Poor adolescent reproductive health (ARH) continues to be a major cause of morbidity and worsening poverty in sub-Saharan Africa [1]. The effectiveness of ARH programmes within the health and education sectors is seriously hampered by adverse prevailing cultural norms and practices within those sectors and the wider community and by poor programme integration [2]. In order to address these problems, Health, Education and Community Integration (InHEC) was designed to develop, implement, and evaluate “evidence-based strategies to increase equity, integration and effectiveness of reproductive health services in Tanzania and Niger”.

**AIM**

The main aim of InHEC is to improve the delivery of reproductive health (RH) services in Tanzania and Niger by successfully engaging policymakers and programmers in the generation of new evidence about effective ways to strengthen the provision, uptake, equity and effectiveness of ARH programmes.

**OBJECTIVES**

1. To conduct a situation analysis of current community and implementer experiences of ARH programmes in Tanzania and Niger to identify weaknesses in ARH service provision
2. To develop and implement an innovative package of pilot interventions that are feasible, equitable and appropriately designed to address identified gaps
3. To document and evaluate the processes of these new interventions and their effects on ARH provision, uptake, and effectiveness
4. To support the development and implementation of feasible, effective and equitable ARH interventions in sub-Saharan Africa through effective collaboration

**Theoretical framework**

InHEC seeks to improve understanding of proximal determinants of health. Using a critical community health psychology approach, it builds alliances with marginalised groups and more powerful individuals and agencies, developing health enabling environments [3]. This approach will address circumstances undermining the communities’ health [5].

**Design: cluster randomisation**

InHEC is a cluster randomised trial implemented in 4 regions in Tanzania and Niger. Two regions per country. Each of the regions has 21 InHEC communities (wards): 3 formative wards, 9 intervention wards and 9 comparison wards. These wards are randomised into rural, urban and special risk strata.

**Randomised household survey**

This is being conducted in a random sample of 14,400 people in Tanzania and Niger for demographic characteristics of participants, their perceived RH needs, formal and informal RH service utilisation and expenditure, rationale for using one service over another, household exposure to school-based and community-based RH promotion, and their attitudes towards these RH promotion activities. A similar survey will be conducted during impact evaluation, and the results of both surveys will be compared to evaluate the impact of InHEC.

**Intervention framework**

ARH interventions are being developed and piloted in formative wards. They will be implemented in intervention wards in health, education and community settings.

**Methods**

**METHODS**

**Quantitative**

Randomised household survey

This study specifies the total number of clients served by providers in health, education and community settings for specific services, including HIV/STI prevention, treatment, care and support, and contraceptive services. During impact evaluation, results from the service provision and uptake will be compared with results from the baseline to evaluate the impact of InHEC.

**Qualitative**

Participatory focus group discussions and in-depth interviews

Adolescents will identify RH risks existing in their communities. Providers and adolescents will map risks identified to existing resources.

**Mystery clients studies**

These will be done in health facilities with adolescents trained as mystery clients. We will use scripted scenarios to assess the quality of services in the health and community sectors, as well as identify practices that limit service quality and integration

**Background**

**BACKGROUND**

Funding

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**References**