JIJENGE! PROJECT

AMREF Tanzania – Lake Zone Programme

FINAL EVALUATION REPORT

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ACRONYMS

AMREF	African Medical and Research Foundation
CBO	Community Based Organisation
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CHMD	Council Health Management Director
CMOH	City Medical Officer of Health
CO	Clinical Officer in Charge
DANIDA	Danish Organisation for Development Assistance
DC	District Commissioner
DfID	Department for International Development
DMO	District Medical Officer
FFQ	Face to Face Questionnaire
FGD	Focus Group Discussions
FGM	Female Genital Mutilation
FP	Family Planning
HIV	Human Immuno-deficiency Virus
ICPD	International Convention on Population and Development
IDI	In-depth Interviews
MCH	Maternal and Child Health
NGO	Non-Governmental Organisation
NIMR	National Institute for Medical Research
PMTCT	Prevention of Mother to Child Transmission
RPA	Rapid Participatory Appraisal
SRH	Sexual and Reproductive health
STI	Sexually Transmitted Infections
TB	Tuberculosis
TBA	Traditional Birth Attendant
TH	Traditional Healer
TZ	Tanzania
VCT	Voluntary Counselling and Testing
VHW	Village Health Worker
WEO	Ward Executive Officer

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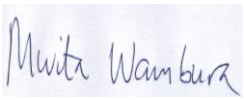

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CHAPTER ONE

INTRODUCTION

This report presents the findings of an evaluation to *JIJENGE!* Project Sites in Mwanza and Mara Regions from 20th May to 20th June, 2009 to reflect on the project's overall outcomes, to determine to what extent the changes in the target groups are attributed to the project activities and to assess the overall impact of the project.

1.1 Objectives and Scope of Evaluation

The *JIJENGE!* Project (*JIJENGE* means 'to build oneself up') originated in the *JIJENGE*! Women's Centre which was established in 1996 through a partnership between two Mwanza based Non-Governmental Organisations (NGOs): the African Medical and Research Foundation (AMREF) Lake Zone Programme and KULEANA, originally an NGO targeting street children in the Mwanza urban context. It was established to respond to two international edicts of 1994; the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Programme of Action for the International Convention on Population and Development (ICPD). *JIJENGE!* Project was established to promote gender and strengthen the role of women in society, by promoting a gender sensitive health care system and improving the already existing infrastructure through personnel training and refurbishment. The project has had 3 phases of implementations to date, with the last phase being in 2006-2009.

To assess the effects, impacts and sustainability of the *JIJENGE*! Project, AMREF Tanzania and other partners were interested in evaluating the project objectives for the period 2006–2009. The evaluation was aimed at providing recommendations to AMREF, District Councils, and other stakeholders on further steps necessary to consolidate and sustain what has worked well while addressing the key existing challenges. Thematic areas covered included:

- The project implementation strategy,
- Institutionalization of the project concept (Reproductive Health in the context of gender relations) with focus on district and community,
- Training strategy
- Advocacy and networking strategy.

Within these thematic areas, the evaluation aimed at ascertaining results (accountability), identifying knowledge gaps, providing lessons learnt and making recommendations to enhance the effectiveness of the *JIJENGE* Project on improving the provision of reproductive health services in the context of gender relations.

Specifically, the evaluation had the following specific objectives:

- Assessing the effectiveness of the capacity built by the project in the promotion of gender equality, human rights and improving the quality of primary health care services at the health facility, council health management teams, community leaderships, and community owned resource people.
- Assessing the level of council and management engagement for sustaining the project initiatives.
- Assessing the mechanisms established for advocacy and lobbying for promotion of women's health, sexual rights at community, district and national levels.
- Analysing the roles and responsibilities of the formed networks at community and district levels as a means of creating a national agenda on reduction of gender based violence and promotion of women's dignity.
- Assessing the level of project success in fulfilling the set benchmarks from the baseline surveys at health facilities and district levels.
- Assessing the level of awareness raised on issues related to gender equality, human rights, sexual and reproductive health issues from health providers and community members.
- Assessing the applicability and influence of the gender and human rights concepts in provision/utilization of client – friendly gender sensitive health service delivery in the project supported health facilities.
- Assessing whether the proposed strategies to define sustainability constitute a crucial task in terms of:-
    - Corresponded with local policies
    - Strengthened local institutional capacity.
    - Were suitable to local social – cultural context
    - Were based on participation of local stakeholders
    - Were based on the participation of men and women.
    - Created positive impacts on education delivery.
- The evaluation was also aimed to recommend to AMREF the lessons learned and recommend the way forward for replication and sustainability purposes.

1.2 Evaluation Approaches and Methods

The team of evaluators used the evaluation framework as an overall practical approach to the evaluation, whereby the main ideas and concerns for this evaluation were assembled in a manner that provided ease of use and analysis especially in summarising results against the core objectives. An overview of evaluation criteria is shown in Box 1.

Box 1 Summary of Definitions & Criteria for Evaluating for the JIJENGE! Project Activities.

Relevance: The extent to which the objectives of a project intervention were consistent with beneficiaries' requirements, needs, and priorities and Country's policies.

Effectiveness: The extent to which the project interventions' objectives were achieved, or were expected to be achieved, taking into their account their relative importance.

Impact: The positive and negative, primary and secondary long-term effects produced by a project intervention, directly or indirectly, intended or unintended.

Sustainability: The continuation of benefits from a project intervention after the project has been completed. The probability of long-term benefits. The resilience of the risk of the net benefit flows over time.

Coherence: The need to assess policies for consistency and ensure that all policies take into account humanitarian and human rights considerations.

Coverage: The need to reach major population groups whenever they are.

1.3 Choice of Tools / Techniques and Justifications

Evaluators used a range of tools and methodologies for the evaluation. These tools were carefully selected based on their appropriateness for the task after a thorough consideration of the objectives of the evaluation.

The evaluation employed both quantitative and qualitative methods. In order to obtain comparative data and due to time and budgetary constraints, the evaluation was conducted in the 3 wards covered in the baseline survey (Bugogwa - Mwanza, Kenyamota - Serengeti, and Chigunga - Geita). The methodology used was aimed to assess whether outcome indicators set out at the inception of the project were achieved. These outcomes are presented in Box 2.

Box 2. Outcome Indicators Set Out at the Inception of the Project.

- Increase access to health services by community members (by 30%)
- Set-up a network of healthcare facilities in the 8 districts with qualified staff to provide quality, gender sensitive SRH services (train 168 health service practitioners in 21 health facilities)
- Improve knowledge and skills on healthcare issues in the 21 health centres
- Facilitate integration of gender sensitive SRH services in health facilities in the 8 districts
- Improved/quality services provided to women
- Gender sensitivity and human rights awareness and knowledge raised among community members
- Women's SRH issues awareness and knowledge raised among community members
- Gender based violent cases reduced
- Reporting of gender based violence increased
- Female rape cases reduced
- Reporting of female rape cases increased
- Improved quality of women SRH services
- Increased satisfaction of SRH services by women (by 50%)
- Increased uptake of SRH services by women
- Increased awareness of women SRH rights among health workers
- Increased awareness of gender and human rights issues among health workers
- Network with partners at different levels of government increased/enhanced
- Increased number of policy/decisions on gender and women human rights at district, ward and villages levels
- Project's good practices integrated into routine SRH provision in the health facilities
- Improved collaboration between the different stake holders at the district and national levels
- Council Health Management Teams (CHMT) adopt specific measures to incorporate quality SRH in the plans
- Wards Development Committees (WADs) adopt specific measures to improve SRH services at health facilities in their administrative areas
- Increased attendance of project staff in CHMT and WADC meetings
- 3 CBO established and functioning in each ward as a result of project activities

Sources of data are outlined below as follows:

1.3.1 Documentary Review Proforma (DRP)

DRP was used to synthesize information from documents that were collected from AMREF and districts and health facilities visited for review. Such documents included policy statements, project reports, annual reports and monitoring and evaluation reports, gender and SRH based violence reports. The purpose of DRP was to provide a structured format to ensure that key questions for the evaluation were covered and that all documents were reviewed in a consistent manner.

1.3.2 Stakeholder Analysis

Stakeholder analysis was used at the start of the evaluation to assess different stakeholders (organizations, groups, departments, structures, networks or individuals) according to their importance, interests and influence. Interest in this context was to assess and measure the degree they were likely to be affected by the JIJENGE! Project activities while influence was the extent in which they could act for or against the achievement of the proposed key outcomes and indicators. The results of the analysis formed the basis of setting-up field meetings and visits.

1.3.3 Field Visits

During the field visits, a team of evaluators visited Chingunga Ward in Geita District, Kenyamonta Ward in Serengeti District and Bugogwa Ward in Ilemela District to assess on-going activities or selected activities implemented and managed during the period of evaluation. In each Ward, the team visited the village that participated in the pre-intervention baseline survey for easy comparability of the data. Table 1 presents the villages and descriptions of the villages that were visited in both pre and post-intervention evaluation.

Table 1. Descriptions of the Project Areas Visited in the Post-Intervention Survey

District	Ward	Village	Characteristics of selected site
Geita	Chigunga	Chigunga	Rural, agricultural area largely dependent on subsistence and cash crop farming, inland and relatively inaccessible during the rains
Serengeti	Kenyamonta	Nyagasense	Rural, agriculture based economy, least accessible of all sites. High prevalence levels of domestic violence due to local ethnic cultural norms
Ilemela	Bugogwa	Igombe	Lakeshore rural area situated close to large urban centre of Mwanza. Petty business, fishing and agricultural activities mainstay of local economy. Influence of urban lifestyles mixed with rural incomes

In village visited, three sub-villages were selected randomly to participate in the evaluation with probability proportional to the sub-village size. In each selected sub-village, the names of all household heads were listed. One household was selected randomly and 14 households were visited on the basis of being nearest to the household under survey. In each house, all respondents aged 15-49 years were listed and then interviewed; therefore 40 interviews (24 females, 16 males) were conducted in each selected sub-village (sex ratio of 6:4). In every study household, one man was interviewed and at most two women interviewed. In total, 120 face to face interviews (72 females, 48 males) were conducted in each village visited. These interviews enabled us to assess the relevance, effectiveness, sustainability and connectedness of the activities to projects objectives. These visits also enabled us to assess how the projects activities have contributed to the outcome and impact indicators and facilitated to put into context information collected through other methodologies and therefore aided analysis and interpretation.

1.3.3.1 Semi-Structured Interviews

A team of evaluators conducted interviews with 4 health workers in each health facility (2 health workers that were trained by *JIJENGE* project and 2 health workers that were not trained by *JIJENGE* project). The aim of these interviews is to assess knowledge and awareness of SRH issues between health practitioners that were trained and those not trained and determine whether trained practitioners were more likely to provide gender sensitive SRH than un-trained practitioners.

1.3.3.2 Focus Group Discussion

FGDs were conducted with a number of community members (representing different categories of groups) to explore awareness issues on gender and women's sexual and reproductive health. FGDs were used to sort out common themes and different perspectives, as well as to score each force according to their magnitude. Furthermore, information arising from the FGDs was important element in assessing drivers of change, 'resistance' (and disincentives) to the achievement of the key outcomes. We conducted 2 FGDs per community (total 6 in 3 communities). One male and one female FGD were done in each community.

1.3.3.3 Exit Interviews

These were conducted with 4 women who visited the health facility for SRH services. The aim was to examine their satisfaction/dissatisfaction with the services received. A total of 12 women in 3 health facilities were interviewed.

1.3.3.4 Structured Observation

Structured observation was conducted to assess the quality of the services offered at each health facility visited. The evaluation team member visiting the health facility observed the physical state of the health facilities, waiting times, patient-health worker interactions (way patients are attended), and the language used by health workers during the service provision service.

1.3.3.5 Key Informant Interviews

Structured and Semi-structured questions were developed to cover the purpose and objectives of the evaluation. The questions served as a guide during in-depth key informant interviews with focal persons at the community, health facility, and district levels. While in the village, we conducted key informants interviews with either the Ward Councillor or Ward Executive Officer (WEO) or the Village Executive Officer (VEO), the representative of Community Based Organizations (CBOs) or Non-Government Organizations (NGO) that worked in partnership with the *JIJENGE* project, District Medical Officer (DMO) or their representatives. In addition, we used information collected from the interviews to undertake a network analysis to asses the nature and functioning of the networks established at the community and district levels for the reduction of gender violence and advocacy of women dignity in general.

1.4 Analysis and Structure of the Report

A large amount of data (quantitative and qualitative) was generated through the face to face interviews, key informants interviews, FGDs, semi-structured interviews and document reviews. These data were collected to ensure consistency that would enable us to draw evidence based conclusions. The reliability of the evaluation was considered in terms of equivalence and consistency. The equivalence reliability was determined by relating data collected in the field to progress reports written by the project staff. In addition, cross referencing of information was done as part of the evaluation process especially where respondents informed us that certain results have been achieved as a direct result of JIJENGE project.

A qualitative data analysis software (NVIVO) was employed to facilitate analysis and write-up of gathered information. A data analyst analysed the data collected and compared with the project targets. This enabled us to cross-reference and provide an audit trail for our conclusions. Quantitative data was analysed in Stata software.

This report is set out in four chapters. Following this introductory chapter, Chapter 2 reviews the JIJENGE project and presents background and contextual information. Chapter 3 presents the best

available evidence about progress towards outcomes. Chapter 4 reviews the factors affecting the progress and discusses JIJENGE's partnership strategy. Chapter 5 consolidates the material and highlights issues arising and some lessons, concludes and puts forward recommendations.

CHAPTER TWO

PROJECT INTERVENTION

2.0 Introduction

In Tanzania as in most developing countries, women face significant risk of dying or encounter life threatening complication during delivery or postpartum. Additionally gender inequalities are institutionalized and practiced from very young ages as manifested in the daily treat and attitude towards women. Regularly, women are seen as their husband's property and thus never question on matters which affect them.

Sex and sexuality issues are not discussed in the open, coupled with traditional practice such as female genital mutilation (FGM), polygamy, and increased work load on women and incest affects women reproductive health. Often, this leads to increased risk of maternal mortality and morbidity. In the event when access to health care services is available, women are faced with unskilled health service providers with detrimental attitude, and facilities that are not able to provide gender-based quality care.

To adders these issues, The JIJENGE project was established. This process aimed to promote gender and strengthen the role of women in society, by promoting a gender sensitive health care system and improve the already existing infrastructure through personnel training and refurbishment. Furthermore, the project aimed to improve the clinical aspect of women's health by providing full access to quality sexual and reproductive health services. The crucial aspect of women's rights and health was addressed through activities organised to educate, sensitize, and mobilize both men and women in the communities in order to not accept gender-based violence and demand positive and active policies in defence of women's rights at levels of civil society and public administration.

2.1 Phase I of the Project (1996-1999)

The JIJENGE project was established in March 1996 by AMREF and Kuleana organization, both of which worked to improve the sexual and reproductive health of women within the context of human rights. At its inception, the project aimed to improve sexual and reproductive health of women through eradication of gender based violence by reinforcing institutional and community health care practices in 8 districts, 2 regions of the Lake Victoria zone in Tanzania. The districts covered included: Mwanza City, Sengerema, Misungwi, Kwimba, Magu, Ukerewe, Geita in Mwanza Region and Serengeti in Mara Region.

Specific services provided during phase I of the project included community awareness and sensitization activities to decrease gender based violations, Address women's sexual and reproductive health care services including syndromic management of sexually transmitted infections (STI) and HIV counselling and testing. In addition, the JIJENGE! Women's Centre provided counselling and support for women in abusive relationships. Training of service providers was a final component of JIJENGE phase I.

Lessons learnt JIJENGE! phase I were adapted and reproduced in 8 facilities (Makongoro RCH clinic, Katungunguru HC, Misungwi HC, Geita Hospital, Ngudu Hospital, Nansio Hospital and Magu Hospital) and four communities (Igogo, Pamba, Isenye and Ring'wani wards) across Mara and Mwanza Regions in the year 2000.

2.2 Phase II of the Project (1999-2002)

The objectives of this phase was to raise awareness and strengthen community support structures, improve knowledge and skills among health workers in the provision of women friendly services, advocating for policies and better practices supportive of women's reproductive health and rights, and establishing partnerships and networks in promotion of the health and rights of women.

In the second phase, provision of Sexual and Reproductive Health (SRH) and counselling services for the community was replaced with capacity building and training to improve health providers' skills in gender sensitive service provision. Advocacy and networking were also key components of this phase to increase awareness amongst the community, district leaders and influential stakeholders in order to effect changes in by-laws and district health policy. In addition, the second phase also expanded in geographical terms to Pamba Ward in Mwanza City and Isenye and Ring'wani in Serengeti District in the neighbouring Mara Region. Serengeti District was chosen because of an increased reporting of the prevalence of violence against women amongst the Kuria,

who compose the majority population in that District. Activities of this phase were evaluated and recommended for expansion to reach more health facilities and communities in Mwanza and Mara regions (Mshana, 2005).

2.3 Phase III of the Project (2006-2009)

Between April 2006 and March 2009, the project was funded by the Madrid Regional Government to expand its positive influence to 21 health facilities and 21 wards of Mwanza and Mara Regions. The direct beneficiaries were 123,991 women at reproductive age (15-49 years) who lived in the intervention area. Indirect beneficiaries were family members (approximately the number of women times 4.9), health personnel in 21 health facilities, Council Health Committees, local government and the general public. In this phase, JIJENGE worked with partners from District and Regional Administrative Committees, community leaders at ward level, Ministry of Health, Ministry of Community Development Gender and Children and other development partners.

The overall goal of the project was to reduce poverty by promoting quality reproductive health care for women and reinforcing institutional and community health care practices in the Lake Zone in Tanzania. Specifically, the project aimed to:

- Improve primary healthcare services in the eight districts of the Lake Victoria zone by the promotion of qualified personnel who provides quality, gender sensitive sexual and reproductive health services.
- Advocate and sponsor the creation of networks with other partners at community, district and national levels for promotion of women' sexual and reproductive health units and improve healthcare coverage in the district of Mwanza.

The project was designed to accomplish this goal by working through existing government structure and build capacity by awareness raising activities of SRH issues, gender and human rights for women to realize their rights to access quality SRH services and their role in the eradication of gender based violence.

2.3.1 Pre-Intervention Survey

Prior to commencement of the project intervention, a pre-intervention survey was conducted to measure pre-intervention levels of awareness of gender sensitive SRH services and women's rights when faced with domestic violence as well as levels of quality and knowledge amongst health service providers of the same issues. The project assessed this from community and clinic perspectives.

The specific objectives of the baseline survey were:

- To collect community and clinical data from primary and secondary beneficiaries based on the established magnitude of SRH services, gender based issues and rights violation problems in the selected wards.
- To assess the skills and knowledge of health service providers on SRH services such as Family Planning (FP) methods, STI case management, counselling, in relation to gender based violence and their role in the struggle to eradicate violence and promotion of human and reproductive rights.
- To assess district health team's capacity in effecting participatory planning processes and gender sensitive budget allocation especially on issues related to quality SRH services.
- To assess community's readiness to work on a voluntary basis versus sustainability issues.
- To highlight the challenges, threats and opportunities for implementing the project within the selected communities.

2.3.2 Findings from the Pre-Intervention Survey

The pre-intervention survey applied a triangulation of methods for data verification and consistency. Qualitative methods were used to understand the situation in depth whilst a quantitative tool was designed using the results from the initial qualitative work, to measure representativeness. Specifically, the research used participatory techniques (RPA), focus group discussions and in-depth interviews and finally a rigorous face-to-face questionnaire. Five research sites were purposively selected, ranging in geographical and socio-cultural characteristics to optimise levels of representation. These were Igombe Village, Bugogwa Ward, Mwanza City; Chigunga Village, Chigunga Ward, Geita District; Muda Village, Nyanguge Ward, Magu District; Kagunguli Village, Kagunguli Ward, Ukerewe District; and, Nyagasense Village, Kenyamonta Ward, Serengeti District.

There were a total of 28,870 people living in all sites in the study. Of these the research team managed to speak to a total of 800 community members and 55 service providers in 5 facilities. The research population was aged between 15 and 65 and included both men and women by a ratio of 3:7. The majority of the population were Sukuma whilst the Kuria comprised the majority of those interviewed in Nyagasense Village. In all wards the majority reported Catholics as their religion except Igombe where there were high numbers of Born-Again Christians (47.4% of respondents). Marital status reflected socio-cultural differences between wards. For example polygamy and female to female formal or informal marriage were reported to be more prevalent in Serengeti (14% and 7% of all marriage types respectively) than elsewhere. The majority of

households in all wards were headed by a father or husband although women heads of household were more common in Serengeti than elsewhere (31% compared to range of 9 to 17%).

Individual levels of inclusion within social networks and participation in community decision-making is likely to affect awareness of gender sensitive quality SRH services and women's rights. The majority of respondents reported participation in one or more community groups such as church based organisations, microfinance organisations, sports or dance groups and agricultural groups. But type of social group may also inversely affect perceptions of acceptability of certain cultural practices that infringe on an individual's human rights such as membership of a Traditional Birth Attendant group and association with female genital circumcision (FGM) in Serengeti.

Uptake of clinic services was variable between sites and dependent on both clinic and community based factors such as reputation of staff and behaviour towards clients, accessibility, and availability of particular services, equipment and medicines and the existence of private alternatives. Population based factors included socio-economic status, prevailing cultural norms, perceptions of aetiology and peer relations. Service providers felt that services were popular and regularly used by communities. Any under-usage was blamed on a lack of habituation to and awareness of new services such as was assumed to be the case with PMTCT services recently established in Nyagasense. Few providers felt that their own behaviour and attitudes contributed to the quality of services provided although many cited long working hours and insufficient training as contributing to reduced quality of service. They also felt that salaries were insufficient to compensate for excessive workloads.

Community perceptions of service provision were often contradictory to those held by providers. The majority of those questioned in the face to face questionnaires had attended their local services (n=470 of 509 or 92%). Only 39 of 509 people reported never having visited their local health centre, the majority were located in Bugogwa and Chigunga. Women use the services more frequently than men due to attendance for FP, antenatal and child health services. The majority of those who had ever visited did so in the previous 3 year period (2004-2006). Perceived quality was measured in terms of accessibility, waiting times, whether services were free or not, availability of medicines and perception of treatment success or failure. Waiting times ranged between 0 and 6 hours overall. In all sites except Kagunguli where waiting times were reported to be an hour, respondents most frequently reported waiting times to be 30 minutes. Thirty-five percent of users had paid for their treatment at the health centre, the majority in Nyagasense and the fewest in Nyanguge. Ten percent of users felt that they had not been cured by their visit to the health centre, the majority were based in Kagunguli.

Sexual and reproductive health services were available in every site. Counselling services were less common and in general there was no formalised system of counselling provided within clinics other than that entailed within family planning (FP) or voluntary counselling and testing (VCT) services. Whilst the majority of service providers claimed to provide services from FP to PMTCT, in reality the differentials in quality of service provision created large disparities between sites. Since the most attended services were found to be FP it is hardly surprising that the majority of attendees were female: nearly 5 times as many women reported to have attended their local health centre for counselling services than men. However, condom promotion is biased towards men so paradoxically, although women attend more regularly, they do not receive condom counselling. Confidentiality of counselling services in general was found to be important and stated satisfaction with service provision did not necessarily reflect feelings of control or an ability to ask questions. Rather assessments of quality were most frequently related to perceived efficacy of treatment. Given this approach to quality assessment it is not surprising that counselling services are less popular than other types of treatment.

Providers felt that they had sufficient knowledge of current service needs and that they provided competent and holistic health services. They did admit that there was a lack of training in counselling and that they would also benefit from further surgical and clinical training. Community perspectives differed in that even if an individual had suffered as a result of this lack of training; for example if s/he had been referred to a district provider due to insufficient skills at ward level, the majority still reported to be satisfied with the service they had received. A lack of alternative exposure is likely to have caused this reduced level of satisfaction amongst users.

Community-based norms and values are likely to impact on acceptance of social change and to influence decision-making in service uptake. Health centre improvements are likely to be ineffective if concomitant changes within the communities they serve are not achieved. There was found to be a low level of awareness of women's rights in all the communities in this study. Incidence of polygamous marriage, wife inheritance, practices such as FGM, rape and domestic violence provides evidence of the lack of awareness of women's rights within these communities. For example a total of 58 of 355 women reported having been circumcised. The majority of these, unsurprisngly, were based in Nyagasense (93.1%) and were Kurya (93.1%), although incidences were reported in Igombe and Kagunguli (3.5% respectively). The majority of those who had been circumcised reported to have been between 6 and 15 (56.9%) and most had been cut by their grandmother, although mothers and ngariba were also common. The presence of embedded

cultural values is demonstrated by the fact that the majority of those circumcised did so voluntarily (84.2%).

Official reporting mechanisms for incidences of rape and domestic violence were found to be insufficient and data was not available in some sites. Since rape has only recently (within the last 10 years) become criminalised, it is often not prioritised by officials, health centre staff or even the women themselves, many of whom remain silent and submit to such acts of violence. This situation is also reflected in incidents of domestic violence. Although official reporting channels do exist, the threat of banishment from the home and children causes many women to retract their statements if they have managed to report the incident to the police and obtain a PF3 form to present to the service provider for treatment. Without this form, they may not be treated by their local health centre. This often results in those women who are aware of their need for treatment reporting the incident whilst others either accept it or attempt to address it within the extended family or other tradition-based system. Of all respondents in the FFQ, 81.7% over all sites, reported that it was acceptable given certain circumstances. When asked under what these conditions were, respondents cited adultery (38.9%), abortion without informing their husband (19%) and staying out late with friends (18.1%). However many also stated that it was acceptable if the woman refused to have sex (17.1%) or if the husband was drunk (6.1%).

Communities were willing to work together to provide solutions to their problems but external support and intervention was also considered important. No groups questioned suggested that a change of attitudes was needed or felt that a reduction in domestic violence would improve living conditions. This evidences the need for awareness raising and structured initial support within all communities for the development of community-based counselling services.

2.3.3 Project Intervention Strategy

The aims of JIJENGE project was to sensitize and mobilize communities on gender and rights issues in relation to sexual and reproductive health, establish and train community groups by the use of community own resource persons, establish and strengthen community/health facility based information system, develop and implement an advocacy strategy to advocate for gender sensitive plans and budgets, production of advocacy materials and identify individuals, groups and institutions for networking and finally provide technical and management support to project activities.

This section presents the project intervention strategy and reviews the delivery of the intervention strategy. In this review, the section covers the implementation strategy at the community levels and district levels focusing on impact and sustainability elements.

2.3.3.1 Impact Component of the Community Strategy

To achieve the above, the JIJENGE project formulated at a community level strategy. The project used women's sexual and reproductive health and human rights as an entry point by working through the community structures to mobilize the community on gender, human rights and sexual and reproductive health issues through trained community owned resource persons (CORPs). These included Trainers of the Community groups, Community interest groups, Domestic Violence Watch group and Community based Counsellors. At the Community level, JIJENGE Project worked together with local community leadership in planning and the project provided feedback on the progress of the intervention through the Ward development Committees.

Trainers of the Community Groups

These groups were trained to train and supervise other community groups and to sustain project interventions at the community level. They were trained on sexual and reproductive health needs of women, community data collection and basic analysis of data collected, basic communication skills and materials development, development and strengthening of partnerships.

Community Interest Groups

In an effort to strengthen community structures and ownership of the change process, a group of leaders and influential community members were brought together and sensitized to take action. This group was intended to increase awareness and knowledge about violence against women and women's sexual and reproductive health rights. They were also trained to become more sensitive to women's rights in their leadership roles. Their training was focused on the basic rights of women and other vulnerable groups, identification of environment at the community levels that impact on the rights of women, awareness of a leadership role in the protection of women's rights and interpretation of community information system to influence community practice.

Domestic Violence Watch group

Members of the watch group are selected from the community to act as pressure group that influences practices at the community level. These recorded incidences of violence, educated and shared information with communities on effects of domestic violence. The group conducted their education sessions through public forums/meetings and also utilized the presence of weekly markets and clinic attendances (mostly in the rural area), while in the urban area the group used

video shows to serve the purpose. They also distribute health-learning materials such as posters and leaflets, were also responsible for the surveillance of violence events in their communities and maintenance of the community information system, which provided feedback to the community leadership on the magnitude of the problem and its effects to community health.

Community Based Counsellors

Counsellors were trained in order to establish a counselling support structure within the community to respond to the needs of affected people and victims of gender and rights violations. Counselling training was focused on basic counselling skills and referral of clients to health, social and legal services. The group was made up of people chosen by the community itself. They also take part in education sessions carried by the other groups in the community.

2.3.3.2 Impact Component of the Health Facility Strategy

At the health facility level the following activities were done as part of the implementation strategy that aimed to effect change.

Health Facility Renovations

Health facilities were renovated where necessary to allow more privacy and confidentiality and to make the health facility more friendly and client-centred (sufficient benches in the waiting places) and hence make the health service delivery system more accessible to women.

Training of the Health Service Providers

Health practitioners were trained on the concept of gender, and delivery of gender sensitive health services, basic counselling skills, SRH rights, Management of STIs and Management of Health information system at the facility level.

Training of Partners on the project activities

Quarterly planning and feedback meetings were held with Council Health Management Teams in the districts to assess and evaluate the progress of the project. These meetings were conducted to ensure comprehensive plan of activities that are geared towards improving quality gender sensitive reproductive health care at their respective districts. Through regular feedbacks, sufficient capacity was built for DMOs and ultimately DMOs were facilitating activities in their own districts. Reports collected during supervisory visits were presented and tabled during the planning session. Success, Weakness and challenges were discussed, and resolution made at the district level to improve the implementation of the project activities.

All districts visited had included project activities in the Council Health plans through basket-funding budget scheme. This include on-the-job trainings, gender sensitive health education sessions at the health facilities, inclusion of awareness raising meetings on gender issues during outreach activities and support for health service providers who underwent JIJENGE trainings among others.

The Council Health Management Teams (CHMTs) have conducted several public health meetings encouraging men to participate in SRH activities. In Geita District, bill boards have been mounted to emphasize that women, men and children should all take part in reproductive health educations.

2.3.3.3 Sustainability Component of the Strategy

To ensure continuity of the project intervention activities, the trained Community Owned Resource persons have formed Community Based Organisations that are committed to continue with project activities well beyond the project intervention period. At the district level, the council health management has incorporated the project activities by infusing the project concept and activities into the council comprehensive health plans and budget.

A multisectoral network was initiated by the JIJENGE project to build coalition on advocacy, gender and human rights issues. Through CBOs and CORPs, community bylaws against gender based violence and Village Human Rights Committees have been formed to support women's rights and gender equality. Gender based violence is discussed in the open and justice is sought without discrimination at the Village Human Rights Committees. These are supported with plans and activities done at the district level. For instance, CHMT are implementing gender sensitive health plans and more resources are mobilised and allocated for reproductive health. CHMTs have formed lobby groups to effect change in reproductive health policy at ministerial level by advocating for infusion of the JIJENGE concept in the in- service training for health service providers.

The project was implemented in 21 wards located in 8 districts in Mwanza and Mara Regions. The Districts in Mwanza Region and their Wards in brackets were Missungwi (Busongo and Nyahomango), Kwimba (Bupamwa and Mallya), Magu (Nyanguge, Nkungulu, Mkula), Ukerewe (Kagunguli, Nduruma, Ilangala), Sengerema (Kagunga, Katwe, Kazunzu), Geita (Chigunga, Nyarugusu, Busolwa) and Ilemela (Bugogwa and Igoma). The other district outside Mwanza Region was Serengeti in Mara Region (Kebanchebanche, Kenyamota, Machocwe).

2.3.4 Design Issues in the Baseline Survey

During the baseline survey, the sampling of the wards to take part in pre-intervention study was purposive (5 wards selected purposively out of 21 wards). This approach introduced shortcomings in the data that was collected as it compromised the representativeness and generalisability of findings. This had some methodological implications in the post-intervention evaluation. In the final survey, we visited the same communities to facilitate the pre- and post- intervention comparability.

In the baseline survey report, it was not clear what criterion was used to determine the sample size (n=500) in the community based survey. In the absence of this criterion and because of logistical and time issues, final survey had a sample size of 360 respondents. The decrease in the sample size was compensated by a triangulation of other data collection tools that are able to elicit information on the perception of how far the objectives and purpose of the project had been achieved over the three years. These tools also harnessed the stakeholders' recommendations on how to address the challenges encountered in the process of implementing the project.

CHAPTER THREE

PROGRESS TOWARDS OUTCOMES

This chapter presents the findings and opinions of the individuals interviewed in the post-intervention survey.

3.0 Demographic Characteristics of Respondents

Ten health facility workers were interviewed in the evaluation (6 trained by JIJENGE and 4 not trained). In Chigunga dispensary, we could not interview 2 health facility workers who had not received JIJENGE training as they were away on the day we visited the dispensary. The majority of the health workers lived in private or hired accommodation outside of their health facilities making it difficult for them to provide services outside of the normal working hours (between 1.30am and 3.30pm). The majority have worked in their health facility for many years hence being conducive for the training they had received as they are likely to apply their SRH training in their facilities for a long time before leaving (Table 2).

Table 2: Demographic Characteristics of Health Facility Workers Interviewed

No	Health facility	JIJENGE training	Cadre	Sex	Age	Village of residence	Period worked at HF	Period lived in the village
1.	Iramba	Yes	Midwife nurse	F	50 yrs	Nyagasense	23 yrs	50 yrs
2.	Iramba	Yes	Health officer (bwana afya)	M	55 yrs	Nyagasense	11 yrs	11 yrs
3.	Iramba	No	Midwife nurse	F	52 yrs	Nyagasense	15 yrs	15 yrs
4.	Iramba	No	Clinical officer	M	45 yrs	Nyagasense	4 months	4 months
5.	Karume	Yes	Public Health nurse B	F	57 yrs	Igombe	7 yrs	7 yrs
6.	Karume	Yes	Clinical officer	F	35 yrs	Igombe	4 yrs	4 yrs
7.	Karume	No	Nursing aide	F	41 yrs	Nyamwirorerwa	10 yrs	16 yrs
8.	Karume	No	Nursing aide	F	54 yrs	Igombe	9 yrs	9 yrs
9.	Chigunga	Yes	Nursing aide	F	40 yrs	Chigunga	9 yrs	9 yrs
10.	Chigunga	Yes	Clinical officer	M	52 yrs	Chigunga	15 yrs	15 yrs

A total of 374 community members [153 (41%) males, 221 (59%) females] took part in the face to face interviews of the post-intervention survey to assess the impact and sustainability of the intervention. Of the males, the percentage participating in the survey increased with increasing age group while for females the participation decreased with increasing age group. Table 3 below presents the population of each ward and numbers of people selected to participate in the post-intervention study.

Table 3. Demographic Composition of the Respondents by Ward and Sex

	Chingunga/Geita		**Kenyamonta / Serengeti**		**Bugogwa/Mwanza**		**Overall**	
	Male n=53 (%)	**Female n=72 (%)**	**Male n=50 (%)**	**Female n=72 (%)**	**Male n=50 (%)**	**Female n=77 (%)**	**Male n=153 (%)**	**Female n=221 (%)**
Age groups								
15-24	10 (18.9)	26 (36.1)	17 (34.0)	30 (41.7)	15 (30.0)	29 (37.7)	42(27.5)	85(38.5)
25-34	13 (24.5)	22 (30.6)	17 (34.0)	19 (26.4)	19 (38.0)	33 (42.9)	49(32.0)	74(33.5)
35-49	30 (56.6)	24 (33.3)	16 (32.0)	23 (31.9)	16 (32.06)	15 (19.5)	62(40.5)	62(28.0)
Tribe								
Mkurya	0 (-)	0 (-)	47 (94.0)	62 (86.1)	0 (-)	1 (1.30)	47 (30.7)	63 (28.8)
Msukuma	21 (39.6)	42 (60.0)	2 (4.0)	3 (4.2)	33 (66.0)	49 (63.6)	56 (36.6)	94 (42.9)
Other	32 (60.4)	28 (40.0)	1 (2.0)	7 (9.7)	17 (34.0)	27 (35.1)	50 (32.7)	62 (28.3)
Religion								
Christian	46 (86.8)	60 (83.3)	49 (98.0)	68 (94.4)	32 (64.0)	67 (87.0)	127 (83.0)	195 (88.2)
Moslems	2 (3.8)	3 (4.2)	0 (-)	2 (2.8)	13 (26.0)	9 (11.7)	15 (9.8)	14 (6.3)
No religion	5 (9.4)	9 (12.5)	1 (2.0)	2 (2.8)	5 (10.0)	1 (1.3)	11 (7.2)	12 (5.4)

The JIJENGE project intervention was implemented within a geographically and ethnically diverse environment. The major ethnic groups in the intervention areas were the Sukuma (37% males, 43% females) and Kurya (31% males, 43% females). However, for purposes of analysis, other smaller ethnic groups such as Kerewe, Jita, Nyamwezi, Jaluo, Sumbwa, Ha, Hangaza, Ngulimi, and Mzinza were grouped together as 'Other' (33% males, 28% females). Appreciating such a diversity of cultural norms in the project intervention areas is important because the ethnicity may have influenced perceptions and behaviour of men and women regarding women's rights and their access to SRH quality services. In all three Wards, the majority of the respondents interviewed were Christians. However, in Bugogwa Ward, 17% of the respondents interviewed were Moslems (26% males, 12% females).

Kenyamonta Ward (82% males, 79% females) had the highest proportion of respondents with above primary school education compared to Chinguga (71% males, 54% females) and Bugogwa Wards (74% males, 69% females). Systematically, more females dropped out of primary school

than males across the 3 Wards. However, reasons for this drop out were not collected though it is a general indication of the community attitudes towards education to young women. Kenyamonta Ward had the lowest proportion of females who did not complete primary education than Chingunga and Bugogwa. Table 4 presents the socio-economic factors among respondents in the post-intervention study by Ward and Sex.

Table 4. Socio-Economic Status of the Respondents by Ward and Sex

	Chingunga/Geita		Kenyamonta / Serengeti		Bugogwa/Mwanza		Overall	
	Male n=53 (%)	Female n=72 (%)	Male n=50 (%)	Female n=72 (%)	Male n=50 (%)	Female n=77 (%)	Male n=153 (%)	Female n=221 (%)
Education								
Incomplete Primary S.	15 (28.3)	33 (45.8)	9 (18.0)	15 (20.8)	13 (26.0)	24 (31.2)	37 (24.2)	72 (32.6)
Primary School	35 (66.0)	36 (50.0)	29 (58.0)	49 (68.1)	35 (70.0)	51 (66.2)	99 (64.7)	136 (61.5)
Above Primary School	3 (5.7)	3 (4.2)	12 (24.0)	8 (11.1)	2 (4.0)	2 (2.6)	17 (11.1)	13 (5.9)
Marriage Status								
Never Married	6 (11.3)	5 (6.9)	17 (34.0)	13 (18.1)	12 (24.0)	10 (13.0)	35 (22.9)	28 (12.7)
Formal male monogamous	38 (71.7)	49 (68.1)	27 (54.0)	28 (38.9)	36 (74.0)	38 (49.4)	101 (66.7)	115 (52.0)
Informal male monogamous	0 (-)	5 (6.9)	1 (2.0)	3 (4.2)	0 (-)	6 (7.8)	1 (0.7)	14 (6.3)
Polygamous	6 (11.3)	9 (12.5)	4 (8.0)	12 (16.7)	1 (2.0)	12 (15.6)	11 (7.2)	33 (14.9)
Widowed/Divorced	3 (5.7)	4 (5.6)	1 (2.0)	16 (22.2)	0 (-)	11 (14.3)	4 (2.6)	31 (14.0)
Occupation								
Farming	48 (90.6)	56 (77.8)	45 (90.0)	56 (77.8)	28 (56.0)	38 (49.4)	121 (79.1)	150 (67.9)
Private Salary	2 (3.8)	9 (12.5)	1 (2.0)	6 (8.3)	14 (30.0)	24 (31.2)	17 (11.8)	39 (17.7)
Others	3 (5.7)	7 (9.7)	4 (8.0)	10 (13.9)	7 (14.0)	15 (19.5)	14 (9.2)	32 (14.5)
Head of the Household								
Both Husband and Wife	5 (9.4)	11 (15.3)	1 (2.0)	2 (2.8)	4 (8.0)	3 (3.9)	10 (6.5)	16 (7.2)
Husband	42 (79.3)	54 (75.0)	35 (70.0)	43 (59.7)	32 (66.0)	56 (72.7)	109 (71.9)	153 (69.2)
Wife	0 (-)	2 (2.8)	1 (2.0)	15 (20.8)	0 (-)	10 (13.0)	1 (0.7)	27 (12.2)
Others	6 (11.3)	5 (6.9)	13 (26.0)	12 (16.7)	13 (26.0)	8 (10.4)	32 (20.9)	25 (11.3)

Unlike in the baseline survey where polygamy and female to female formal or informal marriage were reported to be more prevalent in Kenyamonta Ward, in the post-intervention evaluation, there was no reporting of female to female formal or informal marriage and there was no substantial difference in the reporting of neither informal male monogamous nor polygamous union. However, women in Kenyamonta Ward reported higher proportion of divorce or widowhood (22%) compared to Bugogwa Ward (14%) and Chigunga Ward (6%).

In Chigunga and Kenyamonta Wards, the overwhelming majority of all respondents were dependent on farming while in Bugogwa Ward farming and private salaries were the major sources

of income to the study households. Further, the majority of households in all wards were headed by the father/husband, although this majority was lower in Kenyamonta Wards (at 60%) than elsewhere. In Kenyamonta Wards, women heads of household were more prevalent than elsewhere at 21% compared to 3% in Chigunga Ward and 13% in Bugogwa Ward. Prevalence of households headed by 'Other' was greater in Serengeti and Ilemela District compared to Geita district. Compared to the baseline survey, 7% of the respondents interviewed reported that both husband and wife were joint household heads. This proportion was higher in Geita District (9% males, 15% females) which provides further evidence for the changes in the cultural attitudes regarding the status of women and awareness of women's rights in the intervention areas.

3.1 Social Networks

The majority of respondents reported participation in at least one of the following groups: a church based organisation or choir, village government, local security (sungusugu), village health, HIV, land or orphan committees, a microfinance organisation, *'ngoma'* dance groups, groups of Traditional Birth Attendants (TBA), women's self-help groups, a sports team or agricultural group. If a respondent was a member of any group, s/he was most likely to participate in a church-based (88 individuals), microfinance (59 individuals in all sites) or agricultural groups (67 individuals). Table 5 presents the membership in the social groups by Ward and Sex.

Table 5. Membership in Social Groups by Ward and Sex

	Chingunga/Geita		**Kenyamonta /Serenget**		**Bugogwa/Mwanza**		**Overall**	
	Male n=53 (%)	**Female n=72 (%)**	**Male n=50 (%)**	**Female n=72 (%)**	**Male n=50 (%)**	**Female n=77 (%)**	**Male n=153 (%)**	**Female n=221 (%)**
Membership in groups								
None	18 (34.0)	26 (36.1)	28 (56.0)	36 (50.0)	28 (56.0)	39 (50.7)	74 (48.4)	101 (45.7)
1	16 (30.2)	25 (34.7)	12 (24.0)	21 (29.2)	16 (32.0)	30 (39.0)	44 (28.8)	76 (34.4)
2-3	16 (30.2)	18 (25.0)	9 (18.0)	12 (16.7)	6 (12.0)	8 (10.4)	31 (20.3)	38 (17.2)
≥ 4	3 (5.7)	3 (4.2)	1 (2.0)	3 (4.2)	0 (-)	0 (-)	4 (2.6)	6 (2.7)

3.2 Service Provision

The service utilisation is dependent on provider and community factors. Provider factors include the type of clinic (Dispensary, Health Facility), the reputation of providers among community members, behaviour of providers towards patients, accessibility in terms of location, availability of medicines, services and equipment and availability of alternatives of medical care (traditional healers, private clinics, etc). Community factors include socio-economic status, prevailing cultural norms that affect treatment seeking behaviour and perceptions of aetiology, as well as peer relations.

Considering the year 2006 as the base year, data collected from the clinics shows that service utilisation all three villages increased in 2007 and increased further in 2008 compared to 2007. In Serengeti District, the general service utilisation increased by 13% from 2006 to 2007 and subsequently increased by 14% from 2007 60 2008. This pattern was observed in Ilemela District (21% in 2006-07, 28% in 2007-08) and Geita District (14% in 2006-07, 71% in 2007-08). This indicator may suggest that general service provision improved following the JIJENGE project intervention.

Few cases of SRH were reported in Serengeti Districts compared to cases reported in Geita and Ilemela District while there was a relatively a higher reporting of gender based violence in Serengeti compared to lemela and Geita Districts (Table 6). These issues were further investigated among clients of health facilities to shed more light on low reporting of SRH cases and higher reporting of GBV in Serengeti District.

Table 6. Health Facility Attendance by Year and Sex

	Kenyamonta (Iramba Health Centre) (2005)			**Igombe (Karume Health Centre)**			**Chigunga (Chigunga Dispensary)**		
	2006	**2007**	**2008**	**2006**	**2007**	**2008**	**2006**	**2007**	**2009**
General Attendance	5872	6633	7550	4980	6039	7702	3371	3857	6613
SRH Cases	62	34	12	237	141	426	205	230	114
No of GBV cases	9	32	15	7	15	9	-	13	5

Total number of clients at Chigunga Dispensary include only outpatients since the Dispensary does not provide in patient services although it does provide antenatal and delivery services.

3.2.1 Community Reports On General Service Provision

About 63% (47% males, 74% females) reported that they had visited the clinic in the last 12 months. Data from the FGDs supports this observation of women using health facility services more than men because of ante-natal, family planning (FP) and maternal and child health (MCH) programmes available at the site. Women in Geita District were more likely to visits the health facility, followed by women in Serengeti District than women in Ilemela District. The proportion of men who visited the facility was roughly similar in Chingunga and Nyagansense but much lower in Bugongwa Ward. The low proportion of men and women in Bugogwa Ward visiting the health facility may either be due to factors within the clinic or community.

Of those who had ever visited their local health facility (n=237), reasons for their visits were diverse and varied from diseases such as malaria, fever and child immunization. Of the 8 client exit interviews done, only one patient (Chigunga dispensary) had a problem related to sexual and reproductive health (vaginal itching and discharge).

Table 7. Patients' experiences and views on health services provided by health facilities

Health Facility	Sex	Time used to reach health facility	Waiting time before seeing doctor	Nature of service received	Opinion on services offered at health facility
Iramba Health Centre, Serengeti	Male	60 minutes	3 minutes	-Diagnosed with malaria -6 rings. Quinine injection. Said received good service and got all medicines prescribed.	-Good and quick services. -Proposed that the environment surrounding the clinic be cleaned such as the grass being cut.
	Female	120 minutes	30 minutes	-Diagnosed with malaria-28 rings and amoeba infection. Received quinine injection, amoeba drugs. Got all prescribed medicines free of charge.	-Had opinion that received good and appropriate service. -Recommended increase of health facility staff from the current 4 nurses and 1 clinical officer to 6 nurses and 3 clinical officers.
	Female	120 minutes	30 minutes	Brought child for treatment. Child diagnosed with malaria and given quinine injection and pain killers (paracetamol tablets).	-Had opinion that received good service. -Proposed that the clinical officer and nurse should spend more time in the children ward.
	Female	130 minutes	60 minutes	Brought sick child to hospital. Child diagnosed with malaria. Given quinine injection, Septrine and paracetamol. Got all medicines at health centre after waiting for 30 minutes	-Proposed Family planning services being offered to women coming to clinic -Proposed that blood transfusion services being offered at the clinic especially to women who come for delivery as most loose a lot of blood. The service should also be made available to children.
Karume Health Centre, Ilemela	Female	30 minutes	15 minutes	-Brought sick child to hospital. Child was vomiting, had diarrhoea and malaria and was given injection. Had to buy the rest of the prescribed drugs from elsewhere as they were not available at the health facility.	-Had opinion that service was not good as she had to buy all the medicines prescribed for her child.
	Male	30 minutes	5 minutes	-Diagnosed with malaria, abdominal pain and flu.	-Had opinion that service received was good.
	Male	30 minutes	120 minutes	-Had opinion that he received bad service because he waited for a long time and had to get tests done at a private laboratory outside of the health centre. Also bought all prescribed drugs from shop (costed 8,000/- shillings).	-Had opinion that the service he received was very bad. -Recommended that enough drugs should be brought at the health centre. -Also proposed that an ambulance should be brought to the health centre to help people who cannot afford to hire transport after being referred to a major hospital.
	Female	10 minutes	10 minutes	-Brought child who was diagnosed with malaria. Got some of the drugs from the health centre but had to buy other from shops.	-Only partially satisfied with service received as she did not get all prescribed drugs from health facility.
Chigunga dispensary, Geita	Female	60 minutes	120 minutes	-Brought child who was diagnosed with malaria. -Obtained all prescribed drugs from health facility.	-Satisfied by services offered. -Recommended that laboratory services being introduced at health facility. Recommended that electricity and water be made available at the health facility.
	Female	2 minutes	60 minutes	-Diagnosed with a chest infection and malaria. Obtained all the prescribed medicines at the health facility (aspirin, given a injection and malaria drugs).	-Satisfied by services offered.
	Female	4 minutes	60 minutes	-Respondent had come to attend ANC clinic as she was in her 9th month of pregnancy. Also has problem of vaginal itching and discharge. Was also diagnosed with malaria and high fever. Given malaria tablets and aspirin and advised to got to Geita hospital for delivery because that was her 5th pregnancy.	- Partially satisfied with service for malaria treatment. She was happy for not getting treatment for the vaginal itching and discharge. -Recommended that the number of health workers at the health facility be increased and houses built for them.
	Male	240 minutes (4 hours)	180 minutes (3 hours)	-He had severe fever, abdominal pain, and constipation. -He obtained all prescribed drugs from health facility.	-Was not satisfied with services as did not get laboratory investigation at health facility.

The majority of other exit interviews respondents (adults and children) were diagnosed with malaria. The patient who had a SRH related problem was not given any advice for it but was told that the nurse responsible was away. The clinical officer who attended her told her about VCT services available at the ANC clinic and she reported taking up the service.

Table 8. Providers' Factors affecting General Service Provision

	Chingunga/Geita		Kenyamonta /Serenget		Bugogwa/Mwanza		Overall	
	Male n=53 (%)	Female n=72 (%)	Male n=50 (%)	Female n=72 (%)	Male n=50 (%)	Female n=77 (%)	Male n=153 (%)	Female n=221 (%)
Visited the Health Facility in the last 12 months								
No	23 (43.4)	9 (12.5)	23 (46.0)	21 (29.2)	34 (68.0)	27 (35.1)	80 (52.3)	57 (25.8)
Yes	30 (56.6)	63 (87.5)	27 (54.0)	51 (70.8)	16 (32.0)	50 (64.9)	73 (47.7)	164 (74.2)
Reasons for Health Facility visits								
Malaria/fever	21 (39.6)	37 (51.4)	18 (36.0)	41 (56.9)	8 (16.0)	31 (40.3)	47 (30.7)	109 (49.3)
Stomach problems	5 (9.4)	21 (29.2)	3 (6.0)	22 (30.6)	8 (16.0)	26 (33.8)	26 (10.5)	69 (31.2)
Eye problems	1 (1.9)	2 (2.8)	2 (4.0)	4 (5.6)	0 (-)	7 (9.1)	3 (2.0)	13 (5.9)
Child immunization	4 (7.6)	20 (27.8)	0 (-)	24 (33.3)	0 (-)	26 (33.8)	4 (2.6)	70 (31.7)
Childcare advice	1 (1.9)	6 (8.3)	0 (-)	12 (16.7)	1 (2.0)	16 (20.8)	2 (1.3)	34 (15.4)
Vomiting & diarrhoea	5 (9.4)	18 (25.0)	0 (-)	13 (18.1)	1 (2.0)	12 (15.6)	6 (3.9)	43 (19.5)
FP advice	0 (-)	4 (5.6)	0 (-)	12 (16.7)	0 (-)	12 (15.6)	0 (-)	28 (12.7)
STI	5 (9.4)	8 (11.1)	5 (10.0)	8 (11.1)	2 (4.0)	9 (11.7)	12 (7.8)	25 (11.3)
Antenatal care	3 (5.7)	7 (9.7)	1 (2.0)	10 (13.9)	0 (-)	18 (23.4)	4 (2.6)	35 (15.8)
Other SRH issue	1 (1.9)	3 (4.2)	1 (2.0)	3 (4.2)	0 (-)	16 (20.8)	2 (1.3)	22 (10.0)
Other counselling	0 (-)	3 (4.2)	1 (2.0)	4 (5.6)	0 (-)	5 (6.5)	1 (0.7)	12 (5.4)
Other illness	0 (-)	2 (2.8)	3 (6.0)	5 (6.9)	0 (-)	6 (7.8)	3 (2.0)	13 (5.9)
Accompanying other	2 (3.8)	4 (5.6)	1 (2.0)	3 (4.2)	0 (-)	1 (1.30)	3 (2.0)	8 (3.6)
Nutritional advice	2 (3.8)	2 (2.8)	1 (2.0)	2 (2.8)	0 (-)	2 (2.60)	3 (2.0)	6 (2.7)
Other	2 (3.8)	9 (12.5)	3 (6.0)	8 (11.1)	2 (4.0)	3 (3.9)	7 (4.6)	20 (9.1)
Who provided the services?								
Doctor/Clinician	25 (47.2)	42 (58.3)	24 (48.0)	36 (50.0)	9 (18.0)	27 (35.1)	58 (37.9)	105 (47.5)
Nurse	7 (13.2)	30 (41.7)	5 (10.0)	33 (45.8)	7 (14.0)	44 (57.1)	19 (12.4)	107 (48.4)
Nursing Assistant	2 (3.8)	6 (8.3)	0 (-)	0 (-)	1 (2.0)	15 (19.5)	3 (2.0)	21 (9.5)
Others	0 (-)	0 (-)	0 (-)	0 (-)	1 (2.0)	0 (-)	1 (0.7)	0 (-)
Paid for Treatment								
No	13 (43.3)	42 (66.7)	12 (44.4)	26 (51.0)	6 (37.5)	24 (48.0)	31 (42.5)	92 (56.1)
Yes	17 (56.7)	21 (33.3)	15 (55.6)	25 (49.0)	10 (62.5)	26 (52.0)	42 (57.5)	72 (43.9)
Bought Medicine at the HF								
No	23 (76.7)	53 (84.1)	23 (85.2)	48 (94.1)	14 (87.5)	38 (76.0)	60 (82.2)	139 (84.8)
Yes	7 (23.3)	10 (15.9)	4 (14.8)	3 (5.9)	2 (12.5)	12 (24.0)	13 (17.8)	25 (15.2)
Felt Cured after Treatment								
No	5 (16.7)	12 (19.1)	6 (22.2)	13 (25.5)	2 (12.5)	10 (22.0)	13 (17.8)	35 (21.3)
Yes	25 (83.3)	51 (80.0)	21 (77.8)	38 (74.5)	14 (87.5)	40 (80.0)	60 (82.2)	129 (78.7)

A significant association was observed between marriage and service utilisation (χ^2 = 10.8, P=0.03). Services uptake was highest among respondents in polygamous union (73%) and least in the never married group (46%). However, a low proportion of males in the polygamous union reported to have been cured or satisfied with the services provided in the health facility.

A significant association was also observed between occupation and service utilisation among males (χ^2 = 7.7, P=0.03). Services uptake was lowest among males with other occupations (14%) compared to those in farming (50%) or private salaries (56%). This pattern was not observed among females.

Perceived quality was measured in terms of accessibility, waiting times, whether services were free or not, whether medicines were available at the clinic and if an individual felt s/he had improved as a result of the visit. On average patients took between a few minutes to some hours to reach their health facility. They reported being attended for between 5 to 30 minutes while in the consulting room (Table 7). Of those respondents in the face to face questionnaire (n=234) who knew or were able to estimate how long they waited to see the Doctor or Nurse the last time they attended their local health centre, the mean waiting time was 1 hour and 7 minutes (standard deviation was 70 minutes) with a range of between 0 and 5 hours. Waiting time was higher in Bugogwa Ward (83 Minutes) and lower in Kenyamonta Ward (52 minutes). Of those who visited the health facility, 38% of the males and 48% of the females were seen by Doctor while 12% of males and 48% of the females were seen by the Nurse. Regarding paying for treatment, 48.1% (58% males, 44% females) reported to have paid for treatment or medical advice in the last 12 months (Table 8). The proportion reporting to have paid for treatment or advice was higher in Bugogwa Ward in both male and females than in Kenyamonta and Chigunga Wards. The majority of the patients interviewed were satisfied with health services provided at their health facilities. At Karume Health Centre there were a few complaints from patients of not getting the prescribed drugs at the health facility which they had to buy from private shops. One respondent reported going for laboratory investigation at a private laboratory.

3.2.2 Individual Characteristics of Service Users

Service utilisations and perceptions of successful treatment were cross-tabulated with key socio-economic indicators to attempt to draw up a profile of those likely or not likely to use and appreciate the services (Table 9). Service utilisation tended to be lower among the Sukuma men (35.7%) compared to Kurya men (53.2%) and men from other tribes (56%).

Among females, service utilisation did not vary by tribes, the proportion reporting service utilisation ranged from 73%-74% in all tribes. A higher proportion of those who reported uptake of the services, reported improvement or cure and were satisfied with the advice or treatment offered.

Table 9. Characteristics of Health Facility Service Users

	Service Users		Of the Service users % Cured		Of the Service users % who found Advice Useful		Of the Service users % Satisfied with Treatment	
	M	F	M	F	M	F	M	F
Tribe								
Mkurya	25 (34.3)	47 (29.0)	19 (76.0)	33 (70.2)	22 (88.0)	40 (85.1)	21 (84.0)	41 (87.2)
Msukuma	20 (27.4)	70 (43.2)	18 (90.0)	61 (87.1)	18 (90.0)	60 (85.7)	16 (80.0)	60 (85.7)
Other	28 (38.4)	45 (27.8)	23 (82.1)	33 (73.3)	24 (85.7)	38 (84.4)	24 (85.7)	35 (77.8)
Religion								
Christian	62 (84.9)	147 (89.6)	52 (83.9)	118 (80.3)	55 (88.7)	126 (85.7)	51 (82.3)	127 (86.4)
Moslems	6 (8.2)	9 (5.5)	4 (66.7)	5 (55.6)	4 (66.7)	6 (66.7)	5 (83.3)	6 (66.7)
No religion	5 (6.9)	8 (4.9)	4 (80.0)	6 (75.0)	5 (100.0)	8 (100.0)	5 (100.0)	5 (62.5)
Education								
Incomplete Primary School	15 (20.6)	55 (33.5)	14 (93.3)	41 (74.6)	14 (93.3)	45 (81.8)	11 (73.3)	47 (85.5)
Primary School	48 (65.8)	99 (60.4)	38 (79.2)	80 (80.8)	41 (85.4)	86 (86.9)	41 (85.4)	82 (82.8)
Above Primary School	10 (13.7)	10 (6.1)	8 (80.0)	8 (80.0)	9 (90.0)	9 (90.0)	9 (90.0)	9 (90.0)
Marriage Status								
Never Married	11 (15.1)	18 (11.0)	8 (72.7)	13 (72.2)	9 (81.8)	16 (88.9)	8 (72.7)	14 (77.8)
Formal male monogamous	54 (74.0)	90 (54.9)	47 (87.0)	70 (77.8)	47 (87.0)	78 (86.7)	48 (88.9)	75 (83.3)
Informal male monogamous	0 (-)	9 (5.5)	0 (-)	7 (77.8)	0 (-)	7 (77.8)	0 (-)	9 (100.0)
Polygamous	7 (9.6)	25 (15.2)	4 (57.1)	21 (84.0)	7 (100.0)	21 (77.8)	4 (57.1)	22 (88.0)
Widowed/Divorced	1 (1.4)	22 (13.4)	1 (100.0)	18 (81.8)	1 (100.0)	18 (81.8)	1 (100.0)	18 (81.8)
Occupation								
Farming	61 (83.6)	116 (70.7)	50 (82.0)	92 (79.3)	55 (90.2)	96 (82.8)	52 (85.3)	96 (82.8)
Private Salary	10 (13.7)	26 (15.9)	8 (80.0)	19 (73.1)	7 (70.0)	23 (88.5)	8 (80.0)	22 (84.6)
Others	2 (2.7)	22 (13.4)	2 (100.0)	18 (81.8)	2 (100.0)	21 (95.5)	1 (50.0)	20 (90.9)
Head of the Household								
Both Husband and Wife	6 (8.2)	14 (8.5)	6 (100.0)	11 (78.6)	6 (100.0)	12 (85.7)	6 (100.0)	11 (78.6)
Husband	58 (79.5)	113 (68.9)	45 (77.6)	90 (79.7)	49 (84.5)	97 (85.8)	47 (81.0)	95 (84.1)
Wife	0 (-)	19 (11.6)	0 (-)	16 (84.2)	0 (-)	18 (94.7)	0 (-)	18 (94.7)
Others	9 (12.3)	18 (11.0)	9 (100.0)	12 (66.7)	9 (100.0)	13 (72.2)	8 (88.9)	14 (77.8)
Wards								
Chingunga	30 (41.1)	63 (38.4)	25 (83.3)	51 (81.0)	27 (90.0)	53 (84.1)	26 (86.7)	49 (77.8)
Kenyamonta	27 (37.0)	51 (31.1)	21 (77.8)	38 (74.5)	24 (88.9)	45 (88.2)	23 (85.2)	46 (90.2)
Bugogwa	16 (21.9)	50 (30.5)	14 (87.5)	40 (80.0)	13 (81.3)	42 (84.0)	12 (75.0)	43 (86.0)

Christians (65%) tended to report a higher uptake of the services compared to other religions (52% Moslems, 57% other). Christians also tended to report cure and satisfaction in the services offered. Among males, service utilisation tended to increase with increasing levels of education (41% for incomplete primary school, 49% for primary school leavers and 59% for those with above primary school education). However, this pattern was not observed among female study participants.

A significant association was also observed between the household headships and service utilisation (χ^2 = 8.9, P=0.03). Services uptake was highest among households headed by both husband and wife (77%) and lowest in households headed by others (47%).

3.2.3 Community Characteristics Affecting Service Uptake

Whilst individualised characteristics may affect the utilisation of medical service, community-based characteristics may also affect the community's likelihood to uptake medical services provided by the health facilities. There was a significant variation of medical service uptake in the health facilities among males (χ^2 = 7.4, P=0.02) and females (χ^2 = 10.5, P=0.05) across the Wards (Table 9 above). Males (32%) and females (65%) in Bugogwa Ward were less likely to utilise the health services provided at their health facility than males (54%) and females (71%) in Kenyamonta and Chigongwa ward (males 57%, females 88%). The provider-patient relationship, availability and perception of viable alternatives and specific association of cause with treatment are both likely to affect uptake of services. While, some negative perceptions of service quality in general existed, the majority 84% (84% males, 84% females) reported to be satisfied with the general services provided.

The next section will present evidence as to whether this level of satisfaction is reflected in specific SRH and counselling services and if attitudes towards gender-sensitive service provision are positive.

3.2.3.1 Accessibility of SRH and Counselling Services Provided

Sexual and reproductive health services were available in all sites. The perceived and actual levels of accessibility and quality varied between sites, both from the perspective of service providers and the communities they served. Overall, 45% of males (87% Chigunga, 28% Kenyamonta , 18% Bugogwa Wards) and 60% of females (79% Chigunga, 42% Kenyamonta , 53% Bugogwa Wards) reported that the village health facility was their first place of seeking counselling regarding all SRH issues while 67% of males (68% Chigunga, 72% Kenyamonta , 60% Bugogwa Wards) and 43% of females (47% Chigunga, 43% Kenyamonta , 38% Bugogwa Wards) reported that they would seek

counselling on SRH issues from the health facility after seeking counselling from relatives (Table 10).

When respondents required counselling on marital/domestic problems or family planning counselling in all three sites, male and females were more likely to seek counselling from relatives than from village health facilities. Overall, less than 10% of males and females sought counselling from the village health facility on marital or domestic problems while only 7% sought counselling from the village health facility on family planning issues.

Table 10. Accessibility of SRH and Counselling Services Provided

	Chingunga/Geita		Kenyamonta /Serenget		Bugogwa/Mwanza		Overall	
	Male n=53 (%)	Female n=72 (%)	Male n=50 (%)	Female n=72 (%)	Male n=50 (%)	Female n=77 (%)	Male n=153 (%)	Female n=221 (%)
First place to get SRH Counselling								
Husband/Wife	4 (7.6)	3 (4.2)	13 (26.0)	15 (20.8)	10 (20.0)	15 (19.5)	27 (17.7)	33 (14.9)
Relatives	3 (5.7)	12 (16.7)	23 (46.0)	27 (37.5)	31 (62.0)	21 (27.3)	57 (37.3)	60 (27.2)
Village Health facility	46 (86.8)	57 (79.2)	14 (28.0)	30 (41.7)	9 (18.0)	41 (53.3)	69 (45.1)	128 (57.9)
Second place to get SRH Counselling								
Husband/Wife	10 (18.9)	16 (22.2)	2 (4.0)	6 (8.3)	5 (10.0)	11 (14.3)	17 (11.1)	33 (14.9)
Relatives	7 (13.2)	20 (27.8)	11 (22.0)	31 (43.1)	15 (30.0)	36 (46.8)	33 (21.6)	87 (39.4)
Village Health facility	36 (67.9)	34 (47.2)	36 (72.0)	31 (43.1)	30 (60.0)	29 (37.7)	102 (66.7)	94 (42.5)
Traditional Healer	0 (-)	2 (2.8)	1 (2.0)	4 (5.6)	0 (-)	1 (1.30)	1 (0.7)	7 (3.2)
Marital problem Counselling								
Husband/Wife	5 (9.4)	3 (4.2)	2 (4.0)	6 (8.3)	4 (8.0)	6 (7.8)	11 (7.2)	15 (6.8)
Relatives	42 (79.3)	61 (84.7)	45 (90.0)	63 (87.5)	43 (86.0)	69 (89.6)	130 (85.0)	193 (87.3)
Village Health facility	6 (11.3)	8 (11.1)	3 (6.0)	3 (4.2)	3 (6.0)	2 (2.6)	12 (7.8)	13 (5.9)
Family Planning Counselling								
Husband/Wife	5 (9.4)	3 (4.2)	2 (4.0)	6 (8.3)	4 (8.0)	6 (7.8)	11 (7.2)	15 (6.8)
Relatives	42 (79.3)	61 (84.7)	45 (90.0)	63 (87.5)	43 (86.0)	69 (89.6)	130 (85.0)	193 (87.3)
Village Health facility	6 (11.3)	8 (11.1)	3 (6.0)	3 (4.2)	3 (6.0)	2 (2.6)	12 (7.8)	13 (5.9)

Whilst confidentiality is important for all types of patient presentations, this is vital in SRH diagnosis and treatment. Approximately 61% of the respondents in all sites reported counselling being done in a very confidential environment while 21% reported counselling being done in a fairly confidential environment (Table 11). Similar reports were echoed in the usefulness of the counselling services with 68% of the respondents reporting that counselling was very useful while 19% reported that the counselling sessions were fairly useful. Of these, the majority had received some type of SRH counselling at the health centre.

Levels of satisfaction the respondents received with counselling services did not correspond to the feelings of control or ability to ask questions. This suggests that levels of perceived quality may

reflect expectations of quality which are themselves grounded in service experiences, rather than objective assessment of actual quality. For example, if an individual has never been provided with an alternative type of quality or service, habituation may contribute to a lowering of expectations and satisfaction with lesser levels of quality than someone who had been exposed to alternative services.

Perceptions of quality may also be influenced by socio-demographic characteristics of the patients attending for SRH services. In general women who attended counselling services in the health facility were nearly 5 times as likely to have attended some type of counselling service, than men. Reasons for this have already been discussed above. Attendance for counselling services was found to be significantly associated with the following characteristics: marital status (P=0.03), household headship (P=0.03) and occupation (P=0.03).

Table 11. Quality of Counselling Services Provided

	Chingunga/Geita n= 93 (%)	Kenyamonta /Serenget n= 78 (%)	Bugogwa/Mwanza n=66 (%)	Over all N=237 (%)
Confidentiality of SRH Counselling				
Very confidential	57 (61.3)	49 (62.8)	39 (59.1)	145 (61.2)
Fairly confidential	18 (19.4)	16 (20.5)	15 (22.7)	49 (20.7)
Fairly unconfidential	10 (10.8)	9 (11.5)	6 (9.1)	25 (10.6)
Very unconfidential	8 (8.6)	4 (5.1)	6 (9.1)	18 (7.6)
Usefulness of SRH Counselling				
Very useful	60 (64.5)	52 (66.7)	48 (72.7)	160 (67.5)
Fairly useful	20 (21.5)	17 (21.8)	7 (10.6)	44 (18.6)
Fairly useless	9 (9.7)	8 (10.3)	10 (15.2)	27 (11.4)
Very useless	4 (4.3)	1 (1.3)	1 (1.5)	6 (2.5)
Ease of asking questions				
Very easy	34 (36.6)	37 (47.4)	24 (36.4)	95 (40.1)
Fairly easy	25 (26.9)	27 (34.6)	20 (30.3)	72 (30.4)
Fairly difficult	22 (23.7)	11 (14.1)	20 (30.3)	53 (22.4)
Very difficult	12 (12.9)	3 (3.9)	2 (3.0)	17 (7.2)
Feeling of control				
Lot of control	13 (14.0)	11 (14.1)	5 (7.6)	29 (12.2)
Average control	23 (24.7)	23 (29.5)	17 (25.8)	63 (26.6)
Little control	15 (16.1)	12 (15.4)	11 (16.7)	38 (16.0)
No control	42 (45.2)	32 (41.0)	33 (50.0)	107 (45.2)

Alternative possibilities for service access were related to an individual's financial capacities. The majority of participants felt that they were unable to afford to attend a private clinic and those who

could not afford the government health centre costs tended to visit traditional healers in the community for STI treatment and FP services such as abortion, practices which are common amongst the Sukuma and Kurya.

Frequency of visits to traditional healers is also affected by perceptions of availability of medicines and equipment. Evidence from FGD showed that if an individual is seeking rapid treatment they may fear to be wasting their time in attending the health centre first only to be told that there is no medicine and they will need to go elsewhere to purchase this. Since many people still believed that STIs were caused by witchcraft and could be dangerous for future pregnancies if not treated traditionally in some sites, some individuals continued to seek treatment from traditional healers in preference to government biomedicine.

3.2.3.2 Knowledge and Skills of Health Care Providers

It was not possible given time and budget limitations to test knowledge levels amongst service providers. However, during interviews with clinic staff, it was evident that medical staff ability to optimise the services they provided was dependent on levels of training and knowledge. From community perspectives, quality of service improved after JIJENGE project had provided training to clinic staff though the observed that equipment and regular medical supplies were the only shortfalls. Communities noted that clinic staff that had been trained had better attitudes to SRH clients compared to un-trained ones.

Provider perspectives on their own knowledge and skills

Generally, Clinic staff in all sites felt that they provided competent health services, ensured confidentiality and were able to provide on-site diagnosis and specimen testing for diagnosis of diseases. Health services providers reported to be skilled in all types of counselling ranging from Family Planning, ANC, domestic and marital counselling. However, results from community survey showed that there was a low uptake of domestic and marital counselling done by health service providers. This low uptake of domestic and marital counselling at the clinic level was because of long waiting times the respondents had to wait to be attended due to increased patients being attended by health facility service providers. To address these, in the communities were seeking domestic and marital counselling from the Community Owned Resource Persons (CORPS). A good example was the Village Human Rights Committee in Chigunga Village in Geita District that addressed all domestic and marital issues and has resolved several gender based violence at the community level.

Community perspectives on provider knowledge and skills

In general communities felt that providers were in possession of sufficient levels of knowledge and there was no evidence that any individual had refused to visit their local health centre due to fears of lack of knowledge. Unlike in the baseline survey, when the communities were not satisfied with service provider skills, 84% of the respondents reported being satisfied with advice and treatment provided. Data from Client Exit Interviews suggests that pregnant women expressed a decrease in bribe and abusive languages in the labour wards, ANC and RCH clinics.

Gender-sensitivity of service provision

As pointed out before, data from FGDs showed that JIJENGE is closely related with family planning services at the health facilities. Family planning services available are pills, injections and condoms. Participants said that couples are more likely to obtain advice on family planning from the health facilities because they believe that the health workers will keep the information confidential. Consulting family members or friends is reportedly done with reluctance because people are afraid that such people cannot keep such information confidential.

The majority of FP service users in all sites were female, but women could not use FP methods prior to their husbands approving such usage. The idea that only women attend FP, ANC and MCH clinics is embedded within culture and both communities and service providers had opinions that these services should only target women. However, most women reported that usage of FP methods prior to consulting the husband may either lead to the wife being beaten or even marital dissolution.

More females (58%) than males (45%) reported that they would seek treatment or advice from the government health facility as their first place for counselling if they had SRH problems and 18% of males and 15% of females also responded that they would seek advice from their spouses if they had SRH problems as their first place to get counselling. These percentages were lower in Bugogwa and Kenyamonta Wards which shows a lower utilization of these due the cultural reasons and presence of alternative cares like traditional healers and private clinics.

Treatment of sexually transmitted infections such as gonorrhoea was also reportedly better in the health facilities though one facility was reported to have severe shortage of drugs. FGD participants reported that they are given useful education and advice of SRH issues and family planning at their health facilities.

Though it is important to understand the specific social context within which a particular clinic is located in order to understand the needs of the community concerned and to ensure that the projects activities are culturally appropriate. Data suggests demand creation and promotion of gender sensitive activities in the communities has had an impact in increasing the general uptake of the services provided by the health facilities even in areas like Kenyamonta where there are strong cultural beliefs against women's rights.

3.2.3.3 Community Knowledge of Rights and Gender Sensitive SRH

In order to understand social context within which health services are provided in the JIJENGE project areas, this section reviews the community-based norms and values that are likely to influence decision-making with regard to health centre attendance as well as uptake and perceptions of services provided. Health centre based improvements are likely to be ineffective without associated changes and awareness rising in the communities they serve.

General awareness of women's rights in the community

Compared to the baseline survey, there is an increasing level of awareness of women's rights within all communities visited in the survey. In three years, the proportion of household headed jointly by husband and wives has increased from 1% to 7%. It unlikely that women's rights were raised in response to questions asked and the responses were therefore affected by reporting bias. Though this is a possibility, there are several CBOs that have been formed following the activities of JIJENGE project. For instance, in Geita District two CBOs are operating in Chingunga Ward in collaboration with CORPS. Further evidence is provided with the fall of incidence of polygamous marriages and frequency of domestic violence occurrences.

Polygamous marriage

Overall, 221/374 (14.9%) of the women respondents were in polygamous marriages. The prevalence of polygamous marriage was roughly similar between sites, (12.0% Chigunga, 13.1% Kenyamonta , and 10.2% Bugogwa). Geographical disparity was also reflected in ethnicity of those most frequently married polygamously, who were the Sukuma (10.0% of respondents) and the Kuria (11.8%) and other tribes (14.3%). Level of education was not associated with polygamous marriage though the prevalence of polygamy decreased as level of education increased (13.8% among the primary school incomplete, 11.5% among the primary school leavers and 6.7% among those with above primary school education). Polygamous marriage was not associated with type of occupation

Female Genital Mutilation (FGM)

Overall, 40 of 221 women (18.1%) reported that they had been circumcised (Table 12). Of these, only 3/40 (7.5%) underwent the FGM practice in the last 3 years, the period which JIJENGE interventions were implemented. The majority of women who reported to have been circumcised were from Kenyamonta, Serengeti (97.5%). However, the practise was also reported in Chigunga (n=1 or 2.5%). Of those who reported to have been circumcised in Kenyamonta, the major ethnic group was Kurya (97.4%). Kurya are the only ethnic group in the JIJENGE intervention area that practice FGM. Nearly half of the women in Serengeti had been circumcised 39/74 (54.2%).

Table 12. Female Genital Mutilation

Question	Responses	Frequency (% of all circumcised women)
Who performed the circumcision?	Mother	7 (17.5)
	Grandmother	7 (17.5)
	Other female relative	1 (2.5)
	Ngariba	25 (62.5)
What age were you?	Under 10 years	12 (30.0)
	11-17 years	28 (70.0)
Did you volunteer to be circumcised?	Yes	28 (70.0)
	No	12 (30.0)

The majority of circumcisions were reported to have been performed by Ngariba (62.5%). The oldest age at which circumcision had been performed was 17 and the youngest age was 5 years. Nearly 70% of those who were circumcised volunteered to undergo the procedure. Of those who volunteered, 82.1% were circumcised while in the age range 11-17 years and of those who were forced 58.3% were aged 10 years or less. This association between volunteering for FGM and age of the initiates was significant (χ^2=6.6, P=0.01). This suggests a period of social pressure during which a girl is introduced to FGM and the benefits it would imply in terms of marriage eligibility.

Domestic Violence

Overall 73% of the respondents reported that a man has the right to beat his wife (Kenyamonta 76%, Igombe 73% and Chigunga 69%). Reasons for acceptability of domestic violence were further explored in the face to face questionnaire and in FGDs. Wife beating was one indicator that has not changed since the pre-intervention survey. Several reasons for wife beating were mentioned by respondents. Adultery and abortion without informing the husband were two commonly cited reasons for wife beating in all three communities. Some of the reasons cited by respondents as sufficient basis for beating a woman are impossible for a woman to avoid such as a

husband's drunkenness. In general women felt that if the man was drunk, this was not a sufficient reason to beat his wife.

These findings were supported by data collected from the domestic violence watch groups in the three wards visited. These data showed that the main incidents of violations of women's rights recorded were wife beatings, widows being denied inheritance of family property after the passing away of their spouses and abandonment by husbands. In one example a woman was not allowed to keep cattle after the death of her husband. Common documented reasons for wife beating were accusation of adultery by their husbands, alcohol and drug abuse by their husbands, not returning home early from an errand, and using family possessions without the authorization of her husband. For example one woman was reportedly severely beaten for slaughtering a goat without the consent of her husband (Table 13). Unlike in the baseline survey when women were frequently told to go away, women reported that if they attended their local health centre after being beaten by their husband, they would be frequently counselled and advised to contact CORPS for further counselling.

Table 13. Reported belief in wife beating and where to resolve the conflict

Does a man have the right to beat his wife?	**Chigunga n (%)**	**Kenyamonta n (%)**	**Igombe n (%)**	**Over all n (%)**
Yes	86 (68.8)	93 (76.2)	93 (73.3)	272 (72.7)
No	38 (30.4)	27 (22.1)	34 (26.8)	99 (26.5)
Don't know	1 (0.8)	2 (1.6)	0 (-)	3 (0.8)
Reasons for wife beating				
Abortion without informing husband	67 (53.6)	87 (71.3)	81 (63.8)	235 (62.8)
FP without informing husband	64 (51.2)	67 (54.9)	69 (54.3)	200 (53.5)
No food in house	32 (25.6)	42 (34.4)	42 (33.1)	116 (31.0)
House dirty	46 (36.8)	56 (45.9)	44 (34.7)	146 (39.0)
Adultery	72 (57.6)	85 (69.7)	80 (63.0)	237 (63.4)
Staying out late with friends	49 (39.2)	64 (52.5)	51 (40.2)	164 (43.9)
Refusal to have sex	51 (40.8)	50 (41.0)	57 (44.9)	158 (42.3)
Husband drunk	13 (10.4)	22 (18.0)	25 (19.7)	60 (16.0)
Other Reasons	8 (6.4)	2 (1.6)	16 (12.6)	26 (7.0)
Where to Seek help if beaten by husband				
Resolve with Husband	24 (19.2)	13 (10.7)	22 (17.3)	59 (15.8)
Brother/Sister	47 (37.6)	61 (50.0)	59 (46.5)	167 (44.7)
CORPs	86 (68.8)	89 (73.0)	108 (85.0)	283 (75.7)
Other Relatives/Friends	66 (52.8)	91 (74.6)	83 (65.4)	83 (65.4)
Sub-village leader	76 (60.8)	83 (68.0)	66 (52.0)	225 (60.2)
POLICE	59 (47.2)	74 (60.7)	67 (52.8)	200 (53.5)
Health Facility	38 (30.4)	49 (40.2)	54 (42.5)	141 (37.7)
Traditional Healer	1 (0.8)	6 (4.9)	10 (7.9)	17 (4.6)

*N.B. Other reasons for beating wives were: taking the husbands' property without prior permission and coming home late and drunk.

The severity of domestic beating was also reported to be on the decline. Incidences of cutting wives using long and sharp knives have not been reported in the intervention areas during the post-intervention period like in the baseline survey. The social embeddedness and generalised acceptability of domestic violence makes this a difficult behaviour to change in the intervention communities. Special emphasis has to be put on interventions that are addressing this behaviour.

Table 14. Cases of violence and mistreatment against women reported

Year	District	Ward, village	Cases of GBV	Action taken
2008	Serengeti	Kenyamonta ward, Nyagasense village.	-**4** cases of women beatings.	-2 cases resolved at village office by the village executive officer (VEO). -2 cases taken to police station for action. The accused ran away and are still on the wanted list.
			-**1** case of a window land taken over by force.	-Accused taken to office of the Ward executive officer (WEO) for action.
			-**1** case of a woman denied inheritance of cattle.	-Case taken to primary court for action.
			-**1** case of a woman denied inheritance rights.	-Clan arbitrated the case and decided to give the woman compensation of 16 cows and Tshs 80,000/-.
			-**1** case of a woman's property being taken by force.	-Case reported at police station, accused ran away and is in the wanted list.
2007	Geita	Chigunga ward, Chigunga village.	-**6** cases of women beatings.	-3 cases attended by *Jijenge* counsellors. -2 cases were refered to their in-laws for arbitration. -1 case refered to the VEO for arbitration.
			-**5** cases of husbands abandoning their families (1 got married to another woman, 1 left wife because of old age, 1 abandoned wife for 3 years, 1 abandoned wife for 7 years).	-4 cases were attended by *Jijenge* village counsellors. 1 man had promised to go back to his family after counselling but has not yet complied. 1 case was forwarded by the counsellor to the in-laws of the man for further action. -1 case was referred to the WEO for arbitration.
			-1 case of a woman denied inheritance of property after a long illness.	-Case reported to village government for arbitration.
			-1 case of girl forced to marry someone they did not prefer at the age of 18.	- Case was referred to the WEO for arbitration.
2008	Geita	Chigunga ward, Chigunga village.	-2 case of woman denied inheritance of property.	- 1 case was referred to the WEO for arbitration. -1 case referred to relatives for arbitration.
			-1 case of woman mistreated by in-laws because she was barren.	-Case referred to her parents for discussion.
			-1 case of woman abandoned by husband for another woman.	-Case attended by JIJENGE counsellor.
			-1 case of rape and beating.	-Case referred to VEO, the man was apprehended and case arbitrated at village office.
2007	Ilemela (former Mwanza Urban)	Bugogwa ward, Igombe village.	-1 case of a student married.	-Case attended by JIJENGE counsellor. Husband advised to leave the student so that she continues with her studies. Husband adhered to advice and the student is now back to school.
			-1 case of woman chased away from home by husband.	-Case taken to the ward arbitration council. Later husband took wife back after advice on council.
2008	Ilemela (former Mwanza Urban)	Bugogwa ward, Igombe village.	-1 case of wife beating.	-Case referred to police and later victim taken to health centre for treatment. The WEO and JIJENGE counsellor were also involved in the process. The husband ran away after committing the offence.
			-1 case of woman chased away from her home by in-laws after her husband passed away.	-Case attended by JIJENGE counsellor and woman advised to go to court to claim her rights. She adhered to the advice and the case is currently being pursued through the court.

Most respondents interviewed suggested that women should seek help from the Community Owned Resources Persons (CORPs) or from brothers/sisters and other relatives or friends if they are beaten with their husbands (Table 14). Other common places/people most likely to resolve the dispute between husbands and wives were sub-village leaders, POLICE and health facilities. Only a small proportion suggested they would resolve it between husband and wife. Unlike in the baseline survey where women stated that in most circumstances they do not take the incident further but would rather try to soothe their wounds at home, in the post-intervention survey, most women suggested they sought help from CORPs.

If disputes cannot be reconciled within the nuclear family unit then the woman may turn to relatives or CORPs for counselling and negotiation. If this continues to be ineffective, then the woman may take the dispute to the Sub-village chairman to resolve the dispute. If still unresolved, sub-village Chairman will write a letter to refer her to the police station to pursue a case or PF3 form to complete (if the woman is hurt) and take with her to the health centre in order to ensure treatment. This form also enables her to pursue a case against her husband if she wishes. In the male FGDs, some participants 'complained' that their wives have now become 'difficult' because they know that if they are mistreated by their husbands they would get support of the JIJENGE community counsellors to pursue their cases further through the official channels. They also said that because of the women awareness campaigns conducted by JIJENGE, KIVULINI and TULEANE their wives feel that it is now easy to get divorce and get a share of family property.

3.2.4 Physical Improvement of Health Facilities

The three health visited were overall in a good condition ensuring that patients received treatment in comfort and confidentiality. The evaluation team spent an average of six hours (from morning to noon) conducting the observations at the health facilities. The observations were done systematically by one member of the evaluation team using the structured observation guide. In general, the services offered at the three health facilities were good. For example, the language used by health workers was noted to be polite and health workers offered help when asked by patients and accompanying relatives. It was noted that women generally get good service at the health facilities especially when they come for MCH or delivery services. In two health facilities some staff were not in official uniform. They later told the observer that they were not in uniform as they had not received new ones from their respective councils. The ones they had are worn-out and in bad condition hence they preferred wearing their private clothes instead. The observations made at the health facilities visited are summarised in the Table 15.

Newly built extension at KARUME Health Centre in Bugogwa Ward

Table 15: Physical condition and nature of service offered at 3 health facilities

Health Facility	Rooms with doors	Rooms with ceiling boards	Where patients seat after arriving at facility	Where patients seat while waiting to see doctor	All health workers in uniform?	Average waiting time before seeing doctor	Average waiting time before obtaining prescribed medication
Iramba Health Centre, Serengeti	-All	-All	-Concrete slabs built in the waiting area.	-Concrete slabs built in the waiting area.	-Yes	-15 to 30 minutes	-15 to 30 minutes
Karume Health Centre, Ilemela	-All	-All	-Wooden benches in the waiting area.	-Wooden benches in the waiting area	-No, only some. Health workers say they have not received uniforms from the city council.	-30 to 60 minutes	-Less than 15 minutes
Chigunga dispensary, Geita	-All	-All	-Wooden benches in the waiting area.	-Wooden benches in the waiting area	-All nurses in uniform -Clinical officer not in uniform	-15 to 30 minutes	-Less than 15 minutes

Some participants of the FGDs said that they know some of the renovation work at their health facility was done by the JIJENGE project. Participants said they became aware of JIJENGE activities after they were invited to mobilisation campaigns in their villages or ward.

Participants of FGDs suggested that the project should consider delivering drugs at their health facilities to address shortages. They also proposed that the project built staff houses at the health facilities to facilitate the increase of the number of health workers. They also said that this would make health workers readily available for helping patients even beyond official working hours.

3.2.5 Capacity of the Districts Health Teams to Sustains Project Activities

Project beneficiaries of the JIJENGE project with other project partners in collaboration with Civil Society Organisations and Local Governments have partnered together to make sure that the project activities are sustainable. In Geita District, the District Council is now providing training to other Health Clinic Staff and to the general community on women's and SRH rights. Women groups (CBOs) are now being financed through the partnerships of JIJENGE and District Councils.

FGDs participants reported that JIJENGE project has facilitated the formation of women groups in their villages. In fact, two members of on female FGD are members of the group in their village. Apart from providing moral and psychological support on gender issues amongst members and other villagers, the groups have become avenues for economic support amongst the women themselves. For example it was reported that some groups have started a system of each member contributing 2,000/- each week which is then used to support members of the groups to set up income generating activities.

CHAPTER FOUR

FACTORS AFFECTING PROGRESS

4.1 Introduction

Gender refers to those characteristics of women and men that are socially constructed, while **sex** refers to those that are biologically determined. Girls and boys who grow into women and men are influenced by society in developing their masculine and feminine gender identities. As a result, women and men may be valued differently and thereby have unequal opportunities and life chances. Because of biological (sex) and social (gender) differences, women and men experience different health risks, engage in different health seeking behaviour, and usually receive different responses from health systems, resulting in less than optimal health outcomes. As power is distributed unequally in most societies, women typically have less access to and control over health information, care and services, and resources to protect their health. However, gender norms also affect men's health. This occurs by assigning them roles that promote risk-taking behaviour and cause them to neglect their health, and also that of their partners and children.

4.2 Progress towards Key outcomes and Progress Indicators

Gender inequalities exist in all societies and gender inequality related health problems exist in almost all diseases, but they are clearly most important in Sexual and Reproductive Health. This section discusses the Progress towards Key Outcomes and Impact indicators.

4.2.1 Change in Communities' Knowledge Regarding Women's Rights

During the baseline survey, female to female formal or informal marriage were common in Kenyamonta Ward, in this evaluation, there was no reporting of female to female formal or informal marriage in Kenyamonta Ward though there was no substantial difference in the reporting of polygamous union. It is unlikely that in 3 year's time, female to females marriages would have been abandoned in the Community however this indicator suggests that the community is aware that this impinges the women's human rights and have therefore changed their reporting. Evidence from the FGDs suggests that this cultural behaviour is on the decline and men and women are more aware of human rights issues.

Compared to the baseline survey, the proportion reporting that both husband and wife were joint household heads has increased marginally which provides further evidence of increasing in knowledge regarding the status of women and awareness of women's rights in the intervention areas.

Though a high proportion of males interviewed in face to face interviews said that they could engage in domestic violence, they have become wary of the fact that women are now conscious of their rights and have readily available support from JIJENGE community counsellors and other partners to pursue their cases through the legal system. This example demonstrates the change of attitude towards domestic violence on the part of men as they are unsure if they will go unpunished in the event they choose to engage in such behaviour. Hence the promotion of human rights issues and examples of women who have successfully pursued their rights (such as property inheritance rights) is an indication of the changes of the gender relations landscape in project areas.

4.2.2 Increase in Health Facility Service Uptake

The health facility service uptake increased by 54% from 2006 to 2008 compared to 30% planned in the JIJENGE project implementation documents. The proportion increase was higher in females compared to males. Data from health facility does not give the statistics separately for men and women, however, in the community survey, more women reported visiting the government clinics compared to men. With an exception of Kenyamonta Ward which had an increase of 29% in Health facility service uptake, Igogwa Ward (55% increase) and Chinguga Ward (96% increase) surpassed the target. The reporting of SRH cases decreased overtime in Kenyamonta Ward while the pattern was mixed in Chigunga (increasing gently in 2007 and decreasing sharply in 2008) and in Igogwa Wards (decreasing gently in 2007 and rising sharply in 2008). Likewise, an increasing case reporting of GBV was seen in 2007 compared to 2006 and a decrease was observed in 2008 compared to 2007. Data from FGDs suggests of a decreasing incidence of gender based violence and decreasing of the severity of the GBV cases.

4.2.3 Increase in the Quality of Health Facility Service Provided

Quality was measured in terms whether services were accessible, free, provided in confidential environment, providers were friendly, whether medicines were available at the clinic and if an individual felt her/his situation had improved as a result of the visit. All services provided to adults (> 5 years) were paid for as required by the Government Policy, 2000 TShs was charged as a consultation fee while all services provided to children, elderly and pregnant women were not paid

for. Women (56%) were less likely to report having paid for treatment while males (58%) were more likely to report that they have paid for treatment. In most cases, medicine was not provided at the clinic, but was bought from private pharmacies for use at the clinic. For these reasons, several people reported to have sought treatment and advice from private clinics. Of those who attended the government health facilities, 80% felt the services were either fairly confidential to highly confidential, 80% reported that they felt cured or their situation had improved and 86% felt that the advice or treatment provided was fairly or very useful.

Generally, communities were positive about the quality of services provided to them by the Health service providers. However, an individual's perceptions of quality service provision, ability to critique services provided and ability to assert his/her own rights within the constraints of his/her particular social and socio-economic circumstances is likely to be affected by his/her social position which in turn is likely to be influenced by factors such as level of education, occupation, marital status and access to alternatives clinics. We analysed these factors by service utilisation. Service uptake was highest among respondents in polygamous union and least in the never married group. Due to low uptake of health facility services among the never married group, young unmarried people were less likely to attend to family-planning clinics where they could gain information about condoms and other contraceptives than married people. The young women may face stigmatization if they are seen entering such facilities because of speculations about their "morality," while young men may be discouraged from attending them at all because of provider attitudes that contraception is "women's business." District Councils and Health facilities must ensure that persons of both sexes are welcomed. This may necessitate extra measures to attract young people. It is also possible for rural health clinics to offer special attendance hours for men for services such as family-planning where discussion on domestic violence, HIV/STIs, sexual problems and other gender issues could be discussed.

In the communities visited, expectations about gender dictated that young men had a lot of experience on sexual matters before marriage but little information on family planning issues while women had limited sex education and received lot information on contraceptives and other family planning issues through health facility or relatives' counselling. This leaves men with no sense of responsibility due to lack of information on issues such as contraception, risks of early pregnancy and unsafe abortion. Projects addressing gender issues like JIJENGE need therefore to ensure participation of young people in their project activities. Greater efforts are needed to enable and encourage young women and men to participate in designing, implementing and evaluating SRH services in their communities so that they become truly gender sensitive. One way to achieve this

is to ensure that at least some young women are represented in committees that guide projects and networks.

Services uptake was lowest among males with other occupations (14%) compared to those in farming (50%) or private salaries (56%). This pattern was not observed among females. This shows that service utilisation is affected by not only gender, but also with class and other social stratifications, resulting in unequal benefits among various social groups of women and men as well as between women and men. A gender sensitive approach recognizes that women and men differ in terms of both sex and gender. Such an approach has the potential to define appropriate interventions for men and women accordingly. By bringing attention to gender inequalities, the JIJENGE project has encouraged more effective and gender sensitive SRH counselling and treatment, implying that men and women of all ages have been reached, involved in, and benefited from resources and training conducted by JIJENGE project to prevent and control domestic violence and provision of gender sensitive SRH services. This is commendable because gender is not only a women's issue. Women cannot achieve gender equality by themselves. Men need to be involved if gender equality is to be achieved and health programs including SRH services are to succeed. JIJENGE project needs to reach more men and women who are vulnerable and not accessing the gender sensitive services provided by heath facilities. The project need to ask questions such as: Who does or uses what? How and why?, in relation to men and women. By so doing, gender inequalities are expected to be more systematically addressed, ensuring improved access to all.

Males and females in Bugogwa Ward were less likely to utilise the health services than males and females in Kenyamonta and Chigunga Wards. The provider-patient relationship, availability and perception of viable alternatives and specific association of cause with treatment are all likely to affect uptake of services. While, some negative perceptions of service quality in general existed, the majority (84%) reported to be satisfied with the general services provided.

4.2.4 Domestic Violence

There are strong reasons for JIJENGE to strengthen linkages between gender, domestic violence and sexual and reproductive health when addressing the needs of sexually active men and women. The vulnerable groups are the same, and gender issues are affected by the same causes including sexual violence and inequitable gender relations. Sexual and reproductive health care represents an opportunity to expand care for women and address domestic violence. Similarly, interventions

addressing domestic violence provided a potential platform for sexual and reproductive health care, such as prevention of sexually transmitted infections and family planning to be discussed.

To address domestic violence and deliver gender sensitive SRH services, JIJENGE project developed a gender sensitive approach. Data on the prevalence of domestic violence collected by the domestic violence watch group was a starting point for understanding and responding to these issues. The project realized that addressing gender issues is not something that can be left to 'the Domestic Violence Watch Group' alone, it must be integrated not only in all community activities by but also in all phases of program activities to ensure an effective response. Gender issues are embedded and affected by socio-economic activities and poverty, cultural norms and values. In a participatory way, the communities with support from the **JIJENGE** project established Community Interest Groups and Community Counsellors to raise awareness of the women's rights and promote demand for gender sensitive SRH services at the same time building the capacity of health practitioners to deliver gender sensitive SRH services to women. These interventions are supported by District Councils, Wards Development Committees and other Government structures.

Despite a well designed intervention and fewer cases of gender based violence documented between 2006 and 2008, several factors for wife beating were still mentioned and the proportions reporting that they would beat their wives for these reasons were still unacceptably high. While both women and men need information and education on all aspects of SRH and domestic violence, JIJENGE project need to ensure that extra emphasis is given to the information that can have the greatest impact on reducing women's vulnerability to domestic violence and SRH problems. For example, provision of education regarding men's alcohol and substance abuse and other wife beating factors is very important.

4.3 Challenges Towards Key Outcomes and Progress Indicators

Despite the fact that JIJENGE has made a significant progress in tackling domestic violence and in the provision of quality gender sensitive SRH services, there is little progress in attitude change regarding wife beatings and other socio-cultural norms affecting women's welfare. These challenges could broadly be classified into three namely; Coordination of the Project Activities, Human Resources, Partnership Strategy challenges.

4.3.1 Coordination of the Project Activities,

At the local government level, JIJENGE project activities are supported by the District Council at the District Level, Wards Development Committees at the Ward level and Village Development Committee at the Village level. These Committees meets regularly to plan and review the progress

of the interventions. The project is implementing the interventions through the Community Groups such as CBOs and CORPS and through the Health facility. A focal person is needed at the Ward and District level to coordinate the efforts of all these groups, to make sure that all intervention activities are networked, and to avoid scattered interventions that are ineffective in bringing about the desired change. The focal person position should be inline with the existing Government structure. Such person could be the Community Development Officer at the Ward or District level and will translate meetings' resolution into actions, will ensure best practices are exchanged between communities, CBOs and districts.

Most health service providers trained by JIJENGE project were from the government health facilities. Private-sector involvement in the project activities would expand the impact of the interventions achieved by the project.

JIJENGE developed the Community Information System to collect the data at the community level to help and support decision making at the community and district levels. It was noted that there is inconsistent record keeping of GBV cases at the village and ward levels. We obtained GBV records for 2007 and 2008 in three wards visited as there was little data for 2006. In order to be able to monitor closely trends of GBV in the community, it is important to ensure that data collection and use by the community based monitoring groups is strengthened. In addition, there is little evidence in the review of the utilization of the data across all sectors in the district level. There is need to make sure that the information collected filters into the district level to provide participatory planning and coordination and sharing of responsibilities across sectors at the district level.

At community level, JIJENGE project has established several formal and informal community-based organizations (CBOs). These are making a substantial contribution in tackling domestic violence or empowering women economically, particularly where they have access to technical and financial resources through JIJENGE or other partners. Without a coordinated effort, most of their efforts and challenges may not be captured; therefore, their challenges may not be addressed. Better integration into community and district plans are additional challenges which these CBOs may face and may need to be addressed to enhance coverage and progress towards outcomes.

4.3.2 Declining Number of Health Service Provider

The health sector which manages a substantial part of the JIJENGE Project in providing the gender sensitive SRH services which includes domestic and marital counseling, family planning and STI Counseling is reported to have a serious shortage of human resources. At the national level, the

health workforce, for example, is reported to have been declining over the years by 28% from 67,600 in 1994/95 to 48,500 in 2001/02 and by further 10% to 43,650 in 2005/06[1]. In 2002, the key cadre of health care workers including nurses, clinical officers, and laboratory technicians was reported to be at 50% or less of the agreed staffing norms in 1999[2] although the level was slightly above 60% among the doctors. Although, efforts have been made in recruiting and training health care workers, but this area still remains a major challenge in the future. It is for this reason that JIJENGE project should mainstream the project activities to involve all sectors including health at the district level.

It should be acknowledge that structural issues embedded within the healthcare delivery system are bound to affect any intervention delivered through it. As already pointed out, staff shortages, shortages of drugs and unmotivated workers may have an effect in the quality of the intervention delivered through public health facilities. These issues may also affect the perceptions of the community on the services provided by the project through the healthcare system. Hence in the future the project could consider involving the private sector or mainstream the intervention across the district council sectors and activities (e.g. the approach used in HIV/AIDS campaigns).

4.3.3 Partnership Strategy

There is no clear partnership strategy developed by JIJENGE Project for the various partners engaged in the JIJENGE intervention areas and there is no over-arching framework to guide various strands of support from JIJENGE. The type of partnership adopted was that of joint working based on the various informal agreements and demand responsive approach. Subsequent engagements can be improved with clearly developed strategy and framework for operations that will be useful in measuring success in the utilisation of resources and management of initiatives.

Practice seems to show that JIJENGE is guided by the broad principles of collaboration with other projects or organisations that are like-minded e.g. KIVULINI in areas where they both operate. The vision for reducing poverty through provision of gender sensitive SRH services and addressing domestic violence is the basis for entering into strategic partnerships at different levels. The first one already referred to above is partnership with other organisations operating in the intervention areas. JIJENGE also organises quarterly planning and feedback meetings with Council Health Management Teams in the districts to assess and evaluate the progress of the project. This

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[1] NMSF Human and Financial Assessment Report. AM Kireria & D Ngowi. TACAIDS. March 2007.

[2] Wyss, K. (2004), Human Resources for Health Development for Scaling up ARVs in Tanzania. WHO/Swiss Tropical Institute

experiment has raised interest in looking at alternative funding channels targeting CBOs and other community groups in the event that JIJENGE project funds are either inadequate or after the completion of the project. These partnership strategies have been effective as channels for mobilising resources and for allowing relationships between JIJENGE project, CHMTs and CBOs to exist. But these varied relationships have not really created avenues for sharing of experiences and expertise in responding to domestic violence and provision of gender sensitive SRH services.

CHAPTER FIVE

CONCLUSION, LESSONS LEARNT AND RECOMMENDATIONS

This chapter draws together the conclusions from the *JIJENGE!* project evaluation and puts forward some recommendations. This chapter has been structured to follow the evaluation objectives as reflected in the terms of reference of this report.

5.1. Conclusion

The evaluation of *JIJENGE!* Intervention Project conducted between 2006 and 2009 have revealed that *JIJENGE!* efforts in tackling the domestic violence and provision of gender sensitive SRH is very evident in contributing to poverty alleviation. *JIJENGE!* project support through CHMT and community training, planning and progress feedback meetings to CHMT have contributed to strengthening of technical and institutional capacities for the implementation of project intervention activities.

5.1.1 Progress towards outcomes

Available data from various sources revealed some progress in tackling the domestic violence and provision of high quality gender sensitive SRH services during the review period. Available statistics also revealed that there is progress especially in the areas of knowledge of women's rights by both service providers and the communities, formation of Community Owned Resources Persons (CORPS) and other Human Rights Committees. In addition, the CHMT and communities' perceptions are very positive as regards the contributions of *JIJENGE!* in addressing domestic violence and provision of quality SRH services to the communities.

There are many areas in which the *JIJENGE!* project has made impressive progress. The project succeeded in outing in place the Domestic Violence Watch Group with a Community Information system during this period even though there are still challenges. There have been considerable achievements in increasing knowledge on domestic violence, access to SRH services and provision of gender sensitive SRH services in the intervention areas. More women are using SRH services and are benefiting from community initiated care. In the area of training to health facility service providers, *JIJENGE!* has shown an impressive progress; despite that the health facilities are challenged with human resources and some of these have been transferred, the health facilities were still able to provide gender sensitive, confidential and satisfactory to the communities. Other

areas of progress include the creation of Community Based Organisation that are involved in income-generating activities for women and lobbying for policy and practice change at the national and regional levels, renovation of health facilities, and establishment of partnerships to discuss project plans and progress of the interventions.

5.1.2 Key *JIJENGE!* Contributions

JIJENGE! has developed a workable intervention strategy at both the Community and Districts levels. The project has used women's sexual and reproductive health and human rights as an entry point by working through the community structures to mobilize the community on gender, human rights and sexual and reproductive health issues through trained community owned resource persons (CORPs). These included Trainers of the Community groups, Community interest groups, Domestic Violence Watch group and Community based Counsellors. At the Community level, JIJENGE Project worked together with local community leadership in planning and the project provided feedback on the progress of the intervention through the Ward development Committees.

These multiple channels of support in the community have contributed to key outputs which include development of by-laws at the community level, creation of lobby groups for policy and strategy change within the health facilities at the national level, capacity building of stakeholders for the development and management of SRH, improvements in knowledge and behaviour towards human rights, and possible reduction of STI and HIV prevalence in the intervention areas which ultimately leads to reduced poverty levels.

5.1.3 Factors Affecting Progress Towards Outcomes

Although there were some supporting and hindering factors identified to have influenced the achievement of the key outcomes, these factors were analysed and documented in the report. In chapter four of the report, the key challenges are categorized into three namely; **Coordination of the project activities, Human Resources for Health, Partnership Strategy.** These factors must be considered and addressed in subsequent engagement in order to contribute strategically and effectively to the achievement of key outcomes in the intervention areas. In addition, is the issue of connectivity of the supported interventions which was found to be limited must also be addressed to enhance opportunity of learning from one another and sharing of best practices that will also enhance the impact of the various interventions and their coverage.

5.2. Issues and Lessons

This evaluation of JIJENGE's interventions to selected Districts in Mwanza and Mara Regions has come up with a key number of interesting issues concerning how JIJENGE chooses to interact with

local community and local community leadership and other non-government organisations and how much the interventions activities should be coordinated especially in guiding future engagement.

5.2.1 JIJENGE's Visible Contributions

JIJENGE's most visible contributions were in tackling the domestic violence and provision of gender sensitive SRH services. Looking at the different phases of JIJENGE's support, it seems like the most important parts have been where it has focused efforts on training representatives of the communities. These have formed community structure to address domestic violence at the community level, for instance the formation of Community Human Rights Committee in Chigunga Ward that's acceptable to both men and women and monitors human rights of neglected, poor, vulnerable and disadvantaged.

JIJENGE's efforts in training the health service providers are negated by a number of factors. In the health facilities visited, only half of the service providers were trained, and some of these have been transferred to other health facilities and most communities argued that the government health facilities do not provide medication; they only provide disease diagnosis and referrals. Owing to this factor, some people visited the private clinics as an alternative care when sick. The service providers in the private clinics were not trained on the provision of gender sensitive SRH services.

5.2.2 Can JIJENGE make a difference in gender mainstreaming to sectors?

The JIJENGE project is collaborating with the District Council through the Council Health Management Teams. To increase the capacity of Districts in supporting and implementing gender based violence and provision of gender sensitive SRH services, JIJENGE project should advocate for gender mainstreaming to all sectors and activities that are supported and implemented by the District councils.

The exclusion of HIV/AIDS as one of the key thematic areas that JIJENGE should engage in subsequently is a concern considering the fact that JIJENGE supports and empowers women and women are adversely affected by HIV/AIDS. Nevertheless, this is seen as an opportunity for JIJENGE to emphasise not only gender mainstreaming but also HIV/AIDS mainstreaming and use the available partnership with District Councils to achieve key results.

5.2.3 Engagement with Partners and the need for Gender Issues Focal Person

JIJENGE has been very active in influencing practices and action at the District level and lobbying for policy changes at the national level with regard to gender issues. Mainstreaming Gender and HIV/AIDS across all sectors supported and implemented by the District Councils would need gender issues focal person at the District level. This person will be responsible to translate, support and coordinate the District efforts in addressing gender issues and in supporting the communities that are implementing the gender sensitive interventions. In Geita District, the evaluators met with an officer coordinating AMREF interventions within school in the districts.

For gender and HIV mainstreaming to be effective, there is need for effective policy to influence an efficient implementation of a true multi-sectoral response. Policy influencing comes from the seat at the table and not really the size of budget or programme, but the 'number of voices' in the forums. Lack of focal person on gender issues within the District Council Management will definitely create a vacuum in this regard and could have negative implications to the translation of project efforts at the community level considering that the project aims to address an issue (women's rights) that has been accepted culturally as harmless.

5.3.4 Issue of Partnership

JIJENGE is valued as a partner by the district council, health facilities and community leadership and groups and individuals within the Communities for their interventions that address gender issues. These partners assessed JIJENGE project very positively for having shared objectives, having had no serious disagreements and by JIJENGE not imposing in terms of areas of where interventions should be implemented. But partnership is seen as a way of working rather than a strategy to achieve objectives. The JIJENGE project does not have a strategy to choose partners and develop partnerships. JIJENGE project could develop partnerships with other like-minded organisation like KIVULINI to add voices for lobbying on policy change in the health facilities across the Region and in Tanzania. Such a partnership will therefore need a partnership strategy to guide who JIJENGE will partner with and to achieve what objectives.

5.3.5 Issue of Coordination

JIJENGE has trained Community Owned Resource Persons that includes Domestic Violence Watch Group, Trainers of the Community groups, Community interest groups, and Community based Counsellors. At the Community level, JIJENGE Project has worked together with local community leadership in planning and feedback on the progress of the intervention through the Ward development Committees. JIJENGE project has developed the community information system which provides feedback to the community leadership on the magnitude of the problem. What has

not worked well is the coordination of the activities of these groups at the community level to ensure a well coordinated response to tackle gender based violence and provision of gender sensitive SRH services (a for actors and implementers at the community level to meet and discuss the challenges and progress made, unlike the WARDs meeting that has several agenda on the meeting). This point reinforces the argument that the Community Development Officers at the Ward, District, and Regional Levels to act as focal persons to effectively coordinate the efforts of all these actors.

5.3 Recommendations

The following are the key recommendations arising from the evaluation:

5.3.1 Continuity of the Current Implementation Strategy:

JIJENGE should continue with the current implementation strategy since this has been preferred by the Districts and Communities leadership, and by groups and individuals in the communities. These groups underpin the intervention activities and are in line with Government of Tanzania policy of utilising existing structures to implement project activities. The implementation strategy has also been effective in achieving the project objectives.

5.3.2 Support provision of technical assistance to Gender mainstreaming in key sectors:

There is need for JIJENGE to engage with other partners to ensure provision of technical assistance for effective gender and HIV/AIDS mainstreaming across all sectors and activities implemented and supported by the District Council for an increased impact on provision of gender based interventions and addressing gender based violence.

5.3.3 Address limited connectivity of interventions

The connections of activities supported by JIJENGE at community level must continue with emphasis on implementation of the recommendations and plans arising from the activities for connectivity of interventions. A forum should be created where the stakeholders (actors and implementing partners) involved are able to plan collectively and interact with one another to share lessons and best practices towards the achievement of key behaviour outcomes. This strategy will enhance effective utilisation and coverage of interventions.

5.3.4 Engagement with Local government and Communities on Gender Issues

JIJENGE should continue to engage with the CHMT and consider engaging the Community Development Officers at the District and Ward levels as the gender issues focal persons to engage

with the key stakeholders, identify gaps and coordinate the actors involved in gender based activities. This will ensure connectedness of responses and networking of activities. Most importantly is engagement with other partners at the district, Regional or national levels in the area of policy engagement to enhance voice and expansion of best practices that will impact positively on women's rights.

JIJENGE should consider using the media such as radio and television as a way of reaching more people in their areas of work. Some of the community members reported in the FGDs and KIs that some people in their villages are not aware of JIJENGE activities because they do not attend public meetings and campaigns organised through the project.

5.3.5 JIJENGE to work with other partners to address weak M & E system

JIJENGE should provide technical assistance to local governments and communities (community based GBV monitoring groups) to address the weak community information systems. The quality of the data collected by gender based violence watch group was not optimal. This might be due to lack of technical capacity to systematically collect, store and utilise the information. The community information system is a decision making tool at the community level but should also be availed at the district level to support planning and progress review at the district. JIJENGE should work with other partners in this regard as this will add significant value in ascertaining the status of progress and identifying gaps for subsequent interventions.

5.3.6 Development of Partnership Strategies and Framework for Operations

Clear partnership strategies should be developed with respective partners spelling out the goals of the programme, expected outputs, rationale for the partnership with full consideration to managerial and technical inputs. The strategy should also include the partnership principles and such principles should be adopted for the development of indicative framework to guide measuring of success in the utilisation of resources, management of projects and initiatives. Such strategies should be considered for adoption at all levels and channels utilising JIJENGE resources for gender based interventions.

5.3.7 Strengthening of Community Based Organization

JIJENGE support could make a difference in strengthening the networks of Community Based Organisations in order to enhance their representation in community decision making bodies and voices in policy influencing and be actively involved in decisions that will enhance their participation in addressing gender issues. The CBOs need to be supported to share experiences and exchange

best practices (what works well and what doesn't work well) especially in income generating activities as part of the poverty alleviation and empowering women.

5.3.8 Expansion of Project activities in the District

JIJENGE project provides support to only 21 Wards out of more than 100 Wards in Mara and Mwanza Regions. The Project should consider expanding the interventions to all Wards in these Regions by partnering with District Councils. Communities will benefit more from a combination of community and clinical component since raising community awareness on sexual and reproductive health, gender and rights elevates demand for quality SRH service delivery.

Annexes

Annex 1 Evaluation framework

Evaluation Questions	Detailed Questions	Indicators	Source of Information	Proposed Analysis
1. Assess the project key outcomes *vis à vis* set benchmarks from the baseline surveys at health facilities and district levels.				
1.1 Assess the level of project success in fulfilling the set benchmarks from the baseline surveys at health facilities and district levels.	1.1.1 What has been achieved in each of the key thematic areas?	Findings in relation to the indicators stated below disaggregated on rural/urban basis: <u>OUTCOME INDICATORS</u> -% of women aged 15-49 in the study area who have benefited from JIJENGE! project.**(target by end of project)** -% of women who have been trained on gender equality and human rights. - % of health facility workers who have been trained on gender equality and human rights. - % of members of the council health management team who have been trained on gender equality and human rights. <u>IMPACT INDICATORS</u> -Changes in the institutional and community health care practices (**target by end of project**). **-** Contribution of the project to poverty alleviation **(target end of project).**	- Progress reports - Review reports - Surveys conducted - Data from other secondary sources	Desk reviews to determine the extent at which the project has contributed to the progress made, or the achievement of the key outcomes/Impacts.
	1.1.2 Where and how does the JIJENGE! Project make a difference in the • Provision of primary health care services at the health facility, • Council health management teams, • Community leadership.		- Consultations & interviews with stakeholders using process planning framework, timelines, objectives & Impact Diagrams, etc.	Analysis of information obtained from desk reviews, FGDs and interviews conducted with partners to enable us elicit information to assess extent of progress made with the project support.
	1.1.3 Are the JIJENGE! project activities visible in contributing to these outcomes? (probe for explanation and attribution from other programmes)		- Review of reports - Consultation & interviews with stakeholders and partners. - Force field analysis. - SWOT analysis.	
	1.1.4 What is the assessment of coverage of the project? What is the coverage of population groups targeted?			
2. Assess the mechanisms established for advocacy & lobbying for promotion of women's health, sexual rights at community, district and national levels				
2.1 Identify the mechanisms established for advocacy and lobbying at • Community level • District level • National level		Mechanism for advocacy and lobbying identified.	- Review of existing report of surveys -Consultation with stakeholders (Forcefield analysis, KII & FGDs)	Findings from review, reports and surveys conducted.

Evaluation Questions	Detailed Questions	Indicators	Source of Information	Proposed Analysis
2.2 Identify the factors that has substantially influenced the advocacy and lobbying both positively and negatively	What factors that substantially influence the achievement of these mechanisms?	- Factors and drivers of change identified. - Gender related factors identified. - Human rights and related legal issues identified. - Effects of the factors on outcomes and impacts.	- Review of reports - Consultation with stakeholders (KII & FGDs) - Forcefield analysis	Analysis of findings from review of relevant reports and consultation with stakeholders
2.3 Assess the extent to which these factors have influenced the advocacy and lobbying	How do the factors influence the advocacy and lobbying of the project?			
2.4 Assess roles of various actors at the national, district, and community levels in advocacy and lobbying achievement of the key outcomes.	2.4.1 What roles do these actors play in advocacy and lobbying success? 2.4.2 How do they function to impact positively or negatively? 2.4.3 What resources do they have to function? 2.4.4 How connected are the activities of these actors with the JIJENGE! project contributing to the achievement of outcome and impact indicators?	- Roles played by actors identified. - Resources available and used identified. - Functions of the actors identified - Connectivity of activities of actors with JIJENGE! project identified.	- Review of reports - Consultation with stakeholders (KII & FGDs).	Analysis of findings from consultation and review reports would enable us to synthesise roles played by the actors, resources utilised for the purpose and how they functioned.
3. Assess the level of council and management engagement for sustaining the project initiatives.				
3.1 Identify the council and management contributions to the key outcomes	3.1.1 What are the key areas that the council has supported the project?	- Key supports identified by Stakeholders and beneficiaries	- Consultation with stakeholders and conduct FGDs and key informant interviews. - Review study reports, reports of surveillance. - Review of previous monitoring and progress reports.	Analysis of consultations, interviews and desk reviews to enable us determine extent of Council and management engagement for sustaining the project activities.
3.2 Determine the extent of the outputs in achieving the outcomes	3.2.1 How do the council and management support impacts on the achievement of the outcomes?	- Evidence of contribution to outcomes - Evidence of progress made in achieving the outcomes		
3.3. Assess the extent of coherence and connectedness of various Activities of the Council in supporting the project activities	3.3.1 To what extent do the various activities of the Council support and contribute to the achievement of key outcomes? 3.3.2 How do the outputs from the various Activities of	- Evidence of contribution of support to the outcomes. - Evidence of complimentarity of the various support and contributions to key outcomes.		

Evaluation Questions	Detailed Questions	Indicators	Source of Information	Proposed Analysis
	support compliment each other and contribute to the achievement of the key project outcomes and impact indicators?			
3.4 Explore stakeholders perception of these contributions	3.4.1 What are the stakeholders' perceptions of the Council contributions to the Project activities?	- Evidence of stakeholders satisfaction of the Council and management engagement. - Evidence of the Council and management engagement to the sustainability of the project		
4. EXTRACT LESSONS, FINDINGS & RECOMMENDATIONS TO ENHANCE EFFECTIVENESS OF THE JIJENGE! PROJECT ACTIVITIES				
4.1 Extract lessons learnt from the consultation process and documents to be reviewed	4.1.1 What lessons have been learnt from the review?	- Consultation with stakeholders and conduct FGDs and key informant interviews. - Review study and progress reports - Evidence of best practices in: ➢ Design ➢ Planning ➢ Implementation ➢ Monitoring ➢ Evaluation and ➢ Documentation.	- Desk review of project and activity reports - Project and sites visits - Consultation with Stakeholders (KII & FGDs).	Analysis of data on lessons learnt and best practices would enable us to come up with key recommendations that would provide strategic guidance towards implementation of the project.
	4.1.2 Are there experiences to be shared on ways of improving subsequent engagement?			
	4.1.3 Are there best practices that stakeholders feel have contributed to the indicators that subsequent engagement should build on?			

Annex 2 Community FFQ (Male & Female)

Instructions to Interviewer: *Ask the questions in the order they appear and as they appear on the questionnaire. Read out the introductory sentences to each section as they appear on the page. If the informant does not understand the question, repeat whilst reading out the possible responses.*

Interviewers code |__|__|

Date: |__|__|. |__|__|. |__|__|__|__|

IDNO: |___|. |___|___|. |___|___|___|.|___|___|

First, I am going to ask you some questions about yourself. Please try to respond as honestly as you can.

Q1	**How old are you?** ***Write age in full years***	|___|___|
Q2	**What's your tribe? _____**	
Q3	**What is your religion?** 1=Christian; 2=Moslem; 3=Other religion (including traditional); 4=No religion;	|___|
Q4	**What is the highest education level you have attained?** 1=None; 2=Adult Education only; 3=Primary Incomplete; 4= Completed primary school STD 7; 5=Drop out Ordinary Secondary school; 6=Completed Secondary School Form 4 and Above; 7=Other studies;	|___|
Q5	**What is your marital status?** 1=Never married; 2=Formally Married (Monogamous, male husband); 3=Formally Married (Monogamous, female husband – *Nyumba ntobhu*); 4=Informally Married (Monogamous, male husband - *kutoroshwa*); 5=Informally Married (Monogamous, female husband – *Nyumba ntobhu*); 6= Polygamous marriage; 7=Separated / Divorced / Wido wed;	|___|
Q6	**Who is the head of the household in which you live?** 1= Both husband & wife; 2=Husband; 3=Wife; 4=Maternal Uncle/Aunt; 5= Paternal Uncle/Aunt; 6= Grandparents; 7=Sibling; 8=Child; 9= Others; 9= DK ***Specify if 'other': ……***	|___|
Q7	**What type of work does the main form of income come from?** 1=Agriculture; 2=Private Salary; 3=Cattle; 4=Fishing; 5= Government Salary; 6=Day labour; 7=Small Business; 8=Other; ***Specify if 'other': ……***	|___|

Q8 **Are you a member of any of the following community groups?**

Faith based organisation including church choirs	1=Yes; 2=No;	|____|
Village Government	1=Yes; 2=No;	|____|
Sungusungu	1=Yes; 2=No;	|____|
Village health committee	1=Yes; 2=No;	|____|
Village HIV/AIDS committee	1=Yes; 2=No;	|____|
Microfinance organisation	1=Yes; 2=No;	|____|
Sports team	1=Yes; 2=No;	|____|
Agricultural group	1=Yes; 2=No;	|____|
Other	1=Yes; 2=No;	

Specify if 'other': ……

Section 2: Treatment Experiences

Now, I am going to ask you some questions about your experiences at your local government health facility. This information will not be given to the health facility but will be used to try to understand what gaps there are currently in services provided by your local health facility. Again, please try to respond as honestly as you can.

Q9 **Have you visited your local health facility for any reason in the last 12 months?** |____|

1=Yes; 2=No;

Q10 **What was the reason for your last visit to the health facility?**

Malaria/fever	1=Yes; 2=No;	|____|
Stomach problems	1=Yes; 2=No;	|____|
Eye problems	1=Yes; 2=No;	|____|
Child Immunization	1=Yes; 2=No;	|____|
Childcare advice	1=Yes; 2=No;	|____|
Vomiting & diarrhoea	1=Yes; 2=No;	|____|
FP advice	1=Yes; 2=No;	|____|
STI	1=Yes; 2=No;	|____|
Antenatal care	1=Yes; 2=No;	|____|
Other SRH issue	1=Yes; 2=No;	|____|
Other counselling	1=Yes; 2=No;	|____|
Other illness	1=Yes; 2=No;	|____|
Accompanying other	1=Yes; 2=No;	|____|
Nutritional advice	1=Yes; 2=No;	|____|
Training/education	1=Yes; 2=No;	|____|
Others	1=Yes; 2=No;	

Specify if 'other': .....

Q11 **On your last visit to the health facility, who did you see?**

Doctor/Clinical Officer	1=Yes; 2=No;	|____|
Nurse	1=Yes; 2=No;	|____|
Nurse Assistant	1=Yes; 2=No;	|____|
Others	1=Yes; 2=No;	|____|

Specify if 'other': .....

Q12 **On your last visit to the health facility, how long did you wait before seeing a doctor/nurse (write number of hours and minutes)?** |___|___|. |___|___|

66.66=Never visited; 99.99=DK

Q13 **On your last health facility visit, did you have to pay for treatment?** |____|
1=Yes; 2=No; 8=NA; 9=DK;

Q14 **On your last health facility visit, did you buy medicine from the facility?** |____|
1=Yes; 2=No; 8=NA; 9=DK;

Q15 **On your last health facility visit, did you feel you were cured/made better?** |____|
1=Yes; 2=No; 8=NA; 9=DK;

Q16 **Please state how useful the advice you were given was** |____|
1=Very useful; 2=Fairly useful; 3=Neither useful nor useless; 4=Fairly useless; 5=Useless; 8=NA; 9=Don't know

Q17 **Please state how confidential/private you felt your appointment for advice was with the nurse/doctor?** |____|
1=Very confidential; 2=Fairly confidential; 3=Neither confidential nor unconfidential; 4=Fairly unconfidential; 5=Very unconfidential; 8=NA; 9=DK

Q18 **Please state how easy did you feel to ask questions** |____|
1=Very easy; 2=Fairly easy; 3=Neither easy nor difficult; 4=Fairly difficult; 5=Very difficult; 8=NA; 9=DK

Q19 **Please state how much control did you feel you had over the treatment** |____|
1= Lot of control; 2= Average control; 3= Neither control or no control; 4=Little control; 5=No control;
8=NA; 9=DK

Q20 **Please state how satisfied you were with the advice /treatment you received** |____|
1=Very satisfied; 2=Fairly satisfied; 3=Neither satisfied nor dissatisfied; 4=Fairly unsatisfied;
5=Very unsatisfied; 8=NA; 9=DK

Q21 **Have you ever spent the night in your local clinic?** |____|
1=Yes; 2=No; 8=NA; 9=DK;

Q22 **If yes, did you have a bed to yourself?** |____|
1=Yes; 2=No; 8=NA; 9=DK;

Q23 **If yes, did you have a mosquito net?** |____|
1=Yes; 2=No; 8=NA; 9=DK;

Q24 **If yes, were you provided with food?** |____|
1=Yes; 2=No; 8=NA; 9=DK;

Instructions to Interviewer. This following section (Q25 – Q33) is for women only. For men, move on to Q34 (Say to women).

Now I am going to ask you some questions about childbirth experiences at your health facility. Again, please try to respond as honestly as you can.

Q25 **If you are pregnant, where do you go for antenatal care?**

District Hospital	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Local health centre	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Duka la dawa	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Private clinic/dispensary	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Traditional Birth Attendant	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Ante-natal clinic	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Traditional Healer	1=Yes; 2=No; 8=NA; 9=DK;	|____|
No-one	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Other	1=Yes; 2=No; 8=NA; 9=DK;	|____|
		|____|

Specify if 'other': ……

Q26 **In the last 2 years, have you given birth at your local clinic?** |____|
1=Yes; 2=No; 8=NA; 9=DK;

Q27 **If yes, please state how satisfied you were with the service you received** |____|
1=Very satisfied; 2=Fairly satisfied; 3=Neither satisfied nor dissatisfied; 4=Fairly unsatisfied;
5=Very unsatisfied; 8=NA; 9=DK

Q28 **If yes, please state how easy did you feel to ask questions** |____|
1=Very easy; 2=Fairly easy; 3=Neither easy nor difficult; 4=Fairly difficult; 5=Very difficult; 8=NA; 9=DK

Q29 **If yes, please state how much control did you feel you had over the situation** |____|
1= Lot of control; 2= Average control; 3= Neither control or no control; 4=Little control; 5=No control; 8=NA; 9=DK

Q30 **Have you been circumcised?** |____|

1=Yes; 2=No; 8=NA; 9=DK;

Q31 **If yes, who performed the circumcision?**

Mother	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Grandmother	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Other female relative	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Ngariba	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Doctor/Medical Professional	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Refused to answer	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Others	1=Yes; 2=No; 8=NA; 9=DK;	

Specify if 'other': .....

Q32 **If yes, how old were you (write age in years)?** |____|____|

Q33 **If yes, did you volunteer to be circumcised?** |____|

1=Yes, I volunteered; 2= No, I was forced; 8=NA; 9=Don't know

I am going to ask you some questions about sexual health

Q34 **If you need advice about a sexual health problem, who do you go to first?**

1=Husband/wife; 2=Sister/brother; 3=Mother; 4=Mother-in-law; 5=Father; 6=Father-in-law; 7=Other relative; 8=Friend; 9=Sub-village chairman; 10=Police; 11=Local health clinic; 12=Traditional Healer; 13=Other; 88=NA; 99=DK; |____|

Specify if 'other': .....

Q35 **If you need advice about a sexual health problem, who do you go to next?**

1=Husband/wife; 2=Sister/brother; 3=Mother; 4=Mother-in-law; 5=Father; 6=Father-in-law; 7=Other relative; 8=Friend; 9=Sub-village chairman; 10=Police; 11=Local health clinic; 12=Traditional Healer; 13=Other; 88=NA; 99=DK; |____|

Specify if 'other': .....

Q36 **If you need advice about marital relations, who do you go to see?**

1=Husband/wife; 2=Sister/brother; 3=Mother; 4=Mother-in-law; 5=Father; 6=Father-in-law; 7=Other relative; 8=Friend; 9=Sub-village chairman; 10=Police; 11=Local health clinic; 12=Traditional Healer; 13=Other; 88=NA; 99=DK; |____|

Specify if 'other': .....

Q37 **Who makes the decision about FP and number of children in your house?**

1=Husband/wife; 2=Sister/brother; 3=Mother; 4=Mother-in-law; 5=Father; 6=Father-in-law; 7=Other relative; 8=Friend; 9=Sub-village chairman; 10=Police; 11=Local health clinic; 12=Traditional Healer; 13=Other; 88=NA; 99=DK; |____|

Specify if 'other': .....

Q38 **Are there any circumstances in which a man has a right to beat a woman?**

1=Yes; 2=No; 8=NA; 9=DK;

|____|

Q39 **In what circumstances does a man have a right to beat a woman?**

Abortion without informing	1=Yes; 2=No; 8=NA; 9=DK;	|____|
FP without informing	1=Yes; 2=No; 8=NA; 9=DK;	|____|
No food in house	1=Yes; 2=No; 8=NA; 9=DK;	|____|
House dirty	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Adultery	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Staying out late with friends	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Refusal to have sex	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Request for money for children	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Husband drunk	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Any circumstance	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Other	1=Yes; 2=No; 8=NA; 9=DK;	

Specify if 'other': .....

Q40 **If a woman is beaten by a man, who should she go to for advice?**

Husband/wife	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Sister/brother	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Mother/Mother-in-law	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Father/Father-in-law	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Other relative/Friend	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Sub-village chairman	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Police	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Local health clinic	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Traditional Healer	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Other	1=Yes; 2=No; 8=NA; 9=DK;	|____|

Specify if 'other': .....

Q41 **Do you believe a woman should be circumcised?**

1=Yes; 2=No; 8=NA; 9=DK; \|____\|

Q42 **If yes, why do you believe a woman should be circumcised?**

For cleanliness	1=Yes; 2=No; 8=NA; 9=DK;	|____|
To ensure virginity at marriage	1=Yes; 2=No; 8=NA; 9=DK;	|____|
To avoid prostitution	1=Yes; 2=No; 8=NA; 9=DK;	|____|
To follow tradition/culture	1=Yes; 2=No; 8=NA; 9=DK;	|____|
Other	1=Yes; 2=No; 8=NA; 9=DK;	|____|

Specify if 'other': .....

That is the end of my questions. I would like to thank you for having spent time with me. Please feel free to ask me any questions you may have about this work. Please also remember that what you have told me will be used strictly for the purposes of this study and none of the information will be linked to your name. Thank you.

Annex 3 Focus Discussion Guide for Community Groups

Section A: SRH services

1. What kinds of SRH services are currently available in this ward? Can you tell us a little about each and your experiences of them? [Probe for health centres]

2. If a couple want to discuss family planning with someone where are they most likely to go? Why? [Probe for health centres]

3. If a woman or man is seeking confidential advice for a sexual health problem where is s/he likely to go? Why? [Probe for health centres]

4. If a woman is being regularly beaten by her husband, who can she turn to either in the village or at her local health centre? [Probe for health centres]

5. Does your local health centre offer counselling services for SRH or domestic violence problems? What do you think of these services? Are the staff friendly? How? Do you feel you can be open with staff? Why?

6. What kind of services do you think women have a right to at your clinic?

Section B: GBV and counselling services

7. Are there currently any village based organisations that assist women in difficult circumstances such as if they are being beaten by their husbands? Can you describe these? Who runs them and are they voluntary positions? How long have they been running? Do people access them?

8. Are there currently any village based organisations that provide advice and assistance for SRH problems? Can you describe these? Who runs them and are they voluntary positions? How long have they been running? Do people access them?

9. Do you believe that community's should provide assistance for their own as well as relying on government health centres in providing advice on women SRH rights? Does this already happen? Who is in the position to do this? Why do they do this? What support might they require (other than financial) to continue to do this?

Section C: *Jijenge* project

10. Have you ever heard of *Jijenge* project? If the answer is yes, what do you know about it?

11. How did you learn about the project?

12. Do many people in your area know about the project? What do they know about the project?

13. What was the situation with regards to women's rights before the *Jijenge* project started working in your area?

14. What was the situation with regards to women's rights after the *Jijenge* project started working in your area?

Annex 4 Recorded Gender Based Violence Cases

Source [delete those NA]: Village leader/Ward leader/village task force/ward task force

Other source (please specify)……..

District:……

Ward:……

Village:…….

Year	Type and number of GBV cases	Action taken per each case of GBV
2006		
2007		
2008		
Total		**NA**

Annex 5 Exit Questionnaire for Health Facility Clients

1. Introduction

My name is ……. and I am working with AMREF in Mwanza. I am involved in an exercise of evaluating the sexual and reproductive health services in health centres in Mwanza/Mara Regions to determine whether they meet the needs of the community especially women. I would like to ask you a few questions on the health services you have just gone through here. The information you provide me with will be kept confidential and will be used for purposes of improving health services especially for women.

Participation to this interview is voluntary. Are you ready to talk with me for a few minutes?

2. Access and client's satisfaction on quality of SRH services

2.1 How long did you have to walk/travel to come to this health facility?

2.2 How long did you wait to see the doctor/clinical officer?

2.3 How much time did you spent in the doctor's/clinical officer's room?

2.4 How would you describe the services provided to you by the doctor/clinical officer?

2.5 Did you get the drugs prescribed to you by the doctor/clinical officer? **Probe:** if they got all the drugs or just some.

2.6 How long did you wait to get the drugs prescribed by the doctor/clinical officer?

3. Provision of quality gender sensitive SRH services

3.1. Did your illness relate to sexual and reproductive health?

3.1.1 If yes, how do you explain the services you received? **Probe:** describe in detail the services you received.

3.1.2 Did the doctor talk to you anything about availability of other sexual and reproductive health services? **Probe:** did the doctor/clinical officer refer you to any of these services?

3.2. Did you feel that your health needs were addressed? **Probe:** in what ways, please provide specific examples.

3.3. Are there specific things that would be done to make the services more sensitive to women's needs? **Probe:** give specific examples of such things.

4. Referrals to other support links e.g. social welfare and legal groups

4.1. Did the doctor/clinical officer/health workers at the health facility refer you to any groups outside the hospital for your needs? **Probe:** give specific examples.

Annex 6 Community Attendance to Health Facilities

District:……

Ward:……

Name of health facility:……

Year	General attendance		No of SRH cases		No of GBV cases	
	Female	Male	Female	Male	Female	Males
2006						
2007						
2008						
Total in 3 years						

Annex 7 Structured Observation Guide at Health Facilities

District:…… **Ward:**……..……
Name of health facility:……

Observe and document the following:

1. **Physical state and set up of the health facility**

   1.1 Do all rooms have doors? **Yes/No**

   If no, please give details…….....

   ……..

   1.2 Do rooms have ceiling boards? **Yes/No**

   If no, please give details…….....

   ……..

   1.3 Where do patients sit after arriving at the health facility?

   ……

   1.4 Where do patients sit while waiting to see the doctor?.....

   .....

   1.5 Are all medical staff in uniform? **Yes/No**

   If no, please give details…….....

   ……..

2. **Waiting times [circle answer]**

   2.1 On average how long does it take for a patient to see a doctor/clinical officer?

   a. Less than 15 minutes

   b. 15-30 minutes

   c. 30-60 minutes

   d. More than 1 hour

   2.2. How long does it take a patient to obtain the drugs prescribed to them?

   a. Less than 15 minutes

   b. 15-30 minutes

   c. 30-60 minutes

   d. More than 1 hour

3. **Health workers interactions with patients**

   3.1 Do health workers use polite or harsh language?.....

   ……...

   3.2 Do health workers help patients when asked?.....

   ……...

   3.3 Do women get 'better' treatment from the health facility staff? **Yes/No**

   Please explain if Yes or No……

   ……