



Government of Tanzania/UNICEF 7 Learning Districts Strategy (2007-2011)

External Evaluation

Final Report

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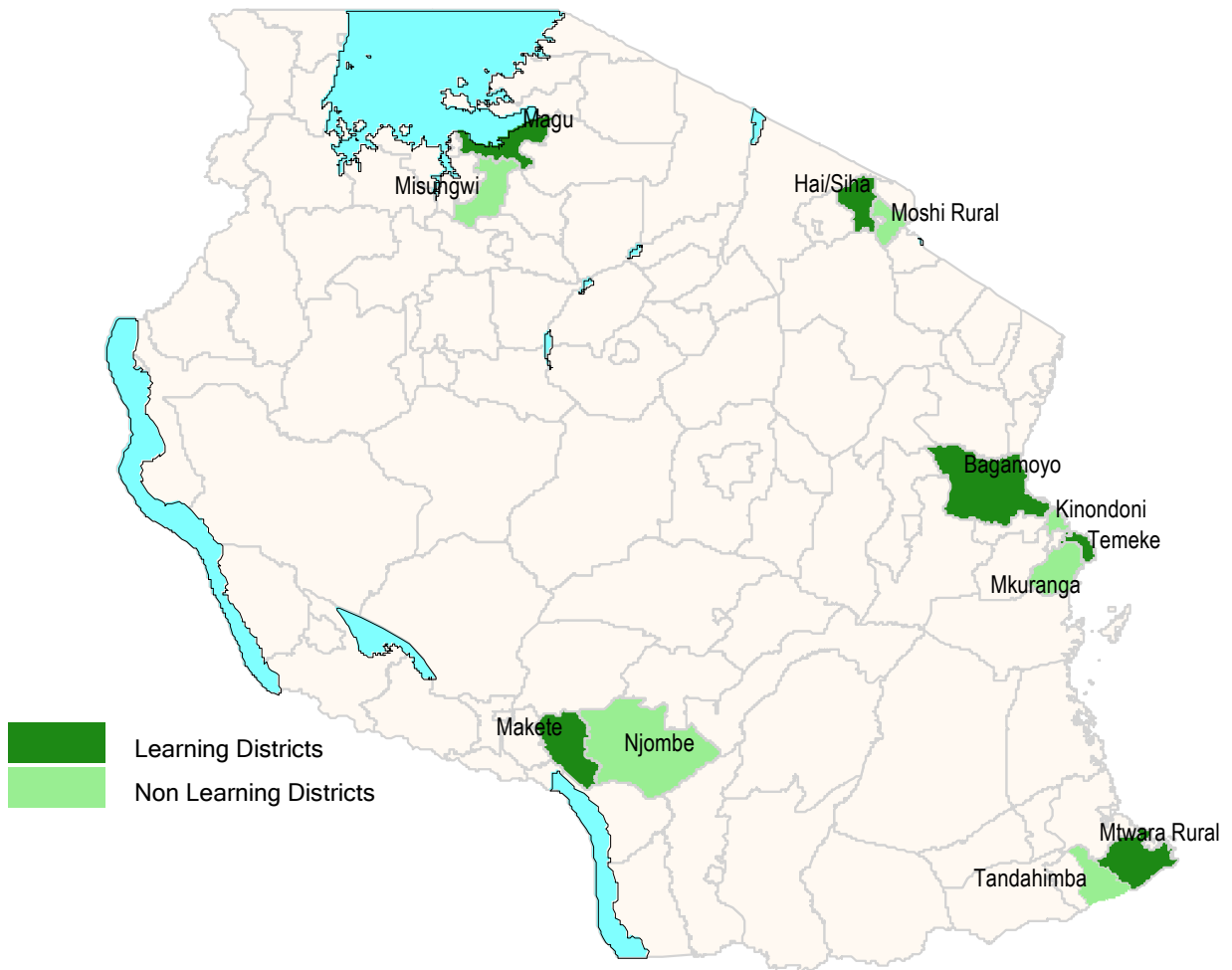
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Disclaimer

The views expressed herein are those of the consultants and do not necessarily reflect the views held by UNICEF or by the Government of Tanzania.

Map of the 7 Learning Districts and Comparison Non-Learning Districts*



*As per the approved Country Programme Document 2007 – 10, six districts were planned to be targeted by the GoT/UNICEF interventions. In 2007, Ha district was divided into two districts: Hai and Siha, bringing the number of intervention districts to 7. Comparison districts were chosen at the time of the Baseline Survey.

ABBREVIATIONS

ADEM	Agency for the Development of Educational Management
AfDB	African Development Bank
AIDS	Acquired Immuno Deficiency Analysis
AMOs	Assistant Medical Officers
ANC	Ante Natal Care
ART	Anti-Retroviral Therapy
ARV	Antiretroviral
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behavior Change Communication
BCG	Bacille Calmette-Guerin
BELS	Basic Education and Life Skills
BeMOC	Basic Emergency Obstetric Care
BEST	Basic Education Statistics
BMI	Body Mass Index
CAG	Controller and Auditor General
CB	Capacity Building
CBO	Community Based Organisation
CCHP	Comprehensive Council Health Plans
CFS	Child friendly schools
CHAC	Council HIV&AIDS Coordinator
CHMT	Council Health Management Team
cIMCI	Community Integrated Management of Childhood Illnesses
CJF	Community Justice Facilitation
CMAC	Council Multi-sectoral AIDS Committees
CMET	Council Monitoring and Evaluation Team
CMT	Country Management Team
COBET	Complementary Basic Education in Tanzania
CoRPS	Community own Resource Persons
COs	Clinical Officers
COSET	Complementary Secondary Education in Tanzania
CP	Country Programme
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CPP	Child Protection and Participation
CPT	Child Protection Team
D by D	Decentralization by Devolution
DAWASCO	Dar es salaam Water and Sewerage Corporation
DCC	District Consultative Committee
DCPT	District Child Protection Team
DED	District Executive Director
DHS	Demographic Health Survey
DMET	District Monitoring & Evaluation Team
DMOs	District Medical Officers
DPLOs	District Planning Officers

DPT Hb3	Diphtheria, Pertussis, Tetanus, Hepatitis B Vaccine
DROMAS	District Roads Management System
DSP	District Strategic Plans
DSWO	District Social Welfare Officer
DToTs	District Training of Trainers
DUs	Drug Users
DWE	District Water Engineer
DWST	District Water and Sanitation Teams
ECD	Early Child Development
ECOSAN	Environmental Sanitation
EPCO	Environmental Engineering and Pollution Control
EFA	Education for All
EID	Early Infant Diagnosis
EMIS/ESMIS	Education (Sector) Management Information System
EmOC	Emergency Obstetric Care
ENA	Essential Nutrition Actions
EPI	Expanded Programme on Immunization
EPR	Emergency Preparedness and Response
ESDP	Education Sector Development Program
FACE	Fund Authorization Certificate of Expenditure
F-ANC	Focus Antenatal Care
FBO	Faith Based Organization
FDG	Focus Group Discussion
FHI	Family Health International
FP	Family Planning
FW	Focus Wards
FY	Financial Year
GoT	Government of Tanzania
GRP	Gender Responsive pedagogy
HIV	Human Immunodeficiency Virus
HIV+	HIV positive
HMIS	Health Management Information System
HoDs	Head of Departments
HSSP	Health Sector Strategic Plan
IEC	Information Education and Communication
IECD	Integrated Early Childhood Development
IGAs	Income Generating Activities
IHI	Ifakara Health Institute
IMCI	Integrated Management of Childhood Illnesses
INSET	In-Service Teacher Education and Training
IPPE	Integrated Post Primary Education
IpTp2	Intermittent preventive Treatment in pregnancy
ITN	Insecticide Treated Nets
ITWG	Integration Technical working Group
IYCF	Infant and Young Child Feeding
JAST	Joint Assistance Strategy of Tanzania
JICA	Japan International Cooperation Agency
KRAs	Key Result Areas

LD	Learning District
LGMD	Local Government Monitoring Database
LHRC	Legal and Human Rights Centre
LISA	Life Skills Association of Tanzania
LLIN	Long Lasting Insecticide Treated Nets
LRHC	Legal and Human Rights Centre
MCDGC	Ministry of Community Development, Gender and Children
MDG	Millennium Development Goal
MFI	Micro-finance Institution
MKUKUTA	MpangowaKukuzaUchuminaKupunguzaUmasikini Tanzania
MLAC	Mobile Legal Aid Clinic
MMACs	Mtaa Multi-sectoral AIDS Committees
MNCH	Maternal, Newborn and Child Health
MoEVT	Ministry of Education and Vocational Training
MoF	Ministry of Finance
MOFEA	Ministry of Finance and Economic Affairs
MoHSW	Ministry of Health and Social Welfare
MoWI	Ministry of Water and Irrigation
MPs	Members of Parliament
MSM	Men Having Sex with Men
MTEF	Medium Term Expenditure Framework
MTR	Mid-Term Review
MUAC	Mid-Upper Arm Circumference
MVA	Manual Vacuum Aspirator
MVC	Most Vulnerable Children
MVCC	Most Vulnerable Children Committee
MVCCs	Most Vulnerable Children Committees
MYR	Mid-Year Review
NBS	National Bureau of Statistics
NCHS	NCHS National Centre for Health Statistics
NCPA	National Costed Plan of Action for MVC
NER	Net Enrolment Rate
NFE-MIS	Non Formal Education Management Information System
NFT	National Facilitation Team
NGO	Non Government Organization
NLD	Non Learning Districts
NLSEF	National Life Skills Education Framework
NLSF	National Life Skills Framework
NMSF	National Multi-sectoral Strategic Framework
NPA	National Plan of Action
NSGRP	National Strategy for Growth and Reduction of Poverty
NWT	North Western Tanzania
O&OD	Opportunity and Obstacle to Development
OECD	Organisation for Economic Cooperation and Development
ORT	Oral Rehydration Treatment
PAAP	Policy Advocacy and Analysis Programme
PAC	Post Abortion Care
PACT	Partners Achieving Change Together

PAIDS	Pediatric Acquired Immune Deficiency Syndrome
P-ARV	Pediatric Anti-Retroviral Treatment
PCA	Partner Cooperation Agreement
PD	Paris Declaration
PEDP	Primary Education Development Program
PEPFAR	President's Emergency Plan for AIDS Relief
PHAST	Participatory Hygiene and Sanitation Transformation
PHC	Primary Health Centre
PHE	Peer Health Educators
PI-ENA	Performance Improvement Essential Nutrition Actions
PLANREP	Planning and reporting Tool
PLHIV	People Living with HIV
PM&E	Planning Monitoring and Evaluation
PMO-RALG	Prime Minister's Office Regional Administration and Local Government
PMTCT	Prevention of Mother-To-Child Transmission (of HIV)
PNC	Post Natal Care
PPP	Public-Private Partnership
PSI	Population Services International
PSLE	Primary School Leavers' Examination
PSS	Psychosocial Support
PW	Pregnant Women
RAS	Regional Administrative Secretary
RBM	Results-Based Management
RCC	Rolling Continuation Channel
RCH	Reproductive and Child Health
REPOA	Research on Poverty Alleviation
RHMTs	Regional Health Management Teams
RITA	Registration Insolvency and Trusteeship Agency
RMET	Regional Monitoring and Evaluation Team
RPO	Regional Planning Officer
RR	Resident Representative
RSWO	Regional Social Welfare Officer
RWSSP	Rural Water Supply and Sanitation Quick-wins Programme
SAM	Severe and Acute Malnutrition
SBAS	Strategic Budget Allocation System
SMART	Specific, Measurable, Achievable, Relevant and Time bound
SP	Sulfadoxine-Pyrimethamine
SRH	Sexual and Reproductive Health
SW	Sex Workers
SWAp	Sector Wide Approach
SWO	Social Welfare Officer
TACAIDS	Tanzania Commission for AIDS
TBAs	Traditional Birth Attendants
TDHS	Tanzania Demographic Health Survey
TGEI	Tanzania Girls Education Initiative
TOMSHA	Tanzania Output Monitoring System for HIV and AIDS
ToTs	Training of Trainers
TRCC	Teachers' Resource Center Coordinator

TRCs	Teacher Resource Centres
TSED	Tanzania Social and Economic Database
TUSEME	Tuseme Club
UN	United Nations
UNAIDS	United Nations Joint AIDS Program
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Fund
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Fund for Women
USAID	United States Agency for International Development
VAC	Violence Against Children
VCPT	Village Child Protection Team
VCT	Voluntary Counseling and Testing
VEOs	Village Executive Officers
VfM	Value for money
VHW	Village Health Workers
VMAC	Village Multi-sectoral AIDS Committee
WASH	Water, Sanitation and Hygiene
WCPT	Ward Child Protection Team
WEC	Ward Education Coordinator
WEO	Ward executive officer
WFP	World Food Programme
WHO	World Health Organisation
WMAC	Ward Multi-sectoral AIDS Committees
WSDP	Whole School Development Plan
WUGs	Water User Groups
YCSD	Young Child Survival and Development
ZnZ	Zanzibar

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EXECUTIVE SUMMARY

A. Introduction/Background

UNICEF has been supporting development cooperation interventions at sub-national level in Tanzania for over 15 years. From 2007-2010, UNICEF implemented a country program (CP) that had a dual purpose of influencing national policies, regulations and standards upstream while at the same time sharpening the testing of promising child-sensitive programming models and intensifying investment in a reduced number of “learning districts” (LDs) (7 in total) to improve service delivery.

Within the 7 LDs (Bagamoyo, Hai, Magu, Makete, Mtwara, Siha, Temeke), UNICEF adopted a comprehensive package designed to achieve results in just under 30 programme components spread over four thematic areas: *Young Child Survival and Development (YCSD)*, *Child Protection and Participation (CPP)*, *Basic Education and Life-skills (BELLS)* and *Policy Advocacy and Planning (PAAP)*.

The **YCSD component** focused on maternal, new-born and young child survival, growth and development. The component was designed to facilitate maternal, new-born and child survival, health, growth and development by strengthening (1) disease prevention and health promotion; (2) strengthening the continuum of care for mothers and children, addressing in particular missed opportunities and promoting quality health care; and (3) strengthening nutrition and early childhood development.

BELS - the component was to increase the completion of primary and pre-primary schooling and transition into secondary and post-primary education institutions, by supporting: (1) child-friendly schooling; and (2) HIV&AIDS and life-skills education focusing on developing a gender-responsive life-skills curriculum for all ages of children, both in-and out-of-school. Child friendly schooling was to focus on strengthening capacity for (i) broad-based quality education, including care, support and protection for all vulnerable girls and boys with special efforts to boost the retention and achievements of girls; (ii) an ‘accelerated’ primary education opportunity through COBET; and (iii) increased access to post-primary, including an ‘accelerated’ secondary education.

CPP aimed at: adopting and applying a national strategic plan for the development of child and youth organizations; linking the national plan of action for MVCs, including cash-transfer mechanisms with the national social protection framework; ensuring MVC were cared for and protected in line with MKUKUTA; supporting young people to participate in child-led and youth-led organizations, and; supporting birth registration for children. It was later re-modelled mid-way to test a new model of child protection.

PAAP was designed to influence policy development, planning and resource allocation to reduce child vulnerability through the use of up-to-date, reliable disaggregated data and evidence; strengthening national structures and processes for monitoring and reporting on implementation of key child rights commitments; integrating priority issues and actions for

children, women and vulnerable groups into the comprehensive national social protection policy and framework, and; enhancing social planning and budgeting around children, women and vulnerable groups through capacity development and improved linkages nationally and in the LDs.

The Country Programme (2007-2010) had 30 key results of which 26 were primarily focused on the learning districts. In line with its corporate accountability policy and the need to document evidence for learning and programme design, UNICEF commissioned an external evaluation of the 7LDs Strategy in August 2011 which has culminated in the production of this findings report.

The overall objective of the evaluation was **‘to assess effectiveness of the area-based programming approach, the “theoretical model” of the 7LDs, and draw lessons learned for future programming internally and in other countries’**.

The Evaluation focused on answering a set of questions under each of the following OECD Evaluation Criteria: *Relevance; Effectiveness; Efficiency; Sustainability; Impact* and the extent to which *Cross-cutting issues* (such as prioritization of the most vulnerable, enhancement of gender equity, extent to which district planning and budgeting are results based, and extent to which community participation was promoted) were addressed.

To conduct the evaluation, two institutions (Jimat Development Consultants and Ifakara Health Institute (IHI)) were competitively selected and twinned to provide the services with the former focusing on the national and district stakeholder interviews and Drafting the Main Evaluation Report, while the latter were tasked with the administration of sub-district data collection and drafting of the End-line Survey report. This report presents the results of the evaluation jointly carried out by these two institutions based on data collection at national, regional, district and community level over a 4-month period. It has 11 Chapters, the first two providing background information and the methodology. Chapter 3 presents the status of facilities and services in the Learning Districts and 6 comparison districts selected as controls at the time of the Baseline Survey in 2009. Chapters 4, 5, 6, 7, 8, 9, present findings in relation to relevance, effectiveness, efficiency, impact, sustainability and treatment of cross-cutting issues, respectively. Chapter 10 presents the lessons learnt while the last Chapter is on Conclusions and recommendations.

B. Methodology

Taking into account the completion status of each of the key result areas funded by UNICEF, a quantitative End-line sample survey was designed and carried out targeting households, and relevant stakeholders at institutions, facilities and within communities who were reached by the UNICEF/GoT interventions in the 7 LDs. A matching sample survey was carried out in 6 NLDs for comparison. The learning districts included: Temeke, Bagamoyo, Hai/Siha, Magu, Makete and Mtwara rural. The non-learning districts were Kinondoni, Mkuranga, Moshi rural, Misungwi, Njombe and Tandahimba. These districts had more or less similar characteristics with the learning districts.

A “difference in difference statistical test” was used to ascertain whether changes in LDs were significantly higher than in NLDs. For purposes of this executive summary we present results by key result area, then the conclusions, main lessons and main recommendations.

C. Evaluation Findings

Overall the 7 LDs interventions were found to be highly relevant and had positive results. The results achieved varied by key result area and below are some of the highlights on major changes that have occurred in Learning Districts versus non-learning districts by programme component.

C1. Component 1 - YCSD

C1.1 Nutrition and ECD

Knowledge of at least 4 of the 7 components of ENA among health workers was found to have improved in LDs by a larger margin than in NLDs. The proportion of health workers trained on ENA who knew at least 4 of the 7 components of ENA increased from 0% to 17% in the learning districts compared to an increase from 0% to 7% in non-learning districts, suggesting significant positive impact of UNICEF support to LDs. Marked improvements were observed in Siha, Makete and Mtwara rural. Kinondoni also had health workers who knew at least 4 components of ENA but was the only NLD with staff with this knowledge. There was no statistically significant increase in the proportion of health facilities that had at least one staff member trained on ENA or ENA-PIA, suggesting that the numbers reached were too few.

The proportion of health workers trained in ENA or ENA-PIA who were fully utilizing the new knowledge and skills acquired through the training in their daily work was high and effectiveness of the training was also highly rated “A” (very good) in Siha, Magu, and Hai districts. Training sessions on IYCF and screening for SAM were also appreciated but health workers sometimes were not able to put into practice what they had been taught because of **high workload** (e.g., long queues), or **re-assignment to other duties that had little to do with nutrition**. Unavailability of equipment (length boards, weighing scales, updated MUAC tapes) and supplies such as PlumpyNut also reduced the effectiveness of nutrition education for health workers, suggesting the need for a comprehensive intervention package that addresses the current deficits in terms of staff numbers as well as other capacity gaps apart from skills.

In both LDs and NLDs, high proportions of CoRPS trained on exclusive breastfeeding assessed the training as having been both well designed and well delivered (content, duration, quality of venue and of facilitation) (95% in LDs and 88% in NLDs). The majority of those trained also found the training useful for their work (92% (12/13) and 83% (35/42), respectively).

However, at community level, results from the household survey showed that the proportion of mothers who delivered in the previous 12 months and breastfed their babies within the first hour of birth did not change significantly in either LDs or NLDs, and remained low at between 21-25% in LDs and 22-24% in NLDs. The percentage of children under the age of 6 months who were exclusively breastfed also remained relatively unchanged compared to the Baseline, and there was no significant difference between LDs and NLDs in terms of the proportion of children below 6 months who were exclusively breastfed. In LDs 39% (43/111) of children below 6 months of age were exclusively breastfed at End-line Survey stage compared to 32% (66/209) at Baseline. This contrasts with 42% (58/130) and 31% (54/175), respectively, for the NLDs.

C1.2 WASH

In districts where UNICEF invested in water supply for vulnerable communities (e.g., Makete and Magu) there was a significant positive impact on household access to improved water sources both in terms of continuity of water access during the dry season and distance (and time taken) to the nearest improved water source. Although the proportion of households with access to piped water supply increased in both LDs (from 43% to 54%) and NLDs (36% to 46%) between the Baseline and the End-line, the change in LDs was significantly higher than in NLDs which confirmed an overall significant positive contribution of the UNICEF intervention.

However, Evaluation findings did not confirm that UNICEF WASH interventions had an impact on access to improved toilet facilities. Access to improved sanitation has not improved overall either in the 7 LDs or the 6 NLDs. Although in Siha, access to improved sanitation showed some slight increase, this was at a very slow pace despite an increase in the supply of trained sanitation artisans, establishment of WASH promotion centres and increase in community awareness on sanitation issues. The results further indicate that the promotion of sanitation can be a long term undertaking if current approaches used by UNICEF, GoT and other development partners are not significantly revisited to strengthen demand creation as much as the focus is also on supply driven interventions. Already, emerging positive evidence from Learning Districts indicate that PHAST trainings had multiplier effects at ward level, and WASH promotion has been institutionalised through bye-laws of village governments that are imposing fines on those without improved toilets or are found to be polluting the environment, and this will sustain improvements that will be made, but the critical constraints that remain to be solved appear to be affordability of the technology of improved toilets, availability of materials for construction and availability of artisans that can construct these.

The training of sanitation artisans and construction of WASH promotion centres was a good intervention reached too few of them to impact significantly on access to sanitation. It also lacked the other elements needed for effectiveness (a viable business model to sustain the activities of WASH promotion centres).

The difference in difference statistical test showed no impact of WASH interventions on the proportion of caretakers and other household members who wash their hands at all four critical moments but an improvement was found with regards to washing of hands at two critical moments and washing hands with soap or ash. There was no significant improvement in the proportion of households demonstrating correct and consistent dosing of water.

At End-line, Makete district had the highest proportion (15%) of households who boil drinking water, and the Evaluation attributes this to more UNICEF's investments in water infrastructure and information education communication on water treatment. Focus group discussions with women in Makete clearly confirmed the positive contribution of UNICEF in this regard. However, overall, NLDs had a higher proportion of households (37% (956/2619)) who boil their drinking water than LDs (33% (828/2545)) and the difference between LDs and NLDs was statistically significant at 95 percent confidence.

A small but statistically significant improvement in the proportion of household treating their drinking water with water guard / aqua-tab was observed in LDs (from 4% at baseline to 6%

(165/2545) at End-line) while it declined slightly in NLDs from 4% to 3% over the same period. These results confirm that UNICEF-funded WASH interventions at community level (PHAST and BCC on WASH) may have had an impact on good practices of water treatment.

With regard to the proper disposal of children's faeces into latrines, there were high proportions of households practicing correct disposal in both LDs and NLDs (76% (269/356) and (74%) (253/344), respectively) and there was no statistically significant difference between the two.

Despite the above achievements, there seemed to be no impact on diarrhoea. Prevalence of diarrhoea in under-fives had increased in both LDs and NLDs but by a wider margin in LDs at End-line. This can be expected since the WASH intervention did not have an impact on access to improved sanitation nor access to protected wells. Furthermore, lack of impact on household hand washing at four critical moments implies that exposure to food and water contaminants and diarrhoeal diseases for under 5 children is unlikely to have been addressed by the WASH intervention. UNICEF may have to study more carefully to disentangle the reasons why households are not washing hands at four critical moments and demand creation interventions for WASH that would make a difference in rural Tanzania, then strengthen its WASH interventions to make a positive dent on diarrhoea prevalence.

C1.3 Behaviour Change Communication

The intervention had an impact on the proportion of pregnant women making preparation for delivery together with those delivering outside a health facility but who then quickly accessed post-natal care services. However it did not have an impact on the management of sick children below 5 years. The proportion of children "receiving early treatment from the on-set of fever from appropriate health providers", improved in NLDs but decreased in LDs. Health workers cited residual constraints in physical and economic access to transport. Hence, in LDs which were provided with ambulances by UNICEF (e.g. Makete), **this intervention (ambulance) was highly appreciated** as one of the most important investments that UNICEF had ever made in contributing to maternal and child health and survival. UNICEF should continue with this support to needy health facilities while at the same time assisting those districts to put in place a sound system for vehicle maintenance.

C1.4 PMTCT/PAIDS

The evaluation found improvements on: proportion of health facilities using national PMTCT and ART guidelines; health facilities offering the minimum package of PMTCT services for the prevention of HIV infection in infants and young children; newborn to HIV positive pregnant women who were given a dose of nevirapine, and; availability of PMTCT drugs in health facilities of the 7LDs. It was also reported that health workers were able to confidently attend to a larger number of clients within a shorter time.

Furthermore, the Evaluation can confirm statistically and with a high degree of confidence (95 percent), that the PMTCT/ PDAIDS intervention had a strong impact on 3 indicators and in three specific districts, namely:

- proportion of pregnant women making at least one ANC visit who have received an HIV test result and post-test counselling (in Temeke);

- percentage of women aged 15-49 years with knowledge that HIV can be passed on from an HIV positive mother to her baby in (Hai/Siha district); and
- proportion of proportion of women 15-49 with knowledge of availability of a drug that can prevent mother to child transmission of HIV (in Hai/Siha)

Apart from the district specific impacts, the intervention did not have a generalised impact as comparison of aggregate change in LDs does not outweigh that in NLDs over the intervention period. Evidence from both LDs and NLDs shows the strong presence of NGOs funded through PEPFAR, the Global Fund and other funds who are offering similar training to health service providers on PMTCT/EID/PDAIDS in both LDs and NLDs.

In addition to these results, all DMOs in the 7LDs and NLDs reported that although the EID system is still not fully functional, there was an overall reduction in HIV transmission to children born to mothers who are living with HIV who deliver at health facilities. In Makete, a model of good practice on male involvement in PMTCT had also clearly emerged following UNICEF's support – whereby district staff, politicians, village governments, CoRPS, churches and other CBOs had been reached with the messages and were aggressively promoting male involvement in PMTCT, and as a result of these efforts, the rate of male participation in ANC visits (for example) had gone up from none in 2007 to 54% of pregnant women using these services by 2010. This practice is worth documenting and replicating countrywide.

They also reported a reduction in frequency of opportunistic infections and magnitude of AIDS-related mortality among children who are living with HIV in their districts because of an increase in HIV testing, counselling and treatment services now being made available to children. The major challenge which remains a major impediment to their efforts is that CTC centres are still too few. In Makete district, for instance, all 33 health facilities are offering full package of PMTCT services (counselling, testing and ARVs) but the district only has 10 CTC sites, and continuation of ARV treatment for pregnant women is very weak. At RCH centres, HIV positive mothers and exposed children get prophylaxis but very few are able to continue with treatment because of unavailability of relevant services in their areas. Furthermore in most LDs, very few health workers have had access to refresher training to equip them with the knowledge on the new PMTCT guidelines and this remains a critical bottleneck to PMTCT scale-up.

C1.5 MNCH

Findings from the 7LDs confirm that training and procurement support provided by UNICEF contributed significantly towards improving availability and quality of MNCH services in health facilities as well as the community level at a time when some of the services were declining in quantity in NLDs. UNICEF support to the 7LDs increased the total number of those trained in MNCH at community, dispensary, health facility and hospital levels.

By 2011, UNICEF-funded MNCH trainings (EmOC, FANC, PAC, essential new-born care) had been very effective in increasing the proportion of health workers trained on MNCH (the increase in LDs was from 20% at Baseline to 74% at End-line, compared to an increase from 27% to 63% for NLDs, respectively). The proportion of health centres (primary health care) providing services with at least two skilled attendants for delivery had also increased from 76% to 100% in LDs. This matched the new level for NLDs, which had increased from a higher figure

of 84% at Baseline to 100% at End-line, thus confirming the significance of the value-added by UNICEF's contribution in LDs.

The proportion of health facilities offering basic EMOC services: Antibiotics, Oxytocics and Anti-convuls also increased from 75% (15/20) at Baseline to 85% (22/26) at End-line in LDs, while it declined in NLDs (from 84% (16/19) to 75% (21/28)). While UNICEF did not support directly the districts to implement Kangaroo Mother Care for management of low birth weight, but its work was at national level, developing the guidelines, it is worth noting that the proportion of health facilities implementing this approach increased in LDs over the same period.

In addition in LDs, the proportion of health facilities offering basic EMOC services: Antibiotics, Oxytocics and Anti-convuls increased from 75% to 85% , 60% to 73%, and 50% to 58% between Baseline and End-line, respectively. In NLDs they all declined, thus suggesting that the presence of UNICEF support in the LDs made a positive difference.

The proportion of health facilities that had "supervision visits involving case management observation in the 6 months preceding the End-line Survey also increased in LDs from 58% to 62% while it declined in NLDs from 53% to 44%. Availability of transport for referral (bicycle or motor-cycle or ambulance) improved in LDs from 31% to 35% while it declined in NLDs from 39% to 32% of facilities interviewed at baseline and End-line, respectively.

Improvements in availability of functional MNCH equipment in health facilities were noted in both LDs and NLDs with no significant differences between them, to some extent suggesting that districts that received funding from UNICEF used other funds at their disposal which they could have used for equipment (such as the health basket fund) for other pertinent health service delivery needs apart from equipment. This way UNICEF support may have had a natural but unanticipated possible funds displacement effect.

Overall, client satisfaction with health facility services increased in LDs especially in relation to "appropriateness of services" (from 90% to 100%), "confidentiality of the service" (92% to 100%), and "service provider attitude" (86% to 100%), but appeared worse for "provision of HIV counselling on that day" (from 90% to 80%) and more or less the same in relation to "waiting time" (86% to 85%). On the contrary, in NLDs most indicators of client satisfaction declined, with the exception of "appropriateness of services" (which remained at 100%), and "whether health provider listened well to the client" (which remained at 98% level of satisfaction).

A major concern expressed by DMOs, however, was the directive issued by Government in 2011 suspending allocation of resources to training activities and directing districts to commit the resources to drugs, infrastructure and equipment. Though the measure is in light of ensuring that critical staff are not removed from their duty stations to be trained, districts will not be in a position to provide further training through centrally managed funds although some residual training may continue through NGO efforts but these are at a small scale and not well coordinated. This directive can contribute to the reversal of gains made by UNICEF in enhancing staff skills especially in the wake of staff turnover that will continue and the recruitment of new staff who are not trained on similar topics covered by the support from UNICEF. With the rapid turnover of staff (including redeployment within the health service) and constantly emerging medical research findings with changes in treatment regimen, absence of

training could have catastrophic consequences on critical MDG indicators for health sector. This fact is made worse by the fact that the unmet demand for training remained high in LDs.

Lastly, whilst the proportion of health facilities with guidelines increased in LDs with respect to IMCI, family planning, PNC and Malaria, there appeared to be a decline in availability of guidelines on OI, VCT, PAC and immunization, suggesting that training delivery and provision of national guidelines may need to be more strongly coordinated in future.

C2. Component 2 – BELS

C2.1 Whole School Development Planning

The Evaluation found consistent evidence of significant contribution of the child friendly schools initiative piloted by UNICEF (in collaboration with MoEVT and learning districts) in focus wards and schools towards improving pass rates for boys and girls in primary schools with higher impact on girls at standard IV level, which has increased the transition rates to Standard V. More generally, for the focus schools there is a deliberate effort to improve the pass rates for the girl child and in most schools reached by the intervention in the LDs, the pass rates for girls at Grade 4 have significantly improved.

Teachers are planning their lessons better, their skills to teach hard subjects (English, Maths and Science) are being enhanced, teaching in class is becoming more gender responsive, and both school meals and MVC support are improving retention rates for pupils coming from poor and vulnerable families. Pupils now know their syllabus and this is an indicator that teachers are planning their lessons according to the national syllabus. Schools in focus wards are also receiving more supervision visits from the WECs (and their checklist includes lesson planning, observation of teaching, teaching environment, projects to raise income to implement the school development plan, discipline of teachers and pupils, weekly tests and pass rates, school lunches). Development projects to improve the school standards are now being prioritised and sequenced for funding and are now being completed one at a time, and on schedule, unlike previously when many projects would be started at the same time, spreading the resources of the school too thinly and completion was significantly delayed as a consequence.

Resource mobilisation by some schools who used their plans to lobby and attract financial and in-kind support from well-wishers like mobile telephone companies was strengthened. **Supporting schools through the WSDP to raise resources through this type of private-public-partnership (PPP) is an innovation that needs to be scaled up in future by UNICEF – and the Evaluation strongly recommends the shift from Child Friendly Schools (CFS) to Child Friendly ‘Viable’ Schools (CFVS) concept. Initiatives to strengthen fund-raising capabilities of schools that are carrying out WSDP are urgently needed to help schools finance their plans.** For instance, in Hai and Magu the district councils had specific plans for all schools to have school lunches. In Makete, the initiative has been taken to other schools and most schools now know how to prepare whole school development plans and planning has enabled schools to invest in school improvements in a more systematic manner. Most schools that have been trained on whole school development planning have also managed to attend to some critical issues such as improving water and sanitation facilities thereby contributing to the improvement of the learning environment.

The results achieved in terms of improving the quality of teaching are significant as the WEC in Hai attributed the recent success of the district in being ranked 2nd best district in Standard VII pass rates in the region and coming among the top 10 country wide to the support provided through UNICEF. In his view “*most of the achievement came out of the community contribution and attitude which had been changed through the WSDP approach*”.

In Magu district, primary education examination results confirmed positive impacts on pass rates for boys and girls at Standard IV and VII and transition rates, especially for girls to Standard V and Form One. The Standard IV pass rate for girls increased from 65% in 2007 to 87% in 2010, while that for boys increased from 69% to 88%. The percentage of boys and girls selected for Form One increased to 100% from 2007 onwards.

In Makete District WECs confirmed that whole school development planning had begun producing a good impact on the pass rate for Standard 4, and especially for girls. Pass rates at Standard VII (though increasing) are lagging behind because of the non-availability of text books, high pupil-to-teacher ratios and shortage of classrooms.

C2.2 Gender Equity

Incidence of adolescent pregnancies in both the school and out-of-school environments

The school principals and DEOs interviewed confirmed that the incidences of adolescent pregnancies in school and out-of-school environments declined in both LDS and NLDs over the period 2007-2010. Bagamoyo reported the largest decline from 98 pregnancies in 2007 to 22 pregnancies in 2010. There were no reported incidences of adolescent pregnancies in the school and out-of-school environments in Hai. In Magu district the statistics on pregnancies among girls in school showed a rapid decline from 2008 to 2010). In NLDs declines were also recorded, with Njombe for example, decreasing from a low level of 8 in 2009 to 4 in 2010.

Furthermore, 78% (18/23) of school principals interviewed in LDS school and 59% (13/22) in NLDs indicated reduction of incidences of adolescent pregnancies in the school and out-of-school environments. This was a result of increased awareness of negative consequences of pre-marital sex and early pregnancies through media, NGO campaigns and the school curricula.

Focus Group Discussions (FGDs) conducted with women in the community revealed that the incidence of adolescent pregnancies is well known among the community members. Women cited the following contributory factors: children’s desire to get quick money, initiation ceremonies, freedom given to children and lack of intervening measures from the parents in terms of counselling and support. The FGDs confirmed that in the school environment the problem was decreasing because of interventions by school authorities which are evidenced by the increasing primary school completion rates among girls. TUSEME club responses in LDS also showed that the incidences of adolescent pregnancies among children have been decreasing in both school and out-of-school environments, with more girls becoming assertive and able to speak out on any potential violations to their rights.

Perceptions on prevalence of early marriages and childhood sexual debut

The incidences of early marriages and childhood sexual debut were reported to be decreasing across the LDS. Information obtained from the District Education Officer for Bagamoyo showed that the reason for the reduction of early marriages and childhood sexual debut was the life

skills education and child rights campaigns by NGOs targeting children directly. These have raised awareness of the negative effects of early marriages and sexual debut on individual learning, social and economic life. Children are more aware of negative health consequences including the risk of contracting HIV/AIDS. This has led many adolescents to take precautions in sexual relations practices that may endanger their lives. As in LDs, the situation in NLDs has been found to be decreasing; a few incidences were reported in Njombe, Mkuranga and Misungwi, though an insignificant number to raise concern.

Perceptions on incidence of child abuse (sexual harassment, physical punishment, emotional abuse, economic abuse) of girls and boys at family, school and community levels

Students from TUSEME clubs (LDs) who participated in FGDs were asked whether they know any adolescent girl(s) (below 18 years) who have been abused, or got married either voluntarily or forced in the last 3 years. The results show that they were aware of the problem though the incidents had been decreasing in their areas over the “past three years” (2008-2010). Primary school students in NLDs through students clubs were also asked on the incidence of child abuse and harassment. Children confirmed they were aware of these, but were decreasing over time. Some students in Magu, Bagamoyo and Mtwara gave their experiences on physical punishments that are hard to eliminate completely amid cultural practices that are still dominant in many rural areas. Pupils are punished by teachers and/or parents on grounds that they are reprimanding and instilling order for offences done.

Primary school completion rates for girls and boys

The primary school completion rates for boys and girls in both LDs and NLDs increased significantly during the period of the intervention (2007-2010) due to a number of national initiatives such as on-going educational campaigns, Primary Education Development Program (PEDP), Equal Education for All (EAF) and improved educational environment in schools which allows for higher retention. Indeed one of the goals of MKUKUTA is to ensure primary education completion for all children. This is achieved through awareness promotion on the importance of education among parents using educational campaigns and opening of educational opportunities both in rural and urban areas. Only a small percentage of pupil's do not complete primary school education due to sickness, repeating classes or death. Again motivational factors such as secondary education programs have inspired many children to continue with education as there is assurance of opportunity for transition to secondary education as long as one passes primary school examinations. The Evaluation noted some differences between the LDs against NLDs, with faster progress being made in LDs.

C3. Child Protection Interventions

C3.1 Birth registration pilot

For most of the CPP interventions, impacts have either not yet been realized or not yet been properly measured. The Birth Registration Pilot which supported the catch up campaign had some positive results in increasing the number of children with birth certificates, but it was discontinued before impacts of the birth certificates in terms of reducing child vulnerability by increasing children's access to protective services, and in terms of reducing child poverty by increasing their access to basic social and economic services, could have been measured.

C3.2 Mobile Legal Clinic

The Mobile Legal Clinic was a well-executed intervention but it was not proven beyond doubt that the model worked in terms of providing legal access to children. In addition, data on legal assistance provided to children and the impact the legal assistance had on children was not available.

C3.3 MVC Plans and Guidelines

The creation and strengthening of MVC structures in the 7 LDs and strengthening of capacities of duty bearers on MVC care and support worked well in helping to identify and register MVCs and characterize their needs, and to also link them to service providers, but a large proportion of MVCs (over 80%) could not access any support due to inadequate resource availability at the district/community level and this was reported to be demotivating the MVCC structures at ward and village level, most of which (up to 70%) have not been reached with training on their roles and responsibilities.

An exceptional case and model of good practice was a village MVC committee in Magu that was running a viable IGA (posho mill) to raise funds for MVCs on its register, and the Makete MVC Education Fund which was raising funds from well-wishers for tuition and in-kind support to MVCs up-to secondary education. Apart from these successful models, which UNICEF should document and replicate, impact was highly concentrated on a few MVCs who were privileged to secure some form of assistance, some of whom (e.g., in Makete) were assisted from secondary to university level education. However, there was no baseline information collected to carry out an analysis of whether through social transfers and social support the MVC system managed to keep girls in school and reduced incidence of child labour, early marriage, and teenage pregnancy and improved child survival.

C3.4 Community Justice Facilitation

The Report on the Evaluation of the CJF Project by Rwezaura et al. (2010) concluded that although the project had produced outputs, impacts were not yet evident. The project needed a clearer conceptual framework and comprehensive strategy to achieve impact. The number of CJFs was too few per village and needed to be increased. The new child protection system has taken on board the CJFs as part of the child protection teams at district, ward and village levels and formalises the links between this cadre and other duty bearers, thus will overall increase their effectiveness both in prevention of child abuse as well as impact mitigation. Some districts (Hai and Makete showed interest in providing resources from council revenue to support the activities of this cadre) and UNICEF advocacy should be in that direction.

C3.5 Child protection system pilot

Child protection teams were found only in LDs. There were no child protection teams operational in NLDs. Initial results¹ from the 3 pilot districts indicate that the new model on “child protection system strengthening” is likely to produce some good impacts, but it was still too early to see impacts at scale due to the short implementation period so far, and the absence of a database on cases reported and successfully attended to so far. It was also not very clear whether the baseline assessment which was conducted for the project in 3 pilot districts collected sufficient time series data to facilitate analysis of impact.

¹Magu district pointed out a number of examples whereby girl children who were being abused at home had managed to receive assistance from the child protection teams at village and district levels, and in some instances the cases had been referred to the police or to children’s homes where the children

C3.6 Child participation

Child participation interventions have seen children becoming more confident to participate through the activities of children's *barazas* in decision making processes and contributing new ideas and priorities to village and district plans. However, their direct participation in village ward development committee meetings and in district budgeting meetings remains barred by adult members of these committees.

C3.7 HIV Prevention

Knowledge of young people about how HIV is transmitted or can be prevented either increased from low levels or remained high during the period of the intervention. The proportion of youth who understand that HIV can be transmitted through: multiple sex partners, sharing injecting needles and blood transfusion increased in both LDs and NLDs but by a higher proportion in LDs.

The proportion of young people who understand that HIV can be prevented by having just one sex partner who is not infected and who has no other partners remained high. The level of understanding by youths that HIV transmission can be prevented through proper condom use increased, but so did youths who feel they are not vulnerable to HIV in both LDs and NLDs, but with a higher increase in the latter. This misconception needs to be addressed.

The Evaluation also confirms that the proportion of youth who identified sexual intercourse as a mode of HIV transmission had been positively impacted upon by the intervention in Hai/Siha but not in the other five Learning Districts. The intervention had no overall positive impact on this indicator in Learning Districts.

There was no overall positive impact in terms of promoting awareness of children on their chances of contracting AIDS as the difference in difference statistical test showed that the "proportion of youth who felt that they were vulnerable to HIV infection and who thought their chances of getting AIDS were not known" had increased in Hai/Siha but more-or-less stayed the same in the other six Learning Districts, with no overall aggregate impact in LDs when compared to all NLDs put together.

The evidence at End-line, confirms that the quality of lives of the youths reached by HIV prevention interventions has been safeguarded or enhanced through the HIV prevention activities supported by UNICEF. Youths interviewed during the evaluation mostly indicated that the quality of their lives had improved as a result of accessing VCT services, referral for services and training of youth groups. Compared to the prevalence of 7% at the beginning of the program, findings of the 2007-08 THMIS, confirmed a reduction of HIV prevalence to 6% of adults of age 15-49 years. TACAIDS, 2009 estimates showed another slight decline in adult HIV prevalence to 5.7%.

However, in rural areas, HIV prevalence is increasing due to a combination of limited knowledge, harmful socio-cultural beliefs and practices, poverty and poor access to health service infrastructure which still denies the youth access to quality HIV-related prevention and treatment services.

C4. Component 4 - PAAP

Short-term impacts are already being realised through the inclusion of child protection interventions in the council budgets as well as other needs of children (e.g., MVC school fee payment, user fee waiver on health care for under-fives and pregnant mothers, and provision of basic needs such as food and clothing).

Medium to longer term impacts will be realised, for example, through more years of schooling for MVCs, success of youth IGAs activities, HIV prevention, and high impact nutrition interventions that are budgeted for in the MTEF.

D. Conclusions

The Evaluation confirms that the 7 LDs Strategy was not only **highly relevant** but also produced many positive results. It has built **capacities of Learning Districts to plan and budget for children's priorities and the capacity will be retained in the government system**. The main challenge reducing the actual amount of financial resources made available by districts to children's priorities is now the absence of an **explicit budget line for social welfare** under which children's priorities, especially of child protection nature, can have a dedicated vote and cost centre from which they can be funded. While nutrition is now a permanent budget line in the MTEF as it is budgeted for first in the Comprehensive Council Health Plan, and then reflected in the MTEF with funding from the health basket fund, child protection and socio-economic support for MVCs do not as yet have a budget line under which they can be funded. The District Social Welfare Officer activities are funded either from a small resource envelop under the mandate of the "Community Development Officer" (and this is not enough nor the proper pipeline to finance such interventions) or by way of small "donations" from sectoral budgets as part of the multi-sectoral HIV and AIDS response. The latter practice was not found in LDs but among NLDs, Moshi Rural, which was innovative.

UNICEF has through the LDs experience **piloted a number of successful models** that need to be well studied, documented and then scaled –up. Hai has good experience on how WDSP has increased pass rates in primary schools, it also has promising experience with the reduction of the number of children's homes that did not provide proper care for children. Makete is an example of good practice on male involvement in PMTCT, in out-scaling the Whole School Development Plan approach, in financially supporting the activities of the ward education coordinators and in preparing high quality MTEFs. Makete also offers good experience in water treatment and other hygiene behaviours. Magu, Makete, and Temeke offer good models for institutionalising WASH through village by-laws and therefore promoting sustainability of WASH promotion activities. UNICEF missed an opportunity to promote replication of some of these best practices in NLDs by not effectively engaging Regional Administrative Secretariats to achieve this objective.

It is also very clear from the evidence that some of UNICEF-supported interventions lacked impact on some very critical indicators contributing to the well-being of children, and these included (a) access to improved sanitation, (b) hand washing at four critical moments, and (c) prevalence of diarrhoea in under-fives. Though access to sanitation is inherently a slow change

indicator, these findings suggest that UNICEF may need to revisit its strategies under the 7 LDs Strategy as it carries on with WASH in the new Country Programme phase; this includes revising both approaches for community WASH and for BCC. Both the BCC component implemented through a PCA agreement with PSI and the Community WASH approach implemented through districts need to be carefully analysed for effectiveness and value for money, and redesigned as necessary.

In some cases, the Evaluation reveals that results achieved by UNICEF could not be analysed sufficiently because the M&E system did not track them. UNICEF's M&E system for the 7 LDs Strategy had a number of gaps that need to be addressed, going forwards into the next phase of sub-national engagement.

We further conclude that by **spreading too thinly, through coverage of several districts with a wide spatial distribution**, UNICEF could not sustain the planned quarterly joint monitoring visits, as some sections with a shortage of staff could not be represented consistently by their own staff member. UNICEF may also have spread its resources too thinly in two other ways, (a) by working both at the national and sub-national level, and (b) by working in more than 30 key result areas, 26 of which were primarily district-oriented. Participation of senior members of staff was needed both at national and sub-national level but proximity to the national level, and frequency of policy dialogues and meetings at the centre limited UNICEF's engagement of districts using its most senior staff.

E. Main Recommendations

1. UNICEF's new strategy for sub-national engagement should be elaborated at the onset of such engagement, with **a clear set of objectives, targets and entry and exit criteria** for each major intervention area.
2. UNICEF together with PMO-RALG should develop explicit entry and exit criteria for sub-national engagement which are based on development results (e.g., child poverty, child vulnerability and critical MDG indicators) in order to improve transparency and objectivity of regional targeting, progress assessment and decisions on phasing out of UNICEF support.
3. Exiting a district or region should not be on the basis of expiry of a Country Programme phase, but rather on exit criteria that are linked to the achievement of results in the form of either output or outcome targets, development impact or learning outcomes. All 7 LDs strongly encouraged UNICEF to consider as exit criteria, "**progress made towards achievement of MDGs**" and the likelihood that results achieved will be sustainable.
4. Within the selected focus regions, and for interventions that cannot achieve full district coverage, UNICEF should assist districts in defining explicit criteria for selecting first priority communities (wards, villages) in order to guide the channelling of the limited resources to the most vulnerable and deprived children.
5. The number of key result areas pursued by UNICEF (thematic scope) and the geographic spread both in terms of the number and spatial distribution of the districts should be informed by child deprivation and/or poverty indicators and **matched with the human and financial resources available within UNICEF** to provide for adequate district and thematic

- level engagement by UNICEF Senior Staff for purposes of (i) more adequately engaging and (where possible) jointly programming with other actors supporting districts/sectors for similar results, (ii) deepening coverage and convergence of UNICEF supported interventions at facility and community levels, (iii) strengthening supportive supervision and quality assurance, and (iv) ensuring systematic evidence generation and learning, effectively feeding into regional replication and national policy influencing discourses.
6. UNICEF should in the future deepen its engagement with development partners with active programmes at the district level. This should be done by senior staff within UNICEF and balancing it with national level policy engagement. This may require strengthening PMO-RALG's coordination capacity and role to ensure better coordination, joint programming and experience sharing.
 7. **Capacity building support should remain one of the priority strategies** for strengthening the protective environment for children, planning and budgeting for children's priorities and improving the quality of basic services that reduce child poverty and vulnerability and improve the well-being of children. **Creation of new structures should be avoided** as much as possible, but rather more investments are needed to re-engineer the current structures to provide missing but priority services for children, imparting critical knowledge and skills into the current structures, providing them with working tools and resources, strengthening linkages between them through an **explicit strategy for promoting programme convergence**, and developing and testing **models for their financial sustainability**. This principle should cut across all key result areas tackled by UNICEF's sub-national engagement.
 8. UNICEF should reinforce programme integration within and across its programme components through an explicitly written strategy for maximizing programme convergence and synergy. Priority should be given to mainstreaming of child protection and participation in the entire country programme portfolio, including by packaging CPP into training packages and BCC messages delivered by the various programmes of UNICEF. Furthermore, UNICEF should identify and make use of a number of opportunities that exist for strengthening convergence of UNICEF supported interventions at health worker, CoRPS, WASH artisan, school teacher, Tuseme Club, MVC Committee, and Multi-sectoral HIV and AIDS Coordination Committee levels. At the minimum UNICEF should explore the use of harmonized training packages and multi-skilling of facility and community based service providers to ensure that UNICEF supported services converge at the facility, community and household levels.
 9. Through greater programme integration, multiple channels for addressing sanitation and hygiene promotion need to be found to address diarrhoea disease incidence in under-fives, which is one of the critical indicators on the quality of life of children which was not impacted upon by the 7 LDs Strategy.
 10. In the specific area of child protection, both **family- and community-centred approaches to address the underlying causes and prevent the perpetration of violence and physical, sexual, emotional and economic abuse against children and their caregivers** should be given more attention than previously, alongside the on-going strengthening of current initiatives to respond to and mitigate impacts of the abuse. The

latter should also be broadened to ensure that the child protection model currently being tested in pilot districts addresses all needs of children in relation to child protection services.

11. In relation to training, specifically, UNICEF should **invest more into institutionalising the on-going trainings by strengthening the curricula and delivery capacities of existing competent national or regional institutions** to play a greater role in providing those courses that need to be delivered at scale and should reach new entrants (e.g., new generation of health service providers, teachers, planners and budget officers) whilst they are still being trained for entry into the service.
12. Due to the high level of unmet need among those already in service delivery, in terms of new skills necessary for child-friendly schooling, delivery of more effective child protection services and higher quality health services the Government of Tanzania and UNICEF **should not abandon or suspend in-service training of service providers**, but explore new models for delivering the trainings in a manner that does not remove trainees for long periods of time from the core business of service delivery. Alternatives to off-station/residential courses (such as innovative approaches for providing on-the-job coaching and mentoring) should thus be identified and tested to establish their comparative advantages vis-à-vis current approaches.
13. Whilst the training of trainer cascading approach works and is important for creating capacity at both national and district levels for continuation of training, resource allocation between courses offered to ToTs, and those offered to service providers at facility and community levels should be reconfigured, by **exploring less resource intensive methods of providing ToT courses**, and availing **adequate resources for training of frontline service providers** (e.g., teachers, health service providers, CoRPS, VMACs, WMACs, village MVCCs, ward MVCCs, sub-district CPTs) and, in where necessary (e.g., in the case of school WASH), final beneficiaries (school pupils).
14. UNICEF should strengthen its M&E System for tracking results of sub-national engagement and provide adequate support to intervention districts especially for tracking results from community based services, and identifying, documenting and sharing learning. Planning for key outcome results and output targets with the learning districts/regions should ideally follow a four year time horizon harmonised with the UNICEF's Country Programme Action Plan in order to have synchrony in objectives and targets (but operationalized through annual plans for financial management). The M&E System should **facilitate aggregation of results** from all LDs to more fully see the contribution of UNICEF and inform exit in a transparent manner.
15. UNICEF should prioritize investments in upgrading **M&E capacities of intervention districts** for all interventions, but with special focus being given to enabling the LGAs and UNICEF (with support from the Regional Advisory Secretariats) to track critical core indicators of performance at output and intermediate outcome levels for all interventions including those of a software nature and for innovations that will be piloted at health facility, school or community level. Such an M&E system should build on (and make use of) existing national M&E systems, with the ultimate objective of further enriching the national systems through institutionalisation of the new elements of the M&E. Hence it is recommended that UNICEF works closely with relevant sector ministries (MoHSW, MoEVT, MoW, and MoG)

and agencies such as the national statistical office, RITA, sector ministries, PMO-RALG and the Planning Commission to develop appropriate **M&E tools for monitoring intermediate outcomes at community level.**

16. **Monitoring of the work of community volunteers should be strengthened** (e.g., the 3 levels of supervision for health services, for example, – national, regional and district health management teams - should monitor the work done by trained CoRPS.
17. PMO-RALG should complement UNICEF efforts at district level through: (1) working with relevant sector ministries to put in place a **well-functioning system for dissemination of national laws, policies, strategies, guidelines, and standards**; (2) influencing GoT and DPs to increase resource allocation to basic education – school per capita grants, teacher housing, text books and stationery; (3) **creating a sub-vote and cost centre for social welfare and child protection services under the mandate of the DSWO**; (4) allocating resources to sustain motivation and activities of WECs, CoRPS and Community Justice Facilitators; and (5) **transforming the DMETs into more autonomous teams with a separate budget line**, providing technical oversight and a mechanism to hold districts to account for performance against budget targets. The excellent work done in registering MVC should be complemented by Ministry of Health and Social Welfare in mapping service providers and strengthening coordination of their support to MVC, together with mobilising more resources from the development partners and Treasury to provide resources to reach these registered children, alongside support for economic strengthening of their families. A child and family centred approach in addressing child poverty and vulnerability is needed for holistic care in future and UNICEF should in collaboration with others champion policy advocacy in this direction.
18. UNICEF Tanzania Country Programme needs to strengthen gender mainstreaming through an explicit **gender mainstreaming strategy** which is linked to both corporate policy and the National Strategy for Gender Development, to inform choice of interventions and whose implementation and achievements are also systematically tracked through the UNICEF and LGA M&E systems.
19. UNICEF, PMO-RALG, sector ministries and LGAs **should document all models of good practice** developed in the 7 LDs, test them in new districts for suitability, and then promote replication in these new districts². Expertise required for this documenting good practices would include thematic specialization, communications, and journalism. The central role Regional Advisory Secretariats can play in promoting replication should be recognised and formally mobilised and supported technically and financially by UNICEF and PMO-RALG.
20. UNICEF and PMO-RALG should together with LGAs take stock of the completion status of all interventions in the previous LDs and come up with a strategy, time-line and resourcing mechanism for completing all unfinished business. In cases where a decision has already been made by UNICEF and PMO-RALG to discontinue some of the support, in order to

² 7 LDs Strategy introduced promising models / approaches in LDs with up-scaling potential, including: WEC supporting school inspectors; Child protection teams; District Monitoring and Evaluation Teams; Children's barazas; GRP, Male involvement in PMTCT (Makete Model); Child Friendly Schools; and capacity building of youth groups and participation in HIV and AIDS prevention activities.

concentrate on new regions, PMO-RALG should assist LGAs to find alternative funding for completion of outstanding work. In the same vein, the Evaluation found special need to continue capacitating Siha District with almost the full package of support, as this district is relatively new and still lagged behind all other LDs on some critical capacity indicators and MDGs. Phasing out support in Siha District would be pre-mature at this stage. Opportunities to continue capacitating Siha District should be found by PMO-RALG.

21. Given the gap between Strategic Plans and MTEFs in incorporating children's issues, with children's issues featuring more in MTEFs than SPs, UNICEF should take advantage of the present opportunity provided by the new round of strategic planning to lobby PMO-RALG to support LGAs in developing new strategic plans that incorporate children's issues as part of exit strategy.

PART 1: STUDY BACKGROUND AND METHODOLOGY

1 INTRODUCTION

1.1 Study Background

UNICEF has been supporting development cooperation interventions at sub-national level in Tanzania for over 15 years. From 2007-2010, UNICEF implemented a country program (CP) that had a dual purpose of influencing national policies, regulations and standards upstream while at the same time sharpening the testing of promising child-sensitive programming models and intensifying investment in a reduced number of “learning districts” (LDs) (7 in total) to improve service delivery. The 7 LDs Strategy, which was retrospectively designed 2 years after the approval and commencement of implementation of the 2007-20120 Country Programme, sharpened UNICEF’s focus towards implementing a critical mass of supply and demand-driven capacity building related interventions which are well monitored and evaluated to draw lessons that would be used to influence the policy agenda at national level as well as strengthen child-sensitive planning, resource allocation and delivery of basic services at district and sub-district levels. At both the national and sub-national levels, UNICEF’s investments built on earlier achievements in supporting the Government of Tanzania in policy development and capacity building for service delivery by continuing to support implementation of successful interventions, or the testing of novel models of practice developed in partnership with the government under the previous CPs.

Within the 7 LDs, UNICEF adopted a comprehensive package designed to achieve results in just under 30 programme components spread over four thematic areas: *Young Child Survival and Development (YCSA)*, *Child Protection and Participation (CPP)*, *Basic Education and Life-skills (BELLS)* and *Policy Advocacy and Planning (PAAP)*, which together sought to primarily improve the wellbeing of children, by strengthening planning and budgeting for children’s priorities and capacity to deliver basic services to children, their mothers and caregivers. The strategy initially focused on piloting development models in 7LDs of Tanzania Mainland, but later in 2009 expanded to support refugee host communities in North Western Tanzania largely using the same approach as applied in the 7 LDs. The country programme was extended until 30 June 2011.

In line with its corporate accountability policy and the need to document evidence for learning and programme design, UNICEF commissioned an external evaluation of the 7LDs Strategy in August 2011 which has culminated in the production of this findings report.

1.2 Study Objectives

The overall objective of the evaluation was **‘to assess effectiveness of the area-based programming approach, the “theoretical model” of the 7LDs, and draw lessons learned for future programming internally and in other countries’**³. More specifically, the evaluation entailed a detailed assessment of both the achievements and the learning that took place in the learning districts, guided by the following specific evaluation objectives:

³ Detailed Terms of Reference and questions for the Evaluation are presented in Annex 2 of this report.

- Examine the degree to which the desired results have been achieved, or expected to be achieved (effectiveness) in each of the key programme areas in the 7 LDs;
- Document on how UNICEF interventions were efficient (efficiency) in the fulfillment of children and women's rights;
- Assess changes which can be attributed to UNICEF's engagement in the 7 LDs; and
- Ascertain the probability of continued long-term benefits from the interventions in LDs (sustainability).

The Evaluation focused on answering a set of questions under each of the following OECD Evaluation Criteria: *Relevance; Effectiveness; Efficiency; Sustainability; Impact* and the extent to which *Cross-cutting issues* (such as prioritization of the most vulnerable, enhancement of gender equity, extent to which district planning and budgeting are results based, and extent to which community participation was promoted) were addressed.

To conduct the evaluation, two institutions (Jimat Development Consultants and Ifakara Health Institute (IHI)) were competitively selected and twinned to undertake this evaluation. This report presents the results of the evaluation jointly carried out by these two institutions based on data collection at national, regional, district and community level over a 4-month period.

1.3 Country Context of the 2007-2011 Country Programme

Geography and demography: The United Republic of Tanzania is the largest country in East Africa, covering 940,000 square kilometres, 60,000 of which are inland water. It shares borders with eight countries: Kenya, Zambia, Uganda, Rwanda, the Democratic People's Republic of Congo, Malawi, and Mozambique. Tanzania has a population of 43 million people (Tanzania Demographic Health Survey (TDHS), 2010) of which only about half are economically active (age 15-64).

Macro-economic performance: Tanzania's macro-economic performance has been strong and robust with annual GDP growth rates achieving the set target of 6-8% over the period 2007-2010 (GoT, 2010). However, this sound performance has had limited impact on household poverty. Between 2000 and 2007, data from the Household Budget Surveys (HBS) 2000/1 and 2007 indicate that poverty declined only by two percentage points from about 36% to 34%, and was outpaced by population growth. Hence the number of poor people actually increased from 11,388,000 in 2000/1 to 12,870,000 in 2007. Income poverty is worse for the rural population as 83% of the people living below the basic needs poverty line reside in rural areas (National Bureau of Statistics (NBS), 2002 and 2009), which partially explains the decision by the Government of Tanzania and UNICEF to primarily focus the 7 LDs Strategy on the rural population.

Child poverty: Poverty is particularly hard on children, with the impact of HIV&AIDS being one of the drivers but not the only factor responsible. Incidence of poverty among Tanzanian children – defined as the population of children who suffer multiple severe deprivations of basic needs – is extremely high at 71% (which is over twice that of the overall population) and that of rural children was estimated to be much higher, being 1.7 times greater, than for urban children for six of the seven deprivations (comprising health, nutrition, water, sanitation, shelter, education, and information) (REPOA, NBS and UNICEF, 2009). Due to these multiple

deprivations, childhood development and growth is severely compromised, with negative consequences for cognitive development and ability of children to realize their full potential in future.

Nutrition and ECD: In Tanzania over one-third of all deaths of children under-five years are associated with malnutrition making it the greatest cause of mortality (UNICEF, Women and Children in Tanzania, 2010). About 42% of children under the age of 5 years are stunted (and this number has not declined in 15 years), 16% are underweight and 5% are wasted (TDHS, 2010). A strong correlation has been found between underweight and low birth weight, alluding to the importance of addressing malnutrition in both the children and their mothers. The TDHS 2004/5 found 10% of women malnourished⁴ and this has not declined. Birth intervals, nutritional and educational status of the mother and household wealth are all documented as critical contributors to improved nutritional status of children (TDHS, 2010). Wasting is highest in the age group 6-8 months, highlighting the importance of integrated young child feeding, complementary feeding and management of childhood illnesses especially diarrhea at the time complementary foods are introduced into the child's life. Under-nutrition has also been robbing children of the opportunity for cognitive development and impairing their later life achievements in school and in economic activities. Hence, knowledge and skills for mothers to screen developmental delays and stimulate children to enable them to fully develop at an early stage have been found to be very critical in Tanzania (UNICEF: Children and Women in Tanzania, 2010).

Maternal health: In Tanzania, maternal mortality remains high and one of the three MDG indicators that remain elusive. According to UNICEF (2010), maternal health outcomes have shown no improvement in Tanzania over the past two decades with maternal mortality rising from 529 per 100,000 births in 1996 to 558 in 2004/5, equivalent to 10,000 deaths every year or one death per every hour! In some of the districts targeted by the 7 LDs Strategy maternal mortality was found to be even higher (at 631 in Mtwara for instance). A recent population-based study in southern Tanzania found that the major cause of maternal death is the lack of proper care at delivery (hemorrhage, eclampsia and sepsis) (Schellenberg, et al., forthcoming). Inadequate preparation by pregnant women and ensuring that they deliver at well-functioning health facilities that are well equipped, adequately capacitated in terms of trained staff and well supplied with critical drugs and other associated medical supplies remain some of the critical challenges. Availability of basic emergency obstetric care services alone could prevent a large proportion of obstetric deaths and reduce Maternal Mortality Rate (MMR) by about two-thirds (Campbell and Graham, 2006). The poor quality of antenatal care services is the second major factor contributing to maternal mortality. While coverage is high (at 97% in 2007/8), the quality is lagging behind as some vital services (e.g. screening for STIs, blood tests, and blood pressure measurement) are only rarely provided (reach 30%-66% of the mothers only) (Tanzania HIV&AIDS and Malaria indicator Survey (THMIS, 2007/8). About 38% of all married women have no participation in decisions regarding their own healthcare, and that these decisions are made by their husbands.

Child health: Both infant and under-five mortality have declined and this MDG indicator is likely to be met. However, one out of 20 Tanzanian children born still dies before the first birthday, while one out of 12 Tanzanian children still dies before the fifth birthday (TDHS, 2010). Malaria

⁴ With a Body Mass Index lower than 18.5 kg/m².

(77% of child illnesses), diarrhea (12%) and fever (7%) are the top three leading causes of illnesses in children. The proportion of children who are fully vaccinated varies between 63% among children of mothers with no education and 88% among children of mothers with secondary or higher; and for children born to mothers in the lowest wealth quintile the coverage is 69% compared to 85% for mothers in the highest wealth quintile. Whilst health sector reforms and the health SWAp have been credited for recent improvements in health outcomes, and the “district health budgets” in particular played an important part in this, the challenge still at that level has been to ensure that the district budgets reflect nationally agreed priorities.

Water and sanitation: Accessibility to clean water is still a challenge in Tanzania and the trend worsened following the last severe drought (NHS, 2007). Only 42% of all households, and 30% of rural ones, are able to collect water from a protected source and return home within 30 minutes. For almost one quarter of rural households, collecting water requires more than one hour (ibid). Institutions such as schools and health facilities face a critical shortage of water and access to sanitation is grossly inadequate, and has worsened with the rapid growth in enrollment after abolishment of school fees in 2002.

The National Strategy for Growth and Reduction of Poverty (NSGRP II) has identified and prioritized this issue for increased attention by GoT and development partners. The fiscal space for water also doubled in 2007/8 fiscal year, consistent with the established trend of Government being by far the largest contributor to the water resource envelope, and many development partners (The World Bank, Germany, etc) also identifying water as one of their top priorities and complementing government efforts in this regard. What remains to be addressed though is the balance between resource allocations to urban and rural water projects and more emphasis on capacity building for sustainability of water schemes, promotion of water treatment and safe storage, hygiene promotion and improved sanitation and alongside investments in water supply.

In relation to sanitation, the TDHS (2010) revealed that only 13% of the population has access to improved sanitation, with the urban population slightly higher at 22% whilst the rural was lower at 9%. Sanitation situation is more appalling in schools and some health facilities. A recent WASH Mapping Study⁵ carried out by SNV, Water Aid, UNICEF in 2009 which sampled 2,697 pre-primary, primary and secondary schools in 16 districts found that only 11% of schools surveyed met the Ministry of Education and Vocational Training “minimum” standards of 20 girls and 25 boys per drop hole, 20% had more than 100 pupils per drop hole and 6% of schools had no latrines at all. Ninety-six percent of schools did not have facilities that are suitable or accessible to children with disabilities. About 52% of latrines for girls did not have doors. Only 8% had functional hand-washing facilities with water, and 1% had soap.

HIV and AIDS, PMTCT and AIDS: Findings of the 2007-08 THMIS, which covered Mainland and Zanzibar, confirmed that 6% of adults age 15-49 were infected with HIV, the virus that causes AIDS. HIV transmission through heterosexual contact accounts for most new HIV infections in the country and more women than men are HIV positive. The HIV epidemic in Tanzania is a generalized one, which since 1999 stabilized around 6%, and TACAIDS, 2009 estimates even show a slight decline in adult HIV prevalence to 5.7%. However, in rural areas HIV prevalence is increasing due to a combination of limited knowledge, constraining socio-

⁵http://www.wateraid.org/documents/plugin_documents/swash_brochure.pdf

cultural factors, poverty and poor access to health service infrastructure denies them access to quality HIV-related services. Furthermore the nexus of HIV&AIDS and severe poverty continues to threaten the well-being of Tanzania's children (MVC costed Plan 2007). The number of children who are forced to drop from school to engage in economic activities has been increasing and is likely to continue rising unless child-sensitive social protection policy and programming improves.

Children and youths are an emerging group that needs urgent attention, as age disaggregated data on HIV prevalence in young people aged 15-24 years show a clear pattern of rapid increase with age, but data on children under the age of 15 years are scant, so have been data on services reaching young children, including the new born babies born to HIV positive mothers to protect them from the high risk of infection at birth. PMTCT services though improving have remained limited especially in rural areas due to absence of HIV testing equipment and supplies, on the one hand, and staff skills to do it professionally on the other hand. GoT has now made it mandatory for all pregnant women to be tested so that babies may be protected or treated on delivery. Work on HIV and AIDS is also well resourced in terms of financial allocations through Overseas Development Assistance (ODA), with over 90% of HIV and AIDS expenditures being funded by ODA and PEPFAR and the Global Fund to Fight AIDS, TB and Malaria (GFTAM) providing the largest share of funding (or 86% of donor support). Donor funding of HIV&AIDS increased significantly from 2007, but immediate concerns relate to disproportionate allocation to care and treatment with significantly less going to preventive services.

Knowledge and willingness among would be target groups remains severely curtailed. Recent research on child poverty in Tanzania also shows that information, education and behavior change communication targeting young people are inadequate (UNICEF, NBS and REPOA, 2010). Youth within the age category 15-19 appear to have lower levels of comprehensive knowledge of HIV&AIDS than those in older age groups. Knowledge of HIV prevention methods is lowest among those who have never had sex (TDHS 2010).

Basic education: National education statistics indicate gains at pre-primary, primary and secondary school levels with GoT's commitment to the Education for All Goal - as demonstrated through an education SWAp (the Primary Education Development Programme (PEDP)) – clearly bearing fruits. Although data on pre-schools is scarce net enrolment ratio for 5-6 year olds rose from 24.6% in 2004, to 36.2% in 2008 and 37.5% in 2010. Although NSGRP/MKUKUTA had set clear targets for school enrolment of girls and boys, and gender parity improved to almost 1 in primary education, disparities remain across regions largely due to varying levels of poverty and vulnerability of the children. Disparities in educational outcomes of boys and girls also remain wide. About 17% of the total population of children aged 0 – 14 years are 'vulnerable', of which some 5% or 930,000 are 'most vulnerable' (NACP for MVC 2007-2010). This vulnerability affects their access to basic services like education and healthcare. Government allocations to social safety nets (e.g., education support to MVC) fall far below the magnitude of needs of these children. Two key challenges encountered in improving access to education include the lack of a comprehensive approach to enrolling marginalized children, and the lack of matching resources to sustain the rapid increase in numbers by investing in school infrastructure and teaching resources. Teaching methods are also not gender friendly nor do teachers have adequate skills to teach Science, Mathematics and English.

Child protection: Only 16% of children under the age of 5 years had a birth certificate in 2010 and birth registration has not improved in the last five years (TDHS, 2010). Though Tanzania had a system for birth registration since independence, its enforcement has been very weak. Without birth registration, Tanzanian children are at risk of further denial of the other rights for children.

The caseload of most vulnerable children who need public assistance for care, protection and access to basic services for survival and development is increasing as HIV&AIDS as well as poverty continue to take their toll especially on the most vulnerable populations, most of whom are in the rural areas and crowded urban informal settlements or shanty towns. The original emphasis of Government was impact mitigation (Erica Gug, *et al.*, 2009) but recent studies continue to point to the fact that drivers of child vulnerability are broader than HIV and AIDS related issues.

GoT has emphasized the role of community structures as a first line of care and protection for children. This is in realization that children have many different types of vulnerabilities and needs, some of which are very urgent and cannot wait for the social welfare officer working from the district office to come and attend to them. A recent study on violence against children commissioned by UNICEF revealed that whilst attending to basic services such as food, education and healthcare is important, children equally (if not more importantly) need protection from abuse not only by both strangers and people the children know – e.g., parents, caregivers, neighbours, friends, teachers and other duty bearers. Property and other types of assets left behind by deceased parents, as an inheritance for children also needs to be protected for children to benefit from these resources.

1.4 The 2007-2010 UNICEF/GoT Country Programme

In response to the development challenges and gaps discussed above, the Country Program (CP) for UNICEF Tanzania (2007-2010)⁶ was developed (through a very consultative process starting in 2004 at the time of the mid-term review for the previous CP) to implement interventions that support policy development and strengthen service delivery capacities at sub-national level primarily focusing on the sectors of health, nutrition, water and sanitation, basic education, HIV and AIDS and child protection and participation in line with UNICEF's corporate mandate. The overall direction and strategy of the country programme was set by the Government of Tanzania through the MKUKUTA and JAS processes. The programme was developed in support of the expected outcomes and outputs of the UNDAF, which in turn were developed around the three pillars of the MKUKUTA: (a) growth and reduction in income poverty; (b) improved quality of life and social well-being; and (c) good governance and accountability. The overall goal of the country programme was “*to contribute through the MKUKUTA, MKUZA and JAS frameworks to the **strengthening of national capacities for priority actions aimed at the realization and protection of the rights of all children, particularly the most vulnerable***”⁷.

In terms of thematic coverage, the 2007-2010 Country Programme had 6 components: *Young Child Survival and Development, Basic Education and Life Skills, Child Protection and*

⁶ Extended to June 2011.

⁷ UNICEF, 2007, Revised Country Programme Document.

Participation, Policy Advocacy and Analysis, Geographically-defined programmes and Cross Sectoral Costs whose budget allocations for both national and sub-national activities were as summarized in Table 1.

Table 1: UNICEF Country Program Budget 2007-2010

Programme	(In thousands of United States dollars)		
	Regular Resources	Other resources	Total
Young child survival and development	11 733	21 190	32 923
Basic education and life skills	5 163	11 691	16 854
Child protection and participation	5 163	20 459	25 622
Policy advocacy and analysis	10 794	3 653	14 447
Geographically-defined programmes	6 101	13 152	19 253
Cross-sectoral costs	7 978	2 923	10 901
Total	46 932	73 068	120 000

Source: UNICEF Country Programme Document.

The Country Programme represented a significant **continuing shift** in the approach of UNICEF support in Tanzania. UNICEF drastically reduced its area-based programming from 15 to only 6 districts⁸ with greater emphasis being placed on supporting policy development.

The reduced geographical coverage was meant to concentrate the limited resources in six focus districts to “support the scaling-up of evidence-based programmes which demonstrate a potential for reducing child vulnerability”. UNICEF sought, on one hand, to promote the continuation of downstream activities in order to strengthen the **application of already proven good practices** that needed to be scaled up in Tanzania (this included, for example, the Essential Nutrition Actions (ENA), community IMCI, PMTCT, infant and young child feeding (IYCF), school planning, and Tuseme Clubs), whilst on the other hand testing new initiatives (e.g., new child protection system) so as to generate lessons, new evidence and good practices to feed into policy.

1.5 Design of the 7LDs Programme Strategy

1.5.1 Intervention Logic Model for the 7 LDs

The intervention logic for the 7LDs was designed for working through the districts so as to achieve the long term desired impact result of improving child well-being by reducing mortality and vulnerability nationally in line with the goals of UNDAF, MKUKUTA and MDGs (Figure 1).

The most immediate activities supported by UNICEF in the 7LDs were focused on achieving the following **outputs**: improved capacity for results based planning, monitoring and evaluation through training and tools for planning; enhanced engagement with key national policies, strategies, guidelines and plans; improved evidence base for sectoral and inter-sectoral planning, and; enhanced participation of children and youth in planning.

⁸These LDs were: Bagamoyo, Magu, Makete, Mtwara Rural, Temeke, and Hai/Siha. One of these districts (Hai/Siha) was later sub-divided into two separate districts (Siha and Hai) by the GoT, thus increasing the district coverage of the UNICEF CP for 2007-2010 to 7.

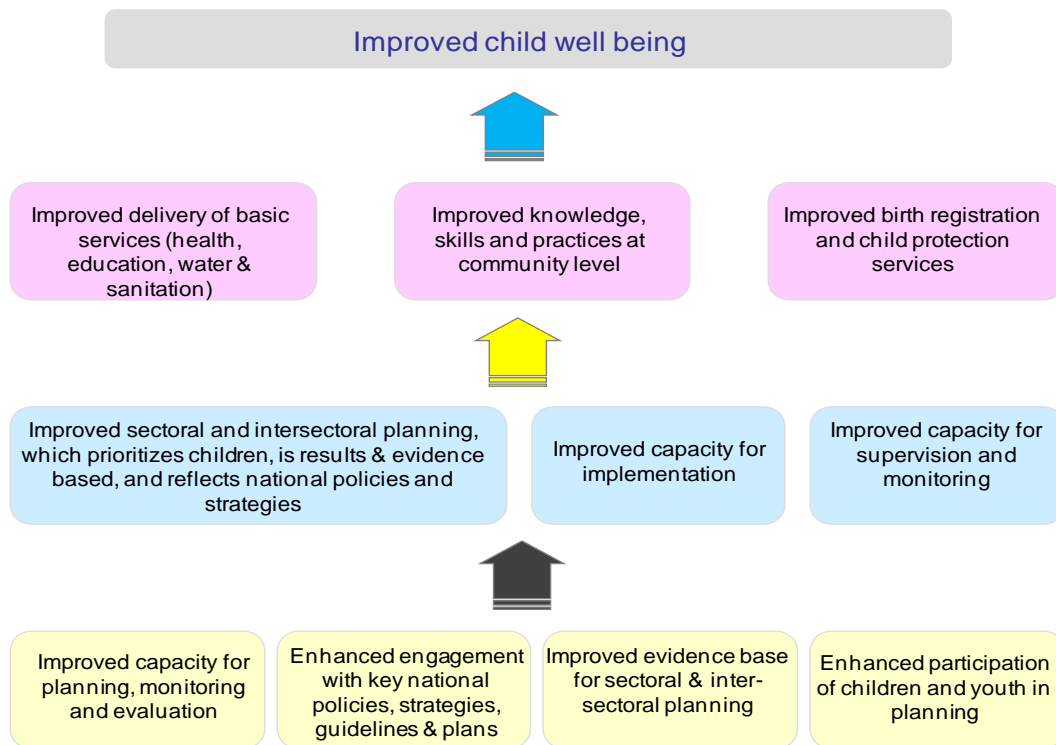


Figure 1: The logic framework for the UNICEF 7LDs strategy

Source: UNICEF, 7LDs Strategy Document.

In the program mid-term period, it was anticipated that these outputs would be utilised to produce some **intermediate outcomes** including: (1) prioritisation of children in sectoral and inter-sectoral planning and budgeting which is results focused and evidence based, and also based on national policies; (2) improved capacity for implementation and (3) stronger capacity for supervision and monitoring.

Utilisation of these intermediate outcomes would by 2010 result in **higher level outcomes** of improved delivery of basic services (health, water, education and sanitation), improved knowledge and skills at community level; and improved birth registration and child protection services, thus ultimately contributing to the achievement of **impact** in terms of improvement in child well-being.

1.6 The 7LDs Program Components and Sub Components

In alignment with the Country Programme Document, the 7LDs Strategy was designed with the following main programme components: Young Child Survival and Development (YCSD); Child Protection and Participation (CPP); Basic Education and Life Skills (BELS); Policy Advocacy and Analysis (PAAP).

The **YCSD component** focused on maternal, newborn and young child survival, growth and development. The component was designed to facilitate maternal, new-born and child survival, health, growth and development by strengthening (1) disease prevention and health promotion; (2) strengthening the continuum of care for mothers and children, addressing in particular missed opportunities and promoting quality health care; and (3) strengthening nutrition and early childhood development. High-impact interventions were to be incorporated in national

policies, strategies and budgets; high-impact interventions in health, nutrition and early development would be effectively implemented through strengthened national and sub national management and delivery systems, and households in wards within the LDs would be sensitized to apply recommended family care practices.

BELS aimed at: developing a strategy for care and support for all children in all schools with special focus on the most vulnerable girls; developing and implementing a national HIV&AIDS prevention strategy; developing and implementing the General Assembly Special Session on HIV&AIDS target on young people; allocating resources for care and support in selected schools within the LDs, and; providing standards and guidelines for the facilitation of life skills at selected schools in the LDs. The component was to increase the completion of primary and pre-primary schooling and transition into secondary and post-primary education institutions, by supporting: (1) child-friendly schooling; and (2) HIV&AIDS and life-skills education focusing on developing a gender-responsive life-skills curriculum for all ages of children, both in-and out-of-school. Child friendly schooling was to focus on strengthening capacity for (i) broad-based quality education, including care, support and protection for all vulnerable girls and boys with special efforts to boost the retention and achievements of girls; (ii) an 'accelerated' primary education opportunity through COBET; and (iii) increased access to post-primary, including an 'accelerated' secondary education.

CPP aimed at: adopting and applying a national strategic plan for the development of child and youth organizations; linking the national plan of action for MVCs, including cash-transfer mechanisms with the national social protection framework; ensuring MVC were cared for and protected in line with MKUKUTA; supporting young people to participate in child-led and youth-led organizations, and; supporting birth registration for children. It was later remodeled mid-way to test a new model of child protection.

PAAP was designed to influence policy development, planning and resource allocation to reduce child vulnerability through the use of up-to-date, reliable disaggregated data and evidence; strengthening national structures and processes for monitoring and reporting on implementation of key child rights commitments; integrating priority issues and actions for children, women and vulnerable groups into the comprehensive national social protection policy and framework, and; enhancing social planning and budgeting around children, women and vulnerable groups through capacity development and improved linkages nationally and in the LDs.

Each of the components in the 7LDs strategy was made operational through implementation of concrete activities under various sub components whose implementation status at end-line is presented in Table 2.

Table 2: 7LDs Strategy components, completion rates and evaluability status

PROG	Component	Completion Status	Evaluability Category
YCSD	701 A: ECD	Completed	Fully evaluable
	701 B: Community WASH	Completed	Fully evaluable
	701 C: Behaviour Change Communication	Delayed by 1.5 years	Fully evaluable
	701 D: School WASH	Upstream + Few schools	Limited evaluability
	701 E: MNCH	Completed	Fully evaluable
	701 F: Nutrition	Completed	Fully evaluable
	701 G: PMTCT/PAIDS	Completed	Fully evaluable
	701 I: IMCI/EPI/Malaria	Completed	Fully evaluable
BELS	702 A: IECD	Completed	Fully evaluable
	702 B: Whole School Development Plan	Completed, limited baseline info	Fully evaluable
	702 C: INSET	Delayed	Not evaluable
	702 D: Gender Equity	Completed	Fully evaluable
	702 E: NLSEF	Limited implementation	Limited evaluability
	702 F: ESMIS	Delayed	Not evaluable
CPP	703 A: MVC Plans and Guidelines	Completed	Fully evaluable
	703 B: MVC Cash Transfer Pilot	Result changed, on-going CP2011-15	Not evaluable
	703 C: HIV/AIDS Prevention Strategy	Completed	Fully evaluable
	703 D: HIV/AIDS Policies	Completed	Fully evaluable
	703 E: Child Participation	Completed, changed strategy to upstream	Fully evaluable
	703 F: Birth Registration Pilot	Dropped, national scale up by RITA	Not evaluable
	703 G: Community Justice	Completed	Evaluated
	New result: Child protection system	On-going in 4 districts	Limited evaluability
	New: Community radio ¹	Started 2010, on-going with plans to scale up	Limited evaluability
PAAP	704 A: Priority issues for children in Social Protection Framework and Strategy	Completed but no national Social Protection Framework	Limited evaluability
	704 C: Government plans and budgets are results-based	Completed	Fully evaluable
	704 D: Children's indicators are incorporated into national surveys	Completed but negligible funding	Fully evaluable

Notes: ¹ Two new interventions were adopted and implemented after the 7LDs strategy was approved, namely: (1) child protection system; and (2) radio based community participation.

1.7 Expected Key Results of Interventions in the 7 LDs

UNICEF's CP was operationalized through the Country Programme Action Plan (CPAP). The CPAP had 30 Key Results of which 26 were to be achieved through the 7 LDs Strategy. Within the CP, UNICEF framed its results for the 7LDs strategy around the following five strategic objectives: (1) learning; (2) vulnerability reduction; (3) policy environment; (4) capacity strengthening; and (5) leveraging additional resources. The key results to be realized by all sectors supported by the 7LDs strategy by end of 2010 included:

- a. District planning and budgeting prioritizes children: Through this result, it was anticipated that: district planning would become results and evidence based; district plans would reflect key national policies, laws, guidelines, strategies and plans, and; district planning processes would involve children and youth.
- b. Improved delivery of basic services: Through this result it was anticipated that there would be improvements in the delivery of child focused services related to health, education, water, sanitation, child protection, pre-schools and community based ECD centres.
- c. Enhanced community awareness and behaviors: Through this result it was anticipated that awareness and health seeking behavior as relates to hygiene, sanitation, HIV&AIDS and reproductive health would improve among child caregivers, 15-24 year olds, young people and school children.
- d. Improved community based services: Through this result it was hoped that community based services related to water, sanitation, hygiene, IMCI, nutrition, PMTCT, malaria, child care, ECD for children under-three, immunization, vitamin A, de-worming, birth registration, ART, ANC services, MVC identification, psycho social support and child protection would also improve.
- e. Enhanced national policies, programmes and strategies: Through this result it was anticipated that evidence from implementation in the 7LDs would provide feedback for refinement of national policies, strategies and programmes which would then be scaled up and expanded countrywide.

A detailed results framework was adopted by UNICEF and GoT for monitoring and evaluating interventions in the 7LDs. This framework specified the country program result, program logic, implementation status, changes expected by 2010, indicators, tools for collecting indicator data as well as indicator definitions.

1.8 Approaches Used to Implement the 7 LDs Strategy

1.8.1 Strategies and approaches applied in interventions within the 7LDs

The main strategies for implementing interventions in the 7LDs were:

- a. Cascading training of trainers approach from national to district, ward, village, health facility and school levels for various topics under the four program components (ECD, IECD, nutrition, MNCH, cIMCI, PMTCT, School Planning, Gender Responsive Pedagogy; WASH, Results Based Planning and Budgeting; Child Protection System, etc);
- b. Ensuring that effective interventions, approaches and strategies were included in the district plans and MTEFs;
- c. Providing equipment, supplies and commodities where stock-outs could have been a bottleneck to implementation of activities in the 7LDs;
- d. Strengthening skills and knowledge of community resource persons who provided services, educated and changed community behavior;
- e. Enhancing capacity of community and GoT committees and coordination structures like DCC, DMET and others involved in the interventions within the districts;
- f. Supporting M&E and supervision capacity of the district authorities;
- g. Supporting community service delivery points like health centres, support centres, ECD centres and schools with spare parts, equipment supplies and knowledge;

- h. Mobilizing and involving target groups like youth and children through youth networks and children's junior councils and other structures;
- i. Providing, training and piloting strategies, guidelines and toolkits for guiding interventions within the districts;
- j. Supporting evidence based planning and harmonization of tools by the districts; and
- k. Providing timely and quality technical assistance during district planning and review processes including: situation analysis; development of District strategic plans and sectoral Plans, and; development of the MTEFs.

1.8.2 Principles governing interventions within the 7LDs

In line with the Paris declaration for Aid Effectiveness, GoT took a lead in planning, implementing, monitoring and reporting on development cooperation activities within the 7LDs. On the other hand UNICEF provided finances, technical support as well as technology and supplies where needed. Most of UNICEF's support was channeled through the exchequer system in the context of the framework of cooperation agreement signed with the Government of Tanzania and was reflected as part of the donor basket funding for districts. The main principles below governed the cooperation between UNICEF and GoT within the 7 LDs:

- a) UNICEF provided the 7LDs with technical assistance in planning, monitoring, reviews and reporting;
- b) UNICEF supported capacity building of key personnel across the sectors within the 7LDs;
- c) Where appropriate, UNICEF provided program supplies to eradicate bottlenecks to implementation of activities in the 7LDs;
- d) UNICEF provided advocacy support for the realization of child rights;
- e) UNICEF support was geared to facilitate partnerships with other actors and civil society and across sectors;
- f) Cash disbursements were made to districts based on agreements made during MTEF and AWP formulation;
- g) UNICEF supported the activities in the 7LDs as part of the UN joint plan; and
- h) UNICEF aligned its staffing to meet needs of the interventions in the 7LDs.

The other part of support was channelled through NGOs of repute such as PSI and FHI. This form of collaboration with established NGO partners was based on proven capacity to deliver, good reach and ability to work with and strengthen local NGOs/CBOs to deliver services and was formalized through the framework of Partner Cooperation Agreements.

1.9 Resource Allocation for the 7 LDs Strategy

The budget for interventions in the 7LDs was not pre-determined at design but was worked out every year in the various sections of UNICEF balancing the needs for programming at national and district levels and drawing from the indicative budgets for the various programme components of the Country Programme. However, at the time of the Evaluation, it was possible to extract disbursement figures to districts for activities under the various sub-components or key result areas (Table 3). The data shows HIV prevention, Whole School Development Planning, planning and budgeting and community WASH (in declining order) received the larger share of the resources. However the funds managed at the central level, e.g. for procurement of equipment and vehicles that were donated to districts in kind rather than cash were not included in the analysis.

Table 3: Summary of Disbursements Made to the LDs by Key Result Area

Code	Component	PSI (701 C)	District	Grand Total	%
701B	Community WASH ¹	653,568,843	1,674,039,140	2,327,607,983	8%
701E	MNCH	714,263,239	942,766,764	1,657,030,003	4%
701F	Nutrition	288,427,861	1,010,859,250	1,299,287,111	5%
701G	PMTCT	100,302,312	1,831,117,500	1,931,419,812	9%
701I	IMCI/EPI/Malaria	198,651,088	1,271,675,250	1,470,326,338	6%
702A	IECD		621,494,002	621,494,002	3%
702B	Whole School Development Plan		2,030,878,102	2,030,878,102	10%
702C	HIV Prevention		2,544,475,770	2,544,475,770	12%
702D	Gender equity		1,611,964,000	1,611,964,000	8%
702E	Life-skills		722,903,096	722,903,096	3%
703AB	MVC		1,468,442,523	1,468,442,523	7%
703G	Community Justice		705,426,638	705,426,638	3%
703I	Child protection system		580,135,000	580,135,000	3%
704C	Planning and budgeting		2,077,449,850	2,077,449,850	10%
Grand Total		1,955,213,343	19,093,626,885	21,048,840,228	100%
PSI as % of total		9%			

Notes: (1) For WASH, in addition to PSI, a key NGO not included in the disbursement figures above is **EEPCO (Environmental Engineering and Pollution Control Organisation)** which implemented (in Magu, Makete, Bagamoyo and Hai) and/or provided technical support to the district team who were implementing (Mtwara and Temeke) on the sanitation activities in all the 7LDs e.g. training and follow up of artisans and establishment of Sanitation Promotion Centres. Total funding used was **USD 606,729 (2007-2009) and USD 190,000 (June 2010 – June 2011) Total = USD 796,729. A second Ngo involved was HAPA (Health Actions promotion Association)** which implemented similar sanitation interventions in Siha District, **Total USD 89,902 (August 2010- June 2011)**. (2) The shaded key results were the ones sampled for full scope evaluation.

1.10 Management, Monitoring Evaluation and Review of the 7lds Strategy

Overall coordination of the 7LDs strategy was charged upon GoT in line with the JAS mechanism and Paris declaration for Aid effectiveness. The overall direction and strategy was set by the GoT and stakeholders through the MKUKUTA and JAS processes. The 7LDs strategy was developed in support of the expected outcomes and outputs of the UNDAF, which in turn were developed around the three pillars of the MKUKUTA.

Resources for implementation of the program activities were disbursed through the exchequer system in alignment to the country financing systems. This system was applied in channeling funds from national levels to the district councils as well as NGOs who were charged with the specific responsibility of implementing various components of the 7LDs strategy.

UNICEF and GoT applied key indicators which were detailed in a summary results matrix so as to assess achievement of the desired program results. The program had a 4 year integrated monitoring and evaluation plan (IMEP). This plan was clearly aligned to UNDAF and MKUKUTA M&E systems so as to enable joint monitoring of the extent to which targets set were met, generate strategic information and use the information to plan activities in the 7LDs annual work plans. Progress in undertaking interventions within the 7LDs was also assessed through the UNDAF annual review mechanism.

To facilitate the M&E processes, the 7LDs strategy also aimed to strengthen the routine national and sub-national monitoring and information systems including capacities to conduct policy-relevant research, analyze then utilize the data generated for policy dialogue and formulation. The strategy also aimed at improving usage of the Tanzania social and economic data base (TSED) to monitor poverty as well as progress towards achieving the MDGs. Using these approaches, UNICEF and GoT succeeded in ensuring that the 7LDs strategy was aligned to and integrated with country systems for planning, management, M&E and reporting on development cooperation interventions within the 7LDs of Tanzania Mainland.

1.11 Organisation of the Evaluation and the Report

1.11.1 Overall Work Plan

The activity schedule for the Evaluation is presented in Table 4.

Table 4: Final work plan of activities

Activity and output	Due dates	Responsibility
Inception phase	Aug – Oct 2011	Jimat/IHI
PDA Programming	Oct 2011	IHI
Training of Research Assistants	Oct 2011	IHI
Pilot Survey	Oct 2011	IHI
Ethical Clearance Certificate Received	Oct 2011	IHI
Finalisation of data collection tools	Nov 2011	Jimat/IHI
End-line Survey Data Collection	Nov – Dec 2011	Jimat/IHI
Data entry – quantitative data	Nov – Dec 2011	IHI
Data entry qualitative data	Dec – Jan 2012	IHI/Jimat
Submission of dummy tables for data analysis	Dec 2011	Jimat
Data cleaning	Dec 2011	IHI
Data analysis	Dec – Jan 2012	IHI
Presentation of preliminary findings to UNICEF staff	Jan 2012	IHI
End-line Survey Report	Jan – Mar 2012	IHI
Full Scope Evaluation Annexes	April – June 2012	Jimat
Main Evaluation Report	May – June 2012	Jimat
Validation Workshops	June 2012	Jimat/IHI
Comments on 1st Draft of Main Evaluation Report	June 2012	UNICEF
Final Evaluation Report	June 2012	Jimat

Notes: * Date for national stakeholders' workshop will be confirmed closer to the date after confirming availability of both a suitable venue and the key national and district level stakeholders.

1.11.2 Institutional Roles and Responsibilities of UNICEF, IHI and Jimat

This evaluation was undertaken by two organisations - Jimat and IHI. UNICEF commissioned the evaluation and provided technical oversight. Jimat was responsible for managing and providing overall technical leadership and direction in the evaluation and end line survey. IHI was responsible for undertaking the all quantitative and some qualitative data collection for the end-line survey. While duties were segregated between JIMAT and IHI, both teams worked as

one team to ensure delivery on the objects of the ToR. In order to successfully undertake the evaluation as planned, each of the organizations concerned (UNICEF, JIMAT and IHI) was assigned clear cut institutional roles and responsibilities.

1.11.3 Institutional roles and responsibilities of UNICEF

UNICEF, together with PMO-RALG (at national and through the learning districts) coordinated and managed the evaluation. UNICEF provided technical assistance at the survey design and preparation of data collection tools, and commenting on outputs produced by the Evaluation team. UNICEF provided the venues and facilities for team meetings and stake-holder consultations. UNICEF set up appointments with stakeholders to be met at national level whilst the local authorities coordinated meetings with stakeholders and the gathering of documents at the district level. UNICEF organized stakeholder validation meetings to review outputs of the Evaluation.

1.11.4 Institutional roles and responsibilities of Jimat

JIMAT provided technical leadership on the Evaluation including overall quality assurance on the outputs. Jimat and IHI were both responsible for putting together the evaluation design, indicator identification, methodological choices and the responsiveness to quality of the evaluation to answer the evaluation questions. Jimat collected qualitative data using KIIs at national level conducted most of the district level interviews focusing on the DED, DPLO, DMO, and the DSW, the CHAC and CMAC, and meet a cross-section of stakeholders at the sub-district level, with the main emphasis being on the VEO, and the WEO. Jimat had the responsibility to draft the Main Evaluation Synthesis Report and the associated Full Scope Evaluation Annexes. Jimat provided 2nd level quality assurance for data analysis.

1.11.5 Institutional roles and responsibilities of IHI

IHI led the field level quantitative data collection exercise, under technical guidance of Jimat. IHI was accountable for ensuring the design and implementation of field work, quality of data collection and processing to respond to the data requirements of the indicator sheet and evaluation matrix (submitted separately). IHI collected and analysed sub-district data as well as through district key informant interviews covering the DWE and DEO. IHI provided 1st level quality assurance for the End-line Synthesis Report and statistical outputs and the written narrative portion of the findings.

1.11.6 Team Composition and Roles

In order to successfully undertake the assignment, a multi-disciplinary team of professionals was put in place from IHI and Jimat. Table 5 contains a description of the team composition and roles for this assignment.

Table 5: Team composition and roles

Name	Organization	Title	Role
Senior Experts			
a. Munhamo Chisvo	Jimat	Team Leader	Social Policy, Economics
b. Julie Tumbo	Jimat	Assistant Team Leader	M&E, Health, Child Protection
c. Leonard Mbwanda	Jimat	Biostatistician	Statistician
d. Mwifadhi Mrisho	IHI	Team Leader	Epidemiologist
e. Fatuma Manzi	IHI	Assistant Team Leader	Health Economist
f. Khadija Kweka	IHI	Research Scientist	Child protection
g. Abdallah Mkopi	IHI	Biostatistician	Statistician
h. Amina Mlawa	IHI	Education Specialist	Education Specialist
i. Adam Myavanu	IHI	Education Specialist	Education Specialist
j. Pazi Mwinyimvua	IHI	Research Scientist	WASH specialist
k. Idda Romore	IHI	Policy & Planning advisor	Policy & Planning
Research Support Team			
l. Hamza Mtunu	IHI	Research Assistant	District Team Leader 1
m. Martin Choma	IHI	Research Assistant	Assistant District Team Leader 1
n. Bakari Fasih	IHI	Research Assistant	District Team Leader 2
o. Eliza Temu	IHI	Research Assistant	Assistant District Team Leader 2
p. Alodia Patric	IHI	Research Assistant	District Team Leader 3
q. Sadick Ismail	IHI	Research Assistant	Assistant District Team Leader 3
r. Rashid Kitundu	IHI	Research Assistant	District Team Leader 4
s. Zulfa Abdallah	IHI	Research Assistant	Assistant District Team Leader 4
t. Amina Mlawa	IHI	Research Assistant	District Team Leader 5
u. Abdulkarim Kadhi	IHI	Research Assistant	Assistant District Team Leader 5
v. Mwanaidi Toroha	IHI	Research Assistant	District Team Leader 6
w. Mohamed Mswala	IHI	Research Assistant	Assistant District Team Leader 6

1.11.7 Structure of the Evaluation Report

This report presents the results of the evaluation jointly carried out by these two institutions (JIMAT and IHI) based on data collection at national, regional, district and community level over a 4-month period. It has 11 Chapters, the first two providing background information and the methodology. Chapter 3 presents the status of facilities and services in the Learning Districts and 6 comparison districts selected as controls at the time of the Baseline Survey in 2009. Chapters 4, 5, 6, 7, 8, 9, present findings in relation to relevance, effectiveness, efficiency, impact, sustainability and treatment of cross-cutting issues, respectively. Chapter 10 presents the lessons learnt while the last Chapter is on Conclusions and recommendations.

2 METHODOLOGY

2.1 Study Area

The end-line survey for UNICEF/GoT interventions was conducted in the 7 LDs and the 6 NLDs under the Government of Tanzania and UNICEF Country Programme of Cooperation 2007-2010. The learning districts included: Temeke, Bagamoyo, Hai/Siha, Magu, Makete and Mtwara rural (cover Map on page ii).

The non-learning districts were Kinondoni, Mkuranga, Moshi rural, Misungwi, Njombe and Tandahimba. These districts had more or less similar characteristics with the learning districts.

2.2 Assessment of Evaluability Status of the LD Key Result Areas

Taking into account the completion status of each of the key result areas (sub-components) it was possible to judge the evaluability status of interventions pursued under each result area (see Table 2 in section 1.6). Under YCSD, school WASH had limited evaluability, but the rest were fully evaluable. For BELS, two key results (INSET and ESMIS) were found not evaluable due to extreme delays in implementation. However, key result areas to do with promotion of IECD, school planning, and gender equity were eligible for full evaluation, while the life-skills sub-component had limited implementation and therefore could not be subjected to a full evaluation including impact assessment at this stage.

As for Child Protection and Participation, interventions on community justice could be fully evaluated and were already evaluated. However, birth registration and the MVC Cash Transfer Pilot Scheme were non-eligible for evaluation due to significant reprogramming or change of strategy.

Similarly, the new result areas: child protection system, and the community radio, could only be subjected to a very **limited evaluation scope** as impact was unlikely to have been achieved at this stage. Apart from these, the rest could be subjected to a **full scope evaluation**. Finally, for PAAP, two result areas were fully evaluable and only one result on the national social protection framework could not be subjected to a full scope evaluation at this stage but only one with a limited scope.

2.3 Approach

An end-line cross-sectional study that employed both quantitative and qualitative research methods was conducted. Most of the quantitative data was obtained from surveys at household level, and health facilities. Complementary data was obtained from reports available in the study districts and relevant ministries and institutions. Ethnographic approaches aiming at triangulation were also used to explore key aspects on key child survival, growth and development practices. Using triangulation, the study allowed the study team to cross-check data collected by different methods for consistency and reliability.

2.4 Data Collection Methods and Tools

Data collection tools in the field included a mix of structured questionnaires administered to households and targeted respondents in health facilities. The survey team visited sampled households and interviewed household heads, care givers or parents of children under the age of five, women who delivered in the previous year and youth (15-24 years). Sampled health facilities were visited and appropriate survey tools were administered to the nurses in charge of the health facilities. Some selected schools (pre-primary and primary) were visited in the 13 districts and key informant interviews were conducted with sampled respondents. Relevant administrative documents were also reviewed. Furthermore, the research team carried out in-depth interviews using key informant tools with different implementers and partners (teachers, health workers, CoRPS, ward and district officers) to complement quantitative data that was collected from households, health facilities and schools.

2.5 Sample Size and Sampling Strategy

2.5.1 Sample size for household survey

2.5.1.1 Sample size determination

To be 80% sure that the statistical analyses would detect the critical level effect, if it existed, minimum sample sizes required were determined at 95% level of confidence to detect an expected difference of 10% due to treatment effects.

A minimum sample size of 364 treatment households per district was found to be adequate to detect a 10% difference due to the interventions designed to have an impact on percentage of households living within 400m of a drinking water source in the dry season, percentage of households with young people aged 15-24 years, percentage of households that had children 0-59 months sleeping under bed nets and percentage of households that had breast-feeding women. The same number of control households was also found to be adequate. The total minimum sample size required was therefore 4,368 households from all treatment and control districts.

Treatment households were randomly selected from a minimum of 30 EAs per district and control households were also selected from a minimum of 30 control EAs per district. This implied that a minimum of 13 households would be sampled from each sampled EA. As a way of adjusting for any possible non-response 15 households were sampled in each selected EA to give a total of 450 households in each district.

Table 6: Minimum sample sizes by indicator to detect a 10% difference

Indicator	Baseline %	% difference	Minimum sample size for treatment households	No of treatment EAs
Households living within 400m of a drinking water source in the dry season	77.0% (2129/2757)	10	223	30
% of households with children 15-24	34% (1799/3452)	10	364	30
% of households with children 0-59 months sleeping under bed nets	86% (858/999)	10	134	30
% of households with breast-feeding women	12% (642/5,442)	10	192	30

Whilst the selected sample sizes indicated in Table 6 above would enable the arrival at conclusions on whether UNICEF interventions had an effect on outcome and impact indicators, this was not the only method relied upon to make these observations and generalizations. End-line data for LDs and NLDs was compared, the team also looked at the plausible links envisaged in the theory of change, and cross comparisons between learning and non-learning districts were done, exploring other factors that could have determined the changes observed in the indicators. The evaluation as a first line of analysis, interrogated the plausibility (logic) of the theory underlying the intervention, and then complemented this with the difference in difference technique to ascertain contribution with a reasonable degree of confidence.

2.5.1.2 Sample size of schools

Stratified random sampling was used to select schools at district level. Four schools per district were randomly selected from the learning and non-learning districts. Plans were reviewed and compared as well as contrasted between focused and non-focused schools. Also, 4 pre-primary school teachers in each district were selected and interviewed.

2.5.1.3 Sample Size of health facilities visited

Measure of relative variance was used to determine sample size for health facilities. The appropriate sample size for health facilities was found to be 49. After factoring in non-response, the actual sample size for health facilities used was 54. A total of 54 health facilities distributed equally in all visited districts were sampled using stratified random sampling (Table 7).

Table 7: Summary of sample sizes for the district level quantitative and qualitative studies

	Name of Interview Tool	LDs# Target	LDs# Actual	NLDs# Target	NLDs# Actual
1	Household questionnaire	2700	2635	2700	2669
2	Health Facility Survey tool	27	26	27	28
3	Health Facility Document review tool	27	27	27	28
4	Health Care Provider tool (to include labour ward staff, to include ECD trainer)	27	36	27	44
5	Client Exit Interview	27	89	27	63
6	Pre-School Teachers	24	29	24	23
7	School Committee	28	29	28	22
8	School Principal	28	27	28	25
9	Tuseme - includes FGDs with children (Tuseme club members) and interview of the focal point teacher	28	12	28	2
9A	FGDs with children (non-Tuseme club members).	14	11	12	12
10	VHW/CoRPS	70	79	70	93
11	Chairman/Secretary Water Project (WUGs)	18	19	18	15
12	Sanitation Artisan	18	13	18	17
13	Youth Groups	18	13	18	17
14	Village Multi-Sectoral AIDS Committee (VMAC)	18	17	18	19
15	MVC Committee (take relevant questions from the ward secretary)	18	14	18	18
16	Village Executive Officer (VEO)	7	7	6	6
17	Ward Multi-Sectoral AIDS Committee (CMAC)	7	7	6	6
18	Ward Secretary (merged with #19 WEO)	7	7	6	6
19	Ward Executive Officer (to include ECD trainer)	7	7	6	6
20	DMO/DMNCH/District nutrition/District ECD Trainers/PMTCT/Sanitation & Hygiene Focal Point	7	7	6	6
21	District Social Welfare Officer (DSWO)	7	7	6	6
22	District Water Engineer	7	7	6	5
23	District education Officer	7	7	6	5
24	DED/DPLO/Treasurer	7	7	6	6
25	DPLO/Budget/M&E Officers	7	7	6	6
26	District Document Review	7	7	6	6
27	Council HIV/AIDS Coordinator (CHAC)	7	7	6	6
28	Women FGD	18	16	18	17

Table 8: Summary of sample sizes for the national level qualitative studies

	Name of Tool	N
29	UNICEF Programme Officer Tool (PME, finance, supply, sections)	14
30	UNICEF Document review tool	1
31	UNICEF management tool	6
32	PMORALG tool	1
33	Sectoral counterparts tool	14
33a	Health	5
33b	Education	2
33c	Social Welfare	3
33d	Water	1
33e	Nutrition	1
33f	HIV&AIDS	1
33g	Finance	1
33h	Community Development	1
34	PSI tool	1
35	National Document Review Tool	1
36	School Planning Document Review	1
37	Council Multi-Sectoral AIDS Committee	1

2.5.2 Sampling strategy for household survey

Multi-stage cluster sampling was used to select 364 treatment households and 364 control households per district. Noting that cluster sampling with probability proportional to size was used to select primary sampling units and subsequent sampling units in the baseline survey, cluster sampling was assumed in the determination of sample size for the end-line survey and in the selection of sampling units at all stages of the sample selection process.

To enhance the fairness of comparisons between the indicators from the end-line survey and the baseline survey the evaluators superimposed the enumeration areas (EAs) sampled in the baseline survey with the enumeration areas to be selected for the end-line survey.

2.5.2.1 Selection of households

The second stage for selection of households consisted of the following steps. First, a sketch map of each selected cluster (EA) provided by the National Bureau of Statistics depicted external and internal boundaries and a rough estimation of the location of households. Second, the evaluators adopted the same approach used for the baseline survey to select the required number of households. Within each enumeration area (EA), a research assistant (RA) went to the “centre” of the EA and spun or bottle a pen to choose a random direction. The RA then walked in the direction pointed by the pen and identified the first household. The RA first visited this household and interviewed the household head and other eligible household members. Upon completion of the interviews with the first household, the RA walked to the “next household”, which was defined as the one whose front door was the closest to the one just interviewed. This process continued until all 15 required households were found.

2.5.2.2 Selection of household respondents

In each sampled household, the head of household, all women with children aged 0-59 months, all breastfeeding women were selected for the survey. In a selected household, a woman aged 0-59 months was asked relevant questions about all children aged 0-59 months.

2.6 Survey Implementation

2.6.1 Recruitment, training of enumerators and supervisors and pilot survey

2.6.1.1 Recruitment of Research Assistants and Supervisors

A total of 6 supervisors and 42 research assistants were recruited to collect data from the 13 districts during the survey period. In each district, 1 supervisor led a team of 6 research assistants during the data collection exercise. Each survey team comprising a supervisor and 6 research assistants collected data from 1 Learning District (LD) and its matching non Learning District (NLD). The size of each survey team was estimated from the sample size for each respective district in view of the time available for data collection.

2.6.1.2 Training of supervisors and research assistants

Research assistants and supervisors were trained to ensure that they understood the objectives of the survey, its importance and also the questions in the questionnaire and the responses they were intended to capture. Research assistants were trained in interview techniques that would maximize response rates and validity of data. During the training, roles of supervisors, research assistants and those of other study team members were also explained.

The role of the team supervisor was to take overall charge of the team, and was responsible among others, for contacting local leaders, locating sampled EAs, assigning work to RAs, maintaining progress in data collection and editing the completed questionnaires on a daily basis. The supervisor was responsible for key informant interviews at EA level. The role of a research assistant was to sample households, select respondents in sampled households and conduct household interviews and complete questionnaires.

A training manual was prepared to enhance effectiveness of training and was also a reference for research assistants during data collection. As part of training, the study instruments were pilot-tested in a district excluded from the survey to ensure that the wording of the questions was correct, it is understood by the interviewer and interviewee and captured the intended data. Pilot testing of instruments also helped to estimate the duration of the actual survey and the cost. Pilot testing also enabled the consultants to ascertain that the survey teams had grasped the techniques for sampling households in the field.

2.6.2 Data collection

A modular questionnaire using handheld computers (Personal Digital Assistant or PDA) was used to collect household data and health facility data. The health facility survey tool was designed as an adaptation from the World Health Organization (WHO) health facility survey tool.

2.7 Quality Control

Our objective in quality assurance (QA) was to ensure credibility of evidence generated, through sufficient sampling rigor and analysis. We viewed QA as the process of verifying or determining whether products or services met or exceeded the information needs of the client and stakeholders consulted. For the purpose of the study quality assurance was guaranteed through pre-defined operational standards regarding the structure, process and outcome of the study. Our approach to quality assurance was process oriented and was aimed at preventing unacceptable practices at every stage of the study and minimizing systematic and random errors in data collection. The survey team was expected to adhere to explicit standards of quality and follow prescribed procedures to achieve such standards. The evaluation followed a

critical path with certification of every step from inception, survey design, drafting of the survey tools, data interpretation together with UNICEF intervention managers, drafting of full scope evaluations (Annexes) and validation meetings with stakeholders at district and national levels.

Rigorous quality assurance procedures were also put in place utilizing international expertise in the study team to achieve commonly agreed and feasible quality standards with regard to such matters as: survey design, design of data collection tools, sample selection methodology, achievement of acceptable response rates, treatment of missing data, data reliability and checks for comparability of the data across population subgroups and districts.

2.8 Ethical Review

JIMAT's Code of Ethics which governs all its operations guided the ethical considerations for the study. The survey team ensured that all fieldwork adhered to internationally accepted ethical standards. This included setting clear policy for processes and conduct when engaging with children and/or vulnerable adults. In particular, consultants respected the rights to consent, privacy, and confidentiality and, as such, tools and data collection systems were designed to ensure anonymity, wherever appropriate. The survey team respected the right of children and adults to choose not to participate. Furthermore, the research team adhered to a dress code that was culturally and religiously acceptable. Approval of the study was sought at all levels (Central and local government, local leadership, household, and individual respondent levels) prior to embarking on the fieldwork. Meetings of community leaders and district officials from each of the proposed districts in the study area were convened in order to explain the nature and importance of the study to stakeholders as well as make appointments with prospective respondents. Ethical approval was also sought from the Ethical Committee of Ifakara Health Institute.

2.9 Limitations of the Evaluation

The main limitations and mitigation measures were identified at inception and are well documented in the Consultant's Inception Report. They include:

- (1) **Difficulty to fully attribute results to UNICEF considering the multiplicity of players in the districts:** This limitation was first identified by the Evaluability Assessment of the 7 LDs Interventions which noted that: *(1) stakeholders at the village and facility levels do not have information regarding the specific interventions of the UNICEF in the seven LDs - such information on UNICEF contribution is available only at the level of district officers i.e. one layer up in the administrative structure of service delivery; (2) therefore, no operational problem is anticipated that might hinder or affect a successful evaluation design, as far as the summative evaluation does **not investigate the attribution of results**.* We also note that it will be difficult to attribute results fully to UNICEF support partly because there were several activities planned and implemented jointly with the UNJP as well as other donors. Furthermore, there were also other local partners aside from UNICEF who worked with the communities on various similar result areas.

To mitigate this limitation the evaluation design controls for these confounding factors by adopting the “**difference in difference**” technique which compares the status of performance indicators for intervention districts against those for adjacent non-intervention districts both at baseline and at end-line survey stages. Using the explanatory power of the sample size, the samples for the household survey was carefully determined based on the magnitude of the expected change the evaluation wanted to confirm with a reasonable degree of confidence. This technique goes beyond the analysis of the before and after

scenarios (which has very limited utility) to look at the “with UNICEF” and “without UNICEF” scenarios. Where joint programming was done, the evaluation handled this as one of the intervention methods that UNICEF used in the treatment districts (in the same way the partnership with NGOs such as PSI or FHI was treated) rather than try to isolate the “UNICEF only” component.

- (2) Comparability between districts could be questionable:** In some cases, it was noted that some LDs had more financial and technical resources from other funders like PEPFAR and GFATM and vice versa. Likewise different socio-cultural factors impacted on performance and facilitated or discouraged child welfare among the districts (both 7LDs and NLDs). To counter this challenge, at district level, the evaluation team gathered as much data as possible on other programmes and factors explaining the trends noted.
- (3) Absence of district level baseline data for some of the program result areas funded by UNICEF right from the onset of the program:** An obvious limitation which was already known within UNICEF was the absence of baseline information for some of the interventions. The 7 LDs Baseline Survey was carried out in 2009, almost 2.5 years into implementation of the programme activities.
- (4) Limited routine monitoring tools and mechanism to capture some intermediate results and lessons learnt at the districts:** As it was impractical to have routine monitoring tools for each of the 32 results, UNICEF put in place standards for field monitoring at cross-sectoral level instead. However, routine monitoring of outputs and intermediate outcomes was weak such that the Evaluators could not find important information on some of the results achieved, for example number of child abuse cases reported to the District Child Protection Team by type of vulnerability, child age and gender.

Furthermore, the periodic reporting format of UNICEF did not provide sufficient detailed breakdown of outputs (e.g., number of trainees, number of equipment provided) achieved by each LD, but made an analysis of target achievement at a consolidated level. For calculation of unit costs, the evaluators need a detailed breakdown of outputs by intervention.

- (5) Wide scope of 7 LDs interventions:** 30 key result areas (sub-programmes) for the 7 LDs. About 30 key result areas were identified for the 7 LDs, each key result being addressed through a package of activities. Many of these constituted individual projects, each project with separate focal points in government at national and district levels, and a UNICEF program officer responsible for it. Each project has a set of documents for review and target groups to be interviewed, although in many cases the 7 LDs Strategy promoted some level of integration of activities at the level of frontline staff whereby the same target group (e.g., CoRPS) received services from more than one type of interventions funded by UNICEF. An obvious challenge is the limited time available to go into depth of enquiry with each and every key result while at the same time not running the risk of not balancing the micro-focus with the more strategic macro-level analysis. Consultants mitigated this by selecting a third of the interventions (10) for deeper analysis, focusing mainly on those that were completed.

PART 2: OVERVIEW OF KEY INDICATOR DATA

3 STATUS OF HOUSEHOLDS, COMMUNITY STRUCTURES, FACILITIES, BASIC SERVICES AND BEHAVIOURS

The purpose of this Chapter is to provide an overview of core indicator data, and a narrative summarising the main changes that have occurred in the learning districts as well as the non-learning districts. It intends to provide quick insights into indicators where the most significant changes have been found in terms of LDs performing better than NLDs (and possibly this is where UNICEF's contributions made the most significant contributions to changes in the indicators). It covers a wide range of thematic areas where the focus of the 7 LD interventions was. It is not exhaustive in terms of indicators or the analysis. Further evidence on these and other indicators as well as causal links are discussed in detail in Chapters 4 through 9. Additional statistical rigour on this data is found in Chapter 8 on Impact where the consultants carryout further analysis using a "Difference in Difference" technique which tracks whether the differences between the LD and NLD status at Baseline are, statistically speaking, significantly different from the differences at End-line, and the direction of the change.

3.1 Basic Household Profiles

3.1.1 Distribution of households by sex of household head and district

Among households surveyed in Learning Districts the proportion of household heads that were male ranged from 41% in Temeke to 50% in Hai/Siha whilst female household heads ranged from 50.5% to 59% as shown in Table 9.

Table 9: Basic Household Profiles

	End-line													
	Temeke	Kinondoni	Bagamoyo	Mkuranga	Hai/Siha	Moshi rural	Magu	Misungwi	Makete	Njombe	Mtwara rural	Tandahimba	LDs	NLDs
No of households surveyed	475	470	433	432	452	433	417	449	412	451	481	451	2670	2686
<i>Sex of household head</i>														
Male	41.3	39.9	46.0	52.5	49.5	50.2	48.0	45.2	42.4	42.6	47.4	45.9	45.8	46.0
Female	58.7	60.1	54.0	47.5	50.5	49.8	52.0	54.8	57.6	57.4	52.6	54.1	54.2	54.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<i>Level of education of household head</i>														
Completed O-Level	8.8	12.3	0.9	1.7	3.2	7.3	3.0	6.1	3.2	1.6	2.0	1.0	3.5	5.0
Completed A-Level	0.9	3.1	0.0	0.0	1.5	0.3	0.7	0.0	0.0	0.3	0.4	0.3	0.6	0.7
Completed primary school	37.3	39.9	21.3	19.9	21.7	29.4	27.4	32.6	22.1	19.9	14.0	18.7	24.0	26.7
None	4.2	3.7	33.2	38.6	15.5	10.5	20.7	19.3	25.6	19.2	34.3	26.0	22.2	19.6
Don't know	3.0	0.9	0.0	0.4	0.0	0.9	0.0	0.0	0.7	0.3	0.0	0.3	0.6	0.5
Other	45.8	40.1	44.6	39.4	58.3	51.6	48.2	42.0	48.4	58.7	49.3	53.7	49.1	47.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<i>Type of energy used by household for</i>														
Firewood	2.4	2.0	73.2	80.2	87.6	91.3	67.0	86.0	96.8	87.5	95.8	96.2	70.5	73.9
Kerosene	4.7	7.4	0.3	0.5	1.4	0.9	0.0	0.3	2.0	0.5	0.4	0.2	1.5	1.6
Charcoal	89.6	86.8	26.5	18.6	9.3	6.4	31.8	13.5	0.5	11.8	3.2	3.6	26.8	23.5
Other	0.9	2.0	0.0	0.7	1.7	1.4	0.7	0.2	0.7	0.2	0.4	0.0	0.7	0.8
Electricity	2.4	1.8	0.0	0.0	0.2	0.0	0.5	0.0	0.0	0.0	0.2	0.0	0.5	0.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<i>Type of roof for household's main house</i>														
Corrugated iron or tiles	99.3	98.5	63.4	63.8	97.2	99.3	76.8	64.2	83.1	88.4	31.8	53.2	75.3	77.9
Grass or leaves from the coconut tree	0.7	1.5	36.6	36.2	2.9	0.7	23.2	35.8	16.9	11.6	68.2	46.8	24.7	22.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: End of Term Household Survey.

Among households surveyed in Non-Learning Districts the proportion of household heads that were male ranged from 40% in Kinondoni to 52.5% in Mkuranga whilst the proportion for females ranged from 47.5% to 60%.

3.1.2 Distribution of households by level of education of household head and district

In both Learning and Non-Learning Districts surveyed the highest proportion of household heads reported that they had tertiary or professional training as the highest level of education. In Learning Districts the proportion of household heads with tertiary or professional training ranged from 44.6% in Bagamoyo to 58.3% Hai/Siha. In Non-Learning Districts the proportion of household heads with tertiary or professional training ranged from 39.4% in Mkuranga to 58.7% Njombe.

In Learning Districts the proportion of household heads with primary education as the highest level ranged from 14.6% in Mtwara Rural to 37.3% in Temeke. In Non-Learning Districts the proportion of household heads with primary education as the highest level ranged from 18.7% in Tandahimba to 39.9% in Kinondoni.

3.1.3 Distribution of households by type of energy used by household head and district

The proportion of households using firewood for cooking in Learning Districts ranged from 2.4% in Temeke to 96.8% in Makete, whilst in Non-Learning Districts it was from 2% in Kinondoni to 96.2% in Tandahimba.

In Learning Districts, the proportion of households using charcoal for cooking ranged from 0.5% in Makete to 89.6% in Temeke and was not too different from the range in NLDs – that is from 3.6% for Tandahimba to 86.8% for Kinondoni.

The proportion of households using electricity for cooking in LDs was low, for example non used this method in Makete and Bagamoyo while 2.4% did so in Temeke. Similarly, in NLDs it was also low, ranging from 0% in Mkuranga, Moshi Rural, Misungwi, Njombe and Tandahimba to 1.8% in Kinondoni.

3.1.4 Distribution of households by type of roof for main house and district

The majority of households in both LDs and NLDs had their houses roofed by corrugated iron or tiles. In LDs, the proportion of households with corrugated iron or tiles as the materials for the main houses varied widely from 31.8% in Mtwara Rural to 99.3% in Temeke. In NLDs, the proportion of households with corrugated iron or tiles as the materials for the main houses ranged from 53.2% in Tandahimba to 99.3% in Moshi Rural.

In LDs, the proportion of households with grass or coconut tree leaves as the materials for the main houses ranged from 0.7% in Temeke to 68.2% in Mtwara Rural. In NLDs, the proportion of households with grass or coconut tree leaves as the materials for the main houses ranged from 1.57% in Kinondoni to 46.8% in Mtwara Rural.

3.2 Early Childhood Development

In Learning Districts, the percentage of pre-primary teachers with knowledge of their key roles and responsibilities vis-a-vis IECD guidelines and minimum standards in focus pre-primary schools or classrooms ranged from 33% in Mtwara Rural to 100% in Temeke and Hai/Siha districts. In Non-Learning Districts, the percentage was from 25% in Tandahimba and Njombe districts to 75% in Moshi Rural and Makete districts (Table 10). The percentage was generally higher in Learning Districts than matching Non-Learning Districts except in Bagamoyo and Mkuranga as well as Makete and Njombe where the proportions for Learning Districts were the same as for Non-Learning Districts.

Table 10: Key Indicator Data for Early Childhood Development

Indicator	End-line													
	Temeke	Kinondoni	Bagamoyo	Mkuranga	Hai/Siha	Moshi rural	Magu	Misungwi	Makete	Njombe	Mtwara rural	Tandahimba	LDs	NLDs
Percentage of pre-primary teachers with knowledge of their key roles and responsibilities vi-a-vis IECD guidelines and minimum standards in Focus Pre-primary Schools/classrooms.	100.0	66.0	50.0	50.0	100.0	75.0	100.0	25.0	75.0	75.0	33.0	25.0	60.0	40.0
Percentage of pre-primary teachers aware of age appropriate teaching and learning methods	100.0	100.0	100.0	50.0	100.0	75.0	100.0	67.0	100.0	75.0	60.0	50.0	93.0	68

Source: End-line Survey 2012.

In Learning Districts, the percentage of pre-primary teachers aware of age appropriate teaching and learning methods ranged from 60% in Mtwara Rural to 100% in the remaining 6 districts. In Non-Learning Districts, the percentage of pre-primary teachers aware of age appropriate teaching and learning methods ranged from 50% in Tandahimba to 100% in the Kinondoni district. The percentage of pre-primary teachers aware of age appropriate teaching and learning methods was generally higher in Learning Districts than matching Non-Learning districts except for Temeke and Kinondoni which had the same proportions.

3.3 Community-Owned Resources Persons

Data presented in Table 11 show that in Learning Districts, the percentage of trained CORPS able to screen for SAM using MUAC tape increased from 52% at baseline stage to 32% at end-line stage. In Non-Learning Districts, the percentage of trained CORPS able to screen for SAM using MUAC tape decreased from 78.5% at baseline stage to 8% at end-line stage.

However, the percentage of trained CORPS able to provide key messages on exclusive breastfeeding to community members increased slightly in LDs from 78% at baseline stage to 80% at end-line stage, but there was a higher increase in in Non-Learning Districts, from 65% to 80%, respectively.

Table 11: Key Indicator Data for Community-Owned Resources Persons

Indicator	Baseline		End-line	
	LD	NLD	LD	NLD
% of children under 3 years receiving at least 1 CoRPS visit in the last 3 months	21% (169/817)	18% (119/676)	31% (148/472)	23% (134/574)
Percentage of caregivers of children under 3 years with knowledge on ECD	44.0	37.0	51.7	48.5
% of caregivers of children under 3 years who have ECD cards	2% (14/818)	2% (15/677)	25% (116/473)	18% (102/574)
% of corps trained on ECD	64% (43/67)	48% (31/64)	44% (33/75)	18% (16/87)
Trained CORPS able to screen for SAM using MUAC tape	52% (35/67)	78% (51/65)	32% (14/44)	8% (4/53)
Trained CORPS able to provide key messages on exclusive breastfeeding to community members	78% (52/67)	65% (41/63)	80% (58/73)	80% (68/85)

Source: End-line Survey 2012.

In Learning Districts, the proportion of CORPS trained on ECD decreased from 64% at baseline to 44% end-line stage while the decline in NLDs was more pronounced, from 48% to 18% over the same period.

The percentage of households with children under 3 years receiving at least 1 CoRPS visit in the last 3 months in LDs increased from approximately 21% at baseline to 31% at end-line. In NLDs, there was a slight increase from 18% to 23%.

In LDs, the percentage of caregivers of children under 3 years with knowledge on ECD increased from 44% to 52% and also in NLDs from 37% at baseline to 48.5% at end-line stage.

In Learning Districts, the percentage of caregivers of children under 3 years who had ECD cards increased dramatically in both LDs and NLD; from 1.6% at the beginning of the project to 25% at the end of the project compared with 1.9% and 18%, respectively.

3.4 Child Protection and Participation

The Evaluation observed that at end-line stage, the percentage of children under five years who had birth certificates was higher in Learning Districts than in non-learning districts. The difference was significant statistically at the 95 percent level of confidence Table 12.

The study further revealed that the percentage of districts having regular MVC coordination meetings in Learning Districts was significantly higher than the corresponding percentage in Non-Learning Districts.

The proportion of Learning Districts with up-to-date MVC data and remitting the data to DSW to incorporate into the national DMS were also found to be significantly higher than the percentage of Non-Learning Districts with up-to-date MVC data and remitting the data to DSW to incorporate into the national DMS at end-line stage. It was also established that all districts whether learning or non-learning were having problems with the web based database as it was

malfunctioning and no longer accessible live, on line, so it was no longer possible to update the data on-line and remit.

Table 12: Child Protection and Participation Key Indicator Data

Indicator	LDs			NLDs		
	n	%	N	n	%	N
Percentage of under five children with birth certificates	132	21.0	629	122	18.0	682
Percentage of districts having regular MVC coordination meetings	6	86.0	7	2	33.0	6
Percentage of districts with up-to-date MVC data and remitting the data to DSW to incorporate into the national DMS	7	100.0	7	4	67.0	6
Percentage of districts that verify information compiled in the MVC village registers to ensure accuracy	5	71.0	7	4	67.0	6
Percentage of districts that use information compiled in the MVC database for planning and resource allocation purposes	5	71.0	7	3	50.0	6
Percentage of districts with child protection teams	6	85.7	7	0	0.0	6
Percentage of MVCC committee members who received at least one training in roles and responsibilities of MVC committee		79.0			59.0	
Percentage of MVCC committee members who received at least one training in financial and organizational management		21.0			17.0	
Percentage of MVCC committee members who received at least one training in data collection and management		50.0			39.0	
Percentage of MVCC committee members who received at least one training in care taking skills		36.0			39.0	
Percentage of MVCC committee members who have received at least one training in one of these areas (roles and responsibilities, financial and organizational management, data collection and management, care taking skills) and are applying the knowledge and learning gained	11	79.0	14	9	50.0	18
Percentage of MVC Committees that have referred children to Community Justice Facilitators in the past 12 months, (MVC to CJF)	4	40.0	10	10	71.0	14
Percentage of children who are in the MVCCs registers who are in need of assistance but the MVCCs lack the resources or other relevant service providers to refer these children to	389	86.0	452	959	83.0	1147
Percentage of Community Justice Facilitators that have referred children to MVC Committees in the past 6 months, 12 months (CJF to MVC)	5	50.0	10	3	21.0	14

Source: End-line Survey 2012.

At end-line, the proportion of Learning Districts that verified information compiled in the MVC village registers to ensure accuracy was significantly higher than the corresponding proportion of Non-Learning Districts.

Table 12 also shows that the percentage of Learning Districts with child protection teams was high whilst no similar structures were found in the Non-Learning Districts. This gives evidence to suggest that child protection was very weak in Non-Learning Districts.

Findings of the end-line survey also revealed that the percentage of MVCC committee members who received some training in roles and responsibilities of MVC committee or in financial and organizational management or in data collection and management was higher in Learning Districts than in Non-Learning Districts at end-line stage. However, the percentage of MVCC committee members who received training in care taking skills was found to be higher in Non-Learning Districts than in Learning Districts. The Evaluation found the presence of similar MVCC training activities funded through TACAIDS and PEPFAR resources having been a confounding factor contributing to better results in NLDs than the LDs.

The study also revealed that in LDs, the percentage of MVCC committee members who had received at least one training in roles and responsibilities or financial and organizational management or data collection and management or care taking skills and were applying the knowledge and learning gained at end-line stage was significantly higher than the corresponding proportion in NLDs.

The study also revealed that in NLDs, the percentage of MVC Committees that had referred children to Community Justice Facilitators (MVC to CJF) in the past 12 month period preceding the survey was significantly higher than the corresponding percentage in LDs.

Percentage of children who were in the MVCCs registers who were in need of assistance but the MVCCs lacked the resources or other relevant service providers to refer these children to was high in both LDs and NLDs although it was slightly higher in LDs than in NLDs.

Furthermore, the percentage of Community Justice Facilitators that had referred children to MVC Committees in the 12 month period preceding the survey (CJF to MVC) was higher in LDs than the corresponding percentage in NLDs. Conversely, the percentage of MVC Committees that had referred children to Community Justice Facilitators (MVC to CJF) was higher in NLDs than LDs.

3.5 Basic Education and Life Skills

Findings presented in Table 13 show that the proportion of schools visited regularly by inspectors and WECS in Learning Districts ranged from 75% in Temeke and Mtwara Rural to 100% in the rest of the districts and was 100% in all Non-Learning Districts. The overall proportion of schools visited regularly by inspectors and WECS in Learning Districts was found to be lower than the corresponding proportion for Non-Learning Districts but the difference was not significant.

Table 13: Key Indicator Data for Basic Education and Life Skills

Indicator	End-line													
	Temeke	Kinondoni	Bagamoyo	Mkuranga	Hai/Sihaha	Moshi rural	Magu	Misungwi	Makete	Njombe	Mtwarara rural	Tandahimba	LDs	NLDs
Percentage of focus schools visited regularly by inspectors and WECS	75% (3/4)	100% (4/4)	100% (4/4)	100% (4/4)	100% (9/9)	100% (4/4)	100% (3/3)	100% (4/4)	100% (3/3)	100% (4/4)	75% (3/4)	100% (4/4)	93% (25/27)	100% (25/25)
Incidence of adolescent pregnancies in both the school and out-of-school environments	100% (4/4)	50% (2/4)	75% (3/4)	75% (3/4)	71% (5/7)	67% (2/3)	50% (1/2)	67% (2/3)	50% (1/2)	25% (1/4)	100% (1/1)	67% (2/3)	78% (18/23)	59% (13/22)
Proportion of primary schools that have started introducing concrete measures to increase girls' access to education (improving latrines for girls and water supply in schools, eliminating corporal punishment and expulsion of pregnant children)	50% (2/4)	0% (0/3)	25% (1/4)	0% (0/4)	22% (2/9)	0% (0/4)	100% (3/3)	25% (1/4)	100% (3/3)	25% (1/4)	75% (3/4)	0% (0/4)	52% (14/27)	12% (3/25)
Girl children systematically participate in school, ward and district education planning processes	75% (3/4)	100% (4/4)	50% (2/4)	75% (3/4)	67% (6/9)	50% (2/4)	100% (3/3)	50% (2/4)	100% (3/3)	75% (3/4)	75% (3/4)	25% (1/4)	74% (20/27)	60% (15/25)
% of primary schools that are supporting Tuseme club activities from own resources	50% (2/4)	0% (0/2)	50% (2/4)	50% (1/2)	11% (1/9)	0% (0/3)	33% (0/3)	0% (0/4)	67% (2/3)	25% (1/4)	75% (3/4)	0% (0/3)	41% (11/27)	16% (4/25)
Average level of financial support for Tuseme clubs from school's own resources	29950		66	7450	59		99		50167		49		14978	7450
% of primary schools with (1) well-functioning channels for boys and girls to confidentially report any violations of their basic rights, and (2) mechanisms to effectively and timely address the concerns raised by children	100% (4/4)	100% (4/4)	100% (4/4)	50% (2/4)	100% (9/9)	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	25% (1/4)	60% (3/5)	25% (1/4)	93% (25/27)	65% (15/23)
% of primary school teachers trained in Gender Responsive Pedagogy	12% (16/131)	0% (0/143)	18% (18/98)	4% (4/149)	27% (31/114)	2% (1/56)	53% (18/34)	10% (5/49)	83% (10/12)	0% (0/52)	5% (3/61)	0% (0/61)	18% (78/443)	2% (10/477)
% of primary schools with peer educators (12-14) in service	25% (1/4)	50% (2/2)	100% (4/4)	0% (0/4)	63% (5/8)	25% (1/4)	100% (3/3)	0% (0/3)	33% (1/3)	25% (1/4)	60% (3/5)	50% (2/2)	62% (16/26)	29% (7/24)
% of primary schools with peer counsellors in service	100% (1/1)	25% (1/4)	100% (4/4)	50% (2/4)	56% (5/9)	25% (1/4)	67% (2/3)	33% (1/3)	100% (3/3)	25% (1/4)	75% (3/4)	50% (2/4)	74% (17/23)	38% (9/15)
% of schools with life-skills teachers in service	100% (4/4)	75% (3/4)	100% (4/4)	75% (3/4)	78% (7/9)	50% (2/4)	100% (3/3)	0% (0/3)	100% (3/3)	25% (1/4)	50% (2/4)	0% (0/4)	85% (22/26)	42% (10/14)
% of primary schools with (1) well-functioning channels for girls and boys to confidentially report any violations of their basic rights, and (2) mechanisms to effectively and timely address the concerns raised by children	100% (4/4)	100% (4/4)	100% (4/4)	50% (2/4)	100% (9/9)	100% (3/3)	100% (3/3)	100% (3/3)	100% (3/3)	25% (1/4)	60% (3/5)	25% (1/4)	93% (25/27)	65% (15/23)
Availability of information on children's representation in school planning committee meetings	100% (0/4)	25% (1/4)	25% (1/3)	33% (1/3)	67% (6/9)	(1/4) 25%	33% (1/3)	100% (1/1)	100% (3/3)	(3/4) 75%	40% (2/5)	0% (0/4)	44% (12/27)	33% (7/21)
Availability of information on children and youth contribution to priority setting and budgeting decisions made during school planning meetings	100% (4/4)	100% (4/4)	50% (2/2)	67% (2/3)	89% (8/9)	50% (2/4)	100% (3/3)	100% (2/2)	100% (3/3)	75% (3/4)	80% (4/5)	25% (1/4)	85% (23/27)	68% (15/22)

Source: End-line Survey 2012.

The proportion of primary schools that had started introducing concrete measures to increase girls' access to education in LDs ranged from 22% in Hai/Sihaha to 100% in Magu and Makete

districts. In NLDs the proportion was much lower, ranging from 0% in four districts to 25% in Misungwi and Njombe districts.

The study revealed that the percentage of Learning District schools that had girl children systematically participating in school, ward and district education planning processes ranged from 50% in Bagamoyo to 100% in Magu and Makete districts. The corresponding percentage for Non-Learning Districts ranged from 25% in Tandahimba to 100% in Kinondoni. A pair-wise comparison between percentages for Learning Districts and matching Non-Learning Districts showed that the percentages for LDs were significantly higher than for NLDs in the case of Hai/Siha versus Moshi Rural, Magu versus Misungwi and Makete versus Njombe, Mtwara Rural versus Tandahimba but percentages for NLDs were higher than for LDs in the case of Temeke versus Kinondoni and Bagamoyo versus Mkuranga.

In LDs, the percentage of primary schools that were supporting Tuseme club activities from own resources ranged from 11% in Hai/Siha to 75% in Mtwara Rural. In NLDs, the range was from 0% in Kinondoni, Moshi Rural, Misungwi and Tandahimba to 50% in Mkuranga. The percentage of primary schools that were supporting Tuseme club activities from own resources was generally higher in LDs than in NLDs and pair-wise comparison between a Learning District and its matching Non-learning District also showed the same pattern except for Bagamoyo and Mkuranga which had the same percentage.

In Learning Districts, the average level of financial support for Tuseme clubs from school's own resources ranged from Tsh 49 in Mtwara Rural to Tsh 50,167 in Makete district. In Non-Learning Districts, the average level of financial support for Tuseme clubs from school's own resources was Tsh 7,450 in Mkuranga district which was the only Non-Learning District with schools that supported Tuseme clubs from own resources. There is evidence therefore to suggest that financial support for Tuseme clubs from school's own resources was present in all LDs but not common in NLDs.

In LDs, the percentage of primary schools with well-functioning channels for boys and girls to confidentially report any violations of their basic rights ranged from 60% in Mtwara Rural to 100% in the other six districts. In NLDs, the percentage of primary schools with well-functioning channels for boys and girls to confidentially report any violations of their basic rights ranged from 25% in Njombe and Tandahimba to 100% in Kinondoni, Mkuranga, Moshi Rural and Misungwi districts. A pair-wise comparison between percentages for Learning Districts and matching Non-Learning Districts showed that the percentages for LDs were higher than percentages for NLDs for Bagamoyo and Mkuranga, Makete and Njombe as well as Mtwara Rural and Tandahimba but the remaining three pairs had the same percentages. Overall, LDs performed much better when compared to NLDs.

In LDs, the percentage of primary school teachers trained in Gender Responsive Pedagogy ranged from 5% in Mtwara Rural to 83% in Makete, but in NLDs it was generally much lower, from 0% in Kinondoni, Njombe and Tandahimba districts to 10% in Misungwi. A pair-wise comparison between percentages for Learning Districts and matching Non-Learning Districts showed that the percentages for LDs were significantly higher than percentages for NLDs. The overall percentage of primary school teachers trained in Gender Responsive Pedagogy was 18% in LDs and this was significantly higher than the corresponding proportion of 2% in NLDs.

In LDs, the proportion of primary schools with peer educators in service ranged from 25% in Temeke to 100% in Bagamoyo and Magu. In NLDs, the same indicator ranged from 0% in Mkuranga and Misungwi to 50% in Kinondoni and Misungwi. A pair-wise comparison between Learning Districts and matching Non-Learning Districts showed that the percentages for LDs were significantly higher than percentages for NLDs except for Temeke and Kinondoni where the NLD had a higher percentage than the LD. The overall proportion of primary schools with peer educators in service was 62% for LDs and this was significantly higher than a corresponding proportion of 29% for NLDs.

In LDs, the proportion of primary schools with peer counsellors in service ranged from 56% in Hai/Siha to 100% in Bagamoyo, Temeke and Makete districts. In NLDs, this proportion ranged from 25% in Kinondoni, Moshi Rural and Njombe districts to 50% in Mkuranga and Tandahimba. A pair-wise comparison between percentages for Learning Districts and matching Non-Learning Districts showed that percentages for LDs were significantly higher than for NLDs. The overall proportion of primary schools with peer counsellors in service was 74% for LDs and this was significantly higher than a corresponding proportion of 38% for NLDs.

In LDs, the percentage of primary schools with life-skills teachers in service ranged from 50% in Mtwara Rural to 100% in Temeke, Bagamoyo and Magu districts. In NLDs, the percentage of primary schools with life-skills teachers in service ranged from 0% in Tandahimba and Misungwi to 75% in Kinondoni and Mkuranga districts. A pair-wise comparison between percentages for Learning Districts and matching Non-Learning Districts showed that the percentages for LDs were significantly higher than percentages for NLDs. The overall proportion of primary schools with life-skills teachers in service was 85% for LDs and this was found to be significantly higher than the corresponding proportion of 42% in LDs.

The percentage of primary schools with well-functioning channels for girls and boys to confidentially report any violations of their basic rights and mechanisms to effectively and timely address the concerns raised by children was 100% in all Learning Districts. In NLDs, the percentage of primary schools with well-functioning channels for girls and boys to confidentially report any violations of their basic rights and mechanisms to effectively and timely address the concerns raised by children ranged from 25% in Njombe and Tandahimba to 100% in Kinondoni, Moshi Rural and Misungwi districts. A pair-wise comparison between percentages for Learning Districts and matching Non-Learning Districts showed that the percentages for LDs were significantly higher than percentages for NLDs in three pairs and percentages were the same in three pairs.

In LDs, the proportion of schools with available information on children's representation in school planning committee meetings available ranged from 25% in Bagamoyo to 100% in Temeke and Makete. In NLDs, the proportion of schools with information on children's representation in school planning committee meetings available ranged from 0% in Tandahimba to 100% in Misungwi. A pair-wise comparison between percentages for Learning Districts and matching Non-Learning Districts showed that the percentages for LDs were significantly higher than percentages for NLDs in the case of Temeke versus Kinondoni, Hai/Siha versus Moshi Rural, Makete versus Njombe and Mtwara Rural versus Tandahimba but percentages for NLDs were higher than those for LDs in the case of Bagamoyo versus Mkuranga and Magu versus Misungwi.

In LDs, the proportion of schools with available information on children and youth contribution to priority setting and budgeting decisions made during school planning meetings available ranged from 50% in Bagamoyo to 100% in Temeke, Magu and Makete. In NLDs, the proportion of schools with available information on children and youth contribution to priority setting and budgeting decisions made during school planning meetings available ranged from 25% in Tandahimba to 100% in Kinondoni and Misungwi districts. A pair-wise comparison between percentages for Learning Districts and matching Non-Learning Districts showed that the percentages for LDs were significantly higher than percentages for NLDs in the case of Hai/Siha versus Moshi Rural, Makete versus Njombe and Mtwara Rural versus Tandahimba but percentages for NLDs were higher than those for LDs in the case of Bagamoyo versus Mkuranga. Corresponding percentages for LDs were the same as percentages for NLDs in the case of Temeke versus Kinondoni and Magu versus Misungwi.

3.6 Water and Sanitation

With the exception of Temeke and Kinondoni, all 7 LDs had higher access to improved water sources (Figure 2) though there was no obvious correlation with UNICEF's investments in the sector under the 7 LDs Strategy as NLDs also had significant budgets for water. In Njombe for instance, in 2008/9 financial year, an amount of over Tsh 431 million was spent on water projects via the RWSSP.

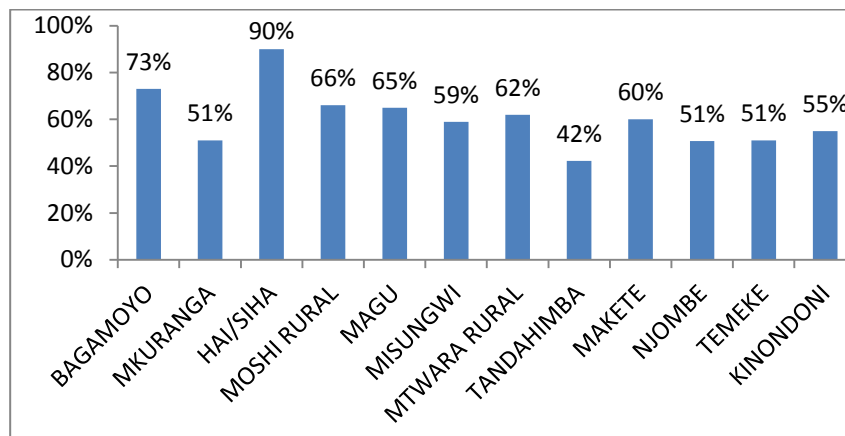


Figure 2: Proportion of the district population with access to improved water sources

Source: Interview of District Water Engineers.

At End-line availability of trained water artisans at village ward levels was reported to be high in both LDs and NLDs. Of the water user group chairpersons interviewed, 76% (13/17) in LDs and 80% (12/15) in NLDs confirmed the availability of trained artisans in their village/ward.

However, functioning water committees were less available in LDs than NLDs, as 26% of WUGs sampled in LDs were not functional while 47% of WUGs in NLDs were functioning well.

In addition the proportion of villages in sampled wards that had functioning committees was also reported to be higher in NLDs by ward executive officers (Table 14).

Table 14: Proportion of villages in sampled wards that have functioning water committees

District	Villages in Ward	Villages with Functioning Water Committees	(%)
Learning Districts			
Bagamoyo	No data – urban	No data – urban	No data
Hai	5	5	100
Siha	3	3	100
Magu	3	3	100
Makete	2	5	40
Mtwara	31	31	100
Temeke	No data- urban	No data - urban	
Non-Learning Districts			
Mkuranga	7	7	100
Moshi	5	5	100
Misungwi	3	3	100
Njombe	6	6	100
Tandahimba	6	6	100
Kinondoni	No data – urban	No data - urban	

Notes: 7 wards were sampled in LDs and 6 wards in NLDs.

Source: End-line Survey – Interviews of Ward Executive Officers.

Interviews of ward executive officers also confirmed the generally higher number of water committees in NLDs than LDs but of those reported to have been operational in the past 5 years, continuity and sustainability of these appeared better in LDs than NLDs (Table 15).

Table 15: Proportion of water committees in sampled 7 LD and 6 NLD wards that were functional in the last 5 years and reported to be still functioning in 2011

District	Committees in last 5 years	Committees functional in 2011	Functional (%)
Learning Districts			
Bagamoyo	Not sure how many	Not sure	No data
Hai	3	3	100
Siha	Not sure how many	1	No data
Magu	32	12	38
Makete	5	5	100
Mtwara	1	1	100
Temeke	Urban	Urban	No data
Non-Learning Districts			
Mkuranga	5	1	20
Moshi	4	3	75
Misungwi	31	18	58
Njombe	9	8	89
Tandahimba	4	4	100
Kinondoni	Urban	Urban	Urban

Source: End-line Survey – Interviews of Ward Executive Officers.

Water and sanitation promotion centres were available only in four of the seven LDs and were non-existent in NLDs (Table 16). The average number of clients reached out to by water and sanitation promotion centres varied widely across districts with Siha reaching out to the largest number of clients (122 per centre) on average.

Table 16: Existence of various support mechanisms for WASH artisans

District	Sanitation Promotion Centre Available?	Functionality	District trainers to train WASH artisans
Learning Districts			
Bagamoyo	No	No	11
Hai	Yes	Some not yet	0 ^{a/}
Siha	Yes	Yes	0
Magu	No	No	0
Makete	Yes	Yes	1
Mtwara	No	No	28
Temeke	Yes	Yes	4
Non-Learning Districts			
Mkuranga	No	No	0
Moshi	No	No	0
Misungwi	No	No	0
Njombe	No	No	0
Tandahimba	No	No	0
Kinondoni	No	No	0

Note: a/ The '0' availability of district trainers to train and provide back up support to artisans in Hai, Siha and Magu was not expected since in each district a team of 2-4 or more DTOTs were trained by the NGOs (EPCO and HAPA) and took part in the whole process to the end. In addition, the DTOTs with support by UNICEF the NGOs have been making follow up to the artisans including recording their performance e.g. number of households that constructed new latrines in past 6 months/year.

Source: Interview of District Water Engineers.

As regards awareness of existence of artisans who can build improved latrines, only 68% of interviewed households from the LDs were aware compared to 80% in the NLDs. The difference was statistically significant.

On new water projects, LDs had more (67%) projects compared to NLDs (20%) and these were more likely to be found in urban compared to rural areas. The main focus of UNICEF on WASH was to build capacity in terms of training. UNICEF supported new water schemes only in Makete and Magu districts. In Makete UNICEF supported establishment of one piped water project serving 3 villages and in Magu UNICEF supported drilling and installation of 17 deep boreholes fitted with hand pumps for community (village) water supply, and installation of 14 rainwater harvesting tanks each of 46,000 litres volume (i.e. one for a Health Centre and one each for 13 schools).

3.7 Maternal and Child Health

Relative to the Baseline values, the proportion of health workers trained on MNCH services ((EmOC, FANC, PAC, essential new-born care) increased significantly in both LDs and NLDs with a significantly higher change in LDs (Table 17).

Table 17: Training in MNCH

Indicators	LDs		NLDs	
	Baseline	End-line	Baseline	End-line
Proportion of health workers trained on MNCH services ((EmOC, FANC, PAC, essential new-born care)	20% (117/327)	74% (110/148)	27% (101/373)	63% (128/204)

Source: IHI and JIMAT 2012, End-line Survey Report.

The proportion of health facilities with guidelines increased in LDs with respect to IMCI, family planning, PNC and Malaria (Table 18). However, a decline in availability of guidelines on OI, VCT, PAC and immunization, was observed in both LDs and NLDs.

Table 18: Availability of guidelines in health facilities

Indicators	LD		NLD	
	2009	2011	2009	2011
Proportion of facilities with guidelines for opportunistic infections (OI)	77% (13/29)	42% (5/12)	67% (12/30)	33% (3/9)
Proportion of facilities with guidelines for VCT	79% (18/29)	63% (12/19)	59% (17/31)	50% (9/18)
Proportion of facilities with guidelines for IMCI	59% (17/28)	81% (13/16)	62% (11/31)	44% (7/16)
Proportion of facilities with guidelines for immunization	77% (17/29)	53% (8/15)	43% (21/31)	41% (7/17)
Proportion of facilities with guidelines for PNC	24% (7/29)	33 (4/12)	23% (7/31)	42% (5/12)
Proportion of facilities with guidelines for PAC	57% (9/28)	43% (3/7)	43% (7/31)	25% (2/8)
Proportion of facilities with guidelines for malaria	57% (21/29)	76% (16/21)	62% (29/31)	68% (17/25)

Notes: Facilities visited during the end-line survey were not necessarily the same as at baseline.

Source: IHI and JIMAT 2012, End-line Survey Report.

Trends in availability of equipment in health facilities showed mixed results with infant weighing scales, needle holders, and vacuum extractors having become more available than previously but scissors becoming a problem (Table 19).

Table 19: Availability of equipment in facilities

Indicators	LDs		NLDs	
	2009	2011	2009	2011
Infant weighing scale	86% (25/29)	92% 24/26	90% (28/31)	100% (28/28)
Stethoscope	100% (29/29)	100% (26/26)	94% (29/31)	96% (27/28)
Clinical thermometer	100% (29/29)	92% (24/26)	94% (29/31)	89% (25/28)
Speculum	79% (23/29)	58% (15/26)	87% (27/31)	36% (10/28)
Vacuum extractor	31% (9/29)	85% (22/26)	42% (13/31)	86% (24/28)
Scissors	97% (28/29)	31% (8/26)	94% (29/31)	25% (7/28)
Needle holders	79% (23/29)	92% (24/26)	90% (28/31)	93% (26/28)

Source: IHI and JIMAT 2012, End-line Survey Report.

Cross-sectional data at baseline and end-line survey stages indicated a decline in availability of most (54%) of the drugs in health facilities in both the LDs and the NLDs (Table 20).

Table 20: Availability of drugs in health facilities

Indicators	LDs		NLDs	
	2009	2011	2009	2011
Ergometrine	90% (26/29)	38% (10/26)	87% (27/31)	43% (12/28)
Misoprostol	4% (1/29)	58% (15/26)	16% (5/31)	50% (14/28)
IPTp drugs	94%	77% (20/26)	82%	71% (20/28)
Diazepam	90% (26/29)	97% (20/22)	97% (30/31)	96% (23/24)
Ampicillin	28% (8/29)	23% (6/26)	30% (9/30)	25% (7/28)
Gentamycin /metronidazole	35% (10/29)	46% (12/26)	53% (16/30)	39% (11/28)
Benzathine penicillin	72% (21/29)	77% (20/26)	80% (24/30)	79% (22/28)
Cloxacillin	62% (18/29)	46% (12/26)	57% (17/30)	54% (15/28)
Ciprofloxacin	62% (18/29)	77% (20/26)	63% (19/30)	71% (20/28)
Tetracycline or doxycycline	66% (19/29)	69% (18/26)	70% (21/30)	61% (17/28)
Artemether and Lumefantrine	86% (25/29)	81% (21/26)	80% (24/30)	68 (19/28)
Sulphadoxine-Pyrimethamine	86% (25/29)	77% (20/26)	83% (25/30)	71% (20/28)
Quinine (inj/tabs)	90% (26/29)	85% (22/26)	87% (26/30)	79% (22/28)

Source: IHI and JIMAT 2012, End-line Survey Report.

With respect to availability of vaccines, the proportion of health facilities reporting stock out of essential vaccines had increased at End-line in both LDs and NLDs but the increase in stock outs in LDs was much less than for the NLDs (Table 21).⁹

Table 21: Availability and stock out of vaccines in facilities in the past 3 months

Indicators	LDs		NLDs	
	2009	2011	2009	2011
TT Availability	100% (29/29)	88% (23/26)	94% (29/31)	96% (27/28)
TT Stock out	4% (1/29)	5% (5/23)	4% (1/28)	7% (2/27)
DPT-HB Availability	100% (29/29)	85% (22/26)	82% (25/31)	93% (26/28)
DPT-HB Stock out	10% (3/29)	12% (5/22)	10% (3/24)	31% (8/26)
BCG Availability	100%	85%	93%	96%

⁹ UNICEF acts as a procurement agency for the government for routine vaccines. Cold chain and Health officers have benefitted from trainings provided by UNICEF and interactions with UNICEF technical officer for EPI. Availability of vaccines at district level is influenced by efficiency of vaccine management at district, regional and national levels.

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Indicators	LDs		NLDs	
	2009	2011	2009	2011
	(29/29)	(22/26)	(29/31)	(27/28)
BCG Stock out	9% (3/29)	17% (4/23)	3% 1/28	15% (4/27)
OPV Availability	100% (29/29)	92% (24/26)	94% (29/31)	96% (27/28)
OPV Stock out	10% (3/29)	25% 6/24	3% (1/28)	19% (5/27)
Measles Availability	100% (29/29)	96% (25/26)	90% (28/31)	96% (27/28)
Measles Stock out	0% (0/29)	20% (5/25)	3% (1/27)	11% (3/27)

Source: IHI and JIMAT 2012, End-line Survey Report.

The proportion of health facilities that had “supervision visits involving case management observation in the 6 months preceding the End-line Survey” increased in LDs from 58% to 62% while it declined in NLDs from 53% to 44% (Table 22). Availability of transport for referral (bicycle or motor-cycle¹⁰ or ambulance) improved in LDs from 31% to 35% while it declined in NLDs from 39% to 32% of facilities interviewed at baseline and End-line, respectively.

Table 22: Availability of MNCH services in health facilities

Indicators	LDs		NLDs	
	2009	2011	2009	2011
Proportion of district hospitals implementing kangaroo mother care for management of low birth weight ¹¹	67% (4/6)	65% (17/26)	33% (2/6)	46% (13/28)
Supervision visits in the last 6 months	90% (26/29)	89% (23/26)	97% (30/31)	82% (23/28)
Proportion of supervision visits in the last 6 months involving case management observation	58% (15/26)	62% (16/26)	53% (16/30)	44% (12/27)
Availability of transport for referral (bicycle or motor-cycle or ambulance) ¹	31% (9/29)	35% (9/26)	39% (12/31)	32% (9/28)
Proportion of health centres (primary health care) providing services with at least two skilled attendants for delivery	76% (16/21)	100% (19/19)	84% (21/25)	100% (22/22)
Average number of outreach services conducted by health facilities (IMCI, EPI, Malaria) in the last 12 months	89% (22/25)	77% (20/26)	96% (22/23)	75% (21/28)
Proportion of health facilities offering basic EMOC services: Antibiotics	75% (15/20)	85% (22/26)	84% (16/19)	75% (21/28)
Proportion of health facilities offering basic EMOC services: Oxytocics	60% (12/20)	73% (19/26)	63% (12/19)	61% (17/28)
Proportion of health facilities offering basic EMOC services: Anti-convuls	50% (10/20)	58% (15/26)	68% (13/19)	57% (16/28)
Proportion of health facilities offering basic EMOC services: Kit for manual removal of placenta	50% (10/20)	50% (13/26)	53% (10/19)	61% (17/28)
Proportion of health facilities offering basic EMOC services: Kit for manual removal of	75% (15/20)	50% (13/26)	74% (14/19)	61% (17/28)

¹⁰ Important to note, UNICEF has not provided LDs with bicycles or motor cycles for emergency referral.

¹¹ Role of UNICEF in kangaroo mother care limited to development of guidelines at national level.

Indicators	LDs		NLDs	
	2009	2011	2009	2011
retained products				
Proportion of health facilities offering basic EMOC services: Assisted vaginal delivery	100% (20/20)	88% (23/26)	95% (18/19)	93% (26/28)

Notes: UNICEF did not supply motor-cycles, antibiotics, oxytocics, anticonvulsants, manual removal of the placenta and kit for removal of retained products were not provided by UNICEF.

Source: IHI and JIMAT 2012, End-line Survey Report.

PART 3: MAIN FINDINGS ON EVALUATION CRITERIA

4 RELEVANCE OF THE 7 LDS STRATEGY

In this Chapter we present the evidence in relation to the question of relevance of the 7 LDS Strategy. We tackle three main issues: (a) whether UNICEF engagements had the potential to reduce child vulnerability then; (b) the extent to which the interventions were consistent with the country programme design, the 7LDS Strategy and district level plans; and (c) the added value of the 7 LDS Strategy in the context of the Paris Declaration on Aid Effectiveness and the delivering as one approach of the UN.

Overall assessment

Overall, using the Organisation for Economic Development and Cooperation (OECD) rating scale of A=Very Good, B=Good, C=Some Problems and D=Major Problems, the Evaluation rates the relevance of the 7 LDS Strategy overall as having been an “A” Very Good. The Evaluation gives a few examples of interventions that were strong on relevance.

4.1 How relevant were UNICEF’s engagements in the 7 LDS supporting the scaling-up of evidence-based programmes to demonstrate a potential for reducing child vulnerability?

4.1.1 Young Child Survival and Development

The evaluation finds the nutrition interventions funded by UNICEF as part of the 7 LDS Strategy highly relevant to the nutrition-related challenges faced by Tanzania. In Tanzania over one-third of all deaths of children under-five years are associated with malnutrition (UNICEF, Women and Children in Tanzania, 2010). About 42% of children under the age of 5 years are stunted (and this number has declined by only eight percentage points since 1992), 16% are underweight and 5% are wasted (TDHS, 2010). Malnutrition is the greatest cause of child mortality.

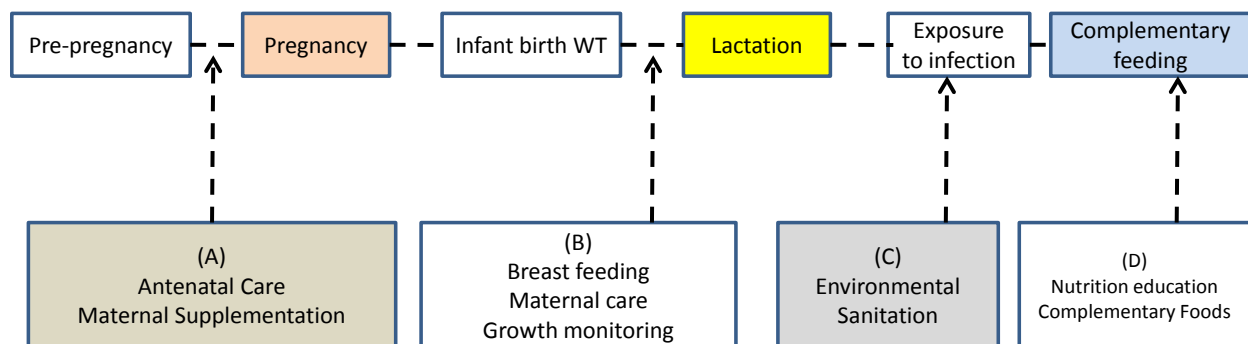


Figure 3: Stages of vulnerability to malnutrition/infection and appropriate interventions

Source: www.unsystem.org/scn/archives/npp10/ch07.htm (30 March 2012).

The package of UNICEF nutrition-related interventions in the 7 LDS has been proven to work elsewhere and its scope covered all critical stages of child growth and development – more specifically the window of opportunity – the first 1,000 days from conception - thus making it pertinent for Tanzania. The Essential Nutrition Actions (ENA) approach (is an innovation recently adopted globally in 2007) and has already been tested and proven to work in Ethiopia, Madagascar and Ghana (this includes promotion of women’s nutrition before, during and after pregnancy (Stage A), promotion of optimal breast-feeding in the context of HIV and AIDS (Stage B), promotion of optimal complementary feeding, promotion of optimal feeding of a sick child during and after illness (Stage D), control of vitamin A deficiency, control of Anaemia,

control of iodine disorders, public health interventions such as de-worming, promoting hygiene and sanitation, school health and nutrition; (c) malaria control; and (d) growth monitoring and nutritional screening (Stages B, C, D). The Lancet Series for January 2008 already documents that the ENA approach has potential to reduce child mortality by 23-25%.

The importance of maternal nutrition interventions at Stage A, promoted through ENA, is confirmed by a strong correlation found between underweight and low birth weight, alluding to the importance of addressing malnutrition in both the children and their mothers (TDHS, 2004/5). In the case of their mothers this is important even before the children are born. The TDHS 2004/5 found 10% of women malnourished (with a Body Mass Index lower than 18.5 kg/m²), and this has not declined as in 2009/10, 11% of women in the reproductive age were thin or undernourished (BMI < 18.5kg/m²) (TDHS, 2010)¹².

The promotion of IYCF (especially the link to PMTCT targeting HIV positive mothers with children under-five years of age) is highly relevant for Tanzania. In some of the districts targeted by the 7LDs Strategy (Siha and Hai, for instance) adult HIV and AIDS prevalence rose during the period under review. Furthermore Makete district, another LD, is among the districts with highest HIV and AIDS prevalence rates in the country though the spread has been contained and the rate of new infections is on the decline.

Training of health workers on optimal infant and young child feeding practices remains pertinent as national guidelines are regularly updated to bring them in-line with revisions to the WHO recommendations for feeding infants and young children in the context of HIV. Wasting is highest in the age group 6-8 months, highlighting the importance of integrated young child feeding, complementary feeding and management of childhood illnesses especially diarrhea at the time complementary foods are introduced into the child's life (Stages B, C and D).

The significance of interventions to screen for SAM may appear of relatively low priority in Tanzania because the prevalence of severe acute malnutrition is less than 1%, but the need to intensify prevention of malnutrition through continuous growth monitoring and screening for SAM remains pertinent, nonetheless. Most health personnel interviewed at the district level confirmed that regular screening for SAM was an important intervention as it enabled cases of moderate acute malnutrition to be identified early, giving the opportunity for counseling of caregivers at home/community level and thus reducing the cost burden on health facilities. It is also important to note that there are pockets of high SAM in the country, such as Zanzibar.

The Baby Friendly Hospital Initiative including the associated training of the CHMT on how to evaluate hospitals for "Baby Friendly Hospital" status, was relatively new in the LDs but important given the proven usefulness of the initiative in other countries (e.g., Malawi) in boosting the rates of exclusive breastfeeding among mothers¹³.

4.1.2 Basic Education and Life-skills

Whole school development planning, TGEI and INSET were highly relevant and geared towards raising school education standards, participatory planning, addressing the essential

¹² However, only 50% of children under the age of five years have known birth weight statistics, recorded at the health facility, the others do not have, and were most likely not delivered in a health institution.

¹³ Malawi National Nutrition Policy and Strategic Plan, 2007 – 2011.

needs of MVC and addressing gender equity for overall social development. The interventions sought to address the main challenges confronting the basic education sector which included: (a) inadequate primary school enrolment ratio of 83% of boys and 81% for girls; (b) inadequate school attendance rate of 71% for boys and 75% for girls; (c) low primary school completion rates – with 88% of primary school children reaching Grade 5; (d) low school net attendance rate at 71% for boys and 75% for girls; (e) low pass rate (62%) for Standard 7 examination; and (f) low transition rate from primary to secondary education (only 36% of learners). The quality of teaching, especially of science, mathematics and English was a major barrier hindering improved academic attainment for boys and girls.

4.1.3 Child Protection and Participation

In the early years of the 2007-2010 Country Programme, the design of the Child Protection and Participation component did not benefit from a well-defined conceptual framework with a logical theory of change model, a clear and coherent results framework and monitorable SMART indicators and targets. The package was made up of several stand-alone projectized actions, some of which had been developed and tested in the previous country programme (e.g., community justice programme). How these were fitting into a coherent whole was not obvious. The same applied to WASH whose design was not well developed because UNICEF lacked sufficient technical expertise.

Initially one of the major pillars of the CPP component focused more on provision of social support to MVCs to mitigate the negative impacts of HIV and AIDS. This was through a two pronged approach – the first strengthening community and district structures to identify and coordinate provision of support to MVCs, whilst the second intervened directly by providing material support in the form of a cash transfer pilot. While the positive impacts of cash transfers on the welfare of MVC are well documented in the region (e.g., the experience of social cash transfer schemes in Malawi, Swaziland, Lesotho and Zambia)¹⁴ this intervention was discontinued after a very short period of implementation as the funding of the cash transfer itself was considered not an area of competitive advantage of UNICEF.

The second approach assumed that resources would be available at the community level and these could be better coordinated through capacitated village and ward MVC committees. However, the Evaluation found that many of the MVC committees that were created and trained on their roles and responsibilities were doing better in identifying and registering MVCs, than they were in providing the needed social-economic support, because they did not have access to resources to support the MVC. Hence, whilst the model was sound in strengthening the identification of MVCs who need support it was weak in actual provision of the required assistance to MVC. The approach strengthened community support systems for the MVC but did not target the MVC directly with capacity strengthening support for self-reliance and financial autonomy. From this stand-point it was not a complete model for reducing child vulnerability to poverty, although UNICEF's choice of HIV impact mitigation as an area of intervention under the 2007-2010 Country Programme was very relevant given the high HIV and AIDS prevalence rates in some of the intervention districts (e.g., Makete).

¹⁴ www.wahenga.net

Although the MVC area has many actors who are carrying out similar activities, some of the NGO programmes are being phased out (e.g., in Makete where 3 of the five NGO programmes had come to an end) leaving many MVC needs unattended.

Birth registration was a very important area of intervention especially considering the very low proportion of children in Tanzania who have birth certificates and that birth registration has not been improving for many years. In 2010, only 16% of children under the age of 5 years in Tanzania had a birth certificate, and this was more-or-less the same situation five years previously (TDHS, 2010). Birth registration is one of the basic rights for children and can reduce child vulnerability to exclusion from other services, especially health care and education¹⁵ that improve child well-being. Without birth registration, children are at risk of further denial of other rights including the protection from abuse, violence, and exploitation, including in prisons, inheritance loss and property grabbing.

4.1.4 Policy Analysis and Advocacy

UNICEF's interventions under PAAP were found to be highly relevant. By emphasising the inclusion of children's issues as priorities in district plans and in MTEFs, UNICEF added value to the district planning process. While most districts already included children's issues in their district plans, these were found to be mostly of a hardware nature, and they were missing the software aspects which are critical for child protection. Most districts derived their priorities from 4 sources: (1) planning guidelines from PMO-RALG; (2) planning guidelines from sector ministries; (3) council's own plans for revenue generation and gap-filling on community projects; and (4) priorities identified through the O and OD approach at community level. Most of the children's priorities came from the "O and OD" process conducted at village level.

UNICEF's interventions were relevant in raising awareness among planners and budget officers at district as well as national levels, on the kinds of issues that should be included in the plans, on which communities and district level staff should be sensitised in order to give adequate attention to the issues of priority to children.

Previously, activities in the village plans directly addressed children's priorities especially those of a "**hardware nature**" (schools, dispensaries), but through the trainings, UNICEF advocated for inclusion of software and other missing aspects (e.g., addressing child abuse, providing legal services, MVC support, school meals, learning materials, promoting child participation in decision-making, recreational facilities for youth, HIV prevention activities for youth, school health and hygiene). The district profiles, M&E tools, planning tools (PLANREP and MTEF) had to be engendered with child-focused indicators from a holistic perspective and this was where UNICEF's intervention was most relevant.

The softer aspects which UNICEF encouraged planners to collect information on and analyse for planning and monitoring purposes, are of high priority to children but were not necessarily priorities to village governments, and politicians who participated either in planning or approved the plans. Prior to UNICEF's interventions in the area of involving children in planning, no other organisation was funding *Baraza la Watoto*. The Evaluation findings confirm the intervention

¹⁵ Isabel de Bruin – Cardoso and Ruth Mampane, 2008, Strategic Analysis on Civil Registration and Children in the Context of HIV and AIDS, Centre for the Study of AIDS, University of Pretoria.

was relevant as children who participated in planning identified other needs not usually prioritised by adults (these include, income generation, HIV prevention, sports and recreational needs, school health and hunger issues).

Strengthening the capacity of planners and budget officers to use data from the LGMD, village registers, MVC registers, the HMIS, TOMSHA, and other sectoral systems to identify and analyse children's issues not only filled a critical gap in planning but placed children at the center of development efforts at district level, and this theme cut across all sectors.

The main gap in relation to evidence of a documented strategy for replication and scale-up of evidence-based models was that the 7LDs Strategy was not effectively "sold" to NLDs. In LDs DMETs had been appointed but not trained. Visibility and publicity materials on the 7 LDs Strategy in general were missing both at RAS level and in NLDs. UNICEF could have learnt from publicity strategies and products of other programmes running in the same districts or regions where the 7 LDs Strategy was implemented. During the field surveys, examples of programmes with a strong visibility strategy and information dissemination materials were given by key informants and these included TASAF, AJISO and KWIECO.

The establishment of DMETs and their training on managing for results was crucial in that it enhanced the quality of monitoring of development projects, not only in relation to achievement of results for children (monitoring children's indicators) but also from the perspective of achieving value for money. Previously monitoring of development projects at district level was being carried out individually by sectors, with little integration, transparency and accountability. Strengthening M&E capacities by encouraging districts to set up multi-sectorial DMETs, providing training on how to do M&E and write reports, and providing financial and logistical support for the DMET members to facilitate inspection site visits, was thus relevant. It made the M&E function more integrated, cross-cutting, open for cross-checking and validation by people with multiple skills; it reduced the conflict of interest associated with self-evaluation of progress, which was happening at sector level; and overall improved the efficiency and timeliness of outputs. For these reasons this type of support from UNICEF was not only highly relevant for improving management of scarce resources at district level but also highly appreciated by LDs who now want the next generation of DMETs to be autonomous teams empowered through a separate budget line and cost centre.

4.2 To what extent were the GoT/UNICEF planned interventions in 7 LDs consistent with country programme design?

In general, there was a high degree of alignment between the GoT/UNICEF planned interventions in the 7 LDs and country programme design. A few key results do illustrate this. For instance, in the case of nutrition and ECD, according to the summary results matrix for the GoT and UNICEF Country Programme of Cooperation for 2007-2010, the key result on nutrition and ECD was "national and sub-national management and delivery systems for health, nutrition and early development strengthened for effective implementation of high impact interventions". The revised Country Programme Document envisioned that nutrition and ECD activities would "focus on: (i) accelerating support to universalizing and mainstreaming interventions to combat micronutrient deficiencies; (ii) developing models for integrated community nutrition

interventions; and (iii) supporting early stimulation and childcare interventions”. The nutrition and ECD activities implemented as part of the 7 LDs Strategy were in full alignment with this orientation of the Country Programme design, although the ambition to develop “models for integrated community nutrition” was not fully pursued.

This finding is similar for PAAP. The revised County Programme Document of UNICEF Tanzania (22 January 2007), unpacked the PAAP component as one that consists of activities to (i) influence policy development and resource allocations to reduce child vulnerability through the use of up-to-date, reliable disaggregated data and evidence; (ii) strengthen national structures and processes for monitoring and reporting on implementation of key child rights commitments; (iii) promote integration of priority issues and actions for children, women and vulnerable groups into a comprehensive national social protection policy and framework that is developed and implemented; and (iv) enhance social planning and budgeting around children, women and vulnerable groups through capacity development and improved linkages at national and subnational levels. The Evaluations also finds a high degree of alignment between what was envisaged under PAAP in the CPD and what was planned under the 7 LDs Strategy. The main gap for PAAP (and this applies to all KRAs), was in execution, starting with the 2 year delay in unpacking of what the 7 LDs Strategy meant in practice - through a document that spelt out concrete interventions at the district level; and subsequently, the development of the social protection framework which failed to proceed in accordance with what was planned¹⁶.

In the case of BELS, all the interventions implemented under WSDP were listed in the country program design. However mid-stream along the program implementation it was also noted that some schools needed very basic supplies like desks and textbooks in order to operate. Absence of these would have adversely affected implementation of the planned interventions. Therefore some minimal targeted relief support for textbooks was provided under the education component. Although this was not planned, it reflected good sense of flexibility required to adapt and ensure that the the country programme achieved the intended purposes.

The flexibility of UNICEF Management to adapt the country programme activities in pursuit of greater value for money was clearly evident in the Child Protection and Participation component of the CP as well, where a number of interventions were either significantly reprogrammed mid-way or phased out (e.g., Birth Registration Pilot, Community Justice Facilitation, Mobile Legal Clinic, etc).

4.3 To what extent were the actual interventions consistent with the GoT/UNICEF 7LDs strategy and district level plans?

The 7 LDs Strategy Document was prepared only after the 7 LDs Strategy Evaluability Assessment of 2008¹⁷ recommended that the results framework and the theory of change for the 7 LDs Strategy be fully elaborated to enable an end-line evaluation. The design document came on board two years into implementation of the strategy. Hence most activities included in the 7 LDs Strategy design document were identified more by retrofitting a “minimum package” of what was already being implemented, rather than being the original design itself¹⁸. The

¹⁶ This gap has been addressed under the CP for the period 2011-2015.

¹⁷ Yantio (2008). Evaluability Assessment of the Government of Tanzania and UNICEF Interventions in the Seven Learning Districts. July 25

¹⁸ UNICEF Planning Monitoring and Evaluation Office, 2009, LDs – Efficiency and Effectiveness (PowerPoint presentation)

concept of consistency with the GoT/UNICEF 7 LDs Strategy therefore would not strictly apply in this case. This finding applies to all 7 LD key result areas.

As for consistency with district level plans, the Evaluation found that YCSD-related interventions were in line with what was prioritised and budgeted for in Comprehensive Council Health Plans in LDs. The CCHP was the main document in which planned activities and budgets for nutrition were captured. The interventions under BELS were innovative (WSDP, INSET, TGEI, etc), and were included into the district education strategic plans through the advocacy role of UNICEF at the time of annual planning and preparation of the MTEFs. Child protection interventions were not ordinarily included in district plans but this is an area where UNICEF's influence was also strong but districts planned together with UNICEF in a harmonious manner.

District councils led and owned the process of formulating their strategic plans. They developed their plans from the grassroots, starting with the implementation of the "O and OD" process to identify priorities at village and health/education facility levels, then aggregating the priorities to produce ward plans, and subsequently aggregating these to district plans. Nutrition-related interventions identified at the village level were less to do with capacity building but more to do with improving local production and supply of staple foods and cash crops (for example in the case of Siha district) or introducing community support school feeding to reduce truancy in primary schools (as the case for Makete district), as opposed to training of CoRPs in screening for SAM or that of health workers on ENA, IYCF and integrated management of severe acute malnutrition. The CB activities were identified more at the health facility, district and national levels, and partly with the input of UNICEF. Activities to be funded by UNICEF were specifically discussed and agreed upon between UNICEF and the district councils before inclusion into the final draft of the CCHP and in annual MTEFs. Once included in the MTEF, LDs confirmed that UNICEF released all the funds agreed upon and implementation, in general, went on as scheduled¹⁹. As a result of this close collaboration between UNICEF and LDs in planning at the district level, the Evaluation concludes that UNICEF-funded nutrition-related activities in the LDs were in line with what was in the district strategic plans (overall rating "A" Very Good).

For Child Protection and Participation, the activities were not ordinarily identified as priorities in village, ward and district plans (most of the plans focused on provision of basic social services like education and health, infrastructure-type investments and agriculture and food security). CPP is an area where UNICEF added value by raising awareness on child protection issues among the planners and budget officers and this contributed to the practice of including the child protection interventions into annual district plans and MTEFs. Without UNICEF, LDs were unlikely to include into their plans the activities on community justice facilitation and Children's Councils, for instance. At least two LDs acknowledged that they had included the CPP interventions as a means of accessing resources from UNICEF and had already stopped including some of the activities into their plans after withdrawal of UNICEF support. Although some LDs (Makete, and Hai) pledged to continue allocating resources to the CPP activities, and to include these activities into the next 5-year District Strategic Plans, they were unsure as

¹⁹ Although the issue of funding delays was reported especially in Makete, the problem was mainly between the Exchequer and the district assemblies as opposed to the delay in disbursement of funds from UNICEF. In addition, despite the few cases of disbursement delays, UNICEF outperformed all other development programmes in terms of reliability of funds disbursement for development programmes implemented by LDs during the period under review (see section on efficiency below).

to their ability to mobilise sufficient resources for these activities especially given that government was also shifting its planning and budgeting approach to a new system whereby it was now focusing more on internally generated revenues. This raises questions about the future sustainability of these activities.

UNICEF provided resources to the LDs quarterly based on agreed priorities. UNICEF met LDs every year to discuss their plans for the following financial year and agreed with them what would be financed by UNICEF in the MTEF. Only after these discussions with UNICEF, would LDs then proceed to finalise their MTEFs. Hence the question of consistency with district plans and MTEFs does not strictly apply because the activities to be included in the MTEFs were already first discussed and agreed upon with UNICEF. The practice of common visioning with the district councils in February, however, was excellent and was in fact highly appreciated by the LDs as the activities agreed upon for funding by UNICEF were usually fully funded and in reasonable time. This was in contrast with activities funded by other development partners whereby disbursements either came extremely late or hardly matched what was planned (sometimes disbursements for the first Quarter activities were made in the second or 3rd Quarter and actual disbursements were below 60% of what was planned), thus forcing districts to significantly scale down their activity plans and targets for the respective year.

4.4 What was the added value of the 7 LDs Strategy in the context of the Paris Declaration principles on aid effectiveness and the delivering as one approach being piloted by the UN?

The Evaluation found evidence of strong alignment of the 7LDs Strategy with Paris Declaration Principles on Aid Effectiveness. The process of district planning and planning for the 7 LDs Strategy activities has a strong element of central and local government ownership and leadership, as well as strong community participation which all districts where the “O and OD” process was initiated, confirmed was playing a crucial role in deciding what the district funded in terms of development projects. Central government provides the necessary leadership in guiding districts to plan for the longer term national targets while sectors provide guidance on specific short term priorities and targets.

UNICEF did not dictate priorities. What UNICEF financed at the district level was mutually discussed and agreed upon with district councils prior to inclusion in the MTEF, and what was agreed was usually fully funded by UNICEF. In general, a three step process was followed: Step 1 involved the preparation of the village and ward plans using the “O and OD” approach; Step 2 involved meetings with UNICEF to discuss the priorities coming from the sub-district level as well as from the top and from within the district council; and Step 3 involved the elaboration of the annual plans and budgets (which incorporated UNICEF-agreed activities).

While the “O” and “OD” approach was highly appreciated, in that it engenders strong community participation in district planning, the approach needs to be sustained by regular refresher courses to equip new leaders at village and ward level who oversee the process at that level with the relevant skills. In most of the LDs, refresher courses were overdue by the time of the Evaluation and this was compromising the quality of the plans (see section on sustainability). At the time of this Evaluation, JICA in collaboration with PMO-RALG had begun piloting a O&OD course in five districts. Since this approach was initially introduced by UNICEF, the support by JICA represents a positive spill-over effect involving another development partner.

5 EFFECTIVENESS OF THE 7 LDS STRATEGY

In this Chapter we present the evidence in relation to the question of effectiveness of the interventions implemented under the 7 LDs Strategy. We tackle the following six main sub-questions:

- a) To what extent do the 7 Learning District plans and budgets prioritise children's issues?
- b) Has service delivery improved in the 7 LDs? If so how?
- c) To what extent did GoT/UNICEF interventions achieve the desired behaviour change results? Which programmes had the more visible/noticeable behavioural impact at household and community level
- d) Is there evidence to show that there are improved community based services in the 7 LDs as a result of UNICEF interventions?
- e) To what extent did the interventions in 7 LDs contribute to enhanced national policies, programmes and strategies?
- f) How effective was the integration and convergence of the four programme components?

Overall assessment

Overall, using the OECD 4-point rating scale of A=Very Good, B=Good, C=Some Problems and D=Major Problems, the Evaluation rates the effectiveness of the 7 LDs Strategy as having been an "A" for PAAP and BELS, while "B" Good for YCSD, and "C+" for CPP but with good prospects to achieve an "A" as evidenced by the preliminary results of the new child protection system now being piloted in the 4 learning districts.

5.1 To what extent do the 7 Learning District plans and budgets prioritise children's issues?

5.1.1 Priority issues for children addressed in social protection framework

Knowledge and application of key planning documents at district level

The findings confirm that in LDs, knowledge of Child Development Policy (CDP) and other national policy and strategy documents relating to prioritising children's issues in planning and budgeting at the time of the end-line was in general higher than in NLDs (e.g., in Misungwi and Njombe, DSWOs were not aware of the existence of the CDP) suggesting that that trainings and awareness promotion had been effective.

In each LD, there were people who knew and brought the knowledge into the planning process, the number of senior officials who knew the CDP was highest in Temeke (4 out of 5), most likely due to proximity and efficient communication channels.

Evidence of resource allocation to children's priorities also exists, for example, networking meetings with child protection duty bearers (Bagamoyo), and dissemination of Child Law Act No. 21 of 2009 at ward level (Siha).

The knowledge of the existence and content of the Child Development Policy among district social welfare officers was lower than for community development offices who were charged

with the responsibility to take care of children's issues. District social welfare officers were new in some of the learning districts and had not received any orientation on the national documents. This highlighted the importance of running orientation trainings regularly and through central level approaches to ensure that people who are supposed to implement these policies are aware of their existence and content.

Districts that have allocated through MTEF resources for children's priorities

MTEF allocations to youth activities (for example, youth IGAs and formation of children's barazas) and child protection interventions featured only in LDs, suggesting a positive outcome of UNICEF's PAAP activities (Table 23).

Table 23: Activities in support of children's priorities allocated resources in the MTEF 2011/12

District	Social Protection (Youth)	Children's issues	Community Justice
Bagamoyo	Dissemination of national youth related issues	Facilitate networking meeting with child protection duty bearers	CJF consultative meeting Training of CJF in new villages in line with Child Law Act No. 21 of 2009
Magu	Training of youth network members on managerial skills and income generating activities Establishing youth <i>barazas</i> at ward levels		
Siha		Dissemination of Child Law Act No. 21 of 2009 at ward levels	

Source: End-line Survey Results.

Capacity building for MVC care and support, identification and registration of MVC, and provision of essential support to MVC feature more or less equally in MTEFs for LDs and NLDs (Table 24).

Table 24: Examples of MVC Care and Support Activities Allocated Resources in the District MTEF 2011/12

Activity	LDs	NLDs
Capacity building on care and support strategy skills and provision of essential services (e.g., school fees)	Bagamoyo Hai Magu Mtwara	Misungwi Tandahimba Mkuranga
Data collection and dissemination modality on care and support for MVC	Hai	
Identification, registration and provision of essential services to orphans	Bagamoyo	Tandahimba Mkuranga
Dissemination of National Costed Plan of Action (NCPA) for MVC and development of follow-up actions	Hai Magu	

Source: End-line Survey Results.

The MVC care and support field has many active players, with the Global Fund and PEPFAR activities also equally visible in both LDs and NLDs. In this sector UNICEF is playing the role of a gap filler (topping up) as opposed to an innovator because the activities of setting up and training MVC structures are on-going countrywide with other donor support. The role UNICEF played in LDs, though, was important in bringing the needs of MVCs to the attention of planners and budget officers who make the decisions on resources. The institutionalisation of the MVC register for example, enhanced the analysis of OVC needs by gender, age, family background and type of vulnerability. However, UNICEF's package for MVC care and support was inadequate as it missed the most critical component of material support which is present in the other programmes implemented by NGOs.

The Evaluation findings also confirm that in LDs, UNICEF focal persons (especially the DPLOs) were to some extent instrumental in ensuring non-conventional children's issues were incorporated into the district plans and MTEFs. Where the DEDs owned the children's agenda they made the difference in allocating resources in the MTEF as well as the use of own revenue sources to these activities.

5.1.2 Government plans and budgets are results-based with clear results for children

Availability in the district strategic plans of information on children issues as per thematic areas of the NPA

In general, information on children's issues featured less in the district strategic plans than in the MTEFs, suggesting a possible disconnect between the two documents, though all district officials interviewed in both LDs and NLDs held the view that the link was strong. The inconsistencies between the SPs and the MTEF allocations for 2011/12 could be attributed to the changes that occurred at district level from the time the SP documents were prepared. Most SPs in both LDs and NLDs, were either being updated or had just been updated at the time of the end-line survey in November – December 2011.

Availability in the MTEF of funds allocated for activities related to children

Children's issues such as IECD, community justice, support for youth activities, dissemination of the Child Law Act No. 21 of 2009, promoting gender equality in education, life-skills education, HIV/AIDs prevention, nutrition and health featured more prominently in MTEFs for LDs than in NLDs, suggesting a positive contribution by UNICEF.

There was no difference in coverage of issues in the MTEFs in relation to activities to enhance the quality of education, capacity building and provision of MVC care and support, indicating the contribution made by national programmes funded by government and other development partners (e.g., USAID support to the MoHSW to implement the NCPA at national scale) were equally important.

We also found NLDs performing better at end-line in terms of allocation of resources in the MTEF to expenditure categories such as 'other' water, planning and monitoring systems. These areas appeared to be given more weight and resources in NLDs than LDs.

Training of Planning and Budget Officers has improved (i) the identification, (ii) analysis, (iii) prioritisation; and (iv) setting of clear results on children's issues during the planning stage

The findings confirm that training improved planning and budgeting in 6 LDs and 3 NLDs. Whilst UNICEF focused on LDs, other districts funded training from other donor programmes or from council resources, as was the case of Njombe district where the planning office has a rotational training programme that is funded out of council's own resources as well as from other donor projects, and had 3 planning and budget officers on training at the time of the Evaluation.

In both LDs and NLDs, the experience in terms of identification, analysis, prioritisation and setting clear results for children was mixed - and the absence of a dedicated budget line for children's priorities was a major limiting factor. Some LDs (e.g., Magu and Makete) had already begun allocating resources from internal/locally generated revenue.

Some NLDs (e.g., Moshi) looked outside the box to allocate resources to MVC activities using basket funds (each sector has to contribute as part of the multi-sectorial HIV and AIDS response)

The Evaluation found both LDs and NLDs using the LGMD data and both with the concern that the indicators were not broad enough to cover sectors such as environment and roads.

In terms of identification the biases in people participating in the "O and OD" approach towards infrastructure projects were reduced by training on children's issues, softer interventions for children – e.g., youth HIV/AIDS prevention activities, Youth IGAs, food and nutrition security, children's *baraza*, and child protection (e.g., capacity building for community justice), are now featuring in budgets in LDs, much more than in NLDs.

In terms of analysis, the village register, the LGMD, the MVC register, sectoral M&E tools, and district socio-economic profiles together with sectoral planning guidelines were mentioned as useful tools in analysis of children's issues and being used more in LDs, although NLDs were also using these data as per national guidelines.

In terms of prioritisation, LDs were found to be "comprehensively thinking" of including children's issues in all sectors (e.g., Makete) and more actors at district level began planning, budgeting for, and implementing child oriented interventions, unlike previously.

In terms of budget allocation, the single major constraint was the absence of a dedicated sub-vote and a cost centre for children's issues, especially those pertaining to social protection under the mandate of the District Social Welfare Office.

5.2 How has service delivery improved in the 7LDs?

5.2.1 Young Child Survival and Development

5.2.1.1 Nutrition and ECD

When the End-line Survey data were compared to the Baseline Survey, there was no statistically significant increase in the proportion of health facilities that had at least one staff

member trained on ENA or ENA-PIA. However, knowledge of at least 4 of the 7 components was found to have improved in LDs by a larger margin than in NLDs, as the proportion of health workers trained on ENA who knew at least 4 of the 7 components of ENA increased from 0% to 17% in the learning districts compared to an increase from 0% to 7% in non-learning districts. Marked improvements were observed in Siha, Makete and Mtwara rural and Kinondoni urban which were the only learning districts with staff who knew at least 4 components of ENA.

The proportion of health workers trained in ENA or ENA-PIA who were fully utilising the new knowledge and skills acquired through the training in their daily work was high and effectiveness of the training was also highly rated “A” (very good) in Siha, Magu, and Hai districts. Training sessions on IYCF and screening for SAM were also appreciated but health workers sometimes were not able to put into practice what they had been taught because of high workload (e.g., long queues), or re-assignment to other duties that had little to do with nutrition. Unavailability of equipment (length boards, weighing scales, updated MUAC tapes) and supplies such as PlumpyNut also reduced the effectiveness of nutrition education for health workers, suggesting the need for a comprehensive intervention package that address the current deficits in terms of staff numbers as well as other capacity gaps apart from skills.

In both LDs and NLDs, high proportions of CoRPS trained on exclusive breastfeeding assessed the training as having been both well designed and well delivered (content, duration, quality of venue and of facilitation) (95% in LDs and 88% in NLDs).

Of those trained, the majority also found the training useful for their work (92% (12/13) and 83% (35/42), respectively). The difference between LDs and NLDs was not statistically significant.

5.2.1.2 Community WASH

Water supply

At End-line availability of trained water artisans at village ward levels was reported to be high in both LDs and NLDs. Of the water user group chairpersons interviewed, 76% (13/17) in LDs and 80% (12/15) in NLDs confirmed the availability of trained artisans in their village/ward. However, functioning water committees were less available in LDs than NLDs, as 26% of WUGs sampled in LDs were not functional while 47% of WUGs in NLDs were functioning well. In addition, the proportion of villages in sampled wards that had functioning committees was also reported to be higher in NLDs by ward executive officers. These officers also confirmed the generally higher number of water committees in NLDs than LDs but of those reported to have been operational in the past 5 years, continuity and sustainability of these appeared better in LDs than NLDs.

The slightly higher proportion of villages in NLDs that had water committees was mainly associated with presence of many water programmes investing in the sector at the district level. Functionality of these schemes was greatly affected by theft of equipment, shortage of funds to run the affairs of the committees, purchase spares and hire artisans to repair the water schemes, shortage of trained artisans who can do good quality work and lack of management skills on the part of the elected water point committee members.

No district (either LD or NLD) kept spares to supply to water user groups, and there were no major changes in the WASH budget except in Makete where this was reported to be increasing

(Table 25). Spare parts for water projects were generally available locally in all districts but perceived to be expensive by both DWEs and trained artisans.

Table 25: Trend in annual budget, supply of spares and affordability

District	Change in annual WASH budget?	Programme to supply spares?	District keeps stocks of spares?	Availability and price of spares?
Learning Districts				
Bagamoyo	Varies	No	No	Not available
Hai	Varies	No	No	Available, expensive
Siha	Varies	No	No	Available, expensive
Magu	Varies	Yes	No	Available, expensive
Makete	Increasing	No	No	Available, expensive
Mtwara	Small increase	Yes	No	Available, expensive
Temeke	Varies	No	No	Available, expensive
Non-Learning Districts				
Mkuranga	Varies	No	No	Available, expensive
Moshi	Varies	No	No	Available, expensive
Misungwi	Varies	Yes	No	Available, expensive
Njombe	Decreasing	No	No	Not available
Tandahimba	Varies	No	No	Available, expensive
Kinondoni	Varies	No	No	Available, expensive

Source: Interview of District Water Engineers.

The annual budget for WASH activities only increased in 2 of the 7 learning districts whilst declining in one of the NLDs. There was no distinct pattern in the other districts, as the amounts varied from year to year based on funding availability from the central level. In relation to availability of spares, there was no evidence to suggest more active involvement of districts in supplying spare parts to water user groups either in LDs or NLDs as no district (either LD or NLD) kept spares to supply to water user groups. Spare parts for water projects were generally available in local hardware shops in the various districts but perceived to be expensive by both DWEs and trained artisans. The commonly used spare parts were: PVC piping, union, elbow, socket, cork, gate valve, water meter, straight coupling, pool corrector, beep cock, nipple, socket plain, GP pipes, and an assortment of fittings. Only Mtwara rural had a mechanism to support the activities of artisans, by paying for the services of artisans when they provide services to water user groups.

On new water projects, LDs had more (67%) projects compared to NLDs (20%) and these were more likely to be found in urban compared to rural areas. The main focus of UNICEF on WASH was to build capacity in terms of training. UNICEF supported new water schemes only in Makete and Magu districts.

It appears from the information collected from the Water Engineers that the objective of training DTOTs to train artisans was only achieved in four learning districts (Bagamoyo, Makete, Mtwara and Temeke) and it was not achieved in the other LDs or in non-learning districts.

During the period of the UNICEF intervention, both LDs and NLDs undertook several investments in water projects mostly without UNICEF funding. As alluded to in Chapter 3, LDs had more reported water projects (336/370) compared to NLDs (34/370). Most of the water schemes where districts had invested resources were old schemes that were rehabilitated, although Mtwara and Temeke districts had a number of new schemes established. The number

of new and rehabilitated schemes still functional at the time of the End-line showed that the investments were contributing to service delivery. The two schemes constructed using UNICEF funds in Makete were operational at the time of the End-line and were reaching a population of 1,161. This was miniscule though compared to what the other programmes were achieving (for example schemes in Mtwara reached 100,000 people), albeit not in a sustainable manner.

With the exception of Temeke and Kinondoni, all 7 LDs reportedly had higher access to improved water sources (Figure 4) though there was no obvious correlation with UNICEF's investments in the sector under the 7 LDs Strategy as NLDs also had significant budgets for water. In Njombe for instance, in 2008/9 financial year, an amount of over Tsh 431 million was spent on water projects via the RWSSP.

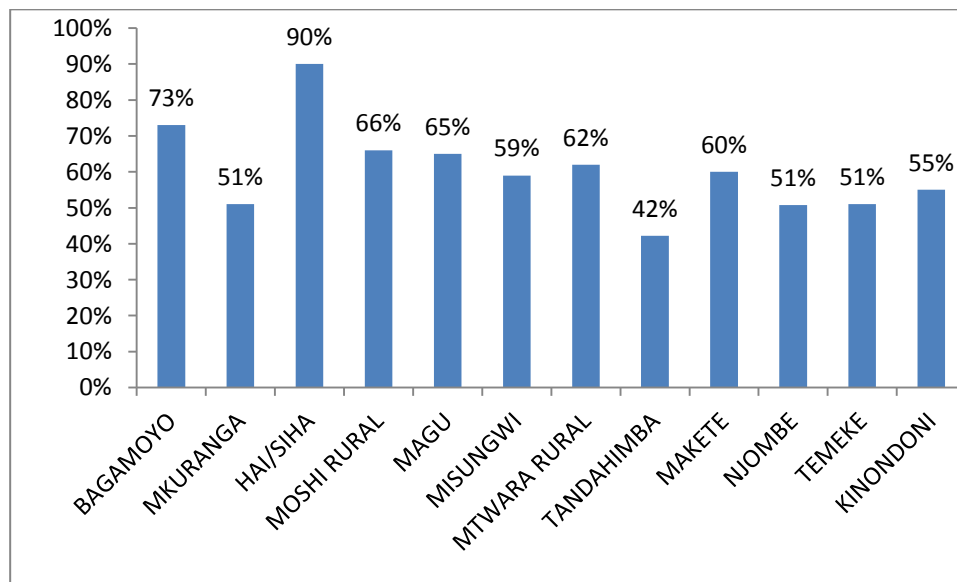


Figure 4: Proportion of the district population with access to improved water sources

Source: Interview of District Water Engineers.

Overall, in LDs, UNICEF contribution on water and sanitation was not enough, apart from Makete and Magu. In Makete, especially, the two water projects had contributed significantly towards alleviating the plight of vulnerable populations. According to the DWE for Bagamoyo, rehabilitation of water projects, training of various stakeholders involved in water projects and construction of low cost water schemes could have yielded more significant results in Bagamoyo.

Sanitation promotion

Water and sanitation promotion centres were available only in four of the seven LDs (Hai, Siha Makete and Temeke) and were non-existent in NLDs. Their functionality differed, with Siha having adopted the approach of “learning by doing”, by establishing some of the facilities at schools, market centres and at village offices, whilst in Hai, one of the promotion centres was not yet operational at the time of the End-line survey. The number of promotion centres per ward was considered by WEOs to be too small in some of the wards that had large populations and covered a large terrain. In addition the level of resources dedicated to the continuous functioning of the centres were either small or non-existent, thus could not support adequately the activities that trained artisans, ward and village leadership expected the centres to play in their communities.

As regards awareness of existence of artisans who can build improved latrines, only 68% of interviewed households from the LDs were aware compared to 80% in the NLDs and the difference was statistically significant. The definition of trained artisan differed from one district to another. In Misungwi artisans were considered to be those who got formal training while in Bagamoyo they ranged from those who got on the job training by working with their grandparents to those who had acquired formal trainings provided by private and public training colleges. The lack of working tools and financial constraints were among the main challenges which hindered most artisans from performing their duties in LDs. Trained artisans also lacked support mechanisms. They were not supervised and data on the number of clients they served and their outputs were not readily available from them or their trainers.

5.2.1.3 MNCH

As was alluded to in Chapter 3 (Section 3.7) findings from the health service provider interviews confirmed that by 2011, UNICEF-funded MNCH trainings (EmOC, FANC, PAC, essential newborn care) had been very effective in increasing the proportion of health workers trained on MNCH (the increase in LDs was from 20% at Baseline to 74% at End-line, compared to an increase from 27% to 63% for NLDs, respectively).

At End-line, it was found that the proportion of health centres (primary health care) providing services with at least two skilled attendants for delivery had increased from 76% to 100% in LDs. This matched the new level for NLDs, which had increased from a higher figure of 84% at Baseline to 100% at End-line. This evidence shows the value added by UNICEF's contribution in LDs.

Although UNICEF did not support implementation of Kangaroo Mother Care for management of low birth weight, it is worth noting that the proportion of health facilities implementing this approach increased from baseline to end-line.

In LDs, the proportion of health facilities offering basic EMOC services: Antibiotics, Oxytocics and Anti-convuls increased from 75% to 85% , 60% to 73%, and 50% to 58% between Baseline and End-line, respectively. In NLDs they all declined, thus suggesting that the presence of UNICEF support in the LDs made a positive difference.

The proportion of health facilities that had "supervision visits involving case management observation in the 6 months preceding the End-line Survey" also increased in LDs from 58% to 62% while it declined in NLDs from 53% to 44%. Availability of transport for referral (bicycle or motor-cycle or ambulance) improved in LDs from 31% to 35% while it declined in NLDs from 39% to 32% of facilities interviewed at baseline and End-line, respectively.

The End-line survey confirmed that provision of MNCH related equipment to health facilities improved availability of functional equipment and the ability of health service providers to accurately diagnose, monitor and manage MNCH related complications in clients. Health staff served more patients per given time period. However, the improvement in availability of equipment was generalized with no significant differences in changes between LDs and NLDs suggesting that districts that received funding from UNICEF used other funds they could also have used for equipment (such the health basket fund) for other essential needs apart from equipment. This way there was natural possible displacement effect of UNICEF support.

The improvement in equipment supply was noted for some types of equipment and not for others. For instance what improved was the availability (in a functional status) of infant weight scales, stethoscopes (sustained at 100% in LDs and 94-96% in NLDs), manual vacuum aspirators (MVA), vacuum extractors and needle holders. What did not improve, and appeared to have declined was availability of scissors and speculums. The CHMT in Siha singled out the quality of scissors and forceps centrally procured by UNICEF as having been problematic – they were quickly getting corroded by rust and rendering them unfit for use. There were also two other issues that affected the utility of equipment purchased by UNICEF for the district, and these were inadequate staff skills to operate the equipment (e.g., in Siha and Makete districts) and the non-availability of functional theatres²⁰ (in Hai and Siha). In Makete, for example, two new incubators purchased using funds from UNICEF had not been utilised for a period in excess of one year because staff had not been trained on how to use them. The Evaluators also found several other pieces of new equipment not functional, including theatre lamps, and these had been purchased through other programmes.

The maintenance of hospital equipment came out as an area lacking resources (or prioritisation in budget allocation decisions at district level) and requiring immediate attention.

The evaluation findings confirm that provision of health facilities with MNCH related equipment and supplies improved their ability to treat and correct MNCH related complications in their facilities, but the results for supplies were short-lived because the supplies were discontinuous and hardly matched the needs. At the time of the End-line survey, availability of disposable supplies such as gloves, syringes and needles, intravenous kit, ANC cards, cord ligatures, and suture needles had actually declined in LDs, but had been sustained even at a higher level for some of these supplies (gloves, syringes and needles, ANC cards and cord ligatures) in NLDs.

Systematic collection of data on the number of clients served by the new equipment and through supplies provided by UNICEF was not done to ascertain the type of equipment and of supplies that were most useful, or the magnitude of the change in the number of clients served as a result of better services, even though the improvement may have been short-lived in the LDs. With such an M&E system, it would have been possible for example to track the number of pregnant women, and of children whose lives were under threat but have been sustained and improved through the services provided by the health facilities using the equipment, training, and supplies provided by UNICEF. For instance the number of surgical cases (involving women and children) that were successfully handled in theatres equipped by UNICEF could easily be tracked and reported on by type of ailment, complication and patient to demonstrate UNICEF's impact. It should be pointed out here that, as would be expected, the benefits arising from improvement in service delivery due to increased availability of functioning equipment was extended beyond women and children as data recorded by the theatre attendants at Makete district hospital showed that some of the surgical operations which took place in the newly equipped hospitals benefitted directly other categories of patients (adult men, youth, etc).

²⁰ Theatres were under construction and districts had purchased equipment in anticipation of early completion of the facilities, but completion was slow due to lack of funds.

Furthermore, in Makete and Siha, the number of MNCH patients attended to and successfully treated by dispensaries and health centres increased and this reduced frequency of referrals to district hospitals previously caused by inadequacies in the quality of service at preventive care level. In Makete, the provision of an ambulance and theatre equipment had significantly increased the number of women with birth complications, who were attended to early and whose lives were saved, thus increasing maternal and child survival.

The provision of PMTCT drugs only temporarily (but not sustainably) improved availability of drugs in health facilities, as cross-sectional data at baseline and end-line survey stages indicated a decline in availability of most of the PMTCT drugs and supplies. Regular stock-outs of drugs and supplies were reported by DMOs as a major bottleneck to PMTCT scale-up efforts.

With respect to availability of vaccines, the proportion of health facilities reporting stock out of essential vaccines had increased at End-line in both LDs and NLDs but the increase in stock outs in LDs was much less than for the NLDs.

At End-line, the proportion of trained corps who found MNCH course relevant and useful in improving their daily tasks were significantly higher in LDs than in NLDs at 71% (34/48) and 29% (14/48), respectively.

At end-line, the proportion of trained corps who found MNCH course relevant and useful in improving their daily tasks were significantly higher in LDs than in NLDs at 71% (34/48) and 29% (14/48), respectively. The indicator was not covered by the Baseline Survey.

Client satisfaction with health facility services increased in LDs especially in relation to “*appropriateness of services*” (from 90% to 100%), “*confidentiality of the service*” (92% to 100%), and “*service provider attitude*” (86% to 100%), but appeared worse for “*provision of HIV counselling on that day*” (from 90% to 80%) and more or less the same in relation to “*waiting time*” (86% to 85%), (Table 26). On the contrary, in NLDs most indicators of client satisfaction declined with the exception of “*appropriateness of services*” (which remained at 100%), and “*health provider listening to the client*” (which remained at 98% level of satisfaction). At end-line a higher proportion of clients (83% (15/18)) were aware of their next visit date in LDs than at baseline (53% (16/30)). In NLDs this indicator declined from 96% to 92%, respectively. This is corroborated by evidence from trainees at district level that the training empowered health workers with more knowledge and skills to deliver higher quality MNCH services to more people, faster, more confidently and appropriately.

Table 26: Overall percentage of clients with positive perceptions of services in visited health facilities

Indicators	LDs		NLDs	
	Baseline	End-line	Baseline	End-line
Child care: Do you intend to use the facility next time you need health services?	95% (59/62)	86% (77/89)	98% (44/45)	83% (52/63)
Child care: Did the health provider listen to your concerns with a positive attitude?	95% (59/62)	92% (82/89)	98% (44/45)	98% (62/63)
Child care: Was the waiting time acceptable?	86% (53/62)	85% (76/89)	76% (34/45)	65% (41/63)
HIV client: services provided were appropriate	90%	100%	100%	100%

Indicators	LDs		NLDs	
	Baseline	End-line	Baseline	End-line
(Overall)	(27/30)	(20/20)	(22/22)	(32/32)
HIV Client: Do you know your revisit date?	53% (16/30)	83% (15/18)	96% (21/22)	92% (24/26)
HIV Client: Have you received HIV counselling today?	90% (27/30)	80% (16/20)	100% (22/22)	78% (25/32)
Delivery: Do you think services you received were appropriate?	81% (29/35)	100% (18/18)	100% (31/31)	96% (23/24)
Delivery: Did the health provider listen to your concerns with a positive attitude?	86% (30/35)	100% (18/18)	100% (31/31)	96% (23/24)
Delivery: During delivery, did the provider ensure that you had privacy?	92% (33/36)	100% (18/18)	94% (29/31)	63% (15/24)

Source: IHI and JIMAT 2012, End-line Survey Report.

A major concern however, expressed by DMOs was the directive issued by Government in 2011 suspending allocation of resources to training activities and directing districts to commit the resources to drugs, infrastructure and equipment. Districts will not be in a position to provide further training through centrally managed funds although some residual training may continue through NGO efforts but these are at a small scale and not well coordinated. This directive can contribute to the reversal of gains made by UNICEF in enhancing staff skills especially in the wake of staff turnover that will continue and the recruitment of new staff who are not trained on topics covered by the support from UNICEF. With the rapid turnover of staff and constantly emerging medical research findings with changes in treatment regimen, absence of training could have catastrophic consequences on critical MDG indicators for health sector. This fact is made worse by the fact that the unmet demand for training remained high in LDs.

Lastly, there appeared to be a decline in availability of guidelines on OI, VCT, PAC and immunization, suggesting that training delivery and provision of national guidelines were not strongly coordinated.

5.2.1.4 PMTCT/PAIDS

The evaluation found improvements on: proportion of health facilities using national PMTCT and ART guidelines; health facilities offering the minimum package of PMTCT services for the prevention of HIV infection in infants and young children; newborn to HIV positive pregnant women who were given a dose of nevirapine, and; increased availability of PMTCT drugs in health facilities of the 7LDs. It was also reported that health workers were able to confidently attend to a larger number of customers within the minimum duration of time.

5.2.2 Basic Education and Life-skills

In the LDs all primary schools in the visited wards had been trained on whole school planning. This was not the case in NLDs. The effectiveness of training of school teachers on whole school development planning was rated highly (rating of "A" Very Effective) in all LDs. In all LDs, except Makete, there were more female trainees 466/799 (58%) than males 333/799 (42%) trained in guidance and counselling and whole school development planning.

The evaluation found the training and subsequent development and implementation of whole school development plans strengthened efforts to improve the school environments. Seventy-

five percent of schools visited in the LDs were found to have made progress towards attaining the national minimum standards for quality education as compared to 28% in the NLDs. The evaluation also found that all school plans in LDs better conform to the minimum standards for education at 100% compared to NLDs 64%. The adherence to the basic minimum standards has been contributed by existence of WECs in all wards and school inspectors at district level who are responsible for monitoring school progresses.

Participation in decision making which enhanced a sense of ownership and responsibility among students, teachers, parents and school committees increased – community financial and in-kind contribution to the implementation of school development plans that they took part in developing increased. Students were consulted and felt part of the decision-making process for the school, when they eventually saw their priorities being addressed (e.g., introduction of school meals, text books in the case of Makete).

Quality of teaching was enhanced with better planning of lessons following the syllabus, encouraged by more supervision visits through activities of WECs that were supported with relevant training and logistical resources (motor bicycles). Inspection visits became more regular and well structured. These factors improved the quality of learning taking place in the classroom, as evidenced by an increase in student completion and pass rates in some focus schools.

Resources mobilisation by some schools who used their plans to lobby and attract financial and in-kind support from well-wishers like mobile telephone companies was strengthened. **Supporting schools through the WSDP to raise resources through this type of private-public-partnership (PPP) is an innovation that needs to be scaled up.** For instance, in Hai and Magu the district councils had specific plans for all schools to have school lunches. In Makete, the initiative has been taken to other schools and most schools now know how to prepare whole school development plans and planning has enabled schools to invest in school improvements in a more systematic manner. Most schools that have been trained on whole school development planning have also managed to attend to some critical issues such as improving water and sanitation facilities.

The End-line survey findings also confirm that 93% of pre-primary teachers in the LDs were aware of age appropriate teaching and learning methods against the 68% in the NLD. Compared to the baseline study, there was substantial improvement of Early Childhood Development (ECD) teachers in terms of professionalism, delivering the services, knowledge base including age appropriate, teaching learning methods all this signifies how effective the IECD trainings have been to the LDs.

Tuseme club activities have seen both boys and girls participating and the number has been reported to be increasing more in LDs than NLDs (Page 27).

Table 27: Average number of boys and girls participating in TUSEME clubs per primary school

Gender	Temeke	Bagamoyo	Hai/Siha	Magu	Makete	Mtwara rural	Overall LDs	Mkuranga (NLDs)
Girls	6% (31/540)	3% (35/1032)	24% (175/737)	4% (34/824)	4% (14/382)	3% (17/574)	8% (329/4089)	4% (23/647)
Boys	3% (19/595)	2% (21/1022)	24% (175/722)	1% (5/856)	48% (166/348)	3% (20/652)	10% (430/4195)	4% (24/639)

5.2.3 Child Protection and Participation

Improvement in birth registration service delivery capacity at district level

On birth registration, the catch-up campaign was completed in the 7 LDs and the proportion of under-five children with birth certificates in LDs significantly increased when compared to the baseline and the increase in LDs was much larger than in NLDs.

Improvement in MVC services provision capacity at district level

The proportion of districts having regular MVC coordination meetings was found to be much higher in LDs than NLDs, largely due to financial and technical support from UNICEF. The proportion of districts with up-to-date MVC data was significantly higher in LDs than comparison districts. The main challenge was only in the electronic database as it was not accessible via internet. At the time of the evaluation, all LDs were failing to update the electronic MVC databases, although they had up-to-date manual registers.

All districts had at least remitted the MVC data once to the DMS and had received feedback at a national workshop. Remission of data was not regular due to the problems with the electronic database. Some of the DSW officers who had been trained to update the electronic database were not doing so due to limited computer literacy skills (a specific case in point was the DSWO for Makete). On a positive note, the district council was hiring a data entry clerk on a part time basis to undertake this activity.

The number of districts that verify information compiled in the MVC village registers to ensure accuracy was found to be slightly higher in LDs than NLDs. While only half of the NLDs were using the information compiled in the MVC database for planning and resource allocation purposes, 71% of the LDs were using this information. Some of the NLDs who were not finding the information very useful for planning indicated that they did not have a budget line to finance such activities, and available council resources were too small for the caseload of MVCs identified through the MVC registration exercise.

Common uses of the information in the database included determining the number of MVCs to be assisted, determining the type of assistance required, confirming gaps in current assistance packages and identifying cases that can be referred to organizations currently providing support to the MVC. Most districts (LDs and NLDs) found the MVC database extremely valuable in broadening the understanding of district technical teams on the need to cater for other needs of MVC, not just education bursaries. NGOs working in these districts were able to quickly identify children in need, the types of needs and package their interventions accordingly. The information in the MVC databases was also enabling NGOs to have a clearer division of labour among them and to complement each other, rather than duplicate their assistance to beneficiaries. In Makete the information from the MVC database enabled the district to reduce

cases of “double dipping” thus extending the scarce resources to a larger number of beneficiaries than previously.

Strengthening of child protection system at district level

Child protection teams were found only in LDs. There were no child protection teams operational in NLDs. When NLDs were asked during the Evaluation, whether they had child protection teams, considerable interest was expressed in knowing the functions of such teams and how to get support to establish the same structures in the NLDs. The fact that the new child protection system has not yet been marketed in NLDs, despite strong interest to also try these structures, was evident and this possibly leads to the question whether UNICEF cannot have “maximum intervention districts” where pilots are run in full and “limited intervention districts” where UNICEF assists interested districts in the same region to try out an innovation with limited technical inputs from UNICEF. The role of the regional offices in transferring UNICEF’s innovations and best practice models developed in LDs to NLDs becomes also central under these circumstances.

5.2.4 Policy Analysis and Advocacy

Districts have functional District M&E Teams that are continuously providing support

All 6 LDs in which DPLOs were available and interviewed had a functional DMET that had been constituted, in contrast with only 4 of the 6 NLDs interviewed. Whilst all LDs had some trained DMET members, only 2 NLDs had trained DMETs (Misungwi and Njombe, these were closer to regional centres). Among NLDs, Mkuranga and Kinondoni did not have DMETs constituted. Altogether, LDs had more DMET members trained than NLDs, at 50, compared to NLDs (only 7 officers were trained) suggesting the significant contribution UNICEF had made in this regard. What was also positive was the fact that those trained were still largely in their positions and performing their functions as DMETs. On average 6 DMETs were trained per LD, compared to 2-3 for NLDs. In all LDs, 78% (39/50) of the trained DMET members were still present in post and continuing with their activities, compared to 71% (5/7) for all NLDs.

Training of District M&E teams (DMETs) has improved the quality of reporting on budget performance

In all 6 LDs and in 4 of the 6 NLDs interviewed, mere presence of DMET improved quality of reporting on budget performance, and where it was carried out, training provided additional benefits. Advantages brought about by the training included introduction of a common reporting format across sectors, inclusion of more accurate information in progress reports, linkage of physical progress to financial progress against set targets, assessment of value-for-money by checking quality of materials, examining the procurement procedures for construction materials, checking quality of workmanship before certifying stage payments for contractors, taking pictures and keeping record of defects to be rectified.

In LDs, the MTEF has clearer indicators and targets, including for children’s issues. Departmental reports now have SMART targets against which to assess progress. DMET members were appointed from many different departments and upon return from training they strengthened M&E reporting at departmental level, thus enabling more delegation of budgeting, monitoring and reporting functions from planning department (this was a success story from Mtwara district).

In Makete district, the trained DMETs are playing the role of ToTs offering non-trained staff on-the-job training by inviting them to participate in M&E visits and report writing activities.

National research, surveys and routine monitoring systems incorporates children's indicators/issues

Availability and use of LGMD, PLANREP and sectoral systems

PLANREP was available in all LDs and non-LDs but extent of use varied, with best practice being found in Makete (LD) and Njombe and Misungwi (NLDs), and least in Siha (LD) and Moshi (NLDs). The capacity to use PLANREP varied but no significant differences were found between LDs and NLDs – indicating impact of higher level interventions that reach all districts. What was evident was the fact that in NLDs, there were problems with the equipment and PLANREP was not operational in Moshi at the time of the evaluation, for example. What was also different was the number of officers trained and able to use PLANREP and how districts were actually using the Planning Tools. In districts that had more staff trained (e.g., Hai and Makete in LDs and Njombe and Misungwi in NLDs) sector staff were preparing the budgets using the PLANREP software, and then passing on their inputs to the Planning Department for consolidation, making the process faster and shorter. For districts that were less endowed with skilled personnel, for example Moshi and Siha, sectors were preparing their budgets on other software, and print and give to the planning office to input into PLANREP and consolidate thus making the exercise slower and longer. In general LDs had more skills and had graduated from manual input to consolidation of section PLANREP data.

The village register was being used in all LDs but not in all NLDs (e.g., Njombe discontinued the use of the tool in 2005 due to high cost). LGMD was considered a useful tool in all districts and was being used though capacity for accurate data collection varied with more capacity at the lower levels being found in LDs than in NLDs.

The national web-based MVC database was not functional and therefore not accessible to all districts, it had collapsed and districts had not been properly informed by the Head Office. Capacity to use the software varied among LDs and among NLDs, with no significant differences between LDs and NLDs.

5.3 To what extent did GoT/UNICEF interventions achieve the desired behaviour change results? Which programmes had the more visible/noticeable behavioural impact at household and community level

5.3.1 Young Child Survival and Development

5.3.1.1 Nutrition and ECD

Results from the household survey showed that the proportion of mothers who breastfed their babies within the first hour of birth did not change significantly in either LDs or NLDs, and remained low at between 21-25% in LDs and 22-24% in NLDs. The percentage of children under the age of 6 months who were exclusively breastfed also remained relatively unchanged compared to the Baseline, and there was no significant difference between LDs and NLDs in terms of the proportion of children below 6 months who were exclusively breastfed. In LDs 39% (43/111) of children below 6 months of age were exclusively breastfed at Endline Survey stage

compared to 32% (66/209) at Baseline. This contrasts with 42% (58/130) and 31% (54/175), respectively, for the NLDs.

5.3.1.2 Community WASH

Water treatment

The End-line study observed that only a third of households (33% (828/2545)) in LDs and 37% (956/2619) in NLDs) boil their drinking water. The difference between LDs and NLDs was statistically significant at 95 percent confidence. **The practice differed by district with the highest prevalence of good practice being in Makete (at 15%), where water supply and PHAST appear to have combined well to significantly increase the proportion of households practicing the boiling of drinking water.** A focus group discussion with women from Lupalilo village in Makete confirmed that the boiling of water in Makete had been facilitated by the abundance of trees for fuel wood through well-established plantations in the district as well as the cold weather.

Makete was followed by Temeke (at 7%) where strong IEC accompanying cholera response may have resulted in more households practicing boiling of drinking water. Magu (at 6%) was third, and most households rely on water piped from Lake Victoria which is not fit for human consumption without treatment.

On water guard, only 6% (165/2545) of the household members in LDs and 3% (92/2619) in NLDs confirmed at End-line that they were treating their drinking water with water guard / aquatab. Compared to the Baseline situation, this had gone up in LDs from 4% at Baseline to 6% at End-line, but declined slightly in NLDs from 4% at Baseline to 3% at End-line.

Investments in improved sanitation

Generally, there was no significant improvement in the proportion of households using improved toilet facilities both in LDs and NLDs, suggesting behaviour had not changed and the investment in such infrastructure was not occurring at a rate matching the growth in population. But there was significant improvement in Makete (LD), Mtwara (LD) and Mkuranga (LND). Mkuranga had significant increase in improved toilet facilities apparently because there were many development partners working in the district on this specific issue.

With regard to the investment in improved sanitation by households, the households were asked to give reasons hindering them from investing in improved sanitation. The reasons included (1) the perception that improved sanitation was not necessary, (2) shortage of artisans, (3) non-availability of materials, and (4) lack of money to purchase the materials and skilled labour. UNICEF has been addressing (1) through education (PHAST), (2) through the training of artisans, but not (3) and (4). **This gap (especially demand creation) may need a new strategy informed by evidence on what works.**

Also, the household members were asked to explain the main factors encouraging them to invest in improved sanitation. The findings showed five main factors, namely: (1) advice by CoRPS (9% LDs, 2% NLDs); (2) encouragement by Fundi Bomba/Choo (artisans) (2% LDs in both LDs and NLDs); (3) campaign of village leaders (19% in LDs but highest in Makete (46%) followed by Temeke and Mtwara both at 22%, compared to any other LD, and 10% in NLDs); (4) to avoid penalties charged by village authorities (4% in both LD and NLDs) and (5)

existence of external support such as NGO/Government project (1% of households in LDs and 2% in NLDs) (Table 28). The contribution made by CoRPS and village governments is clearly evident in learning districts, which could go to illustrate the impact of UNICEF –funded training activities especially in Makete and Temeke districts.

Table 28: Factors encouraging investment in improved sanitation

District	Encouraged by a Fundi Bomba and Fundi Choo	Encouraged by CoRPS	Campaigns of village leaders	To avoid penalties charged by village authority	Existence of external support (NGO/GoT)
Temeke	1/185 (1%)	29/185 (16%)	41/185 (22%)	16/185 (9%)	3/185 (2%)
Bagamoyo	0	1/44 (2%)	6/44 (14%)	0	0
Hai/Siha	2/114 (2%)	0	11/114 (10%)	1/114 (1%)	0
Magu	2/41 (5%)	1/41 (2%)	5/41 (12%)	0	2/41 (5%)

Source: End-line Survey.

Environmental sanitation is a learning agenda and in some places (especially Makete, Mtwara and Temeke) WASH is being successfully institutionalized through incorporation into village by-laws.

Interviews of the village and ward executive officers from Makete, Magu, Siha districts confirmed that village governments are discussing WASH and are adequately informed about the status of WASH in their communities. They actually know how many households lack access to improved sanitation facilities in each village. In Magu the village development committees have health sub-committees whose members visit every homestead quarterly to assess the status of sanitation and hygiene issues and these visits inform the quarterly plan progress review meetings of the VDCs, thus enabling them to discuss the situation and penalties that may be required to enforce village by-laws on environmental sanitation. In Magu, given the water table which is very high, and the threat of environmental pollution, environmental sanitation issues are taken quite seriously by villagers.

The Evaluation found that in urban areas, there is a conflict of interest with politicians which undermines the authority of Village Development Committees. When a person is fined they go directly to politicians who instruct the Village Executive Officers VEOs to reverse fines to stop imposing fines on their supporters (voters). **This is an area of potential advocacy targeting politicians.**

5.3.1.3 Behaviour Change Communication

Hygiene and sanitation

With regard to the proper disposal of children's faeces into latrines, there were high proportions of households who practice correct disposal in both LDs and NLDs (76% (269/356) and (74%) (253/344), respectively) and there was no statistically significant difference between the two. However, as will be discussed further under the section on impact, improvement related to hygiene was found with regard to the proportion of households washing hands at two critical moments and washing hands with soap or ash. However there was no significant improvement on washing hands at three or 4 critical moments or on demonstrating correct and consistent dosing of water. One of the constraints mentioned was the difficulty to get water. In remote and

dry rural districts like Mtwara Rural and Tandahimba it was observed that even getting water for drinking alone is a challenge, now having water for washing hands could be an almost hard to realize dream. This is mainly because the district does not have much in terms of rainfall or well developed alternative water sources.

A lesson learnt from this experience is that water supply constraints can undermine the success of BCC efforts that seek to promote good hygiene practices in districts where the targeted households have a ready excuse (in shortage of water) for not changing their hygiene practices in as far as washing of hands at four critical moments or the use of pour flush latrine technology is concerned.

Malaria prevention and treatment

There were several national level malaria campaigns funded by other donors which also had a spill-over effect into the LDs. The catch up campaign is currently conducted nationally and it has even distributed free Insecticide Treated Nets (ITNs) in some LDs. The evaluation found improvements in the proportion of children who slept under ITNs as well as the number of women who had been pregnant and slept under an ITN in both LDs and NLDs, with no significant differences between the high intensity districts (LDs) and low intensity districts (NLDs), suggesting that the BCC interventions within LDs may not have had measurable additional benefits compared to other on-going national initiatives which also improved practices in the NLDs (Table 29).

Table 29: Behaviour change on use of ITNs

Indicator	LDs		NLDs	
	Baseline	End-line	Baseline	End-line
Children aged 0-59 months who slept under an ITN	86% (858/999)	96% (756/789)	84% (750/868)	94% (860/913)
% of women that gave birth in the last year and slept under an insecticide treated mosquito net during their last pregnancy	76% (186/244)	92% (155/169)	79% (166/209)	92% (220/238)

Source: 7LDs Strategy End-line Survey.

It is also not clear from the available evidence whether presence of PSI interventions in the LDs may have displaced other BCC activities to NLDs for equity and therefore may have been needed all the same in the LDs.

Exclusive breastfeeding

The evaluation found that some mothers of children under 5 still do not know that infants should be exclusively breastfed for 6 months with NLDs slightly better off in this regard. Some district health officials observed that myths and misconceptions concerning breastfeeding issues are rife in some of the communities. It was also found that while some health facilities are already educating mothers living with HIV on absolute breastfeeding for 6 months in line with the World Health Organization (WHO) guidelines, others are still advising them not to breastfeed. In some cases, it was noted that some mothers are unable to absolutely breastfeed for 6 months due to illness, inability to produce adequate amounts of milk to satisfy the baby, or in cases when they eventually succumb to illness and die.

Management of diarrhoea

It was found that management of diarrhoea improved as evidenced by an increase in the children who received Oral Rehydration Treatment (ORT). There were significant increases in both LDs and NLDs but with a larger increase in LDs.

New-born care

Knowledge on new-born care did not seem to significantly change in LDs when assessed through recognition of danger signs in new-borns by the mothers and caretakers. There was however a significant difference in LDs in recognition of danger signs in under-fives by the mothers and caretakers. What was also evident is that the knowledge levels on danger signs in new-borns was sustained at a very high level in both LDs and NLDs with LDs being slightly better but NLDs fast catching up. Recognition of danger signs in under-fives increased among mothers and caregivers in both LDs and NLDs but with no significant differences between LDs and NLDs.

Routine child health services

The proportion of children receiving routine child health services as evidenced through immunization rate remained high with no significant differences in coverage between LDs and NLDs despite the LDs having been covered by the End-line Survey before an immunization campaign and the NLDs after the campaign. In some communities it was reported that some misconceptions and mistrust still exist at community levels. These deter some of people from taking children for immunization. For instance, in Bagamoyo some communities had misconceptions that the vaccines were not laced with poison, and therefore did not take their children for immunization. It was noted that in some remote rural health facilities did not have electricity hence could not maintain the cold chain for vaccines. In Mtwara EPI activities were disrupted by temporary stock-outs of fuel for the cold chain during the rainy season.

Management of a sick child

The management of sick children below 5 years improved only in NLDs as evidenced by receiving early treatment from the on-set of fever from appropriate health providers. However, in the LDs, the practice deteriorated. Health workers noted that although the care givers may see the need to seek prompt health care, they lacked the means of transport to reach the health facilities. Hence in LDs which were provided with ambulances by UNICEF (e.g. Makete), this intervention (ambulance) was highly appreciated as one of the most important investments that UNICEF had ever made in contributing to maternal and child health and survival.

The Evaluation noted that in remote places within Mtwara rural and Bagamoyo, some mothers and caregivers still do not seek medical care from facilities for their sick children. This is mainly because they believe the child's illness is a result of witchcraft or evil spirits. They therefore prefer to visit witch-doctors or simply give up on the intervention.

Delivery at health facility

Ante Natal Clinic (ANC) visits among pregnant women were sustained at very high levels in both LDs and NLDs, and there was also an increase in the numbers making preparation for delivery, which was larger in LDs. The proportion of women who delivered outside a health facility in the past one year who accessed post-natal care within 2 days of giving birth, and those with infants who received 2 doses of SP during their last pregnancy also increased in the

LDs, and not in NLDs. However, the proportion of health facility deliveries and deliveries attended to by skilled health personnel remained very low in both LDs and NLDs.

It was found that there are a number of reasons why some women still deliver at home. These include: to sustain family beliefs and practices; they do not have own transport or means of travel to facilities; and more friendly service from the Traditional Birth Attendants (TBAs).

5.3.1.4 MNCH

The proportion of women who delivered outside a health facility in the previous one year who accessed PNC within 2 days of giving birth increased in LDs from 25% to 49% but declined from 42% to 35% in NLDs (Table 30).

Table 30: MNCH related behaviour

Indicator	LDs		NLDs	
	Baseline	End-line	Baseline	End-line
% of births in the year preceding the survey occurring in a health facility	68% (244/350)	58% (120/208)	76% (230/302)	79% (200/253)
% of women who delivered outside a health facility in the past one year accessing PNC within 2 days of giving birth	25% (25/99)	49% (22/45)	42% (27/64)	35% (12/55)
% of women with infants who received 2 doses of SP during their last pregnancy	32% (84/263)	45% (202/451)	43% (99/229)	40% (196/493)
% of women who had at least one antenatal care visit	99% (348/350)	99% (167/169)	99% (301/302)	98% (234/238)
% of women who made preparation for delivery (for those who gave birth in previous 12 months)	63% (221/350)	71% (120/168)	70% (210/302)	74% (175/238)

Source: IHI and JIMAT 2012, End-line Survey Report.

The proportion of women with infants who received 2 doses of SP during their last pregnancy also increased from 32% to 45% in LDs while declining from 43% to 40% in NLDs during the period of the LD intervention. Another positive outcome of the UNICEF interventions was that the proportion of women who made preparation for delivery (for those who gave birth in the previous 12 months) also increased from 63% to 71% in LDs. There was similar but lower increase in NLDs from 70-74%.

The proportion of births in the year preceding the survey occurring in a health facility declined in LDs but remained high in NLDs. Factors that inhibited an increase in LDs need to be unravelled if maternal mortality is to be more significantly reduced than at present and if UNICEF and the Ministry of Health and Child Welfare are to devise more appropriate strategies. In some health facilities (e.g., Magu district hospital) sanitation was an issue, whilst in other circumstances it was evident that delivering at the health centre was no guarantee of being attended to by a qualified health worker.

5.3.1.5 PMTCT/PAIDS

CoRPS working at community level, and health workers in facilities consistently provided education to women on PMTCT/PDAIDS. The evaluation found that there were improvements in knowledge and health seeking behaviour among pregnant women at community and

households levels. There was an increased proportion of: women aged 15-49 whose knowledge that HIV can be passed on from an HIV positive mother to her baby; women who had knowledge that exclusive breastfeeding can reduce HIV transmission, and subsequently; pregnant women who made at least one ANC visit and who have received an HIV test result and post-test counselling.

5.3.2 Basic Education and Life-skills

WSDP has been embraced by focus schools and wards, and the focus districts had begun to replicate the approach in non-focus schools, though without adequate resources to do it at scale. Some of the lessons from the excellent experience of focus schools have already been adopted by non-focus schools (e.g., school meals) as good practices. The approach engages pupils and boosts their contribution to the development of their schools thereby stimulating community contribution to projects they feel they were a part of in terms of the process of developing them.

Due to multi-stakeholder involvement in planning, comprehensive but realistic and sound plans are being produced which lead to successful learning outcomes. SDCs are preparing 3 year plans and know what activities to implement in each year. Infrastructure construction projects, especially, are now being sequenced logically and based on available budgetary resources, implemented one a time and completed on schedule. **The approach of whole school development planning has improved prioritisation of the projects as well as resource mobilisation for successful completion (one at a time).** In Hai, school infrastructure improvement projects are no longer being left half-complete with communities wanting to start another project before the previous one has been completed. This approach has been proven to work and can now be replicated through policy and relevant guidelines nationally.

It has become easier for schools to make self-evaluations of performance against what they had planned and to improve their planning and delivery. One of the main achievements mentioned by the WECs in Makete district relates to the ability of schools to clearly prioritise investments that they need to undertake to improve the quality of education. Previously schools were starting many projects (teacher's house, latrines, classroom construction) at the same time and finding it difficult to complete any of the projects due to inadequate resources. The approach of whole school development planning has improved prioritisation of the projects as well as resource mobilisation for successful completion (one at a time). Schools now plan and go step by step in addressing the identified priorities. More importantly committee members and village leaders have been sensitized and are now beginning to work together as a team. This way they are succeeding to secure more community contribution towards school improvement projects.

5.3.3 Child Protection and Participation

The new child protection system is effective in addressing children's legal cases within a short space of time. In Hai district, members of the district child protection team confirmed that the threat of being arrested and being brought before the courts is now deterring many would be perpetrators of child abuse. The number of cases of abandoned children for instance was reported to be on the decline. However, hard data on the number of children (disaggregated by gender) assisted by child protection teams or the MVC Committees (village fund) or by

Community Justice Facilitators over time by type of assistance (i.e., separating income poverty from the perpetration of violence and neglect against children) were not readily available.

Other evidence of behaviour change was the decision by Hai district authorities to close children's homes or orphanages that had been opened more for profit and failing to provide proper care to orphans and other vulnerable children. According to the progress report for the Child Protection System Strengthening Programme in Hai District, covering the 18 month period - May 2010– August 2011 – the number of children's homes had been reduced from 22 to 8, and 23 children (10 males, 13 females) out of 50 children from these children homes had been reunified with their families. Quality of services provided to children in the remaining institutions had also improved due to improved monitoring by district authorities.

HIV Prevention

Knowledge of young people about how HIV is transmitted or can be prevented either increased from low levels or remained high during the period of the intervention (Table 31). The proportion of youth who understand that HIV can be transmitted through: multiple sex partners, sharing injecting needles and blood transfusion increased in both LDs and NLDs but by a higher proportion in LDs.

Table 31: Level of youth knowledge on HIV prevention

Indicators	LDs		NLDs	
	Baseline	End-line	Baseline	End-line
Percentage of youth who can correctly identify how HIV is transmitted (prostitution)	13% (177/1343)	20% (157/786)	14% (178/1259)	17% (106/615)
Percentage of youth who can correctly identify how HIV is transmitted (sharing needles)	27% (367/1343)	38% (301/786)	22% (275/1259)	31% (194/615)
Percentage of youth who can correctly identify how HIV is transmitted (blood transfusion)	13% (176/1343)	22% (172/786)	15% (188/1259)	18% (108/615)
Percentage of targeted youth who can articulate ways to avoid HIV transmission (having just one sex partner who is not infected and who has no other partners)	83% (866/1038)	83% (655/788)	81% (761/943)	83% (512/615)
Percentage of targeted youth who can articulate ways to avoid HIV transmission (using condoms [male or female] each time they have sex)	74% (765/1038)	79% (621/788)	72% (676/934)	79% (487/615)
Percentage of youth who feel that they are NOT vulnerable to HIV infection	42% (431/1038)	49% (388/788)	41% (380/934)	(303/615) (49%)

Source: End-line Survey.

The proportion of young people who understand that HIV can be prevented by having just one sex partner who is not infected and who has no other partners remained high. The proportion of youth who understood that HIV transmission can be prevented through proper condom use increased so did the proportion of youth who feel they are not vulnerable to HIV in both LDs and NLDs, but with a higher increase in the latter. The status at End-line was not significantly different between the LDs and NLDs for the last 3 indicators. For these three indicators, the magnitude in change in NLDs was slightly faster than in LDs and by the time of the End-line

NLDs had caught up with the LDs on these indicators, and this indicates the impact of non-UNICEF interventions or interventions funded by UNICEF from the national level.

The results further illustrate the gap in knowledge among young people on their vulnerability to HIV infection as more than half of the interviewed young people thought they were not vulnerable to HIV infection.

5.4 Is there evidence to show that there are improved community based services in the 7LDs as a result of UNICEF interventions?

5.4.1 Young Child Survival and Development

5.4.1.1 Nutrition and ECD

Ninety-percent of villages in the sampled wards in learning districts had at least 2 CoRPS trained to orient caregivers of children under 3 years on ECD, compared to 67% for NLDs. The proportion of CoRPS trained on ECD was higher in LDs than NLDs, but significantly declined in both LDs and NLDs (Table 32). The decline was more pronounced in NLDs from 48% to 18% compared to 64% and 44%, respectively, in LDs.

Table 32: Training of CoRPS on ECD and home visits

Indicators	LDs		P-value	NLDs		P-value
	2009	2011		2009	2011	
	% (n/N)	% (n/N)		% (n/N)	% (n/N)	
% of corps trained on ECD	64% (43/67)	44% (33/75)	0.0161	48% (31/64)	18% (16/87)	0.0001
% of children under 3 years receiving at least 1 CoRPS visit in the last 3 months	21% (169/817)	31% (148/472)	0.0001	18% (119/676)	23% (134/574)	0.0001

Source: Baseline and End-line Surveys.

The decline in the proportion of CoRPS trained on ECD suggests that the rate of training was outpaced by attrition in CoRPS, implying that not enough training is being delivered. This is true as evidence from Magu for instance shows that training of CoRPS on ECD only reached 6% of the district's needs, yet that for health workers reached 21% to 62% of need, suggesting a possible imbalance in resource allocation.

Table 33: Capacity gaps in nutrition for health workers, Magu

Courses offered	Number in need of Training	Number Trained	Needs met (%)	Not yet covered	Unmet needs (%)
IECD for CoRPS	1,082	62	6%	1,020	94%
ENA for health workers	200	125	63%	75	38%
PI-ENA for health workers	125	20	16%	105	84%
IYCF for health workers	340	70	21%	270	79%
cIMCI for CoRPS	1,082	62	6%	1,020	94%

Source: Magu District Council, 2011.

The proportion of children under 3 years of age receiving at least 1 CoRPS visit in the last 3 months improved significantly in both learning and non-learning districts from 2009 to 2011, with a larger improvement in learning districts (Table 33).

The proportion of caregivers of children under 3 years with ECD cards also increased significantly in both learning and non-learning districts, but with a faster increase in learning districts. The increase should have been even higher had ward ToTs been provided with adequate supply of ECD cards to distribute to CoRPS for subsequent distribution to mothers and caregivers of children under 3 years.

In Mtwara and Temeke, UNICEF supplied MUAC tapes to CoRPS for use in the screening of children for severe acute malnutrition and referral to health facilities. The proportion of CoRPS equipped with MUAC tapes (found to have MUAC tapes in their possession) was in general low in both LDs and NLDs, but it was slightly higher in LDs. The proportion of CoRPS who had the tapes and showed them to research assistants was 18% in LDs and none in NLDs. Those who had but could not show them to research assistants were approximately 39% in LDs against 14% in NLDs. The data are consistent with the information on the proportion of CoRPS who reported being able to screen for SAM.

5.4.1.2 Community WASH

Village governments increasingly discussing WASH issues in their meetings

As a result of WASH promotion in the learning districts, WASH issues are increasingly featuring in meetings of village councils and although there is little difference between the LDs and NLDs in terms of including the WASH issues on the agendas of these meetings, the biggest difference is in how adequately informed the meetings are with LDs performing better on this (Table 34). Half of village governments interviewed in NLDs confirmed that they were adequately informed, compared to 83% for LDs.

In Bagamoyo, the most recent meetings discussed challenges relating to water supply were discussed. In Hai, water supply issues were discussed, especially how communities can make contribution so that they can have their own water supply schemes. They also have a Quarterly Village Health Day and they meet quarterly to discuss preparations for this day. Activities planned on the Health Day include community mobilization, cleaning of streets, weighing of babies (screening for SAM), provision of EPI services, cleaning of water sources, IEC on latrine construction with the assistance of trained artisans. In Siha, the village government interviewed had met to discuss how water will reach all households, the cleanliness of the home and community, tree planting, attributes of good homes, importance of latrines. However, the village government was focusing less on the objective of latrine construction since the majority of people now have latrines (albeit not improved).

Table 34: Village governments discussing WASH issues regularly and adequately informed

District	Village Governments Meet Regularly to Discuss WASH promotion activities	Village Governments Adequately informed on WASH
Bagamoyo	Yes	Yes
Hai	Yes	No
Siha	Yes	Yes
Magu	Yes	Yes
Mtwara	No data	No data
Makete	Yes	Yes
Temeke	Yes	Yes
LDS Overall	6/6	5/6

District	Village Governments Meet Regularly to Discuss WASH promotion activities	Village Governments Adequately informed on WASH
Mkuranga	Yes	No
Moshi rural	Yes	No
Misungwi	Yes	Yes
Tandahimba	Yes	No
Njombe	Yes	Yes
Kinondoni	Yes	Yes
NLDs Overall	5/6	3/6

Source: End-line Survey.

In Magu district, the village government that was sampled for interview had discussed the control of water pollution and set a penalty of Tsh 20,000 for people practicing high risk activities that could pollute water sources. They had also discussed sanitation, with a target of having each household own a toilet that was to be kept clean. They were also emphasizing the importance of having a clean environment in general. In Makete the focus of the discussions was on how to keep water sources clean and how to treat water for human consumption with water guard.

Since lack of water was not considered a real problem in Temeke, what the village government had discussed in most recent meetings focused on hygiene promotion and environmental cleanliness and how to mobilize community groups to address these issues.

In non-learning districts issues discussed in village government meetings were somewhat similar to those in NLDs but went further coverage water for irrigation activities in Moshi district. They also discussed environmental protection (tree planting) and gully rehabilitation. In Mkuranga, the village government had discussed water tanks needed, how to keep a hygienic environment and sanitation issues. In Misungwi, the discussion covered a much wider range of issues - tree planting, water supply and construction of improved latrines. They had resolved to (1) look for dumping place for waste, (2) secure land for cemetery (problem of land-use planning), and (3) to encourage construction of improved toilets and to put in place by-laws for environmental conservation. The fine "*mufano washeriya*" applicable if a homestead did not have a toilet facility was set at Tsh 50,000²¹ households (with 1 day grace period to pay fine and 1 week grace period to build the toilet at household level).

In Tandahimba the Malopokero village council had deliberated on encouraging people to preserve water sources, to build proper toilets and take proper care of them, since some built "but surrounded toilet holes with *makuti* (cocnut leaves) or even mosquito nets". Similarly, in Njombe the village council meetings minutes recorded the following issues: (i) decision that every house should have a toilet; (ii) every toilet should have a door and a roof; (iii) the toilet must always be in good condition (clean and usable); and (iv) every household must have a pit for the disposal of waste. In Kinondoni, there had been an exchange of experiences between the director of DAWASCO and water engineers from Kinondoni and Mwanza including funding requirements for water.

²¹ Exchange rate approximately USD1 = Tsh 1,600.

Average number of clients served by trained artisans

About 69% of WASH artisans interviewed in LDs confirmed having built toilet facilities for households in their communities during the 12 months preceding the End-line Survey, compared to 36% in NLDs and the difference was found to be statistically significant. Data on number of toilets built by artisans was not systematically kept. The average number of toilets built by trained artisan based on their recall was 19 in LDs and less at 11 in NLDs and the difference was significant. Temeke, Hai and Siha among LDs had higher numbers of clients reached by trained artisan compared to the other districts. In NLDs, Misungwi had a high number of toilets constructed by trained artisans. Some of the artisans in Siha confirmed that they had constructed latrines for schools, health centres and business persons at trading centres and institutional demand was in general higher than from villagers. The same applied to Misungwi.

Access to improved sanitation

The End-line survey confirmed that access to improved sanitation has not improved overall in the 7 learning districts as there was no significant increase, relative to the baseline) in the proportion of households with access to improved sanitation.

Unit costs for latrine construction

Data on unit costs for latrine construction were inconsistent, but generally showed higher costs in Bagamoyo and Mkuranga at between Tsh 375,000 - 1,050,000, depending on the type of latrine. In Makete latrines built at primary schools were estimated at Tsh 600,000 for boys latrine, and Hai/Siha and Magu had more or less similar costs per unit. There were no significant differences between LDs and NLDs in terms of unit costs of construction.

Perceptions on quality of workmanship of trained WASH artisans

Very few artisans were reported by Water Engineers to be doing good quality work in both LDs and NLDs, indicating an acute shortage of such cadres. In Bagamoyo the number of artisans that do good quality work was estimated at 10, in Mtwara it was estimated at 40%, whilst in Makete 10 and Njombe 12. In Temeke all 21 trained artisans were reported to be of a good workmanship. The training of artisans improved the number of those that have a good workmanship but the numbers trained were too low to meet the needs of the districts. While the target for UNICEF was to have 1 trained artisan per ward, it exceeded this target by reaching at least one artisan per village.

In relation to training of artisans for latrine construction, all VEOs and WEOs interviewed in the LDs indicated that the number of trained artisans (1 per village) was not enough and requested UNICEF to continue supporting their district authorities to train more artisans, as the number trained was too small to cater for the rising demand for improved latrines, and suggested as many as four artisans per village. In Hai the WEO indicated that a number that would be enough was one per *habab*, giving rise to a target of 22 artisans (*Fundi Choo*) per ward up, almost 4 times the revised target of 4-5 per ward (1 per village).

Regarding availability of water and sanitation promotion centres, WEOs in wards sampled from 4 LDs confirmed their existence in the ward. The 4 LDs were Hai, Siha, Temeke, and Magu. The demonstration centres were almost non-existent in NLDs where only the ward in Njombe confirmed existence of a sanitation promotion centre.

The need for more water and sanitation promotion centres was confirmed almost in every district. The reasons that were given include:

- *“Need one per village due to high dispersion of households and the high number of households in the ward, we could start with 2 centres per 2-3 villages”* (Makete).
- *“Yes because only one out of 5 Mtaas has a sanitation promotion centre yet the number of people migrating into the ward is large”* (Temeke).
- Artisans are too few so demonstration centres are needed – *“1 per ward is enough, ward is small”* (Magu);
- Each technician has own design, they are not standardized – *“we need appropriate technology for rocky terrain and high water table areas”* (Moshi);
- In order to reinforce behaviour change, *“we need models for learning, we need 8 to be located at market places, recreational centres, and shops”* (Misungwi);

Data on the cumulative total number of water and sanitation promotion centres established per ward and district were not systematically kept by District Water Engineers further suggesting the need for **UNICEF to work with district authorities to strengthen their M&E systems** for WASH interventions.

5.4.1.3 PMTCT/PAIDS

The percentage of CoRPS who received training on community PMTCT who are fully applying the new knowledge acquired was at End-line higher in LDs than NLDs, being 78% (35/45) and 71% (24/34), respectively. They were complementing MNCH health workers who were trained on PMTCT with outreach services holding dialogues with women in their homes. At the time of the evaluation, the proportion of trained CORPS who were still actively providing MTCT/PDAIDS services within the communities, was high in general although the CHMTs interviewed were of the view that the proportion may eventually come down to below 60% (e.g., in Siha district) due to lack of incentives, lack of refresher training and supervision. Women interviewed noted that those CORPS who visited them in their homes, improved their knowledge and skills in PMTCT. CORPS also provided families with education and advice to build a supportive environment for the women within their households, and raised awareness on other issues, for instance sensitising pregnant women and village leaders on Malaria prevention and treatment, importance of early ANC bookings to improve coverage of ITPT (e.g., Siha and Makete). This had reduced (in Siha) the prevalence of Malaria cases in pregnancy.

5.4.2 Basic Education and Life-skills

In LDs, 75% of schools in wards visited during the evaluation have made progress towards attaining the national minimum standards for quality education, whilst in NLDs, only 28% had achieved this. High Standard VII pass rates in Magu were reflected in the district's high ranking in the region and at national level. Yet in Makete, although all 5 primary schools in the ward visited had made some progress; only 2 had made significant progress. Reasons given for the lack of progress varied between schools but were to do with residual constraints associated with the inability of the government to recruit more teachers and retain them in the system, the low per capita grant amounts disbursed to schools by the government, high cost of the investments required at school level to significantly improve the student to classroom ratio,

access to improved sanitation, and the textbook-to-pupil ratio. Rural schools in Makete are also failing to attract trained teachers due to the poor state of teacher housing infrastructure.

In the LDs WECs are assisting school inspectors with routine supervision to ensure that schools conform to the basic minimum standards.²² Minimum standards which focus schools in the LDs set as a benchmark include: availability of qualified teachers; pupil to teacher ratios; availability and adequacy of improved sanitation; provision of school meals; improved school environmental hygiene; upholding of human rights and gender equality, and; availability of facilities like books.

Strategies which were applied to ensure that school plans conform to the standards included: training of teachers and school committees; quality assurance of planning by experts; monitoring planning techniques, and; use of inspection reports and community feedback meetings to monitor quality and implementation of the plans. About 93% of schools visited in LDs during the evaluation indicated that they were regularly inspected by WECs. All the 25 school principals visited in the NLDs also indicated that they are regularly visited by the school inspectors. The evaluation findings also confirm that 89% of LDs and 87% of NLDs utilize inspection reports to improve their school environment by conforming to basic standards.

All ward education coordinators who were assisted with motor cycles purchased by UNICEF had increased the number of school inspection visits and were now spending more time per school. Due to their more regular inspections, teachers had improved their lesson planning, and reduced teacher absenteeism. The WECs were sometimes supported with stationery but this remains a challenge for most of them. Another constraint reported was the lack of proper offices to operate from although in some wards, construction of ward government offices was on-going or had just been completed and they would be accommodated. WECs do not have capitation grants, with which to run their office, the GoT provided this funding once in 2005 but was discontinued only after one year.

Already, Makete district has begun allocating 10 litres of fuel per month to WECs from council own revenue sources. UNICEF supplied the motorcycles in May 2011 after approval of the MTEF budget, however, the district managed to allocate resources recognizing the importance of this cadre in strengthening quality of teaching in the primary schools. This is a **good practice worth documenting and replicating**. In addition, the WECs were found using their salaries to purchase stationery (bond paper).

The evaluation found that school sanitation in the LDs having far better improved, with 70% of interviewed school principals confirming this compared to 52% in NLDs. There was more reasonable support for MVC at 19% in the LDs compared to 9% in the NLDs. Furthermore, the study findings indicated that the capacity building through trainings on school planning had enhanced the monitoring skills of the LDs to ensure realization of the minimum standards.

There is an urgent need though to improve the quality of the education in schools and match the increase in enrolment with complementary investments to ensure that the schools are child-friendly. Whole school development planning is effective but works best if complementary investments in teacher education and deployment and capitation of schools continue at a

²² E2g Percentage of school that conform to agreed standards (disaggregated by standard)

higher level than presently. In Makete, as of November 2011, the per capita grant was equivalent to Tsh 44 per student implying that the primary school had to collect at least two years of per-capita grants to afford five text books for one subject.

5.4.3 Child Protection and Participation

Whilst hard evidence is scant from LDs to examine trends in child abuse or violence against children, it was possible to assess the functionality of MVC committees and CJFs at End-line Survey stage. The coverage of MVC training activities gradually faded as districts went down from district ToT to ward and village MVCCs. A larger proportion of MVCC members trained on their roles and on financial and organizational management and care taking skills in the LDs was reported to be fully applying the newly acquired skills, in contrast with only 50% in NLDs (Table 35).

Table 35: Indicators on service delivery capacity of MVC committees and CJFs

Indicator	LDs	NLDs
Number of MVCC committee members who have received at least one training in one of these areas (roles and responsibilities, financial and organizational management, data collection and management, care taking skills) and are applying the knowledge and learning gained	11/14 (79%)	9/18 (50%)
Proportion of MVC Committees that have referred children to Community Justice Facilitators in the past 6 months, 12 months, (MVC to CJF)	4/10 (40%)	10/14 (71%)
Number (and %) of children who are in the MVCCs registers who are in need of assistance but the MVCCs lack the resources or other relevant service providers to refer these children to	389/452 (86%)	959/1147 (83%)
Proportion of Community Justice Facilitators that have referred children to MVC Committees in the past 6 months, 12 months (CJF to MVC)	5/10 (50%)	3/14 (21%)

Source: (Own Source) End-line Survey Results.

It appeared a higher proportion (71%) of MVCCs had referred children to community justice facilitators in NLDs than in LDs where only 40% of the MVCCs had done this. Most of the children in the MVC register in both LDs and NLDs (86% and 83%) who are in need of assistance fail to access the support (40%). MVCCs lack the economic means to mobilize financial resources to support MVCs in their registers. The Evaluators found one exception in Magu, whereby one of the MVCCs had invested in a maize flour mill (posho mill) as an income generating project to raise financial resources for MVCs. However, there were not many examples of this type of investment in the LDs. In Makete, the District Council has created a fund “**Makete Child Education Fund**” that mobilizes resources from well-wishers to finance school bursaries for MVCs. It is a **good practice worth documenting for replication** in other districts.

5.5 To what extent did the interventions in 7LDs contribute to enhanced national policies, programmes and strategies?

The Evaluation notes that this information was less well documented within UNICEF. Documentation of learning from UNICEF’s experience in sub-national engagement for upstream influence needs more structured system for capturing the learning, analysing its

potential for upstream policy influencing and identification of strategic entry points for policy leverage. UNICEF may also need human resources whose key result areas would be to identify and document the learning and processes that UNICEF will use to influence the results. The M&E system for UNICEF should for example include indicators for learning.

Available evidence shows that UNICEF's work in nutrition and ECD has contributed significantly to enhancement of national policies, programmes and strategies (Box 1).

Box 1: 7LDs contribute to enhanced national policies, programmes and strategies

The nutrition and ECD interventions in the 7LDs contributed to enhanced national policies, programmes and strategies in the following ways:

- The ECD home-based model is an integral part of the recently developed IECD policy
- Because of their impact on children's nutrition, the interventions falling within the ENA package (including IYCF and SAM) all fall within the priority interventions in the National Nutrition Strategy, which was approved in September 2011
- The experiences of BCC for nutrition through the PSI and Black Berries supported programmes are being factored into the design of a National Social and Behavioural Change Communication Strategy
- The ENA training package, together with the IYCF training package, are expected to form the basis of a harmonized training package for in-service training of health service provider. The need for this harmonized training package came about as a result of the experiences of the 7LD approach, and specifically the need to rationalize the number of training packages in nutrition to ensure more cost-effective scale-up among health workers.
- SAM screening using MUAC has been accepted as the primary method to identify children in need of therapeutic feeding, and has been incorporated into the draft Guidelines for the Integrated Management of Acute Malnutrition.
- Experiences in working with districts to plan and budget for nutrition services were reflected in the National Guidelines for Planning and Budgeting for Nutrition for Councils that were developed in November 2011.

Source: UNICEF Nutrition.

Similar achievements were reported in other programme components: Child Protection, BELS and PAAP. In the case of CPP for example, lessons from the birth registration pilot have been taken upstream to strengthen RITA, and used to inform the streamlining of the birth registration process so as to make it less cumbersome. Lessons learnt from the child justice programme informed the design of the new child protection model which has great potential for scale-up through national policy. The success of child protection teams is likely to attract interest from other districts to establish similar structures. GoT may also decide to scale up the new child protection model through a national child protection policy and national guidelines on the creation of child protection teams, including through the new National Plan of Action for MVC, currently under development.

UNICEF's work on MVCs fed into the design of the National Costed Plan of Action for MVCs, which was launched in 2008 and whose implementation is being scaled up nationwide through the financial and technical support of other development partners (the main one being USAID) who are complementing UNICEF's work in the 7 LDs. However the transaction costs associated with developing and sustaining a volunteer MVC committee and para-social worker in every village and two CJFs in every ward are beyond what can be afforded by councils' own

revenue sources and therefore depend on central government funding which is heavily augmented by donors.

Although the mobile legal aid clinic pilot project was well implemented, and LRHC developed and published a series of guides on legal aid for children on the mobile legal aid clinic model, the main lesson learnt is that this approach is not the most appropriate for promoting children's access to legal aid. However, the approach can be a useful tool for increasing access of poor and marginalised people who lack the means to travel long distances to secure legal aid.

5.6 How effective was the integration and convergence of the four programme components?

UNICEF used two management approaches to ensure integration of programme components. The first was through the mechanism of annual planning meetings, mid-year reviews and the joint quarterly monitoring visits which were made to districts by teams comprising officials from various programme sections, the regional secretariat offices, and counterpart line ministries. The interconnectedness of sub-components was addressed through the joint planning and review meetings. For instance, the outputs of the MYR of July 2007 clearly demonstrated that linkages between components were discussed and addressed. Key issues such as how to coordinate activities of different sections within UNICEF, how to harmonise implementation approaches and how to support each other were discussed and strategies mapped (Box 2).

Box 2: Outputs of Mid-Year Review, July 2007

- ⊙ Increased understanding of the status of programme implementation and issues of common interest
- ⊙ Agreement on how Programme Sections will collaborate/support each other
- ⊙ Harmonized implementation strategies and responsibilities, and synchronized timeframes
- ⊙ Areas/issues that require management/CMT attention identified
- ⊙ Status of budget utilization, programme implementation, CAG and supplies requisitioning reviewed
- ⊙ Clearer understanding of bottlenecks to effective/efficient programming
- ⊙ Agreement on better ways to manage programme planning, budgeting, implementation, reporting and M&E
- ⊙ Agreement on planning, coordination and other operational level processes
- ⊙ Increased understanding of transition issues/hand-over from RPOs and operational issues
- ⊙ Updates and detailed discussion of issues of mutual programmatic interest
- ⊙ Staff training needs identified that will support improved programme implementation

Secondly, the office handled cross-cutting issues such as HIV and AIDS, child protection and WASH through training of a cross section of staff to effectively integrate these into their programme activities²³. Staff members from other sections were also involved when the issue being addressed by a particular section was cross-cutting, - e.g., Multi-sectoral Task Force for the VAC study and the Adolescent Pregnancy Task Force.

Conceptually, the theory of change used by UNICEF allowed for a certain level of automatic integration of programme components to be achieved. For instance the cascade model of training which capacitated ToTs at national, regional, district, ward, health facility and school levels, permitted some ToTs to receive more than one type of training within a programme component (e.g., CPP) and across programme components (e.g., YCSD, BELS, PAPP). What was missing was a specific written down strategy for promoting integration. For instance,

²³ According to the UNICEF Tanzania Mid-Year Review Report (July 2007), child participation was identified as being "*part of everyone's work and not solely the child protection sector*". The same applied to WASH whereby BELS and YCSD were encouraged to meet to "*discuss WASH in schools*". For child protection, UNICEF staff resolved to "*revitalize*" the child participation tools that were in place and that "*internal training sessions should be repeated*".

UNICEF could have targeted all CPTs with psychosocial support and life-skills training and all district IECD ToTs with child protection training because these are complementary.

Furthermore, at individual key result area level, UNICEF made efforts to integrate its portfolio. For example, nutrition, WASH and MNCH were all imbedded in the BCC work carried out in partnership with PSI. CoRPS that received training on Malaria prevention among pregnant women also received training on nutrition. The design of the BCC component was such that it allowed UNICEF to pursue a number of inter-related results across the difference sub-programme components (e.g., nutrition, maternal and child health, and WASH).

Programmatically, child protection and participation interventions, BELS and YCSD interventions were well complemented by PAAP. PAAP sought to raise the level of understanding and the priority given to children's welfare (including MVC care and support, children's access to justice, education and health services) in district planning and budgeting, although the results in terms of actual budget allocation to child protection through the MTEF remains to be realised because of budget constraints and prioritisation of tangible things.

The integration between CPP and BELS and YCSD was not strong until the introduction of the new child protection model in 2009 which expanded the level of integration to other sectors. Under the new child protection system strengthening model, for example, the involvement of the magistrates and police personnel connected the community justice facilitation system to the formal judicial system as opposed to keeping it within the social welfare system as had been the case during the previous country programme. In addition, where the district child protection teams were created, the different sectors at district level (Education, Health, Police, Judiciary, Social Welfare and Community Development) started working more closely together on child protection issues, referring cases to one another for service provision. In Hai District, the number of reported cases of children whose rights have been violated (e.g., cases of rape) has since increased and cases brought to the attention of the child protection teams are being attended to quicker than previously. Previously, cases were delayed due to the weak link between the service providers. Given the strong integration, cases brought before the courts are now being concluded more decisively, fairly and faster, and this improvement in service provision is reported in pilot districts to have become a major deterrent to potential perpetrators of violence and abuse against children.

At the community level, there is a good degree of integration between the work of MVC committees, village child protection teams, and community justice facilitators. CJFs are members of MVCCs and village and ward child protection teams, while members of the Children's Councils are also members of the District Child Protection Teams. There is also a good integration with work done by other NGOs, as NGOs are also represented in the DCPTs. CJFs are also working in close liaison with CoRPS. The role of the former in monitoring new investments in day care centres is supported with information from CoRPS whose work also involves educating mothers and caregivers on ECD. When CoRPS carryout their routine task of visiting mothers, monitoring growth of children and dialoguing with parents, they identify cases of child abuse and report these to CJFs, but this interface is not well structured, the role for the CoRPS in the child protection needs to be worked out. Data on children's cases handled by this referral system was also not being systematically recorded for M&E purposes and this needs to be addressed.

In Hai District, children targeted under the child participation sub-component are also resource persons for the community radio programme. Some of the members of the Junior Council in Hai District were producers and presenters of child protection programmes on the community radio. These junior council members were defining the problems, the causes, effects and recommendations, and then packaging these into messages for the communities to be aired through the radio. Some of the child abuse cases were being reported to the junior council members and these would in turn report to the CJFs, Ward or Village Leaders, or district child

protection team members. Junior councils were also found to be playing an important role in following up the children to ensure that they were safe, and if they were going to school. Any child of school going age who was found not attending school would be reported to the ward community development officers²⁴. These ward community development officers are members of ward CPTs and serve the role of secretary. They also attend cases in the ward tribunal. The WCDOs received training on ECD which shows some integration between YCSD and CPP. However the WCDOs are not in every ward, thus limiting this opportunity for integration of ECD with child protection.

By design, the training of WASH artisans was supposed to be complemented by the BCC through PSI. However, the delay in launching PSI activities on the ground meant that synchronisation with training of artisans and establishment of water and sanitation promotions centres could not be achieved until much later in the course of implementation of the country programme. Within the WASH component there was no evidence of strong linkage between sub-components, for example, between hygiene promotion and water supply, especially as the activities of WUGs were not always involving sanitation and hygiene promotion as well (Table 36).

Table 36: Extent of UNICEF programme convergence at target group level

Question	Water artisans involved in hygiene and sanitation projects?	WUGs promoting hygiene and sanitation?	MTEF budget for WASH promotion centres?	CoRPS involved in water projects?	DWE aware of Child Development Policy (CDP)?	Does CDP influence planning/resource allocations to children's priorities?
Bagamoyo	No	No	No	Yes	Not aware	No
Mkuranga	Used to repair water taps	Yes	No	Yes	Not aware	No
Hai/Siha	No	No data	No	Yes	Yes	No
Moshi rural	No	No data	No	Yes	Yes	No
Magu	No	No data	No	Yes	Yes	No
Misungwi	No	No data	No	No	Yes	No
Mtwara rural	Yes	Yes	No	Yes	Yes	No
Tandahimba	No	Not involved, still new	No	No	Not aware	No
Makete	Some were involved	Were involved via Rufiji Water Basin	No	No data	Yes	No
Njombe	No	Not involved, katiba does not allow	No	Yes	No	No
Temeke	Yes	Yes	No	No	Not aware	No idea
Kinondoni	No	No data	No	No	No	No

Notes: Shaded districts are the non-intervention sites.

With the exception of Mtwara, Makete and Temeke water artisans in LDs were not involved in promotion of good hygiene and sanitation which should be expected from an integrated programme. At the community level, there appeared to be a good degree of integration between the work of water user groups and CoRPS who complement these by raising awareness to community members on importance of good hygiene practices, such as washing of hands at critical moments, and treatment of drinking water.

²⁴ Similar findings were highlighted in the Appraisal of the Functioning of Children's Councils report.

6 EFFICIENCY OF THE 7 LDS STRATEGY

This section discusses efficiency from both cost-effectiveness and speed of implementation points of view. It analyses available evidence to inform four main questions, namely: a) the extent to which programme management (human and financial resources, supplies, etc) and delivery were cost-effective; more specifically, whether it led to the best results at the cheapest cost; b) How efficient the coordination in fund disbursement and reporting was at national and district levels; c) Whether the use of national systems contributed to, or hindered the achievement of the objectives and results; d) Whether and to what extent the 7 LDs field monitoring system did ensure quality programme delivery?

Overall assessment

Overall, using the OECD 4-point rating scale of A=Very Good, B=Good, C=Some Problems and D=Major Problems, the Evaluation rates Efficiency of the 7 LDs Strategy as having been a “B” Good, noting: (a) the improvement in fund disbursement from UNICEF to the Exchequer, but residual constraints being delays from the Exchequer to the district council accounts and accounting for the funds by district councils; (b) generally good ratings for all trainings delivered except a few that need to be improved (this is UNICEF’s main delivery method); c) some mixed results with equipment delivery; d) shortage of staff within UNICEF and greater focus on upstream engagement at the cost of closer supervision of district activities and coordination with other actors; and e) delayed design of the 7LDs Strategy and inadequate staff resources at the beginning of the programme to fully develop some elements of the 7 LDs Strategy (WASH, child protection). The Evaluators particularly note the gaps in the M&E system.

6.1 To what extent was the programme management (human and financial resources, supplies, etc) and delivery cost-effective? Did it lead to the best results at the cheapest cost?

Overall, data on costs of UNICEF interventions was not easily available from UNICEF or learning districts for the full range of courses delivered at the district level, nor was it possible to get it in one document collated. The Evaluators used data compiled by Magu District and other training activity reports from other districts to draw comparisons across the various UNICEF thematic areas. A general conclusion made from the analysis is that courses aimed at national and district ToTs absorbed more resources and were better funded, with trainees enjoying subsistence allowances whilst those targeting community members were not well funded, resulting in a “funnel shape” of resource allocation, with more resources being concentrated at the top in institution-based residential courses as opposed to community level trainings. Some of the interventions, for example, in MNCH and nutrition were more complex and required 2-3 week residential course arrangement off-duty station and therefore requiring more investment per trainee. Costs were managed by reducing the duration of the courses and by holding the trainings at local venues either at the district centre or at ward or village government offices and schools. Actual costs per trainee per day for various interventions are presented in the sections below starting with YCSD.

6.1.1 Young Child Survival and Development

Nutrition

The unit costs of providing training on nutrition varied by type of training (Figure 2). Actual cost data for the period 2007 – 2011 from Magu District, showed that the community-oriented 1 day courses (training on SAM for community health workers conducted in 2009) were the least costly, at US\$9-\$10 per trainee and were in fact the lowest in comparison to all the other

YCSD- related trainings. ENA 1 offered in 2009 was the most expensive course at US\$62 per trainee. This was a 5-day course targeting COs, Nurses and AMOs. A 10-day IMCI case management course targeted at nurses and COs was the next most expensive at US\$48 per trainee, with training on how to resuscitate a baby coming closely third at US\$47.

District assemblies tried to mitigate costs by shortening the duration of training and by using council halls as venues for the trainings. This helped in reducing costs. However, an assessment by the CHMT from both Hai and Magu districts showed that shortening the duration of the courses was not always in the interest of programme effectiveness. For instance, the 4-day ENA course and the 1-day course on screening for SAM were found to be too short for the content that was aimed to be delivered.

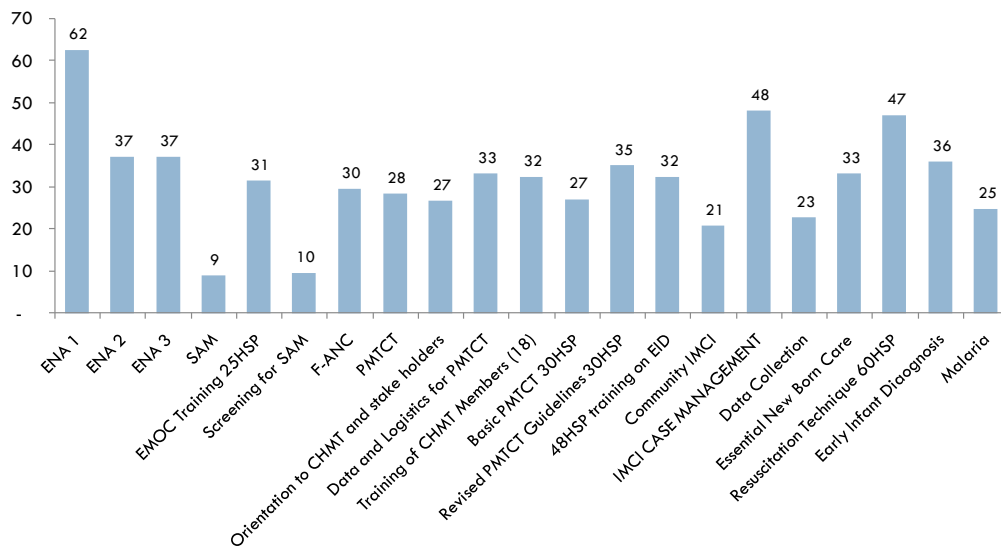


Figure 5: Unit costs of various YCSD courses in Magu, 2007-2011

Source: End-line Survey, Training Data from RCH Coordinator, Magu District.

While the data on suitable comparators at district level was not available, experience from elsewhere does show that the cost of training on SAM screening is comparable to those of mass media nutrition education campaigns and the promotion of breastfeeding which cost about \$1 - \$5 per beneficiary.

BCC

The cost per beneficiary of communicating BCC messages by type of message, channel and type of audience could not be calculated because of lack of data on beneficiary reach. The project proposal did not specify the population to be reached with BCC messages in the 7LDs. However, it is positive to note that the PCA with PSI included a cost-sharing arrangement whereby UNICEF and PSI would jointly contribute financial resources to the interventions with the grantee contributing 27% (US\$331,848) of the total resource requirements of the project whilst UNICEF was to contribute 83% (US\$1,000,262). The budget estimate also showed that project support costs were only 10%, indicating low cost of transfer, or high delivery efficiency.

MNCH

Unit costs for MNCH training were comparable to those for other interventions funded by UNICEF under YCSD (Figure 5). Most of the MNCH courses were residential courses and therefore more expensive than community level courses which were not residential. For instance community IMCI training was delivered at an average unit cost of US\$21 per trainee

per day when compared to the 13-day residential course on Basic EmOC which was provided at a cost of US\$31 per trainee per day. Most of the MNCH training courses were in the range of US\$30-US\$40 per trainee per day and the highest cost was for IMCI Case Management at US\$48 per trainee per day. The unit costs were comparable to costs for other components (CPP and BELS) within UNICEF and for courses funded through TACAIDS.

PMTCT

For PMTCT unit costs for training ranged from US\$27 to US\$33 for training on data and logistics. The costs compare well with other unit costs for trainings conducted across YCSD as shown in Figure 5.

WASH

The cost data on hand washing facilities at 10 schools in Magu district indicates that the unit cost for these facilities averaged USD455 per school, and their existence had enabled pupils to wash their hands after using the toilets. In addition, cost data on 6 latrines constructed at 6 schools and 10 latrines constructed at fish markets in Magu district also shows an average unit cost of USD 2,842 per latrine or 8 times the cost reported by artisans for household latrine structures. Information on the catchment population using the latrines was not readily available to assess the cost per user. Training of Trainers targeting 24 teachers from 12 primary schools on sensitisation of pupils on hand-washing after using the toilet was at a cost of USD155 per ToT graduate, or USD0.46 per trainee including all the students reached by the sensitisation programme (Table 37).

Table 37: Training costs per trainee for various WASH training courses, Magu District 2007-2011

No	Name of course (year)	Trainees	Year	Number	Cost per trainee (USD)
1	Sensitization of school pupils on hand washing after attending toilets at 12 primary schools	Teachers, pupils	2009/10	7,595	0.46
2	2 Day orientation to 400 CORPS on emergency preparedness and control of cholera	CORPS	2010/11	400	24
3	Orientation meeting to food vendors in 27 wards	Food Vendors	2010/11	150	13
4	One-day orientation training to school health teachers from 10 Child Friendly Schools and training of 2 primary teachers (head teachers and health teachers) from 188 primary schools and 27 ward education coordinators on washing hands with soap	School Health Teachers, Head Teachers, WECs	2010/11	407	30

Source: Magu District, 2011. A brief report on UNICEF supported programme presented to UNICEF Country Representative for Tanzania Her Excellence Dorothy Rozga during her visit to Magu district Council in Mwanza Region 23rd – 26th May 2011.

Notes: (1) Nat= National, (2) Exchange rate is USD1=Tsh 1,600.

Compared to other trainings, the WASH trainings were generally cost efficient, especially when considering the results achieved at school level versus the resources invested per child.

WASH trainings in Magu also benefitted a wide variety of stakeholders, and offered a good example of good integration between the whole school planning interventions and WASH.

6.1.2 Child Protection

MVC and Child Protection System

The total cost per trainee for CPP interventions ranged from US\$22.60 to US\$202.98 indicating the skewed distribution of costs in favour of officers at district level who were trained on their roles and responsibilities (Table 38) and less going to community level trainings. In terms of unit costs the costs compared favourably with trainings in the YCSD and PAAP components as well as similar community level trainings in Tanzania and the Southern African Region²⁵.

Table 38: Training costs per trainee for various CPP courses, Magu District, 2007-2011

No	Name of course (year)	Duration (days)	Participants		Number of Facilitators			Cost per trainee (USD)	Cost per trainee per day (USD)
			Male	Female	Nat	Regional	Local		
1	MVCC Roles and Responsibilities (FY 2007/2008)	3 days	88	20	-	-	30	57.01	19.00
2	MVC Roles and Responsibilities (FY 2009/2010)	3 days	128	112	-	-	2	22.60	7.53
3	Police, Magistrates, DCPT (FY 2010/2011)	3 days	92	26	2	-	-	98.20	32.73
4	MVCC and CPT Roles and Responsibilities (FY 2010/2011)	9 days	73	47	-	-	9	52.66	5.85
6	District Trainers on Manual for CJF (FY 2010/2011)	7 days	13	9	2	-	-	202.98	29.00

Source: Magu District, Information on UNICEF Funded Trainings.

Notes: Nat= National

HIV Prevention

An analysis of the unit costs of training CHACs, CMACs, WMACs and VMACs on their roles and responsibilities shows that, in Magu district²⁶, they ranged from US\$5 to US\$38 per trainee per day with much less being spent per trainee at the village level than at ward and district levels (Table 39). The cost intensity appeared to be at the district level where senior officials were trained as trainers and this pattern was consistent with findings on trainings for other components. The cost per trainee (total) was high for orientation training on the National HIV and AIDS Strategy and for CMAC at US\$149 and US\$190 per person, respectively but was less than the US\$202 per trainee for District Trainers on the Manual for CJF. Considering that these were residential courses for 3-4 days, however, and the multiplier effect of the ToT approach, especially with second and third generation trainings they provide at the ward and village level, the costs were not prohibitive. In addition, unit costs for ward level trainings were comparable to the same achieved by courses funded by other programmes (e.g., TACAIDS).

²⁵ A 2010 Evaluation of the UNICEF/Government of Zimbabwe Programme of Support for the National Plan for Orphans and Other Vulnerable Children found training costs within the same range for child protection interventions (Jones et al, 2010).

²⁶ Magu district is the only district which provided unit cost information. Data on costs of the trainings was not captured into a central database to facilitate analysis.

Table 39: Unit costs of orientation trainings on the National HIV prevention Strategy and Multi-Sectoral AIDS Committees at village and ward levels

Name of course	Date delivered	Venue	Duration (days)	Number of participants			Original Target	Number of Facilitators			Total Cost (Tsh)	Cost per trainee (USD)	Cost per trainee per day (USD)	Source of Funds
				Male	Female	Total		National	Regional	Local				
Orientation on National HIV Prevention Strategy	15-18 June 2010	TRC Conference Hall	4	29	10	39	Preparation of District HIV/AIDS Prevention Strategy 2010 – 2012 Magu District	1	0	2	9,075,000	145	36	UNICEF
	28-31 December 2010	In the respective Ward	4	80	50	130	Orientation on National HIV/AIDS Prevention Strategy and Development of Action Plans for 2010/2011	1	0	20	10,890,000	52	13	UNICEF
CMAC (roles and responsibilities)	05-09 April 2010	Magu District Conference Hall	5	17	8	25	To conduct 5 days training to 25 CMAC members	0	0	4	7,605,000	190	38	UNICEF
WMAC (Roles and Responsibilities)	20-23 December 2010	In the respective Ward	3	80	50	130	To Re- orientate CMAC, WMAC on their roles and responsibilities	1	0	23	7,940,000	38	13	UNICEF
	24-28 May 2011	In the respective Ward	3	216	135	351	To Re- orientate CMAC, WMAC on their roles and responsibilities	0	0	14	18,363,880	33	11	TACAIDS
	07-11 November 2011	In the respective Ward	5	32	20	52	To Re- orientate CMAC, WMAC on their roles and responsibilities	0	0		5,617,600	68	14	TACAIDS
VMAC (Roles and Responsibilities)	07-09 May 2009	In the respective Village	3	496	248	744	To Orientate 31 VMACs on their roles and responsibilities	0	0	10	16,928,000	14	5	TACAIDS

For Junior Councils, the district-level trainings which were carried out mostly for the leaders were higher than those conducted at ward level for members (Table 40).

Table 40: Unit costs of training Junior Councils at district and sub-district levels

Date delivered	Venue	Duration (days)	Number of participants			Original Target	Number of Facilitators			Total Cost (Tsh)	Cost per trainee (USD)	Cost per trainee per day (USD)	Source of Funds
			Male	Female	Total		National	Regional	Local				
21-27 October 2009	In the respective Ward	1	540	540	1,080	Formation of Ward Junior Councils	1	0	8	19,845,000	11	11	UNICEF
12-Nov-09	Macheta Conference Hall	1	27	27	54	To facilitate election of District Junior Leaders	0	0	2	1,741,000	20	20	UNICEF
16-19 March 2010	In the respective Ward	4	540	540	1,080	To conduct supportive supervision of Junior Councils	0	0	3	8,640,000	5	1	UNICEF
24-26 February 2010	Macheta Conference Hall	3	27	27	54	To conduct training to Junior Councils leaders	0	0	2	4,120,000	48	16	UNICEF
15-19 July 2010	TRC Conference Hall	3	5	5	10	To carryout workshop for junior council leaders	0	0	3	2,500,000	156	52	UNICEF
07-08 October 2010	In the respective Ward	1	320	280	600	To support ward junior councils meetings in 10 wards in order to empower children for their rights and Make them functional	0	0	10	5,040,000	5	5	UNICEF
01-14 December 2010	In the respective Ward	1	110	90	200	Child Participation tool kit training for guardians from 10 wards	1	0	10	5,200,000	16	16	UNICEF
3-Jan-11	In the respective Ward	1	320	280	600	To support ward junior councils meetings in 10 wards in order to empower children for their rights and Make them functional	0	0	20	5,200,000	5	5	UNICEF
25-29 March 2011	In the respective Ward	1	320	280	600	To support ward junior councils meetings in 10 wards in order to empower children for their rights and Make them functional	0	0	10	5,200,000	5	5	UNICEF
18-20 July 2011	In the respective Ward	1	320	280	600	To support ward junior councils meetings in 10 wards in order to empower children for their rights and Make them functional	0	0	10	5,200,000	5	5	UNICEF

Source: Magu District, Information on Training Activities.

6.1.3 BELS

Whole School Development Plan

In Magu district (the only district to provide the Evaluation Mission comprehensive data on trainings), the cost per trainee for whole school development planning (various topics) ranged from US\$100.15 for the piloting and review of inspection guidelines to US\$220.00 for WECs on Inspection Guidelines (see Appendix 1). District level residential courses were generally more expensive than those offered at community level²⁷. The cost per trainee per day was lowest for school committees at US\$19.58 followed by pupils at US\$29.68 (or US\$148.49 per trainee in total). The cost for training district education officials on the care and support strategy averaged US\$128.75 per individual (US\$42.92 per trainee per day).

In general, the cost of whole school planning per trainee per day was much lower than for training on pre-primary curriculum to education stakeholders which was about US\$300 per trainee. It was comparable to the cost of various YCSD-related trainings.

PAAP

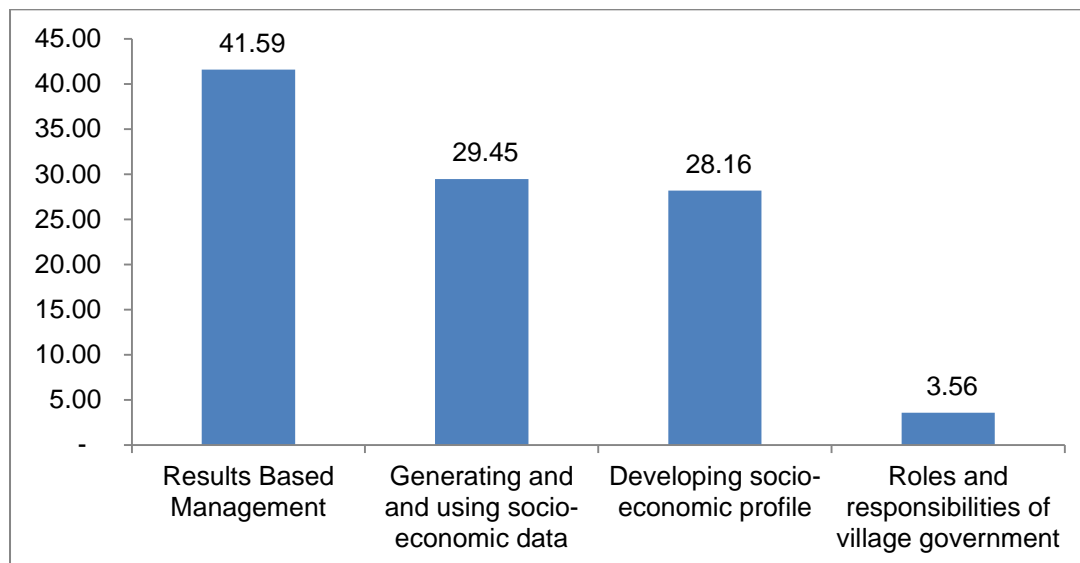


Figure 6: Cost per trainee per day, PAAP Courses Magu (\$)

Source: Magu District, Information on Training Activities.

Unit costs of trainings on policy advocacy and analysis in Magu District indicate that the course on RBM was the highest (US\$41.59 per trainee per day), followed by that on generating and using socio-economic data (29.45) (Figure 6). Third placed was developing socio-economic profiles (US\$28.16) and the lowest unit cost was for training of village governments on their roles and responsibilities (US\$3.56). The findings are consistent with observations made in other thematic areas where district level courses were in general delivered at a higher cost per trainee than community level courses. The cost of the PAAP district level courses were also consistent with costs of other UNICEF-funded training courses delivered to district professionals.

²⁷ This low cost of training was mainly because schools were used as training venues and per diem allowances paid were based on school rates which are lower than GoT rates.

6.2 How efficient was the coordination in fund disbursement and reporting at national and district levels?

Learning districts appreciated the joint planning and review meetings held together with UNICEF. According to the district treasurer for Makete for instance, what they particularly valued was the fact that interventions to be funded by UNICEF were discussed and agreed upon prior to the finalisation of their annual MTEFs and once agreed there was relative “certainty that UNICEF would release the funds”²⁸. All LDs indicated that UNICEF did not impose interventions, but respected the priorities identified from the grassroots using the “O” and “OD” process, and as long as they were in line with UNICEF’s mandate and resource envelope they would be financed. The DSWO for Hai emphasized that the district had strong ownership of the objectives of the child protection interventions, including reducing prevalence of child abuse, neglect and violence against children, improving the quality of care for children in institutions, reducing the number of children’s homes from 22 to 7, and promoting the reunification of children in children’s homes with their families.

LDs also indicated their flexibility to include activities which UNICEF officers proposed, noting that this was important for the districts to receive UNICEF funding. An internal review conducted in 2009 by the PM&E, analysing the level of engagement between UNICEF, LDs and institutions contracted by UNICEF through PCAs, revealed that there was stronger engagement and leveraging on interventions implemented through PCAs than those through district plans and MTEFs. Learning districts had stronger leadership and ownership of the priority setting process, which in the case of Siha and Makete districts, was also informed by sound problem analysis – through baseline socio-economic profiles (conducted jointly with the national statistical agency, and in keeping with the Paris Declaration principles on aid effectiveness). However, the trade-off was at times in the lack of programme focus, with the bottom-up process coming up with too many priorities for the limited funding available²⁹.

In terms of timeliness of requests and disbursements, data from the PM&E Section of UNICEF reveals significant challenges in previous strategy periods and also in the early part of the 2007-2010 strategy, largely due to delays in disbursement of funds to district bank accounts by the Exchequer and delays in reporting for the funds received by district councils. Some LDs (Hai, Makete) reported that it took the Exchequer at times one month to disburse the funds to district accounts, from the date UNICEF had transferred the funds to the Exchequer. An adverse consequence of these delays was the shortening of the window period for implementation and reporting. In 2009, districts had between 84 – 155 days, on average, to implement and report on funds from the date of cash transfer. However, reporting significantly improved with time.

Despite the delays in disbursement of funds from the Exchequer, when compared to other development funds channelled through district councils, all LDs confirmed that UNICEF outperformed all other funds (e.g., Health Basket Fund, Local Government Capital Development Grant, Rural Water Supply and Sanitation Fund, Road Fund, etc) both in terms of timeliness and reliability of disbursements. This was despite the fact that UNICEF did not always disburse the full portion of the development budget earmarked to it for funding. For instance, LDs in 2008-09 allocated to UNICEF 27% of district development budget in MTEF and UNICEF actually disbursed only 17% of the LD development budget³⁰.

NGOs jointly planned and budgeted for their interventions with district assemblies, but did not channel their funds through district council accounts. They implemented child protection activities using a parallel financial management system to that of council.

²⁸ Interview of Dennis Mwaitete, District Treasurer (Acting DED) for Makete District, December, 2011.

²⁹ Interview of District Executive Director, Siha District, November 2011.

³⁰ Analysis done by Abheet Solomon, Head, UNICEF PM&E, 2009.

Regular reviews of the challenges affecting disbursement and reporting processes enabled UNICEF to identify critical bottlenecks and strategies to resolve them. UNICEF significantly improved internal processing of FACE requests. To speed up disbursement from Exchequer to district councils, UNICEF also provided the councils (through PMO-RALG regional offices) with the notification of transfer (release letter) to enable them to follow-up with the Exchequer. The Evaluation finds this strategy effective in that it “shortened” disbursement delays.

Once funds were received by the district councils, implementation and resource absorption was in general efficiently carried out. Some districts, such as Hai, pre-financed some of the trainings from their own resources once UNICEF had confirmed release of funds to the Exchequer. In Temeke, Evaluators learnt that activities were immediately implemented, as allowances paid to trainers and trainees also acted as an incentive for faster implementation. For some programme components, delays in implementation reported in some districts (e.g., Siha) were to do with problems in securing availability of national level trainers, who appeared overwhelmed by the high demand for training from several districts (both learning and non-learning).

Financial reporting was a challenge for most districts as it added an extra reporting burden on already resource constrained districts. Disbursements from UNICEF were consolidated for all programme components (YCSD, BELS, PAAP and CPP), and financial reporting also needed to be consolidated at district level. The main issue was that for components with fewer activities that could be completed early there was no real incentive for faster reporting since they had to wait till all other components had completed their activities and the respective financial reports to be able to submit a consolidated report to UNICEF to trigger release of more funding for the subsequent quarter. The rule of the lowest common denominator thus applied, with the slowest programmes determining the pace. In a number of districts, activities under YCSD constituted the largest share of resources disbursed to LDs and determined the pace of implementation and reporting.

6.3 Did the use of national systems contribute to, or hinder the achievement of the objectives and results?

Implementation of activities was largely within the framework of national systems. For example the cascade model of training adopted for CPP, nutrition and ECD interventions, relied on government line ministry staff, mostly district health and social welfare officers and community development officers from the Ministry of Health and Social Welfare (MoHSW), and the Ministry of Community Development, Gender and Children. National trainers offered the initial rounds of CPP training at district level, after which the district ToTs cascaded the trainings to sub-district cadres (e.g., ward and village child protection teams and community justice facilitators). In general, the quality of facilitation of CPP-related training from both national and district facilitators, and the effectiveness of training (measured by extent to which the new knowledge and skills were being applied by trainees in their day-to-day work) was highly rated (A or B). For example in Magu, the quality of facilitation of training workshops on ECD and ENA by national and district facilitators was rated “*very good*” (or “A”), while that for IYCF was good (or “B”). Furthermore, the training on child protection provided to district child protection teams was highly appreciated and trainees recommended that the same be provided to the entire technical team at the district level. For MNCH interventions, the use of existing health facilities in districts facilitated reach of more remote locations resulting in reduced implementation costs as no parallel structures were created.

In contrast, BCC interventions under PSI were implemented through NGOs with partial involvement of the national system (only limited to preparing training materials, packaging the messages and development of quality assurance guidelines).

6.4 To what extent did the 7LDs field monitoring system ensure quality programme delivery?

In terms of the general approach to monitoring and supervision, UNICEF organised Quarterly Field Monitoring Visits which were conducted by at least one member from each Section (YCSD, BELS, CPP, PAAP, and RR) and members of the Council Monitoring and Evaluation Team. UNICEF also invited the PMO-RALG Regional Secretariat staff to participate. This strategy worked well in noting achievements and challenges and in coming up with joint solutions.

The quarterly monitoring visits were complemented by field visits organised by individual sections either to support implementation of activities (e.g., training) or attend to other needs or requests from the LDs. However, within the WASH section more specifically, staffing was a constraint and therefore field monitoring was irregular. This was not helped in any way by weak district M&E capacities for WASH in general. In Siha district, the CHMT highlighted three main issues that were not addressed in so far as WASH M&E was concerned:

“There was no monitoring, and no impact assessment. Funds were not enough for follow-up. There were no M&E tools for WASH at district level” (CHMT, Siha District, November 2011).

The Evaluation finds that the quantity of field monitoring visits was inadequate and uneven against the office target of at least one visit per quarter per section per district. The quality of field monitoring was also uneven across the UNICEF Programme Components. All components were not covered. Mostly junior officers as opposed to section heads participated in the joint reviews; section heads travelled to districts mostly on joint visits with the Representative, but these were few. An internal review of the monitoring system carried out by the PM&E section in 2009 also noted gaps in the monitoring of the interventions covered by PCAs, and in systematic follow-up of action points.

In the most cases (for example CPP and WASH), the quantity of monitoring visits was severely curtailed by a critical shortage of staff. Staffing of the CPP and WASH Sections improved towards the end of the country programme (2009-2010). The expansive geographic coverage of the intervention districts spread too thinly the staff resources available for monitoring.

The Evaluation found that in some districts (e.g., Magu) NGOs staff had more regular visits to the LDs than UNICEF staff. For CPP in particular, UNICEF was severely constrained in terms of staff capacity to monitor the programme, until the staffing situation improved in 2010. It appeared proximity of NGO staff, through local office presence in the district, contributed to enhanced oversight and district engagement, though the Evaluation did not compare the outcomes of these in terms of quality of activities. In Makete, the capacity for monitoring activities was limited by challenges imposed by shortage of staff/M&E skills, mountainous terrain and shortage of logistical equipment and UNICEF support through the provision of training and cars for CMET activities greatly strengthened their monitoring roles. In Hai, the DSWO also indicated the lack of a vehicle dedicated to child protection as having been one of the most severe constraints hampering monitoring.

In all districts, there was little or no follow-up or supervision of trainees. This features across all UNICEF areas of programming.

The 7 LDs Strategy was particularly weak in that it lacked a routine output monitoring system. Systematic compilation of information on trainings (who was trained, by whom, where, when, which course and at what cost) was missing, neither was there course evaluation. Activity reports were produced more for expenditure tracking as opposed to output tracking, and evaluation of programme effectiveness. There was no central database on trainees, which consolidated information from all programmes, and all LDs. This made it impossible at the time of the Evaluation to quantify outputs in aggregate terms. Although Magu District was able to provide the evaluators data on various training programmes, other districts found the task of compiling such information, too onerous, or impossible since the activity reports had not been systematically filed, and some could not be found. The task was made more difficult if the respective focal person who managed the particular training was not available (either moved on to another district or was on leave).

For WASH and Child Protection and Participation, a major gap was absence of baseline information, to enable analysis of trends, for example in the number of cases reported to the DSWO, DCPT, WCPT or VCPT or Community Justice Facilitators or the number of clients attended to by trained artisans (for example).

Another shortcoming with the monitoring system used by the district authorities and UNICEF is that activity reports did not have a common structure to be followed, neither was there systematic capturing of gender disaggregated data on trainees across all programme components. Some activity reports captured the total number of trainees only while others went further to disaggregate by gender.

Like other districts, the LDs prepared and submitted Quarterly Progress Reports (covering all activities) to the Regional Secretariats. District Consultative Committee and Regional Consultative Committee Meetings were used as fora to engage Regional Secretariat to discuss fund management and follow-up of issues. District councils made presentations to Quarterly Regional Consultative Meetings. Quarterly monitoring and oversight visits from the Regional Secretariat were funded by government and other development partners (e.g., RHMT funded through Health Basket Fund) with no specific budget provision from UNICEF. The consequence was insufficient attention was given to some of the UNICEF interventions, because the RHMT covered all activities but focused mainly on health facility based services. Community level trainings targeting CoRPS for instance did not receive fair attention in monitoring exercises commissioned at the Regional Secretariat level.

The lack of UNICEF resources at regional level to support RMET activities somewhat disempowered RMET (there was an initial expectation to receive daily assistance allowances from LDs for monitoring UNICEF activities which resulted in a conflict of interest scenario). Active participation of cadres at Regional Secretariat level varied. For CPP the Social Welfare Officer stationed at Regional Secretariat level was missing, yet this cadre could be an important conduit for taking the child protection agenda to the regional level. On the other hand, active participation of the Regional Water Engineer stationed at Regional Secretariat level was visible for large new infrastructure projects at district level but not so for community level WASH activities, especially those of a software nature.

Finally, the Regional Secretariat M&E team was not a mechanism for holding districts to account for non-performance, but were designed as a mechanism for providing “supportive” supervision.

7 IMPACT OF THE 7 LDS STRATEGY

This Chapter presents evidence on the contribution that UNICEF has made toward changing positively key indicators of behaviour change (outcomes) and child well-being (impacts) in the 7 LDs. The Chapter answers the question whether the 7 LD strategies improved child well-being in the 7LDs, and whether there are any significant differences in child well-being³¹ between learning and non-learning districts? As data on impacts was not readily available, the evidence presented here is not confined to impact (in its strictest definition) in terms of quality of life of women and children and their caregivers, such as nutritional status, diarrhoea disease prevalence, empowerment, self-esteem, and mortality but covers also the contribution UNICEF has made towards outcomes at behaviour change level or access to, and use of basic and quality services which could be considered proxies for impact. How UNICEF contributes to access to services and behaviour change has an impact on nutrition, disease prevalence and other indicators of child and maternal well-being. We present results of the difference in difference analysis for all household level variables that are relevant for the above.

Overall assessment

Overall, using the OECD 4-point rating scale of A=Very Good, B=Good, C=Some Problems and D=Major Problems, the Evaluation rates the “Impact” of the 7 LDs Strategy as having been **between a “B” Good and a “C” Some problems** with more inclination towards a C but with some evidence of very strong and positive results in some critical child poverty and well-being indicators that have been positively influenced by BELS (especially whole school development planning, TGEI and Life-skills Education), the new CP system (especially through the work of child protection teams), nutrition, WASH (especially the experience of Makete and Temeke) and PAAP (the strengthening of M&E systems at district level). It could easily be improved to a “B” overall status with more comprehensive programming (such as the new child protection model), narrower focus and deepening interventions at community level by addressing the “funnel shape” of resource use in training, addressing multiskilling needs of health workers and with more strategic leveraging of complementary resources by stronger district engagement which provides also M&E support.

7.1 Impact of YCSD Interventions

7.1.1 Nutrition Interventions

Data released by the districts on nutritional status of under-fives indicate an overall improvement in nutrition. According to a report on the performance of UNICEF supported programme in Magu District, Severe Acute Malnutrition reduced consistently over time from 3.9% (2000) to 1.3% (2010) largely as a “*result of increased awareness among community about right child feeding, Breastfeeding and child protection measures, and the knowledge*”

³¹While the office has no composite ‘child well-being indicators’ for the purposes of this evaluation the 7LDs strategy intervention logic indicators are being used as the parameters for defining child well-being. In this chapter we combine child poverty indicators (access and quality of basic services) which are at outcome level and child-well-being indicators (disease prevalence and mortality) which are at impact level. The word “impact” is used to mean “significant measurable contribution” in cases where contributions of other could not be totally eliminated by the difference and in difference technique.

gained from community IMCI training”³². Vitamin A supplementation in Magu District also increased markedly over the same period for children under-five years (from 58% in 2008 to 87% in 2010). Similarly, Makete District reported a decline in severe acute malnutrition from 1.9% in December 2007 to 1.1% in June 2011. This improvement appears to be more generalized to the national level since the proportion of under-fives who are underweight has declined at national level by 6 percentage points from 22% in 2004/5.

The information provided by the districts was based on routine data captured in health facilities but left out those children not visiting facilities. In the absence of robust data on nutrition and ECD impacts, the Evaluation used proxy methods for assessing the impact of various trainings on nutrition and ECD on the lives of children. The Evaluation Team requested a sample of CHMTs to indicate their perceptions on the impact of the various trainings on children and the results are summarized in Table 41.

Table 41: Perceptions of DMO and Team on impact of nutrition and ECD interventions on children¹

Courses offered in LDs	Hai	Magu	Makete
ECD for CoRPs	B	A	A
ENA for health workers	B	B	
PI-ENA for health workers	A	No data	
IYCF for health workers	A	A	
Screening of SAM for CoRPs	B	No data	

Notes: ¹ A=Very good, B=Good, C=Some problems, D=Major problems

Source: End-line survey results.

ECD for CoRPS received “A” category rating in Magu and Makete, but not in Hai where it was rated “B” because CoRPS do not have incentives to do home visits frequently. Though ENA is known to have strong impact as it provides all the fundamental knowledge and skills on the provision of nutrition services, it was rated a “B” because the course duration was too short for trainees to master all concepts and health workers trained on nutrition were being reassigned to duties where they are not required to apply the knowledge and skills they acquired via the ENA training, and this problem was due to the persisting staff shortage in health facilities.

While the district facility-based nutrition data showed a positive and encouraging trend, the link between increased community awareness and child nutrition status (and the contribution of UNICEF) could not be independently and empirically verified or quantified during the End-line Survey because a nutrition survey component was not incorporated into the End-line Survey, this having been missing also from the 2009 Baseline Survey conducted for the 7 LDs Strategy. In addition, the intervention period between ‘baseline’ survey and ‘end-line’ survey was too short (only two years) to expect a measurable impact on nutritional status.

Although health facility data were available and useful, the major gap in UNICEF nutrition interventions (and which applies to all UNICEF funded LD activities) noted by this Evaluation is the absence of a system to collect evidence on impact. Tracking of impact is left to national systems (Health Management Information System (HMIS), the Demographic Health Survey),

³² PMO-RALG, Mwanza Regional Office, Magu District Council, 2011 “ A brief Report on UNICEF Supported Programme to UNICEF Representative for Tanzania Her Excellence Dorothy Rozga During Her Visit to Magu District Council in Mwanza Region, 23rd – 26th May, 2011”.

but these are weak in relation to methodology and skills of staff who are supposed to capture the nutrition data on a routine basis, or have gaps related to their infrequent nature. The DHS results are generalized at a higher level than the district, making them inappropriate for assessment of impact of nutrition interventions that have a district focus (i.e., the 7 LDs Strategy). The HMIS reports on monthly nutritional status of under-fives. Results are at district level, thus making them more appropriate for nutrition impact tracking by UNICEF. However, the nutrition data captured and reported through the HMIS is facility-based (which means it captures nutritional status of children that are brought to the clinic for growth monitoring or for treatment, but leaves out children who do not report to the clinic). This makes the data partially adequate for UNICEF impact monitoring purposes.

To address this gap in future it may be necessary to include an outcome-and impact assessment-oriented nutrition and ECD survey component in the baseline survey for the next UNICEF LDs Strategy. Establishing the contribution of UNICEF to nutrition and ECD outcomes would be very important in informing UNICEF in designing the nutrition component for greater effectiveness.

With the adoption of the National Strategy for Infant and Young Child Nutrition in 2004 the impact on nutrition could have been greater, but has been slow partly due to limited adaptation of strategies to suit the socio-cultural variations across ethnic groups in Tanzania. In the learning districts impact of UNICEF interventions was mitigated by limited coverage and dilution effect caused by staff transfers to departments where their nutrition knowledge and skills were not required. The number of health workers trained on nutrition was inadequate for achievement of a critical mass that is needed to achieve more discernible impact at district level.

Statistics on health workers trained using funds from UNICEF and the training gaps still to be filled in Magu District showed that the intervention has a varied contribution to meeting the demand for training among health service providers, with some courses having made more significant contributions than others during the period under review. In general, though the contribution is significant, the unmet demand for training remained large (Table 42).

Table 42: Capacity gaps in nutrition for health workers, Magu

Courses offered	Number in need of Training	Number Trained	Needs met (%)	Not yet covered	Unmet needs (%)
IECD for CoRPS	1,082	62	6%	1,020	94%
ENA for health workers	200	125	63%	75	38%
PI-ENA for health workers	125	20	16%	105	84%
IYCF for health workers	340	70	21%	270	79%
cIMCI for CoRPS	1,082	62	6%	1,020	94%

Source: Magu District Council, 2011.

The unmet demand is not only confined to nutrition but other UNICEF supported interventions as well. This evidence goes to show the high demand for UNICEF's trainings at district level. On the other hand, it also begs the question: how far UNICEF wants to go in terms of filling the skills gap in nutrition and ECD at the district level, and what difference this would make in terms

of impact on child nutrition status and growth milestone achievement? UNICEF should consider this question in designing its next phase of sub-national engagement.

7.1.2 MNCH Interventions

7.1.3

Data in Table 43 below show that the MNCH intervention had a significant contribution towards improving the proportion of mothers and caretakers of new-born children who practice essential new-born care in Makete District since the difference in difference p-value was much less than 0.0025. The intervention also had an overall positive impact in Learning Districts.

Table 43: Proportion of mothers and caretakers of new-borns who practice essential new-born care

	LD baseline value			NLD baseline value			Difference at baseline stage (D1)	LD end-line value			NLD end-line value			Difference at end-line stage (D2)	Difference in difference (D2-D1)	p-value	
	n	N	%	n	N	%		n	N	%	n	N	%				
Temeke-Kinondoni	17	46	37.0	19	42	45.2	-8.3	17	68	25.0	43	145	29.7	-4.7	3.6	0.386	
Bagamoyo-Mkuranga	14	67	20.9	10	39	25.6	-4.7	22	128	17.2	25	134	18.7	-1.5	3.3	0.371	
Hai/Siha-Moshi Rural	16	55	29.1	14	50	28.0	1.1	21	93	22.6	6	76	7.9	14.7	13.6	0.093	
Magu-Misungwi	44	81	54.3	54	95	56.8	-2.5	72	236	30.5	81	257	31.5	-1.0	1.5	0.436	
Makete-Njombe	0	40	0.0	13	42	31.0	-31.0	10	78	12.8	6	63	9.5	3.3	34.2	0.000	***
Mtwara Rural-Tandahimba	11	61	18.0	10	34	29.4	-11.4	44	178	24.7	48	174	27.6	-2.9	8.5	0.206	
Overall	102	350	29.1	120	302	39.7	-10.6	186	781	23.8	209	849	24.6	-0.8	9.8	0.011	**

Table 44 shows that the MNCH strategy had an impact on the proportion of women who made preparation for delivery (for those who gave birth in the previous 12 months) in Hai/Siha where it increased from 53% to 58% from the Baseline to End-line, respectively. The strategy did not have an impact in the other 5 Learning Districts.

Table 44: Proportion of women who made preparation for delivery (for those who gave birth in the previous 12 months)

	LD baseline value			NLD baseline value			Difference at baseline stage (D1)	LD end-line value			NLD end-line value			Difference at end-line stage (D2)	Difference in difference (D2-D1)	p-value	Significance
	n	N	%	n	N	%		n	N	%	n	N	%				
Temeke-Kinondoni	39	46	84.8	35	42	83.3	1.4	41	68	60.3	91	145	62.8	-2.5	-3.9	0.3594	
Bagamoyo-Mkuranga	48	67	71.6	32	39	82.1	-10.4	81	128	63.3	85	134	63.4	-0.2	10.3	0.1562	
Hai/Siha-Moshi Rural	29	55	52.7	40	50	80.0	-27.3	55	95	57.9	33	76	43.4	14.5	41.7	0.0001	***
Magu-Misungwi	35	81	43.2	48	95	50.5	-7.3	92	238	38.7	115	261	44.1	-5.4	1.9	0.4129	
Makete-Njombe	29	40	72.5	32	42	76.2	-3.7	61	79	77.2	53	64	82.8	-5.6	-1.9	0.4364	
Mtwara Rural-Tandahimba	41	61	67.2	23	34	67.6	-0.4	95	178	53.4	112	175	64.0	-10.6	-10.2	0.1841	
Overall	221	350	63.1	210	302	69.5	-6.4	425	786	54.1	489	855	57.2	-3.1	3.3	0.2296	

Survey results presented in Table 45 also confirm that the MNCH strategy contributed to the improvement in the proportion of women with infants who received 2 doses of SP during their last pregnancy in Mtwara Rural since the difference in difference p-value showed significant difference with the matching Non-Learning District. The strategy had an overall impact in the Learning Districts as well.

Table 45: Percentage of women with infants who received 2 doses of SP during their last pregnancy

	LD baseline value			NLD baseline value			Difference at baseline stage (D1)	LD end-line value			NLD end-line value			Difference at end-line stage (D2)	Difference in difference (D2-D1)	p-value	Significance
	n	N	%	n	N	%		n	N	%	n	N	%				
Temeke-Kinondoni	13	38	34.2	12	31	38.7	-4.5	24	45	53.3	45	100	45.0	8.3	12.8	0.1922	
Bagamoyo-Mkuranga	21	57	36.8	14	29	48.3	-11.4	29	96	30.2	29	98	29.6	0.6	12.1	0.1788	
Hai/Siha-Moshi Rural	6	40	15.0	16	36	44.4	-29.4	30	62	48.4	18	35	51.4	-3.0	26.4	0.0351	
Magu-Misungwi	14	48	29.2	22	65	33.8	-4.7	48	99	48.5	49	116	42.2	6.2	10.9	0.1635	
Makete-Njombe	14	33	42.4	19	36	52.8	-10.4	25	60	41.7	24	49	49.0	-7.3	3.0	0.4207	
Mtwara Rural-Tandahimba	16	47	34.0	16	32	50.0	-16.0	46	89	51.7	31	95	32.6	19.1	35.0	0.0043	**
Overall	84	263	31.9	99	229	43.2	-11.3	202	451	44.8	196	493	39.8	5.0	16.3	0.0013	**

Despite the positive gains child health within the 7LDs, it was noted that there are still some critical factors outside the health system which act as bottlenecks or barriers for access to universal health care among mothers and their children within the 7LDs. Among the main challenges here include misconceptions and myths related to health, subordinate status of women which does not allow them to make critical decisions about their health, excessive burden of household chores that deters women from seeking health care for them and the children, challenges with travel including remote impassable roads and being too poor to afford bus fare to health facilities.

7.1.4 PMTCT/PDAIDS Interventions

7.1.5

A difference in difference p-value significantly less than 0.025 showed that the PMTCT/PDAIDS intervention had a strong impact on the proportion of pregnant women making at least one ANC visit who have received an HIV test result and post-test counselling in Temeke District (Table 46). The data indicate that while in the LD the proportion was sustained at a very high level, in the NLD it declined from the time of the baseline to the time of the end line survey. However, there was no evidence of impact in the other 5 Learning Districts and no evidence was found to suggest an overall impact in the Learning Districts.

The PMTCT/ PDAIDS intervention had a strong impact on the percentage of women 15-49 with knowledge that HIV can be passed on from an HIV positive mother to her baby in Hai/Siha district since the p-value gives evidence to suggest that the district performed much better than the matching control district during the project period.

Table 46: Percent of pregnant women making at least one ANC visit who have received an HIV test result and post-test counselling

	LD baseline value			NLD baseline value			Difference at baseline stage (D1)	LD end-line value			NLD end-line value			Difference at end-line stage (D2)	Difference in difference (D2-D1)	p-value	
	n	N	%	n	N	%		n	N	%	n	N	%				
Temeke-Kinondoni	44	44	100.0	42	42	100.0	0.0	18	18	100.0	106	115	92.2	7.8	7.8	0.0009	***
Bagamoyo-Mkuranga	47	51	92.2	36	37	97.3	-5.1	111	115	96.5	123	126	97.6	-1.1	4.0	0.2148	
Hai/Siha-Moshi Rural	48	49	98.0	48	50	96.0	2.0	65	69	94.2	35	40	87.5	6.7	4.7	0.2451	
Magu-Misungwi	33	37	89.2	54	62	87.1	2.1	111	116	95.7	156	165	94.5	1.1	-0.9	0.4483	
Makete-Njombe	39	39	100.0	26	28	92.9	7.1	52	52	100.0	53	55	96.4	3.6	-3.5	0.2611	
Mtwara Rural-Tandahimba	50	51	98.0	21	23	91.3	6.7	108	115	93.9	123	130	94.6	-0.7	-7.4	0.1401	
Overall	261	271	96.3	227	242	93.8	2.5	465	485	95.9	596	631	94.5	1.4	-1.1	0.3121	

However the difference in difference technique also showed that Misungwi and Tandahimba which were control districts performed much better than Magu and Mtwara Rural which were the matching Learning Districts. The intervention did not have an overall impact on percentage of women aged 15-49 years with knowledge that HIV can be passed on from an HIV positive mother to her baby in Learning Districts (Table 47).

Table 47: Percentage of women 15-49 with knowledge that HIV can be passed on from an HIV positive mother to her baby

	LD baseline value			NLD baseline value			Difference at baseline stage (D1)	LD end-line value			NLD end-line value			Difference at end-line stage (D2)	Difference in difference (D2-D1)	p-value	
	n	N	%	n	N	%		n	N	%	n	N	%				
Temeke-Kinondoni	45	46	97.8	42	42	100.0	-2.2	19	25	76.0	112	145	77.2	-1.2	0.9	0.4602	
Bagamoyo-Mkuranga	42	54	77.8	35	39	89.7	-12.0	113	124	91.1	125	132	94.7	-3.6	8.4	0.1515	
Hai/Siha-Moshi Rural	42	54	77.8	43	50	86.0	-8.2	64	91	70.3	32	73	43.8	26.5	34.7	0.0005	***
Magu-Misungwi	57	81	70.4	55	94	58.5	11.9	126	234	53.8	158	252	62.7	-8.9	-20.7	0.0071	**
Makete-Njombe	35	39	89.7	35	42	83.3	6.4	50	59	84.7	50	64	78.1	6.6	0.2	0.4920	
Mtwara Rural-Tandahimba	54	61	88.5	23	34	67.6	20.9	101	162	62.3	113	163	69.3	-7.0	-27.9	0.0038	**
Overall	275	335	82.1	233	301	77.4	4.7	473	695	68.1	590	829	71.2	-3.1	-7.8	0.0250	

A difference in difference p-value significantly less than 0.025 showed that the PMTCT/PDAIDS intervention had a strong impact on the proportion of women 15-49 with knowledge of availability of a drug that can prevent mother to child transmission of HIV in Hai/Siha Learning District (Table 48). There was no evidence of impact in the other 5 Learning Districts and no evidence was found to suggest an overall impact in the Learning Districts.

Table 48: Proportion of women 15-49 with knowledge of availability of a drug that can prevent mother to child transmission of HIV

	LD baseline value			NLD baseline value			Difference at baseline stage (D1)	LD end-line value			NLD end-line value			Difference at end-line stage (D2)	Difference in difference (D2-D1)	p-value	Significance
	n	N	%	n	N	%		n	N	%	n	N	%				
Temeke-Kinondoni	33	46	71.7	26	42	61.9	9.8	16	25	64.0	97	145	66.9	-2.9	-12.7	0.189	
Bagamoyo-Mkuranga	15	67	22.4	14	39	35.9	-13.5	49	124	39.5	74	132	56.1	-16.5	-3.0	0.394	
Hai/Siha-Moshi Rural	23	54	42.6	33	50	66.0	-23.4	47	91	51.6	27	73	37.0	14.7	38.1	0.001	**
Magu-Misungwi	15	81	18.5	20	94	21.3	-2.8	63	234	26.9	76	252	30.2	-3.2	-0.5	0.472	
Makete-Njombe	25	39	64.1	17	42	40.5	23.6	40	59	67.8	39	64	60.9	6.9	-16.8	0.113	
Mtwara Rural-Tandahimba	16	61	26.2	10	34	29.4	-3.2	47	161	29.2	71	163	43.6	-14.4	-11.2	0.154	
Overall	127	348	36.5	120	301	39.9	-3.4	262	694	37.8	384	829	46.3	-8.6	-5.2	0.129	

In conclusion, the study revealed that the PMTCT/ PDAIDS intervention had a strong impact mainly on 3 indicators and in three districts, namely:

- proportion of pregnant women making at least one ANC visit who have received an HIV test result and post-test counselling (in Temeke);
- percentage of women aged 15-49 years with knowledge that HIV can be passed on from an HIV positive mother to her baby in (Hai/Siha district); and
- proportion of women 15-49 with knowledge of availability of a drug that can prevent mother to child transmission of HIV (in Hai/Siha)

The intervention lacked significant aggregate impact in LDs when compared to all LDs.

In addition to the findings from the quantitative survey, all DMOs in the 7LDs reported that although the EID system is still not fully functional, anecdotal evidence shows them that there is an overall reduction in HIV transmission among children born to mothers who are living with HIV. They also reported that frequency and magnitude of opportunistic infections and AIDS deaths among children who are living with HIV in their districts have also been reducing.

7.1.6 BCC Interventions

The End-line study observed that only a third of households (33% (828/2545)) in LDs and 37% (956/2619) in NLDs) boil their drinking water. The difference between LDs and NLDs was statistically significant at 95 percent confidence. The practice differed by district with the highest prevalence of good practice being in Makete (at 15%).

On water guard, only 6% (165/2545) of the household members in LDs and 3% (92/2619) in NLDs confirmed at End-line that they were treating their drinking water with water guard / aquatab. Compared to the Baseline situation, this had gone up in LDs from 4% at Baseline to 6% at End-line, but declined slightly in NLDs from 4% at Baseline to 3% at End-line.

With regard to the proper disposal of children's faeces into latrines, there were high proportions of households who practicing correct disposal in both LDs and NLDs (76% (269/356) and (74%) (253/344), respectively) and there was no statistically significant difference between the two.

7.1.7 WASH Interventions

Use of piped water

The End-line survey confirmed a significant increase in the use of piped water during the period between the baseline and end-line from 43% to 54% in LDs and 36% to 46% in NLDs as shown in Table 49. Among the LDs, marked improvements in access to piped water were observed in Makete, Magu and Mtwara rural whilst slower improvements were found in Hai/Siha and Bagamoyo. Among the NLDs marked improvements in access to piped water occurred during the project period in Njombe and Tandahimba.

The study revealed that that the treatment versus control difference in difference in the proportion of households using piped water as a main source was significant for Makete versus Njombe and for Magu versus Misungwi. UNICEF invested in community water supply facilities and water user group training in Makete and Magu districts and this contributed to the significant positive change noted at End-line.

Treatment versus control difference in difference in the proportion of households using piped water as a main source was also significant for Hai/Siha versus Moshi Rural, Bagamoyo versus Mkuranga and Mtwara Rural versus Tandahimba but in this case the Non-Learning Districts performed better than the Learning Districts. The presence of other large water development funds in the Kilimanjaro region, and absence of explicit support from UNICEF for water supply in that region should be noted, as the positive difference in the case of Ha/Siha is not attributable.

Table 49: Proportion of households using piped water as the main source

	LD baseline value			NLD baseline value			Difference at baseline stage (D1)	LD end-line value			NLD end-line value			Difference at end-line stage (D2)	Difference in difference (D2-D1)	p-value	
	n	N	%	n	N	%		n	N	%	n	N	%				
Temeke-Kinondoni	239	430	55.6	321	409	78.5	-22.9	316	451	70.1	399	457	87.3	-17.2	5.7	0.0853	
Bagamoyo-Mkuranga	211	484	43.6	52	361	14.4	29.2	177	426	41.5	89	424	21.0	20.6	-8.6	0.0212	*
Hai/Siha-Moshi Rural	372	447	83.2	272	438	62.1	21.1	306	441	69.4	293	425	68.9	0.4	-20.7	0.0000	***
Magu-Misungwi	62	433	14.3	73	392	18.6	-4.3	146	405	36.0	89	446	20.0	16.1	20.4	0.0000	***
Makete-Njombe	183	462	39.6	168	437	38.4	1.2	263	400	65.8	224	448	50.0	15.8	14.6	0.0009	***
Mtwara Rural-Tandahimba	129	501	25.7	8	457	1.8	24.0	190	469	40.5	112	449	24.9	15.6	-8.4	0.0110	*
Overall	1196	2757	43.4	894	2494	35.8	7.5	1398	2592	53.9	1206	2649	45.5	8.4	0.9	0.3264	

Use of protected wells

The difference in difference statistical test on proportion of households using protected wells as the main source revealed that the program had an impact in Temeke and Mtwara Rural as these Learning Districts performed better than the matching Non-Learning Districts. However the difference in difference statistical test on proportion of households using protected wells as the main source revealed that the Moshi Rural and Misungwi Districts performed significantly better than their matching Learning Districts which were Hai/Siha and Magu districts respectively.

The difference in difference statistical test on proportion of households using protected wells as the main source revealed that the Non-Learning Districts combined performed significantly better than the Learning Districts (Table 50).

Table 50: Proportion of households using protected wells as the main source

	LD baseline value			NLD baseline vale			Difference at baseline stage (D1)	LD end-line value			NLD end-line value			Difference at end-line stage (D2)	Difference in difference (D2-D1)	p-value	
	n	N	%	n	N	%		n	N	%	n	N	%				
Temeke-Kinondoni	114	430	26.5	7	409	1.7	24.8	132	451	29.3	52	457	11.4	17.9	-6.9	0.0217	*
Bagamoyo-Mkuranga	49	484	10.1	114	361	31.6	-21.5	48	426	11.3	146	424	34.4	-23.2	-1.7	0.3336	
Hai/Siha-Moshi Rural	6	447	1.3	46	438	10.5	-9.2	2	441	0.5	8	425	1.9	-1.4	7.7	0.0000	****
Magu-Misungwi	114	433	26.3	67	392	17.1	9.2	82	405	20.2	132	446	29.6	-9.3	-18.6	0.0000	****
Makete-Njombe	40	462	8.7	63	437	14.4	-5.8	15	400	3.8	54	448	12.1	-8.3	-2.5	0.1814	
Mtwara Rural-Tandahimba	48	501	9.6	17	457	3.7	5.9	33	469	7.0	28	449	6.2	0.8	-5.1	0.0136	*
Overall	371	2757	13.5	314	2494	12.6	0.9	312	2592	12.0	420	2649	15.9	-3.8	-4.7	0.0000	****

Table 51: Proportion of households using protected/covered spring as the main water source

	LD baseline value			NLD baseline vale			Difference at baseline stage (D1)	LD end-line value			NLD end-line value			Difference at end-line stage (D2)	Difference in difference (D2-D1)	p-value	
	n	N	%	n	N	%		n	N	%	n	N	%				
Temeke-Kinondoni	0	430	0.0	0	409	0.0	0.0	1	451	0.2	0	457	0.0	0.2	0.2	0.1587	
Bagamoyo-Mkuranga	0	484	0.0	0	361	0.0	0.0	1	426	0.2	1	424	0.2	0.0	0.0	0.5000	
Hai/Siha-Moshi Rural	9	447	2.0	36	438	8.2	-6.2	95	441	21.5	93	425	21.9	-0.3	5.9	0.0322	
Magu-Misungwi	0	433	0.0	11	392	2.8	-2.8	2	405	0.5	13	446	2.9	-2.4	0.4	0.3745	
Makete-Njombe	30	462	6.5	23	437	5.3	1.2	4	400	1.0	15	448	3.3	-2.3	-3.6	0.0268	
Mtwara Rural-Tandahimba	44	501	8.8	4	457	0.9	7.9	5	469	1.1	1	449	0.2	0.8	-7.1	0.0000	****
Overall	83	2757	3.0	75	2494	3.0	0.0	108	2592	4.2	123	2649	4.6	-0.5	-0.5	0.2578	

Use of protected/covered spring as the main water source

The difference in difference statistical test on proportion of households using protected or covered spring as the main source revealed that Tandahimba District performed much better

than Mtwara Rural district which was the matching Learning Districts. The intervention had no impact in the other 6 Learning Districts and also had no overall impact in the Learning Districts (Table 51).

Distance to main water source during the dry season

The difference in difference statistical test on proportion of households living within 400m of a drinking water supply in the dry season revealed that the program had a strong impact in Magu and Makete district as shown in Table 52. This again confirmed the significant contribution made by UNICEF towards increasing access to improved water supply in these two districts. The program did not have a significant impact on proportion on households living within 400m of a drinking water supply in the dry season in the rest of the project districts. UNICEF intervention had an overall impact in Learning Districts.

Table 52: Proportion of households living within 400m of a drinking water supply in the dry season

	LD baseline value			NLD baseline value			Difference at baseline stage (D1)	LD end-line value			NLD end-line value			Difference at end-line stage (D2)	Difference in difference (D2-D1)	p-value
	n	N	%	n	N	%		n	N	%	n	N	%			
Temeke-Kinondoni	410	430	95.3	383	409	93.6	1.7	372	394	94.4	339	359	94.4	0.0	-1.7	0.230
Bagamoyo-Mkuranga	331	484	68.4	267	361	74.0	-5.6	242	396	61.1	306	420	72.9	-11.7	-6.2	0.087
Hai/Siha-Moshi Rural	412	447	92.2	396	438	90.4	1.8	301	334	90.1	230	277	83.0	7.1	5.3	0.057
Magu-Misungwi	255	433	58.9	274	392	69.9	-11.0	213	381	55.9	210	444	47.3	8.6	19.6	0.000***
Makete-Njombe	390	462	84.4	394	437	90.2	-5.7	248	359	69.1	204	378	54.0	15.1	20.9	0.000***
Mtwara Rural-Tandahimba	331	501	66.1	202	457	44.2	21.9	291	456	63.8	168	354	47.5	16.4	-5.5	0.121
Overall	2129	2757	77.2	1916	2494	76.8	0.4	1667	2320	71.9	1457	2232	65.3	6.6	6.2	0.000***

Access to improved toilet facilities

In aggregate, there was no significant improvement in the proportion of households using improved toilet facilities in LDs, yet a small slight increase was noted in NLDs (Table 53). But there was significant improvement in selected districts including Makete and Mtwara (among LDs) and Mkuranga (NLD). Mkuranga had Njombe had significant increases in improved toilet facilities because there were many development partners working in these districts.

Table 53: Access to improved sanitation

District	Before (2009)	After (2011)	Attributable difference	P-Value
Temeke	68% (273/399)	67% (300/451)	-1%	0.5549
Bagamoyo	20% (91/462)	15% (62/426)	-5%	0.0426
Hai/Siha	41% (158/384)	36% (160/439)	-5%	0.1672
Magu	22% (80/369)	17% (67/401)	-5%	0.0795
Makete	4% (17/451)	13% (53/401)	9%	0.0041
Mtwara rural	4% (16/429)	8% (39/468)	4%	<0.0001
LDS Overall	25.46% (635/2494)	26% (681/2586)	1%	0.4777
Kinondoni	70% (228/327)	63% (289/457)	-7%	0.0892
Mkuranga	4% (17/451)	25% (106/425)	21%	<0.0001
Moshi rural	40% (163/409)	30% (127/425)	-10%	0.0025
Misungwi	6% (21/326)	8% (37/445)	2%	0.33
Njombe	12% (49/417)	23% (102/448)	11%	0.0011
Tandahimba	5% (22/448)	8% (38/448)	3%	0.0325
NLDs Overall	24% (539/2260)	26% (699/2586)	2%	0.0113

Source: End-line Survey.

The difference in difference statistical test on “proportion of households using improved toilet facilities” revealed that households in Mkurunga and Misungwi districts experienced an improved access to safe sanitation compared to households in Bagamoyo and Magu which were the matching Learning Districts respectively. The WASH intervention did not have an aggregate impact on access to improved toilet facilities in Learning Districts.

Whilst the above analysis combined Hai and Siha districts, data collected from Siha alone showed a slightly different picture, with access to improved sanitation having increased, albeit at a snail’s pace indicating that promotion of sanitation can be a long-term undertaking if current approaches used by UNICEF and other development partners in the learning districts are not significantly revisited (Table 54).

Table 54: Access to improved sanitation facilities in Siha District, 2008 - 2010

Year	HH with latrines ²	%	HH without improved latrines	%	HH with improved latrines	%
2008 Before	15,308	75	5,103	25	5,715	28
2009 Before	16,329	80	4,082	20	6,123	30
2010 After ¹	18,646	83	3,818	17	7,638	34

Notes: ¹ After training funded by UNICEF. ² HH=Households.

Source: Siha District Annual Reports on Sanitation and Hygiene.

The lack of impact on household access to improved sanitation is to some extent associated with the approach used by UNICEF. Using water and sanitation promotion centres was innovative but the package was not complete. No funds were set aside to support the running costs of these centres or to kick-start the businesses of the artisans. Water and sanitation promotion centres were not conceptualised as a business that would recover running costs or even make a profit for the artisan. Districts did not provide artisans with the moulds to make the Sungura slabs. Artisans were not provided with all the equipment and supplies they needed to continue holding demonstrations and pass on the skills to other artisans or clients who wanted to construct modern toilets. There was no provision for someone to man the centres full time with a mode of compensation. Furthermore training of artisans appeared to be end in itself as there was no follow-up or assessment of the outcomes of the training.

When asked “in what ways the training of artisans had impacted people on the use of improved latrines, ward executive officers had mixed views with some in Bagamoyo, Mtwara and Temeke indicating that the impact was minimal:

- “people did not have a good understanding of the toilet construction work and the need for their use” (WEO, Bagamoyo);
- “Uptake is slow, however around 10 new toilets have been built” (WEO, Mtwara); and
- “Not much impact; trained artisans need support in marketing skills to change people’s behaviour” (WEO, Temeke).

The WEOs from Magu, Siha and Hai had more favourable assessment of the contribution made by trained artisans, in that “when people are visiting places where the artisans are building toilets the latter gives them information on how to build their own” (Hai), and “passport size toilets are now disappearing; artisans are building VIP toilets” (Magu). In Makete the WEO

indicated that training of artisans was long awaited by the locals who “needed artisans who can construct modern toilets”.

In Mkuranga, the opinion of the WEO was that the “demonstration toilets are too expensive for people to construct or use”, suggesting perhaps that UNICEF continues the search for more cost-effective sanitation technologies that could be tested in the LDs. In Njombe the WEO emphasised the need for continuous training of artisans if more significant results are to be achieved: “some who were trained had died, others needed refresher trainings and new ones needed training”.

Hand-washing

The difference in difference statistical test on “proportion of caretakers and other household members who wash their hands on at all four critical moments” revealed that the WASH intervention did not have an impact on hand-washing behaviour by household members in Learning Districts since there was no significant difference between the proportions in Learning Districts and Non-Learning Districts. An improvement related to hygiene and sanitation was found with regards to washing of hands at two critical moments and washing hands with soap or ash (Table 55). However there was no significant improvement on proportion of households demonstrating correct and consistent dosing of water.

Table 55: Behaviour change on washing of hands

Indicator	LDs		NLDs	
	Baseline	End-line	Baseline	End-line
Caretakers and other household members who wash their hands at four critical moments	0%	2% (17/882)	0%	3% (30/997)
Caretakers and other household members who wash their hands at three critical moments	6% (86/1403)	5% (45/882)	6% (56/1136)	4% (37/997)
Caretakers and other household members who wash their hands at two critical moments	13% (179/1403)	20% (176/882)	17% (194/1136)	15% (152/997)
Caregiver washing hand with soap or ash	79% (255/323)	to 99% (350/354)	82% (261/317)	99% (340/344)

Source: 7 LDs Strategy End-line Survey.

Prevalence of diarrheal diseases

The difference in difference test “for proportion of under-5 suffering from diarrhoea in the two-week period prior to the survey” was significant for Magu district versus Misungwi district. The test also revealed that the prevalence of diarrhoea increased in Learning Districts combined and Non-Learning Districts combined but Learning Districts deteriorated at a significantly higher rate than Non-Learning Districts, indicating that WASH interventions in the LDs did not have a significant impact in terms of reducing diarrhoeal disease prevalence (Table 56). This can be expected since the intervention did not have an impact on access to improved sanitation and protected wells. Furthermore, partial impact on household hand washing behaviour implies that exposure to diarrhoeal diseases for under-five children is unlikely to have been addressed by the WASH intervention.

Table 56: Proportion of under 5 suffering from diarrhoea in the two-week period prior to the survey

	LD baseline value			NLD baseline value			Difference at baseline stage (D1)	LD end-line value			NLD end-line value			Difference at end-line stage (D2)	Difference in difference (D2-D1)	p-value
	n	N	%	n	N	%		n	N	%	n	N	%			
Temeke-Kinondoni	6	164	3.7	11	152	7.2	-3.6	13	39	33.3	9	35	25.7	7.6	11.2	0.152
Bagamoyo-Mkuranga	16	219	7.3	13	176	7.4	-0.1	5	19	26.3	3	30	10.0	16.3	16.4	0.082
Hai/Siha-Moshi Rural	11	237	4.6	7	177	4.0	0.7	8	26	30.8	3	23	13.0	17.7	17.0	0.071
Magu-Misungwi	13	354	3.7	33	331	10.0	-6.3	17	35	48.6	18	54	33.3	15.2	21.5	0.023 *
Makete-Njombe	5	164	3.0	5	166	3.0	0.0	6	15	40.0	5	10	50.0	-10.0	-10.0	0.312
Mtwara Rural-Tandahimba	13	266	4.9	8	129	6.2	-1.3	7	47	14.9	5	53	9.4	5.5	6.8	0.169
Overall	64	1404	4.6	77	1131	6.8	-2.2	56	181	30.9	43	205	21.0	10.0	12.2	0.004 ***

Source: End-line Household Survey.

7.2 Impact of BELS

7.2.1 Whole school development planning

The Evaluation found consistent evidence of impact of the child friendly schools initiative of UNICEF on pass rates for boys and girls in primary schools with higher impact on girls at standard IV level, which has increased the transition rates to Standard V.

In Magu district, primary education examination results confirmed positive impacts on pass rates at both Standard IV and VII, and transition rates, especially for girls to Standard V and Form One (Table 57). The Standard IV pass rate for girls increased from 65% in 2007 to 87% in 2010, while that for boys increased from 69% to 88%. The percentage of boys and girls selected for Form One increased to 100% from 2007 onwards.

Table 57: Impact of BELS on primary education pass rates and transition rates, Magu 2001 – 2010

Year	Candidates, Standard IV			Passed and joined Std V, %			Candidates, Standard VII			Selected for Form One, %		
	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total	Boys	Girls	Total
2001	4205	4369	8574	80%	68%	74%	2984	2543	5527	16%	59%	25%
2002	5335	5520	10855	81%	54%	75%	3632	3139	6771	16%	43%	23%
2003	6569	6641	13210	92%	57%	89%	3936	3629	7565	26%	64%	37%
2004	7441	7745	15186	82%	73%	77%	4084	3356	7440	51%	82%	61%
2005	9489	9237	18726	81%	60%	75%	5078	4086	9164	54%	84%	63%
2006	9386	9883	19269	74%	64%	69%	6167	5103	11270	77%	96%	84%
2007	8954	9777	18731	69%	65%	65%	6388	5727	12115	100%	100%	100%
2008	8372	9076	17448	85%	66%	81%	7867	7096	14963	100%	100%	100%
2009	7501	7895	15396	87%	89%	83%	7055	7176	14231	100%	100%	100%
2010	6882	7283	14165	88%	87%	85%	6660	6963	13623	100%	100%	100%

Source: Magu District.

Ward Education Coordinators interviewed in Makete District also confirmed that one of the most important areas where whole school development planning had produced good impacts was the pass rate for Grade 4, and especially for girls, but that for Grade 7 (though increasing) is still lagging behind because of the non-availability of text books.

More generally, for the focus schools there is a deliberate effort to improve the pass rates for the girl child and in most schools reached by the intervention in the LDs, the pass rates for girls at Grade 4 have significantly improved. Teachers are planning their lessons better, their skills to teach hard subjects (English, Maths and Science) are being enhanced, teaching in class is becoming more gender responsive, and both school meals and MVC support are improving retention rates for pupils coming from poor and vulnerable families. Pupils now know their syllabus and this is an indicator that teachers are planning their lessons according to the national syllabus. The number of pupils transitioning to secondary schools is also increasing.

Overall, the impact-level results achieved in terms of improving the quality of teaching are significant as one of the WECs in Hai district attributed the recent success of the district in being ranked 2nd best district in Standard VII pass rates in the region and coming among the top 10 country-wide to the support provided by UNICEF (WSDP and training of coordinators of teacher resource centres). In his view “*most of the achievement came out of the community contribution and attitude which had been changed through the WSDP approach*”³³.

7.2.2 Gender Equity

7.2.2.1 Incidence of adolescent pregnancies in both the school and out-of-school environments

The school principals and DEOs interviewed confirmed that the incidences of adolescent pregnancies in school and out-of-school environments declined in both LDS and NLDs over the period 2007-2010. Bagamoyo reported the largest decline from 98 pregnancies in 2007 to 22 pregnancies in 2010. There were no reported incidences of adolescent pregnancies in the school and out-of-school environments in Hai. In Magu district the statistics on pregnancies among girls in school showed a rapid decline from 2008 to 2010 (Figure 7). In NLDs declines were also recorded, with Njombe for example, decreasing from a low level of 8 in 2009 to 4 in 2010.

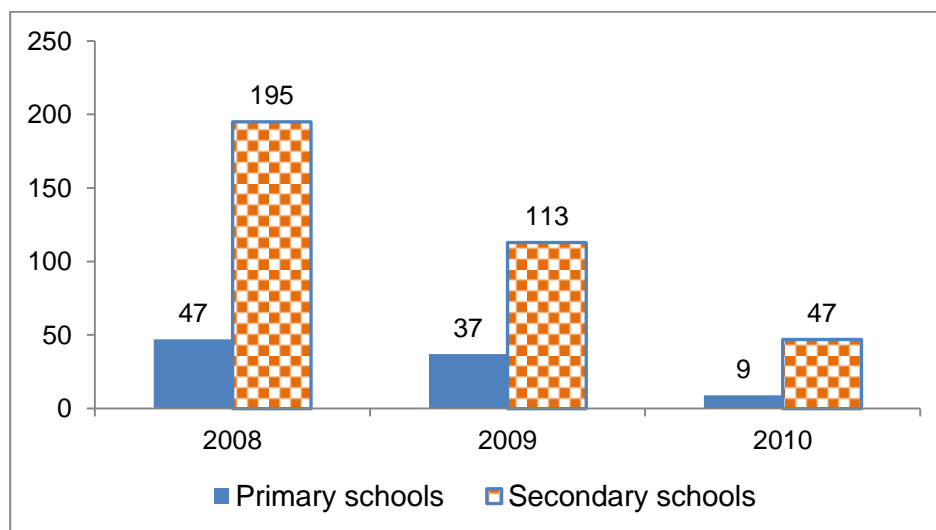


Figure 7: Incidence of school girl pregnancies, Magu district

Source: Magu District Council.

³³ Interview with Charles J. Bwana, Ward Education Coordinator, Masama Rundugai Ward, Hai District, Kilimanjaro Region, November 2011.

Furthermore, 78% (18/23) of school principals interviewed in LDs school and 59% (13/22) in NLDs indicated reduction of incidences of adolescent pregnancies in the school and out-of-school environments. This was a result of increased awareness of negative consequences of pre-marital sex and early pregnancies through media, NGO campaigns and the school curricula.

Focus Group Discussion (FGDs) conducted with women in the community revealed that the incidence of adolescent pregnancies is well known among the community members. Women cited the following contributory factors: children's desire to get quick money, initiation ceremonies, freedom given to children and lack of intervening measures from the parents in terms of counseling and support. The FGDs confirmed that in the school environment the problem was decreasing because of interventions by school authorities which are evidenced by the increasing primary school completion rates among girls. TUSEME club responses in LDs also showed that the incidences of adolescent pregnancies among children have been decreasing in both school and out-of-school environments, with more girls becoming assertive and able to speak out on any potential violations to their rights.

7.2.2.2 Perceptions on prevalence of early marriages and childhood sexual debut

The incidences of early marriages and childhood sexual debut were reported to be decreasing across the LDs. Information obtained from the District Education Officer for Bagamoyo showed that the reason for the reduction of early marriages and childhood sexual debut was the life skills education and child rights campaigns by NGOs targeting children directly. These have raised awareness of the negative effects of early marriages and sexual debut on individual learning, social and economic life. Children are more aware of negative health consequences including the risk of contracting HIV/AIDS. This has led many adolescents to take precautions in sexual relations practices that may endanger their lives. As in LDs, the situation in NLDs has been found to be decreasing; a few incidences were reported in Njombe, Mkuranga and Misungwi, though an insignificant number to raise concern.

7.2.2.3 Perceptions on incidence of child abuse (sexual harassment, physical punishment, emotional abuse, economic abuse) of girls and boys at family, school and community levels

Students from TUSEME clubs (LDs) who participated in FGDs were asked whether they know any adolescent girl(s) (below 18 years) who have been abused, or got married either voluntarily or forced in the last 3 years. The results show that they were aware of the problem though the incidents had been decreasing in their areas over the "past three years" (2008-2010). Primary school students in NLDs through students clubs were also asked on the incidence of child abuse and harassment. Children confirmed they were aware of these, but were decreasing over time. Some students in Magu, Bagamoyo and Mtwara gave their experiences on physical punishments that are hard to eliminate completely amid cultural practices that are still dominant in many rural areas. Pupils are punished by teachers and/or parents on grounds that they are reprimanding and instilling order for offences done.

7.2.2.4 Primary school completion rates for girls and boys

The primary school completion rates for boys and girls in both LDs and NLDs increased significantly during the period of the intervention (2007-2010) due to a number of national initiatives such as on-going educational campaigns, Primary Education Development Program

(PEDP), Equal Education for All (EAF) and improved educational environment in schools which allows for higher retention. Indeed one of the goals of MKUKUTA is to ensure primary education completion for all children. This is achieved through awareness promotion on the importance of education among parents using educational campaigns and opening of educational opportunities both in rural and urban areas. Only a small percentage of pupils do not complete primary school education due to sickness, repeating classes or death. Again motivational factors such as secondary education programs have inspired many children to continue with education as there is assurance of opportunity for transition to secondary education as long as one passes primary school examinations. The Evaluation noted some differences between the LDs against NLDs, with faster progress being made in LDs.

7.3 Impact of Child Protection Interventions

For most of the CPP interventions, impacts have either not yet been realized or not yet been properly measured. The Birth Registration Pilot which supported the catch up campaign had some positive results in increasing the number of children with birth certificates, but it was discontinued before impacts of the birth certificates in terms of reducing child vulnerability by increasing children's access to protective services, and in terms of reducing child poverty by increasing their access to basic social and economic services, could have been measured.

The Mobile Legal Clinic was a well-executed intervention but it was not proven beyond doubt that the model worked in terms of providing legal access to children. In addition, data on legal assistance provided to children and the impact the legal assistance had on children was not available.

The creation and strengthening of MVC structures in the 7 LDs and strengthening of capacities of duty bearers on MVC care and support worked well in helping to identify and register MVCs and characterize their needs, and to also link them to service providers, but a large proportion of MVCs (over 70%) could not access any support due to inadequate resource availability at the district level. Impact was therefore isolated, being concentrated on a few MVCs who managed to secure some form of assistance, some of whom (e.g., in Makete) were assisted from secondary to university level education. However, there was no baseline information collected to carry out an analysis of whether through social transfers and social support the MVC system managed to keep girls in school and reduced incidence of child labour, early marriage, and teenage pregnancy and improved child survival.

The Report on the Evaluation of the CJF Project by Rwezaura et al. (2010) concluded that although the project had produced outputs, impacts were not yet evident. The project needed a clearer conceptual framework and comprehensive strategy to achieve impact. The number of CJFs was too few per village and needed to be increased.

Initial results³⁴ from the 3 pilot districts indicate that the new model on "child protection system strengthening" is likely to produce some good impacts, but it was still too early to see impacts at

³⁴Magu district pointed out a number of examples whereby girl children who were being abused at home had managed to receive assistance from the child protection teams at village and district levels, and in some instances the cases had been referred to the police or to children's homes where the children

scale due to the short implementation period so far, and the absence of a database on cases reported and successfully attended to so far. It was also not very clear whether the baseline assessment which was conducted for the project in 3 pilot districts collected sufficient time series data to facilitate analysis of impact.

Child participation interventions have seen children becoming more confident to participate through the activities of children's *barazas* in decision making processes and contributing new ideas and priorities to village and district plans. However, their direct participation in village development committee meetings, ward development committee meetings and district budgeting meetings remains barred by adult members of these committees.

7.3.1 Impact of the HIV Prevention Interventions

The difference in difference statistical test on the proportion of youths who feel that they are vulnerable to HIV infection and responded that everyone has the possibility of acquiring HIV/AIDS revealed that the HIV Prevention intervention had an overall positive impact in Learning Districts (Table 58).

Table 58: Proportion of youth who feel that they are vulnerable to HIV infection and responded that everyone has the possibility of acquiring HIV/AIDS

	LD baseline value			NLD baseline value			Difference at baseline stage (D1)	LD end-line value			NLD end-line value			Difference at end-line stage (D2)	Difference in difference (D2-D1)	p-value	Significance
	n	N	%	n	N	%		n	N	%	n	N	%				
Temeke-Kinondoni	188	221	85.1	213	243	87.7	-2.6	120	131	91.6	108	118	91.5	0.1	2.7	0.2877	
Bagamoyo-Mkuranga	127	148	85.8	102	112	91.1	-5.3	129	139	92.8	74	78	94.9	-2.1	3.2	0.2676	
Hai/Siha-Moshi Rural	149	167	89.2	149	160	93.1	-3.9	107	126	84.9	70	78	89.7	-4.8	-0.9	0.4364	
Magu-Misungwi	165	211	78.2	147	178	82.6	-4.4	112	160	70.0	108	157	68.8	1.2	5.6	0.1977	
Makete-Njombe	94	116	81.0	79	110	71.8	9.2	94	108	87.0	66	81	81.5	5.6	-3.7	0.3192	
Tandahimba	118	175	67.4	100	128	78.1	-10.7	101	124	81.5	83	103	80.6	0.9	11.6	0.0571	
Overall	841	1038	81.0	790	931	84.9	-3.8	663	788	84.1	509	615	82.8	1.4	5.2	0.0233	*

Source: End-line Household Survey.

The statistical test also showed that the "proportion of youth who felt that they were vulnerable to HIV infection and who thought their chances of getting AIDS were not known" had increased in Hai/Siha but more-or-less stayed the same in the other six Learning Districts (Table 59). The interventions had no overall positive impact in terms of promoting awareness of children on their chances of contracting AIDS.

received help to secure their rights. In Hai the number of cases of children whose rights had been violated increased after the establishment and training of the DCPT and court cases involving children are being resolved faster.

Table 59: Proportion of youth who feel that they are vulnerable to HIV infection and who thought their chances of getting AIDS were not known

	LD baseline value			NLD baseline value			Difference at baseline stage (D1)	LD end-line value			NLD end-line value			Difference at end-line stage (D2)	Difference in difference (D2-D1)	p-value	Significance
	n	N	%	n	N	%		n	N	%	n	N	%				
Temeke-Kinondoni	13	221	5.9	16	243	6.6	-0.7	0	131	0.0	0	118	0.0	0.0	0.7	0.3783	
Bagamoyo-Mkuranga	25	148	16.9	12	112	10.7	6.2	1	139	0.7	0	78	0.0	0.7	-5.5	0.1020	
Hai/Siha-Moshi Rural	10	167	6.0	24	160	15.0	-9.0	0	126	0.0	0	78	0.0	0.0	9.0	0.0037	**
Magu-Misungwi	34	211	16.1	26	178	14.6	1.5	0	160	0.0	0	157	0.0	0.0	-1.5	0.3409	
Makete-Njombe	19	116	16.4	12	110	10.9	5.5	0	108	0.0	0	81	0.0	0.0	-5.5	0.1151	
Mtwara Rural-Tandahimba	48	175	27.4	29	128	22.7	4.8	0	124	0.0	0	103	0.0	0.0	-4.8	0.1711	
Overall	149	1038	14.4	119	931	12.8	1.6	1	788	0.1	0	615	0.0	0.1	-1.4	0.1762	

Source: End-line Household Survey.

In relation to the proportion of youth who identified sexual intercourse as a mode of HIV transmission, the difference in difference test revealed that the HIV Prevention intervention had an impact in Hai/Siha but had no impact in the other five Learning Districts and also had no overall impact in Learning Districts (Table 60).

Table 60: Proportion of youth who identified sexual intercourse as a mode of HIV transmission

	LD baseline value			NLD baseline value			Difference at baseline stage (D1)	LD end-line value			NLD end-line value			Difference at end-line stage (D2)	Difference in difference (D2-D1)	p-value	Significance
	n	N	%	n	N	%		n	N	%	n	N	%				
Temeke-Kinondoni	183	337	54.3	182	351	51.9	2.5	122	131	93.1	104	118	88.1	5.0	2.5	0.3156	
Bagamoyo-Mkuranga	137	179	76.5	102	134	76.1	0.4	127	139	91.4	69	78	88.5	2.9	2.5	0.3520	
Hai/Siha-Moshi Rural	154	230	67.0	139	241	57.7	9.3	105	126	83.3	73	78	93.6	-10.3	-19.5	0.0008	***
Magu-Misungwi	191	239	79.9	157	233	67.4	12.5	131	159	82.4	120	157	76.4	6.0	-6.6	0.1379	
Makete-Njombe	100	151	66.2	95	145	65.5	0.7	89	108	82.4	70	81	86.4	-4.0	-4.7	0.2676	
Mtwara Rural-Tandahimba	146	207	70.5	118	152	77.6	-7.1	107	123	87.0	87	103	84.5	2.5	9.6	0.0721	
Overall	911	1343	67.8	793	1256	63.1	4.7	681	786	86.6	523	615	85.0	1.6	-3.1	0.1210	

Source: End-line Household Survey.

Youth interviewed during the evaluation mostly indicated that the quality of their lives had improved as a result of accessing VCT services, referral for services and training of youth groups. Compared to the prevalence of 7% at the beginning of the program, findings of the 2007-08 THMIS, confirmed a reduction of prevalence to 6% of adults age 15-49 were infected with HIV. TACAIDS, 2009 estimates even showed another slight decline in adult HIV prevalence to 5.7%.

However, in rural areas HIV prevalence is increasing due to a combination of limited knowledge, harmful socio-cultural beliefs and practices, poverty and poor access to health service infrastructure which denies them access to quality HIV-related prevention and treatment services.

7.4 Impact of PAAP

Short-term impacts are already being realised through the inclusion of child protection interventions in the council budgets as well as other needs of children (e.g., MVC school fee payment, user fee waiver on health care for under-fives and pregnant mothers, and provision of basic needs such as food and clothing).

Medium to longer term impacts will be realised, for example, through more years of schooling for MVCs, success of youth IGAs activities, HIV prevention, and high impact nutrition interventions that are budgeted for in the MTEF.

8 SUSTAINABILITY OF RESULTS ACHIEVED BY THE 7 LDS STRATEGY

This Chapter analyses the likelihood that activities promoted by UNICEF under the 7 LDS Strategy will continue after UNICEF support has been phased out, and the results already achieved at output, outcome and impact levels will continue to benefit the target groups reached by these interventions. It seeks to answer 3 evaluation questions pertaining to sustainability, namely:

- To what extent are the outcomes and results of the programme sustainable at their respective levels (communities, district, regional and national level)?
- What is the potential for scale up, replication and/or integration into national policies, strategies and future programming strategies/approaches?
- Did the 7 LDS Strategy have a clear exit strategy? What critical factors or criteria should be considered when deciding on the appropriate exit strategies?

Overall assessment

Overall, using the OECD 4-point rating scale whereby A=Very Good, B=Good, C=Some Problems and D=Major Problems, the Evaluation rates the “Sustainability” of **activities “C” Some Problems** given that a large part of the activities UNICEF was funding (such as training) will be discontinued for reason of suspension of Government financial support, while others will continue albeit with limited financial support through the MTEF (e.g., HIV prevention activities, and MVC educational support). Sustainability of **results achieved is rated a “B” Good**, results based strategic planning is likely to continue, behaviour change in the area of WASH, MNCH, is likely to be sustained, girls and boys empowered through TGEI and Life-skills interventions are likely to continue to speak-out on their rights, low rate of staff turnover in government implies skills imparted in health service providers will be retained in the health sector although application will be affected by staff redeployment to duties not requiring the same skills.

8.1 To what extent are the outcomes and results of the programme sustainable at their respective levels (communities, district, regional and national level)?

8.1.1 Early childhood development

In relation to ECD, two indicators were identified to assess the extent of sustainability of the interventions (proportion of ward trainers trained on ECD who are still in post; and proportion of CoRPs trained in ECD at ward level who are continuing to visit caregivers and families to educate them on ECD). Information obtained from the ward executive officers indicated that all LDs had ward ToTs on ECD in the wards sampled for this evaluation (1 ward per district was sampled in both LDs and NLDs) but the turnover was high in LDs as only half of those trained ward level facilitators were still in post and continuing to train CoRPS. No ward ToTs on ECD had been conducted in any of the wards sampled in the NLDs except in the ward for Moshi rural, whose facilitators were all in post.

The proportion of CoRPs trained on ECD at ward level who were continuing to visit caregivers and families to educate them on ECD was 94% (84/89) for the 7 wards sampled in the LDs and 91% (10/11) for the ward in Moshi Rural where a ToT course on ECD had been conducted. In general ward executive officers pointed out the turnover in CoRPS was in general low, but the frequency of the visits to the mothers was the main challenge given the lack of incentives. Incentives varied from one district to another with some indicating that CoRPS were rewarded indirectly by being prioritised for recruitment on other short-term activities such as managing elections, child health days, training activities that paid an allowance, or other national events.

8.1.2 Nutrition

In relation to sustainability of results from various trainings on nutrition, in both LDs and NLDs, trained health workers are continuing to provide on-the-job training to fellow staff. Staff turnover at the district level was reported to be in general very low (less than 10% per year in both LDs and NLDs) but staff transfers from one health facility to another in the same district or from one department to another within the same health facility are frequent and this is where the problem is in terms of sustaining the utilisation of the trainings provided on nutrition.

8.1.3 WASH

Sustainability of water schemes remains a big challenge in both LDs and NLDs (see Table 61). UNICEF did not do enough in the area of strengthening water user groups, due to budgetary and human resource constraints, but it remains a priority area of future intervention. Both LDs and NLDs had large proportions (20%-83%) of new or rehabilitated schemes no longer operational after 4 years. The main challenges were theft of equipment, low water yield of some water sources (e.g., boreholes which were poorly sited), poor maintenance, water committees misusing the money raised through user fees and the misuse of the community assets as users consider them to be government property.

In some areas there was community reluctance to pay user fees due to non-transparent management of the funds. In a case study in Kilimanjaro region in Moshi district, a German NGO raised funds and community members contributed in kind (e.g., manpower) under a project entitled Tanzania Promotion Trust and worth Tsh 600 million. After completion of the project the local organisation started charging money from the local communities to contribute to the running costs, but local community refused to pay 10 Tsh per 20 litre. The reason for the

reluctance was poor communication between the local NGO supervising the construction and the local communities³⁵.

A major constraint encountered during this evaluation was the absence of data on water scheme operational status. District water engineers in both LDs and NLDs were not aware how many schemes were still operating at the time of the End-line Survey. They do not have a functional M&E and reporting system that allows them to obtain information from the community level to the district, so as to inform their decision-making and prioritisation of monitoring/backstopping visits.

Recommendation 18: UNICEF could, in the context of the new Country Programme (2011 – 2015) consider assisting learning districts to build a model M&E system for water schemes, which would feed the national M&E system with up to date information on functionality of water schemes in Learning Districts. If tested successfully and proven to work, it could be replicated through national level policy instruments and budget support that tapes from several programmes for water at national level.

Table 61: Number of trained artisans still operating in sampled villages

District	Total number of villages in sampled ward	Number of villages with at least one trained water artisan still operating	%	Number of villages with at least one trained sanitation artisan still operating	%
Learning Districts					
Bagamoyo	No data	No data	No data	No data	No data
Hai	5	0	100	5	100
Siha	3	3	100	No data	No data
Magu	3	3	100	3	100
Makete	5	5	100	5	100
Mtwara	6	4	67	4	67
Temeke	5	1	20	1	20
All LDs	27	16	59	18	67
Non-Learning Districts					
Mkuranga	7	2	29	2	29
Moshi	5	0	0	0	0
Misungwi	3	3	100	3	100
Njombe	6	6	100	No data	No data
Tandahimba	6	0	0	0	0
Kinondoni	No data	No data	No data	No data	No data
All NLDs	16	11	69	5	50

Source: End-line Survey, Interviews with District Water Engineers.

Data on the proportion of trained artisans still working in the local area indicate higher retention rates for water artisans in NLDs and for sanitation artisans in LDs. This could suggest that UNICEF had better impact on sanitation artisans as opposed to water artisans. It may have been outperformed on the former by other development programmes for the water sector (e.g., the World Bank funded RWSSP) which are offering similar trainings and at larger scale.

With respect to the committees having funds for water scheme operations, the findings showed that 42% (8 /19) of the committees had funds in LDs and 60% (9 /15) in NLDs, again indicating higher prospects for sustainability in NLDs. The average size of financial resources reserved by water groups for repairs and maintenance of the water schemes varied widely between water

³⁵ Mwananchi Newspaper, 13 January 2012.

user committees a minority of districts (17-43%) that had committees able to save above USD500 per year (on average) for water scheme maintenance (Table 62). Self-sufficiency in scheme maintenance was therefore very low. Most of the schemes were not sustainable because communities were not ready to pay.

Table 62: Funds reserved annually for water scheme maintenance (average)

Funds reserved, USD	Number of LDs	%	Number of NLDs	%
0-100	3	43	2	33
101-300	0	0	3	50
301-500	0	0	0	0
501-1,000	1	14	1	17
>1,000	2	29	0	0
No data	1	14	0	0
Total number	7	99	6	100

Source: End-line Survey, Interview of Water User Groups.

Some communities (e.g., in Mtwara and Tandahimba) could not afford to pay because of poverty. Application of water by-laws was not the same everywhere – where the water by-laws and community contributions were not addressed then the sense of ownership was low. In such cases, the scheme was mainly donor funded and did not involve the District Water Engineer’s Office.

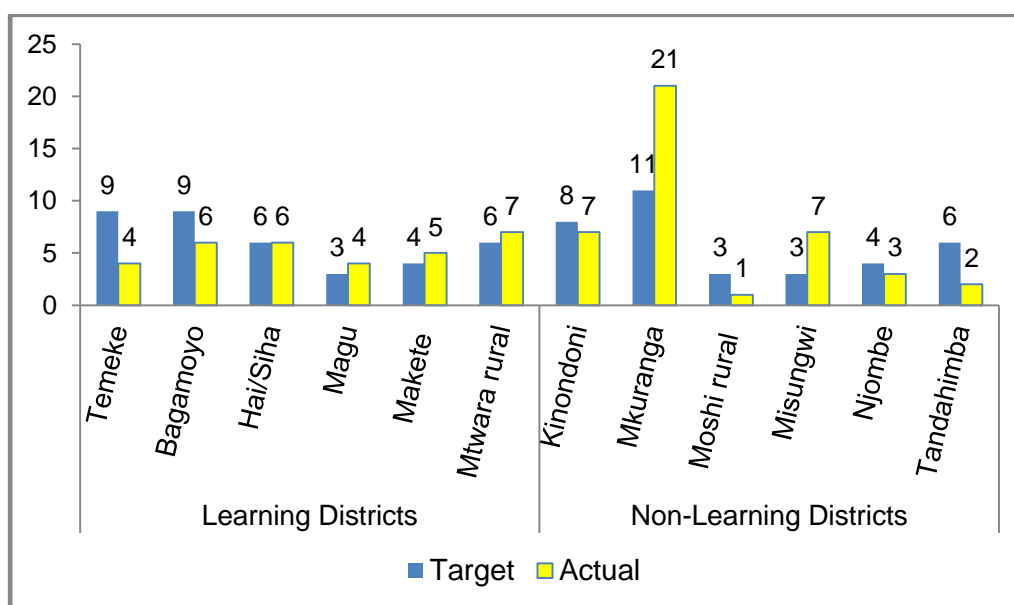


Figure 8: Frequency of meetings of water user groups, previous 12 months

Source: End-line Survey, Interview of Water User Groups.

On average, water committees met 6 times per year in both LDs and NLDs which is above average of quarterly meetings stipulated in by-laws of most water user groups (Figure 8). Ad-hoc meetings were called upon whenever there was a need. The study further showed that a significant proportion of water project committees were functional in LDs and NLDs as they were holding regular meetings as evidenced by presence of minutes and agenda. These similarities might be due to the fact that most water issues were subjected to national water legislation and water by-laws.

Allocation of funds in district MTEFs especially for WASH software activities remains a pipe dream. None of the districts provided financial support to sustain activities of WASH promotion

centres, implying that this model may not be sustained. Only two of the districts (Makete and Mtwara) had WASH budgets increasing in real terms in the MTEF, although for Mtwara it was a small increase. In some NLDs (e.g., Njombe) the WASH budget was declining in real terms, whilst in others the budget fluctuated with no distinctive pattern of change.

8.1.4 MNCH

In general, highly variable proportions of MNCH DToTs (50-80% depending on the course) were confirmed to be still in post and available to continue with training. Only 5 of the 15 DToTs for cIMCI had by the time of the End-line Survey succeeded to offer second round training to health service providers. Those still in post in general lacked resources to continue cascading the courses to existing and new health service providers. For cIMCI, it appears Siha district had experienced a very high turnover. Less than 50% of cIMCI DToTs were still in post; some had gone for further studies, or relocated for family reasons whilst others had retired.

In a few districts, cascading of knowledge from DToTs to health service providers was continuing with training support provided by NGOs (e.g., EGPAF, Engender Health, FHI, Primary Health Care Institute), but this is not happening at a scale comparable to that of UNICEF. DToTs would have continued providing the training using resources from the Health Basket Fund, if government had not issued a directive in 2011 to suspend budget allocations to training activities in the MTEF. If the government continues with the suspension of training activities, it is unlikely that the results achieved by UNICEF in the LDs through MNCH trainings will be sustained.

The turnover of DMOs and RCH Coordinators who organised the trainings was minimal, however. The security of their jobs in government increases the prospects for sustainability of capacity building results achieved in the LDs. Only in a few cases did Evaluators find DMOs or RCH Coordinators having relocated. This was after having transferred the knowledge and skills they gained through training to other health personnel.

A more significant problem was the reassignment of staff to short-staffed departments within the same or a different health facility. The DMOs and RCH Coordinators revealed that re-deployment of trained staff from intervention to non-intervention districts was regular occurrence.

Changes in tasks assigned to trained health service providers compromised the results of the MNCH training programmes whenever trainees got reassigned to departments where they no longer needed to make use of the new knowledge or skills gained from the training. The same applied to non-MNCH courses (Table 63).

Table 63: Estimated proportion of trainees (PMTCT, Nutrition, cIMCI, WASH) reported to be fully utilising what they learnt, Siha District, November 2011

Course	Estimated proportion of trainees fully utilising what they learnt	Reasons why
PMTCT	60-80%	<ul style="list-style-type: none"> • Negligence • Staff assigned to outpatients department due to staff shortage • Staff shortage, too busy to provide all services
CoRPS	At most 60%	<ul style="list-style-type: none"> • No incentive

Course	Estimated proportion of trainees fully utilising what they learnt	Reasons why
		<ul style="list-style-type: none"> • Lack of refresher training • Infrequent supervision from district • No means of transport
EPI	78%	<ul style="list-style-type: none"> • 1 transferred out of district • 3 failing to perform well despite receiving training
CHWs	60%	<ul style="list-style-type: none"> • Lack of incentives • Lack of transport to cover large villages • Replaced by community • Migration
Nutrition	80%	<ul style="list-style-type: none"> • Transfer to male/female wards due to shortage of staff
Artisans	No data	<ul style="list-style-type: none"> • No following up of trainees
Malaria	80%	<ul style="list-style-type: none"> • CCAs being paid Tsh10,000/month by PSI, motivation is high

Source: End-line Survey, SIHA DMO and MNCH Staff Interviews.

This could be solved in future through better staff planning, multi-skilling and simply training more staff. The latter two would require more financial resources.

Activities such as provision of drugs and equipment will continue through the government budget and other pool funds for health. With the suspension of training, the training budget will be reallocated to sustain the purchase of medical supplies and drugs. However, the gap in drug supply will remain as existing funds are not adequate to meet the demand. At End-line the proportion of health facilities interviewed that were experiencing stock-outs of drugs had increased relative to the Baseline period.

With respect to equipment, the Evaluation findings revealed that districts have challenges with equipment maintenance. They are failing to maintain equipment donated by other development partners due to a lack of financial resources to pay for technicians from regional centres, and shortage of technical expertise in their local areas. They do not have back up support from equipment manufacturers. No concrete plan was put in place for preventive maintenance let alone replacement of obsolete equipment. This was assumed to be taken care of by the government.

Some LDs (e.g., Bagamoyo and Makete) were unable to assemble or correctly use the equipment supplied. Bagamoyo was unable to assemble the anaesthesia machine while Makete district was not able to operate two incubators, despite the fact that they had the manuals. Others like Mtwara, Hai and Siha³⁶ had not yet started using the theatre equipment because these facilities were still under construction. The districts also reported that some BP machines, beds and weighing scales had broken down and had not yet been repaired.

Due to the above reasons, most learning districts indicated that they were not ready for UNICEF to exit, nor was there an explicit exit strategy for MNCH.

³⁶ In these district decisions were made for UNICEF procurement to equip the new district hospital that they were planning to build as opposed to setting these up in an existing health centre as per original plan. As these districts did not have their own district hospitals they felt they should delay using the equipment until they had their own hospitals. How much more time the equipment will be idle is uncertain.

Whilst trainings took place and routine facility-based supervision is continuing, case management supervision and follow-up was found to be irregular, thus reducing the momentum and prospects for sustaining application of training outputs.

8.1.5 HIV prevention

Basic knowledge about how HIV is transmitted and how to reduce chances of infection was gained by the youth and structures trained. It is unlikely that this knowledge and skills could be lost. If lost then the national campaigns which are on radio, television and the school based HIV&AIDS program could sustain the HIV knowledge and skills among the young people. Members of the C/W/V-MACs were sourced from among the targeted communities; therefore it is likely that their knowledge and skills gained from training will be sustained locally. However it is possible that CHACs who were trained within 7LDs could be posted and reallocated like any other Council staff. Financing for implementing HIV prevention activities among the Councils will be sustained through the Government MTEFs. This is because the MTEFs are by now reflecting HIV&AIDS prevention after receiving support and guidance from UNICEF.

Furthermore the interventions were done by CBOs and the youth from within the community so the skilled personnel continue to be available to continue carrying out the activities with little additional support.

8.1.6 WSDP

The evaluation found that in all the FS visited, the school planning activities have been institutionalised and now form part of routine procedure within the schools. Planning formats and procedures have been internalized and therefore will always be used within the schools, by the Ward Education Coordinators as well as at district level. Stakeholders concerned have now gained sufficient interest and mastered the knowledge and skills they require in order to sustain the school planning approach. Additionally the planning activities take place with minimal additional costs; therefore they can be sustained. The approach was introduced to all levels (district, ward and school) and targeting all the main stakeholders (pupils, school committees, teachers, head teachers and district education officials). The mandate of the WEC in monitoring implementation of school activities also ensures the sustainability of schools in preparing quality school plans that again conforms to the basic education minimum standards. The institutionalization of activities has been strengthened as the school principals and teachers are accountable to the WECs who report the progress made by the school to the school inspectors and/or DEOs. However, the WECs lack financial support for fuel, stationery, and offices. Some are purchasing stationery using their own salaries which is a sign that they appreciated their work but also an indicator that this issue needs urgent solutions before fatigue creeps in.

8.1.7 CPP

MVC Plans and Guidelines

LDs were having more regular MVC coordination meetings than NLDs. Sustainability of structures built to coordinate MVC activities was found to be stronger at the level of the district administration, and less at the ward and village levels (Table 64). The structures set up to coordinate MVC activities at the district level (e.g., CMAC) are structures that have financial support and are connected to the political governance structures of the district. The councillors who head the CMAC are elected officials and may be changed from time to time depending on

outcomes of elections hence sustaining the capacity of the committees requires continuous training, which to some extent is available through other funds for HIV-related activities.

Table 64: Indicators of sustainability of MVC committees

Indicator of sustainability	LDs	NLDs
Proportion of districts having regular MVC coordination meetings	86%	33%
Proportion of villages with functioning MVC committees	59%	11%

A major constraint in sustaining UNICEF achievements is the absence of a dedicated sub-vote and cost centre under the control of the district social welfare's office to finance MVC care and support and other child protection activities. Districts were relying on UNICEF and other donor funds.

Sustainability of the MVC database is questionable, given that the web-facility was dysfunctional at the time of the Evaluation and all district social welfare officers interviewed were not well informed about the challenges the DMS was facing with the current web-based facility, nor were they clear about the next steps. Many districts were trying to connect and update the database without success. Whilst the utility of the data in decision making was strong, the main issue was the inadequacy of financial and material resources to cater for the needs of all MVCs in the register. The failure to provide support to the registered MVC was frustrating and demotivating MVCCs, thus casting serious doubts on the continuation of the activities of MVCCs at the ward and village levels.

Child protection system strengthening

The new Child Protection System is building on existing structures (education officers, social welfare officers, judiciary, medical personnel, and the police) to establish and capacitate district child protection teams. At the ward level, existing structures are also being used (MVCCs, social workers, NGOs and FBOs and CJFs). UNICEF is building on existing structures to introduce new ideas from the NPA. UNICEF has provided goods, training on child protection, tools to work with, all of which will continue to be utilised when UNICEF activities are phased out. Overall, the improvement in knowledge of MVC needs, the rights of MVCs and the imperative to respond by both district authorities and local committees is likely to be sustained. However, what really threatens sustainability of MVCCs is the dwindling resources base for supporting MVCs economically and materially.

District councils have started allocating budgets to MVC activities in both LDs and NLDs. In Makete, the council has begun using their own revenue to provide school bursaries to MVC, whilst in the NLDs they are using other budget lines funded centrally (e.g., the Health Basket Fund). Each year there is a target set for the number of MVCs to be supported by council resources and there is evidence from both LDs and NLDs that the number is increasing in absolute terms yet not as a proportion of total number of children on the MVC register. However, this good practice of allocating resources to MVC through donor funded budget lines is expected to continue in both LDs and NLDs.

Child Protection Teams (CPTs), MVCCs and CJFs are the main organs for child protection, but are largely based on voluntarism and donor funding. In terms of sustainability of achievements of the CJF programme, there is emerging evidence from some LDs (e.g., Makete) that the functions of the cadre may continue to be financially supported through councils' own revenues. The main challenge being faced is that so far the work of the CJFs is on a voluntary basis although some districts provide indirect incentives by way of involving the community of volunteers (CJFs, CoRPS, CPTs, VMAC, WMACs, etc) on short term paid work during national

elections and vaccination campaigns. The number of CJFs is still too few to have impact. They will soon be overwhelmed with the work as more people get to know the type of assistance they can provide. Hence to sustain the work of CJFs, it may be important to institutionalise training of CJFs mainly as para-legal workers who may also carry responsibilities of para-social workers in areas where there is no social welfare officer or community development officer.

8.1.8 PAAP

Districts have functional District M&E Teams that are continuously providing support

All 6 LDs in which DPLOs were available and interviewed had a functional DMET that had been constituted, in contrast with only 4 of the 6 NLDs interviewed. Whilst all LDs had some trained DMET members, only 2 NLDs had trained DMETs (Misungwi and Njombe, these were closer to regional centres). Among NLDs, Mkuranga and Kinondoni did not have DMETs constituted. Altogether, LDs had more DMET members trained than NLDs, at 50, compared to NLDs (only 7 officers were trained).

On average 6 DMETs were trained per LD, compared to 2-3 for NLDs. In all LDs, 78% (39/50) of the trained DMET members were still present in post and continuing with their activities, compared to 71% (5/7) for all NLDs.

Other findings on sustainability: Positives

LDs are continuing with data collection through the village register and the LGMD and also updating the district socio-economic profile report using own money and working with the NBS (e.g., Makete). Makete MTEF for 2011/12 was taken as best practice and shared with other districts in the Iringa region by Ministry of Finance.

LDs are continuing with strategic planning using internally generated revenue (e.g., Makete). LDs are also commissioning socio-economic profile in collaboration with NBS using internally generated revenue. Inclusion of children's priorities in SP (5 year) and MTEF (3 year) indicates that the outcomes of UNICEF's contribution are being sustained.

Other findings on sustainability: Negatives

Sub-district training is expensive, O and OD not afforded by districts. Training of VEOs and other sub-district staff who collect information through LGMD is expensive, and beyond reach of LDs. Printing of the village registers constitutes a significant cost to districts (e.g. Njombe) though Makete has printed another batch indicating that districts that have understood the importance of the registers are likely to continue using own resources.

8.2 What is the potential for scale up, replication and/or integration into national policies, strategies and future programming strategies/approaches?

Several models UNICEF has piloted in the 7 LDs are scalable. The community based care model tested for ECD is a simple and readily applicable model which can easily be replicated in other districts. Moshi Rural an NLD had already adopted this model. However, the lack of involvement of the Regional Secretariats in the previous phase of the LD strategy was clearly a missed opportunity. The Regional Secretariat offices could have played a key role in promoting the sharing of lessons across all districts in a region (LDs and NLDs) and facilitated replication of approaches across districts in the same region.

As for nutrition, the nutrition interventions promoted through the trainings (ENA, PI-ENA, IYCF, screening for SAM) are interventions that have already been proven to work not just in Tanzania but elsewhere and are being scaled up in many developing countries. Already, the training of health service providers on nutrition is on-going and being scaled up in Tanzania as a matter of national strategy for improving maternal and child nutrition through funding from the Health Basket Fund, a Sector Wide Approach (SWAp) and other donor-supported programmes.

Furthermore, in recognition of the importance of exclusive breastfeeding and infant and young child feeding practices the Ministry of Health and Social Welfare (MoHSW) together with the support of development partners (including UNICEF) already developed and rolled out implementation of a National Strategy for Infant and Young Child Nutrition in 2004. A National Nutrition Strategy was also developed and was approved by Cabinet in September 2011. The costed implementation plan is expected to be completed by June 2012.

Health sector reforms including decentralized planning and resource allocation have also played a part in shaping the operating environment for nutrition actions, and provided an enabling environment for short routes to addressing malnutrition in children, though the percentage of mothers providing exclusive breastfeeding to their infants remains low, and infant feeding practices during the complementary feeding stage remain inadequate thus continuing to put children at risk (UNICEF, 2010).

The WSDP approach has proven to work in focus wards and focus schools and with little additional input has been replicated in Makete and Hai in non-focus schools, however the districts lack resources to cascade the training to the next generation of school principals, school committees, teachers, WECs and students. This type of training does not require frequent refreshers since, once mastered at a school, and the first generation of WSDP have been produced and implemented successfully, the approach is likely to be sustained for a long time by the practicing schools because the results of the approach in terms of increasing community participation and contribution quickly become visible.

The PMTCT awareness promotion model used in Makete which involved all stakeholders at district and community level is a scalable approach, it only requires to be documented and the NGO that was contracted for the IEC programme provides technical support to districts interested. Most districts are grappling with the issue of stimulating an increase in male involvement in PMTCT, as it is one of the bottlenecks to increased coverage of PMTCT services. The evaluation observed that while male involvement in Makete had reached 54% by 2010, in NLDs like Moshi, it was very low hardly reaching 15%. The structures used to promote male participation in Makete are in all districts and the approach is the innovation that only needs to be shared, and with little resources, significant results could be achieved in new districts.

In the context of the results from water supply and PHAST trainings which were carried out under WASH, it is evident that combining water supply and hygiene education is a good model but not easily replicable as investments in piped water supply schemes is expensive. Investing in piped water is a high cost undertaking, but the social acceptability of the behaviour change required is high, in terms of for instance, treating water supplied for drinking using water guard or through boiling. Boiling of water is feasible in Tanzania in areas where there is a ready

supply of firewood. Hence promotion of this practice in districts that have depleted their forests may be a challenge unless UNICEF promotes alternative energy saving stoves. It is evident that promoting the washing of hands at critical moments is not easy in an area where the communities are facing water supply difficulties; they will have a ready excuse for not practicing in non-availability of water. Under those circumstances, UNICEF may have to go with a twinning approach – either working on software whilst another development partner addresses the water infrastructure issues, or UNICEF does both. Due to the high cost, it may be necessary for UNICEF to target regions or districts with acute shortages of water or those with the highest incidence of diarrhoea.

The concept of a water and sanitation promotion centre still needs further refinement to build into it a business model that ensures continuity of their activities and cost recovery to compensate artisans that will be man these centres.

The approach used by TGEI and life-skills education to reach young people in school and out of school through Tuseme clubs is popular with the school children and can be scaled up easily, by training focal teachers and students.

The new child protection system model is still being tested but is already showing that it is indeed a promising model in so far as results achieved and scaling it up is concerned. The strength of the system is that it uses existing structures to build up a stronger child protection system. District child protection teams that are being set up are based on institutional representation and the institutions have already been duty bearers in so far as child protection is concerned but their relationships for child protection are being strengthened, organisationally and in terms of knowledge so that they are better equipped to carry out their mandates in creating a protective environment for children.

9 EXTENT TO WHICH CROSSCUTTING ISSUES WERE ADDRESSED BY THE 7 LDs STRATEGY

This Chapter presents evidence on the extent to which UNICEF and implementing partners within Government at central level and at the district level as well as within NGOs addressed four cross-cutting issues and provides answers to the following evaluation questions:

- To what extent did the actual interventions prioritize the most vulnerable?
- To what extent did the actual interventions enhance gender equity?
- To what extent were the district planning, budgeting and review process results based?
- To what extent did the community members participate/involved in decisions during implementation?

Overall assessment

Overall using the OECD 4-point rating scale whereby A=Very Good, B=Good, C=Some Problems and D=Major Problems, the Evaluation rates the “Mainstreaming of Cross-Cutting Issues” in the 7 LDs Strategy as having been **between a “B” Good for issues of dealing with targeting of the most vulnerable, between “C” and “D” for gender, “A” for results based planning and budgeting, and “B” for community participation.**

9.1 Vulnerability and Equity considerations in Interventions Targeting

9.1.1 To what extent did the actual interventions prioritize the most vulnerable?

Young Child Survival and Development

Vulnerability and Equity considerations in Targeting of Nutrition Interventions

In relation to nutrition, interventions were district-wide and not targeted to specific wards known to have the highest prevalence of severe malnutrition, or poor IYCF practices. The choice of the seven learning districts was not explicitly based on malnutrition criteria. The choice of districts was directed more by PMO-RALG. The wide geographical spread of the 7 LDs, for example, was meant to have every region covered. By focusing on child nutrition, however, UNICEF targeted a vulnerable group and the training of CoRPS in particular was meant to assist children at high risk of acute malnutrition, and the close correlation between severe acute malnutrition and HIV and AIDs in children confirms that UNICEF did target a very vulnerable group through its trainings on nutrition and the provision of updated MUAC tapes to CoRPS.

However, it is also evident that in the case of Magu, for instance, that the number of CoRPS trained in either IECD or cIMCI was very small in relation to the total needs, when comparing to training of health workers. For CoRPS, which are supposed to target the most vulnerable children, who usually do not have access to health facilities, the coverage was only 6% of the needs, compared to those for health workers, namely: IYCF (21%), ENA (60%) or PMTCT (40%). Information on the cost per trainee and beneficiaries of the various training courses, indicates clearly that at district level, most of the resources for training on nutrition and ECD went towards training of facility-based health service providers as opposed to front-line community cadres (CoRPS) who attend to the most vulnerable children (those who do not come to the health facilities because they cannot even afford health care).

Vulnerability and Equity considerations in Targeting of MNCH Interventions

UNICEF did not select LDs on the basis of the degree of concentration of the most vulnerable. However, by nature of the interventions, the MNCH programs were targeting the most vulnerable, who include, mothers in their reproductive ages, new-borns and infants. The interventions were designed to improve the quality of services to children and mothers who needed health care. However, strategies applied by the districts in mobilizing participation in MNCH were not tested among at risk population groups like Sex Workers (SW), Drug Users (DU), children who are victims of abuse and the mentally challenged.

Vulnerability and Equity considerations in Targeting of PMTCT/PDAIDS Interventions

PMTCT targets the most vulnerable among women and their children – those who are expectant and living with or exposed to HIV are prioritized in the targeted group of women and

children highlighted as a priority in National PMTCT and ARV Scale up Plan, National HIV Prevention Strategy, National, NMSF and HSSP. The PMTCT program was open for all women and children who need the service in all the districts. Strategies applied by the districts in mobilizing participation in PMTCT worked well for the general population but were not tested among key population groups like Sex Workers (SW), Drug Users (DU) and the mentally challenged.

Vulnerability and Equity considerations in Targeting of BCC Interventions

BCC interventions were aimed at improving lives of the most vulnerable being pregnant mothers, the unborn child and already born child. The health issues which were addressed through the BCC interventions are those which are most common among children and women who are socially or economically disadvantaged within the country.

Vulnerability and Equity considerations in Targeting of WASH Interventions

Only 2 districts from each LDs and NLDs confirmed having a list of prioritized communities for water projects. In the LDs these were Mtwara and Makete, while among the NLDs these were Mkuranga and Njombe. Only these districts explicitly prioritized the most vulnerable. In Makete District, the local authority confirmed that they prioritized vulnerable groups including the disabled, the old people and those chronically ill for water supply. In Mtwara, the district sets criteria including accessibility of water source, availability of funds and readiness of the community to contribute financially towards the project and this enhances local ownership and sustainability. However, criteria such as readiness to contribute funds tend to marginalize those who do not have good income sources as they cannot raise the needed matching community contribution.

Apart from the selection of Makete district on the basis of high HIV and AIDs prevalence, there is no other evidence that the learning districts were selected on the basis of an explicit objective to prioritize the most vulnerable. However, the CPP, the MVC care and support sub-component, the mobile legal aid clinic, community justice and birth registration pilot programme were all designed with the view of helping the most vulnerable children in the districts that were selected. By design water supply interventions funded by UNICEF were specifically earmarked for vulnerable communities and this was corroborated by Evaluation evidence collected from Makete. Sanitation and hygiene interventions have impact e.g. of reducing diarrhoea only if they reach the whole population, hence were targeting all villages in each of the districts. Within each village these interventions reached the most vulnerable HHs who have the least ability to afford an improved latrine. Targeting these without compromising the whole intervention is still a challenge.

Basic Education and Life Skills

Vulnerability and Equity considerations in Targeting of Whole School Development Plan Interventions

All the FS plans addressed basic needs of the most vulnerable among students – the MVC. Among the provisions which had most impact on addressing needs of MVC included guidance and counselling initiatives, gender and human rights, and school lunch.

Child Protection and Participation

Vulnerability and Equity considerations in Targeting of Child protection Interventions

By their very nature, the child protection interventions funded by UNICEF were designed for children who are most vulnerable. However, within the districts selected the Evaluation found no evidence that pilot activities were targeted first at communities with either the highest concentration of the most vulnerable children or the highest child poverty levels.

Vulnerability and Equity considerations in Targeting of HIV Prevention Interventions

Youth in Tanzania are likely to be vulnerable to HIV due to unemployment, low economic status and inadequate access to health information and services. Emerging evidence shows that youth also exist among key population groups who are most vulnerable to HIV including SW, DUs, and Men Having Sex with Men (MSM). The UNICEF supported interventions therefore targeted youth as a truly vulnerable population group within the communities. The interventions deliberately went further and targeted low income groups of youth who often were unemployed and therefore came together in a bid to elevate their social and economic status.

It was noted that most HIV prevention messages were not deliberately designed and tailored to improve knowledge and skills for HIV prevention among the children 0-14 years. Although they are perceived to be less at risk, these children represent a unique window of opportunity to start instilling health seeking knowledge and behaviour way in advance, for an entire generation age-group.

9.2 Gender Mainstreaming and Equity

9.2.1 To what extent did the actual interventions enhance gender equity?

Young Child Survival and Development

Gender Mainstreaming and Equity in Nutrition

The Evaluators were not privy to any specific gender mainstreaming strategy adopted for the 7 LDs Strategy. Nutrition, by virtue of it directly assisting women improve their reproductive gender roles, was targeted more to women than men, but largely to simplify their reproductive health functions. Nutrition education provided to health workers did not deliberately target a certain threshold in terms of participation of women and men. Selection of trainees did include both men and women but was based more on the existing gender balance of the staff resources available in the health facilities and their current functions.

Gender Mainstreaming and Equity in MNCH Interventions

Women and their children were effectively targeted in MNCH service delivery. However there was no report provided by districts about any deliberate and conscious efforts made to analyze and address the unique needs and circumstances of women, men, girls and boys in their programming.

Some of the major challenges which affected the extent to which women accessed MNCH services included low involvement of men in MNCH interventions as well as women's inadequate authority to make decisions affecting their health. This included for instance women's decisions to suspend or postpone child birth if they are ill.

Gender Mainstreaming and Equity in PMTCT/PDAIDS Interventions

Within the LDs and NLDs visited, there were some efforts to analyze and address unique needs and challenges of women, men, girls and boys as relates to PMTCT, EID or P-ARV. All the districts visited have designed and are undertaking interventions to promote male involvement in PMTCT. This is in recognition that men as the gate keepers in the household should accompany their women and give them moral and financial support through PMTCT programs. Sex was also considered in the PMTCT training through balancing numbers of women and men trained.

Gender Mainstreaming and Equity in BCC

BCC activities were mainly designed to address health and hygiene issues affecting pregnant mothers and children under 5. The BCC interventions did not undertake an in-depth gender analysis which would inform the design and content of messages communicated. The word “gender” was conspicuous by its absence in the PSI project proposal.

Gender Mainstreaming and Equity in WASH

By investing in water supply for vulnerable communities in Makete, UNICEF contributed towards meeting the reproductive gender needs of women by providing households with piped water. This freed up women’s time for child care and other more strategic gender issues.

In addition a number of specific measures were included to address gender issues, including the following:

- 1) UNICEF interventions followed the National Water Policy guidelines that each Water User committees comprised equal numbers of men and women, and consequently many key positions e.g. Chair/Secretary/Treasurer are held by women.
- 2) Artisans trained on hand-pump maintenance and CORPs trained on sanitation & hygiene promotion included women.
- 3) School water supply, sanitation and hygiene interventions especially toilets had special rooms for menstruating girls – as research shows that this is a major area keeping girls out of school during menstruation periods. Also UNICEF has developed the “Growth and Change” Girls’ Menstrual Hygiene Book and associated Teachers Orientation materials which are distributed to all districts implementing school WASH including LDs.
- 4) Women as care givers of U-5 children were targeted as a critical part of the target group for sanitation and hygiene education (e.g. in the PSI integrated package).

However the training of artisans was by nature of the gender configuration of the artisans not intended to address gender equality issues directly such as through setting thresholds for women participation in artisan training programmes. In Magu, the training statistics show that career of artisans is not a domain for women; out of 125 artisans trained by EEPCO in Magu in 2008/09, only one of them was a woman, the rest were men.

Data on other forms of training e.g., WASH orientation for CORPS, was not gender disaggregated but this intervention could have targeted more women than men since a higher proportion of CORPS are female.

Basic Education and Life Skills

Gender Mainstreaming and Equity in Whole School Development Plan Interventions

The results from the school principals' interviews showed that issues of gender are identified and addressed in the Whole School Development Plan 69% (18/26) in LDs compared to 32% (8/25) in NLDs. All the FS visited indicated that they had included efforts towards gender equity in their Whole School Development Plan as a critical consideration in planning. This enabled them to address the unique gender-related challenges that confront boys and girls while considering their different circumstances and needs.

The specific interventions which were targeted at achieving gender equity within the Whole School Development Plan included: equal representation in Tuseme clubs, provision of school water and sanitation services, prevention of adolescent pregnancies and affirmative action to improve examination pass rates for girls.

Although NSGRP/MKUKUTA had set clear targets for school enrolment of girls and boys, and gender parity improved to almost 1 in primary education, disparities remain across regions largely due to varying levels of poverty and vulnerability of the children. Disparities in educational outcomes of boys and girls also remain wide. It is estimated that about 17% of the total population of children aged 0 – 14 years are 'vulnerable', of which some 5% or 930,000 are 'most vulnerable' (NACP for MVC 2007-2010). This vulnerability affects their access to basic services like education and healthcare. Government allocations to social safety nets (e.g., education support to MVC) fall far below the magnitude of needs of these children. Girls who are transitioning to secondary education are fewer than boys, and those that complete secondary are even less. In 2008, the percentage of school entrants who had completed seven years of schooling had declined to approximately 65% from 78% in 2007. In addition both the pass rate in the Primary School Leavers' Exam and the transition rate from Standard VII to Form I decreased in 2007 (UNICEF, NBS, and REPOA, 2010). Though by 2010, completion rate to Standard 8 had risen marginally to 81.4%.

Child Protection and Participation Gender Mainstreaming and Equity in Child protection

Unlike other components, CPP appeared to have a strategy to address gender issues. For instance, guidelines on the formation of junior councils required equal gender participation in the membership of junior councils, and insisted on the marginalised groups (children with disabilities) to be included. Gender composition of MVC committees was also in favour of women in senior positions (Table 65). Women were three times more likely to occupy the position of Chairperson of MVC Committees in LDs than in NLDs, they were 1.5 times more likely to occupy the position of Secretary and equally likely to occupy the position of treasurer. However it was not clear whether these women were adequately sensitised on the different needs of boys and girls identified as MVCs.

Table 65: Gender composition of MVC Committees

Indicator	LDs	NLDs
Gender composition of MVC Committees: a) Chairperson	78% (7/9)	25% (3/12)
Gender composition of MVC Committees: a) Secretary	75% (9/12)	58% (7/12)
Gender composition of MVC Committees: a) Treasurer	64% (9/14)	63% (10/16)

While girl children are viewed as most vulnerable to abuse, neglect and exploitation, and need more attention to protect them, no evidence was found of sound analysis of gender issues that guided programming. It was not clear also whether there were deliberate and conscious efforts to analyze and address unique needs and challenges of girls and boys as related to MVC care and support, birth registration, legal aid and the new child protection model. In M&E, gender was not systematically addressed.

It is the Evaluation's view that the CPP interventions such as the legal aid clinic project could have been better informed by a good analysis of the gender issues, for example, the gender dynamics promoting or hindering access of children to mobile legal aid.

Gender Mainstreaming and Equity in HIV Prevention Interventions

Actions undertaken in this KRA to enhance gender equity included ensuring equal representation of women and men where possible. For instance among the representatives of the committees and among youth trained, gender balance was given a key consideration.

9.3 Planning, Budgeting, Monitoring and Reporting

9.3.1 To what extent were the district planning, budgeting and review process results based?

Prior to the preparation of their most recent 5-year Strategic Plans, Siha and Makete districts commissioned independent service providers and the national bureau of statistics to conduct research and prepare baseline district social economic profiles to inform planning. This is a practice more common in LDs than NLDs. District plans and MTEFs had a clear articulation of indicators for performance measurement, as well as targets with specific timeframes.

LDs are also using the LGMD tool to collect information on an annual basis on output targets for all sectors including health, WASH, and education but with less emphasis on roads and natural resources since not enough indicators are included in the LGMD tool for these sectors.

Nutrition interventions are specifically planned for in the Comprehensive Council Health Plans (CCHP) and evidence from the review of CCHPs collected from both LDs and NLDs indicates that each plan document has a chapter devoted to the situational analysis, where key health outcome indicators are discussed (see example in Table 66).

Table 66: Summary of important HMIS Indicators showing the trend, CCHP (July 2011-June 2012), Hai District

S/N	Indicator	Year 2008	Year 2009	Year 2010
1	Proportion under five children of weight < 60kgs	0.6%	0.5%	0.2%
2	Vitamin A Supplementation (in %)	99.2%	99.9%	99.6%
3	Severe malnutrition rate (in %)	0	0	0
4	Moderate malnutrition rate (in %)	0.2%	0.3%	0.1%
5	Proportion of low birth weight (in %)	1.4%	2.1%	1.5%

Source: CCHP (July 2011-June 2012), Hai District.

In Hai, malnutrition is ranked as a secondary health problem and not a top priority. For each identified priority, the CCHP articulates the priority area, area of intervention, the problem to be addressed, the objective and targets to be achieved, the activities to be implemented and the cost centre that will finance the activities.

MNCH, PMTCT and PAIDS interventions were planned for, budgeted and reviewed based on evidence generated from the Health Management Information System (HMIS) as well as the MNCH and PMTCT program monitoring systems. Clear results, objectives and indicators were outlined in the Comprehensive Council Health Plans and budgets on MNCH. District plans specified clear results and objectives for children as relates to MNCH, PMTCT and PAIDS in line with the National MNCH Strategy and the PMTCT Scale-Up Plan.

BCC activities were planned, designed and implemented through a sub-contract with PSI. Therefore the activities were not necessarily aimed to be included into the district plans during this phase of the program.

UNICEF interventions have historically been informed by the Situational Analysis of Women and Children. During the 2007-2010 Country Programme many other studies were carried out with a view to specifically guide the choice of interventions in the WASH, CPP and BELS fields.

Schools plans which were developed in all the focus schools visited had clear objectives and results for children with smart indicators and targets which were used for budgeting.

The UNICEF supported HIV Prevention activities were planned, designed and implemented through a cooperative agreement with FHI. The agreement with FHI contained clear results and indicators with targets which were to be achieved. In turn the program also built capacity and supported District Councils to mainstream clear activities, results and indicators for youth HIV prevention in their MTEF plans.

9.4 Community Involvement and Participation

9.4.1 To what extent did the community members participate/involved in decisions during implementation

Young Child Survival and Development

Community Involvement and Participation in Nutrition Interventions

CoRPS, who are targeted by the training on screening for SAM, and CIMCI interventions, are a community cadre, selected by communities and willing to volunteer and service the communities that have selected them. After receiving the training, CoRPS are visiting mothers and caregivers of children under the age of five years teaching them on best practices for feeding infants and other young children and dialoguing with them on ECD. This a community contribution though not quantified in terms of time input or financial resources invested in the form of opportunity cost.

Community Involvement and Participation in MNCH Interventions

MNCH interventions were subjected to the normal district planning process that encouraged wider participation of the general community at grassroots in priority setting through

organizational development processes. Community members participated in MNCH interventions through their representation in various village, ward and district level committees. Communities including adults and youth contributed through the village and ward meetings. Children made contributions through the schools and barazas in districts which had barazas. Health facilities from sub-district to district level also participated in identifying priorities for inclusion in village, ward and district strategic plans.

Community Involvement and Participation in PMTCT/PDAIDS Interventions

PMTCT/PDAIDS was subjected to the normal district planning process that encouraged wider participation of the general community at grassroots in priority setting through organizational development processes. Community members participated in PMTCT/PDAIDS interventions through their representation in various village, ward and district level committees.

Community Involvement and Participation in WASH Interventions

The Evaluation confirmed that water projects are managed by water user committees that are elected at the community level. Water users mobilise financial resources required to finance the servicing and maintenance of water supply infrastructure. Government and donors have set a standard for community contribution for water projects which is 20-25% depending on the WASH programmes in question. The local authorities are providing various kinds of support to water user groups, including:

- Rehabilitation / construction of water schemes;
- Training of artisans;
- Technical advice to water user committees;
- Hydrological surveys;
- Auditing of books of WUGs; and
- Assisting with project management.

What makes the water user committees successful were found to be the following critical factors:

- Good leadership;
- Knowledge of record keeping;
- Financially accountability to the community;
- Community awareness and participation; and
- Sales from water.

The role of communities is mostly compromised by high running costs (fuel), poverty, illiteracy and drought.

On sanitation, village governments are playing their part by incorporating what they will have been taught into by-laws to sustain outcomes at the local level.

Basic Education and Life Skills

Community Involvement and Participation in Whole School Development Planning Interventions

Systematic planning procedures were applied by 7LDs to prioritize Whole School Development Planning in their budgets. This procedure entailed: school principals organizing students, parents, teachers and the school committees to identify and prioritize main issues; forwarding schools issues and plans to the Wards; Wards analyzing and consolidating school plans into

one plan which they submit to the districts. This cascade system ensured that all priority issues concerning school plans were addressed at all levels.

During the evaluation, a majority of community members expressed satisfaction with the way they are represented and the way the committees were executing their responsibilities. The interviews also revealed that in both LDs and NLDs, all the schools visited had school committees that were functional. The committees addressed key issues like quality of education, minimum standards and accountability.

There was a fair representation of the children in school planning committee meetings in the LDs 59% than in NLDs 40%. More than 56% of the chairpersons in the LDs responded that the views of the children are taken on board while the situation in NLDs was only 44%. In all FS, Tuseme clubs and School barazas were used to engage children and youth in setting their priorities for the school plans.

Child Protection and Participation

Community Involvement and Participation in Child protection Interventions

CPP interventions opened up many opportunities for community engagement during implementation. The selection of CJFs was done at community level, based on criteria developed locally by the communities. MVCCs, CPTs and CJFs are all community cadres who have volunteered to serve their communities.

Shifts in programming were not always clearly explained to, or properly understood by district authorities. Criteria for exiting some of the 7 LDs were not always explicit or transparent.

Community Involvement and Participation in HIV Prevention

By being members of community structures, the youth were able to make an input in the process of planning for HIV activities at the council levels. The CHAC worked closely with youth groups to identify challenges, issues and priorities for CMACs, WMACs, VMACs and youth groups to address in the district plans. These challenges were then presented to the district planning processes by the CHACs. CHACs interviewed felt that indeed youth make meaningful contribution and suggestions for improving the HIV prevention activities. Only they mentioned that due to funding constraints not all these suggestions could be addressed in all district plans and budgets.

PART 4: LESSONS, CONCLUSIONS AND RECOMMENDATIONS

10 LESSONS LEARNED FROM THE 7 LDS STRATEGY

10.1 Monitoring, Impact Measurement and Learning

Relying on current district and national M&E systems for outcome and impact tracking for UNICEF interventions, especially those at community level (artisans, CoRPS, CJFs, and WECs) in the 7 LDs only works partially and is not sufficient, especially for new interventions such as those promoted under WASH, nutrition and child protection. National M&E systems are either at too high a level in the theory of change³⁷ or in geographic³⁸ generalisation of findings in terms of results tracking or carryout assessments too infrequently to inform UNICEF interventions sufficiently for programming. Customised additional M&E tools and processes would help to capture systematically intermediate results at output and outcome level to inform UNICEF and its intervention districts on how to improve programming.

Innovations (such as the new child protection system which creates new structures in the form of child protection committees and working relationships among duty bearers in the system of securing children's rights) and community level initiatives require specially tailored M&E systems implemented alongside the intervention in order to generate adequate evidence on performance which subsequently, could be used to strengthen the national M&E System.

Geographic spread of 6 or more intervention districts at current staff capacity of UNICEF would spread UNICEF's staff resources for M&E too thinly. Deployment of special staff to district to assist with coordination and M&E could strengthen UNICEF's presence on the ground and enhance quality of programming, strengthen integration of cross-cutting issues and quality of monitoring and evaluation.

10.2 Role of Regional Secretariat

Without engaging Regional Secretariats in a strategic and formalized manner, UNICEF misses a critical opportunity to leverage policy change and regional multiplier effects through capacities already resident at regional level which can be targeted with the information on the innovations in the 7 LDS, can be supported to scale up successful models in NLDs, and can complement UNICEF in supportive supervision of not only facility based services but community level initiatives.

10.3 Enhancing effectiveness of the 7 LDS Strategy

Without reaching a critical mass of trainees and multi-skilling the health service providers, staff shortages and occasional redeployment within and between health facilities will continue to undermine the effectiveness of the training provided to health personnel on MNCH, Nutrition and PMTCT.

³⁷ They do not assist districts to track intermediate results which help to inform programming.

³⁸ Due to shortage of resources, national nutrition surveys generalise findings at regional level instead of the district level.

Provision of ambulance vehicles and medical equipment to health facilities in learning districts that lack adequate systems for equipment maintenance or support to upgrade such systems, can result in an unnecessary wastage of resources by UNICEF and does not resonate well with growing calls for greater effectiveness and value for money in development finance.

Supplying MNCH related theatre equipment to districts on the basis of district plans to construct or complete on-going theatre construction projects may result in ineffectiveness of UNICEF investments through idleness of equipment when the completion of the theatres is significantly delayed.

Water supply constraints can undermine the success of WASH related BCC efforts that seek to promote good hygiene practices in districts where the targeted households have a ready excuse (in shortage of water) for not changing their hygiene practices in as far as washing of hands at four critical moments or the use of pour flush latrine technology is concerned.

Achieving significant impact on hygiene practices such as hand washing at three to four critical moments in remote and dry areas like Mtwara district with challenges regarding water access would require a combination of investments in water supply infrastructure, capacity for water management, and hygiene promotion as was done in Makete by UNICEF.

Investing in key result areas where UNICEF neither has adequate human resources nor the financial resources to participate effectively at all stages of the project cycle³⁹ can lead to otherwise avoidable ineffective programming.

Too little of anything at community level is not good enough as shown by evidence from the establishment of water and sanitation promotion centres and training of water and sanitation artisans, VMACs and village MVCs which (though in some cases exceeded targets, e.g., training of WASH artisans) did not reach a critical mass at the grassroots level to stimulate measurable behaviour changes. Support tended to be concentrated at District ToT level, subliming at the ward level and almost evaporating at the village level. Interventions that have sufficient depth and coverage at the village level have more success in terms of promoting child development indicators, suggesting the need for more focused and deepened interventions.

The cascade model of training generates a pool of trainers that can be retained at district level, but does not guarantee sufficient multiplier effects in second and third generation trainings that should be extended to health service providers (in the case of MNCH, PMTCT and Nutrition Training), ward education coordinators and teachers (in the case of school plans), and community volunteers (CoRPS) (in the case of WASH, MNCH, Nutrition and ECD) unless districts continue allocating resources through other funds towards cascading of training.

Whole school development planning towards reaching child-friendly school status is a model that is popular with district authorities and can easily be scaled up with little additional support from UNICEF.

³⁹ Good design, strong financial support to districts through the disbursements, strong technical support to districts to implement the UNICEF funded interventions, and to coordinate well other similar and complementary investments by other players at district level, strong monitoring and evidence gathering and sharing, and adjusting the interventions for greater impact.

One size does not fit all. Too broad a coverage of thematic areas or of districts with a standard package of supply-led interventions spreads UNICEF human and financial resources too thinly and is not supported by evidence of impact, suggesting the importance of taking up more demand-driven, well researched and customised activities that target fewer (than the current seven) districts for testing innovations so as to guarantee the depth required to sufficiently reach the grassroots (where the women and children targeted by UNICEF are).

Intervening in thematic areas where there are several other development programmes offering similar packages of support (e.g., procurement of MNCH drugs and supplies, provision of MNCH equipment, procurement of vaccines and micro-nutrients) may result in displacement of resources which dilutes UNICEF's impact and confounds its quantification and attribution to UNICEF. Under such circumstances, strengthening of national systems for health service delivery may be more prudently done through the national programmes as opposed to micro-level activities in the learning districts.

Supply-led interventions that support established national systems for service delivery, such as provision of drugs, vaccines and equipment, are best executed through national programmes reaching all districts, not just the learning districts.

10.4 Sustaining the interventions of UNICEF and results achieved in LDs

Institutionalising the promotion of positive behaviours in WASH, MNCH, PMTCT and Education through village level governance systems (especially, village leadership meetings and by-laws) is a promising innovation that works to reinforce behaviour change communication and results from UNICEF BCC interventions in the 7 LDs.

Where villages have economic resources and thriving economic activities, there can be good opportunities for using the mechanism of village by-laws to mobilise resources from local communities to further promote positive behaviours.

Off-station and residential short term training programmes for health service providers provide sufficient depth of knowledge to trainees but are more costly and take away a substantial part of staff time from service delivery hence should be balanced with appropriate on-the job training approaches that achieve the same objectives at reasonable cost and without compromising, in the short term, delivery of critical health care services.

10.5 Leveraging more resources for children through district level coordination

If policy and programme coordination at district level is of equal priority to, and strength comparable to that given by UNICEF to national level engagement it could capture resources availed through parallel and larger donor funds but which may or may not enter the national system for financial management (e.g., PEPFAR funds which are channelled through NGOs). This would require UNICEF to strengthen its local presence at district level not only for quarterly M&E meetings or ad-hoc back up support, but more structured timesharing of principal staff between national and district level engagement.

It is possible to map already existing district and regional stakeholder platforms as strategic entry points for UNICEF to influence joint programming between UNICEF, LDs and other

partners at district level. Deployment of technical expertise to support more adequately programming, coordination and M&E is essential for districts to deliver.

11 CONCLUSIONS AND RECOMMENDATIONS

11.1 Conclusions

The Evaluation confirms that the 7 LDs Strategy was not only **highly relevant** but also produced many positive results. It has built **capacities of Learning Districts to plan and budget for children's priorities and the capacity will be retained in the government system**. The main challenge reducing the actual amount of financial resources made available by districts to children's priorities is now the absence of an **explicit budget line for social welfare** under which children's priorities, especially of child protection nature, can have a dedicated vote and cost centre from which they can be funded. While nutrition is now a permanent budget line in the MTEF as it is budgeted for first in the Comprehensive Council Health Plan, and then reflected in the MTEF with funding from the health basket fund, child protection and socio-economic support for MVCs do not as yet have a budget line under which they can be funded. The District Social Welfare Officer activities are funded either from a small resource envelop under the mandate of the "Community Development Officer" (and this is not enough nor the proper pipeline to finance such interventions) or by way of small "donations" from sectoral budgets as part of the multi-sectoral HIV and AIDS response. The latter practice was not found in LDs but among NLDs, Moshi Rural, which was innovative.

In relation to planning and budgeting, it is also evident that the quality of strategic plans and MTEFs in terms of results focus has greatly improved and Makete's MTEF for 2011/12 was picked as an example of best practice in the Iringa Region by the Ministry of Finance. This is attributable to the training funded by UNICEF which was provided to planning and budget officers. The quality of reporting on budget performance has also improved significantly in learning districts when compared to progress in NLDs, as the training of DMETs has made districts start looking at value for money in addition to budget absorption and pace of physical progress in implementation of development activities. Progress reports on budget utilisation are now accompanied by narratives on the quality of implementation of activities and that of outputs achieved. A critical barrier holding back results still in this area though is the delay in release of Government resources to districts, which is a generalised problem. Government had not released the Quarter1 budget to districts by the middle of the second quarter, and this affected implementation of planned activities at district level, with Makete for instance indicating that if the disbursement coincides with rains then there can be up to 6-9 month delay before activities can be commenced as roads will not be pliable. Another challenge hindering effectiveness of district monitoring and evaluation teams is the absence of a dedicated budget line for their activities, they depend on sector budgets which are supervising and leads to a conflict of interest in which sectors lagging behind may be reluctant to provide financial and logistical resources to DMETs to go and visit project sites where work is behind schedule or is of poor quality.

In the area of **capacity building to strengthen district service delivery**, evidence is strong that by the End-line UNICEF had contributed significantly to the growing proportion of health service providers trained on MNCH, but the demand for training yet to be met still remained very large across all sectoral interventions (YCSD, BELS and CPP) suggesting to many LDs that UNICEF's exit was untimely, especially as the exit was not clearly linked to the progress made in relation to MDG targets, but tended to be linked to the achievement of some outputs targets, the expiry of a Country Programme Phase, and discussions with PMO-RALG. The premature departure was even more conspicuous as there was no exit strategy with transparent exit criteria which had been shared with districts at the beginning – exit was discussed towards the end of the Country Programme with some LDs remaining as pilot district for some initiatives whilst other districts were completely phased out. Furthermore, the directive issued by the GoT in 2011, to suspend budget allocations to training activities in order to focus on service delivery stands out as a bottleneck likely to reverse the gains made by UNICEF in the LDs. In general all trainings did not have sufficient depth, or much multiplier effect, as more resources were spent at the centre, and for courses with more sophisticated course content, which had higher unit costs, as opposed to the community level where the frontline staff who interact with mothers and caregivers of children, or with the young people targeted by the interventions are actually working. The cost of delivering ToT courses ranged from about 10 to 20 times greater value than community based courses. Going forwards, it is imperative that UNICEF explores how best to deepen the coverage of training to cadres closer to the front-line (health workers in facilities, CoRPS, artisans, VMACs, WMACs, village and ward MVCCs, CJFs/para-social workers), without necessarily compromising on the ToT targets at the centre since the evidence from the Evaluation points to the fact that those trained at the centre are likely to be retained in the system and continue to be a potential pool of resources to tap from in cascading the knowledge and skills further to the health service providers through retraining and refresher courses later on, but this process of cascading to the second and third generation of trainees would require budget support which at the present is either minimal within government or is provided off-budget through NGOs managing the PEPFAR and Global Fund resources. Districts have little control over off-budget ad-hoc resources.

Further evidence suggests that the proportion of health facilities offering critical MNCH services (e.g., Basic EmOC) increased almost 4-fold in the LDs at a time when there was a decline of the same in NLDs. This is a clear testimony to the contribution UNICEF has made during the implementation of the 7 LDs Strategy.

Provision of training and equipment and supplies greatly strengthened health service delivery, boosted client satisfaction with health services in general and where it strengthened capacities at lower levels of care (dispensaries and health centres) it reduced the workload at district hospitals as cases were treated at lower levels of care. However, residual constraints still hamper many women from delivering at the health facilities, and these need to be isolated and dealt with directly. In addition some equipment was not installed and was new and idle for lack of skills to operate the machines correctly or the infrastructure such as theatre rooms were still under construction. The conclusion from this is that procurement support should be accompanied by a structured arrangement for staff orientation on how the equipment should be correctly used, and should be conditional upon completion of the necessary buildings where the equipment will be installed and used.

UNICEF has through the LDs experience **piloted a number of successful models** that need to be well studied, documented and then scaled –up. Hai has good experience on how WDSP has increased pass rates in primary schools, it also has promising experience with the reduction of the number of children’s homes that did not provide proper care for children. Makete is an example of good practice on male involvement in PMTCT, in out-scaling the Whole School Development Plan approach, in financially supporting the activities of the ward education coordinators and in preparing high quality MTEFs. Makete also offers good experience in water treatment and other hygiene behaviours. Magu, Makete, and Temeke offer good models for institutionalising WASH through village by-laws and therefore promoting sustainability of WASH promotion activities. Through PSI, UNICEF also promoted the application of an innovative “community change agents approach”. UNICEF has not been meticulous enough to capture systematically or evaluate the learning from these innovations. UNICEF missed an opportunity to promote replication of some of these best practices in NLDs by not effectively engaging Regional Administrative Secretariats to achieve this objective.

It is also very clear from the evidence that some of UNICEF-supported interventions lacked impact on some very critical indicators contributing to the well-being of children, and these included (a) access to improved sanitation, (b) hand washing at four critical moments, and (c) prevalence of diarrhoea in under-fives. Though access to sanitation is inherently a slow change indicator, these findings suggest that UNICEF may need to revisit its strategies under the 7 LDs Strategy as it carries on with WASH in the new Country Programme phase; this includes revising both approaches for community WASH and for BCC. Both the BCC component implemented through a PCA agreement with PSI and the Community WASH approach implemented through districts need to be carefully analysed for effectiveness and value for money, and redesigned as necessary. The available evidence from communities where the community WASH intervention was implemented clearly indicates that the intervention lacked impact on the above variables for four main reasons: (a) limited coverage - too few artisans and water promotion centres, and too few community members reached through PHAST cascade approach (shallow depth of coverage at community level), (b) non- inclusion of water supply component in districts like Mtwara where shortage of water can be used as an excuse for poor hygiene practices (lack of complete packages), (c) the absence of a business model to support the activities of water and sanitation promotion centres (weak design), and (d) inadequate attention to activities needed to increase purchasing power for demand creation.

In some cases, the Evaluation reveals that results achieved by UNICEF could not be analysed sufficiently because the M&E system did not track them. UNICEF’s M&E system for the 7 LDs Strategy had a number of gaps that need to be addressed, going forwards into the next phase of sub-national engagement. Firstly the late commissioning of the 7 LDs Baseline Survey meant some activities that had started prior had their impacts under-estimated at End-line. Secondly, Systematic tracking of outputs and intermediate outcomes, for instance was not carried out. Third, LDs could have benefitted more from UNICEF in terms of developing and running M&E systems for tracking qualitative outputs and intermediate outcomes, especially from **community based services supported by UNICEF**. LDs have relatively better systems for tracking outputs at facility level (through national sectoral M&E systems such as HMIS), and for tracking physical infrastructure types of outputs at the community level (e.g., through the LGMD), but lacked strong systems for systematic tracking of outputs of software interventions like training (DToTs, health workers, artisans, CoRPS) and the whole range of child protection services funded by UNICEF. Some of the approaches were new to district staff and needed to

be accompanied by training on how to track the development results. Fourth, whilst UNICEF supported the strengthening of data collection through village and MVC registers, and this capacity has been created, sustaining the capacity and its utilisation requires more resources and a few districts have demonstrated the capability and willingness to continue funding after phase out of UNICEF support (e.g., Makete (LD) printed another set of village registers in 2011 using councils own revenue, but Njombe (an NLD) discontinued the collection of data using village registers after failing to sustain the funding and training of data collectors required).

Still on M&E the Evaluation findings lead us to conclude that, **UNICEF may have spread its staffing and financial resources too thinly on some of the interventions**, where it went with a standard package to many LDs, with WASH and Child Protection-related key results having suffered the most at the beginning before staff resources increased from 2009 onwards. The design of the various components where skills were limited was compromised in the process and this might to some extent explain the delayed implementation (e.g., in the case of the PSI contract for BCC) or the fragmented nature of activities (series of pilots - child protection at the beginning). Both child protection and WASH activities improved significantly with redesign at the middle of the Country Programme and this flexibility in programming illustrates sound programme management.

We further conclude that by **spreading too thinly, through coverage of several districts with a wide spatial distribution**, UNICEF could not sustain the planned quarterly joint monitoring visits, as some sections with a shortage of staff could not be represented consistently by their own staff member. UNICEF may also have spread its resources too thinly in two other ways, (a) by working both at the national and sub-national level, and (b) by working in more than 30 key result areas, 26 of which were primarily district-oriented. Participation of senior members of staff was needed both at national and sub-national level but proximity to the national level, and frequency of policy dialogues and meetings at the centre limited UNICEF's engagement of districts using its most senior staff. Examples of interventions that started at the centre and only reached districts towards the end of the Country Programme do testify the seemingly imbalanced time allocation between engaging in the national policy discourse and effectively collaborating with district counterparts as well as other development partners active at the district level. Such an engagement may need more proactive mapping of entry points or platforms already existing so as to identify the best way UNICEF can engage other partners through them. Alternatively UNICEF could together with district authorities or the Regional Secretariats and other partners in the intervention districts set up a relevant platform for this purpose, which can be used for lesson sharing and leveraging of resources for up-scaling. This could call for more substantive representation of UNICEF at the district level through senior staff stationed there (benefits and costs of such an option would have to be weighed especially in relation to need for district support in M&E).

Some activities (e.g., training of health workers on ENA and PI-ENA) did not seem to show impact in LDs when compared with the NLDs and it could be concluded that either UNICEF had a displacement effect in the LDs, or presence of other but stronger actors in the NLDs may have overshadowed the observed magnitude of difference in the changes in indicator values in between LDs and NLDs. It is also evident that some of the trained staff were not fully utilising their skills after being transferred to other departments within the same health facility or in another, where they were assigned new roles which did not necessarily require them to use nutrition training. A possible conclusion from this experience is also that the absence a

significant difference between LDs and NLDs should not be interpreted as lack of impact, but evidence that a dialogue and social contract may be needed with district authorities to ensure the resource displacement effect of UNICEF support is minimised in the LDs. In the case of staff transfers, it can also be concluded that training should be accompanied by skill sensitive staff management within the health facilities.

Finally below are the main recommendations

11.2 Main Recommendations

1. UNICEF's new strategy for sub-national engagement should be elaborated at the onset of sub-national level engagement, with **a clear set of objectives, targets and entry and exit criteria** for each major intervention area.
2. UNICEF together with PMO-RALG should develop explicit entry and exit criteria for sub-national engagement which are based on development results (e.g., child poverty, child vulnerability and critical MDG indicators) in order to improve transparency and objectivity of regional targeting, progress assessment and decisions on phasing out of UNICEF support.
3. Exiting a district or region should not be on the basis of expiry of a Country Programme phase, but rather on exit criteria that are linked to the achievement of results in the form of either output or outcome targets, development impact or learning outcomes. All 7 LDs strongly encouraged UNICEF to consider as exit criteria, "**progress made towards achievement of MDGs**" and the likelihood that results achieved will be sustainable.
4. Within the selected focus regions, and for interventions that cannot achieve full district coverage, UNICEF should assist districts in defining explicit criteria for selecting first priority communities (wards, villages) in order to guide the channelling of the limited resources to the most vulnerable and deprived children.
5. The number of key result areas pursued by UNICEF (thematic scope) and the geographic spread both in terms of the number and spatial distribution of the districts should be informed by child deprivation and/or poverty indicators and **matched with the human and financial resources available within UNICEF** to provide for adequate district and thematic level engagement by UNICEF Senior Staff for purposes of (i) more adequately engaging and (where possible) jointly programming with other actors supporting districts/sectors for similar results, (ii) deepening coverage and convergence of UNICEF supported interventions at facility and community levels, (iii) strengthening supportive supervision and quality assurance, and (iv) ensuring systematic evidence generation and learning, effectively feeding into regional replication and national policy influencing discourses.
6. UNICEF should in the future deepen its engagement with development partners with active programmes at the district level. This should be done by senior staff within UNICEF and balancing it with national level policy engagement. This may require strengthening PMO-RALG's coordination capacity and role to ensure better coordination, joint programming and experience sharing.

7. **Capacity building support should remain one of the priority strategies** for strengthening the protective environment for children, planning and budgeting for children's priorities and improving the quality of basic services that reduce child poverty and vulnerability and improve the well-being of children. **Creation of new structures should be avoided** as much as possible, but rather more investments are needed to re-engineer the current structures to provide missing but priority services for children, imparting critical knowledge and skills into the current structures, providing them with working tools and resources, strengthening linkages between them through an **explicit strategy for promoting programme convergence**, and developing and testing **models for their financial sustainability**. This principle should cut across all key result areas tackled by UNICEF's sub-national engagement.
8. UNICEF should reinforce programme integration within and across its programme components through an explicitly written strategy for maximizing programme convergence and synergy. Priority should be given to mainstreaming of child protection and participation in the entire country programme portfolio, including by packaging CPP into training packages and BCC messages delivered by the various programmes of UNICEF. Furthermore, UNICEF should identify and make use of a number of opportunities that exist for strengthening convergence of UNICEF supported interventions at health worker, CoRPS, WASH artisan, school teacher, Tuseme Club, MVC Committee, and Multi-sectoral HIV and AIDS Coordination Committee levels. At the minimum UNICEF should explore the use of harmonized training packages and multi-skilling of facility and community based service providers to ensure that UNICEF supported services converge at the facility, community and household levels.
9. Through greater programme integration, multiple channels for addressing sanitation and hygiene promotion need to be found to address diarrhoea disease incidence in under-fives, which is one of the critical indicators on the quality of life of children which was not impacted upon by the 7 LDs Strategy.
10. In the specific area of child protection, both **family- and community-centred approaches to address the underlying causes and prevent the perpetration of violence and physical, sexual, emotional and economic abuse against children and their caregivers** should be given more attention than previously, alongside the on-going strengthening of current initiatives to respond to and mitigate impacts of the abuse. The latter should also be broadened to ensure that the child protection model currently being tested in pilot districts addresses all needs of children in relation to child protection services.
11. In relation to training, specifically, UNICEF should **invest more into institutionalising the on-going trainings by strengthening the curricula and delivery capacities of existing competent national or regional institutions** to play a greater role in providing those courses that need to be delivered at scale and should reach new entrants (e.g., new generation of health service providers, teachers, planners and budget officers) whilst they are still being trained for entry into the service.
12. Due to the high level of unmet need among those already in service delivery, in terms of new skills necessary for child-friendly schooling, delivery of more effective child protection services and higher quality health services the Government of Tanzania and UNICEF

should not abandon or suspend in-service training of service providers, but explore new models for delivering the trainings in a manner that does not remove trainees for long periods of time from the core business of service delivery. Alternatives to off-station/residential courses (such as innovative approaches for providing on-the-job coaching and mentoring) should thus be identified and tested to establish their comparative advantages vis-à-vis current approaches.

13. Whilst the training of trainer cascading approach works and is important for creating capacity at both national and district levels for continuation of training, resource allocation between courses offered to ToTs, and those offered to service providers at facility and community levels should be reconfigured, by **exploring less resource intensive methods of providing ToT courses**, and availing **adequate resources for training of frontline service providers** (e.g., teachers, health service providers, CoRPS, VMACs, WMACs, village MVCCs, ward MVCCs, sub-district CPTs) and, in where necessary (e.g., in the case of school WASH), final beneficiaries (school pupils).
14. UNICEF should strengthen its M&E System for tracking results of sub-national engagement and provide adequate support to intervention districts especially for tracking results from community based services, and identifying, documenting and sharing learning. Planning for key outcome results and output targets with the learning districts/regions should ideally follow a four year time horizon harmonised with the UNICEF's Country Programme Action Plan in order to have synchrony in objectives and targets (but operationalized through annual plans for financial management). The M&E System should **facilitate aggregation of results** from all LDs to more fully see the contribution of UNICEF and inform exit in a transparent manner.
15. UNICEF should prioritize investments in upgrading **M&E capacities of intervention districts** for all interventions, but with special focus being given to enabling the LGAs and UNICEF (with support from the Regional Advisory Secretariats) to track critical core indicators of performance at output and intermediate outcome levels for all interventions including those of a software nature and for innovations that will be piloted at health facility, school or community level. Such an M&E system should build on (and make use of) existing national M&E systems, with the ultimate objective of further enriching the national systems through institutionalisation of the new elements of the M&E. Hence it is recommended that UNICEF works closely with relevant sector ministries (MoHSW, MoEVT, MoW, and MoG) and agencies such as the national statistical office, RITA, sector ministries, PMO-RALG and the Planning Commission to develop appropriate **M&E tools for monitoring intermediate outcomes at community level**.
16. **Monitoring of the work of community volunteers should be strengthened** (e.g., the 3 levels of supervision for health services, for example, – national, regional and district health management teams - should monitor the work done by trained CoRPS).
17. PMO-RALG should complement UNICEF efforts at district level through: (1) working with relevant sector ministries to put in place a well-functioning system for dissemination of national laws, policies, strategies, guidelines, and standards; (2) influencing GoT and DPs to increase resource allocation to basic education – school per capita grants, teacher housing, text books and stationery; (3) creating a sub-vote and cost centre for social welfare and child

protection services under the mandate of the DSWO; (4) allocating resources to sustain motivation and activities of WECs, CoRPS and Community Justice Facilitators; and (5) transforming the DMETs into more autonomous teams with a separate budget line, providing technical oversight and a mechanism to hold districts to account for performance against budget targets. The excellent work done in registering MVC should be complemented by Ministry of Health and Social Welfare in mapping service providers and strengthening coordinating of their support to MVC, together with mobilising more resources from the development partners and Treasury to provide resources to reach these registered children, alongside support for economic strengthening of their families. A child and family centred approach in addressing child poverty and vulnerability is needed for holistic care in future and UNICEF should in collaboration with others policy champion advocacy in this direction.

18. UNICEF Tanzania Country Programme needs to strengthen gender mainstreaming through an explicit **gender mainstreaming strategy** which is linked to both corporate policy and the National Strategy for Gender Development, to inform choice of interventions and whose implementation and achievements are also systematically tracked through the UNICEF and LGA M&E systems.
19. UNICEF, PMO-RALG, sector ministries and LGAs **should document all models of good practice** developed in the 7 LDs, test them in new districts for suitability, and then promote replication in these new districts⁴⁰. Expertise required for this documenting good practices would include thematic specialization, communications, and journalism. The central role Regional Advisory Secretariats can play in promoting replication should be recognised and formally mobilised and supported technically and financially by UNICEF and PMO-RALG.
20. UNICEF and PMO-RALG should together with LGAs take stock of the completion status of all interventions in the previous LDs and come up with a strategy, time-line and resourcing mechanism for completing all unfinished business. In cases where a decision has already been made by UNICEF and PMO-RALG to discontinue some of the support, in order to concentrate on new regions, PMO-RALG should assist LGAs to find alternative funding for completion of outstanding work. In the same vein, the Evaluation found special need to continue capacitating Siha District with almost the full package of support, as this district is relatively new and still lagged behind all other LDs on some critical capacity indicators and MDGs. Phasing out support in Siha District would be pre-mature at this stage. Opportunities to continue capacitating Siha District should be found by PMO-RALG.
21. Given the gap between Strategic Plans and MTEFs in incorporating children's issues, with children's issues featuring more in MTEFs than SPs, UNICEF should take advantage of the present opportunity provided by the new round of strategic planning to lobby PMO-RALG to support LGAs in developing new strategic plans that incorporate children's issues as part of exit strategy.

⁴⁰ 7 LDs Strategy introduced promising models / approaches in LDs with up-scaling potential, including: WEC supporting school inspectors; Child protection teams; District Monitoring and Evaluation Teams; Children's barazas; GRP, Male involvement in PMTCT (Makete Model); Child Friendly Schools; and capacity building of youth groups and participation in HIV and AIDS prevention activities.

11.2.1 Specific recommendations on Health and Nutrition

Nutrition and ECD

22. UNICEF should strengthen the assessment of the impact of its nutrition and ECD interventions through in-built routine monitoring systems or studies at community level, focusing on: (1) knowledge and behaviour change among mothers and caregivers in relation to child feeding practices, early stimulation and integrated management of childhood illnesses; (2) child nutritional status as reflected by child anthropometric data.
23. Where UNICEF is providing training on nutrition to health workers, it should assist the Ministry of Health and Social Welfare to procure and distribute updated equipment for collection of child anthropometric measurements (MUAC tapes, weighing scales, height boards, etc), where such equipment is not available in health facilities.
24. UNICEF and LGAs should ensure that training of health workers in nutrition (e.g., ENA and PI-ENA) is at sufficient scale to compensate for attrition and staff transfers, if the intervention is to contribute significantly towards increasing the proportion of health workers trained in nutrition. To ensure that skills are fully utilized by the trainees, UNICEF should ensure that LGAs strengthen the supervision of people who have been trained and limit the movement of trained staff to departments where they do not use the skills acquired through the in-service training. Training support should be accompanied with advocacy for skill sensitive staff re-deployment.
25. UNICEF and LGAs should ensure that in relation to IECD, the CHMT are also trained on IECD to have knowledge on what to supervise in the field, and continuous refresher training for CoRPs is provided.

MNCH

26. It is recommended that UNICEF continues to advocate for the continuation of funding for training of health service providers through the government budget, while at the same time identifying and testing alternative models for providing in-service training with the objective of shifting to more work-station based training, coaching and mentoring which is less disruptive to service delivery. UNICEF should complement these capacity building efforts by assisting MoHSW to mainstream the training modules into in-service and pre-service training curricula, as a mechanism for sustaining refresher training and upgrading health workers on new or revised regulations, standard operating procedures and treatment regimens. Efforts to institutionalize MNCH training should target curricula of both the public and private training institutions as is being successfully pursued in education.
27. As part of an exit strategy for districts where UNICEF is operating, UNICEF should identify NGO partners and Regional Training Centers that can be capacitated to continue providing the in-service training after UNICEF has phased out its support. UNICEF could work with such partners to harmonize training approaches and content where necessary.
28. The mechanism to monitor and ensure availability and utilisation of national guidelines for MNCH services in health facilities needs to be strengthened, and it is recommended

that UNICEF could assist the Ministry of Health and Social Welfare at national, regional and district levels to improve the effectiveness of the existing system. Training on MNCH should more closely be coordinated with the supply and monitoring of utilization of guidelines⁴¹.

29. UNICEF and the Ministry of Health and Social Welfare should ensure that for all new MNCH equipment supplied to health facilities, relevant staff are given adequate orientation training on how to operate the equipment, and a good support system for equipment maintenance and repair is functional at district level.
30. UNICEF should consider in future investing more in strengthening systems for coordinating equipment supply to health facilities, tracking utilization of existing equipment, rationalizing allocation of equipment to facilities, and repair and maintenance (through the revitalization of the Zonal Workshops or local technicians). Commitment to purchasing equipment should be only in exceptional and highly targeted cases, where the gap in focus districts is large, the equipment complements training, and the needed physical infrastructure to house the equipment (e.g., theatres) is available. UNICEF should not procure equipment where staff to operate the equipment is not available or the buildings to house the equipment are absent or still under construction. UNICEF should assist the LGAs to develop distribution plan in consultation with the health facilities so that the procured equipment are distributed and utilized well
31. UNICEF and the Ministry of Health and Social Welfare should in future consider testing alternative systems of equipment supply to health facilities, including the system of leasing equipment from the private sector, where (depending on the type of equipment and the location of the health facility) this can be feasible.

PMTCT

32. UNICEF should advocate for more resources to be made available by GoT and development partners for the scale up of CTC services alongside the scale up of PMTCT. Where feasible, UNICEF should provide directly complementary support to GoT, in districts where UNICEF is supporting LGAs to scale up PMTCT services. This is crucial for the continuation of care and treatment of HIV positive children and mothers who have been diagnosed through PMTCT services.
33. UNICEF and PMO-RALG should document the successful model of promoting male involvement in PMTCT services used in Makete District, and replicate in new focus regions and districts.
34. It is also recommended that UNICEF in future maps out and strengthens its collaboration with NGOs and other partners⁴² implementing interventions to scale up PMTCT services, including joint programming on training and provision of equipment, drugs and supplies. This will enhance effectiveness of training and other inputs provided by UNICEF while increasing prospects of continuation of the PMTCT services.

⁴¹ This applies especially to EPI, VCT, PAC and treatment of opportunistic infections, guidelines for which were less available in health facilities at End-line than at Baseline.

⁴² These include mostly those funded through the Global Fund and PEPFAR.

35. As very few children are accessing treatment, even in districts with maximum interventions that are focusing on strengthening children's access to ART services, UNICEF should consider commissioning an analysis of the bottlenecks to Paediatric ART to enable GoT to better understand the barriers and design appropriate interventions.
36. UNICEF and TACAIDS to jointly advocate for the use of multiple entry points for children to access ART services. The feasibility of linking children accessing immunization services to PMTCT/PAIDS services should be explored, together with the potential for strengthening vertical integration, for example, how to use VMACs and WMACs to mobilize the communities (identify children early) with children to access PMTCT/PAIDS services.

HIV and AIDS Prevention

37. The Government of Tanzania should come up with a strategy for sustainable financing of community structures for HIV and AIDS coordination and prevention, such as VMACs and WMACs and Youth Groups. The process would be better informed by a study that contributes to better understanding of LGA decisions on resource allocation between HIV prevention and impact mitigation interventions, as well as exploring feasibility of resource mobilization through community contribution; IGAs; and innovative Public and Private Sector Partnerships (PPP).
38. In view of attrition and membership renewal within the HIV and AIDS coordination committees, and the high number of the committees at ward and village levels, it would be beneficial for support to WMAC and VMAC training activities to be guided by clear targets of achievement and at a scale sufficient to contribute measurably to planned outcomes. Should UNICEF decide under the Country Programme (2011-2015) to continue with training of WMAC and VMAC structures, it should do so in collaboration with other partners in order to pool resources together and ensure that the training reaches a sufficiently large proportion of WMACs and VMACs to achieve impact.
39. Lessons and good practices emerging from UNICEF's work with Youth Groups and CMACs should be documented and replicated in new districts where UNICEF will be implementing its interventions.
40. The Ministry of Health and Social Welfare and TACAIDS should speed up the process of developing and disseminating guidelines for behavioral change communication on HIV prevention with special focus on the young people.

Behaviour Change Communication

41. The PCA for Population Services International should be evaluated in detail for impact and cost-effectiveness in order to inform future interventions using this model. The evaluation should weigh the value added by district focus as opposed to national campaigns before investing more into the district-focused BCC model.
42. In particular, UNICEF should assess the added value of having PSI promote BCC on behaviours that did not show significant change in LDs, relative to NLDs, with special attention being given to identification of barriers to behaviour change in LDs for behaviours that changed positively in NLDs and yet did not change in LDs. Based on the findings of this analysis, UNICEF should identify/develop and test alternative models for increasing knowledge and influencing positive changes in the problem indicators, such as proportion of mothers and caregivers with knowledge on danger signs in new-borns.

43. While it is recommended that BCC to promote deliveries at health facilities should continue, UNICEF should together with the Ministry of Health and Social Welfare develop and test alternative approaches for increasing the proportion of deliveries attended to by skilled health personnel⁴³. To significantly reduce maternal mortality approaches that have been tested elsewhere and proven to be more effective in increasing the proportion of deliveries attended to by skilled health personnel should be identified and tested in the new districts/regions of focus under the 2011-2015 Country Programme.

The text coloured red above, in my opinion, is not correct. What does the author mean? Does he mean all health workers who are in the facilities do not have the skills necessary to be qualified as a skilled birth attendant? Or does he mean any one can deliver babies in a health facility?

44. UNICEF should explore working with new districts more directly to pilot some local, traditional, affordable and sustainable means of BCC within their respective communities building on initiatives that use village leaders and community bye-laws to promote sustainable behaviour change. To enhance alignment, and ownership at the local level, district authorities could be empowered to continue contracting the NGOs and CBOs directly to work with the village governments and communities, as was done in Siha for WASH promotion activities.

45. It is recommended that UNICEF assists the MoHSW to develop national guidelines for behaviour change communication on HIV and AIDS and other critical areas.

WASH

46. UNICEF should increase its engagement in upstream influencing of policies and strategies with special focus on improving the quality of programming and increasing the allocation of resources to sanitation and hygiene promotion. In this respect, it is recommended that UNICEF, in collaboration with the Ministry of Health and Social Welfare and the Ministry of Water, commissions a study to analyse the market for sanitation services in both rural and urban areas and contributes to the development of a national strategy and programme for promoting investments in improved sanitation at the household level. The study should explore options for demand creation in relation to improved sanitation, and relevant supply response interventions required to increase the proportion of households owning and using improved sanitation facilities.

47. In regions where household access to improved water supply is low, hygiene promotion should be jointly pursued with interventions to improve water supply (Local Government Authorities should champion this with other Development Partners at the district level).

48. UNICEF should influence strong integration between activities of District Water and Sanitation Teams and those pursued under mandate of DMOs - DMOs should be more involved in issues of water access.

⁴³ While the proportion of mothers delivering at health facilities significantly increased, the proportion attended to by a skilled health worker did not change significantly. Hence while continuing to encourage mothers to deliver at health facilities is a good practice, **not all health facility deliveries are necessarily attended to by skilled health workers.**

49. UNICEF's WASH promotion activities should in future build on good practices emerging from the experience of the 7 LDs Strategy, such as the use of village leaders and the system of local by-laws as an effective strategy for sustaining positive behaviour change in relation to investments in improved sanitation. In so doing, constraints noted in the urban areas whereby politicians undermined the work of the Mtaa leadership and local by-laws, should be tackled by advocacy that targets politicians.
50. UNICEF in collaboration with the Ministry of Health and Social Welfare should consider commissioning a study on bottlenecks to behaviour change on hygiene practices, especially focusing on "*hand-washing at 4 critical moments*" and use this evidence to inform the design of future hygiene promotion interventions.

11.2.2 Specific recommendations on Basic Education and Life-skills

Whole School Development Planning

51. UNICEF in collaboration with MoEVT should document and promote the scaling up of the whole school development planning model which has proven to work successfully under the 7 LDs Strategy. While promoting this scale-up, UNICEF and MoEVT should innovate further and test the concept of **Child Friendly "Viable" Schools (CFVS)**, whereby focus will be on assisting schools not only to attain the minimum standards for quality education but financial sustainability through school income generating activities and sustainable public-private partnerships (PPPs). Best practice approaches in strengthening school income generating activities need to be promoted among the focus schools.
52. Building on the success of the model of strengthening school supervision through trained Ward Education Coordinators, the Ministry of Education and Vocational Training should take a step further to explore the merits of upgrading the skills and mandates of the WECs into formally recognized Primary School Inspectors and to allocate resources for their activities through the main budget, or through council resources. Emerging good practice from Makete District in terms of council support to the activities of Ward Education Coordinators, and the impact of WECs on pass rates in Hai District, should be documented for replication in other districts. UNICEF could also play a significant role by assisting MOEVT to find an innovative model for financially sustaining the school supervision activities of the WECs.
53. UNICEF is encouraged to continue with its upstream engagement at policy level as well as leveraging resources for education from development partners through the Education SWAp. This is a critical role in ensuring that the remaining barriers to quality education in the form of the shortage of classroom space, textbooks and extra-curriculum resources are eliminated. Advocacy should be pursued in partnership with organisations that have a similar mandate and requisite experience in this area.

Gender Equity

54. The success of GRP and Life-Skills Education in focus schools should be documented by UNICEF and MoEVT and where possible replication should be facilitated in NLDs by

involving Regional Secretariats to disseminate information and training packages to other districts or mainstreaming the curriculum into regular teacher training courses.

55. Gender Equity and Child protection Interventions should continue to be more closely linked, implying that the same districts and focus schools targeted by gender equity interventions should also be targeted by CPP interventions.
56. To ensure that boys' needs are also addressed equally as those for girls, MoEVT should ensure that in schools where GRP is offered, at least one male and one female teacher should be trained in guidance and counselling and school planning.
57. UNICEF should extend GRP orientation trainings to parents and guardians to ensure that the gender sensitive learning environment created at school is replicated at home, and impact can also be achieved at home.

11.2.3 Specific recommendations on Child Protection and Participation

Child Protection and Participation

58. UNICEF should include interventions to mitigate the impact of HIV and AIDS on MVCs within the new model of child protection system which is being tested in four districts. Impact mitigation support remains crucial especially since the majority (83%) of MVCs registered by LGAs do not have economic support. Given that financing of cash transfers to a large caseload of MVCs is not UNICEF's area of comparative advantage, it should not provide direct cash transfers to MVCs, but remain in capacity building with MVC activities being more closely integrated with those of others providing the direct economic support to MVCs. Mapping of institutions providing economic strengthening support to MVCs should thus be prioritized with the view to strengthening collaboration and integration of activities at district level. This should entail joint programming wherever possible, and such programming should be more comprehensive typically combining capacity building support for MVC identification, needs analysis, and response coordination, on the one hand, with capacity building for resource mobilization through locally relevant and sustainable income generation activities, on the other hand.
59. To strengthen the child protection system at district and sub-district level, UNICEF and LGAs should lobby PMO-RALG for the creation of a sub-vote and cost centre under the mandate of the District Social Welfare Officer, together with the creation of social welfare officer posts at ward level (or assistant SWOs) in rural districts (as is the case with municipalities), and a formal mechanism for deepening the technical backstopping role of the Regional Social Welfare Officer to the District Social Welfare Officer on child protection.
60. UNICEF should invest in the establishment of a structured system for adequate follow-up of beneficiaries as well as collection, analysis and use of critical M&E information such as the number of cases of violence, abuse and neglect against children reported per given time period, and the types of child rights violations, the age and gender of the children affected, the nature of assistance provided, source of support, and the time taken overall to resolve the cases (in the event of court cases). Towards this end, it is recommended

that UNICEF assists the DCPTs to establish databases of cases, with programmable automatic statistical outputs that analyze trends and immediately feed into the monitoring reports and programme reviews.

61. In future UNICEF should avoid creating new structures for child protection, but explore ways of using and building upon existing structures, equipping them with knowledge and skills necessary to perform well their new roles.

PART 5: ANNEXES

Annex 1: Documents Reviewed

1. A Report on Evaluation of Community Justice Facilitation Project, September 2010.
2. Baseline Study on the Quality of Teaching and Learning Processes in Tanzanian Primary Schools, December 2008
3. Campbell and Graham, 2006, Strategies for reducing maternal mortality: Getting on with what works.
4. Childhood Poverty in Tanzania: Deprivations and Disparities in Child Well-Being (2009), NBS, UNICEF, REPOA
5. Comprehensive Study to Assess the Capacity of The Health System to Deliver Maternal and New-born Services in Dodoma Region
6. Costs and effects of the Tanzanian national voucher scheme for insecticide-treated nets, 2008.
7. Draft the United Republic of Tanzania, Water Sector Performance Report for the Year 2007/2008 Ministry of Water and Irrigation
8. Early Childhood Cognitive and Psychosocial Development Project Kibaha District Experience, October 2008
9. ECD Baseline Study, September 2008
10. Effects of Programs Supporting Orphans and Vulnerable Children: Key Findings, Emerging Issues, and Future Directions from Evaluations of Four Projects in Kenya and Tanzania
11. Evaluability Assessment of the Government of Tanzania and UNICEF Interventions in 7 LDs.
12. GoT/UNICEF interventions in 7 Learning Districts Baseline study in Learning and non-learning districts, April 2009
13. Government of Tanzania and UNICEF Interventions in the 7LDs, 2007-2010, Strategy Paper
14. Household Budget Surveys (HBS) 2000/1 and 2007
15. Joint Assistance Strategy for Tanzania, November 2006
16. Joint External Evaluation: the health sector in Tanzania, 1999-2006
17. Local Government Fiscal Review 2007 Measuring Progress on Decentralization by Devolution
18. Mapping and assessment of formal and informal child protection structures, systems and services in Tanzania
19. Mkukuta 1, National Strategy for Growth and Reduction of Poverty (NSGRP), June 2005.
20. Mkukuta 2, National Strategy for Growth and Reduction of Poverty II NSGRP II, June 2010
21. National Bureau of Statistics (NBS), 2002 and 2009
22. Oxfam GB, 2008, Regional policy implications and responding to acute watery diarrhoea and cholera in the Horn, Central and Eastern Africa: Learning from experiences improving for the future.
23. PMO, 2007, National Multi-Sectoral Strategic Framework on HIV/AIDS
24. RAPID SURVEY OF TEACHERS' RESOURCE CENTRES (TRCs) CAPACITY IN SEVEN LEARNING DISTRICT COUNCILS TANZANIA, November 2008
25. Salt, soap and shoes for school: The impact of pensions on the lives of older people and grandchildren in the KwaWazee project in Tanzania's Kagera region, An Evaluation Summary
26. Situation analysis of newborn health in Tanzania Current situation, existing plans and strategic next steps for newborn health,
27. Supporting Improved Public Financial Management in Tanzania: Challenges to the Effective Financing of the Health Sector, September 2008
28. Tanzania Commission for HIV/AIDS (TACAIDS) 2008, Tanzania Public Expenditure Review-Multi-sectoral Review: HIV/AIDS (Final report)
29. Tanzania Demographic Health Survey (DHS), 2010

30. Tanzania HIV/AIDS and Malaria indicator Survey (THMIS, 2007/8)
31. Tanzania HIV/AIDS and Malaria Indicator Survey 2007-08
32. Tanzania Human Rights Report 2007 Incorporating Specific Part on Zanzibar
33. Tanzania National Development Vision, 2025
34. Tanzania Reproductive Health and Child Survey (TRCHS), 2009
35. Tanzania: A review of PHAST (Participatory Hygiene and Sanitation Transformation) From a step too few. to haya..haya..vyoo bora, mikonosafi, majisalama
36. The Status of Implementation of Decentralization by Devolution on Mainland Tanzania & The Way Forward
37. UNICEF Country Programme Results Matrix, 2007-2010
38. UNICEF Revised Country Programme Document, 2007-2010
39. UNICEF, Women and Children in Tanzania (Vol 1: Mainland), 2010
40. UNITED NATIONS DEVELOPMENT ASSISTANCE FRAMEWORK (UNDAF, 2007-2010), United Republic of Tanzania
41. Water: more for some or some for more? Monitoring equity in water and sanitation, September 2008

Annex 2: Evaluation Terms of References

7 Learning Districts Background

UNICEF supports the implementation of health, nutrition, water, sanitation, education, HIV and AIDS and child protection programmes in Sub-Saharan Africa. In Tanzania, the UNICEF Country Programme Action Plan (CPAP) (2007-10 extended up to June 2011) is based on the need for more concentrated 'upstream' policy and advocacy work to support the scaling up of evidence-based programmes which demonstrate potential for reducing child vulnerability, in line with the UN Development Assistance Framework (UNDAF) 2007-10 (extended up to June 2011) and National PRSs (MKUKUTA / MKUZA).

The CPAP established that its four programme components will work at national, regional, district and community levels to influence policy design and implementation, to leverage resources to reduce child mortality and vulnerability, and to ensure that sectoral strategies and annual plans are in place, resourced and made operational. The four components comprised of Young Child Survival and Development (Health, Nutrition, and WASH), Basic Education and Life Skills, Child Protection and Participation, and Policy Advocacy and Analysis. The number of 'special focus' districts were reduced from sixteen to six (one district was later administratively divided by the GoT – thus seven learning districts), to support the scaling-up of evidence-based programmes which demonstrate a potential for reducing child vulnerability. All programme components have a policy element in their work and increasingly focus on evidence-based, 'upstream' support for policy analysis and development. In addition to the seven learning districts, the Country Programme also has a special focus on Zanzibar and four districts in north-western Tanzania (NWT) which plays host to refugees.

The expected results from the Government of Tanzania (GoT)/UNICEF interventions in the 7 LDs are embedded in the 30 Country Programme results, often indicating the importance of the 7 LDs results to the overall Country Programme results.

In order to achieve long term impact of improving child well-being by reducing mortality and vulnerability, UNICEF broadly supports the 7 LDs in building capacity to plan, budget, implement and monitor service delivery, complemented by Behaviour Change Communication strategies.

Through this engagement, it is expected that sectoral and intersectoral planning will prioritize children, will be results and evidence based, and will reflect national policies, strategies, guidelines and plans. UNICEF addresses capacity gaps that hinder implementation through support to technical capacity building, technical assistance and the provision of supplies. UNICEF will also provide support to building capacity (by providing training and tools) to enhance monitoring and supervision across the sectors.

By the end of the Country Programme in 2010 (extended up to June 2011), through the above support UNICEF and GoT expect to achieve the following key results in the LDs:

- Improved delivery of basic services
- Improved knowledge, skills and practices at community level
- Improved birth registration and child protection services

The details of the 7LDs interventions that contribute to the results above are available in the UNICEF/GoT strategy paper on interventions in the 7 LDs.

Furthermore, it should be noted that two important studies that were conducted as part of the 7LDs strategy implementation and have a significant bearing on the approach and methodology of the proposed evaluation; these are the Evaluability Assessment of the 7LDs and the baseline survey. Given the novelty of the Country Programme implementation approach and complexity of stakeholders involved, an evaluability assessment was commissioned prior to establish whether the Government of Tanzania and UNICEF interventions in the 7LDs could

be evaluated and what might be the barriers to an effective and useful evaluation. The findings of this assessment were useful in suggesting areas where the programme should be fine tuned during the GoT/UNICEF reviews in mid 2008 before the programme progressed too far. In addition, the results of the evaluability assessment serve as the basis for evaluating achievements and lessons learned in the 7 learning districts in the proposed evaluation.

The baseline survey was commissioned in 2008 to provide information on the immediate outputs/outcomes expected from the UNICEF/GoT interventions in the 7 LDs by the end of programme implementation. The key objectives of the baseline survey included, (i) assessment of the current levels of service provision in the areas of Community ECD, Pre Schools, EPI, Nutrition, PMTCT/PAIDS, WASH, IMCI and Birth Registration, (ii) assessment of the current levels of knowledge and practices in the areas of ECD, IMCI for children under five years and HIV/AIDS prevention for 15-24 year olds, (iii) assessment of current status on children's participation and prioritization in planning; including reflection of national priorities around children in district planning documents, with particular emphasis on education planning at all levels. The above general objectives were guided by the specific data requirements emerging from sectoral consultations during the inception phase, which were dependent on results from GoT/UNICEF interventions in 7 LDs. The survey was carried out in 6 Non Learning districts from the same regions as the 7 Learning Districts with similar socio-economic profiles for comparison purposes. Although the baseline survey was conducted midway through the 2007-2010 programme cycle, it is expected to serve as an important benchmark for the proposed evaluations.

Purpose of the evaluation

The proposed evaluation will assess the effectiveness of the area based programming approach, the 'theoretical model' of the 7LDs strategy, and draw lessons learned for future programming internally and other countries. This is important as the country programme comes to a close in June 2011. The independent evaluation will thus primarily contribute to accountability and learning, and recommend improvements for future programming strategies. Beyond UNICEF Tanzania, the application of this may be useful for other countries in the region following area based programming approaches. An important contribution is to have a critical and independent view of the balance between upstream and downstream components, and how (and if) UNICEF's downstream approach enriched national policy engagement. This is particularly important in helping UNICEF to position itself as it moves towards the new country programme and make informed choices on how UNICEF in Tanzania can support, (i) national policy level engagement and, (ii) engaging in the downstream national programme implementation, service delivery and decentralized capacity development activities.

Scope and Focus

The evaluation will apply the standard DAC evaluation criteria of relevance, effectiveness, efficiency and sustainability and impact⁴⁴. The evaluation will be informed by other simultaneous evaluations in particular the evaluation of Planning, Budgeting, Monitoring and Reporting and the UN Joint Programme 6.1. In each of the key programme areas in the 7LDs, the evaluation will examine the degree to which the desired results have been achieved, or expected to be achieved (effectiveness); how economical and efficient was the engagement (efficiency); and the contribution to the improvements, if any, in the fulfilment of children and women's well being. The evaluation will also assess the positive and negative changes produced by UNICEF's engagement in the 7LDs, directly or indirectly, intended or unintended and the probability of continued long-term benefits from the interventions made (sustainability). Specific evaluation questions are below:

1. Relevance

- How relevant were UNICEF's engagements in the 7 LDs supporting the scaling-up of evidence-based programmes to demonstrate a potential for reducing child vulnerability?

⁴⁴ The assessment of the programme according to these criteria will focus on UNICEF's interventions in the areas of health, education, child protection, planning and budgeting and HIV and AIDs.

- To what extent were the GoT/UNICEF planned interventions in 7 LDs consistent with country programme design?
 - To what extent were the actual interventions consistent with the GoT/UNICEF 7LDs strategy and district level plans?
2. Effectiveness
- To what extent do the 7 Learning District plans and budgets prioritise children’s issues?
 - How has service delivery improved in the 7LDs?
 - To what extent did GoT/UNICEF interventions achieve the desired behaviour change results? Which programmes had the more visible/noticeable behavioural impact at household and community level
 - Is there evidence to show that there are improved community based services in the 7LDs as a result of UNICEF interventions?
 - To what extent did the interventions in 7LDs contribute to enhanced national policies, programmes and strategies?
 - How effective was the integration and convergence of the four programme components?
3. Efficiency
- To what extent was the programme management (human and financial resources, supplies, etc) and delivery cost-effective? Did it lead to the best results at the cheapest cost?
 - How efficient was the coordination in fund disbursement and reporting at national and district levels?
 - Did the use of national systems contribute to, or hinder the achievement of the objectives and results?
 - To what extent did the 7LDs field monitoring system ensure quality programme delivery?
4. Sustainability
- To what extent are the outcomes and results of the programme sustainable at their respective levels (communities, district, regional and national level)?
 - What is the potential for scale up, replication and/or integration into national policies, strategies and future programming strategies/approaches?
5. Impact
- Did the 7 LD strategies improve child well-being in the 7LDs? Are there any significant differences in child well being⁴⁵ between learning and non-learning districts?
6. Cross Cutting Considerations
- To what extent did the actual interventions prioritize the most vulnerable?
 - To what extent did the actual interventions enhance gender equity?
 - To what extent were the district planning, budgeting and review process results based?
 - To what extent did the community members participate/involved in decisions during implementation

Evaluation Process, Methods and Outputs

The evaluation will employ a variety of methodologies including desk reviews, stakeholder meetings, and endline survey (in learning and non-learning districts). During the inception phase, the evaluation team will review relevant national policy documents to give an overall context of the country programme. The team will also consider any thematic studies/papers; selected programme documents and programme support documents as well as any reports from monitoring and evaluation at country level, as well as documentation and studies from other development partners. Relevant statistical data will also be assessed. A wide stakeholder consultation and

⁴⁵ While the office has no composite ‘child well being indicators’ for the purposes of this evaluation the 7LDs strategy intervention logic indicators are being used as the parameters for defining child well being.

involvement is envisaged. The evaluation team will meet with government ministries and institutions at national, regional, district and village levels, NGOs and UN agencies and communities.

The proposed evaluation will have the following segregation of duties and responsibilities between the international institution/consulting firm evaluation team and the national research institute:

An **international evaluation team leader** and **assistant team leader** will be responsible for managing and providing overall leadership and direction in the proposed evaluation and endline survey. The team leader is expected to have specific competencies of managing complex evaluations, while the assistant team leader is expected to have capacities to manage surveys including working with national research institutions in managing and implementing surveys.

A **national research institute** will be responsible for conducting the endline survey to facilitate impact analysis based on a set of key indicators established during the baseline survey. This work will be based on this ToR and the annex to these generic ToRs. The survey will assess the relative contribution of UNICEF support taking into consideration the interventions of other development partners, government counterparts and other exogenous factors. Some of the main conclusions and lessons learned will be derived from the endline survey.

While there is a segregation of duties between the international and national consultants, both teams are expected to work together to ensure the delivery of the objects of this ToR.

The evaluation will go through the following interrelated processes: **preparatory phase, inception phase, field phase, final report writing phase and, dissemination and follow-up**

Preparation Phase

Preparatory work at the local level will be carried out in advance to provide substantive background for the Evaluation Team. This will include an analysis of achievements and challenges in achieving the CP results in the 7LDs.

The preparatory phase also involves the identification of an evaluation reference group that will act as the main professional interface between the evaluation team, UNICEF TCO and the government of Tanzania. The group's principal functions will be:

- To provide the evaluation team with all available information and documentation about the objectives of the evaluation;
- To review the inception report and subsequent reports produced by the evaluation team;
- To provide a judgments on the quality of work of the evaluation team.

Inception Phase

Upon selection of the evaluation team, the evaluation will move to the structuring stage, which leads to the production of the inception report.

The main part of the inception work consists of all the key documents which are relevant to UNICEF's and government of Tanzania's cooperation (in particular the 7LDs strategy and programming documents).

On the basis of this ToR, additional information collected and discussions, the evaluation team will propose in its inception report the following:

- a) Any refinements to the evaluation questions, and clarify at the outset any limitations that can be foreseen in adequately responding to the questions.

- b) Elaborate an evaluation matrix, that details sub-questions against the questions, indicators, and data collection methods that will be used. Detail to the extent feasible, the analytical frameworks that will be used to respond to the evaluation questions.
- c) Elaborate a detailed weekly calendar for the forthcoming months, including the endline survey. This detailed calendar will identify the in-country engagement by the international consultants, the endline survey details and establish more precise deadlines for consultations and submission of outputs.
- d) Include pre-pilot data collection tools that will be used for gathering primary data

Field Phase

Following the acceptance and signing off of the inception report, the evaluation team will undertake the necessary data collection activities as per agreed schedule. If during the course of the fieldwork any deviations from the agreed methodology and/or schedule are perceived necessary, the evaluation team must receive approval of UNICEF before they can be applied. At the conclusion of the field work the evaluation team presents preliminary findings of the evaluation.

A mix of quantitative and qualitative methods will be used including techniques such as direct observation, informal and semi-structured interviews and focus group discussions where feasible and appropriate. Visit to project areas will help validating findings and triangulating them with community views through household survey and focus group discussions. The evaluation team will interview UNICEF staff (current and past) and partners (in government and CSOs etc) about all aspects of the programme over the 4 year implementation period. Unless there is a compelling rationale, the endline survey will employ the baseline survey sampling frame and methodology.

Fieldwork trips outside Dar es Salaam, beyond the endline survey, will be used as applicable as specified in the inception report with a clear rationale and justification.

Final report writing phase

The evaluation team will submit the draft final report in conformity with UNICEF standards and guidelines. If the PME unit considers the report of sufficient quality, it will be circulated for comments to the reference group. On the basis of comments expressed by the reference group, the evaluation team will make appropriate amendments. The UNICEF Monitoring and Evaluation Specialist will facilitate the process of consolidating the comments from the office. The revised final draft will be presented at a workshop in Dar es Salaam. The purpose of the workshop is to present the results, the conclusions and preliminary recommendations of the evaluation to national stakeholders and counterparts as part of the validation process.

The evaluation team shall prepare a presentation for the workshop. This presentation shall be considered as part of the evaluation in the same way as other outputs and products.

On the basis of the comments expressed at the workshop, the evaluation team will prepare the final report. There will be a management response to the evaluation recommendations.

Dissemination and follow-up

After approval of the final report, the PME unit in consultation with other UNICEF sections will proceed with the dissemination of the results of the evaluation.

Evaluation Outputs and Timing

The evaluation is scheduled start during the last quarter of 2010 and should be completed by the end of the first half of 2011 so that findings and conclusions can feed into the preparation of the next country programme cycle for UNICEF Tanzania. The detailed evaluation outputs and timing including the payment schedule are shown in the

table below. The payment schedule for the proposed evaluation consultancy is linked with the satisfactory delivery of the related outputs.

Outputs
Request for proposals issued.
Proposals reviewed, evaluated and consultants selected
Contract Signature and preparatory mission by evaluation team leader and national endline survey team.
Draft Inception Report and draft Evaluation Matrix prepared including endline survey implementation plan.
Final Inception Report and Evaluation Matrix prepared including field data collection tools for the endline survey.
Main evaluation mission and endline survey data collection undertaken.
Endline survey dataset shared with UNICEF.
1 st draft of main evaluation report plus draft synthesis endline survey report shared.
Stakeholders' debriefings workshop held.
Final evaluation report drafted (integrating comments from the stakeholders' workshop) and finalisation of endline survey synthesis report.
Final version of report sent for printing and disseminated.
Evaluation management response prepared and disseminated.

Reporting Framework

The final report should include the following elements: an executive summary, background to the design of the 7LDs strategy, a profile of the evaluated activities, and description of the evaluation methods employed, the main findings in line with the DAC evaluation criteria, conclusions, recommendations and lessons learned.

The evaluation report should follow the logic of this ToR and evaluation matrix agreed and finalised during the inception phase. All evaluation questions listed in the ToR and evaluation matrix, as well as additional ones that may come up during the evaluation process should be addressed in the evaluation report.

Data should be presented in different forms to facilitate reading and understanding. Boxes may be useful to highlight key issues.

Conclusions, recommendations and lessons learned should be firmly based on evidence and analysis, be relevant and realistic, with priorities for action made clear. The team should avoid making recommendations that are too general or impossible to implement. Ideally recommendations should be grouped by intended users, such as Programme Sections, national stakeholders, as well as partners.

Stakeholder Participation

A number of stakeholders will be closely involved in the evaluation mission through briefings and debriefings. Some will be involved in the peer review of evaluation outputs (in particular the draft reports). Stakeholders include:

- UNICEF Tanzania Country Office;
- Relevant MDAs and LGAs (PMO-RALG, MoHSW, MoEVT, MOFEA, etc);
- National and international NGOs engaged as part of the 7 LD strategy;
- Civil Society Organisations, Community Leaders and Communities in the 7 LDs and 6 NLDs