapinga	RESPOND Fo	Field Officer EHCoastal Region	Coast Region	17/07/2017
Fatuma Ngaluma	Mlandizi Health Centre	Rch Incharge	Coast Region	17/07/2017
Cyril Malya	RESPOND Fo	Monitoring &Evaluation Officer	Coast Region	17/07/2017
Joyce Gordon	Rchmt	RRCHCO	Coast Region	17/07/2017
Bonza Mshana& Japhal Mwamafupa	Chmt Kibaha Dc	Act. DMO &DHMIS	Coast Region	17/07/2017
Bridgiter Michael Cheyo	Chmt Kibaha Dc	DRCHCO	Coast Region	17/07/2017
Dr. Martha Kisanga	RESPOND Fo	Field Officer Morogoro	Morogoro Region	17/07/2017
Teresia Shemsika, Hidaya Omary, Angeline Joseph& Vijan Shaban	Chmt Morogoro Municipal	Pharmacist, Act.DMO, DHMIS, Act.DRCHCO	Morogoro Region	17/07/2017
Faith Kisulwa	RESPOND	Program Officer Fp	Morogoro Region	17/07/2017
Liu Ndunguru	Uhuru Health Centre	Rch Incharge	Morogoro Region	17/07/2017
Catherine Madaha & Edward Mahenge	RCHMT	RRCHCO& RHMIS Focal Person	Morogoro Region	17/07/2017
Facility Observation	Mlandizi Health Centre		Coast Region	17/07/2017
Facility Observation	Uhuru Health Centre		Morogoro Region	17/07/2017
Training Followup (7)	Mlandizi Health Centre		Morogoro Region	17/07/2017
Training Followup (5)	Uhuru Health Centre		Morogoro Region	17/07/2017
Fgd Community Mobilizer M(2) F(6)	Mlandizi Health Centre		Coast Region	17/07/2017

ANNEX IV. A LIST OF INFORMATION SOURCES

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ANNEX V. COPIES OF THE ACTUAL DATA COLLECTION TOOLS

(IDI, Site Obs, Site observation checklist, FGD Guide)

1. IDI Instrument (English and Swahili)

2. Training Follow-up SAQ (English and Swahili)

3. Health Facility Observation checklist (English only)

4. FGD Guide (English)

1. IDI Instrument (English and Swahili)

GH PRO 400 s PROJECT

PERFORMANCE EVALUATION

DRAFT DATA COLLECTION TOOLS AND INSTRUMENTS
Key Informant Interview (KII) Guide

This Semi-structured instrument (SSI) questionnaire is intended for a wide range of respondents:

(Ministry counterparts, Implementing partners, Donors, NGOs, Community Service Agencies)

Draft 0.8 5 July 2017

NB: Cover page provides additional confidentiality for respondents.

Draft only- not for distribution

Instructions prior to beginning interview: (5 MINUTES)

- **Eligibility:** Determine respondent's position, how long employed in position, what type of facility and integration model, and which Result (R1, R2, R3, R4) respondent has been primarily involved in.
- If respondent has no knowledge of RESPOND ***they can still be interviewed*** as long as they are employed in RH/FP related activities. But, if respondent has no knowledge of RESPOND and is not involved in any pertinent activity, do not proceed.

1. Unique ID number: __,__,__
2. Name of interviewer_____
3. Name of note taker_____
4. Date: __Day__Mo__Year
5. Respondent name:
6. Respondent Sex:
7. Position:
8. Organization:
9. Number of years has worked in this position: _____Years (or months)
10. Region: _____
11. District: _____
12. Facility Name: _____
13. Type of facility:_____ (Public/ Private/ FBO etc.)
14. A. Which type of integration model is associated with this District?(Circle One)

    None (only RCH Clinic), GBV, CTC, PMTCT, cPAC, OPD, Youth FP
15. A. Which type of integration models at this site?: (Circle one of more) RCH (FP; ANC/PMTCT, Immunization, Postnatal); GBV; CTC; OPD; IPD (cPAC); labour and Delivery; TB; Cervical Cancer).

16. Knowledge of RESPOND:
    a. Are you aware of the RESPOND project? Yes or No. (circle one)
    b. Can you tell me how you have been involved in the RESPOND?

[Confirm whether the respondent knows what the RESPOND is and what it has done in at least one of the four Result areas shown below. Validate this by asking them to briefly describe the RESPOND Result they are most familiar with and any examples of specific activities RESPOND is supporting in this area]

17. We would like to talk with you about the work RESPOND has been doing in your districts since 2012. The RESPOND has been working on four areas to increase uptake of family planning, and expand the choice of methods to include LARC/PMs. We would like you to participate in conversation on four ways to increase FP uptake: quality, integration, health system strengthening, and community engagement. RESPOND has been supporting:
    1. Result 1. **Improved quality of services to increase uptake of FP,**
    2. Result 2. increased access and uptake of FP with **integrated services**,
    3. Result 3. **Strengthening health systems**, and
    4. Result 4. **Engaging communities** for greater access to FP with a wider choice of methods, including LARCs/PMs, especially for hard to reach communities like youth and adolescents and in remote areas.
    5. Not familiar with any the four Results.
    6. Familiar with all four Results

NB: Be sure that this instrument is not read verbatim. Do your best to use a conversational approach.

Informed Consent: Provide informed consent **before** asking any questions.

Informed Consent Statement

- Hello. Our names are_____names of interviewers_____. We are from Gh Pro and we are conducting an evaluation of the EH RESPOND Tanzania Project and we would like you to participate.
- We would like to ask you some questions about the RESPOND Tanzania Project since it started in 2012.
- Our evaluation is intended assess the achievements of the RESPOND and help improve the integration of FP services within future MoH programs in Tanzania. **Mention BENEFITS for Respondent**
- Participation in this evaluation is voluntary and you may decide not to answer any of the questions. However, we hope that you will participate in this evaluation since your answers are very useful to us. Do you have any questions for us about the evaluation?

Summary of Ground Rules for the interview:

1. This interview is confidential and voluntary.
2. Your name will not be linked to any of the findings.
3. If you are willing to be quoted, this is appreciated. But no interview notes will be associated with your name unless cleared in advance by you.
4. You can end the interview at any time and have no obligation to answer any questions asked.

May be begin the interview on this basis? Can we proceed? Yes or No. (circle one)

NB: No signature required: Verbal consent is sufficient.

Item 1. Improved quality of services to increase uptake of FP (15 MINUTES)

****Item 1.1.** As we discussed, the RESPOND has been supporting activities in your region/district to **facilitate greater access and uptake to FP**. Can you share with me your ideas about what **specific enablers or facilitating factors** affect FP uptake/increase in FP use? **Elaborate how they work?**

****Item 1.2** How about **specific constraints** that affect FP uptake/use in your region/district? Can you share some examples? Please explain **what they are and how they work?**

Probes for Item 1.1 and 1.2: What types of things affect FP uptake, **either positively or negatively**? For example, what about **age**, sex, geography, marital status? What about the knowledge**, attitudes and practices of providers and clients**.

****Item 1.3** Now we would like talk about quality of services. (R1.1) Have there been **any changes; in capacity and performance** of health service **PROVIDERS** as a result of the RESPOND program?

PROBES for Item 1.3: -**Are there now more trained staff available** to perform/ provide a better contraceptive services with **enlarge contraceptive mix particularly LARC/ PM** ? Ask for examples.

****Item 1.4.**Can we talk about the quality of facilities? (R1.1) Have there been any **changes, in capacity and performance of HEALTH FACILITIES** as a result of RESPOND program?

PROBE for 1.4: Are there any changes in the **MIX OF FP METHODS available** to clients due to RESPOND implementation? If yes, **what contraceptive methods** have been **INCLUDE IN YOUR FACILITIES** due to capacity building effort under RESPOND?

[**Note to the interviewer**] -Collect service statistics of the performance for the last two or three years that are available. In real time or after completion of interview.

****Item 1.5 (R1.2)** Have there been any changes in **SUPPORTIVE SUPERVISION** for improvement in quality of service delivery as a result of RESPOND project implementation?

****PROBES for Item 1.5:** What changes in **supportive supervision** have you observed? Can you give examples?

****Item 1.6** (R1.3) Have there been **any changes** in the **availability of <u>contraceptives</u>** (contraceptives, essential drugs, and other supplies) in the past four years, **especially for the most REMOTE SERVICE** DELIVERY points like clinic and dispensaries? If **YES,** what changes? What has **CONTRIBUTED TO THE CHANGES**?

What method/ drug/ supplies you feel were earlier not available and now available? What method/drug/supplies you feel were earlier available are now not available?

****Item 1.7. a**) Of the various improvements in the uptake and quality of FP services that we have discussed, in your opinion, what was the **most important ACHIEVEMENTS**?

****b**) What were the **BEST PRACTICES**, /successes,

****e)** What were the **KEY LESSONS LEARNED**?

Item 2. Increased access and uptake of FP with integrated services (15 MINUTES)

****Item 2. Introduction:** Respond has been working on integrating family planning into various health services, such RCHS and HIV related services as a way to increase FP uptake. **Have you integrated FP into your services?** Can you tell us where and in **what services FP** has been i**ntegrated** into your facility**? INS: Circle all that R mentions**

1. RCH (FP) 2. ANC/PMTCT 3. Immunization 4. Post-natal. 5.GBV 6. CTC

7. OPD; 8. IPD (Gyn, Pid) 9. cPAC 10. Labour & Delivery 11. TB; 12. Cervical Cancer

13. Other: Write description here: _____

****Item 2.2.** How did **integration of FP** into other **health services** [integration model] affect **ACCESS, UPTAKE AND QUALITY OF FP SERVICES**, including the availability of LARCs/PM methods**?**

{NB: If a NON-INTEGRATED SITE, ask them to comment on the issue of integration and FP. How do they feel about this? Has there any integration taken place in their facility / area}

****PROBE: Among all these sites / health service units which is the the primary type of integration in the area?**

INS: The following discussion is only related to the prime type of integration of FP respondent identified.

If it is not possible to restrict to just one primary type of integration, focus on the type of integration with which the District has been identified

****Item 2.3.** Which FP methods did you introduce to **EXPAND CONTRACEPTIVE CHOICE**?

****Item 2.5.** You mentioned some examples of integrating FP into health services. Are you aware of any other integration approaches? **From your perspective, which INTEGRATION APPROACH is most effective in increasing FP uptake?**

****Item 2.6.** What is the **DIFFERENCE** between service delivery sites with **INTEGRATION COMPARED TO SITES WITHOUT INTEGRATION** as far as FP uptake is concerned? **[**Team to compare RESPOND sites with integration and without integration**.]**

****Item 2.7. In summary, when you think about RESPOND support for integration of FP into health services,**

- **What** do you think is the most important A**CHIEVEMENT** for integration activities supported by RESPOND?

- **What** were the **BEST PRACTICES that can be replicated?** Could you give some examples?

- **What** were the **CHALLENGES/ BARRIERS** to integration of FP services ?

- **What** were the **FACILITATING FACTORS**?

- **What** are the key **LESSONS LEARNED**. (Also: probe for any issues of sustainability.)

<u>ITEM 3</u>. [SECTION 3 DISTICT CENTERED APPROACH AND STRENGTHEING OF HEATH SYSTEM

THIS IS ONLY TO BE ASKED TO THE LEVEL OF DISTRICT HEALTH MANAGERS & ZONAL RESOURCE CENTRES AND FACILITY INCHARGE] (15 MINUTES)

****Item 3.1.** Now, I would like us to discuss how the **DISTRICT CENTERED APPROACH** has contributed to strengthening Health system management, monitoring and evaluation to increase uptake of FP, including LARCs/PMs and RH services**.** First of all, could you **briefly tell me how you understand district centre approach works?**

[if the respondent does not know what district-centred approach is, explain]

- In the this approach, districts are categorized into **three levels based on the FP uptake** where the poorly performing districts gets the maximum resources and inputs.
- Districts are also **capacitated to plan, monitor and supervise** their services without having to wait for someone from the higher level.

Are you aware/have you heard of this?

1. Yes…2. No…. Circle one. NB: DO <u>NOT</u> SKIP QUESTIONS 3.2 THROUGH 3.5

****3.2.** How did the district-centered approach affect the **LOCAL GOVERNMENT' CAPACITY** to **manage and implement** FP programs**?**

****Has** the district centre approach helped in bringing about any **changes in FP/RH RESOURCE ALLOCATION** in Comprehensive Council Health Plans (CCHPs) leading to improved performance of FP uptake **?**

****Item 3.3 (R3.3)** Has district centre approach helped in **changing district coordination** and **PARTNER COLLABORATION at the district level?**

****Item 3.4 (R3.4)** How did RESPOND **build capacity to support integrated services** at the National, regional, and district level?

****Item 3.5.** How did the RESPOND program affect the **ROLL-OUT and implementation of the DHIS2?**

PROBE Questions for Item 3.5 The DHIS 2 went national in 2015.

- Were there any changes made in the DHIS2 to capture impact of integrated system?

- What changes were made? How is the change system helping?

- Did DHIS improved utilization of data in decision-making. If yes give examples

What are the benefits of DHIS2 at **the facility and district level**, what are the **challenges?.**

****Item 3.6. In summary, thinking about RESPOND's support for the district-centered approach,**

- **What** were the main **ACHIEVEMENTS** of the district-centered approach?

- **What** are the **BEST PRACTICES that can be replicated**?

- **What are CHALLENGES/ BARRIERS?** Can you recommend ways to overcome these challenges?

- **What** were the **FACILITATING FACTORS?**

- **What** are the **KEY LESSONS LEARNED. (Also: probe for any issues of sustainability.)**

Section 4: Result 4. Now, I would like to talk to you about how has RESPOND contributed to community mobilization for increasing utilization of FP services, including greater access to LARCs/PMs. (10 MINUTES)

****Item 4.1** (**R4.1)** How are the communities mobilized towards increasing use of family planning in general and LARCs/PMs in particular? Can you give examples. How has the **RESPOND contributed to community mobilization** activities?

****PROBE** Questions for Item 4.1:

- Who, among the front-line workers / CHWs, has been involved to mobilize people for FP in the community? Have RESPOND played any role in strengthening their counseling and client –provider skills?
- How have other NGOs been engaged to do mobilization? Did RESPOND played any role in engaging NGOs

****Item 4.2 (R4.2)** What did EH do to improve the knowledge and acceptability of FP among youth and males and urban populations?

- What are the different myths about the different contraceptives? How and to what extent have efforts been made to address them?

NB: At each facility observe what BCC materials have been displayed, whether communication materials are available and leaflets to distribute is available in stock. Take pictures for discussions among the evaluation team/report writing***? USE OBSERVATION SHEET DEVELOPED FOR THIS PURPOSE***

****Item 4.3. Considering what we have discussed regarding community mobilization activities to increase FP uptake;**

a) What were the most important **ACHIEVEMENTS**? To what extent are these sustainable**?**

b) What are be the **BEST PRACTICES?**

c) **What** are the challenges/ **BARRIERS/DIFFICULTIES**?

d) **What** are the **FACILITATING FACTORS** ?

d) What are key **LESSONS LEARNED?**

****Item 5. Optional Final Questions:**

5.1: How would you rate the performance of the Respond Project, taking one as very poor and 5 as excellent?

5.2: What should have EH/RESPOND done differently?

5.3: What do you recommend for the next phase of EH to make the program more effective and more useful for the Tanzania FP programme?

5.4: If RESPOND leaves today and is no longer there, what would change/how would that affect the various activities/services available currently?

GH PRO 400 RESPOND TANZANIA PROJECT

PERFORMANCE EVALUATION

DRAFT DATA COLLECTION TOOLS AND INSTRUMENTS
Key Informant Interview (KII) Guide

This Semi-structured instrument (SSI) questionnaire is intended for a wide range of respondents:

(Ministry counterparts, Implementing partners, Donors, NGOs, Community Service Agencies)

Draft 0.4 26 June 2017

NB: Cover page provides additional confidentiality for respondents.

Draft only- not for distribution

Instructions prior to beginning interview: (5 MINUTES)

- ***Haki ya kuhojiwa:*** *Hakikisha nafasi ya mhojiwa, ni muda gani amekuwa kwenye nafasi hiyo, ni aina gani ya kituo na aina ya matokeo ya muingiliano wa huduma (integration), na matokeo gani (R1, R2, R3, R4) mhojiwa amekuwa akihusika nayo moja kwa moja.*
- *Kama mhojiwa hana taarifa kuhusu RESPOND bado wanaweza kuhojiwa ilimradi tu ni mwajiriwa wa RESPOND au amehusika kwenye shughuli mbalimbali za mradi. Lakini, kama mhojiwa hana ufahamu wa RESPOND na hajahusika kwenye shughuli za mradi, usiendelee.*
  1. *Namba ya utambulisho:*
  2. *Jina la Mhojaji*
  3. *Jina la mchukua tarifa*
  4. *Tarehe: …….Siku……..Mwezi……Mwaka*
  5. *Jina la mhojiwa*
  6. *Jinsi ya mhojiwa*
  7. *Nafasi:*
  8. *Shirika*
  9. *Namba ya miaka aliyofanya kazi……Miaka (au Miezi)*
  10. *Miaka*
  11. *Wilaya*
  12. *Jina la kituo*
  13. *Aina ya kituo (Serikali/Binafsi/za kidini)*
  14. *Ni aina gani ya Integration: Hakuna, GBV, PMTCT, cPAC, Youth FP (zungushia moja)*
  15. A. Je, ni aina gani ya integration ipo kwenye kituo hiki? (zungushia moja) RCH (FP; ANC/PMTCT, Immunization, Postnatal); GBV; CTC; OPD; IPD (cPAC); labour and Delivery; TB; Cervical Cancer)
      B. Je, ni aina gani ya integration inafanyika kwenye wilaya hii? (zungushia moja)

      None (only RCH Clinic), GBV, CTC, PMTCT, cPAC, OPD, Youth FP

  16. *Uelewa wa RESPOND*
      - *Je, una ufahamy wa mradi wa RESPOND? Ndio or Hapana (Zungusha moja)*
      - *Je, unaweza kuniambia ni kwa namna gani umekuwa ukishiriki kwenye mradi wa RESPOND?*

  Hakikisha kama mhojiwa anaufahamu wa RESPOND na nini mradi umefanya katika tokeo angalau moja kati ya manne kama inavyoonyeshwa hapo chini. Hakikisha hili kwa kuuliza mhojiwa aelezee kidogo kuhusu

matokeo ya RESPOND ambayo wanayafahamu na mifano halisi ya shughuli za RESPOND wanazosaidia katika eneo hilo.

17. *Tungependa kuongea na wewe kuhusu kazi za RESPOND ambazo zimefanyika katika wilaya yako tangu 2012. RESPOND imekuwa ikifanyia kazi maeneo makuu manne ili kuongea utumiaji wa FP na kuongeza wigo wa kuchagua njia ya Uzazi wa mpango zikiwemo LARCs/PMs. Tungependa ushiriki kwenye mazungumzo haya yanayoangalia hayo maeneo manne ya kuongeza matumizi ya njia za Uzazi wa mpango ambao ni; ubora wa FP, integration, uimarishaji wa Mfumo wa afya na ushirikishwaji wa jamii. RESPOND imekuwa imesaidia kutokea matokeo haya yafuatayo:*

    <u>Tokeo 1: Kuboresha ubora wa huduma ili kuongeza utumiaji wa FP</u>

    Tokeo 2: Kuongeza upatikanaji na utumiaji wa FP hususan kwenye integration
    Tokeo 3. Kuimarisha Mfumo wa afya
    Tokeo 4. Kushirikisha jamii ili kuongeza upatikanaji wa FP kukiwa na wigo mkubwa wa njia za FP zikiwemo LARCs/PMs, hususan kwenye maeneo ambayo ni magumu kufikika kama kwenye makundi ya Vijana.
    Hana uelewa na matokeo yote manne
    Ana uelewa na matokeo yote manne

NB: Be sure that this instrument is not read verbatim. Do your best to use a conversational approach.

Informed Consent: Provide informed consent **<u>before</u>** asking any questions.

Ridhaa ya kushiriki

Habari, Majina yetu ni ……majina la wahojaji……..Tumetokea katika mradi GH Pro na tunafanya tathmini ya ya mradi wa RESPOND Tanzania na tungependa wewe uwe mshiriki.

Tungependa kuuliza maswali kuhusu huu mradi wa RESPOND Tanzania Tangu ulipoanzishwa mwaka 2012

Tathmini hii inalenga kupima matokeo ya mradi huu wa RESPOND Tanzania na pia kusaidia kuboresha huduma zinazotolewa kwa kuingiliana (intergration) ya huduma za njia za uzazi wa mpango katika programu za Wizara ya afya hapa Tanzania kwa baadae.

Ushiriki katika tathmini hii ni wa hiari na kama kuna swali lolote ambalo hutapenda kulijibu basi unahiari ya kufanya hivyo. Hatahivyo ni matumaini yetu kuwa utashiriki katika tathmini hii kwani majibu yako ni muhimu sana katika tathmini hii. Je una swali lolote kuhusu hii tathmini?

Summary of Ground Rules for the interview: Muktasari wa taratibu za mahojiano

Mahojiano haya ni ya siri na ya hiari
Jina lako halitahusishwa na matokeo ya tathmini hii
Kama utapenda kunakiliwa, tutashukuru. Lakini hakuna taarifa za mahojiano haya zitakazohusishwa na jina lako labda kwa ridhaa yako.
Unaweza kusitisha mahojiano hayo muda wowote na hakuna ulazima wa kujibu kila swali utakaloulizwa.

Tunaweza tukaanza mahojiano yetu? Ndio au Hapana (zungushia moja)

NB: *Hakuna sahihi inayohitajika: Ridhaa ya mdomo tuu inatosha.*

<u>Kipengele cha 1: Uboreshwaji wa ubora wa huduma ili kuongeza upatikanaji wa FP (15 MINUTES)</u>

** Kipengele cha 1.1: *Kama tulivyojadiliana, mradi wa RESPOND umekuwa ukisaidia shughuli mbalimbali katika mkoa/wilaya ili kuongeza upatikanaji na utumiaji wa FP. Unaweza kunishirikisha mawazo yako kuhusu ni nini vinavyowezesha utumiaji wa njia za Uzazi wa mpango/ongezeko la matumizi ya njia za Uzazi wa mpango kwenye huu mkoa/wilaya? Tafadhali elezea ni jinsi gani*

**** KIpengele cha 1.2 :** *Na Je, ni nini vimekuwa vikwazo vinavyoathiri utumiaji wa njia za Uzazi wa mpango kwenye huu mkoa/wilaya? Tafadhali elezea ni jinsi gani*

Dodosa: Je, kuna chochote kati ya hivi vifuatavyo kinaathiri upatikanaji wa njia za Uzazi wa mpango? Kama ndio kivipi? (uliza kwa kila moja) umri, jinsi, jiografia, hali ya ndoa ete…pamoja na elimu, mitazamo and matendo ya watoa huduma na wateja.

** Kipengele cha 1.3: Sasa ningependa tuongee kuhusu ubora wa huduma. (R1.1) kumekuwa na mabadiliko kwenye uwezo na ufanisi wa watoa huduma za afya ikiwa ni matokeo ya mradi wa RESPOND?

Dodosa sehemu 1.3: Je, kwasasa kuna idadi kubwa ya watoa huduma waliopata Mafunzo ili kufanya/kutoka huduma bora zaidi kukiwa na wigo mpana wa njia za FP hususani LARCs/PMs? Uliza mifano

** Kipengele cha 1.4: Tunaweza kuongelea ubora wa sehemu za kutolea huduma? (R1.1) Je, kumekuwa na mabadiliko katika uwezo wa utoaji huduma wa vituo kutokana na mradi wa RESPOND?

Dodosa for 1.4: Je, kuna mabadiliko kwenye uwepo wa njia mbalimbali za Uzazi wa mpango kwa wateja kutokana na utekelezaji wa mradi wa RESPOND? Kama ndio, ni njia zipi za Uzazi wa mpango zimeongezwa kwenye kituo chako kutokana na kuwezeshwa na mradi wa RESPOND?

(Mhojaji kumbuka) – Chukua taarifa za takwimu za uendeshaji wa shughuli za FP kwa miaka miwili au matatu iliyopita ambazo zinapatikana.

**Kipengele cha 1.5 (R1.2) Je, kumekuwa na mabadiliko kwenye supportive supervision ili kuboresha ubora wa huduma zinazotolewa kutokana na utekelezaji wa mradi wa RESPOND?

**Dodosa kwa sehemu 1.5: Je, ni mabadiliko gani ya supportive supervision umeyaona? Unaweza kunipa mifano?

** Kipengele cha 1.6 (R1.3) Je, kumekuwa na mabadiliko kwenye uwepo/upatikanaji wa bidhaa za afya ya Uzazi (njia za Uzazi wa mpango, madawa na bidhaa nyingine) katika miaka minne iliyopita, hususan kwenye maeneno ambayo ni magumu kufikika mfano zahanati? Kama NDIO, mabadiliko yapi? Nini kimechangia mabadiliko hayo? **NB: ASK ABOUT CONTRACEPTIVES, <u>NOT</u> RH SUPPLIES.**

Ni njia zipi/madawa/bidhaa unahisi hazikuwa zinapatikana na sasa zinapatikana? Ni njia zipi/madawa/bidhaa unahisi mwanzo zilikuwepo lakini sasa hivi hazipo?

** Kutokana na maboresho mbalimbali kwenye upatikanaji na ubora wa huduma kama tulivyojadiliana, kwa maoni yako

a) Ni nini yamekuwa mafanikio makubwa?

**b) Je, nini yamekuwa Bets Practice ?

**e) Je, nini kimekuwa Key lessons learned?

0

Kipengele cha 2: Kuongezeka kwa upatikanaji na utumiaji wa FP kwenye huduma integration

(15 MINUTES)

*** Kipengele cha 2: Utangulizi: Respond imekuwa ikifanya kazi kwenye huduma za integration ya FP katika sehemu mbalimbali kama RCH na kwenye huduma za HIV ikiwa ni njia ya kuongeza utumiaji wa FP. Je umefanya integration ya FP kwenye huduma za hapa? Je, unaweza kutuambia ni wapi na kwenye huduma gani FP imekuwa integrated kwenye kituo chako?*

1. RCH (FP) 2. ANC/PMTCT 3. Immunization 4. Post-natal. 5.GBV 6. CTC

7. OPD; 8. IPD (Gyn, Pid) 9. cPAC 10. Labour & Delivery 11. TB; Cervical Cancer

12. Other: Write description here: _____

*** Kipengele cha 2.2: Je, ni kwa vipi integration ya FP kwenye huduma zingine imeathiri upatikanaji, utumiaji na ubora wa FP services, tukijumuisha uwepo wa LARCs/PMs.*

(NB: Kama ni sehemu ambayo haina integration, uliza ili waweze kutoa mawazo yao kuhusu integration ya FP. Waulize wanaionaje integration? Je, kuna integration yoyote imekuwa ikifanyiwa kazi katika kituo chako.

Dodosa: Ukiangalia sehemu hizi zote/huduma za afya, ni aina gani ya integration (mbili) ambazo zinatolewa hapa. ***NB: Revised Probe. What is the one primary type of integration in the area? Not two types.***

Maelezo: Majadiliano yafuatayo yanalenga ile integration inayotolewa hapo tu

Kama haiwezekani kuzungumzia aina moja tu ya integration, zungumzia integration inayopatikana katika wilaya

** Kipengele cha 2.3. Ni aina gani ya FP iliingizwa ili kuongeza wigo wa kuchagua?

Kipengele cha 2.5. Umeniambia baadhi ya mifano ya integration ya FP kwenye sehemu nyingine za kutolea huduma. Je, una fahamu modeli nyingine yoyote ya integration? Kwa mtazamo wako, ni modeli gani ya integration iko na ufanisi zaidi kwenye kuongeza utumiaji wa FP?

**** Kipengele cha 2.6: Je, ni nini tofauti ya huduma za FP katika vituo ambavyo kuna integration ukilinganisha na vile ambavyo Hakuna integration hususan kwenye utumiaji wa FP? (Timu kulinganisha vituo ambayo vina integration na vile ambavyo havina)**

Kipengele cha 2.7: Kwa kifupi, unapofikiria kuhusu msaada wa RESPOND kwenye maswala ya integration kwenye huduma za afya

- **Je, unafikiri ni yapi yamekuwa mafanikio makubwa ya shughuli za integration zilizofanya na RESPOND?

- ** Je, ni yape yamekuwa matendo yakipekee ambayo yanafaa kuigwa/kuendelezwa? Unaweza kunipa mifano?

- ** Je, zipi zimekuwa changamoto/vikwazo vya integration ya FP kwenye huduma nyingine?

- **Je, zipi zimekuwa chachu/viwezeshi?

- **Je, yapi yamekuwa Mafunzo(Key lesson Learned) (Pia: Dododsa kuhusu muendelezo wa shughuli za RESPOND)

Kipengele cha 3: District centered approach na uimarishaji wa Mfumo wa afya. Hii itaulizwa tu kwenye ngazi ya wilaya au kwa wakuu wa zoni na wakuu wa vituo vya afya. (15 MINUTES)

***Kipengele cha 3.1: Sasa, ningependa tujadili ni kwa jinsi gani District centered approach imechangia kuimarisha Mfumo wa fya kwenye maswala ya uongozi, ufatiliaji na tathmini ili kuongeza utumiaji wa FP, ikijumuisha LARCs/PMs na huduma za afya ya Uzazi. Kwanza kabisa, unaweza kunieleza unaelewa nini kuhusiana na District centered approach inavyofanya kazi?*

(Kama mhojiwa haelewi, mueleze)

- In this approach, districts are categorized into **three levels based on the FP uptake** where the poorly performing districts gets the maximum resources and inputs.
- Districts are also **capacitated to plan, monitor and supervise** their services without having to wait for someone from the higher level.

Je, umeshawahi kusikia kitu kama hicho?

1. **Ndio…… 2. Hapana ~~(Kama Hapana, acha kuuliza sehemu hii)~~ NB: Do not skip questions 3.2-3.6!**

***3.2 Je, ni kwa namna gani District centered approach imeathiri uwezo wa serikali za mitaa katika kuongoza na kutekeleza miradi ya FP?*

***Je, District centered approach imesaidia kuleta mabadiliko yoyote kwenye maswala ya FP/Huduma za afya ya Uzazi pamoja na uingizwaji wa rasilimali kwenye mpango kazi wa wilaya (CCHP) ili kuboresha ufanisi kwenye utumiaji wa FP?*

**Kipengele cha 3.3 Je, district centered approach imesaidia kubadilisha ushirikiano baina ya wadau katika ngazi ya wilaya?

**Kipengele cha 3.4 (R3.4) Je, ni kivipi RESPOND imeweza kujenga uwezo wa kusaidia huduma za integration katika ngazi ya taifa, mkoa na wilaya?

***Kipengele cha 3.5 Je, ni kwa vipi mradi wa RESPOND umeweza kuathiri matumizi na usambazwaji wa Mfumo wa DHIS2?*

Dodosa Maswali yafuatayo kwenye kipengele 3.5

-The DHIS 2 went national in 2015.

- Were there any changes made in the DHIS2 to capture impact of integrated system?

- What changes were made? How is the change system helping?

- Did DHIS improved utilization of data in decision-making. If yes give examples

What are the benefits of DHIS2 at **the facility and district level**, what are the **challenges?.**

Kipengele 3.6: Kwa kifupi, ukifikiria kuhusu msaada wa RESPOND kwenye District centered approach

- **Je, ni nini yamekuwa mafanikio makubwa ya Mfumo huo?
- Je, ni yape yamekuwa matendo yakipekee ambayo yanafaa kuigwa/kuendelezwa? Unaweza kunipa mifano?
- ** Je, zipi zimekuwa changamoto/vikwazo vya integration ya FP kwenye huduma nyingine?
- **Je, zipi zimekuwa chachu/viwezeshi?
- **Je, yapi yamekuwa Mafunzo. (Pia: Dododsa kuhusu muendelezo wa shughuli za RESPOND)

Sehemu ya 4: Tokeo la 4: Sasa, ningependa tuongee na wewe kuhusu jinsi gani RESPOND imechangia kwenye community mobilization ili kuongeza matumizi ya huduma za Uzazi wa mpango, ikijumuisha kuongeza upatikanaji wa LARCs/PMs (10 MINUTES)

**Kipengele 4.1 (R4.1). Je, ni kwanamna gani community mobilization inafanyika ili kuongeza matumizi ya huduma za FP kwa ujumla pamoja na zile za LARCs/PMs? Unaweza kunipa mifano….

**Dodosa Maswali haya kwa kipengele 4.1

- Ni nani kati ya watoa huduma walio mstari wa mbele (CHW) wameshirikishwa kwenye community mobilization? Je, RESPOND imefanya kazi yoyote kwenye kuimarisha namna unasihi unavyotolewa kwa wateja na watoa huduma?
- Je, ni kwa namna gani NGO nyingine zimeshirikishwa kwenye community mobilization? Je, RESPOND imeshiriki kwa namna yoyote kwenye kushirikisha NGOs?
- Je, kuna myths tofauti kuhusu FP? Je, ni kwa namna gani na kwa kiasi gani juhudi zimefanyika kuziondoa?

NB: Kwenye kila kituo cha kutolea huduma chunguza ni aina gani ya BCC materials zimebandikwa, je kuna materials nyingine za kugawa? Chukua picha kwaajili ya kujadiliana na timu au kwenye kuandika report

Item 4.3. Considering what we have discussed regarding community mobilization activities to increase FP uptake;

a) **Je, ni nini yamekuwa mafanikio makubwa ya Mfumo huo?

b) Je, ni yape yamekuwa matendo yakipekee ambayo yanafaa kuigwa/kuendelezwa? Unaweza kunipa mifano?

c) ** Je, zipi zilikuwa changamoto au vikwazo?

d) **Je, zipi zimekuwa chachu/viwezeshi?

e) **Je, yapi yamekuwa Mafunzo. (Pia: Dododsa kuhusu muendelezo wa shughuli za RESPOND)

Training Follow-up Questionnaire Draft 0.2 – 19 June 2017 Not for distribution

Introduction: This interview as part an evaluation of the RESPOND Project of Engender Health.
This interview is ***voluntary and confidential***. No information from your responses will be linked to you.
Please do not write your name on this form.

1. Unique Questionnaire ID Number: ___/___ **2. Date: dd/mm/yr** **3. Name of interviewer:**	**4. Location of Interview** (Name Office and Town)
5. **Age:** **7. Place of current posting? ……**	**6. Sex:** 1 Male 2 Female **(Circle one)**

8. Designation of trainee: (**Circle the appropriate one)**
1.**MO, 2.Asst. MO, 3.Clinical officer, 4.CA, 5. Nurse, Other_____)**

9. Before undergoing your professional training what basi**c** educational level you had completed.
(**Circle the appropriate one)**
1. Less than Secondary 2. Secondary 3 College graduate 4. Post graduate.

10. What type of training did you receive through **RESPOND / EH project?**
(Circle family planning clinical training that you received most recent)

1. Mini lap 2. PPIUD 3. IUD 4. Implants 5. NSV

10a Was this training: 1. On the job training 2. Off site training

10b Duration of training in days ---------

11. After the above training, have you been transferred from another facility to your current place of posting?
1. Yes 2. No

12. Was this training (mentioned above in item 10) useful to you? 1.Yes 2. No (Please explain)

13. During training how many procedures of IUD / PPIUD insertion / implant / mini Lap / did you **observe** ?
Number ……..
14. During training in presence of the trainers did you **perform** the procedures in which you were trained?
1. Yes 2. No
14. a If Yes, how many procedures? ----------

15. In the facility where you currently work, are there others who have this skill and perform this procedure?
1 Yes 2. No

15.a How many such trained persons are there in your current facility? ……..

16. Are you now using your new acquired skills (per above in item 10) to provide family planning services?
1. Yes 2. No

17. How are you currently performing the procedure (per item 10 above) you were trained to do?
{ML/ Implant/ PPIUD/ IUD (whichever is applicable)}?
(**CIRCLE whichever is applicable)**
1. Able to do independently. 2. Not able to do independently 3. Currently not providing.
18. How many generally you do in a month? ----------/ month

PLEASE TURN OVER AND COMPLETE THE OTHER SIDE

19. Was there any post-training support for this training program? 1. Yes 2. No

19 a If yes Explain what did do or how did they help?

19.b If NO, do you think follow up supervision would have been useful and important?

1.Yes 2. NO 8. Not sure .

20. Apart from the above clinical training, have you any received other training organized by RESPOND?
(Circle the appropriate one. if more than one, circle as many as apply)

1. Management 2. Supportive supervision 3. DHIS-2 ____4_Other

21. Did the training mentioned in item 22 have any relevance for your daily work?
If yes how?

____

Thank You

Training Follow-up Questionnaire Draft 0.2 – 21 June 2017 Not for distribution

Utangulizi: Mahojiano haya ni sehemu ya shughuli za tathmini ya mradi wa RESPOND wa Engender Health.
Mahojiano haya ni ya hiyari na usiri na hakuna taarifa kati ya utakazotoa zitaoanishwa na wewe moja kwa moja. **Tafadhali usiandike jina lako kwenye fomu hii**

1. Namba ya Utambulisho: ___/___ **2. Tarehe: siku/mwezi/mwaka** **3. Jina la anayehoji:**	**4. Mahali pa Mahojiano** (Taja jina la Ofisi na Mji)
5. Umri: **7. Kituo cha kazi? ……**	**6. Jinsi:** 1 Mme 2 Mke **(Zungushia Moja)**

8. Kada yako: (**Zungushia jibu sahihi)**
1.**MO 2. Asst. MO, 3.Clinical officer, 4.CA, 5. Nurse, Other_____)**

9. Kabla ya kuhudhuria mafunzo ya taaluma yako kuu hapo juu (swali no. 8), ulikuwa na kiwango gani cha elimu? (**Zumgushia jibu sahihi)**
1. Chini ya elimu ya sekondari 2. Elimu ya sekondari 3 Elimu ya chuo 4. Mafunzo za ziada baada ya elimu ya chuo.

10. Ni aina gani ya mafunzo umepata kupitia mradi wa RESPOND/Engender Health?
(Zungushia aina ya mafunzo ya kitabibu uliyopata siku za karibuni Zaidi)
1. Mini lap 2. PPIUD 3. IUD 4. Implants 5. NSV

10a Je, mafunzo hayo yalitolewa: 1. Sehemu yako ya kazi 2. Nje ya kituo cha kazi

10b Andika namba ya siku ambazo mafunzo hayo yalitolewa ----------

11. Je, toka upate mafunzo hayo tajwa hapo juu, umewahi kuhamishwa kutoka kituo chako cha kazi cha awali kwenda katika kituo ulipo sasa?
1. Ndiyo 2. Hapana

12. Je, mafunzo hayo (yaliyotajwa hapo juu) yamekuwa yenye manufaa/msaada wowote kwako?
1.Ndiyo 2. Hapana (Tafadhali elezea)
13. Je, wakati wa mafunzo hayo, ni procedure ngapi za IUD / PPIUD / implant / mini Lap / ulishuhudia ?
Andika namba ……..
14. Je, wakati wa manfunzo hayo na mkufunzi akiwepo, ulifanya procedure ambazo ulikuwa unafundishwa?
1. Ndiyo 2. Hapana
14. a Kama ndiyo, ulifanya procedures ngapi? ----------

15. Je, katika kituo chako cha kazi cha sasa kuna watoa huduma wengine wenye ujuzi kama huo na wanaofanya procedure hiyo?
1 Ndiyo 2. Hapana

15.a Je, kama wapo ni wangapi? ……..

16. Je, kwa sasa unautumia ujuzi ulioupata kwenye mafunzo uliyoyapa hivi karibuni (uliyotaja katika swali la 10) kutoa huduma za uzazi wa mpango?
1. Ndiyo 2. Hapana
TAFADHALI GEUZA NYUMA NA UMALIZIE MASWALI YALIYOBAKI =>
17. Je, ufanyaje procedure uliyojifunza (kwenye swali la 10 hapo juu) ?
{ML/ Implant/ PPIUD/ IUD (zungushia yoyote inayohusu)?
1. Naweza kufanya procedure mwenyewe 2. Siwezi kufanya mwenyewe 3. Kwa sasa sitoi huduma hiyo
18. Je, kwa wastani huwa unafanya procedure ngapi kwa mwezi? ----------/ mwezi

19. Je, kumekuwa na support yoyote baada ya mafunzo inayohusiana moja kwa moja na mafunzo uliyopatiwa?
1. Ndiyo 2. Hapana

19 a Kama ndiyo, tafadhali elezea support hiyo ilihusu nini na ilifanyikaje?

19.b Kama hapana, je, unafikiri ufuatiliaji/support baada ya mafunzo ni muhimu na ingesaidia?

1.Ndiyo 2. Hapana 8. Sina Uhakika.

20. Mbali na mafunzo hayo ya kitabibu, umepokea mafunzo mengine yoyote kupitia mradi wa RESPOND?
(Zungushia mafunzo sahihi Zaidi. Kama umepokea mafunzo Zaidi ya aina moja, zungushia yote yanayohusika)

1. Management 2. Supportive supervision 3. DHIS-2 ____4_Nyingine

21. Je, mafunzo uliyopata hapo juu kwenye swali la 10 yalikuwa na umuhimu wowote kwa kazi yako? Kama ndiyo, kivipi?

_

Asante Sana

Facility Observation Check List - Draft 0.3 26 June

Name of the observer Date

Name of the facility ----------

Type of the facility 1. Hospital - 2. Medical center 3. Dispensary -Other (specify)

A. Availability and provision of services,

Type of contraceptive services providing	Male Sterilization	Female Sterilization	IUD	Norplant	DMPA
Since when (Year began/ or Not providing (NP))					
Performed by trained person posted at clinic or using other clinic / out reach facility (in position IP / outreach OR					
Number staff trained since 2012?/Number still present.					
Is all the required equipment available? Y or N					
If not, since when out of stock/ not being provided. (Month/Year)					
Main reasons for not being in the stock.					
How many times stock-out has happened in past one year?					
Is the OT room functional? Y or N					
Areinfection prevention agents in stock? Y or N					

Reminder: Be sure to do an inspection of the storage room.

A4 Does this clinic provide condom, OCP and ECP? Circle what ever is provided

1. Condom 2. OCP 3. ECP

A5 Check availability and stock position of other spacing methods

Condom In stock not in stock since when out of stock: mo___yr___

OCP In stock not in stock since when out of stock: mo___yr___

ECP In stock not in stock since when out of stock: mo___yr___

B. Inter-personal Communication and Counseling (IPC&C) and availability of BCC material

B1. Who does the counseling to clients and potential clients? (Circle all applicable)

1. AMO 2. CO 3. ACO 4. Nurse 5. Social worker 6. Other specify

B2. Has he /she been trained on inter-personal communication (IPC) and counseling skills?

B3. When did they receive last training on IPC and counseling skills?

B4 who organized this training? 1 Respond / EH project 2 others (specify)

B5. What is done to educate/ inform or motivate people living the community about family planning particularly LARC/ PM?

B6. Who carry out this motivational campaign?

Prob; Any one else

B7. Check for the availability of counseling aids (protocol/guideline and job aids) and checklist for observation

	Male Sterilization	Female Sterilization	IUD	Norplant	DMPA	Condom /OCP
Counseling aid (model/ poster)						
Distribution material						
Are the distribution material in stock						
Since when it is out of stock?						

Fill by Observation

Walk through the clinic and Observe family planning displayed material / advertisement and tell was the displayed material.

(a) Where it was displayed?

1. Waiting space 2.AMO/ CO/ACO room 3. Counselor room / place Other

(b) Was visually clear I Yes all case 2. Some case 3. No

c) Were messages were and understandable

I Yes all case 2. Some case 3. No case

(d) Language? Local language (LL) or in English (En)

I All / Most in LL 2. Some in LL some in En 3. Most /All in En

(e) Count the number of display materials and note down the number …….

C. Integration of Services: Walk through the clinic and check what are the department / section where family planning has been integrated.

Indicate with Yes or No, where FP services are available and if so, LARC and/or Short-term

FP services integrated into:	CTC	Postnatal	Immuniza - tion/ under 5	OPD/STI	IPD (Pediatric, Female/ Gyn)	Cervical Cancer	TB clinic
Any FP? Yes/No							
LARC available? Yes/ No							
Short-term methods? Yes/No							
Sufficient Equipment?							

Check from our record according to the district list FP is integrated in which model? Circle which is appropriate

1. PMTCT 2 GBV 3. c/PAC 4. ANC 5. Youth/ Other

Reminders:

- **Be sure to do an inspection of the storage room.**
- **Remarks: Be sure to provide comments on overall impressions/findings.**

Focus Group Discussion Guide for Community Members Draft 0.3 26June2017

We are conducting a study to help health clinics improve the Family Planning services and care provided in your community. We are here today to talk about the services provided and to listen to your opinions about those services. This group discussion should not take more than 45-60 minutes and all answers will remain confidential; however, you may choose not to answer any questions if you are not comfortable. There is no right or wrong answer, please feel free to say what you think. We hope you will, as your responses will assist in improving these services. May be begin? Start with introducing yourself and the group.

Interviewer/s: _____ Date: _____
District: _____ Notetakers: _____
Community involved in this discussion: See sign up sheet.

The key themes that this FGD will cover include

- Perceived family planning needs, method choice and accessibility
- Observed changes over the last three years in method choice, use of FP, and accessibility including LARC/ PM
- Perception about out-reach services, its role in increasing method mix and accessibility of LARC/ PM
- Integration about FP with other health services
- Perceived quality of services received at health facilities
- Community norms supporting, accelerating or resisting acceptance of contraceptive, including decision making process to family planning

The guideline given bellow provides **examples of questions** that could be used to stimulate discussion and or steer the discussion. The information should be allowed to flow in its natural way as the discussion progress. Stimulate **a group dynamic** where **participants discuss among** themselves, with **moderators steering the discussion** and keeping focused on topics. As much as possible encourage **PARTICIPATION OF ALL** present in FGD. Questions given here per se and its order are **not important**. You need to watch that at the end, **you have covers most of the themes**. And there is a **general broad agreement** on the issues discussed. However, there could be always some diversion.

Given expected time allocation of one and half hours, **each topic could be allocated 10-12 min.**
Before starting the discussion, the introduction about the FGD given above should be mentioned. A list of the participants with some basic information should be collected as soon as the come on a sheet of paper with **name age, sex, education** and location where FGD is being conducted.

7. **FP availability and needs**: In your opinion, are family planning services available in your community? Do FP services meet the needs of all community members? If they want a LARC/PM, where can these methods be easily obtained? Is there any family planning service that you need but not available when required? What are those services or methods that are not available when required?

    8. Integration of FP with other health services: In these days, government clinics are trying to provide many services at the same place/same clinic so that people can get services more easily, without spending too much time. Are you aware of this? Have you heard of women or men receiving FP counseling/services from clinics like OPD, or Immunization or HIV/AIDS clinics? How do people feel about obtaining FP services at a place that offers other services as well? Does it save time for them, do they receive the same services they expect? Are there problems when a clinic offers multiple services? They spend less time or more time with the patient? Do they have more visits or fewer visits to clinics? How is the quality of FP services provided at clinics where many other services are provided? What about waiting time? More waiting or less waiting? Do they get more time to spend with the service provider or less time?

9. **Quality of FP Services:** What do you think of the services provided by different facilities or at the outreach clinics? Are the FP services provided meet need of all community members – young, newly married, old? Are the services provided as you expect, or below or above expectation in terms of quality and behavior of providers? Do think your community members could get the method they want?

10. **Trends in past two years:** What changes have happened in the use of FP in your community in the past two years? Are some methods increasing or decreasing? Do you think there has been any change in the acceptance / use of some methods of FP? What about the use of LARCS/PMS methods in your community during the last two years? What changes? Why do you think these changes in use of LARCs/ PMs has happened? **Probe in detail irrespective whether answer is increase, decrease, or no change.**

11. **FP Method Choice:** How do people on community decide which method should be used? How do you think a person decides about a family planning method to use? Who in the family has maximum influence selecting a particular method? **Probe: How about n adopting a LARC / PM?**

12. **Outreach:** In these days government is organizing outreach clinics/ services to provide LARC/PM close to community. Are you aware of it? Has in the past such outreach clinic for providing LARC/PM organized in nearby health facility from where community members could easily obtained? How do you come to know the date when such outreach clinic for LARC/PM is being organized? What do you think of outreach / mobile clinic approach to provide LARC/ PM. Probe for whatever response they give**.**

13. **Attitudes toward LARCs/PM:** Is there any opposition to its acceptance of LARC/PM in community or fear of side effect of the method? Has such opposition/ fear declined or increase over time? Ask to elaborate and give example and reason behind that.

ANNEX VI. METHODOLOGY RELATED MATERIALS

Annex VIA. Evaluation Questions, Key Findings, Conclusions and Recommendations.

Annex II.B Evaluation Timeline

ANNEX VI. A EVALUATION QUESTIONS, KEY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS.

Evaluation Questions and Key Findings, Conclusions and Recommendations.				
	Evaluation Question	**Findings**	**Conclusions**	**Recommendations**
1	What and how did specific **enablers and constraints** affect FP uptake in RESPOND regions? - Team to look at factors related to age, sex, geography, marital status, etc., as well as knowledge, attitudes and practices of providers and clients. - Team should also look at GBV and PMTCT in districts where RESPOND works on these issues with FP.	1. Since the first year of the RESPOND Project, LARCs, and to a lesser degree PMs, have shown an increasing trend of uptake. 2. An analysis of the couple years of protection (CYP) from year 1 through 4 shows that CYP has increased significantly during the RESPOND Project period, reflecting the increasing uptake of PM and LARC. 3. The proportion of low performing districts (2000 TDHS CPR < 29) reduced from 49.2% in 2012 to 15.4 % in 2016). During the same period, the percentage of good performing districts (2000 TDHS CPR > 40%) increased from 17% in 2012 to 39.1% in 2016. 4. Increased access to contraceptive services was repeatedly mentioned by almost all the informants (81% of the 92 IDI) due to the outreach approach in which on a pre-announced date a team of skilled providers visits smaller facilities (health centers (HC) and dispensaries) and provide all family planning methods as well as other MCH and health services. 5. As RESPOND trained providers in provision of clinical contraceptive services, access to these methods in routine clinic settings has increased. The increase in routine clinic availability of PMs/ LARCs is reflected in the declining share of outreach/ family planning weeks in the total uptake of the PM/LARC methods. 6. Over the years, the average cost per MP/LARC provided in the outreach/ FP week varied between $4.3 to $6.7 per acceptor with an average of $4.9 over the five-year period. The corresponding cost for per couple-year-protected was estimated between $0.95 to $1.3 with a five-year average of $1.10 per CYP. These costs are considerably lower when compared with similar outreach program managed by other organization in Tanzania	1. RESPOND has succeeded in increasing access to contraceptive services and enhancing contraceptive choice, thereby leading to the increased uptake of contraceptive methods, particularly PMs/LARCs. 2. The key factors that contributed to the uptake include capacity building of providers to provide PMs/LARCs, organizing outreach and FP weeks to make all contraceptive available along with other MCH services closer to villages. 3. RESPOND has improved the quality of services by strengthening monitoring and supervision and ensuring no or fewer stock-outs by systematic contraceptive security planning. 4.Taking services closer to community enhance uptake, method mix, and reach to remote areas. 5. Building competency of providers and facilities helps enhance routine uptake of FP and method mix. 6. Supportive supervision helps maintain quality of services, motivation self-efficacy of workers. 7. A combination of FP and other MCH/ health services provides anonymity for FP services.	• Continue capacity building until most facilities start providing LARC/ PM and MCH services as routine service. Task shifting could be considered and negotiated with MOHCDGEC to accelerate the process and overcome shortage of staff to provide some the services at the Dispensary level. (Conclusions 1 and 2). • On-the-job training instead of off-site training with an in-built accreditation system to accredit the trainees could reduce training cost substantially. (Conclusions 2 and 1). • Continue outreach. Start gradual withdrawal when majority of facilities build capacity to provide all methods. Continue outreach effort in difficult to reach areas. (Conclusions 4 and 1). • Institutionalize supportive supervision, assure adequate allocation of funds for transport and per diem to mentor and monitor the quality of services as a key outcome. (Conclusions 6 and 3).

Evaluation Questions and Key Findings, Conclusions and Recommendations.				
	Evaluation Question	**Findings**	**Conclusions**	**Recommendations**
		7. A facilitating factor mentioned by most (87%) of the informants interviewed was the RESPOND effort to build capacity of providers in providing clinical contraceptives. RESPOND trained 4,833 providers up through the second quarter of Year 5. 8. The quality of training was assessed by collecting data through self-administrated semi-structured questionnaire to 54 providers who were trained by RESPOND in clinical contraceptive methods and were available on the day of visit to different facilities. Most (90% or more) of the trainees interviewed had a positive view on the way training was implemented. As part of their training, most (77.8%) observed the performance of five or more procedures, and majority (57.4%) performed five or more procedures during training. All of the trainees reported that they had received supportive supervision after training and presently 97% of the 54 trainees who answered this question stated they were currently providing the procedure independently. 9. Despite progress under RESPOND, analysis shows that majority (between 77% to 90%) of the 4,323 facilities in the 110 districts covered under RESPOND do not have trained providers to provide PMs/ LARCs. This points to the huge work of capacity building yet to be done 10. Visit of 17 facilities and site observations showed that PMs were largely available at district level facilities or large health center with operation theaters where skilled providers were available. Discussion with the providers revealed that all of them were independently providing good counseling and quality services. Improvement in quality of counseling and services was attributed to good training and continuous supportive supervision provided by district and Council level officials.		

Evaluation Questions and Key Findings, Conclusions and Recommendations.				
	Evaluation Question	**Findings**	**Conclusions**	**Recommendations**
		11. Site visits at 17 hospitals and clinics confirmed that most of the contraceptive methods were available in the RCH/FP units as well as at the departments like care and treatment centers (CTC), Labor and delivery, post-abortion care (PAC), immunization clinic and GBV counseling and treatment units where family planning had been integrated with these services. 12. Some of the key constraints that were mentioned by more than 10 percent of IDI informants include: resource constraints (34%), limited staff (29%), shortage of trained providers in clinical contraceptive methods (16%), transfer of trained providers to position/facilities where s/he could not use learned FP skills (13%), limited BCC effort to remove misconceptions about family planning methods (11%), and fear of side effects (21%). 13. Both the training of providers and number of clients served was heavily skewed towards women. Most (more than 90%) of the providers trained in provision of clinical contraceptive were female and almost all clients who accepted any PMs were females. Thus gender gaps both in capacity building and acceptance of contraceptive are clear. 14. Increased use of LARCs/PMs was observed in all four RESPOND regions. However, Arusha zone showed a steep increase in the uptake of contraceptive methods followed in Mwanza. Coastal zones showed a healthy increase but in the fifth year (annualized), its performance decreased. In Iringa, the uptake remained somewhat stationary stopped after Year 3.		
2	How did RESPOND's model(s) of **integration** affect the uptake of FP services from various perspectives, e.g. Local Government Authorities (LGA)s, Service	1. There is evidence of an increase in FP uptake by having several additional service delivery points providing FP methods. 2. Based on data supplied from EH for 114 integrated service delivery sites, over time this integration approach has increased FP uptake from just 414 clients in Year 1 (2012) to 83,996 in Year 5 (2016).	1.Integration needs systematic and comprehensive implementation – from region to district, training in clinical skills, integration process, administration, and Monitoring and Evaluation.	• Develop suitable plan for staff deployment, turn over and internal rotations in order to avoid paralyzing integrated services. (Conclusion 1).

Evaluation Questions and Key Findings, Conclusions and Recommendations.				
	Evaluation Question	**Findings**	**Conclusions**	**Recommendations**
	Providers(SPs)/Health Facilities, Beneficiaries? - Team to compare RESPOND sites with integration and without integration. - Team will also compare which integration model is more effective	3. RESPOND secondary data demonstrate that districts with integration had more FP uptake than those without integration. However, it was not foundfor PMs . 4. Findings imply that integration may increase uptake of short-term methods more than LARCs/PMs. 5. Based on field interviews, most of the respondents mentioned FP-Immunization as the best integration model in increasing client's uptake for FP methods. Other integration models that were effective included Labor and Delivery for PPIUD, postnatal, and CTC. 6. Based on IDIs, site visits, and document review, the most important facilitating factors for integration included: the NOGI, the orientation of staff at the regional and districts (R/CHMTs). 7. Integration provides anonymity for clients. It emerged that a key facilitating factor from integration is its ability to provide anonymity for women seeking FP services. 8. Based on IDIs, site visits, and document review, the most important limiting factors for integration included: Staff deployment and turnover remain a constant ongoing problem that affects the feasibility of integration. Lack of an integrated HMIS makes it difficult to measure the impact of integration on the uptake of contraceptive methods, t. While significant improvement has been made in HMIS at the clinic level, service registers for FP clients have not been properly coordinated.	2.Not all facilities are fit for integration. Priority should be given to facilities with large volume of clients, adequate space and proper staffing. 3. Commodity security needs to be ensured at all facilities that are considered fit for integration, with special attention to providing commodities to all appropriate locations. 4. Integration of PPIUD in Labour and Delivery, and FP services within the immunization clinic are considered among the best practices and should be given special attention. 5. HMIS tools/registers need to be integrated in order to sustain quality data collection and data usage among all sites providing FP services.	• Strengthen community engagement on Integration through training more CHWs and using influential people. (Conclusion 1). • Scale up integration of services with Boresha Afya partners with more focus on the high-volume sites. (Conclusion 2). • Strengthen FP immunization integration through immunization outreach and required facilities at immunization service areas. (Conclusion 4). • Strengthen FP-post natal/LND integration through trainings of staff for LARCs and postpartum IUD (PPIUD). (Conclusion 4). • Develop suitable plan to integrate the HMIS tools in order to reduce multiple recordings, which pose great challenges to quality data collection. (Conclusion 5).
3	How did RESPOND's district-centered approach result in **strengthening the capacity** of local government to manage and implement FP programs? - The team should compare the different levels of support to	1.A large number of government staff were trained in various project leadership and management skills at the regional and district level. By Year 4 (2015), RESPOND had trained 3,612 members of the RHMTs/CHMTs. 2. A significant proportion of regional and district health managers (23/34) reported that they can better plan and manage the various program activities now after they have received training as compared to years back.	1. The district targeted approach is a highly effective strategy towards identifying and improving the performance of poorly performing districts. 2. Orientation of RHMT/CHMT members, particularly the Health Secretaries, on importance of FP	• For continuous inclusion of FP activities in the CCHPs, a systematic and sustained advocacy on importance of FP is required at RHMTs, CHMTs and national level. (Conclusion 2). • The partner's practice of sharing theirwork plans with CHMTs before implementation should continue for better partners coordination and

Evaluation Questions and Key Findings, Conclusions and Recommendations.				
	Evaluation Question	**Findings**	**Conclusions**	**Recommendations**
	Level 1, 2, and 3 districts and identify the successes/best practices that should be sustained in future programming as well as challenges encountered, and provide recommendations on how to overcome those. (See background documents for definitions of levels of support)	3. The improvement in supportive supervision was reported by almost all (31/34) key members of RHMTs & CHMTs. 4. In regions and districts where RESPOND worked with the RHMTs/CHMTs to organize partner coordination meetings, it was reported that these meetings were very instrumental in reducing duplication of efforts among partners. 5.Through targeted advocacy, capacity building, and technical assistance in budgeting by RESPOND and other implementing partners, there was an increase in the proportion of the 110 districts allocating funds for FP in CCHPs. 6. There is evidence that districts have increased allocation of local sourced funds for FP in their CCHPs. 7. The increase proportion of CCHP allocations for FP funded by District or by MOH went from 64% in year 1 to 84% in year 5. 8. The number of districts with CCHPs with FP allocations increased steadily from 51 districts in Year 1 to 91 in Year 5. 9. These trends can be attributed, at least in part, to RESPOND advocacy and capacity building. 10. While the increase in the total USD value of CCHP funds from Year 1 to Year 5 is impressive, when adjusted for the number of districts allocating funds within each of the four RESPOND administrative regions, the trends in amounts allocated per district have not increased (except for Mwanza RESPOND regional administrative area). 11. Data quality improvement (DQI) activities by RESPOND and other partners were reported to have	was key to inclusion of FP activities in CCHPs. 3. The improved allocation of funds for FP activities in CCHPs in some districts may facilitate sustainability for the key activities that were initiated under RESPOND. 4. Partner coordination and collaboration may significantly increase impact of FP activities at the district level with the possibility of some partners taking roles that were performed by RESPOND. 5. Strengthening of the HMIS and data use for decision making remains a crucial factor for proper program planning and management at district and facility level. 6. Setting targets, e.g., Levels 1, 2 and 3 in the district targeted approach, was reported as having facilitated proper resources allocation and improved performance of districts. It was evident that districts can be capacitated to plan and manage various program activities within their districts.	collaboration at the district level. (Conclusion 2). • Efforts to strengthen and sustain data quality and utilization for decision making should be made by advocating for allocation of funds for these activities in the CCHPs. (Conclusion 5). • Adapt the district targeted approach by integrating a limited number of key indicators (e.g. one key indicator for malaria, one for HIV, and one for FP) under Boresha Afya project. (Conclusion

Evaluation Questions and Key Findings, Conclusions and Recommendations.				
	Evaluation Question	**Findings**	**Conclusions**	**Recommendations**
		improved the accuracy, completeness, and timely reporting of services data. 12. The increase in use of data for decision-making was also mentioned among achievements of the RESPOND by the majority (22/34) of respondents at the district and regional level. The improvement in data use, especially for commodities forecasting, was reported as having led to significant reduction in stock-outs of commodities at facilities in the project catching area.		
4	How has RESPOND contributed to community mobilization for increasing utilization of FP and RH services, including greater access to LARCs/PMs? Sub-questions: How has RESPOND increased community engagement and action for accessing tailored /adapted FP-LARCs/PMs services? To what extent has RESPOND improved knowledge and acceptability of FP services among targeted populations such as youth, males, urban populations in selected areas?	1.RESPOND has supported the use of diverse, locally appropriate approaches to sensitize the target population about the availability of FP services in their communities. 2. RESPOND supported the use of loud speakers, printing and providing leaflets, posters with information on FP methods, obtaining support from Religious and community leaders for community sensitization, training and use of community health workers (CHWs). 3.There was a strong awareness and appreciation for RESPOND supported community engagement activities. 4. RESPOND's community engagement initiatives focused on local leaders and influential individuals at the community level. Examples include Ward and Village leaders, religious leaders, traditional authorities, as well as community level structures and institutions. 5. RESPOND built capacity among the CHWs in the community, and provided them orientation trainings on family planning for five days so they can educate people on importance of family planning. Over 400 CHWs were trained during eight sessions in Year 2 through Year 3. 6. RESPOND used different efforts to reach targeted populations, such as men and youth. One approach was	1. FP campaigns that integrate MCH and other health services with FP messages makes the FP messages more attractive and acceptable to clients, especially to women. 2. Timely and effective use of local media by community leaders/CHWs makes mobilization successful and attract clients to outreach services. 3. A package of locally adapted, culturally appropriate mobilization techniques succeeded in generating high levels of attendance at outreach events (FP days, FP Weeks, and Immunization days). 4. Effective community mobilization requires active engagement with CHWs, community, and religious leaders. 5. At the rural areas, community meetings and CHWs are important for effective community sensitization.	• Strengthen focused mobilization efforts using local media techniques with emphasis on low-cost and well-timed outreach that promotes integrated health messages and activities that link FP with related MCH issues. (Conclusion 1). • Adapt and sustain a set of locally adapted, culturally appropriate mobilization techniques within Boresha Afya (e.g., In Lake Regions, find ways to combine FP mobilization with MCH and Malaria eradication). (Conclusion 2). • Develop and implement a strategic BCC campaign covering all components of Boresha Afya with a focus on youth, men, women and key community decision makers. (Conclusion 3 and 4).

Evaluation Questions and Key Findings, Conclusions and Recommendations.				
	Evaluation Question	**Findings**	**Conclusions**	**Recommendations**
		to call upon satisfied clients, including satisfied male FP users, to address male involvement. 7. RESPOND was focused on short-term engagement, linking community to outreach services on a short-term basis, and therefore had a limited role in community mobilization.		

ANNEX VI. B EVALUATION TIMELINE

Site visit Schedule Draft 0.8 18 Dec 2017 Team 1=M.E., Catherine, Rose, Edward. **Team 2**=Sam, Neema, Deo, Mercy

Date	Day	Mo	Event Name	Location of Data Collection	Proposed Travel Logistics
6/10/2017	SAT	JUN	Travel to country		
6/11/2017	SUN	JUN	Travel to country		
6/12/2017	MON	JUN	In-brief AM USAID; In-brief PM w RESPOND		
6/13/2017	TUE	JUN	Data Collection DQA Workshop		
6/14/2017	WED	JUN	Data Collection DQA Workshop		
6/15/2017	THU	JUN	Data collection	Dar with implementing partners/MOH	
6/16/2017	FRI	JUN	Data collection	Dar with implementing partners/MOH	
6/17/2017	SAT	JUN	Data collection	Debrief with the Team in Dar	
6/18/2017	SUN	JUN	Team report to Mission	Rest day	
6/19/2017	MON	JUN	Data collection	Dar with implementing partners/MOH	
6/20/2017	TUE	JUN	Data collection	Dar with implementing partners/MOH	
6/21/2017	WED	JUN	Team Travel	Travel to Iringa PM, interviews with Zonal FP Coordinator and RESPOND Regional Staff	**PM** flight to Iringa (AM flight cancelled) - Interview with Zonal FP Coordinator at Zonal Resource Centre(PHCI) and -Interview RESPOND field office staff: interview with 2 RESPOND program staff Zonal managers, interview with RESPOND FP coordinator and M&E Officer.
6/22/2017	THU	JUN	Data collection by 2 Teams	Iringa 2 teams 2 GBV FP districts (Kilolo, Mufindi) Kilolo Dc Facilities (Ilula Hospital & Kilolo Dispensary)	A.M. Iringa Regional Hospital. Interview w RMO, RHMIS, Joint interview with 3 R staff: RHealth Secretary, RPharmacist, RRSH Coord. -Team 1:travel to Kilolo DC (1 hr) -Courtesy call Kilolo District Council Interview DMO, DPharma. Interview DRCHC, DHIS Focal Person - HF interview: Kilolo Dispensary Interview Disp MO in charge,

Date	Day	Mo	Event Name	Location of Data Collection	Proposed Travel Logistics
					interview RCH in charge. Site observation, No Training follow-up interviews.
				Mufindi Dc Facilities (Mafinga Hospital & Kasanga Health Center (1hr))	-Team 2: Travel to Mufindi (1hr) Courtesy call Mafinga Town Council MO, Interview Mafinga TCO. Group Interview - (6 members of CHMT) DMO, DRCHCo, DHMIS, DPharmacist, DHealth Secretary, DGBV Focal) - HF interview: Mafinga Hospital Interview w RHC in-charge. Site observation. 1 Training follow up interview.
6/23/2017	FRI	JUN	Data collection by 2 Teams	Iringa 2 teams 2 GBV FP districts (Kilolo , Mufindi) Kilolo Dc Facilities (Ilula Hospital & Kilolo Dispensary) Mufindi DC Facilities (Mafinga Hospital & Kasanga Health Center)	Team 1: Travel to Kilolo DC (1 hr) - Ilula Hospital Interview MO in charge, interview w RCH Corrdinator and FP Unit in charge. Six 6 training follow-up interviews with Implant /IUD trainees with post-interview discussion. (PM) Community FGD 7 men. - Team 2: Travel to Mufindi DC in Mafinga (1 hr) courtesy call w DRCHCO -HF Kasanga Health Center (1 hr). Interview with Matron-in-charge, and HC Facility In-charge. Site observation Walk through. 1 Training follow up. (PM) Mafinga Hospital Community FGD 8 women.
6/24/2017	SAT	JUN	Data collection by 2 Teams	Return to Dar PM	
6/25/2017	SUN	JUN	Team report to Mission	Rest/Data synthesis in Dar	
6/26/2017	MON	JUN	HOLIDAY: Eid el Fitri (TZ)	Travel to Mbeya in PM	Departure 2 pm – Arrival Mbeya 4 pm Dinner/ planning meeting with EH Regional Staff 7 pm.
6/27/2017	TUE	JUN	Data collection Teams combined	Two teams combined in one non-integration district (Mbeya City)	-Courtesy call/Interviews to RHMT (RMO, RRCHCo, RHMIS, RPharmacist, RHealth Secretary)

Date	Day	Mo	Event Name	Location of Data Collection	Proposed Travel Logistics
				Mbeya City Facilities; Ruanda Health Center –(integration facility) & Iyunga Health Center (non-integration facility)	-Courtesy call/Interviews to CHMT(DMO, DRCHCo, DHMIS, DPharmacist, DHealth Secretary) - Visit 2 HF: Ruanda HC and Lyunga HC (HF i/c, RCH i/c) Site walk thru and 3 T-F-up interviews at Lyunga; Site walk thru and 3 T-F-up interviews at Ruanda.
6/28/2017	WED	JUN	Data collection Teams combined	Data collection in the A.M. (if feasible). Return to Dar PM	Community FGD (AM) 6 women Ruanda HC.
6/29/2017	THU	JUN	Team Travel	Travel to Arusha both teams. PM Regional courtesy meeting.	-Afternoon flight: -Courtesy calls/interviews (PM) Interview RESPOND field office staffs (3) Zonal FP Coordinator, RRCHCo, Zonal RCH Coordinator. Interview w Reg FP Coordinator Zonal Trainer, Training Center CEDHA
6/30/2017	FRI	JUN	Data collection by 2 Teams	Arusha 2 teams 2 non-integ districts (Arusha City Council , Karatu DC)	Team 1: Travel (2 hrs) Aru-Karatu Team 1:Karatu DC - Courtesy call/Interviews to CHMT (DMO,DRCHCo,DHMIS,DPharmacist,) -HF interviews: Karatu HC(HF i/c, RCH i/c,) 4 Training F-up interviews. Team 2:Arusha city - Courtesy call/Interviews to CHMT DRCHCo,DHMIS, -visit/interviews at HF: Ngarenaro HC and Kaloleni HCs (HF i/c, RCH i/c,) Site walk throughs, 2 training follow up interviews at each HC
7/1/2017	SAT	JUL	Data collection by 2 Teams	Arusha 2 teams 2 non-integ districts (Arusha City Council, Karatu DC)	Team 2: Community FGD (AM)in Arusha Ngarenaro HC 8 men.
7/2/2017	SUN	JUL	Travel Team report to Mission	Travel to Manyara by road. Estimated time to travel: Three hours.	

Date	Day	Mo	Event Name	Location of Data Collection	Proposed Travel Logistics
7/3/2017	MON	JUL	Data collection by 2 Teams	Manyara 2 teams 2 HIV FP districts (Babati DC, Hanang DC) - Integration districts	- Courtesy calls by both teams with RHMT RMO and Regional Admin Sec (RAS) Team 1 Interviews w (Acting RMO, RRCHCo, Zonal FP Coordinator) - Team 1: Babati DC Courtesy calls/interviews (Acting DMO, Acting DRCHCo,) - visit interviews at HF: Galapo HC) (HF i/c, RCH i/c, Site walk, Training F-up 4) -Team 2: Hanang DC Courtesy calls/interviews (Acting DMO, as HF IC DRCHCo, DHMIS,) - Visit/interviews at HF: Tumaini hospital HC(RCH i/c, Site walk through 2 Training FUp)
7/4/2017	TUE	JUL	Data collection by 2 Teams	Manyara 2 teams 2 HIV FP districts (Babati DC, Hanang DC) - Integration districts	Community FGD (AM) at Galapo HC 8 female community members. Travel to Arusha (PM)
7/5/2017	WED	JUL	Team Travel	Arusha	Connect from KIA to Mwanza
7/6/2017	THU	JUL	Data collection by 2 Teams	Mwanza Regional level meetings (both teams together) Mwanza 2 teams 2 CPAC FP districts (Nyamagana, Misungwi)	-Courtesy calls RHMT(AM) Interviews with (RRCHCo, RHMIS) -Courtesy call and Interviews at RESPOND Field office staffs(5) Team 1: Interview with M&E and Ass. M&E Team 2: Interview with Zonal manager, Finance officer, Program Officers (FP, FP/cPAC and Community Engagement) Travel to the Districts: Team 1: Courtesy call with CHMTs (PM) and Interview Nyamagana (Act. DMO, DRCHCo, DHMIS, Ass. DRCHco) -Team 2: Courtesy call with DED and CHMT and interview Misungwi with (Act. DMO, Ass. DRCHco, DHMIS, Hospital Matron)

Date	Day	Mo	Event Name	Location of Data Collection	Proposed Travel Logistics
7/7/2017	FRI	JUL	HOLIDAY: Saba (TZ)	Data synthesis and relax.	
7/8/2017	SAT	JUL	Data collection by 1 Team	Data collection in the A.M.	Team 1 conduct Community FGD with 7 women in Nyamagana District
7/9/2017	SUN	JUL	Team report to Mission	Rest and analysis	
7/10/2017	MON	JUL	Data collection by 2 Teams	Mwanza 2 teams 2 CPAC FP districts (Nyamagana, Misungwi)	Team1: visit/Interviews at 1 HF in Nyamagana (Nyamagana DH,) (Acting DMO, Acting RCH i/c, 4 SP training follow-up interviews) Site walk through Team2: visit/Interviews at 1 HF in Misungwi (Misasi Hc) (HF i/c, RCH i/c, 2 SP training follow-up interviews) Site walk through
7/11/2017	TUE	JUL	Data collection by 2 Teams	Mwanza to Simiyu Region/ Bariadi Est time to travel 4 hrs. Sleep in Bariadi	A.M. Travel to Simiyu /Bariadi (4hrs) -Courtesy calls/interviews with RHMT (Acting RMO, RRCHCo,)
7/12/2017	WED	JUL	Team Travel	Simiyu 2 teams 2 CPAC FP districts	-Travel to Maswa (AM) (1hr) -Courtesy call/interviews CHMT (DMO, DRCHCo, DHMIS,) -Team 1: HF Interviews at Malampaka HC(HF i/c, RCH i/c, 2 SP training Follow-up Interviews) Site walk through One Community FGD (PM) 8 men (community mobilizers, religious and community leaders, CHWs) -Team2: HF Interviews at Maswa DH (HF i/c, RCH i/c, 5 SP training follow-up interviews) Site walk through -Travel to Mwanza
7/13/2017	THU	JUL	Consolidation of interview notes and data synthesis..	Mwanza	Mwanza

Date	Day	Mo	Event Name	Location of Data Collection	Proposed Travel Logistics
7/14/2017	FRI	JUL	Consolidation of interview notes and data synthesis. Preparation of draft outbrief presentation.	Mwanza	Mwanza
7/15/2017	SAT	JUL	AM Travel	AM. Mwanza fly back to Dar	
7/16/2017	SUN	JUL	Team report to Mission	Rest AM PM 2 teams drive to 2 regions (Morogoro (5hrs),Kibaha(1hr))	PM Planning meeting with RESPOND Zonal Manager and FP Coordinator.
7/17/2017	MON	JUL	Data collection Teams combined	Coast 2 teams in 2 Regions (1 Youth FP MorogoroMC,1 non-integ – Kibaha DC).	Team 1:Courtesy call Kibaha RHMT /Interviews (RRCHCo) -Team 1: Courtesy call Kibaha CHMT (Act DMO, Act. DRCHCo) -Team 1: HF Interviews at HF: Mlandizi HC (HF i/c, RCH i/c, SP) Site walk through. Focus Group Discussion with Community mobilizers in Mlandizi Team 2: Courtesy call /interviews Morogoro RHMT/Interviews (Ass. RRCHCo, RHMIS) Interview RESPOND staff (Zonal Manager and Program Officer FP) -Team 2: Courtesy call Morogoro MC CHMT (Act. DMO, Act. DRCHCo, DHMIS, DPharmacist) -Team 2: HF Interviews at Uhuru HC (RCH i/c, SP) Site walk through and Training follow up
7/18/2017	TUE	JUL	AM Travel	Travel Back to Dar for both Teams	
7/19/2017	WED	JUL	Consolidation of interview notes and data synthesis. Preparation of draft outbrief presentation.	Sea Cliff Hotel	
7/20/2017	THU	JUL	A.M. Data analysis and completion of outbrief presentation.	Sea Cliff Hotel	
7/20/2017	THU	JUL	2 P.M. Debrief USAID Sam depart 22:00	USAID	
7/21/2017	FRI	JUL	Data analysis	Sea Cliff Hotel	
7/22/2017	SAT	JUL	Data analysis	Sea Cliff Hotel	
7/23/2017	SUN		Rest		

Date	Day	Mo	Event Name	Location of Data Collection	Proposed Travel Logistics
7/24/2017	MON	JUL	Data analysis	Sea Cliff Hotel	
7/25/2017	TUE	JUL	Data analysis	Sea Cliff Hotel	
7/26/2017	WED	JUL	IP & Stakeholder debrief wrk shp	TBD	
7/27/2017	THU	JUL	Depart country		

ANNEX VII. DISCLOSURE OF ANY CONFLICT OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.
2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.
3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.
4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.
5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.
6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.
7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to $5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).
8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to

Page 113 of 131

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature _____ Date 3 May 2017

Samuel D. Clark, Jr.

Name _____ Title Consultant

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature Rest Date 11/05/2017

Name ROSE ERNEST Title SOCIOLOGIST

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

	05/04/2017
Signature	Date
NEEMA FRITZ MATEE	FP/RH EXPERT/FIELD COORDINATOR
Name	Title

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

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ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature NAlatemu. Date 26/05/2017.

Name MERCY JOSEPH. Title MS.

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Ckahabuka 15-05-2017

Signature Date

CATHERINE KAHABUKA

Name Title CONSULTANT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

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Ckahabuka 15·05·2017

Signature Date

CATHERINE KAHABUKA

Name Title CONSULTANT

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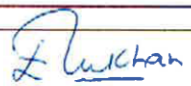
ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature  Date 05.06.17

Name MOHAMAD E KHAN Title INT. CONSULTANT HEALTH

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature Date 10/05/2017

DR. DEODATUS MWINGIZI

Name Title MD/Local Expert

ANNEX VIII. SUMMARY BIOS OF EVALUATION TEAM MEMBERS

Sam Clark, Team Lead. Responsible for managing the team's activities, ensuring that all deliverables are met in a timely manner, serving as a liaison between USAID and the team, and leading briefings and presentation. Sam Clark has held senior positions and consultancies in the design, implementation, monitoring, and evaluation of gender-equitable sexual and reproductive health programs (maternal, newborn and child health, family planning and the prevention of HIV/AIDS). Education and training includes a Doctorate (Sc.D.) and Masters with Honors (Sc.M.) from the Johns Hopkins University School of Hygiene and Public Health. Extensive applied qualitative and quantitative M&E experience to assess public health programs. Experienced in program management and budget monitoring. Diverse in-depth computer skills using SPSS, SAS, Epi-Info, and MS Office (Word, Excel, PowerPoint, Outlook). More than nine years program management in public health at Program for Appropriate Technology in Health (PATH).

ME Khan, International FP/RH Expert. Took the lead in assessing the ability of RESPOND to achieve its four major sub-purposes and provide technical leadership in the area of FP/RH programming. Dr. M E Khan is internationally recognized for implementation research in reproductive health and family planning. Presently, he is president of Center for Operations Research and Training and also works as independent health consultant. His areas of interest include operations research, monitoring and evaluation, community mobilization, BCC, GBV and capacity building of young researchers and program mangers. He has contributed more than 60 papers and written several books.

Neema Matee, National Health Specialist/Field Coordinator. Provided expertise on Tanzania health systems, particularly FP/RH. She will serve under the Team Lead. She will support the evaluation team with all logistics and administration to allow them to carry out this evaluation. Neema Mattee is a trained sociologist with 15 years' experiences in research and M&E. As an evaluation coordinator, she has participated in a number of project performance, mid- and endlin-e evaluations of social and behavior change communication projects, health projects (mainly HIV/AIDS, malaria and family planning) with USAID, UNICEF, and other international consulting firms. She also experienced in project planning, logistics, research tool preparation, data collection/management and analysis for both qualitative and quantitative methods. She is a masterful translator in English/Swahili.

Catherine Kahabuka, National Health Specialist, Provided expertise Tanzania health systems, particularly FP/RH. Dr. Kahabuka has more than seven years' experience in health systems research, particularly in areas of maternal, newborn, child and adolescent's health. Since January 2013, Dr. Kahabuka has worked as a consultant for health systems research where she has been providing both technical and implementation support to various research and program M&E activities in Tanzania, including at the national level. Dr. Kahabuka has offered research support to programs under more than 15 international organizations, the majority being FP programs, including the mid-line and end-line evaluation of the National FP Costed Implementation Plan (NFPCIP).

Deodatus Mwingizi, Local Evaluator. Assisted the evaluation team with data collection, analysis, and data interpretation. Has strong knowledge of government health offices which was a special asset for the evaluation. Deodatus Mwingizi has extensive experience in research designing, planning, training of field teams, implementation data collection, data management, analysis of research findings, progress

reporting writing, monitoring and evaluating health programs. He has worked with both national and international organizations.

Rose Ernest, SociologyLocal Evaluator. Assisted the evaluation team with data collection, analysis, and data interpretation. Rose Ernest is a sociologist with experience in rural development and specialized in community development programs in Tanzania. She has been involved in a number of research activities aimed at developing communities ranging from socio-economic, cultural, and health research projects. Her expertise in research is demonstrated in both qualitative and quantitative methodologies and this ability in both methodologies has been enabled her in working with different research computer programs such as NVivo 8 and SPSS. She has worked with different local and international organizations such as USAID in a number of evaluations.

Edward Nkya, Local Evaluator. Assisted the evaluation team with data collection, analysis, and data interpretation. Edward Nkya has served as Local Evaluator, Consultant, Field Interviewer and Research Coordinator on various evaluations in Tanzania.

Mercy Joseph, Local Evaluator. Assisted the evaluation team with data collection, analysis, and data interpretation. Mercy Joseph has experience in development practice focused on the design, implementation, and evaluation of development programs using both qualitative and quantitative methods. She has worked as a consultant in different international programs and has experience working with public, integral private, and International programs in the Tanzania environment.

For more information, please visit

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