FINAL EVALUATION OF JIJENGE PROJECT – FILLING THE GAP

"Strengthening the right of women to receive health assistance through community sensitisation and training of Health Service Providers in Mwanza and Mara Regions"

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AMREF
Better Health for Africa

Junta de Castilla y León
Consejería de Familia e Igualdad de Oportunidades

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ACRONYMS

AMREF	African Medical and Research Foundation
ANC	Ante-natal Clinic
CEDAW	Elimination of All Forms of Discrimination against Women
CHMTs	Council Health Management Teams
CORPS	Community Owned Resource Persons
DMO	District Medical Officer
DCDO	District Community Development Officer
FGDs	Focus Group Discussions
FGM	Female Genital Mutilation
FP	Family Planning
GBV	Gender Based Violence
HC	Health Centre
HIV	Human Immuno-deficiency Virus
HSPs	Health Service Providers
ICPD	International Convention on Population and Development
IEC	Information, Education and Communication
MDGs	Millennium Development Goals
PHC	Primary Health Care
RCH	Reproductive and Child Health
SRH	Sexual and Reproductive Health
STIs	Sexual Transmitted Infections
TASAF	Tanzania Social Action Fund
TOR	Terms of Reference
VEO	Village Executive Officer
WEO	Ward Executive Officer
WDC	Ward development Committee

CHAPTER 1

INTRODUCTION

1.1 Background Information

Jijenge filling the gap project in Tanzania was implemented through AMREF Spain and funded by Junta Castila Leon to institutionalize a gender responsive approach in the primary health care services in the Lake Victoria zone. The project's broad aim was to strengthen the right of women to receive health assistance through community sensitization and training of Health Service Providers (HSPs) in eight districts of Mwanza and Mara Regions. The districts included: Mwanza City, Sengerema, Missungwi, Kwimba, Magu, Ukerewe, Geita, and Serengeti. These districts were chosen as a focus area because of the high prevalence of violations against women in the region such as female genital mutilation (FGM), women battering and deeply rooted customs and taboos that deny women to access quality health care.

Rights based gender sensitive approach was the backbone of the intervention. This project was responding directly to the 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 also addressing the Millennium Development Goals (MDGs) where among other critical issues of concern sexual and reproductive health (SRH) and human rights were sited to be key intervention areas.

The Jijenge filling the gap has been operating for two years between September 2008 and September 2010 as a back up of the 3 years Jijenge extension phase that ended in June 2008. The direct beneficiaries were women of reproductive age (15-49 years) that lived in the intervention areas. Other beneficiaries were family members; health personnel in 21 health facilities; Council Health Committees, Local Government and the

general public. Jijenge filling the gap project worked in partnership with the district and regional administrative committees; community leaders at ward level, Ministry of Health, Ministry of Women, Children, Gender and Community Development and other development partners.

Jijenge filling the gap had aims of strengthening the capacity of the health systems by training health service providers, improving participatory planning processes and resource allocation among district Council Health Management Teams (CHMTs) and Ward Development Committees (WDC). The WDCs and CHMTs would therefore become more knowledgeable and well informed on gender issues concerning reproductive health thus contribute to quality services and reduction of gender based violence by employing rights based approaches in their action plans. The project also had aims to reach community volunteers through training and working sessions on gender and human rights issues. The involvement of community volunteers through training would make them an important linkage between community members and the project.

The project expected that additional knowledge imparted at the community level will revitalize women to realize their basic and reproductive health rights and therefore be able to advocate on prevention of harmful traditions and stereotypes that expose them to ill health. Men were also expected to support women's health by increasing uptake of sexual and reproductive health (SRH) services in that men would consider SRH as family agenda and eventually improve women's health and well being. At sectoral level, the expected results were overall reduction of related disease prevalence, maternal and infant mortality and morbidity due to improved sexual and reproductive health services as well as increased mobilization and leadership by community members.

The project goal was therefore to contribute to the reduction of poverty by promoting quality reproductive health care for women and community health care practices in the Lake Victoria zone.

Specifically, the project intended to

To improve community based health system in response to quality gender sensitive SRH services in eight districts of Mwanza and Mara regions.

To improve access to community based health information through training of community local structures including health service providers.

Advocate facilitating linkage with networks of partners at community, district and national levels for promotion of women's sexual and reproductive health and rights in the districts of Mwanza and Mara regions.

Linked to these objectives were key expected projects results.

Women and the communities in general of the Mwanza and Mara regions are aware of their rights to access quality healthcare on sexual and reproductive health services and are sensitized on women's rights and stop gender based violence.

Communities identify sexual and reproductive health problems and set possible solutions with appropriate actions.

Health facilities in the community providing quality and client friendly gender sensitive sexual and reproductive health services.

The health network established in the Mwanza and Mara regions offer improved gender sensitive sexual and reproductive health services.

Stakeholders and policy makers are informed on how to address gender and human rights in the sexual and reproductive health programmes.

1.2 Objective and Scope of the Evaluation

In order to assess the effects and impacts of the project, AMREF Tanzania called for bids to evaluate the project. This report makes recommendations to AMREF, district councils and other stakeholders on further steps necessary to consolidate and sustain what has worked well and address key existing challenges to date. The report also draws out key lessons learnt with the design, implementation, monitoring and evaluation of the project initiatives and recommend improvements in design for future similar projects. The report covers key thematic areas such as project implementation strategy,

institutionalization of the project concept (reproductive health in the context of gender relationships) with a focus on the district and community levels, training strategy, advocacy and networking strategy.

The evaluation intended to:

- To analyze effectiveness of inputs in relationship to outputs of the project objectives and activities.
- To assess the extent to which the project and her stakeholders have achieved the project goal and explore the different levels of successes attained in the course of implementation in the 8 districts as well as the progress based on the benchmarks from the baseline surveys.
- Find out whether the knowledge and skills gained through training sessions facilitated by the project at district, ward and community levels has been utilized and hence contributing towards attaining the higher project objectives. To what extent skills obtained are being sustained.
- Assess the impact of the advocacy and networking strategies and its activities implemented towards attaining the final project goal to the needs of beneficiaries.
- To assess the applicability of the proposed strategies to define project sustainability and their positive impacts on sexual and reproductive health.
- Recommend to AMREF, the district councils and other stakeholders potential mechanisms for scaling up and effective ways of enhancing sustainability.

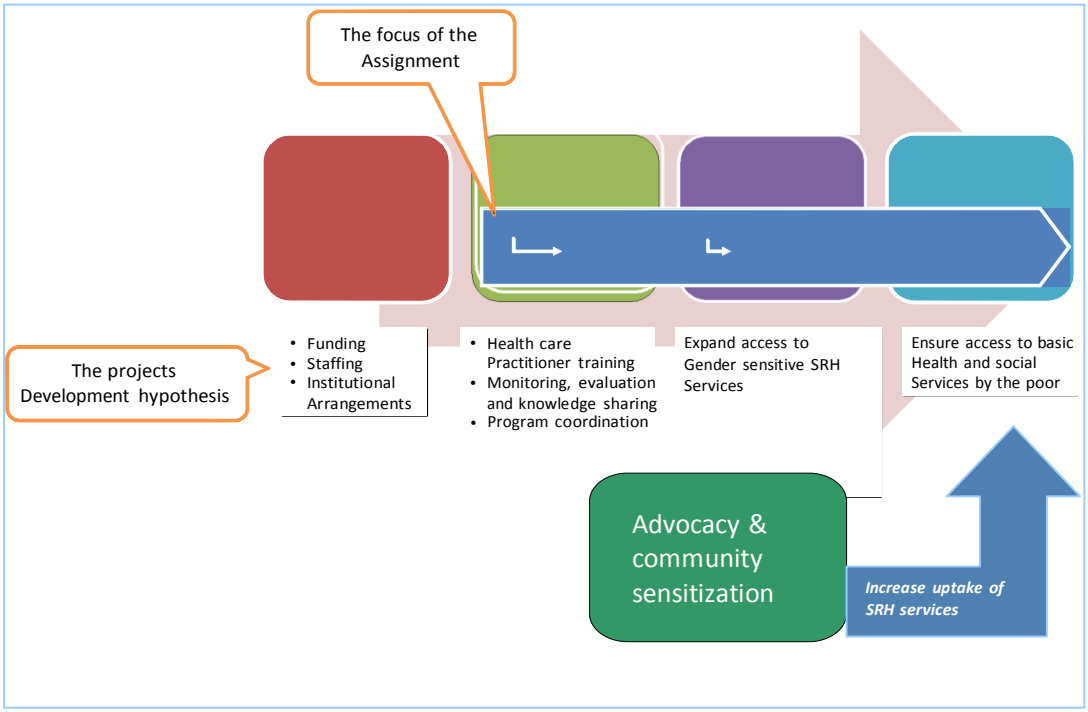
1.3 Evaluation Model: Theory and Framework

In this section, we present the overall practical approach to the evaluation, whereby the main ideas and concerns for this evaluation were assembled in a manner that provides ease of use and then ease of analysis. The “Kirkpatrick’s model” was modified and adopted as our evaluation framework for training provided to the community owned resources persons (CORPS) and health service providers (HSPs); the effect of this training on service provision at the health facilities and service uptake due to increased community sensitization activities (Annex 1).

The framework links the evaluation objectives to areas of enquiry, detailed questions, and hence to sources of information to answer those questions. Annex 2 illustrates Kirkpatrick's model to TOR and scope of analysis.

The TOR stresses the importance of ensuring that the impact evaluation analyses the effectiveness of inputs in relationship to outputs of the project objectives and activities. Figure 1 below superimposes Kirkpatrick's levels onto the results chain to illustrate how this study fits into the bigger Jijenge filling the gap project's picture.

Figure 1: Relating Kirkpatrick's Modified Five levels of learning to the results chain



Our approach to this work was based on our understanding of evaluation with regard to the project's broad aim which is to strengthen the right of women to receive health assistance through community sensitization and training of Health Service Providers in eight districts of Mwanza and Mara regions. This involved the collection and reduction of subjective and objective data from a number of sources using a variety of techniques. It

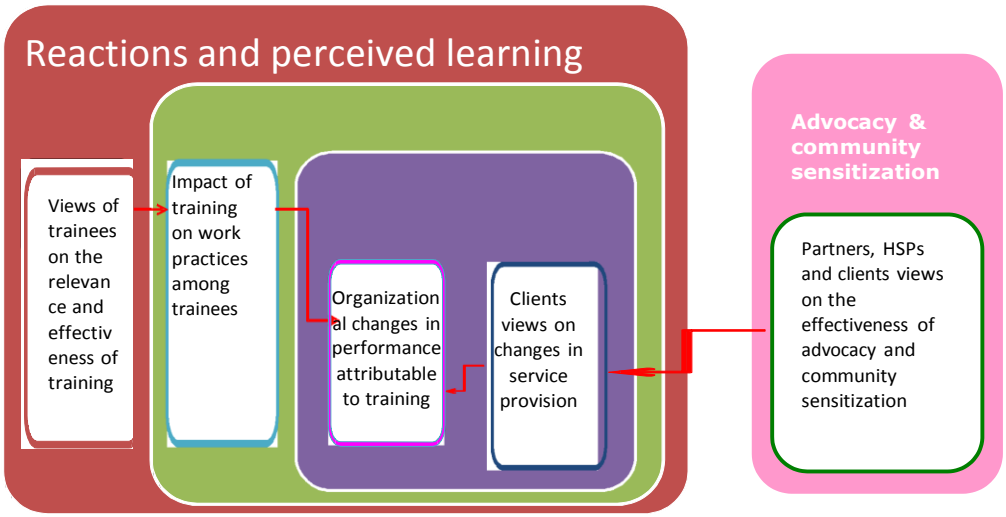
also involved analysis and synthesis of this data into a report containing a summary of results and recommendations about the programme being evaluated.

Based on the above, we viewed this evaluation as an integral part of human resource development function, which in turn is part of the whole organisational process of ensuring quality gender sensitive SRH services delivery and clients/ service users' satisfaction. Evaluators had an opinion, that evaluation of trainings of healthcare workers cannot be separated from needs assessment, course design and presentation and transfer of learning to the workplace (training cycle) while community sensitization involves information sharing and addressing barriers to the uptake of gender sensitive SRH services. Efforts were made to explore these in the evaluation assignment.

1.4 Methodology, Sampling and Data Collection

Jijenge filling the gap was implemented in eight districts of Mwanza and Mara Regions. In order to obtain comparative data and due to budgetary constraints, the evaluation was conducted in 3 districts selected randomly from 8 districts. In every selected district, all wards where the project was implemented were compiled and one ward was randomly selected to participate in the evaluation.

Figure 2: Data Required for the Evaluation



The above data requirement (Figure 2) was collected using various sources of information: the findings of surveys, in-depth interviews and focus group discussions conducted with stakeholders, as well as secondary data from AMREF and other organisations involved one way or the other in the project. These several sources of data enabled us to triangulate information. This approach ensured the accuracy, reliability and balance of data collected.

Data Collection Tools at AMREF Mwanza Offices

Secondary sources of data were used to synthesize information from documents collected from the project offices at AMREF. These included project reports, annual reports and monitoring and evaluation reports. Evaluators used documentary review proforma which provided a structured format to ensure that key questions for the evaluation are covered and documents are reviewed in a consistent manner.

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 project staff, healthcare providers, district and community leaders and other stakeholders. The information collected from these interviews were used 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.

Focus Group Discussion (FGDs)

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 different forces according to their magnitude. Furthermore, information arising from the FGDs were important element in assessing drivers of change, 'resistance' (and disincentives) to the achievement of the key

outcomes. Evaluators conducted two FGDs per community (total 6 in 3 communities). One male and one female FGD were done in each community.

Field Visits

Prior to field visits, the study community was approached by an initial meeting involving the District Medical Officer (DMO) and District Community Development Officer (DCDO) to explain the rationale for the evaluation. Other meetings were conducted at the community level where ward, village and community leaders were informed of the objectives and rationale of the study. Community leaders are gatekeepers, thus the community level meeting was the critical entry point to engage potential study participants. During the field visits, a team of evaluators visited Busongo in Misungwi District, Nyarugusu in Geita District and Nyanguge in Magu District to assess on-going activities or selected activities implemented and managed during the period of evaluation. Table 1 presents the villages and descriptions of the villages that were visited in this evaluation.

In wards 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+ years were listed and then interviewed; therefore 40 interviews (20 females, 20 males) were conducted in each selected sub-village. In total, 364 face to face interviews (181 females, 183 males) were conducted. These interviews enabled us to assess the relevance, effectiveness, sustainability and connectedness of the activities to projects objectives.

Field visits were used to assess on-going activities or selected activities implemented and managed during the period of evaluation. These visits enabled the evaluators to assess how the projects activities have contributed to the outcome and impact indicators and facilitated the evaluators to put into context information collected through other methodologies and therefore aid analysis and interpretation.

Table 1. Descriptions of the Project Areas Visited in the Final Survey

District	Ward	Population in the Ward in 2002	Characteristics of selected site
Misungwi	Busongo	14,520	• Rural Community. Agricultural activities mainstay of local economy. • High prevalence levels of domestic violence due to local ethnic cultural norms
Geita	Nyarugusu	33,129	• Mining communities, the economy is based on Gold mining and petty business. • High prevalence levels of domestic violence due to local ethnic cultural norms
Magu	Nyanguge	9,916	• Roadside Centre Community, The economy is based on agriculture and petty business. • High prevalence levels of domestic violence due to local ethnic cultural norms

During the field visits, interviews with the trainee were conducted at every health facility visited and community visited. Evaluators collected data on trainee reactions and perceptions of learning, application of learning and behaviour change in the workplaces and changes in the performance of health facilities following training, evaluators administered questionnaires to a sub-sample of trainees.

This design provided sufficient information to draw clear conclusions. Thus findings that recur or are supported at different steps along the way are confidently presented as conclusions. Evaluators also supported the findings with secondary data.

CHAPTER 2

Findings

2.1 Project Intervention Logic

2.1.1 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.

2.1.2 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).

2.1.3 Jijenge Extension Phase (2006-2008)

This 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.

2.1.4 JIJENGE project - Filling the Gap (2008-2010)

The project's broad aim was to strengthen the right of women to receive health assistance through community sensitization and training of Health Service Providers (HSPs) in eight districts of Mwanza and Mara Regions. The districts included: Mwanza City, Sengerema, Missungwi, Kwimba, Magu, Ukerewe, Geita, and Serengeti. These districts were chosen as a focus area because of the high prevalence of violations against women in the region such as female genital mutilation (FGM), women battering and deeply rooted customs and taboos that deny women to access quality health care. Chapter 1 provides a detailed description of the Jijenge project – filling the gap.

2.1.4.1 Project Intervention Strategy

The aims of JIJENGE project –filling the gap was to strengthen the capacity of the health systems by training health service providers, improving participatory planning processes and resource allocation among district Council Health Management Teams

(CHMTs) and Ward Development Committees (WDC). The WDCs and CHMTs would therefore become more knowledgeable and well informed on gender issues concerning reproductive health thus contribute to quality services and reduction of gender based violence by employing rights based approaches in their action plans. The project also had aims to reach community volunteers through training and working sessions on gender and human rights issues. The involvement of community volunteers through training would make them an important linkage between community members and the project.

The project expected that additional knowledge imparted at the community level will revitalize women to realize their basic and reproductive health rights and therefore be able to advocate on prevention of harmful traditions and stereotypes that expose them to ill health. At sectoral level, the expected results were overall reduction of related disease prevalence, maternal and infant mortality and morbidity due to improved sexual and reproductive health services as well as increased mobilization and leadership by community members.

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.

2.1.4.1.1 Community level Strategy

To achieve the above, the JIJENGE project – filling the gap formulated 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 volunteers. These included trainers of the community groups (2 people trained per ward), Community mobilisers (4 people trained per ward) and community based counsellors (2 people trained per ward). At the Community level, JIJENGE Project –filling the gap worked together with local community leadership in

planning and the project provided feedback on the progress of the intervention through the ward development committees (WDC).

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. The trainers conducted educational sessions in open forums using different methods such as lectures, drama, role plays, singing, discussion, etc.

Community Mobilisers

Members of the mobilisation group were selected to mobilise the community to attend the open forum education meetings and to mobilise people to utilise sexual and reproductive health services. The group conducted their education sessions through public forums/meetings and through interpersonal communication (one-on-one) and they also utilized the presence of weekly markets and clinic attendances (mostly in the rural area). They also distributed 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.

Community taskforce and Local Community Based Organisations

Two taskforces (human rights committee and sexual and reproductive health committee) with 10 members each were trained. The taskforce committee were responsible for sensitising the communities to take-up the services. Community volunteers trained formed the community based organisations (CBO) which were responsible for mainstreaming gender and sexual reproductive health services into all activities done in the communities through drama, singing, etc.

2.1.4.1.2 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. Two groups were trained the trainer of trainers (TOT) and the counsellors. TOTs were trained to train and supervise other healthcare workers on provision of gender sensitive SRH services while counsellors were trained to enhance their ability to support, supervise and monitor community based counsellors and counselling services.

2.1.4.1.3 Networking and Training of Partners

Quarterly planning and feedback meetings were held with Council Health Management Teams (CHMTs) 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 CHMTs and ultimately CHMTS 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.

In an effort to strengthen community structures and ownership of the change process, members of the Ward development Committee and community influential people 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.

2.1.4.1.3 Sustainability Component of the Strategy

To ensure continuity of the project intervention activities, the trained community volunteers have formed CBOs 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 community volunteers, 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, Machochwe).

2.2 Impact of the Training Component

Overall, 30 trainees participated in the survey that evaluated the impact of the training on achieving the objectives of the survey (Table 2).

Table 2. Descriptions of the Jijenge Trainees interviewed

Factor	Misungwi	Geita	Magu	Total No.
Course attended				
Health Service providers	1	1	1	3
Community volunteers	5	5	5	15
WDC members	2	2	2	6
CHMT Members	2	2	2	6
Age				
25-34 years	4	4	3	11
35-44 years	3	4	2	9
45-54 years	3	2	5	10
Sex				
Male	4	5	4	13
Female	6	5	6	17

2.2.1 Reactions and Perceived Learning

Overall, 28/30 (93.3%) and 27/30 (90.0%) of the trainees who participated in the survey reported that the objectives of the training program and personal objectives of attending the training were achieved. Most trainees have conducted cascaded training on family planning, gender based violence and have mobilised the communities on the uptake of gender based sexual and reproductive health services and the community has responded favourably. Initially, trainees mobilised the communities through open forums, there was little response. Therefore they developed a new strategy of using peers to sensitise and educate the communities on the need for family planning, reducing gender based violence and human rights abuses and increasing the uptake of gender based sexual and reproductive health services.

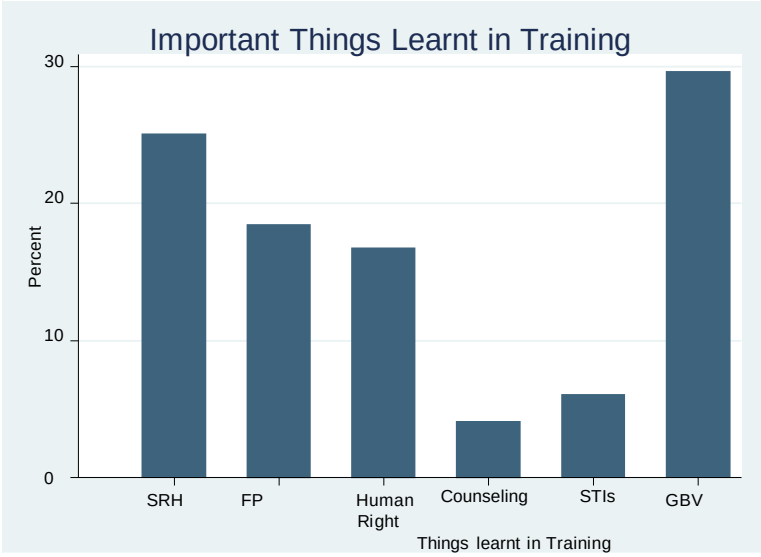
Almost all trainees except 2 reported that the training was insightful and improved their knowledge and skills. This is because the training package was good, the facilitators were experienced and knowledgeable in their areas and delivery was also good. However, duration of training which varied from one day to two weeks was reported to be very short compared to what was learnt.

All health service providers, members of the CHMT and WDC reported that the training course has helped them to appreciate and understand their jobs (in terms of what they are supposed to do and why they are doing it). Similarly, all would recommend the Jijenge training course to their colleagues with similar challenges. Generally, the training was rated favourably by the trainees who participated in the course.

2.2.2 Learning and Behaviour

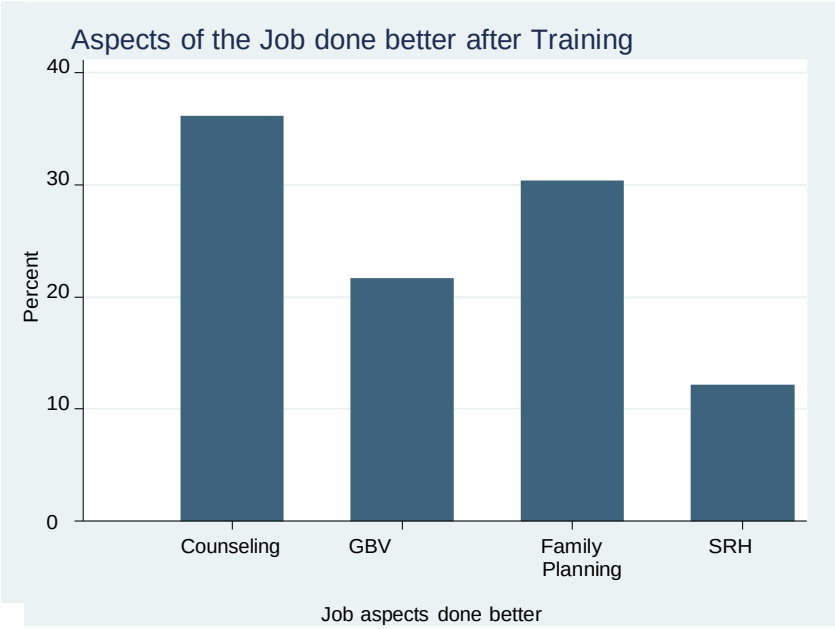
Trainees were asked to list areas/topics they learnt in the Training that they considered important for Jijenge project. The areas most listed were sexual and reproductive health, family planning, human rights, counselling and STIs (figure 3). Trainees were also asked to list what they were expecting to learn from the training that they did not learn. The topics most listed were rights for men as husbands and correct use of female condoms.

Figure 3: Important Topics Learnt in Training



As a result of the training, counselling at the health facilities and communities, the understanding gender based violence and the uptake of family planning and sexual and reproductive health services have improved (Figure 4).

Figure 4: Aspects of the Job done better after Training



Twenty five trainees (83.3%) reported that the course had influenced or changed their behaviour and was changing the behaviour of the community with regard to their opinion regarding gender, gender based violence, family planning and uptake of the sexual and reproductive health services.

2.2.3 Organizational Performance

Overall, 12/15 (80%) of the healthcare workers, members of the CHMT and WDC reported that the performance of their organisation has improved following the training. Areas of improvement were the acquisition of the participatory planning skills and quality of work and increased number of clients on the side of healthcare providers.

2.3 Findings from the Community Based Survey

2.3.1 Demographic Characteristics of Respondents

A total of 364 community members [183 (50.3%) males, 181 (49.7%) females] took part in the face to face interviews of the post-intervention evaluation to assess the impact and sustainability of the intervention. In each district, almost a similar proportion of males across the age groups participated in the study (χ^2 = 6.5; P=0.37). A similar pattern was observed among females (χ^2 = 3.9; P=0.69). Table 3 below presents the population of each ward and numbers of people selected to participate in the post-intervention evaluation. The project intervention was implemented within a predominantly Sukuma culture except in the mining communities of Geita district where there was mixture of ethnicity due to mining activities. In all three districts, the majority of the respondents interviewed were Christians.

Male respondents had similar education levels across the districts (χ^2 =1.6; P=0.80) while among females, respondents in Nyarugusu ward in Geita district and Nyanguge ward in Magu district tended to drop out of school compared to those in Busongo ward in Misungwi district (χ^2 =9.0; P=0.062). Systematically, more females dropped out of primary school than males across the three 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.

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

	Misungwi		Geita		Magu	
	Female n=61 (%)	**Male N=61 (%)**	**Female n=59 (%)**	**Male n=60 (%)**	**Female n=61 (%)**	**Male n=62 (%)**
Age groups						
15-24 years	14 (23.0)	9 (14.8)	13 (22.0)	13 (21.7)	14 (23.0)	11 (17.7)
25-34 years	20 (32.8)	18 (29.5)	20 (33.9)	17 (28.3)	14 (23.0)	12 (19.4)
35-50 years	14 (23.0)	16 (26.2)	14 (23.7)	8 (13.3)	13 (21.3)	18 (29.0)
50+ years	13 (21.3)	18 (29.5)	12 (20.3)	22 (36.7)	20 (32.8)	21 (33.9)
Tribe						
Sukuma	61 (100.0)	58 (95.1)	24 (40.7)	36 (60.0)	59 (96.7)	56 (90.3)
Others	0 (-)	3 (4.9)	35 (59.3)	24 (40.0)	2 (3.3)	6 (9.7)
Religion						
Catholic	23 (37.7)	19 (31.2)	16 (27.1)	18 (30.0)	23 (37.7)	26 (41.9)
Other Christian	30 (49.2)	18 (29.5)	23 (39.0)	18 (30.0)	34 (55.7)	25 (40.3)
Others	8 (13.1)	24 (39.3)	20 (33.9)	24 (40.0)	4 (6.6)	11 (17.7)

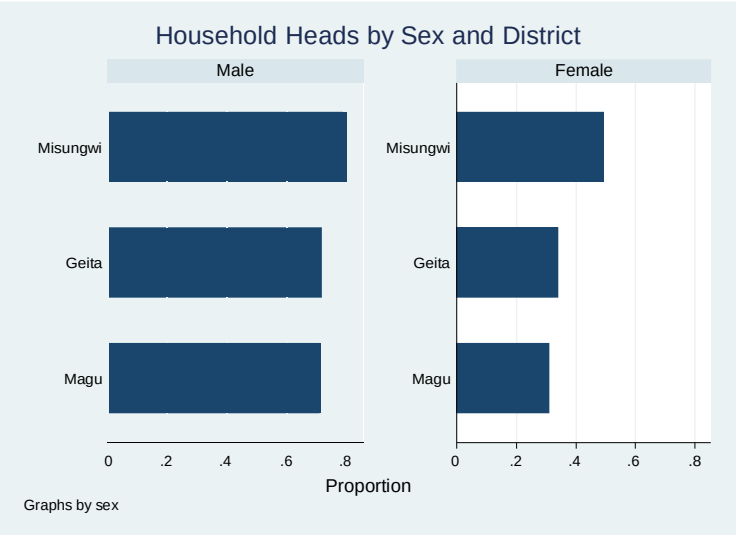
Nyarugusu ward in Geita district had the highest proportion of females who did not complete primary education than Nyanguge and Nyarugusu wards in Magu and Misungwi district, respectively. Table 4 presents the education and occupation status among respondents in the post-intervention study by ward and sex. In all three wards, farming was the main occupation though in Nyarugusu and Nyanguge wards, mining and business activities were also reported.

Table 4. Education and Occupation Status of the Respondents by District and Sex

	Misungwi		Geita		Magu	
	Female n=61 (%)	**Male n=61 (%)**	**Female n=59 (%)**	**Male n=60 (%)**	**Female n=61 (%)**	**Male n=62 (%)**
Education						
Incomplete Primary Sch.	24 (39.3)	21 (34.4)	38 (64.4)	23 (38.3)	33 (54.1)	18 (29.0)
Primary School	36 (59.0)	37 (60.7)	19 (32.2)	34 (56.7)	27 (44.3)	39 (62.9)
Above Primary School	1 (1.6)	3 (4.9)	2 (3.4)	3 (5.0)	1 (1.6)	5 (8.1)
Occupation						
Farming	56 (91.8)	53 (86.9)	47 (79.7)	47 (78.3)	44 (72.1)	49 (79.0)
Private Salary	3 (4.9)	6 (9.8)	1 (1.7)	7 (11.7)	5 (8.2)	4 (6.5)
Others	2 (3.3)	2 (3.3)	11 (18.6)	6 (10.0)	12 (19.7)	9 (14.5)

There was no significant difference on the proportion of males who reported to be household heads across the district (χ^2 = 1.2; P=0.56) (Figure 5). Among females, Busingo Ward in Misungwi District had a higher proportion of females who reported to be household heads compared to Nyarugusu ward in Geita and Nyanguge ward in Magu District (χ^2 = 4.9; P=0.09).

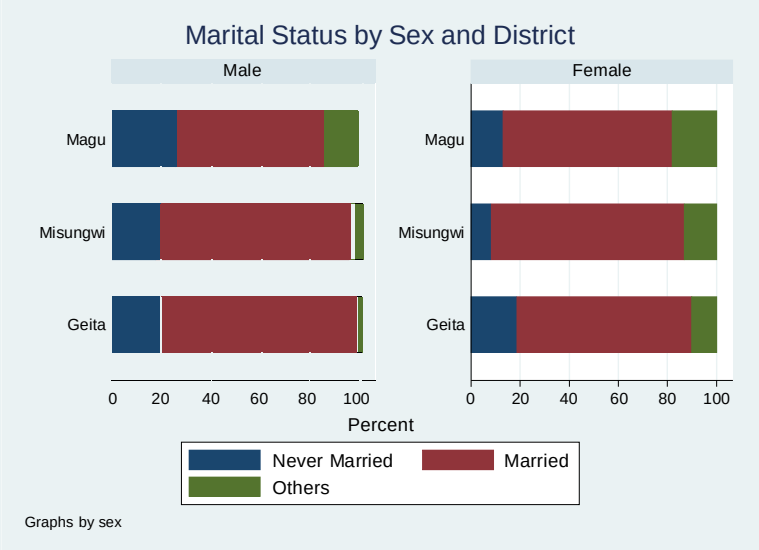
Figure 5. Households Heads by Sex and District



2.3.2 Spousal Selection, Bride Price and Marriage

Generally, the majority of the respondents interviewed were married (Figure 6). However, Nyanguge wards in Magu district had a higher proportion of males who are either divorced, separated or widowed (14.5%) compared to 3.3% who reported the same in Busongo ward in Misungwi district and 1.7% in Nyarugusu ward in Geita district. This difference was statistically significant (χ^2 = 12.1; P=0.016). Among females, similar marriage pattern was observed across the 3 wards (χ^2 = 4.3; P=0.37)

Figure 6. Marital Status by Sex and District



Of females married, 45.9% in Busongo ward in Misungwi district, 45.8% in Nyarugusu ward in Geita district and 39.3% in Nyanguge ward in Magu district reported that both marital partners chose each other (Table 5). Among married males, 44.3% in Busongo ward in Misungwi district, 46.7% in Nyarugusu ward in Geita district and 56.5% in Nyanguge ward in Magu district reported that both marital partners chose each other. The higher proportion of males and females reporting that both partners chose each other 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.

More females interviewed in Busongo ward in Misungwi district (54.1%) and Nyanguge ward in Magu district (59.0%) reported that bride price was not paid for their marriage compared to 33.9% who reported the same in Nyarugusu ward in Geita district. Among males, more males in Nyarugusu ward (65.0%) reported paying bride price for their families compared to 45.9% in Busongo ward in Misungwi district and 45.2% in Nyanguge ward in Magu district. A lower proportion of respondents reported that the bride price had good effect on their marriage.

Table 5. Spousal Selection, Bride Price and effects of Bride-price on Marriage

	Misungwi		Geita		Magu	
	Female n=61 (%)	**Male n=61 (%)**	**Female n=59 (%)**	**Male n=60 (%)**	**Female n=61 (%)**	**Male n=62%)**
Of those Married: who chose the spousal partner						
Both	28 (45.9)	27 (44.3)	27 (45.8)	28 (46.7)	24 (39.3)	35 (56.5)
spouse of the respondent	17 (27.9)	4 (6.6)	20 (33.9)	0 (-)	22 (36.1)	2 (3.2)
Respondent	9 (14.8)	18 (29.5)	1 (1.7)	20 (33.3)	1 (1.6)	6 (9.7)
Others	2 (3.3)	1 (1.6)	0 (-)	0 (-)	6 (9.8)	3 (4.8)
Was bride-price paid?						
No	33 (54.1)	22 (36.0)	20 (33.9)	9 (15.0)	36 (59.0)	18 (29.0)
Yes	23 (37.7)	28 (45.9)	28 (47.5)	39 (65.0)	17 (27.9)	28 (45.2)
NA	5 (8.2)	11 (18.0)	11 (18.6)	12 (20.0)	8 (13.1)	16 (25.8)
Effect of bride-price to marriage						
Bad	1 (1.6)	3 (4.9)	3 (5).1	3 (5.0)	0 (-)	0 (-)
Good	16 (26.2)	14 (23.0)	14 (23.7)	16 (26.7)	10 (16.4)	5 (8.1)
No effect	6 (9.8)	11 (18.0)	11 (18.6)	20 (33.3)	7 (11.5)	23 (37.1)
NA	38 (62.3)	33 (54.1)	31 (52.5)	21 (35.0)	44 (72.1)	34 (54.8)

2.3.3 Healthcare Service Provision

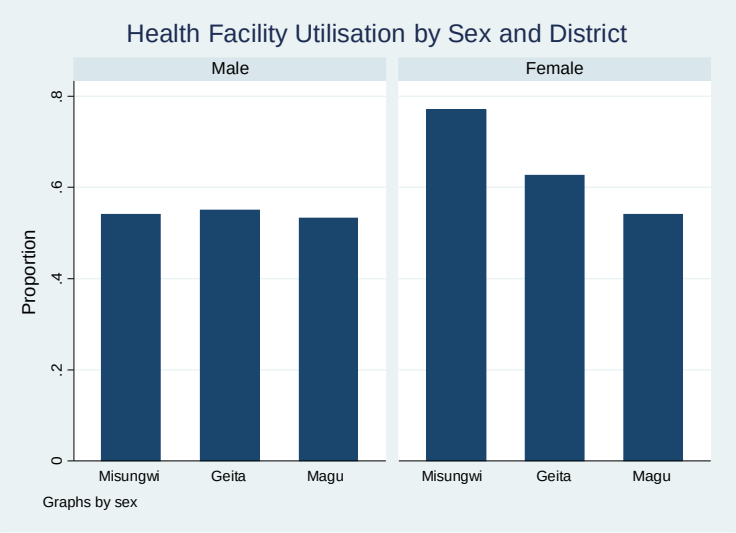
The service utilisation is dependent on inherent factors embedded within the health systems such as supply of medicines, services, equipments, reagents and other consumables, health facility level providers (the reputation of providers among community members, behaviour of providers towards patients, etc) and community factors. Community factors include socio-economic status, prevailing cultural norms that affect treatment seeking behaviour and perceptions of aetiology, as well as peer relations. In this section, findings from the community survey are presented on general healthcare service provision.

2.3.3.1 Community Reports On General Service Provision

About 59.3% (54.1% males, 64.6% females) reported that they had visited the clinic in the last 12 months (Figure 7). Data from the FGDs supports this observation of women using health facility services more than men because of ante-natal, family planning and reproductive and child health (RCH) services. Women in Busongo ward were more

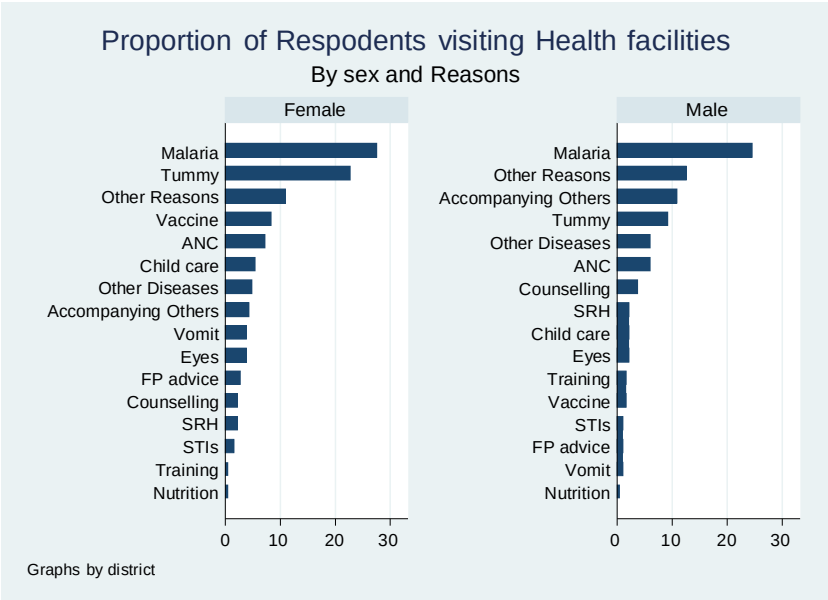
likely to visits the health facility, followed by women in Nyarugusu ward. The proportion of men who visited the facility was roughly similar in all the 3 wards.

Figure 7. Healthcare Utilisation by Sex and District



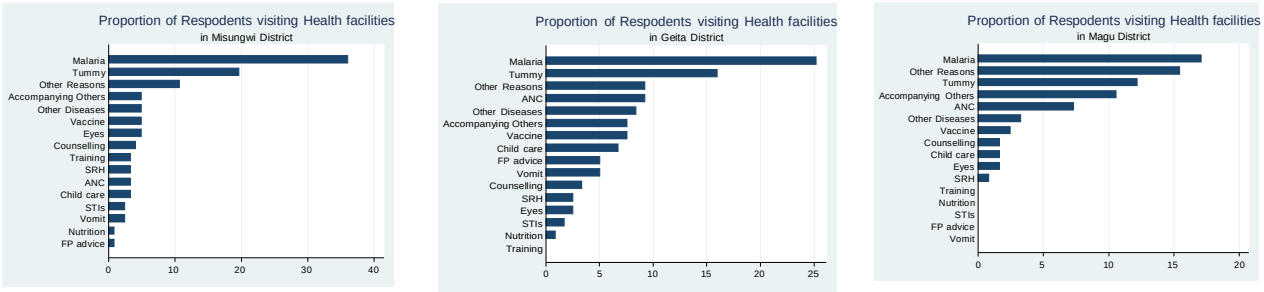
Of those women who had ever visited the local health facility, reasons for their visits were diverse and varied from diseases such as malaria/fever and stomach problems to other issues as well as antenatal care and child immunization. Conversely, for males, the major reasons were malaria/fever and other reasons (Figure 8).

Figure 8. Reasons for Health Facility Visit by Sex



These reasons were almost similar across the districts. Figure 9 below presents the reasons for health facility visits by district.

Figure 9. Reasons for Health Facility Visit by District



Perceived quality of healthcare services was measured in terms of 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. Of those respondents in the face to face questionnaire (n=216) 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 56 minutes (standard deviation was 42 minutes) with a range of between 0 and 3 hours. Waiting time was higher in Nyarugusu Ward in Geita district (66 Minutes) and lower in Nyanguge Ward in Magu district (49 minutes).

Of those who visited the health facility, majority of respondents in Busongo Ward in Misungwi District and Nyanguge Ward in Magu District were seen by the doctor or clinician. In Nyarugusu Ward, males were mostly seen by the nurse while females were mostly seen by the clinician/doctor (Table 6). Regarding paying for treatment, males were more likely to pay for treatment and buy medicine at the health facility compared to females (χ^2 =13.1, P=0.001). However, there was no significant difference among males and females across the district in paying for treatment and buying medicine. Generally, the majority of the patients interviewed were satisfied with health services provided at their health facilities though a higher proportion of males significantly reported being cured compared to females (χ^2 =4.4, P=0.037).

Table 6. Providers' Factors affecting General Service Provision

	Misungwi		Geita		Magu	
	Female n=47 (%)	**Male n=33 (%)**	**Female n=37 (%)**	**Male n=33 (%)**	**Female n=33 (%)**	**Male n=33 (%)**
Who provided the services?						
Doctor/Clinician	31 (66.0)	33 (100.0)	19 (51.4)	26 (78.8)	17 (51.5)	20 (60.6)
Nurse	22 (46.8)	8 (24.4)	25 (67.6)	20 (60.6)	14 (42.4)	17 (51.5)
Nursing Assistant	4 (8.5)	5 (15.2)	8 (21.6)	12 (36.4)	0 (-)	1 (3.0)
Others	2 (4.3)	2 (6.1)	5 (13.5)	12 (36.4)	1 (3.0)	1 (3.0)
Paid for Treatment & bought medicine						
No	31 (66.0)	18 (54.6)	23 (62.2)	15 (45.5)	21 (63.6)	17 (51.5)
Yes, bought medicine or Treatment	4 (8.5)	2 (6.1)	5 (13.5)	2 (6.1)	5 (15.2)	0 (-)
Yes, did both	12 (25.5)	13 (39.4)	9 (24.3)	16 (48.5)	7 (21.2)	16 (48.5)
Felt Cured after Treatment						
No	10 (21.3)	3 (9.1)	6 (16.2)	2 (6.1)	14 (42.4)	9 (27.3)
Yes	37 (78.7)	30 (90.9)	31 (83.8)	31 (93.9)	19 (57.6)	24 (72.7)
Was advice given useful?						
No	13 (27.7)	1 (3.0)	3 (8.1)	4 (12.1)	10 (30.3)	11 (33.3)
Yes	34 (72.3)	32 (97.0)	34 (91.9)	29 (87.9)	23 (69.7)	22 (66.7)
Confidentiality of SRH Counselling						
No	14 (29.8)	11 (33.3)	6 (16.2)	16 (48.5)	14 (42.4)	4 (12.1)
Yes	33 (70.2)	22 (66.7)	31 (83.8)	17 (51.5)	19 (57.6)	29 (87.9)

2.3.3.2 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 7). Service utilisation tended to be significantly associated with religion among males with a higher proportion of Catholic males utilising the services (χ^2 =6.3, P=0.043). The majority of males and females in all religions reported being cured and satisfied by the services provided by the health facilities visited.

Table 7. Characteristics of Health Facility Service Users

	Respondents		Of those interviewed % who used Services		Of the Service users % Cured		Of the Service users % found Advice Useful	
	Male N=183	Female N=181	M n=99 (%)	F n=117 (%)	M n=85 (%)	F n=87 (%)	M n=83 (%)	F n=91 (%)
Tribe								
Msukuma	150	144	78 (52.0)	94 (65.3)	67 (85.9)	67 (71.3)	67 (85.9)	70 (74.5)
Others	33	37	21 (63.6)	23 (62.2)	18 (85.7)	20 (87.0)	16 (76.2)	21 (91.3)
Religion								
Catholic	63	62	41 (65.1)	44 (71.0)	34 (77.3)	34 (77.3)	32 (78.1)	30 (68.2)
Other Christian	61	52	26 (42.6)	52 (59.8)	38 (73.1)	38 (73.1)	22 (84.6)	43 (82.7)
Others	59	21	32 (54.2)	21 (65.6)	15 (71.4)	15 (71.4)	29 (90.6)	18 (85.7)
Education								
Incomplete Primary	62	95	30 (48.4)	51 (53.7)	26 (78.8)	37 (69.8)	27 (81.8)	39 (73.6)
Primary School	110	82	60 (54.5)	62 (75.6)	50 (87.7)	48 (77.4)	48 (84.2)	50 (80.7)
Above Primary Sch.	11	4	9 (81.8)	4 (100.0)	9 (100.0)	2 (100.0)	8 (88.9)	2 (100.0)
Marriage Status								
Never Married	39	24	15 (38.5)	10 (41.7)	14 (93.3)	7 (70.0)	13 (86.7)	9 (90.0)
Married	132	132	77 (58.3)	93 (70.5)	67 (87.0)	70 (75.3)	65 (84.4)	73 (78.5)
Others	12	25	7 (58.3)	14 (56.0)	4 (57.1)	10 (71.4)	5 (71.4)	9 (64.3)
Occupation								
Farming	149	147	82 (55.0)	94 (64.0)	69 (84.2)	72 (76.6)	70 (85.4)	74 (78.7)
Private Salary	17	9	9 (52.9)	7 (77.8)	9 (100.0)	5 (71.4)	7 (77.8)	5 (71.4)
Others	17	25	8 (47.1)	16 (64.0)	7 (87.5)	10 (62.5)	6 (75.0)	12 (75.0)
Wards								
Misungwi	61	61	33 (54.1)	47 (77.1)	30 (90.9)	37 (78.7)	32 (97.0)	34 (72.3)
Geita	60	59	33 (55.0)	37 (62.7)	31 (93.9)	31 (83.8)	29 (87.9)	34 (91.9)
Magu	62	61	33 (53.2)	33 (54.1)	24 (72.7)	19 (57.6)	22 (66.7)	23 (69.7)

Service uptake was significantly associated with marriage status among males (χ^2 =4.9, P=0.087) and females (χ^2 =8.3, P=0.016). Services uptake was highest among married males and females and least among those never married. Similarly, service uptake was also associated with education among females (χ^2 =7.9, P=0.019) and Ward of residence among females (χ^2 =7.2, P=0.028) with females in Busingo Ward in Misungwi District reporting the highest level of service uptake compared to women from other Wards. A higher proportion of those who reported uptake of the services, reported improvement or cure and were satisfied with the advice or treatment offered.

2.3.3.3 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 significant variation of medical service uptake across the Wards among females (χ^2 =7.2, P=0.028) but not among males (χ^2 = 0.04, P=0.98) (Table 6 above). 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 81% (84% males, 78% females) reported to be satisfied with the general services provided. Among females accessing ANC services, the overwhelming majority of females accessed ANC services at the health centres (Figure 10).

Figure 10. Providers for ANC Services

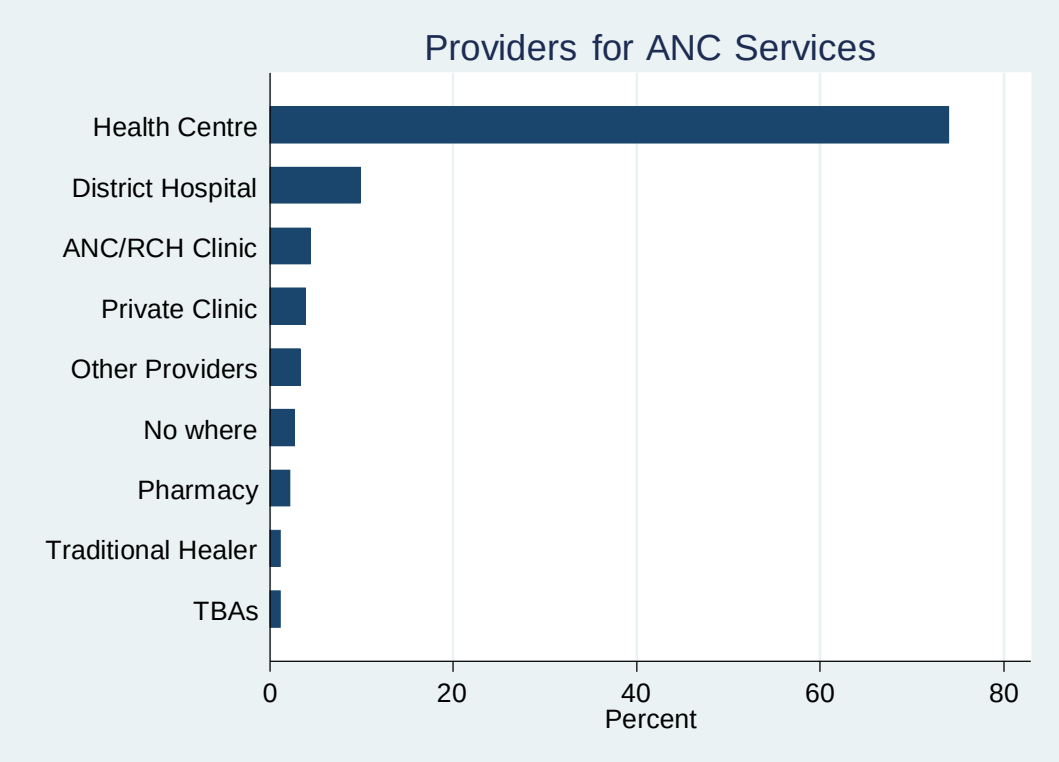
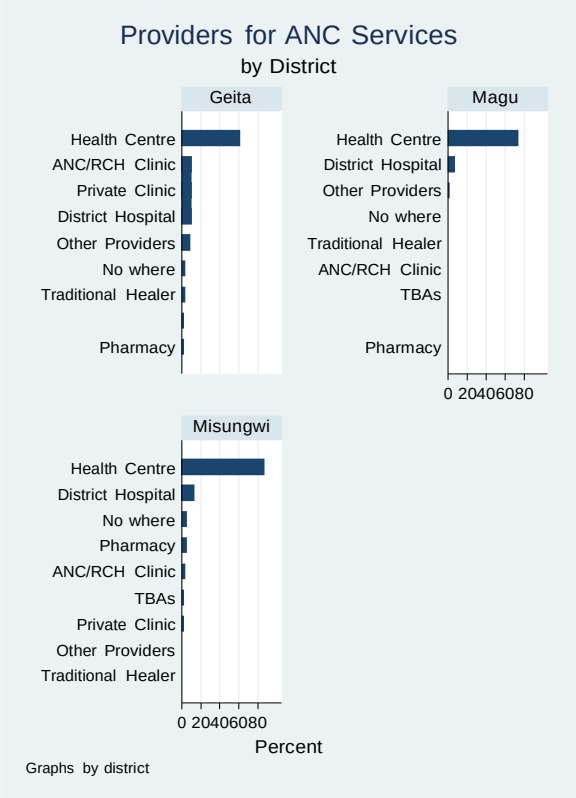


Figure 11. Providers for ANC Services by District



Across the districts, women in Magu district received services either in the

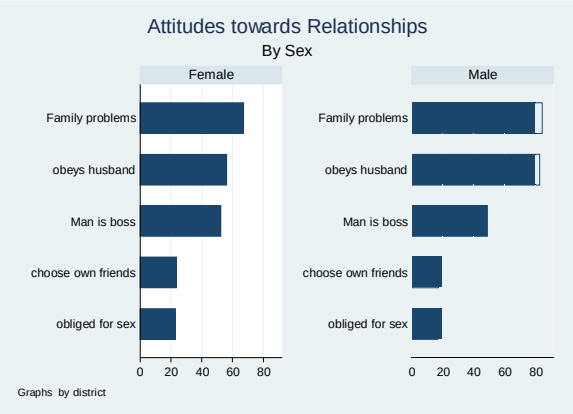
while in Misungwi district and Geita district, women received services from a range of ANC service providers though mostly received services from the health services (Figure 11).

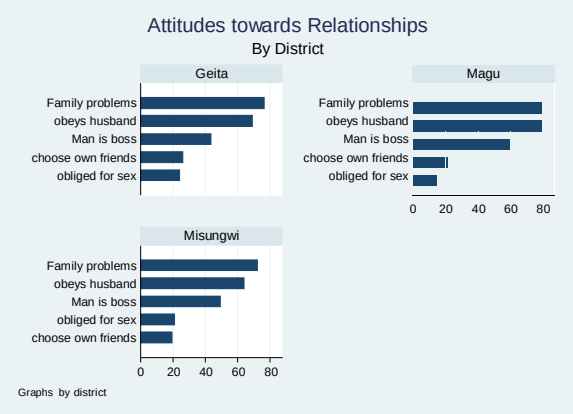
2.3.3.4 Gender Based Violence

2.3.3.4.1 Attitudes towards Relationships

A very similar pattern of attitudes towards relationship was reported by males and females across the districts evaluated (Figure 12). Males and females were in agreement that family problems should only be discussed with people in the family. Nearly 80% of males and 57% of females were in agreement that a good wife obeys her husband even if she disagrees while nearly half of women and women supported that statement that “it is important for a man to show his wife/partner who is the boss. The majority of men and women disagreed with the statement that “a woman should be able to choose her own friends even if her husband disapproves” and the statement that “it’s a wife’s obligation to have sex with her husband even if she doesn’t feel like”.

Figure 12. Attitudes towards Relationships by Sex and District



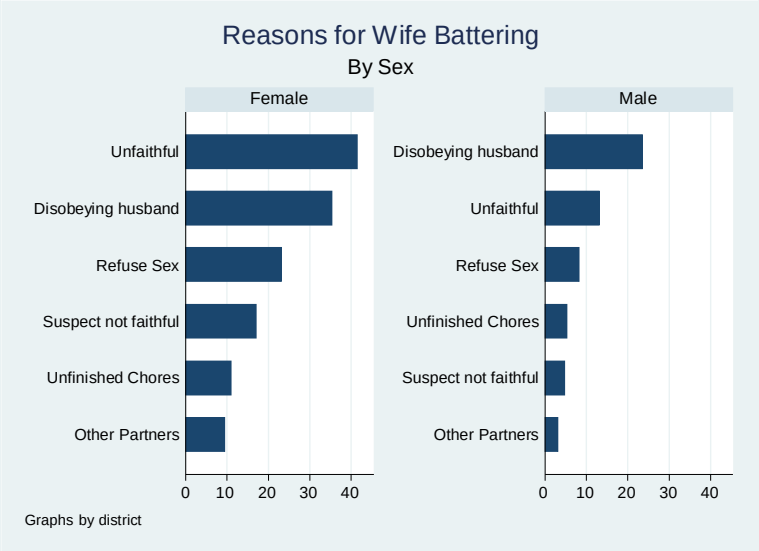


2.3.3.4.2 Extent and Reasons for Wife Battering

Several reasons for wife battering were reported. These include wife disobeying her husband, failure to complete household chores to the husband's satisfaction and wife refusing to have sexual relations with her husband. Other reasons for wife battering were if she asks him whether he has other girlfriends, he suspects that she is unfaithful or he finds out that she has been unfaithful.

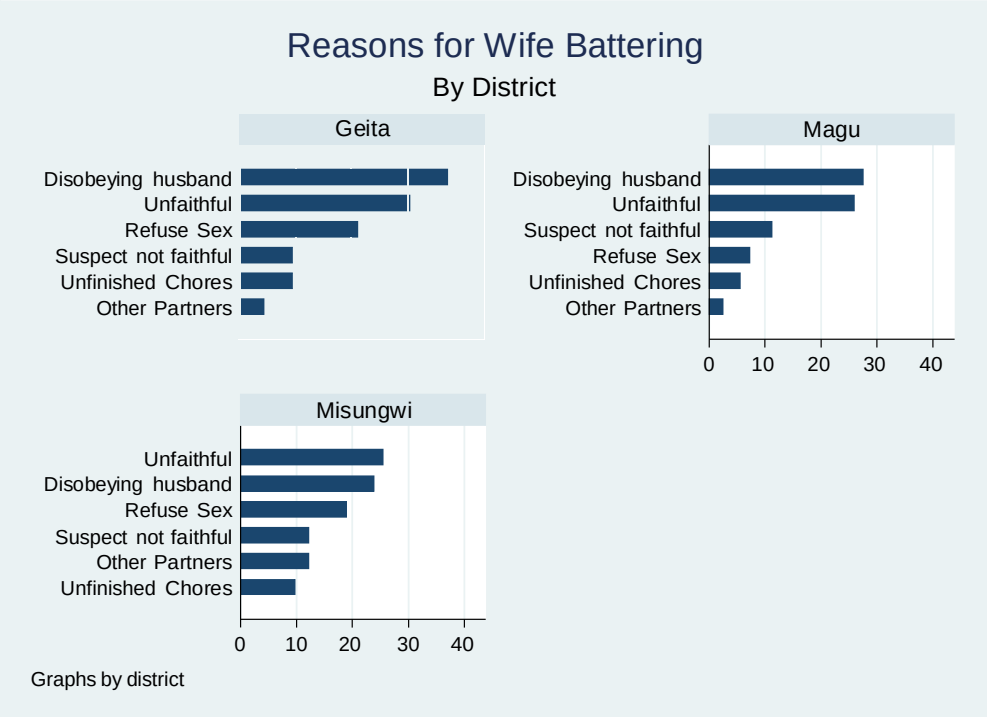
A higher proportion of women reported that they would be beaten by their husbands for these reasons compared to the proportion of males who report the same (Figure 13). Among females, the major reasons for wife battering were if the wife was found out be unfaithful, disobeying the husband, refusing sex, husband suspecting that the wife is being unfaithful and if the husband did not finish household chores. Conversely among males, disobeying the husband was ranked first as the major reason that would make a man beat his wife. Other reasons were if the wife was found out to be unfaithful or refused to have sex with her husband, unfinished household chores and suspecting that the wife was unfaithful.

Figure 13. Reasons for Wife Battering by Sex



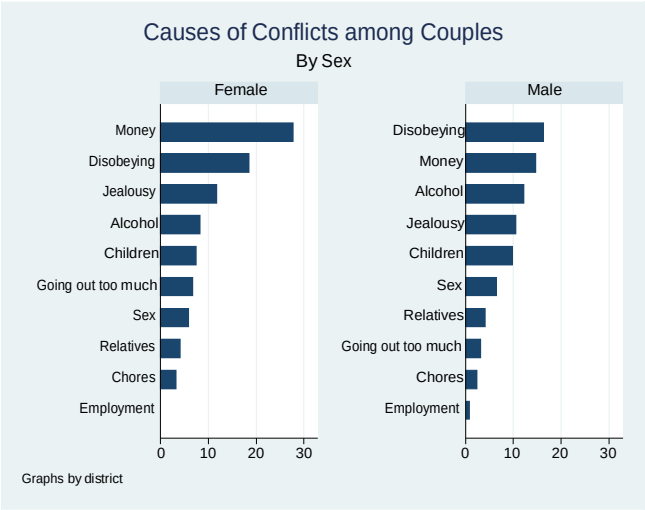
Almost a similar pattern of wife battering was reported across the three districts evaluated though a higher proportion of respondents in Nyarugusu Ward in Geita district reported a wife battering compared to other districts (Figure 14).

Figure 14. Reasons for Wife Battering by District



During the evaluation, evaluators asked the respondents the number of times in a month the respondent would say they had an argument with his/her spouse. The Majority of respondents reported that their couple had at least one conflict in a month (Figure 15). Conflicts and arguments were most frequent in the mining communities of Nyarugusu ward in Geita District compared to the rural communities of Busingo Ward in Misungwi District and trading communities of Nyanguge Ward in Magu district (χ^2 = 9.9; P=0.043).

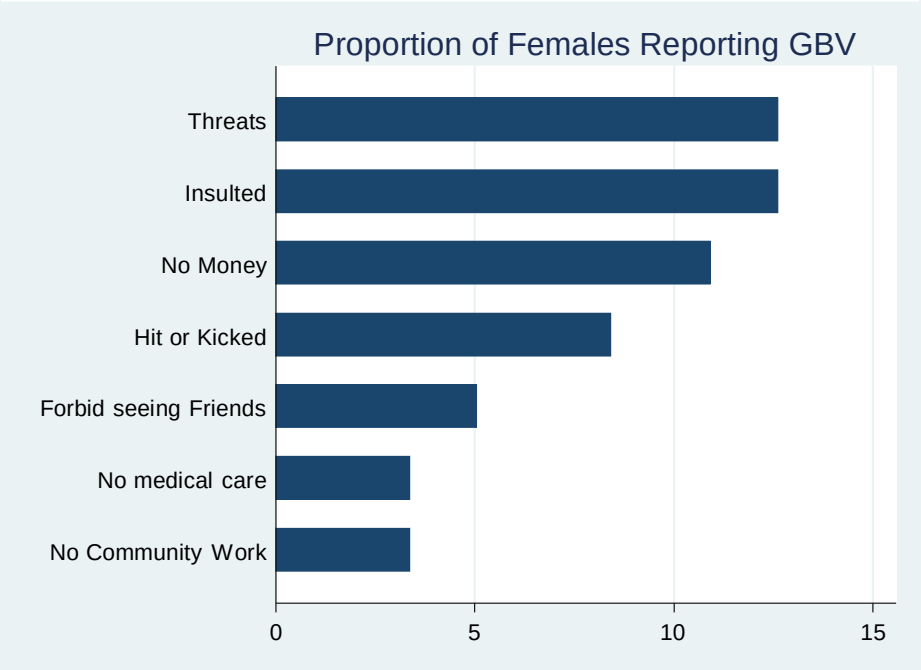
Figure 15. Frequency of Conflicts by Districts and Causes of Conflicts by Sex



Among males, a wife disobeying her husband was reported to be the leading cause of many conflicts among couples while female respondents reported that a wife asking her husband for money was the leading cause of conflicts among couples. Other reasons for conflicts and arguments reported were jealousy, alcohol, children, going out too much, sex, relatives and chores (Figure 15 above).

Due to these conflicts, some of the women in violent relationships were threatened to be beaten, insulted, or the man refused to give the money his wife or even beaten or denied to see friends and relatives, to participate in the community work and accessing medical care (Figure 16).

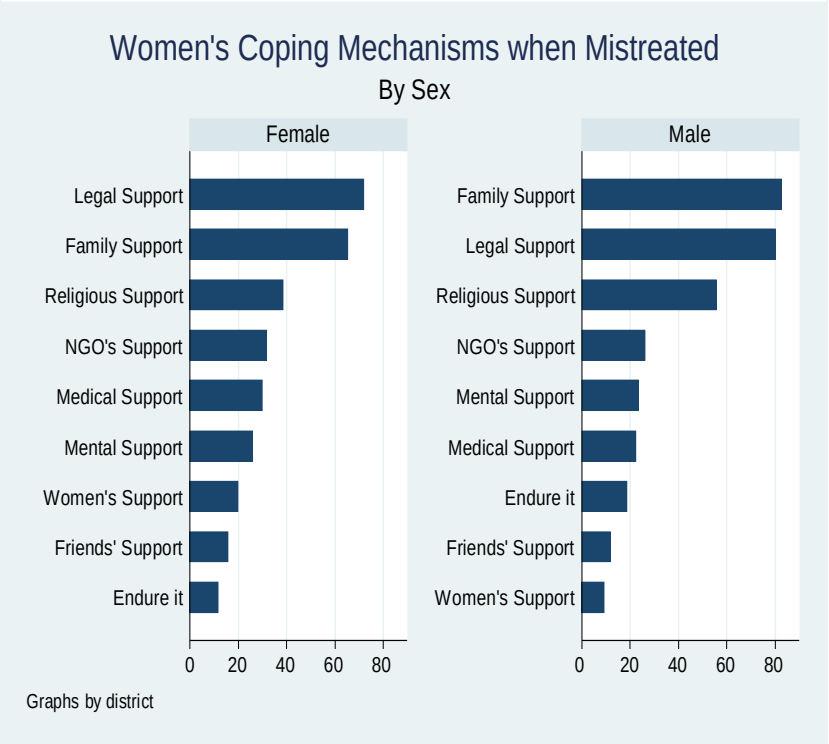
Figure 16. Prevalence of GBV among Women



2.3.3.4.3 Women's coping Mechanisms against Mistreatment

Different coping mechanisms were reported by males and females for women who are in violent relationships. Females reported legal support as the first option and family negotiation as the second option for mistreated women while men preferred family negotiation first before considering legal procedures. Other mechanisms for women in violent relations were religious support; NGO's fighting gender based violence, medical and mental support and women's and friends support. Almost 20% of the men suggested that women in violent relationships should endure the mistreatment while only 10% of the women reported that they would endure the mistreatment (Figure 17).

Figure 17. Women's Coping Mechanisms when Mistreated



2.4 Findings from the Focus Group Discussion

2.4.1 Gender Based Violence.

The focus group discussion was conducted to collect detailed information on gender based violence and measures taken by the community members to prevent gender based violence.

Community's perception on GBV

During the discussion, rape, sex with young girls and forcing women to have sex without using condoms were considered forms of gender based violence. Perpetrators for such offenses are punished by the community. However, women are who are raped were blamed if she was excessively under the influence of alcohol, had received payment for sex but refused sex or wore clothes that exposed private parts of the body.

Women participants also reported emotional abuses as forms of gender based violence. Examples given included refusal of husbands to provide money for household consumption or threats of divorce and beating.

Participants reported that the number of GBV cases especially rape and physical abuse were on the decline compared to previous years. The major reason for such a decline was the introduction of Jijenge project which has built awareness to the community especially among women on their rights. It was reported that some men have been jailed in the last 2 years for beating their wives.

"Currently, the ward mediation council doesn't have any work to do, you couldn't stay here for some minutes without receiving a case of a woman injured or raped"

VEO, Nyanguge Ward, Magu District

Regarding mediation involving gender based violence; most participants reported that disputes are first discussed at the family level. In the event they are not resolved, then the dispute is taken to Sub-village Arbitration Council, then to the Village Arbitration Council and Ward Arbitration Council before the matter goes to the courts of law if unresolved. However, rape cases are reported directly to the courts of law through Village Executive Officer and police. On some few occasions, members of the Jijenge network have been able to resolve some cases. This procedure is applicable to both men and women.

Reproductive Health Services provided in the Community

Generally, the participation of men in the reproductive and child health services has increased in recent years due to Jijenge project. The Ward development Committees and village health committees of the districts visited reported to be encouraging couples to RCH services together and receive SRH counselling together. However, women in Nyarugusu Ward reported consulting traditional herbalist for abortion of unintended and unwanted pregnancies.

"The project has had a substantial influence on family planning. Men from this community permit their wives to use various contraceptive methods. In addition, Ward development committee and village governments have initiated human rights committees for addressing GBV".

Nurse, Busongo Ward, Misungwi District

During the discussion, it emerged that women recognizes their right to family planning though decision has to be reached by couples. However, male participants were reluctant to use injectables due to fear of adverse events of using such family planning methods.

2.5 Findings from the Key Informant Interviews

2.5.1 Gender Based Violence.

Most community informants interviewed on the purposes of the project said the project was educating the communities on human rights, family planning and provision of gender sensitive SRH knowledge. It was also noted that women and men alike were active participant of the project.

"At this ward, the project has initiated some groups, which are divided into three categories; mobilization, counselling and capacity building to provide education to community members. The mobilization category works at household and sometimes holds their meetings at the open spaces because they do not have an office. The capacity-building group deals with provision of education on human rights and reproductive health. In the past days it was not easy to teach people on Stigma and Discrimination and condom use without building capacity".

WEO, Nyarugusu Ward, Geita District

Key informant interviews collected detailed information on networks collaborating with Jijenge for the reduction of gender violence and advocacy of women dignity in general. Most informants reported that the project has been working with village government and Ward development Committees at the community level and the council Health management team at the district level.

In Misungwi District, the Jijenge project has been partnering with the Tanzania Social Action Fund (TASAF) and Tunajali project in conducting HIV/AIDS education campaigns and especially fighting stigma and discrimination of the people living with HIV/AIDS emanating not only form the community but form the healthcare delivery point as well.

Regarding the policy and decision influence of the project at the local government level, it was reported that there is now an increase of men participating in the reproductive and child health services. In addition, the leaders of Community Owned Resource person (CORPS) are members of the Ward development Committees (WDC) and on realising the importance of gender based violence, Ward and Village Committee has initiated the human rights committees for addressing GBV. The reports produced by these Committees are discussed quarterly in the WDC meetings. By-laws have also been formulated as shown by these excerps

Community members have accepted the project. In my village by-laws have been enacted to deal with men who physically abuse their wives and abandon their families.

Community Volunteer, Nyarugusu Ward, Geita District

2.6 Data from Healthcare delivery Points

The team of evaluators collected data from the health facilities visited on the utilisation of services provided by these facilities. Data were collected quarterly and for women utilising ANC services, vaccination, family planning, labour and delivery and PMTCT services. Since all new clients of ANC are supposed to receive PMTCT services, only 243/721 (34%) of the women who were attending ANC services were also receiving PMTCT services in 2008. This proportion increased to 80.1% in 2009. This pattern was observed in all three health centres visited.

Bosongo Health Centre in Year: 2008

	Ante-natal Care	**Vaccination**	**Family planning**	**Labour & Delivery**	**PMTCT**
1st Quarter	163	3086	51	0 *	0 *
2nd Quarter	214	4363	75	44	50
3rd Quarter	187	4284	88	98	126
4th Quarter	157	3150	73	86	67
	721	**14883**	**287**	**228**	**243**

*the facility was under rehabilitation

Bosongo Health Centre in Year: 2009

	Ante-natal Care	**Vaccination**	**Family planning**	**Labour & Delivery**	**PMTCT**
1st Quarter	167	2304	82	72	171
2nd Quarter	163	2672	91	87	171
3rd Quarter	217	2940	64	88	89
4th Quarter	186	2578	58	92	156
	733	**10494**	**295**	**339**	**587**

CHAPTER 3

Progress towards Outcomes

3.1 Issues and Challenges

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. To address this, AMREF designed and implemented JIJENGE project –filling the gap. The aim of the project was to strengthen the right of women to receive health assistance through community sensitization and training of Health Service Providers (HSPs) in eight districts of Mwanza and Mara Regions. The project also aimed at strengthening the capacity of the health systems by improving participatory planning processes and resource allocation among district Council Health Management Teams (CHMTs) and Ward Development Committees (WDC). This section discusses the progress towards key outcomes and impact indicators.

3.1.1 Training

At the community level, the project trained community groups (2 people trained per ward), community mobilisers (4 people trained per ward) and community based counsellors (2 people trained per ward). Members of the WDC and community influential people were brought together and trained to become more sensitive to women's rights in their leadership roles. However, most members of the mediation councils were not trained. Women were being mobilised and sensitised to demand their rights however sufficient capacity was not being built to mediation councils that rules over marital disputes to support women's efforts. Therefore most gender based violence cases were arbitrated using cultural practices which are oppressive to women. Data from this evaluation shows that most disputes are first discussed at the family level. In the event they are not resolved, then the dispute is taken to Sub-village Arbitration Council, then to the Village Arbitration Council

and Ward Arbitration Council before the matter goes to the courts of law if unresolved. However, rape cases are reported directly to the courts of law through Village Executive Officer and police.

The self assessment of the impact of training on the job and organisational performance by trainees noted that the Jijenge training had had an impact on their job and organisational outputs. Behaviour changes occurred which improved the quality of counselling and provision of gender based SRH services. There were improvements in job performances observed by clients whom we met during field visits and interview sessions. Trainees also noted they were more confident on the job, had improved job satisfaction, quality of work output had increased, stigma in the work place decreased, and interest in gender sensitive SRH care increased. While the reported benefits are excellent, there was little documented evidence to substantiate these claims.

After initial training provided to community volunteers and healthcare workers, refresher course training was not sufficiently done to address gaps in skills and knowledge required to effectively carry on the project mandate. In addition, some of the community trainers and counsellors and health practitioners TOTs and counsellors have permanently moved away from the communities. In places, where this has happened, the trainers and counsellors have not been replaced. To ensure maximum use of the investment of trainees, there is a need to conduct the refresher trainings and replace the trainees where they have moved. But also there is a need to build a pool of trainers who will conduct refresher training and training to the volunteers newly recruited. With constant engagement of training, they will become proficient in conducting training, thus maximising the invested resources.

3.1.2 Change in Communities' Knowledge Regarding Women's Rights

Except for Nyanguge Ward in Magu district, almost an equal proportion of males and females reported that both partners chose each other. In addition, there is an

increasing proportion of females and males who report that bride price once an important component of marriage institution in an African setting was not paid. The bride price system embedded within culture empowered men to demand sex and necessitated women to provide sex to their husbands' even when they were not feeling so or was sick. However, women felt that women who were married with no involvement of bride price were being labelled as being "cheap". This change in bride price practices provide further evidence for the changes in the cultural attitudes 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 is an indication of the changes of the gender relations landscape in project areas.

3.1.3 Increase in the Quality of Health Facility Service Provided

Perceived quality of healthcare services was measured in terms of 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. 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 were less likely to report having paid for treatment while males were more likely to report that they have paid for treatment. For those who paid for treatment, in most cased, respondents paid for both medicine and treatment. Of those who attended the

government health facilities, only 71% females and 69% males felt the services were confidential, 74% females and 86% males reported that they felt cured or their situation had improved and 77% females and 84% males 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. This in turn is likely to be influenced by factors such as level of education, occupation, marital status and access to alternatives medicines. We analysed these factors by service utilisation. Service uptake was highest among catholic respondents, males with above primary schools and females with primary school education and male and females who are married. 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 welcome. 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.

Evidence has shown that programs targeting men should develop messages focused on the economic and health benefits of family planning. The inclusion of financial benefits was found to be more convincing for men than maternal-child

health considerations alone (Kishindo, 1994), but this is not to suggest that men do not care about the welfare of their families.

Services uptake was lowest among males and females with incomplete education compared to those with above primary school education. 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. By so doing, gender inequalities are expected to be more systematically addressed, ensuring improved access to all.

3.1.4 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 community volunteer 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 community volunteers 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 based organisations to raise awareness of the women's rights and promote demand for gender sensitive SRH services. The project has also built 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, 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.

3.2 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, and Partnership Strategy challenges.

3.2.1 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 government at the Village level. At the district level, two departments are involved: the district medical office and the district community development office. The district community development officer (DCDO) is not a member of the council health management team (CHMT) but is the chairman of Council Muti-sectoral AIDS Committee (CMACs). The project is implementing the interventions through the community groups such as CBOs and CORPS and through the Health sector. For sustainability purposes, community groups will benefit from support provided by Community Development department while healthcare delivery points benefit from the support provided by district medical office. For project efforts to be successful, gender based violence should be mainstreamed across all activities conducted by the district. In addition, 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 health information system to collect the data at the community level to help and support decision making at the community and district levels. The data collected at the community level was first discussed at the community level and subsequently taken to the district level for evidence based decision making. The evaluators conducted meetings either with the DRCHCO or the council health management team, there was no evidence that the data collected from the district was being analyzed and used for decision making. Likewise, data collected by healthcare facilities as part of the health management information system was not discussed at the community level for evidence based decision making. There is need to make sure that the information collected by the community 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.

3.2.1 Shortage of Health Service Providers

The health sector which manages a substantial part of the JIJENGE Project in providing the gender sensitive SRH services which includes domestic and marital counselling, family planning and STI Counselling 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,

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

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 healthcare 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).

3.2.3 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.

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

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. TASAF, TUNAJALI 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 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 FOUR

CONCLUSION, LESSONS LEARNT AND RECOMMENDATIONS

This chapter draws together the conclusions from the JIJENGE! project – filling the gap 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.

4.1 Institutionalization of Jijenge Concept

Gender Based Violence (GBV) occurs all over the world, regardless of age, class, ethnicity, and culture. It can include physical, sexual or psychological violence and can have serious implications for a woman's physical and mental health. GBV also contributes to the cycle of poverty for many women, children, and families by disempowering women, restricting their participation in the community, and degrading the health status and economic capacity of the family as a whole.

While both men and women experience violence, the risk factors, patterns, and consequences of violence against women are different than violence against men. Referring to violence as 'gender-based' highlights the need to understand violence against women in the context of the behaviours, norms, and attitudes that legitimise and perpetuate the subordinate position of women in Mwanza and Mara Regions.

Violence against women has been recognised as a major public health and human rights issue. In the context of sexual and reproductive health (SRH), GBV has been linked to an increased risk of unwanted pregnancies, pregnancy complications, gynecological disorders, unsafe abortions, miscarriages, and sexually transmitted infections (STIs), including HIV and AIDS. Fear of violence may also hinder women's ability to seek and access treatment and care.

There are many benefits for instutionalizing the Jijenge concept, that's providing reproductive health services in the context of gender relationships:

- Women who experience GBV are at increased risk for a variety of SRH-related problems. Violence can limit a woman's ability to negotiate the use of condoms or other contraception, thereby increasing her risk of unintended pregnancies and STIs.

- Providers may misdiagnose clients or offer inappropriate care if they do not ask about violence. Without knowing a woman's experience of violence, it can be difficult for providers to properly diagnose or treat conditions such as re-occuring STIs and chronic pain, or provide effective and appropriate counselling.

- Health care providers are strategically placed to identify women at risk of GBV. Health programs especially those that provide SRH programs are often among the few institutions that have routine contact with most adult women in Tanzania.

- Health professionals can help to change societal attitudes about violence against women because they can reframe violence as a health problem instead of just a social custom or private family problem. Conservative elements of society that tolerate or justify violence against women sometimes change their views when health professionals demonstrate the negative consequences of GBV for women's health and children's health.

Similarly, health professionals can inadvertently put women at risk or increased risk, if they are uninformed or unprepared. This could happen by:

- Expressing negative attitudes to clients about women who are beaten and raped.
- Responding poorly to a disclosure of violence (e.g., blaming the victim).

- Breaching patient confidentiality by sharing information about a client's medical history without her consent or discussing a woman's injuries in an environment where a potentially violent partner can overhear.
- Missing warning signs that woman is in danger of suicide or homicide and failing to offer crisis intervention.

4.2 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 healthcare 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 Jijenge Project has increased the women's awareness and knowledge on human rights and reproductive health and the need for women to access SRH services. Following the implementation of the project, women now contribute substantially to the decision making process at the household and community levels.

- 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.

- Due to renovation of health facilities and HIV/AIDS education campaigns conducted to fight stigma and discrimination of the people living with HIV/AIDS emanating not only form the community but form the healthcare delivery point as well. The number of people testing for HIV infection has increased. Similarly, home based care services has improved and identified a large number of patients who are receiving ART treatment.

- The GBV cases have decreased in the community following the introduction and implementation of the Jijenge project compared to pre-intervention levels of the GBV cases.

- The reported number of pregnant women with the health facility delivery has increased compared to the pre-intervention levels. For instance in Busongo Ward, the number increased from 228 in 2008 to 339 in 2009.

- The number of women who are utilising family planning services has increased compared to the pre-intervention levels. The proportion of males attending ANC and RCH with their wives has also increased compared to pre-intervention levels.

- Due to shortages of healthcare providers, others tasks such as counselling has been delegated to less specialised workers e.g. community counsellors. By reorganizing the workforce in this way, task shifting presents a viable solution for improving healthcare coverage by making more efficient use of the human resources already available. A large number of community workers who are in need of counselling are now counselled by community counsellors thus reducing the number of people flowing to healthcare delivery points for counselling.

- The project has trained community volunteers who own the project activities and data on domestic violence is recorded regularly at the community level

even though there are still challenges on the level of utilisation of these data.

- The health facilities are providing gender sensitive, confidential and satisfactory services to the communities.

- 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,

4.3 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.

- Despite several success outlined above, the coverage of the project to the rural and remote areas has to continue as a large number of community members are not informed on the objectives of the project.

- Change of village leadership at the community level also constrains progress of the project due to lack of strong supervision. Community trainers have been trained but there is little evidence that they have conducted cascaded training to new village leadership when there has been change of village leadership.

- The 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 impact of the project is limited by several factors inherent within the health systems such as shortage of staff, lack of medication in the healthcare delivery system and availability of other alternative sources of care e.g. traditional healers and traditional birth attendants.

- JIJENGE project – filling the gap 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 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.

- For gender 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.

- 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, TASAF, and TUNAJALI 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.

- Interventions aiming to change behaviour tend to be long term in order to achieve that aim. There is a still a need for gender based SRH and human rights intervention to continue. This education has to be provided by NGOs, government and religious institutions. Brochures about human rights could be essential in bringing about the desired change for adolescents. For instance, the evaluation team observed that *Si Mchezo* magazine published in Dar es Salaam was read by a large number of adolescents in the communities. Such brochures could be used to bring about the behaviour change among adolescents.

4.4 Recommendations

The following are the key recommendations arising from the evaluation:

4.4.1 Continuity of the Current Implementation Strategy:

JIJENGE should continue with the current implementation strategy since this has been preferred by the districts and community 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.

4.4.2 Support Gender Mainstreaming in Key Sectors

There is need for JIJENGE to engage with other partners to ensure provision of technical assistance for effective gender 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.

4.4.3 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.

4.4.4 Engage with Partners 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.

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

JIJENGE should provide technical assistance to local governments and communities to address the weak community information systems. Data collected at the community level does not contribute into providing evidence for decision making at the district level likewise data generated by health facilities does not contribute into decision making at the community level. 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.

4.4.6 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.

4.4.7 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.

4.4.8 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 scaling-up the interventions to all wards in these regions by partnering with District Councils. Districts could infuse project concept and activities in the Council Health plans through basket-funding budget scheme. This will include on-the-job trainings, gender sensitive health education sessions at the health facilities and inclusion of awareness raising meetings on gender issues.

References

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Annex 1: Modified Kirkpatrick's Five levels of Learning

Evaluation level and related questions	*Examples of evaluation tools and methods*	*Relevance and practicability*
Level 1. Reaction – how the HSPs felt, and their personal reactions to the training or learning experience		
Did the trainees enjoy the training in terms of style, content and the level of effort required to make the most of the learning? Did they consider it relevant to their needs? The perceived practicability of the training and the potential for applying the learning back in the workplace.	Typically end of training feedback forms based on subjective personal reaction to the training experience. Verbal reaction which can be noted and analyzed. Post-training surveys or questionnaires. Subsequent verbal or written reports given by HSPs to managers back at their jobs.	Can be done immediately the training ends. Very easy to obtain reaction feedback. Feedback is not expensive to gather or to analyse for groups.
Level 2. Learning – the measurement of the increase in knowledge or intellectual capability from before to after the learning experience		
Did the trainees achieve the intended learning outcomes? Has achievement of learning outcomes equip trainees to carry out their duties more effectively? Did the trainee experience what was intended for them to experience? What is the extent of advancement or change in the trainees after the training, in the direction or area that was intended?	Typically before and after training tests, based on the curriculum and closely linked to learning outcomes. Measurement and analysis is possible and easy on a group scale. Reliable, clear scoring and measurements need to be established, so as to limit the risk of inconsistent assessment.	Relatively simple to set up, but more investment and thought required than reaction evaluation. Highly relevant and clear-cut for certain training such as quantifiable or technical skills. Less easy for more complex learning such as attitudinal development.
Level 3. Behaviour – the extent to which the trainees applied the learning and changed their behaviour.		
How did the trainees apply their learning when back on the job? What noticeable and measurable changes were there in trainee performance when back on the job? Was this sustained? To what extent was the trainee able to transfer their learning to other staff? Is the trainee aware of their change in behaviour, knowledge, skill level?	Observation and interview over time are required to assess change, its relevance and sustainability. Assessments need to be designed to reduce subjective judgement of the observer or interviewer, which is a variable factor that can affect reliability and consistency of measurements. Assessments can be designed around relevant performance scenarios, and specific key performance indicators or criteria. Online and electronic assessments are more difficult to incorporate - assessments tend to be more successful when integrated within existing management and coaching protocols.	The opinion of the trainee, which is a relevant indicator, is also subjective and unreliable, and so needs to be measured in a consistent and defined way. Cooperation and skill of observers, typically line-managers, are important factors, and difficult to control. Behaviour change evaluation is possible given good support and involvement from line managers or trainees, so it is helpful to involve them from the start, and to identify benefits for them.
Level 4. Results – the effect of training on the organisation/health facility or environment resulting from the improved performance of the trainee.		
What quantifiable aspects of performance	It is possible that many of these measures are already in	Individually, results evaluation is not

have improved since staff received training – for instance: quality gender sensitive SRH services provided; What qualitative aspects of performance have improved since staff received training – for instance: staff satisfaction, client satisfaction, etc.? To what extent can these improvements be attributed to learning outcomes recorded under levels 1 and 2 and behavioural changes recorded under level 3?	place via normal management systems and reporting. The challenge is to identify which and how relate to the trainee's input and influence. Therefore it is important to identify and agree accountability and relevance with the trainee at the start of the training, so they understand what is to be measured. This process overlays normal good management practice - it simply needs linking to the training input. Failure to link to training input type and timing will greatly reduce the ease by which results can be attributed to the training.	particularly difficult; across an entire organisation it becomes very much more challenging, not least because of the reliance on line-management, and the frequency and scale of changing structures, responsibilities and roles, which complicates the process of attributing clear accountability. Also, external factors greatly affect organisational and business performance, which cloud the true cause of good or poor results.
Level 5. Community Sensitization – raising people's awareness about the availability of improved gender sensitive sexual and reproductive health services in the nearest health services.		
Has the right information been shared regarding the available services at the health care facilities? What are the community led structures that have been established to address gender imbalances and other community factors affecting the uptake of services?	It is possible that the communities have observed changes in service provision or privacy and confidentiality following training Information sharing and provision of high quality gender sensitive sexual and reproductive health services will increase the uptake of the services Failure to address the community barriers for the uptake of the services will greatly reduce the uptake of the services	Very easy to obtain reaction Feedback is not expensive to gather or to analyse

Annex 2: Relating Kirkpatrick's modified model to TOR and scope of analysis

Kirkpatrick's levels	*Main evaluation objectives*	*Detailed evaluation questions*	*Sources*	*Analysis*
Level 1: Reaction How the delegates felt, and their personal reactions to the training or learning experience	Aspects of training leading to knowledge and skills transfer and behavioural change	- To what extent were training objectives achieved? - Were your personal objectives for attending training programmes achieved? - Did your understanding of the subject improve as a result of the training programme? - Top what extent has the programme helped to enhance your appreciation and understanding of your job as a whole?	Training Needs Assessment Report Training reports Survey questionnaires FGDs In-depth Interviews	Analysis of quantitative and qualitative data would enable us to synthesise reactions of participants to the gender sensitive SRH training.
Level 2: Learning The measurement of the increase in knowledge or intellectual capability from before to after the learning experience	Knowledge & skills gained and retained	- Did the trainees learn what intended to be taught? - Did the trainees experience what was intended for them to experience in order to acquire knowledge and skills? - What is the extent of advancement or change in knowledge and skills in provision of gender sensitive SRH services? - What knowledge and skills have been gained by health workers who were trained?	Training Needs Assessment Review of training reports including pre and post test scores Survey questionnaires FGDs In-depth Interviews	Analysis of quantitative and qualitative data would enable us to synthesise knowledge and skills gained and retained.
Level 3: Behaviour The extent to which the trainees applied the learning and changed their behaviour.	Behavioural changes amongst trainees	- Have there been behavioural changes among trainees and the other health care practitioners as a result of their training or mentorship? - Did the training put their learning into effect when back on their job? - What kinds of changes can be witnessed?	Survey questionnaires Documents reviews Self assessments Interviews with service users	Analysis of quantitative and qualitative data would enable us to synthesise findings in relation to behavioural changes among trainees as compared to non-trainees.

Kirkpatrick's levels	*Main evaluation objectives*	*Detailed evaluation questions*	*Sources*	*Analysis*
Level 4: Results The effect on the organisation or environment resulting from the improved performance of the trainee.	Changes in services provision due to training	- Has the training resulted in changes in SRH service provision? - Has this training resulted in better treatment and care practices? - How much more effective/ or efficient are the participants in the workplace? - Questions would also be developed to focus on health facility performance indicators such as: i. No of patients seeking services pre and post trainings. ii. Numbers of complaints or commendations iii. Quality ratings iv. Achievement of standards, etc. - Did the training help the health facility to meet its objective? - Did the training provide additional spin-off benefits for the organisation?	Survey questionnaires Documents reviews FGDs Interviews with service users Most significant change technique	Analysis of quantitative and qualitative data would enable us to synthesise findings in relation to changes in health practices as a result of conduct of trainings.
	Satisfaction The analysis will also examine the satisfaction of trainee to determine whether a more satisfied trainee is more likely to use the information learned compared to someone who is not satisfied.	- Were the trainees able to satisfy their personal objectives - How much of learning do trainees found useful in the workplace? - What factors helped or deters transfer of learning? - Which aspects of learning have not been applied in the workplace and why? - How much more effective and efficient have trainees be in providing services to the users?	Survey questionnaires Documents reviews Self assessments Consultation with stakeholders Interviews with service users	Analysis of quantitative and qualitative data would enable us to synthesise findings in relation to satisfaction of trainees with the trainings and utilisation.
	Advocacy and Networking The analysis will also examine the impact of advocacy and networking activities	- Have advocacy strategies impacted the uptake of quality SRH services? How? - Were appropriate materials and culturally sensitive messages used by partners for advocacy?	Survey questionnaires Documents reviews Self assessments Consultation with partners Interviews with service users	Analysis of quantitative and qualitative data would enable us to synthesise findings on the quality of trainings.