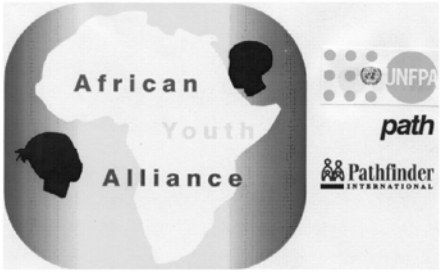
Youth-Friendly Services: Tanzania
End of Program Evaluation Report

African Youth Alliance (AYA)

December 2005



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List of Acronyms

ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
AYA	African Youth Alliance
BCC	Behavior Change Communication
ECP	Emergency Contraceptive Pills
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
IDC	Infectious Disease Center
MOH	Ministry of Health
MST	Marie Stopes Tanzania
NGO	Nongovernmental Organization
PAC	Postabortion Care
PATH	Program for Appropriate Technology in Health
PNC	Postnatal Care
SRH	Sexual Reproductive Health
STI	Sexually Transmitted Infection
TOT	Training of Trainers
UMATI	The Family Planning Association of Tanzania
UDSM	University of Dar es Salaam
UNFPA	United Nations Fund for Population Activities
VCT	Voluntary Counseling and Testing
YFS	Youth-Friendly Services

EXECUTIVE SUMMARY

The African Youth Alliance (AYA) was launched by Pathfinder International, the Program for Appropriate Technology in Health (PATH), and the United Nations Fund for Population Activities (UNFPA) in the fall of 2000. AYA was funded with a grant from the Bill and Melinda Gates Foundation and administered through the U.S. Committee for the UNFPA. AYA sought to improve overall Adolescent Sexual and Reproductive Health (ASRH) and reduce the spread of HIV/AIDS and other Sexually Transmitted Infections (STIs) in four African countries – Botswana, Ghana, Tanzania, and Uganda. Pathfinder International was responsible for the implementation of two of the six component areas of AYA, namely Youth-Friendly Services (YFS) and institutional capacity building in each of these countries.

The AYA/Pathfinder approach to YFS focused on the following:

- Building on existing resources, using available facilities and service providers;
- Reaching young people through a variety of channels such as: static clinics, outreach including peer education, and the private and commercial sectors;
- Establishing linkages with effective referral sites;
- Creating partnerships with other institutions for future scaling-up; and
- Instituting a minimum package of youth-friendly Sexual and Reproductive Health (SRH) services, including:
    - Information and counseling on sexuality, safe sex and reproductive health;
    - Contraceptive method provision (with an emphasis on dual protection);
    - STI diagnosis and management;
    - HIV counseling (and referral for testing and care);
    - Pregnancy testing and antenatal and postnatal care;
    - Counseling on sexual violence and abuse (and referral for needed services); and
    - Postabortion care counseling and contraception (with referral for treatment of complications when necessary).

Specifically, the AYA/Pathfinder strategy for implementing youth-friendly SRH services included the following:

- Facility assessments
- Development and implementation of action plans for quality improvements based on the results of the facility assessments
- Provision of essential technical assistance and monitoring to the institutions, management and clinics as per identified needs
- Training of service providers using Pathfinder's Reproductive Health Services for Adolescents Curriculum
- Training of supervisors in supportive supervision of youth-friendly SRH services
- Orientation of program managers and site supervisors and other non clinical staff on basic SRH issues and how to interact with youth clients
- Training and assistance on data collection and analysis of service statistics
- Implementation of youth input and feedback mechanisms
- Creation and/or expansion of peer education programs

- Community sensitization in SRH and involvement in peer selection for outreach work
- Institutionalization of YFS through development of standards and guidelines, YFS tools, and YFS curricula for in-service training

YFS interventions were implemented in Tanzania by 14 partners in 10 districts, including:

- Marie Stopes Tanzania (MST),
- Dar City Council/Infectious Disease Center (IDC),
- University of Dar es Salaam (UDSM),
- The Family Planning Association of Tanzania (UMATI)
- Arusha Municipal Council,
- Ilala Municipal Council,
- Karagwe District Council,
- Kasulu District Council,
- Kibondo District Council,
- Kinondoni Municipal Council,
- Tarime District,
- Temeke Municipal Council,
- MOH Zanzibar (Unjuga and Pemba Island), and
- MOH Mainland.

AYA/Pathfinder achieved the following results, organized by static facility, outreach, case study, and overall results:

Static Facility Results

Facility Reassessment: All reassessed facilities showed improvements in their overall scores between baseline and endline assessment. Most of the elements assessed also showed improvement from baseline to endline. Improvements included increased privacy and confidentiality, addition or expansion of peer education or other outreach programs, increased publicity of services, increased competency of staff, greater orientation of non-medical staff, the creation of separate spaces for youth, more counseling in dual protection, more educational materials available for youth, and improved attitudes of service providers towards youth clients. Elements identified as needing additional attention include expanding ongoing orientation of non-medical staff, strengthening formal referral systems, decreasing client waiting time, and ensuring supplies of contraceptive methods, testing reagents, and educational materials. While AYA did not provide commodities, efforts should be made to improve commodity security.

Analysis of Client Satisfaction Data: Mystery client, exit, and in-depth interviews, as well as client feedback registers, revealed that staff were friendly and welcoming (both reception staff and service providers), materials with ASRH messages were generally available, and service providers effectively counseled and communicated with youth.

However, further improvements are needed in ensuring greater availability of teaching and job aids and condoms, as well as in ensuring privacy and reducing interruptions during counseling.

Trend Analysis: Analysis of service statistics showed that the numbers of visits increased from January to December 2004, but did not always increase from quarter to quarter. Females in the 20-24 year age range utilized the services more than any other group and new visits exceeded revisits. Counseling was the most utilized service by youth, particularly counseling on RH and sexuality issues. The male condom was the most requested method of contraception.

Outreach Results

Analysis of Client Satisfaction and Peer Assessment Data: Data showed that youth clients found peer providers friendly and received information on HIV and abstinence from them. The study also found youth increased their SRH knowledge as a result of their exposure to a peer service provider. The majority of peer providers demonstrated proper condom use and communication skills through their assessments.

Analysis of In-Depth Interview Data: Peer providers noted that challenges to their work included the need for more training, community member misperceptions of ASRH, lack of adequate support and supervision, and an inadequate supply of BCC materials and contraceptives.

Case Study Results

AYA/Pathfinder in Tanzania, together with the Ministries of Health of the mainland and Zanzibar Island, demonstrated that it is possible to integrate youth-friendly SRH services in public health facilities. This is contrary to the popular perspective that NGOs are always better placed to offer youth-friendly SRH services. The collaboration between AYA/Pathfinder and the Ministries of Health has been documented in detail in a separate publication (*Integrating Youth-Friendly Sexual and Reproductive Health Services in Public Health Facilities: A Success Story and Lessons Learned in Tanzania).*

Overall Results

Challenges to implementation included interruptions in supplies such as BCC materials and contraceptives for facilities and peer providers, community misperceptions of ASRH, heavy workload of facility staff, lack of understanding of the term YFS by youth clients, and lack of adequate monitoring and supervision of facilities and peer providers. Recommendations for future projects such as AYA include more human resources to provide technical assistance and supervision, work with government and other donors to ensure that supplies of contraceptives and other necessary materials are in place in sufficient quantity and consistently, establish stronger systems for recruitment, training and mentoring of peer providers, ensure inclusion of the public sector in YFS efforts, and ensure evaluation tools and systems are in place at the beginning of the project.

INTRODUCTION

The African Youth Alliance (AYA) was launched by Pathfinder International, the Program for Appropriate Technology in Health (PATH), and the United Nations Fund for Population Activities (UNFPA) in the fall of 2000. AYA was funded with a grant from the Bill and Melinda Gates Foundation and administered through the U.S. Committee for the UNFPA. AYA sought to improve overall Adolescent Sexual and Reproductive Health (ASRH) and reduce the spread of HIV/AIDS and other Sexually Transmitted Infections (STIs) in four African countries – Botswana, Ghana, Tanzania, and Uganda.

The main beneficiaries for the project were young people between the ages of 10 and 24, with an emphasis on 10 – 19 year olds. The secondary targets included teachers, health workers, social workers and parents. In addition, the tertiary target group included religious leaders, the media, politicians, and policy makers. The latter group was crucial for creating a supportive environment for the project. The project was developed with a focus on six broad areas, including:

1) Advocacy and policy – The creation of supportive community and political environments through advocacy and policy efforts at both the national and community levels, and efforts to improve communication between young people and the adults in their lives.
2) Behavior Change Communication (BCC) – The development and expansion of behavior change communication through interpersonal communication; folk and mass media, including drama; life planning skills programs for youth; peer education and counseling; and social marketing campaigns.
3) Youth-Friendly Services (YFS) – The improvement of young people's access to – and the quality of – reproductive health services by developing, expanding and institutionalizing youth-friendly services in a variety of settings.
4) Institutional capacity building – Strengthening the institutional capacity of the country-level partners so they can better plan, implement, manage, and sustain programs and services.
5) Life and livelihood skills development – The integration of sexual and reproductive health into existing livelihood skills development and training programs for youth.
6) Coordination and dissemination – Coordination and information sharing of program activities, lessons learned, and best practices.

Pathfinder International was responsible for the YFS and institutional capacity building components implemented in each country.

Needs assessments conducted by AYA Tanzania confirmed earlier known facts that most available sexual and reproductive health service outlets were specifically designed to serve adults and youth feel intimidated to use such facilities. In addition, the assessments found that the low rate of service utilization for the youth, including a low contraceptive use, was attributable to a number of factors, including the following:

- Lack of access to YFS
- Lack of information on availability of services
- Lack of skills among service providers on how to deal with youth
- Stigma associated with seeking sexual and reproductive health services by youth
- Limited understanding of the need for youth-friendly SRH services by parents, teachers, policy makers and faith leaders

Through the YFS component, AYA/Pathfinder sought to address the factors that hinder young people from seeking services and to make them youth-friendly. Youth-friendly services are those that attract youth, meet a variety of young people's needs comfortably and responsively, and succeed in retaining them for continuous care.

Pathfinder had, through previous work worldwide, developed a list of the key elements of youth friendly services. Under AYA, these have been categorized into essential and supportive elements as presented in table 1.

Table 1: Characteristics of Youth Friendly Services

Essential	*Supportive*
• Convenient open hours • Privacy ensured • Competent staff • Respect for youth • Minimum package of services available • Sufficient supply of commodities and drugs • Range of family planning methods offered • Emphasis on dual protection/ condoms • Referrals available • Young adolescents (12-15) are served • Confidentiality ensured • Waiting time not excessive • Affordable fees • Separate space and/or hours for youth	• Youth input/feedback to operations • Accessible location • Publicity for YFS • Comfortable setting • Peer providers/counselors available • Educational materials available • Delay of blood test and pelvic exam, if possible • Partners welcomed and served • Non-medical staff oriented • Provision of additional educational opportunities • Outreach services available

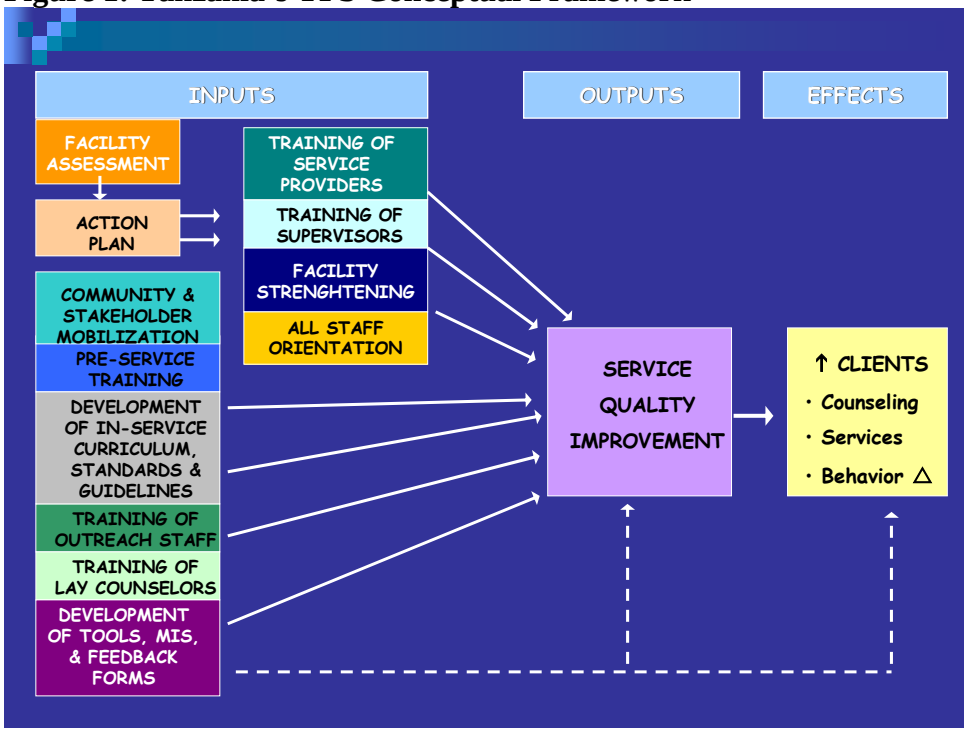
The AYA Pathfinder approach to YFS focused on the following:

- Building on existing resources by using available facilities and service providers;
- Reaching young people through a variety of channels such as: static clinics, outreach including peer education, and the private and commercial sectors;
- Establishing linkages with effective referral sites;

- Creating partnerships with other institutions for future scaling-up; and
- Instituting a minimum package of youth-friendly SRH services, including:
    - Information and counseling on sexuality, safe sex, and reproductive health;
    - Contraception and protective method provision (with an emphasis on dual protection);
    - STI diagnosis and management;
    - HIV counseling (and referral for testing and care);
    - Pregnancy testing and antenatal and postnatal care;
    - Counseling on sexual violence and abuse (and referral for needed services); and
    - Postabortion care counseling and contraception (with referral for treatment of complications when necessary).

AYA/Pathfinder's YFS work is reflected in the conceptual framework presented below (figure 1).

Figure 1: Tanzania's YFS Conceptual Framework



The AYA/Pathfinder strategy for establishing youth-friendly SRH services included the following activities:

1) Facility assessments;
2) Development and implementation of action plans for quality improvements based on the results of the facility assessments;
3) Provision of essential technical assistance and monitoring to the institutions, management, and clinics as per identified needs;
4) Training of service providers in ASRH and YFS;

5) Training of supervisors in supportive supervision of youth-friendly SRH services;
6) Orientation of program managers and site supervisors and other non clinical staff on basic SRH issues and how to interact with youth clients;
7) Training and assistance on data collection and analysis of service statistics;
8) Implementation of youth input and feedback mechanisms;
9) Creation and/or expansion of peer education programs;
10) Community sensitization in SRH and involvement in peer selection for outreach work; and
11) Institutionalization of YFS through the development of standards and guidelines, YFS tools, and YFS curricula for in-service training.

The work was implemented in collaboration with the government of Tanzania through 14 partners. The partners were chosen based on their experience in implementing reproductive health and/or programs for youth, and on their potential to reach more youth through integration of YFS. AYA staff also looked for organizations with good financial capability and aimed to include a mix of public and private organizations. Selected partners included:

- Marie Stopes Tanzania (MST),
- Dar City Council/Infectious Disease Center (IDC),
- University of Dar es Salaam (UDSM),
- The Family Planning Association of Tanzania (UMATI),
- Arusha Municipal Council,
- Ilala Municipal Council,
- Karagwe District Council,
- Kasulu District Council,
- Kibondo District Council,
- Kinondoni Municipal Council,
- Tarime District,
- Temeke Municipal Council,
- Ministry of Health Zanzibar (Unjuga and Pemba Island), and
- Ministry of Health Mainland.

This report highlights the results of the YFS work implemented in Tanzania. It describes the work implemented by AYA/Pathfinder, the process used to evaluate the interventions, and the findings of the evaluation. It also offers recommendations on implementing and evaluating future YFS efforts.

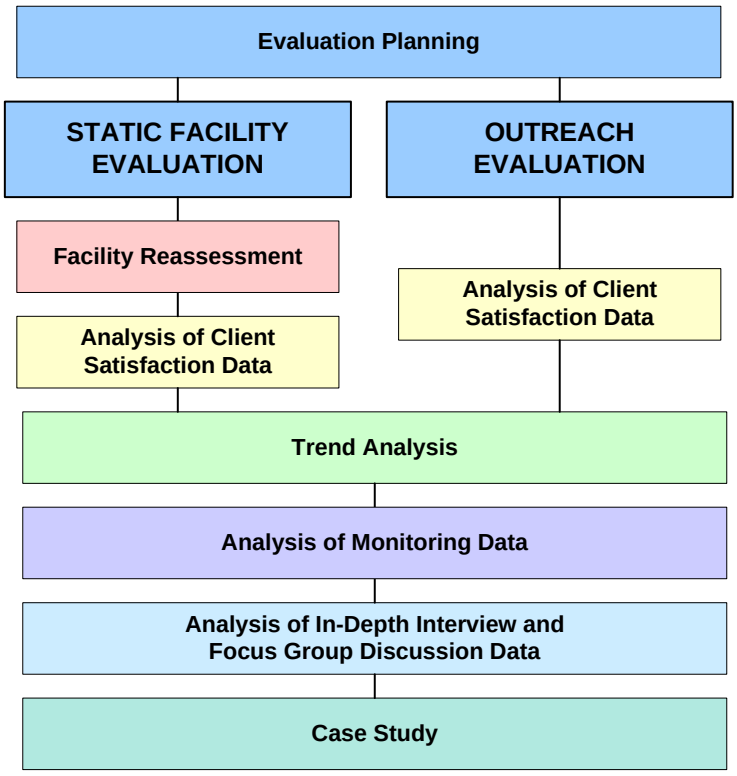
OVERALL METHODOLOGY

The YFS evaluation consisted of a number of activities designed to assess the extent to which the interventions met their objectives (increased use of services), and to capture successes, challenges, and lessons learned of both the facility and outreach efforts. The evaluation process was designed by both Pathfinder headquarters and field staff and implementation was carried out by the field staff, with assistance from Pathfinder headquarters. Key evaluation activities included:

1) Evaluation planning,
2) Facility reassessments,
3) Analysis of client satisfaction data,
4) Trend analysis,
5) Analysis of monitoring data,
6) In-depth interviews and focus group discussions, and
7) Case studies.

The diagram below shows the evaluation activities under both the static facility and outreach efforts, forming the outline for this report.

Figure 2: Tanzania Evaluation Framework



Each of the activities is described generally in this section and then more specifically as it relates to the facility and outreach evaluations later in the report.

Evaluation Planning: An evaluation strategy meeting was conducted in November 2004 with headquarters and field staff from three AYA countries (Ghana, Tanzania, and Uganda). During this meeting, the team inventoried data already available, mapped their respective conceptual frameworks, mapped and prioritized inputs for evaluation, identified methodologies, developed their end of program evaluation plans, and discussed how to manage and monitor the plan. As part of the process, Tanzania listed its major intervention areas and then weighted these in relation to the level of effort invested (time, human resources, and money). Using this information, staff selected the following key activities to evaluate based on available resources for evaluation: facility strengthening, client satisfaction, and outreach.

Facility reassessments: AYA/Pathfinder field staff reassessed a sample of facilities (16) using the facility assessment tool,[1] and applied the certification tool[2] to establish endline results in March and April 2005. These results were compared against the baseline scores obtained at the outset of the project. It should be noted that the original baseline information obtained through the facility assessment tool was qualitative in nature and was intended primarily for planning purposes. In order to quantify the baseline, a retroactive scoring process was used whereby a quantitative scoring tool (i.e., the certification tool) was applied to the facility assessment results to obtain a numerical score.

Essential and supportive elements were scored as follows:
Score 2: If the element meets the criterion fully
Score 1: If the element meets the criterion partially or if actions are underway to comply
Score 0: If the element does not meet the criterion

Analysis of client satisfaction data: Youth served as mystery clients in order to gauge client satisfaction of service provision at the clinics and of the peer service providers. A total of 92 mystery client visits were conducted in 21 clinics in March and April 2005. In addition, results of a Marie Stopes study of their peer provision program was reviewed and reported, including interviews with a sample of 287 youth (both exposed and not exposed to peer providers) in the intervention areas and assessments of 52 peer providers.

Trend analysis: Each facility and peer provider collected and reported service statistics on a quarterly basis. A trend analysis of those data was conducted in June 2005 to reveal changes in the service statistics following the YFS intervention. At the November 2004 evaluation strategy meeting, AYA/Pathfinder staff agreed to examine trends in the following indicators:

- Number of visits (categorized by new and revisits)
- Number of visits by age (10-14, 15-19, 20-24) and sex
- Number of visits by type of service

[1] The facility assessment tool, *Clinic Assessment of Youth-Friendly Services: A Tool for Improving Reproductive Health Services for Youth*, can be downloaded from Pathfinder International's website at http://www.pathfind.org/site/PageServer?pagename=Publications_Guides_and_Tools_Assessment_Tools.
[2] The *Certification Tool for Youth Friendly Services* can be downloaded from Pathfinder International's website at http://www.pathfind.org/site/PageServer?pagename=Publications_RH_Resources_ASRH.

Analysis of monitoring data: Analysis of monitoring data, including supervision, training, and quarterly reports, was done in May 2005 to provide additional information for this report.

In-depth interviews and focus group discussions: Interviews and focus group discussions were held with service providers, peer providers, and a peer provider supervisor at 16 sites from March to April 2005. These included 22 interviews and 1 focus group discussion with service providers, 1 interview with a peer provider supervisor, and 6 interviews and 5 focus group discussions with peer providers.

Case study: A case study, *Integrating Youth-Friendly Sexual and Reproductive Health Services in Public Health Facilities: A Success Story and Lessons Learned in Tanzania*, was written and is presented as a separate publication.

Overall Data Limitations

There were a number of limitations to the data and the evaluation itself, including:

Service statistics: AYA/Pathfinder was unable to get monitoring data from all of its partners, including facility and peer provider service statistics, despite several attempts. In addition, many of the public partners began in 2004, so their reported statistics only covered one year. Finally, some data were not reported properly and could not be analyzed. For these reasons, a trend analysis was not possible for the peer provider data and trend analysis of the facility service statistics is limited to nine facilities.

Baseline data: As mentioned earlier, the original baseline was qualitative and in order to assign a numerical value, it was necessary to retroactively score the original data. The retroactive scoring process was a limitation to the reassessment data because many baseline assessments were scored after the initial assessment, which was done without the certification tool. This meant that in some cases, related information required to score was missing and could not always be collected retroactively. Because the endline assessments were done after the development and application of the certification tool, endline assessment information was found to be more complete.

Lack of funding: As often happens as multi-year projects near an end, funding limitations affected the end of project activities. Because of resource limitations, both human and financial, the evaluation design had to be modified to provide the best information possible.

The following section discusses the static facility evaluation.

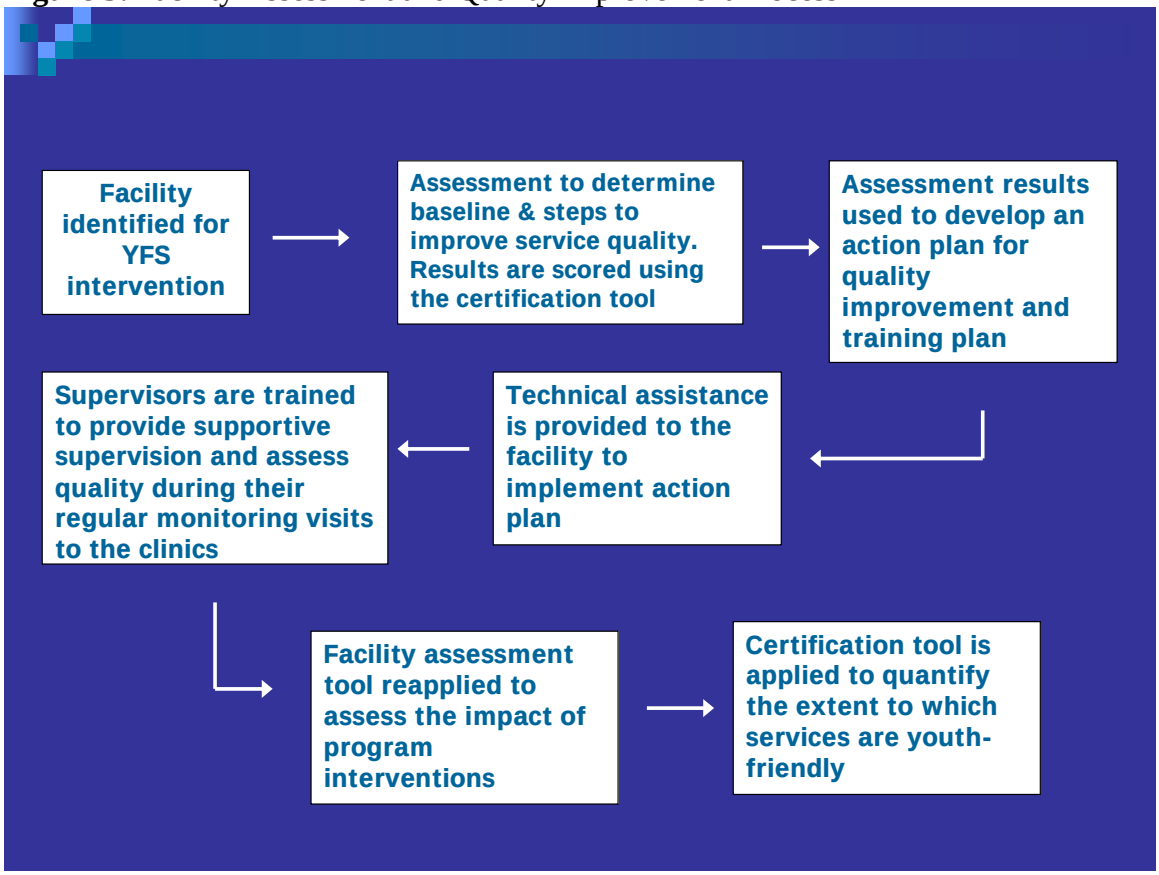
STATIC FACILITY EVALUATION

This section describes the activities done under the static facility component and describes the results of the evaluation of the static facility work, including facility reassessment, analysis of training data, analysis of client satisfaction data, and trend analysis. For each section, the methodology for evaluation, data limitations, and results are provided.

Static Facility Activities

AYA/Pathfinder worked to improve the youth friendliness of the partner facilities through the static facility component. The process of integrating YFS into the facilities included the selection of facilities, assessment of those facilities using a facility assessment tool, development of action plans to address gaps in youth friendliness, implementation and monitoring of the action plan, and then reassessment and certification of those facilities. The process is shown in figure 3.

Figure 3: Facility Assessment and Quality Improvement Process



As part of this process, the following activities were conducted in Tanzania:

- Selection of clinics,
- Facility assessments,
- Development of action plans,

- Implementation of action plans,
- Monitoring and supervision, and
- Monitoring client satisfaction.

Selection of clinics

Facilities were considered for AYA if they were within the selected AYA project areas, had minimum reproductive health services available for all age groups, had providers that had been trained in reproductive health, and had basic infrastructure. Staff also chose facilities to ensure a balance of urban and rural facilities. See Appendix A for a list of the facilities with which AYA worked.

Facility assessments

The first facility assessment was carried out in 2002 by AYA/Pathfinder headquarters, field staff, and partner staff using Pathfinder's facility assessment tool. Trainings were held with partner staff to enable them to carry out future assessments.

Before each assessment, the facilities were informed of the upcoming visit and assessments were typically carried out in one day by teams of three to four members, including youth members in some cases. After finishing each assessment, the assessment teams conducted a participatory debriefing session with facility staff. Staff were asked for their suggestions on improving services for youth and the team also shared their feedback on the overall key findings and recommendations that required immediate attention. This provided an opportunity for facility staff to understand the concept of YFS and served as a first step into involving them in the creation of relevant action plans to address key areas to focus on for scaling up youth friendliness at their facility. Following the assessments, individual facility narrative reports were developed by the assessment team, which highlighted opportunities and challenges that could form the basis of making improvements. These reports were then shared with facility management as well as key partner staff.

Development of action plans

Technical assistance was provided to facility staff in developing their action plans. The plans included the action to be taken, the staff responsible, the budget, and any possible barriers to implementation of the activity. The action planning process gave the facility staff an active role in, and significant responsibility for, improvement of the sites. The plans also allowed for easy monitoring, as monitoring and supervision staff then used the plans to track progress.

Implementation of action plans

Facility strengthening primarily focused on training service providers and other staff on YFS, SRH, and Management Information Systems (MIS) and identifying improvements that could be made to the clinics to make them more youth friendly. For example, clinics

were painted, youth-specific posters were hung on walls, partitions were built to increase privacy, extra spaces were created for youth-specific services, and signs were posted outside the clinics to notify youth of available services. Clinics also worked to improve procurement of supplies and equipment, organize suitable youth hours, reorganize services to address client flow, revise administrative procedures, and add or improve peer outreach services (see "Outreach Evaluation").

The training of service providers for the provision of youth-friendly SRH services was done at two levels, in-service and pre-service.

In-service training

To ensure that providers who currently worked in the YFS facilities were well equipped to deliver SRH services to youth, AYA conducted in-service trainings in collaboration with its partners. An in-service training consisted of the following process:

- Review of Pathfinder's training manual,
- Training of trainers, service providers and other staff
- Development of a national training curriculum.

Introduction of Pathfinder's Training Manual

Pathfinder's ASRH training manual was introduced to selected YFS partners in Tanzania by Pathfinder headquarters technical staff and Pathfinder technical officers from Botswana and Uganda, in May 2001. The lead training officer from the Ministry of Health's reproductive health section was selected as a cofacilitator. Next, a larger group of participants was invited to be trained using the curriculum as part of the pre-testing effort. Participants of this training included staff working with youth from the Ministry of Health (MOH), nongovernmental organizations, and tutors from the mainland nursing college.

Training of Trainers, Service Providers, and Other Staff

To ensure that youth were provided YFS, AYA organized service provider trainings with its implementing partners. A Training of Trainers (TOT) was conducted in December 2002. The 19 participants were chosen by the partners and included nurses, midwives and medical officers from the MOH, Marie Stopes, UMATI, and the University of Dar es Salaam. Another TOT was conducted in Zanzibar in 2004. Participants of these trainings then trained other service providers on ASRH and YFS.

The trainings were conducted using Pathfinder's "*Module 16: Reproductive Health Services for Adolescents."* Topics included adolescents and their SRH needs; counseling and communication; contraceptive options; STI and HIV prevention and management; sexual abuse; pregnancy, birth, and postpartum care; and elements of YFS. Trainers also gave an overview of AYA and discussed the reproductive health situation of Tanzania's youth with participants.

Trainings were also conducted with service providers to improve their understanding of MIS. These trainings did not use a set curriculum, but rather were practical, hands-on trainings using register sheets and other facility records.

The table below shows the numbers of service providers trained by training topic and year.

Table 2: Type of Training and Number of Service Providers Trained[3]

Type of Training	2002	2003	2004	Total
TOT in ASRH/YFS	19	0	30	49
Training of Service Providers in ASRH/YFS	97	84	341	522
Training of Service Providers in MIS	0	75	117	192

In addition, training was provided to supervisors to equip them with the information and skills needed to help their providers adopt positive attitudes and practices for providing YFS, understand and improve ASRH care, and learn monitoring and evaluation skills. Other facility health staff were also trained to increase their understanding of ASRH and increase their competency in service provision to youth.

Table 3: Type of Training and Number of Nonservice Providers Trained[4]

Type of Training	2002	2003	2004	Total
Supervisors training in YFS	0	12	66	78
Orientation of health staff	0	0	204	204

Development of National Curriculum

In an effort to standardize YFS training throughout the country, curriculum development for the mainland started late in 2004, following the finalization of an agreement between the MOH and AYA. The purpose of the effort was to review the relevancy of Pathfinder's curriculum and adapt it to the Tanzanian context.

The exercise was done in four phases, including:

1) Review meeting by technical experts (including district and regional trainers) in curriculum development and ASRH. In this meeting, participants agreed on format, content, and the type of manuals needed for the country (for service providers, peer providers, and paraprofessionals). In each of these manuals, the team outlined the functions of each group, so as to ensure the training was appropriate for the tasks required after the training.
2) The Pathfinder curriculum was adapted, using the agreed upon format.
3) The manuals were pre-tested in three non-AYA areas (Moshi, Singida and Mtwara).
4) Comments were incorporated into the manual and it was edited, and printed.

[3] As not all partners reported training data, the numbers trained are underreported.
[4] Same as above.

Pre-service

As provider attitudes and lack of skills in ASRH were identified as contributing factors to youth's low patronage of existing health facilities, there was a need for specialized provider training in ASRH/YFS. As in-service training can be costly and is often not sustainable due to staff attrition and transfer, AYA collaborated with the College of Health Sciences, beginning in July 2004. A TOT was conducted for tutors using Pathfinder's manual and the tutors have subsequently trained 50 outgoing nurse midwives and clinicians to date.

Although a new manual was not developed for this purpose (as training manuals are only revised every five years and the most recent revision had already been done), the college developed a skills checklist that could be used during the training practicum and in the clinical setting. This tool has continued to be used by outgoing students.

Monitoring and supervision

Monitoring and supervision was carried out to identify weak areas and make improvements to the facilities and in project implementation. Monitoring and supervision included collection and analysis of facility service statistics and regular supervision by trained supervisors and AYA/Pathfinder staff, as described in more detail below.

Collection and analysis of service statistics: Facility service statistics were collected and monitored throughout the project period. Facilities were provided with data collection forms, which disaggregated data by sex, age (10-14, 15-19, 20-24), type of visit (new or revisit[5]), and services provided. The data was compiled and submitted to AYA/Pathfinder on a quarterly basis by the partners. AYA staff reviewed the statistics for purposes of strengthening data collection and implementation, and provided technical assistance in data collection and reporting as needed.

Supervision and monitoring by trained supervisors: To ensure the quality of services was maintained, each facility was supported by a supervision and monitoring system. Fifty supervisors were trained using Pathfinder's "*Supervision Training Manual"* and supervision guidance tools were provided to facilitate comprehensive monitoring of YFS. The trained supervisors made site visits in accordance with their supervision schedules. During these visits, the supervisors reviewed planned activities and implementation status and discussed new developments with facility staff. They also discussed personnel issues, staff time, client attendance, and solicited feedback from clients, if available.

[5] If the client was new to the facility, the visit was marked as new. If the client had been served at the facility previously, regardless of what they were served for, the visit was marked as revisit.

AYA/Pathfinder staff with service providers, supervisors, and peer providers during a field visit.

Monitoring visits by AYA/Pathfinder: A minimum of one monitoring visit was conducted per facility during the project period. During these visits, AYA/Pathfinder staff had opportunities to learn by observing and interacting with service providers, supervisors, and youth clients who openly expressed their feelings concerning the services. During the visits, a number of critical issues and challenges in YFS provision were identified, including shortages of some supplies, drugs, contraceptives, and BCC materials for youth, and challenges in coping with data entry, analysis and reporting. Staff tried to resolve any issues they could on the spot, including data issues.

Monitoring client satisfaction

Client satisfaction was measured throughout the project primarily through feedback registers in the clinics (where clients were free to jot down their opinions, ideas, and thoughts concerning the services while waiting before or after receiving services) and via supervision visits. Information provided through both means was regularly reviewed by facility staff and improvements were made as a result.

The following section discusses the various evaluation activities carried out (facility reassessment, analysis of client satisfaction data, and trend analysis), including methodologies, data limitations, and results.

Facility Reassessment

Evaluation Methodology

The primary means of evaluating the facility strengthening activities was through a reassessment of facilities using the facility assessment tool and certification tool to receive an endline score. In addition, interviews were held with service providers and facility managers and available training reports were reviewed to gather supplementary information.

Facility Reassessment

AYA/Pathfinder and partner staff conducted reassessments of facilities in March and April 2005 using the facility assessment tool and certification tool to receive an endline score. To economize time and resources, a sample of 16 facilities was chosen for reassessment. The sample included a mix of public, private, urban, and rural facilities, facilities implementing YFS for varied lengths of time, and those with varied results at baseline.

The sample included the following facilities, by partner:

- MST – Mwenge, Temeke, Zanzibar, Arusha, Ilala;
- MOH Zanzibar – JKU, Mwenbeladu;
- Arusha Municipal Council – Ngarenaro, Kaloleni;
- Dar City Council/IDC – IDC, Tandale;
- Kinondoni Municipal Council – Kimara;
- Kasulu District Council – Kasulu Hospital;
- Tarime District Council – Tarime Hospital;
- Karagwe District Council – Kayanga; and
- UDSM – University Health Center.

In conducting the reassessments with the facility assessment and certification tools, the methods below were applied.

Review of clinic records: This involved looking critically at the daily, monthly, and quarterly statistic forms to see how many youth were served, with what services, and what age groups and sex were served to uncover issues like younger youth not being served or youth being counseled but not really given FP. In addition, the team would note if data was collected by age groupings and if there were problems with data recording.

Observations/ examination: This involved observing the general layout of the clinic and client flow as well as availability of equipment, commodities, and educational materials. Client-provider interaction was also observed to determine provider attitudes toward serving youth clients and technical competency in ASRH.

Interviews with clinic managers, staff and clients: Questions were posed to managers, clients and providers to elicit their opinions on the youth-friendliness of the clinic and to

determine their attitudes and practices in serving youth. During the reassessment, questions were asked to find out more detail about clinic improvements.

Review of policy and procedures: At each facility, managers were asked if they had any policy documents that were in support of ASRH, YFS, or both. If they did, these documents were reviewed, but in absence of the documents, providers or mangers were only asked whether such documents existed and whether they were aware of the policies mentioned in the documents. Different scenarios were presented to the managers and staff related to the appropriate age group for ASRH services, especially on eligibility of contraceptives to explore barriers such as minimum age or parental consent.

Training Data

Available training reports were reviewed in June 2005 to examine pre- and post-test results and evaluation forms.

In-Depth Interviews and Focus Group Discussions

Twenty-two in-depth interviews and one focus group discussion were conducted by AYA/Pathfinder staff with service providers at the conclusion of the project. Service providers were interviewed from seven facilities (MST Temeke, IDC, Tandale, Kimara Dispensary, UDSM, Temeke, MST Ilala) to find out the challenges they faced in implementing YFS, plans for sustainability, and recommendations for improvement.

Data Limitations

Quantitative analysis of facility assessment data was difficult in some cases due to the qualitative nature of the tool, particularly where there were close-ended questions and when two providers responded differently to the same question. A limitation to the training data is the lack of data for all trainings, as training reports were not always submitted.

Results

Facility Reassessments

All sampled facilities showed improvements in their scores between baseline and endline assessments as shown in the chart below. In addition, facilities improved their overall essential and supportive scores in each case. Of the facilities reassessed, the highest gains were seen by MST Zanzibar, IDC, and UDSM. These facilities gained 17 points from baseline to endline (the highest possible score was 50). The lowest gains were seen by Kayanga and JKU, with three and four point gains respectively.

Table 4: Baseline and Endline Facility Assessment Scores, by Facility

Facility	***Baseline Date***	***Endline Date***	***Baseline Score***			***Endline Score***			***Gain***
			Essent	***Support***	***Total***	***Essent***	***Support***	***Total***	
MST Arusha	7/2002	2005	21	10	***31***	25	21	***46***	***15***
MST Ilala	7/2002	2005	15	10	***25***	20	19	***39***	***14***
MST Mwenge	7/2002	2005	18	12	***30***	19	19	***38***	***8***
MST Temeke	8/2002	2005	16	15	***31***	24	16	***40***	***9***
MST Zanzibar	7/2002	2005	16	11	***27***	25	19	***44***	***17***
Ngarenaro	10/2002	2005	18	6	***24***	21	8	***29***	***5***
Kaloleni	10/2002	2005	19	6	***25***	20	10	***30***	***5***
JKU	3/2004	2005	7	5	***12***	14	12	***26***	***4***
Mwembeladu	10/2003	2005	12	6	***18***	22	12	***34***	***16***
IDC	7/2002	2005	17	14	***31***	27	21	***48***	***17***
Tandale IDC	7/2002	2005	18	10	***28***	23	20	***43***	***15***
UDSM	7/2002	2005	6	7	***13***	16	14	***30***	***17***
Kasulu Hospital	4/2004	2005	14	7	***21***	15	11	***26***	***5***
Tarime Hospital	11/2003[6]	2005	20	14	***34***	26	21	***47***	***13***
Kimara	6/2004	2005	14	12	***26***	20	16	***36***	***10***
Kayanga	3/2004	2005	14	8	***25***	18	11	***28***	***3***

As seen in the table below, in looking at the individual elements (essential and supportive) across facilities, a majority (21) improved. Two elements maintained their score (waiting time and accessible location), while two decreased (affordable fees[74] and delay of tests). Each element and its total baseline and endline score is shown below. The total possible score was 32 for each.

[6] An assessment was conducted in August 2002, however, it was deemed not complete enough to serve as baseline. Once the Tarime team was trained in facility assessment, a more rigorous assessment was conducted.

[7] It should be noted that when AYA support ended in December, MST began charging for VCT services that were free during the project period. As a result, we find that the score declined in this area.

Table 5: Total Element Scores across Facilities

	Element	Baseline	Endline	% Increase
Essential	Privacy ensured	12	20	67%
	Competent staff	16	28	75%
	Respect for youth	26	28	8%
	Minimum package of services	21	28	33%
	Range of family planning	23	27	17%
	Confidentiality	12	19	58%
	Referrals available	21	22	5%
	Sufficient supplies of commodities	20	24	20%
	Convenient hours	27	29	7%
	Emphasis on dual protection	9	26	189%
	Young adolescents served	10	20	100%
	Waiting time	22	22	0%
	Affordable fees	23	22	-4%[7]
	Separate space	5	16	220%
Supportive	Youth input feedback mechanism	11	15	36%
	Accessible location	30	30	0%
	Publicity for YFS	5	22	340%
	Comfortable setting	13	24	85%
	Peer educator	5	23	360%
	Educational materials	9	22	144%
	Delay of tests	29	27	-7%
	Partners welcomed	23	26	13%
	Outreach service available	11	19	73%
	Non medical staff oriented	7	27	286%
	Provision of additional educational opportunities	11	18	64%

As is shown by the table above, the greatest improvements were found in the following:

- Most facilities added or expanded peer education or other outreach programs to complement their services (see "Outreach Evaluation" for more information);
- Publicity of services increased (mostly via signposts and BCC activities);
- Most sites oriented their nonmedical staff;
- Most facilities created a separate space for youth;
- There was more counseling on dual protection;
- More educational materials were available for youth;
- Majority of staff had positive attitude to youth, including younger youth;
- Many of the facilities made changes to make their spaces more comfortable for youth;
- There was increased knowledge and competency among staff concerning ASRH and communicating with youth;
- Confidentiality and visual privacy improved (use of curtains, wall partitioning);
- Many facilities increased opportunities for youth to provide input and feedback;
- Services were accessible within convenient times;
- There was more support from managers (relocating staff for extra hours and planning for additional supplies); and
- Most facilities provided free services.

Several areas for further strengthening of the clinics were identified through supervision and the endline assessments, including:

- Although most sites oriented their nonmedical staff, this was not a continuous process;
- Facilities lacked formal referral systems to other centers or services (since facilities did not have the full package of services);
- Client waiting time averaged two hours, and the minimum waiting time was thirty minutes;
- The sites were not well known by the public, as the signposts were often located only at the clinic;
- Many facilities did not have educational materials available;
- The ASRH policies were not always clear to service providers;
- Very young clients (age 10-14) did not necessarily come for youth-friendly SRH services, but attended for other medical reasons, offering a potential opportunity for ASRH education; and
- Recording of daily data was poor (mix-up of adolescent clients and other age groups).

Training Data

Participants in the first ASRH and YFS TOT showed gains from pre- to post-test scores. At pre-test, the highest score was 95% and the lowest was 34%, while at post-test the range was from 98% to 70%. In addition, participants noted on feedback forms the information they gained and their expectations of how it would affect their service provision, as shown below:

Table 6: TOT Evaluation Form Responses

Statement	Strongly Agreed	Somewhat Agreed	Disagreed
I learned new information in this course	75%	13%	--
I will now be able to provide YFS to adolescent clients	94%	6%	--
I will now be able to adapt the counseling process to address the needs of adolescents	75%	--	25%
I will now be able to dispel rumors and misconceptions about using protection	63%	31%	--

Participants of the other trainings also showed gains from pre- to post-test scores, as shown in the chart below:

Table 7: Comparison of Pre- and Post-Test Scores from ASRH/YFS Trainings

Partner	*Ave. pre*	*Ave. post*	*Ave. gain*
Kibondo	48	77	29%
Temeke	53	70	17%
Karagwe	58	63	5%
Zanzibar – TOT	49	78	29%
Zanzibar – service provider	56	77	21%
Zanzibar – pre-service	41	72	31%
Zanzibar – MIS	15	76	61%
UMATI	47	71	24%

Seven of the Temeke participants noted that learning about ASRH and YFS was most useful and four participants suggested more training (including longer duration of training, refresher training, and training of additional providers). The Zanzibar YFS supervisor training pre- and post-test results showed increases in twelve of the fourteen trainees. Increases ranged from 2 to 14 points, with an average gain of 5 points.

In-Depth Interviews and Focus Group Discussions

Through the in-depth interviews and focus group discussions, clinic staff gave their thoughts on challenges, recommendations, and sustainability of the YFS intervention in the clinics. It should be noted that challenges and recommendations regarding peer provision appear in the "Outreach Evaluation" section.

The biggest challenge providers identified was the large workload and insufficient staff. Providers noted that youth clients are very impatient, but that due to lack of client knowledge and the fact that youth are not always open or clear about their issues, service provision to this group can take time.

Another major problem was the lack of supplies needed for service provision. Service providers noted a lack of contraceptive supplies, testing reagents, BCC materials, and demonstration tools.

Several providers noted other problems with YFS provision, including that youth cannot afford the prices facilities have to charge, the length of time needed to change youth's

behavior, the difficulty in tracing the youth's partners (in cases of STI treatment), and the lack of communication between youth and their parents. Others identified data collection, data analysis, and sustainability as challenges.

Recommendations were made for AYA and future projects regarding training. Two providers noted they lack knowledge of Voluntary Counseling and Testing (VCT) and one emphasized that not all staff had been trained to serve youth in the clinic. Recommendations for training included training and retraining clinic staff, conducting training more frequently, conducting longer training, and conducting a training needs assessment. In addition, one recommended that every provider be trained on counseling and life skills and that more training be provided on STIs and family planning.

For sustainability, several providers recommended that their clinics seek funds from other donors to sustain the program. In addition, a few believed that community awareness and sensitization activities were needed and others remarked that providing activities for youth at their clinic would attract youth clients. Other recommendations included linking with international staff to share experiences, getting more BCC materials for distribution, obtaining adequate job aids and tools for YFS, working on data collection and analysis, providing follow-up technical assistance to service providers, and involving partners in implementation planning.

In terms of sustainability, several providers believed that incorporating YFS into district and clinic plans and budgets would be beneficial and a few noted that the staff in their clinic will continue to practice the skills and knowledge gained throughout the project. Other recommendations included extending services into the community via peer providers, and taking advantage of networks built through the project.

Many service providers and supervisors from selected facilities reported that apart from improving the services and their attitudes regarding youth, they have experienced a tremendous change in their day-to-day relationships with their family and community. *"Sasa niko bomba (now I am cool) . . . to talk not only to adolescent clients coming to the facility for service, but also on my way home, youth stop me without hesitation and ask me for clarification on certain SRH issues. More important, I have been capacitated to even talk to my own children about SRH problems, after the YFS training. I really enjoy working with adolescents . . . I have more to learn from them,"* said one provider from Kayanga Health Center.

Staff also noted a few strengths and weaknesses of the facility assessment and strengthening process. Strengths included the use of the assessment tool to provide baseline and endline information, the participatory nature of the assessment and planning process, and the use of the action plans to guide the strengthening work and for monitoring purposes. In fact, staff noted that in facilities where plans were reviewed regularly, improvements were more focused and effective. In addition, facilities that involved staff and management in the process saw better results. In addition to the challenges noted in the interview analysis above, staff noted the longer than expected time between assessment and action planning that delayed improvements.

Analysis of Client Satisfaction Data

Evaluation Methodology

Several activities were undertaken by AYA/Pathfinder and partner staff in 21 of the facilities to measure client satisfaction of services, including mystery client interviews, in-depth interviews, a focus group discussion, exit interviews, and a review of feedback registers. The 21 facilities represented a mix of public and private facilities in both urban and rural areas in seven districts, Arusha, Temeke, Ilala, Kinondoni, Tarime, Unguja and Pemba.

The following activities were undertaken:

Mystery Client Interviews: Mystery client interviews were the primary means used to evaluate client satisfaction with the facilities. Ninety-two mystery clients (47 female and 45 male) participated in a one-day orientation before visiting 21 facilities. The orientations were conducted at the district level (Temeke, Ilala, Kinondoni and Arusha in March 2004, Pemba Island and Unguja in September 2004 and Tarime in November 2004) and were used to train the mystery clients in the process and the type of information that they would gather from the facilities. In addition, they participated in role play to prepare them for the visit and any challenges they might face.

The mystery clients were instructed to go to a specific clinic seeking services and while there, observe many elements of the service provision and the facility itself, including the communication and interaction with the service provider, availability of ASRH materials and job aids, confidentiality and privacy (auditory and visual), and follow-up services. They were given three days to conduct the visits and then met together to present and discuss their findings. The information collected by the mystery clients was fed back to the respective facilities soon after analysis, so that the facilities could improve their service provision to meet client satisfaction and expectations.

Some mystery clients, among other clients, wait to be served in one of Zanzibar's YFS facilities

In-Depth Interviews and Focus Groups: Facilities invited youth clients to participate in interviews and a focus group discussion conducted by AYA/Pathfinder staff. Eleven in-depth interviews and one focus group discussion were conducted with clients from eight facilities (IDC, MST Ilala, UHC, Kimara Dispensary, Tandale, Kawe, Temeke, and MST Temeke) at the conclusion of the project (March – April 2005) to assess whether their needs and expectations were successfully met. Issues raised with the youth included their understanding of YFS, the types of services it should include, the service hours that would be most convenient for them, the extent of privacy they wanted, how they learned about YFS at the facility, and what information they need regarding SRH.

Exit interviews: In March and April 2005, 127 exit interviews were conducted in three clinics, MST Mwenge (44), UMATI Temeke (49), and Tandale (34). Interviewees were chosen randomly at clinics following receipt of services to respond to a 20-question interview guide.

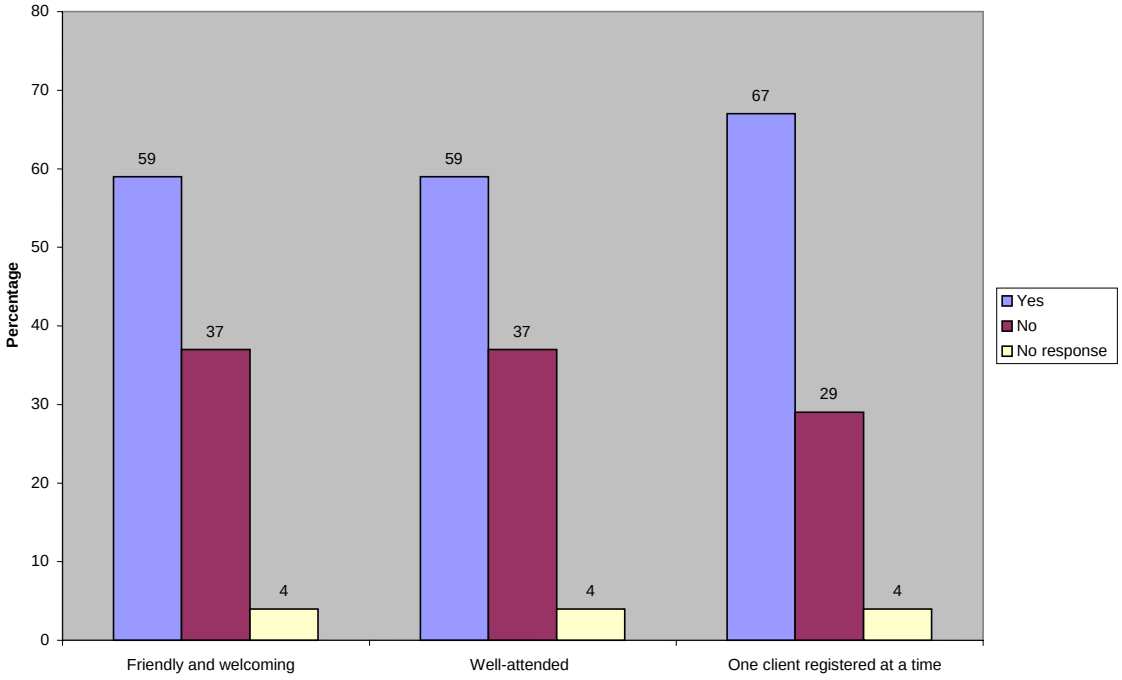
Review of feedback registers: AYA/Pathfinder staff collected and analyzed the registers from five facilities to provide supplementary information for the endline evaluation in March and April 2005. Registers were collected from the following facilities: IDC, MST Temeke, MST Zanzibar, Tandale, Mwembeladu, Ngarenaro, Kasulu, Kayanga, UDSM, MST Ilala, Tarime, and Kaloleni.

Results

Mystery Clients

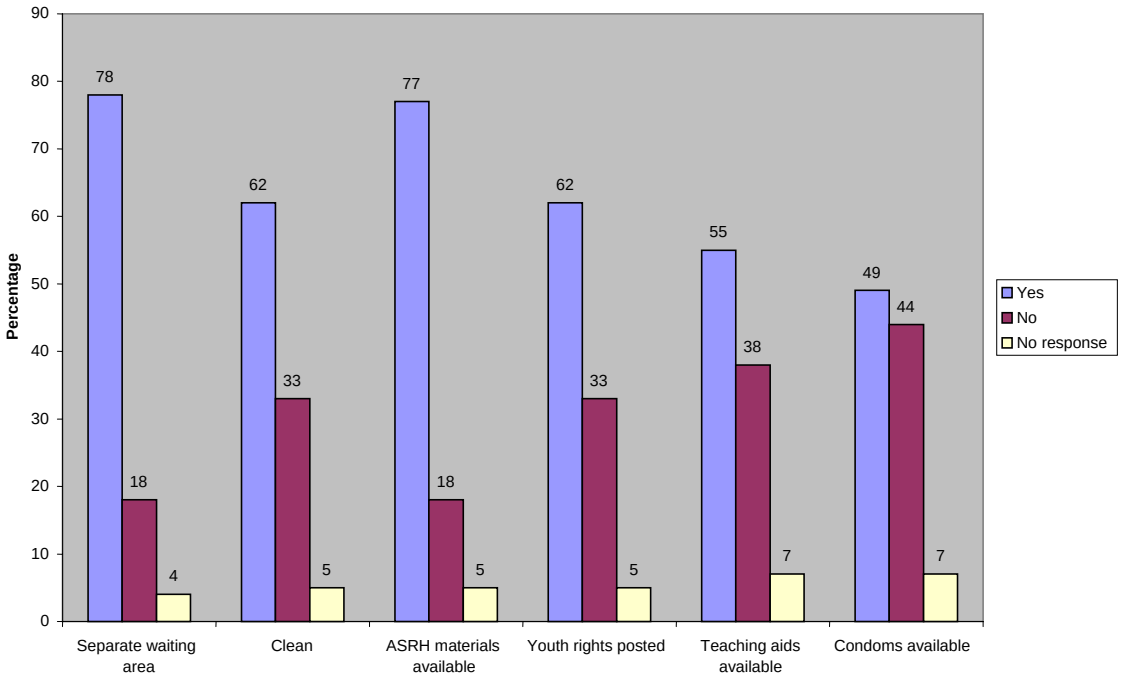
As shown in the graph below, 59% of mystery clients reported that reception staff were friendly and welcoming, 57% felt they were well attended, and 67% reported that clients were registered one client at a time.

Figure 3: Reception Services



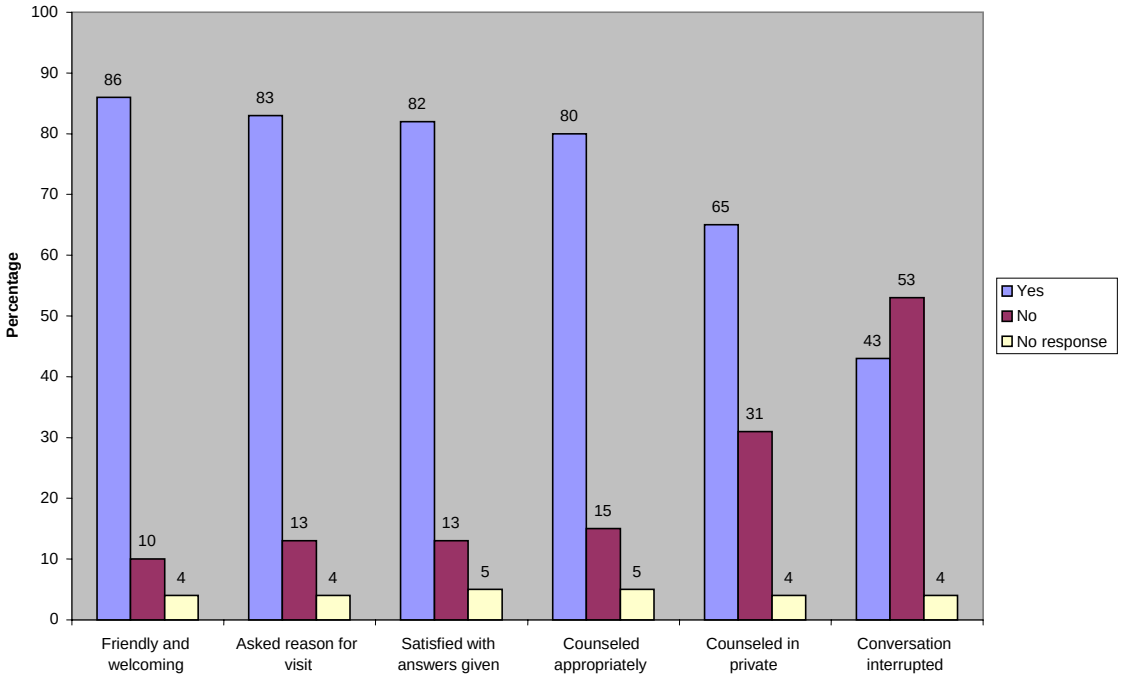
Seventy-eight percent of mystery clients reported that a separate space or hours were available for adolescent clients to be served. Sixty-two percent felt that the waiting area was very clean. Seventy-seven percent reported there were materials with ASRH messages (such as posters and leaflets) available to read. Sixty-two percent reported that a list of youth rights was posted. Fifty-five percent said that teaching aids were available, and 49% noted that condoms were available for take away.

Figure 4: Waiting Area



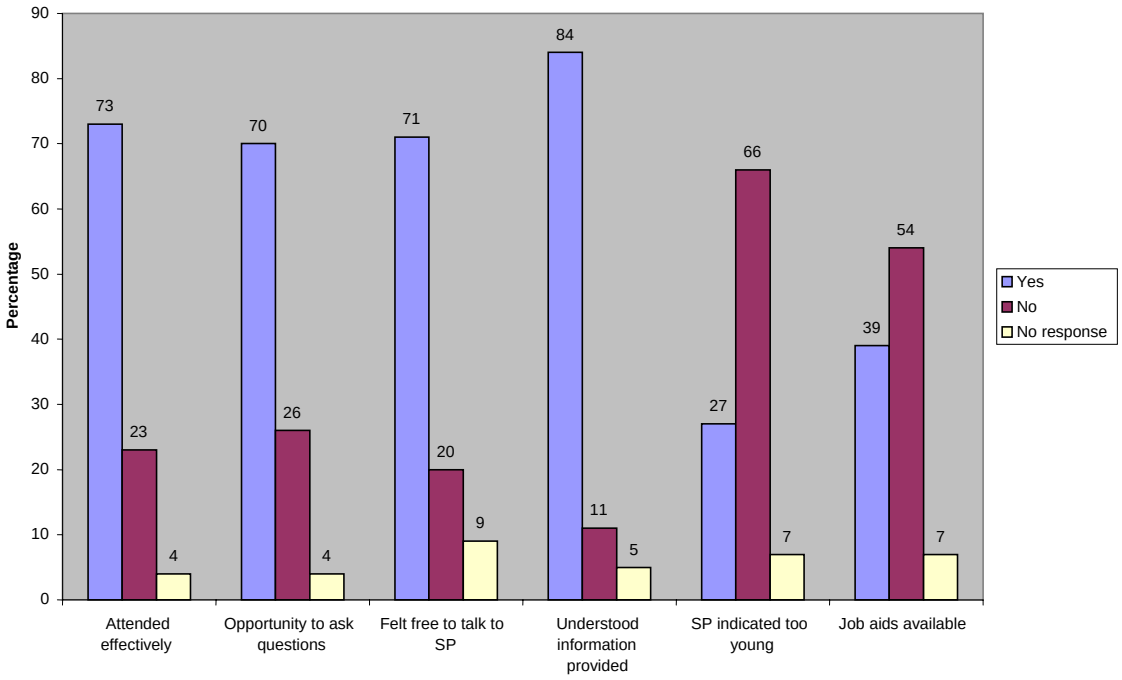
Eighty-six percent of mystery clients received a warm welcome. Eighty-three percent were asked the reasons for seeking the services. Sixty-five percent were counseled appropriately. Eighty-two percent were satisfied with the answers given by the provider. Sixty-five percent of mystery clients were counseled in private, and 53% reported no interruptions during service provision. Of the 43% that reported interruptions, the reasons given for lack of privacy included: a lower tone of voice was used, but did not guarantee privacy (10%), doors were open (14%), the facility was crowded (25%), phone calls and other service providers came in regularly (38%), and two clients were attended to at a time (10%).

Figure 5: Service Provision



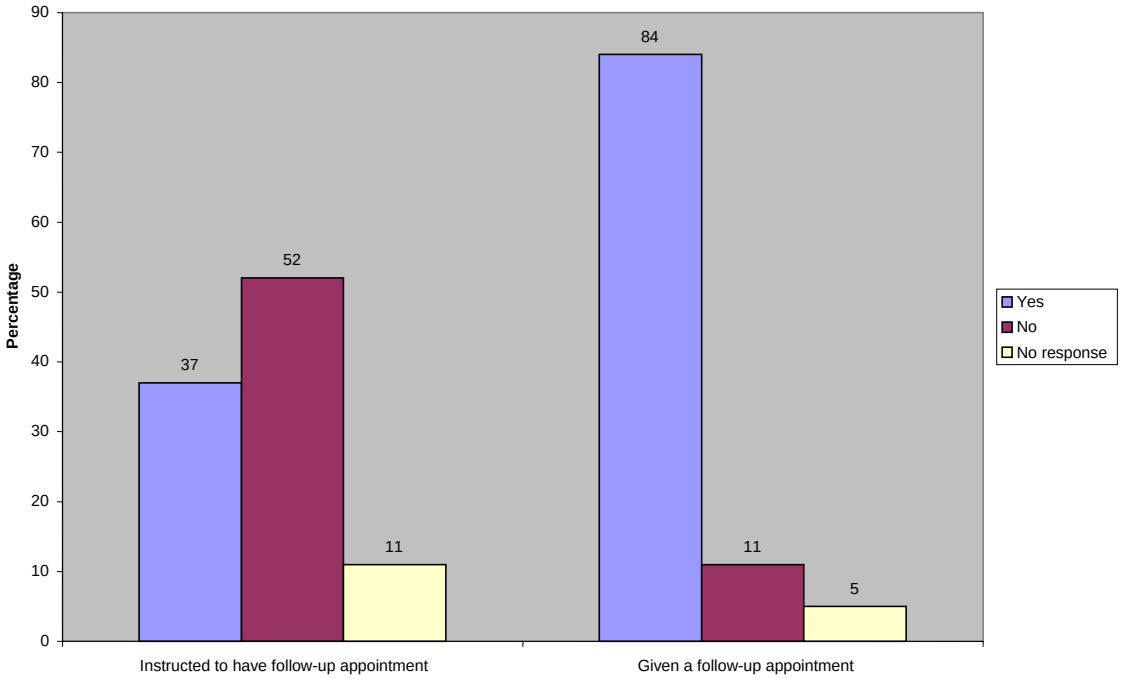
Seventy-three percent of mystery clients felt they were effectively attended and served, 70% were given the chance to ask questions and clarify issues during the conversation, and 71% felt free to openly discuss issues with the service provider. Thirty-five percent of clients were given more explanation when asked, and 51% were given reading materials. In addition, 66% of mystery clients reported that service providers did not make them feel they were too young to be sexually active, 39% noted that job aids (such as penis models) were available, and 51% were not forced to go for further check ups (e.g., pelvic examination) in order to be attended.

Figure 6: Service Provision



Thirty-seven percent of the clients were instructed to return for a follow-up visit and 84% of them were given follow-up appointments.

Figure 7: Visit Follow-up



Mystery client visits revealed that both reception area staff and service providers were friendly and welcoming, materials with ASRH messages were available, and service providers effectively counseled and communicated with youth. However, their feedback indicates that improvements can be made in ensuring availability of teaching aids, condoms, and job aids, and ensuring privacy and reducing interruptions during counseling.

In-Depth Interviews and Focus Groups

All of the interviewed clients felt that the services they received were good and the providers were kind and welcoming. Several noted that the clinics were easily accessible and offered privacy. The clients felt they could bring their partners to seek services, and that they appreciated the feedback boxes and registers that were made available. One noted appreciation for the video available in the waiting room, saying, *"it reduces my anxiety."* There were a few complaints concerning long waiting times for service and absence of BCC materials at the clinic. In addition, one client felt the time with the doctor was too short, one wanted a means to provide feedback to the clinic, and one felt it was not easy to reach the clinic.

An interesting finding is that the majority of youth did not know the meaning of youth-friendly services (Huduma Rafiki in Swahili). One youth indicated they thought it

referred to clients under five years of age and another thought it related to tuberculosis patients. One client also noted that because she has a child, she does not consider herself to be a youth. The terms "youth" and "youth-friendly services" will need to be explored further to determine their impact on youth utilization of the clinics. Several youth recommended that clinics use "Adolesent Sexual and Reproductive Health services" on signposts instead and list the specific services offered so as to avoid confusion. This recommendation warrants further discussion as some youth reported during baseline assessments that listing the services could create stigma as community members would be aware of what services they were accessing. Formative research could provide greater insight into appropriate logos or names for YFS that would be recognized by youth but would not stigmatize youth clients.

Another finding of interest is that youth indicated a variety of times that were best for them to attend the clinics, including morning hours, afternoon, and after 5 p.m. Youth also recommended that clinics expand the working hours dedicated for YFS and reduce waiting time. Given the variety of times that were identified as convenient, there needs to be further examination of this issue before changes are made to YFS hours of operation.

In addition to the recommendations above, youth also recommended that clinics publicize YFS better and expand the waiting room to allow for more chairs.

Exit Interviews

The exit interviews yielded mostly positive results in all three facilities. In particular, the majority of clients noted that it was easy to get to the clinics, the waiting time was under 30 minutes, the waiting area was good, counseling and communications were confidential, and they received enough information on clinic hours, lab exams, treatments, return date, and condition. The majority were satisfied with treatment, would like to return, and would advise a friend to attend the clinics.

Half of MST Mwenge and UMATI Temeke clients found no reading materials in the reception areas, and the majority was asked for parental consent for service. In addition, many of the MST Mwenge client counseling sessions were interrupted by staff and other clients. Clients recommended that clinics add more staff and space to better serve them. These results are summarized in the table below.

Table 8: Exit Interview Results by Facility

	MST Mwenge (44)	**UMATI Temeke (49)**	**Tandale (34)**
Time to arrive: under 30 minutes	74%	71%	88%
Easy to arrive	98%	94%	100%
Wait for service: under 30 minutes	100%	94%	91%
Waiting area: good	82%	92%	100%
Reading materials available at reception	49%	51%	100%
Received enough information on clinic hours	93%	86%	100%
Received enough information on lab exams	93%	73%	96%
Received enough information on treatments	93%	92%	100%
Received enough information on return date	83%	81%	100%
Satisfied with treatment	82%	96%	97%
Need parental consent for service	72%	69%	35%
Explained confidentiality	34%	80%	100%
Confidentiality in counseling/ communication	73%	98%	100%
Interrupted by staff	57%	12%	0%
Interrupted by clients	46%	4%	0%
Enough explanation on condition	77%	94%	97%
Would like to return	98%	94%	100%
Advise friend to attend clinic	98%	98%	100%
Recommend more staff	68%	71%	56%
Recommend more space	66%	82%	29%

As was found with the mystery client interviews, interruptions were a problem at one clinic, though clients were generally pleased with counseling and service provision at the three clinics.

Review of feedback registers

Feedback registers contained both positive and negative comments, as well as recommendations for improvement of the facilities and their services. Below are the comments and recommendations taken from the registers of the 12 facilities.

Positive comments included:

- *The clinic staff are very charming and welcoming,*
- *I was impressed with the condom demonstration,*
- *The place is very clean,*
- *The staff need to be promoted,*

- *We are grateful to get this separate corner,*
- *Providers are very nice to us, and*
- *When we are sent to test for HIV to other centers we don't feel comfortable.*

Negative comments included:

- *The receptionist is a bit slow . . . she should consider doing fast registration for youth;*
- *We are being told to only use Norplant and it is not available;*
- *We have missed Depo and pills for three months now, we are waiting to deliver unplanned babies by December;*
- *Nobody is around to operate the video and explain it for us;*
- *Doctors should avoid talking with their mobile phones when we are being attended; and*
- *If you don't have enough money, you don't get services.*

Recommendations included:

- *It would be good to get more video shows on other health problems,*
- *We would like to be treated for other diseases, and*
- *It will be good to open clinic for school girls and boys on Saturdays so that we get health education.*

A group of students, not at a school ground, but at one of the YFS facilities getting registration cards for service.

One youth client commented, *"Please serve us with food as well.***"** Although the comment seemed trivial to facility staff at first, they realized that 80% of the youth clients being served in that facility were students from a nearby secondary school. Upon further investigation, it was found that these students spent up to two hours at that facility

waiting for services. By the time they were provided services and returned to school, lunchtime was over and they had to wait until dinnertime to eat. The facility decided to assign service providers specifically to their young clients, and students no longer complained. As a result, the facility reported an increase in the number of youth clients.

As was found with the mystery client interviews, the feedback register comments highlight the friendliness of facility staff, the lack of contraceptive method supply, and interruptions of service delivery.

Trend Analysis

Evaluation Methodology

The data for years 2003 and 2004 was compiled and analyzed to see the trends in youth visits. However, there were many limitations to this exercise. As many facilities began work in 2004, data are not available for many facilities during 2003 and even into 2004. In addition, some facilities had difficulty completing the required data collection. Despite technical assistance and management information systems training, several facilities continued to submit data that could not be included in the analysis.

Therefore, we are only able to show data for nine facilities for the year 2004. These include, by partner: MST (Zanzibar and Mwenge), Dar CC/IDC (Tandale, IDC, Mbagala, and Vingunguti), and Arusha Municipality (Ngarenaro, Levolosi, and Kaloleni). In addition, we have included the aggregate information for an additional 14 facilities (shown in the table below).

Table 9: Facilities Included in the Aggregate Data

Facility	Quarter 2	Quarter 3	Quarter 4
Mwembeladu	X	X	X
Konde	X	X	X
JKU	X	X	X
Mkoani	X	X	X
Sebuleni	X	X	X
KMKM	X	X	X
Mnazi	X	X	X
Vitunguji	X	X	X
MST Ilala	X	X	X
MST Temeke	X	X	X
MST Mabibo	--	X	X
Kayanga	--	X	X
Chake Chake	--	X	X
Wete	--	X	X

Data Limitations

As noted above, a limitation was the lack of complete data. Some facilities did not begin implementation and reporting until March 2004, limiting their work and the data to nine months.

Results

Total Youth Visits

A total of 102,493 youth visits were made to 24 facilities in 2004[8]. The following tables show the youth visits by age and sex, and type of service for the facilities. More females (59%) than males visited the facilities, most likely because traditionally these services have been housed with maternal and child health services so the perception is that these services are for women. Additionally, young women, not young men, need Antenatal Care (ANC), Postnatal Care (PNC), and Postabortion Care (PAC) services. In addition, half of the visits were youth 20-24 years old and only 19% of visits were from youth 10-14 years old.

Table 10: Total Youth Visits by Age and Sex

Age Group	**Male**		**Female**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**
10-14 years	9,169	21%	10,866	18%	20,035	19%
15-19 years	13,032	31%	18,517	31%	31,549	31%
20-24 years	20,272	48%	30,637	51%	50,909	50%
Total	**42,473**	**100%**	**60,020**	**100%**	**102,493**	**100%**

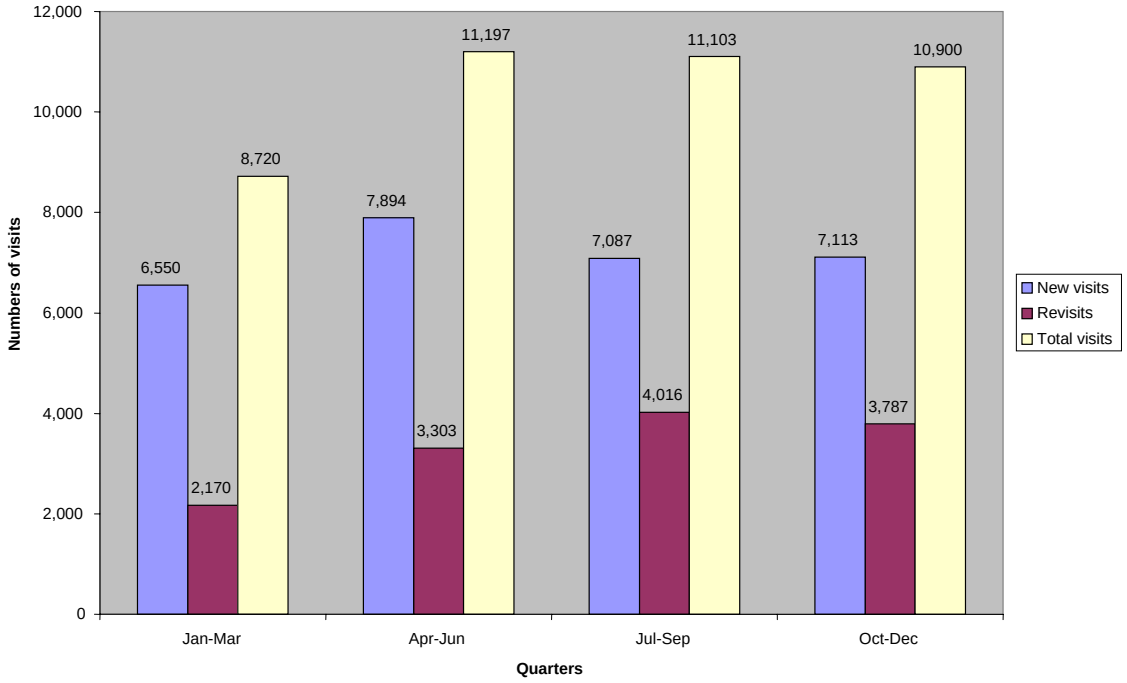
[8] According to data received from all facilities, 152, 955 visits were made to facilities in 2004 and 63,764 visits were made in 2003.

Number of Youth Visits by New and Revisit

The nine facilities recorded 41,920 youth visits during 2004. Data was collected on whether youth were visiting for the first time or were revisiting the health facility. The figure below shows the total youth visits per quarter and the numbers of new and revisits. The number of new visits remained consistently higher than the number of revisits during the year. It is not known whether this is attributable to client satisfaction issues or whether the first visit sufficiently met clients' needs. It is recommended that facilities investigate the reasons for low numbers of revisits to ensure that the needs of the youth are being met.

Whereas both new visits and revisits increased over the year, revisits increased steadily from quarter one to quarter three, and then decreased in quarter four. The new visits increased from quarter one to two, decreased in quarter three, and then increased in quarter four. Due to the high number of new visits, the overall clinic visits followed the same trend as new visits.

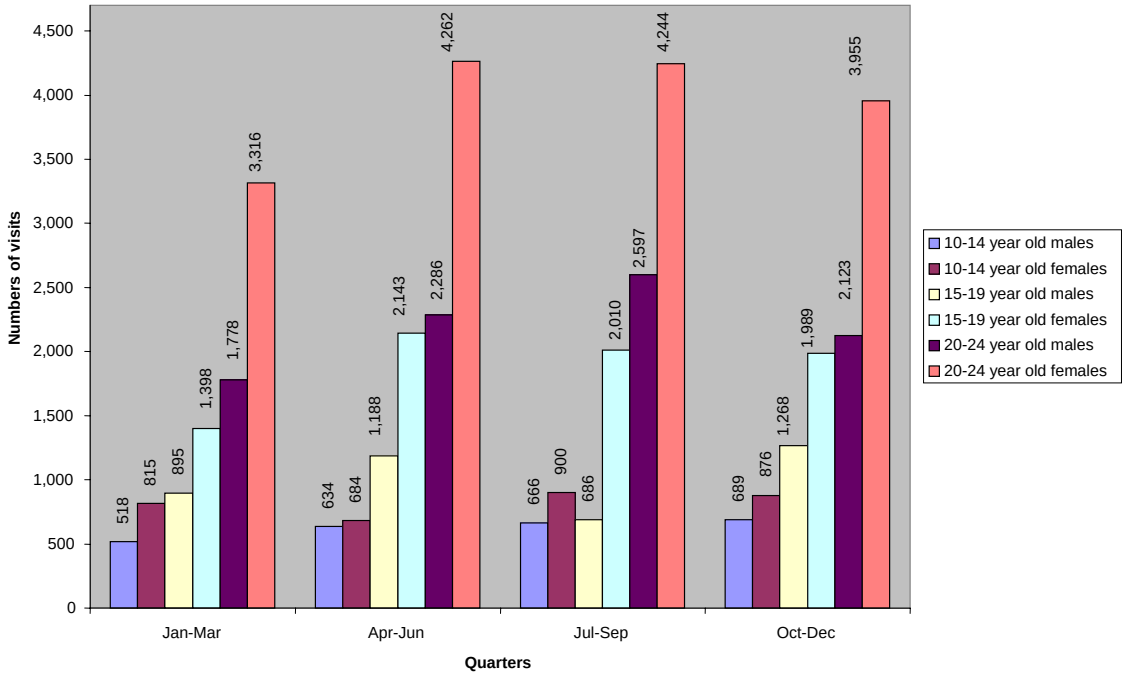
Figure 8: Clinic Visits by New and Revisit



Number of Youth Visits by Sex and Age Group

As seen by the graph below, the numbers of visits for each group did increase over the course of the year, but did not do so with a consistent increase from quarter to quarter. Females 20-24 used the services more than any other group, followed by males 20-24 and females 15-19. The greater number of visits by females is probably because reproductive health services have traditionally been perceived to be only for females. This attitude may also be attributed to the location of most of these services in maternal and child health wards. Also, young men have not traditionally been encouraged to seek out SRH services and usually rely on pharmacies or chemical shops and peer providers for these services. Utilization was low for 10-14 year olds of both sexes as would be expected since many youth in this age group are not sexually active and may not need SRH services.

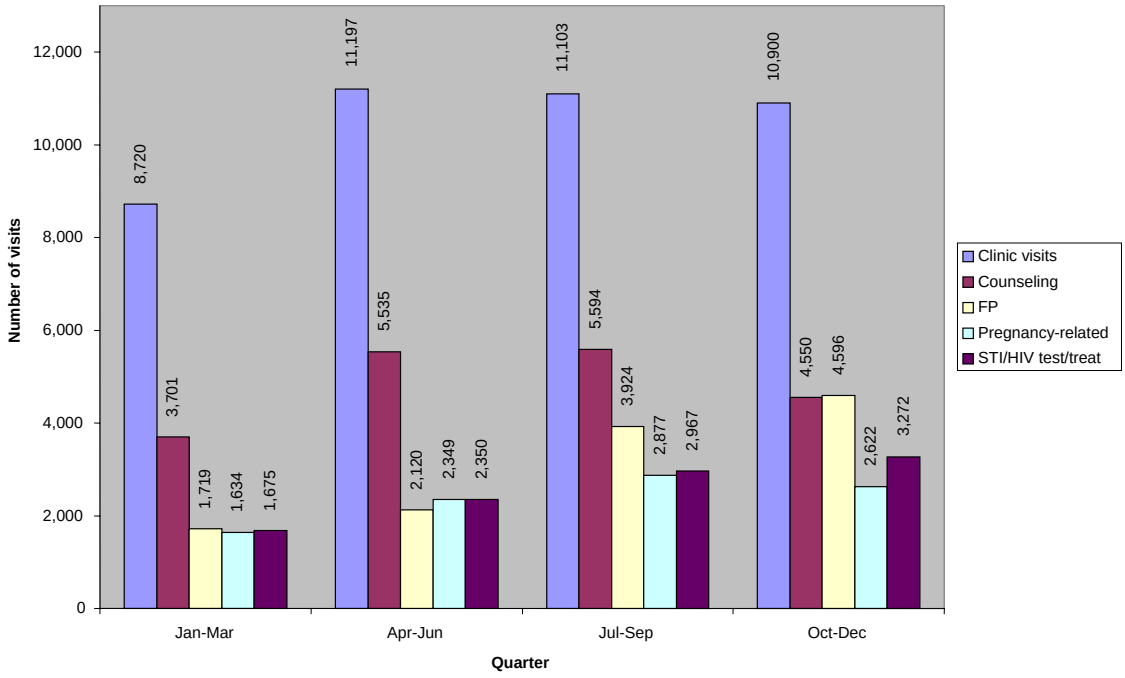
Figure 9: Clinic Visits by Age and Sex



Service Delivery

Data collected by the facilities included the services used by the youth at each visit. In the figure below, the total visits per quarter are shown, as well as the services used by quarter. Although there are increases in each of the services over the course of the year, not all show a steady increase from quarter to quarter. For example, while family planning, VCT, and STI testing and treatment visits show a steady increase from the beginning of the year to the end, pregnancy-related and counseling visits increase in the second and the third quarters, and then slightly decrease in the fourth quarter. Each of these services is described in more detail throughout this section.

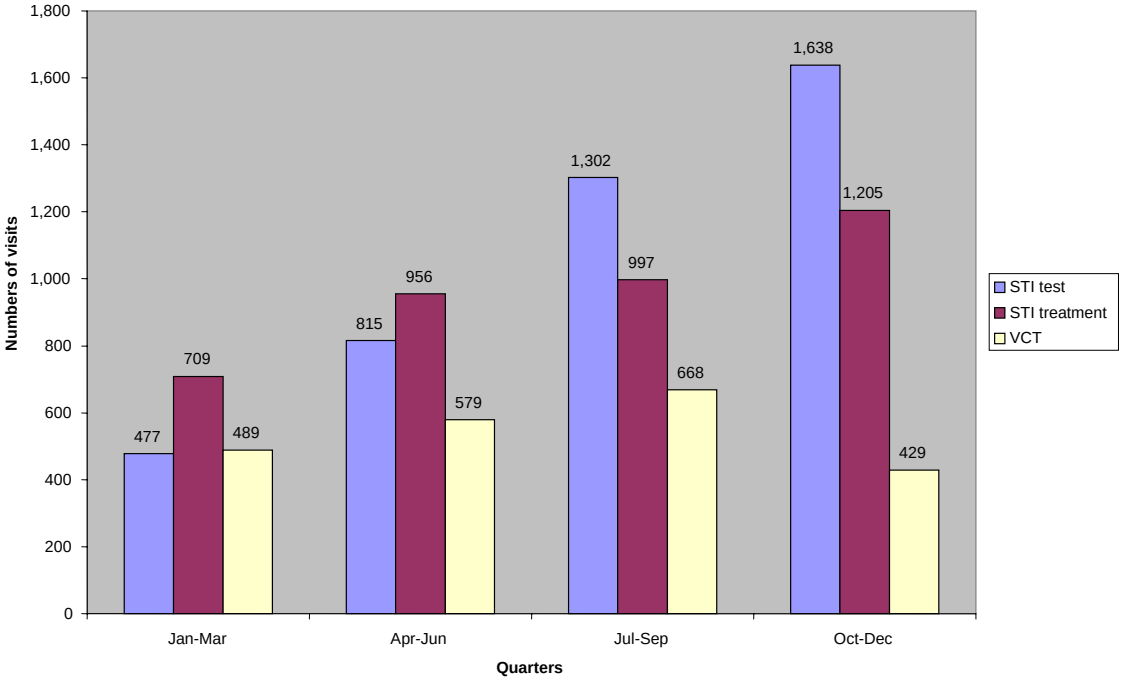
Figure 10: Clinic Visits by Service Provided



STI Testing and Treatment and VCT

Facilities offered STI testing and treatment, and VCT to youth (Ngarenaro did not offer VCT). The figure below shows the numbers of visits to the facilities for each of these services, by quarter. STI testing and treatment visits increased steadily over the year, but VCT visits increased steadily from quarter one to three, and then decreased to their lowest levels in quarter four. This decrease in visits could be due to the lack of testing reagent noted by service providers earlier in this report. The lower number of VCT visits may be explained in part by the fact that not every facility offered VCT.

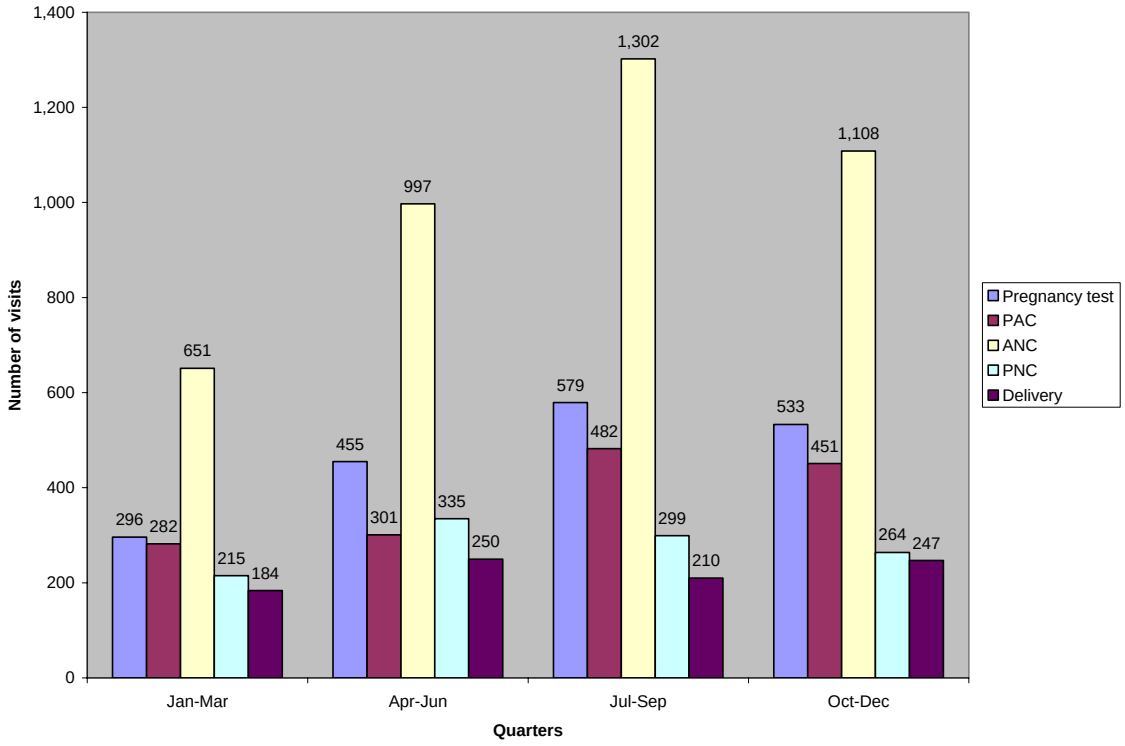
Figure 11: STI Testing and Treatment and VCT



Pregnancy-Related Services

A variety of pregnancy-related services were also offered to youth, including pregnancy testing, PAC, ANC, PNC, and deliveries. The figure below shows the numbers of visits for each service, by quarter. While all services increased overall from quarter one to four, different trends were seen. For example, pregnancy testing, PAC, and ANC increased from quarter one to three, and then decreased in quarter four. Deliveries increased from quarter one to two, decreased in quarter three, and then increased in quarter four. PNC visits increased from quarter one to two, decreased in quarter three, and then decreased further in quarter four.

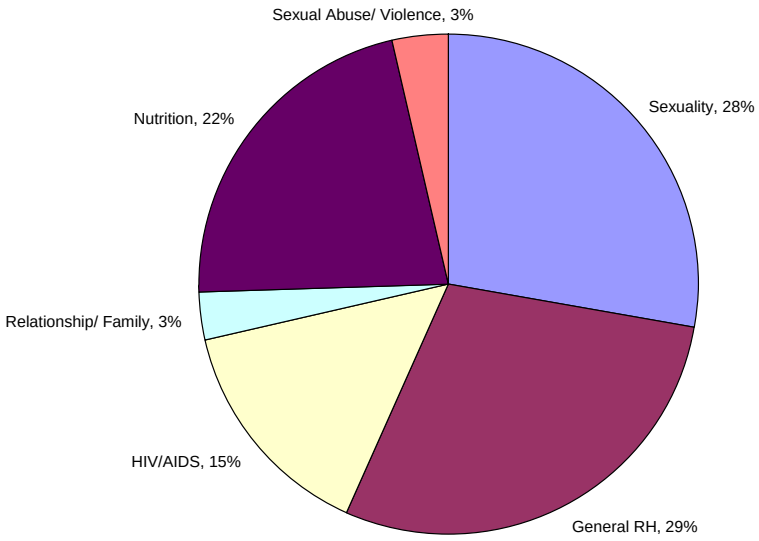
Figure 12: Pregnancy-Related Visits



Counseling Services

Service providers noted the topics discussed with youth during counseling sessions. The following figure shows the breakdown of counseling topics during 2004 at the nine facilities. General reproductive health and sexuality were the most discussed topics, followed closely by nutrition for HIV+ youth or pregnant youth during ANC. It should be noted that VCT is included in an earlier section – therefore the HIV counseling noted below refers to general HIV counseling and does not include pre- or post-test counseling.

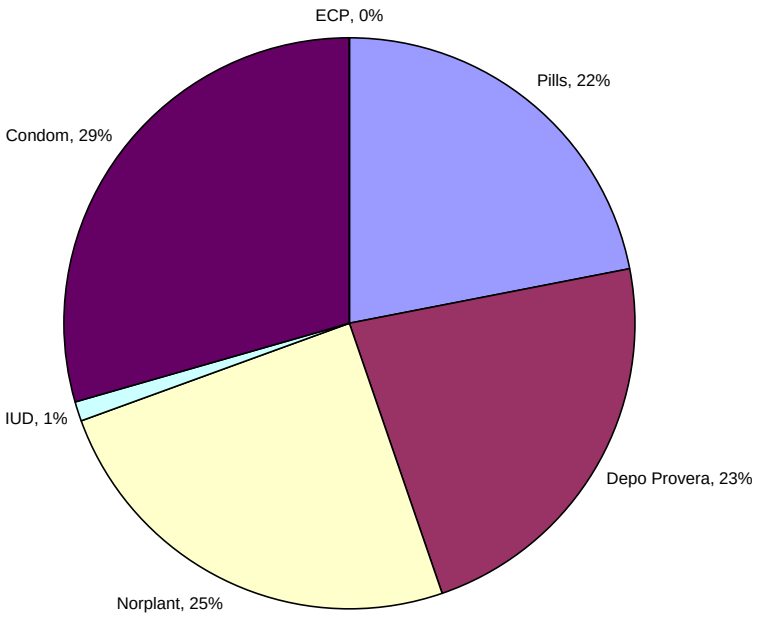
Figure 13: Counseling Visits by Type



Family Planning Services

Service providers also noted the types of services and products sought during family planning visits that youth made to their facilities. The figure illustrates the the breakdown of family planning visits made to the facilities. Condom visits were the highest at 30%. Norplant, Depo Provera, and pill visits were close behind at 25%, 23%, and 22% respectively. Emergency Contraceptive Pill (ECP) visits were minimal (0%). However, it should be noted that as part of the effort to increase youth's access to services, many facilities provided condoms to youth in waiting rooms or youth centers, therefore these numbers are not captured in the data. In addition, many youth sought condoms from peer providers in the communities, whereas other contraceptives could only be obtained in the clinics. Therefore, though the number of visits to clinics for condoms is not significantly greater than that of other contraceptives, the number of users is expected to be much higher.

Figure 14: Family Planning Visits by Type



OUTREACH EVALUATION

This section describes the activities done under the outreach component and describes the results of the outreach evaluation, including analysis of client satisfaction data, trend analysis, and analysis of in-depth interview and focus group discussion data. For each section, the methodology for evaluation, data limitations, and results is provided.

Outreach Activities

Provision of outreach was primarily done through youth peer providers. Each partner selected its peer providers in collaboration with the community leaders. The basic criteria for selection of youth included:

- Received formal education,
- Accepted by fellow youth in the community,
- Able to communicate on basic information,
- Ready to work on a voluntary basis, and
- Ensured parental support for participation.

In addition, the partners ensured a balance of male and female peer providers to best serve youth.

After the selection, the peers were given an oral interview and a simple test to evaluate their writing skills and aptitude. They then underwent a five-day basic YFS training, led by partner staff. As there was no AYA peer service provider training manual, most of the partners used UMATI's training manual titled "*Mwongozo wa Kufundishia Waelimishaji Rika"* ("*A Guide to Training Youth Peer Educators"*) and incorporated a few topics from the *"Life Planning Skills*" manual (used under PATH's life and livelihood skills development component).

Table 11: Peer Provider Training by Type

Type of Training	2002	2003	2004	Total
Peer Provider YFS training	48	65	416	529
Refresher Training for Peer Providers in YFS	0	140	0	140

Peer providers reached youth through group talks (where a peer educator discussed a particular topic with a group of youth and provided information and services to the group), one-on-one visits (where a peer educator provided information and services to an individual), and through BCC activities (larger events in which entertainment was offered to youth in addition to information and services).

Peer providers documented service delivery through daily and group intervention forms, tracking the numbers of youth they met, what contraceptives they distributed, and what topics they discussed with youth. They aggregated the data from these forms and entered this onto monthly data forms, which were submitted to their supervisors. The monthly

data was aggregated by supervisors, submitted to the partner, and then given to AYA staff on a quarterly basis.

IDC peer providers worked with 10 trained lay counselors to more effectively link outreach and facility service provision. The lay counselors provided additional support to peer providers in mobilizing youth for SRH information and service provision.

Data from peer providers linked to six facilities (Kayanga and MST Temeke, Ilala, Mwenge, Mabibo and Zanzibar) found that over 38,065 outreach visits were made in 2004[9]. The visits are shown by age group and sex in the chart below. Slightly more visits were made by peer providers with females than with males, due to the larger number of visits by females aged 10-14. The 20-24 year age group used the peer providers more than the other age groups, followed closely by the 15-19 year olds. Youth 10-14 years old used both outreach and clinic services the least. However, it is important to note that peer providers did reach a higher percentage of young men than were reached by facility-based services, making this a viable approach for reaching young men with needed SRH information and condoms.

Table 12: Youth Outreach Visits by Age and Sex

Age Group	**Male**		**Female**		**Total**	
	No.	**%**	**No.**	**%**	**No.**	**%**
10-14 years	4,956	26%	5,223	27%	10,179	27%
15-19 years	6,620	35%	6,597	35%	13,217	35%
20-24 years	7,375	39%	7,294	38%	14,669	38%
Total	**18,951**	**100%**	**19,114**	**100%**	**38,065**	**100%**

In addition to peer provider activities, outreach also consisted of sensitization and mobilization meetings. These meetings were held by partner staff to sensitize community stakeholders, including city and municipal authorities, on unmet SRH needs of youth and the rationale for their involvement and support. A total of 369 meetings were held during the project (29 in 2002, 87 in 2003, and 253 in 2004).

[9] According to data received from all facilities implementing outreach programs, 96,547 outreach visits were made in 2004.

Analysis of Client Satisfaction and Peer Assessment Data

Evaluation Methodology

Due to funding limitations, client satisfaction with outreach and peer assessment was conducted by one partner, MST, at the conclusion of the project, by external evaluators in March and April 2005. Interviews using an interview guide were conducted with a sample of 287 youth in the MST intervention areas, of which 52% (149) had sessions with peer providers. Fifty percent of the youth came from Dar, others were from Arusha, Zanzibar and Sirari. Fifty-two peer providers were also assessed by the evaluators on their knowledge of ASRH using a six-question test. Peer providers assessed were from Dar, Arusha, and Zanzibar.

Results

Client satisfaction

A majority (91%) of youth were satisfied with the services of the peer provider. When asked what they liked about the peer providers, youth gave the following responses:

- Are friendly and charming (35%),
- Taught the importance of HIV testing (13%),
- Taught how to protect myself from HIV/AIDS (11%),
- Taught the proper usage of condoms (11%),
- Nothing (10%),
- Taught us how to abstain from sex at an early age (8%),
- Distributed condoms (3%),
- Taught us about AIDS issues and pills usage (3%),
- Distributed pills for family planning (3%), and
- Others (3%).

When asked what they did not like about the peer providers, youth gave the following responses:

- Nothing (66%),
- Did not give us brochures to read (7%),
- Did not give us time to ask questions (5%),
- Were harsh and unapproachable (4%),
- Were too explicit in the language they used (3%),
- Did not explain the proper usage of a condom (3%), and
- Did not distribute condoms (2%).

Other responses included: it appeared that the things they said were targeted at girls, they don't come often, they appeared to be advocating for sex by distributing condoms, peer providers are very negative about having sex, and the peer educator was not focused during the lesson.

Over 74% of those who had met with a peer provider had done so within the last six months. When asked what information they received from the peer educators, 65% mentioned issues relating to HIV and 44% mentioned abstinence, as shown below:

- General information on HIV (65%);
- Information on how to abstain from sex (44%);
- Information on family planning (32%);
- Clarified rumors and misinformation (20%);
- Supplied condoms (11%).

When asked if they had ever had sex, 67% of respondents who had been exposed to a peer provider, and 44% of those who had not said yes. Therefore, youth who are seeking peer provider services are more likely to be sexually active than not.

Youth were also asked about their main sources of SRH information. Radio and TV were mentioned as the largest source of information (more than 75%) for both exposed and not exposed respondents, and 49% of youth exposed to peer providers mentioned peer providers as a source, as compared with 19% of unexposed youth. MST is looking into the use of videos in peer provider sessions, as a result of this data.

The study also found significant differences in SRH knowledge and attitudes between those who had exposure to peer providers as opposed to those who did not, as shown below.

Table 13: Comparison of SRH Knowledge and Attitudes between Youth Exposed and Not Exposed to Peer Service Providers

	Peer exposed	Not exposed
Does not harbor stigma towards people living with HIV/AIDS	51%	36%
Perceived ability to determine whether someone is a risky sexual partner (including whether they are HIV+)	19%	7%
Correct knowledge that mosquitoes do not transmit HIV	80%	69%
Correct knowledge on HIV prevention	37%	24%
Positive towards HIV testing	69%	54%
Positive attitude towards females initiating condom use	38%	19%
Positive attitude towards condom	21%	22%
Reported ability to abstain	58%	50%
Know that when a girl says no to sex, she means no	58%	58%

The results in the section above show the satisfaction of the youth towards peer service provision, and increased knowledge and positive attitudes regarding SRH issues.

Peer provider assessment

The 52 peer providers were assessed with a questionnaire that asked what they would advise youth given four scenarios. The following are the scenarios, the responses given, and the percentage of peer providers giving each response.

Table 14: Peer Provider Responses to Scenarios

Scenario	Responses
A 17 year old boy has been having sex with his girlfriend for months, and they usually do not use condoms because he doesn't like the way they feel.	-87% would emphasize the importance of condom use for dual protection -27% would advise HIV testing -17% would explore the problems encountered during condom use -13% would advise on proper condom use
A 13 year old girl has been spending time with a young man (she believes to be 19 or 20) who has been giving her gifts and has told her he wants to have sex with her.	-69% would explain risks of early sex -48% would suggest she end the relationship -31% would stress the importance of abstinence -19% would offer suggestions of how to say no to the older man's advances -2% mentioned teaching her about safe sex -2% mentioned reporting the matter to her parents
A 15 year old girl is concerned that she might be pregnant, as she and her boyfriend had sex and she missed her period this month.	-85% would advise taking a pregnancy test/ seeing a doctor -21% would advise against abortion -17% would propose abortion, with one advising for safe abortion and promoting PAC services, if needed -8% would advise on family planning options for the future -6% would recommend an HIV test
A male teenager tells you it hurts when he urinates.	-94% would advise the young man it could be a STI and to see a doctor -27% would stress the use of condoms in future sexual activity -25% would stress the need to follow the doctor's orders (particularly on medication) -12% would encourage the young man to bring his partner in for testing and treatment

Peer providers were also asked to explain how they would show proper condom use to youth. The following table shows the percentage of peer providers who mentioned each key aspect of condom use.

Table 15: Number of Peer Providers Observed Demonstrating Proper Condom Use Steps

Key steps to appropriate condom use	**Number of peer providers**
Check expiration dates	65%
Inspect condom package	35%
Carefully tear open	85%
Ensure condom not inside out	46%
Pinch tip, unroll on erect penis	85%
After ejaculation, remove before penis is soft	50%
Carefully remove not to spill semen, tie knot	46%
Properly dispose of condom	71%
One condom per ejaculation	27%

Although a majority responded well to the scenarios and explained most steps in proper condom use, it appears that some peer providers are not providing all of the key AYA messages (e.g., dual protection) or providing condoms to youth who request them. Refresher training and supervision could help ensure that these messages are consistent across all peer providers and for all clients.

Analysis of In-Depth Interview and Focus Group Discussion Data

Evaluation Methodology

In-depth interviews were conducted by AYA/Pathfinder staff in March and April 2005 with six peer providers and one peer supervisor. Five focus group discussions were also held with peer providers. Facilities invited youth clients to participate in the interviews and the focus group discussion. The focus group discussions consisted of three to eight participants. A few of the 22 service providers interviewed also noted the challenges and recommendations they saw in the peer provision program; their comments are also included in this section. In addition, the IDC peer providers conducted an assessment of their peer program in April 2005, and their recommendations have also been included.

Results

Peer providers were interviewed to identify the challenges they faced in their work and to offer recommendations for improvement. The challenge most identified by youth was the need for more training. Three noted that peer providers that began after the initial trainings were never officially trained, two believed the training they received was too short, one felt it was time for refresher training, and another felt that training was needed on life skills. One peer educator explained that he feels his failure to respond to some questions from youth has lead to a lack of trust in his knowledge and skills. A peer supervisor corroborated the need for training, noting that some peer providers do lack skills important to their work.

Another major challenge was objections to peer provider's efforts from community members. *"Parents think we provoke their children to practice sex by distributing condoms to them,"* explained a peer provider from MST Temeke. Another peer provider (MST Mwenge) described how that perception is changing in her community, *"Support from the community is very little because some people do hate us for what we are doing…. but the situation is different when you reeducate people."*

Other challenges faced included deficiencies in support and supervision, inadequate supplies (BCC and condoms), lack of job aids, lack of identification (i.e., cards, badge, or T-shirt) as a peer provider (for which some community members ask), insufficient and often tardy transportation allowances, safety concerns, and poor access to hard-to-reach groups. Peers also mentioned some other occasional challenges: some youth do not always see value in their services, the misconception that condoms have tiny pores, the belief by some that they are too young to counsel other youth, political conflicts, referrals to health center, few resources to reach other peers or try innovative approaches (i.e., reaching schools), and teasing from peers.

Several service providers noted that sustaining the peer program has been challenging and one noted that peer providers lack enough skills. Recommendations from the service providers were to train and retrain peer providers and give them incentives.

Peer providers made a number of recommendations for the future, including: training (more and longer training, refresher training, training for those who have not been trained, and training on life skills); provide more equipment and supplies; provide more timely and bigger transportation allowances and/or transportation; offer more support and supervision; and provide identifying items (identification cards, bags, uniforms). Other recommendations mentioned include more parent sensitization activities be conducted, the clinics stock adequate reagents needed for HIV testing, assistance be offered with data collection and analysis, and the age criteria for peers be raised to 30.

An assessment of peer provider programs conducted by youth themselves in IDC resulted in the following recommendations:

- Ensure capacity-building, such as ongoing supervision and follow-up with peer providers to ensure program quality;
- Capitalize on and use more of the knowledge, creativity, and energy of peer providers in program planning; and
- Provide more nonmonetary incentives (e.g., bicycles, T-shirts, materials) as well as financial incentives (e.g., compensation for travel expenses) to motivate peer providers.

As shown by the interview data above, training was identified as a need by peer providers, and challenges include some community member misperceptions, lack of sufficient support and supervision, and inadequate BCC and contraceptive supplies. Key recommendations include provision of more training, ensuring adequate supplies and allowances, and transportation provision.

CONCLUSIONS AND RECOMMENDATIONS

Although AYA's start up period took longer than expected, leaving less time to fully accomplish expected results, much was achieved. AYA was able to increase awareness of the rationale and need for YFS provision. And through its training and orientation work, AYA increased the capacity of district and facility staff to provide SRH services to youth.

Over the course of the project, facilities strengthened their ability to offer and promote youth-friendly services in many ways. Renovations of the facilities were done to make them attractive and to create separate space to serve youth. In some facilities, youth have their own waiting and consulting rooms equipped with television, video, newspapers, and BCC materials, providing added privacy. Some clinics changed their hours to allow for better youth access and have improved advertising of YFS through the erection of signposts outside their facilities.

AYA and the MOH on the mainland have taken steps to institutionalize YFS in the country by developing YFS training manuals for health providers, peer service providers, and paramedical counselors, including a TOT guide. In collaboration with the College of Health Sciences, the MOH in Zanzibar now includes YFS including a skills checklist as part of the pre-service training for health staff. This development will ensure standardization of YFS training and help control the quality of training. Previously, each organization or project had its own guides and manuals.

Monitoring and evaluation tools and systems were developed, strengthened, and used under AYA to improve the facilities' functioning. Youth were trained as mystery clients to monitor YFS and peer service providers, and a facility assessment tool was used at baseline and endline to monitor improvements made over the course of the project. Management information systems were strengthened through development of tools and training of staff on their use. AYA also supported the strengthening of provider supervision through training and the introduction of supervision tools. The MOH Zanzibar is planning to adapt the AYA tools for island-wide use.

Youth input and involvement have increased in YFS service provision. In addition to youth serving as mystery clients, assessment team members, and peer service providers, they have also provided feedback through suggestion boxes and feedback registers at the facilities, served on youth or health boards (two youth were subsequently employed by the Municipal Council), and are otherwise discussing their needs and issues with community members and service providers.

Challenges previously mentioned in this report include interruptions in supplies such as BCC materials and contraceptives for facilities and peer providers. Facility staff noted their heavy workload, which affected waiting times for youth. More training was identified as a need for service providers, non-health staff, and peer providers. Also, interviews of youth revealed the need to ensure understanding of the term YFS or to use

other terms that will be understood by youth. AYA/Pathfinder staff described limits of staff to monitor the large number of facilities covered under AYA.

Based on the results, the following recommendations are made for future projects such as AYA:

- In planning for a project of such magnitude, more human resources are needed to provide technical assistance and supervision. AYA worked with a large number of facilities across the country with limited YFS experience, and given the number of activities that were implemented, more human resources were needed to allow for greater and more frequent coverage. Additional human resources would have also ensured higher quality data and reports from partners.
- Future efforts such as this need to work with government and other donors to ensure that supplies of contraceptives and other necessary materials are in place in sufficient quantity and consistently. Such collaboration may need to target the commodity supply system at both central and district levels. Service provision was hampered by the lack of contraceptives and testing agents throughout the project, though not part of AYA's mandate.
- There is a need to establish stronger systems for recruitment, training and mentoring of peer providers.
- AYA/Pathfinder showed that government facilities can provide YFS; future projects should look for ways to provide such services through the public sector.
- Evaluation tools and systems should be in place sooner, to ensure participation and involvement of staff and stakeholders and in the collection of quality data.

Given the positive results that AYA/Pathfinder achieved in Tanzania in increasing access of youth to SRH information and services, it is hoped that efforts will continue beyond the project. In terms of sustainability, in all 10 districts where AYA was operating, there is high enthusiasm among facility staff and district and council health management teams to scale-up integration of YFS in as many health facilities as possible. Districts have been using their own financial and human resources to do this, and have committed to continuing this work. In fact, in many cases service providers have volunteered to extend their working hours and days to meet the needs of the youth without requesting salary increases or overtime pay. In addition, in financial year 2004/2005, for the first time the central government allocated funds (US $100,000) for youth SRH activities through the Reproductive and Child Health Section of the MOH in the mainland. An increased number of council authorities in AYA implementing sites have also integrated a few aspects of YFS into their development plans and have allocated portions of funding for it.

APPENDIX A: AYA Tanzania Facilities

Partner	*Facility*	*District/ Municipality*	*Region*
Marie Stopes Tanzania (MST)	Arusha	Arusha	Arusha
	Ilala	Ilala	Dar
	Mabibo	Kinondoni	
	Mwenge		
	Temeke	Temeke	
	Sirari	Tarime	Mara
	Zanzibar	Zanzibar	Zanzibar
Dar City Council/ Infectious Disease Center (DCC/IDC)	IDC	Ilala	Dar
	Vingunguti		
	Tandale	Kinondoni	
	Mbagala	Temeke	
University of Dar es Salaam (UDSM)	UHC	Kinondoni	Dar
	UCLAS/Ardhi Institute		
UMATI	Ngarenaro	Arusha	Arusha
	Temeke	Temeke	Dar
	Muhimbili	Ilala	
	Pemba	Pemba	Pemba Island
	Zanzibar	Zanzibar	Urban West
Arusha Municipal Council	Ngarenaro	Arusha	Arusha
	Kaloleni		
	Levolosi		
Ilala Municipal Council	Pugu Kajiungeni	Ilala	Dar
	Tabata A		
	Buguruni		
Karagwe District Council	Ihembe	Karagwe	Kagera
	Kayanga		
	Kishojo		
	Rwabwere		
Kasulu District Council	Kasulu	Kasulu	Kigoma
	Kiganamo		
	Muyama		
	Rusesa		
Kibondo District Council	Kibondo	Kibondo	Kigoma
	Kifura		
	Mabamba		
	Nyanziga Kakonko		
Kinondoni Municipality	Kawe	Kinondoni	Dar
	Kimara		
	Sinza		

Partner	Facility	District/ Municipality	Region
Tarime District	Kinesi	Tarime	Mara
	Nyamagaro		
	Nyamongo		
	Shirati		
	Tarime		
Temeke Municipality	Kigamboni	Temeke	Dar
	Yombo Vituka		
MOH Zanzibar	JKU Saateni	Unguja	Urban West
	KMKM		
	Mwembeladu		
	Rahaleo		
	SDA Clinic		
	Sebuleni		
	Mnazi Mmoja		
	Gombani Chake	Pemba	Pemba Island
	Konde		
	Mkoani		
	Vitongoji		
	Wete		