THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN

NATIONAL ACCELERATED ACTION AND INVESTMENT AGENDA FOR ADOLESCENT HEALTH AND WELLBEING (NAIA-AHW)

2021/22 – 2024/25

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LIST OF ABBREVIATIONS AND ACRONYMS

AA-HA!	Global Accelerated Action for the Health of Adolescents
ADDO	Accredited Drug Dispensing Outlets
AFHS	Adolescent-Friendly Health Services
AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
ARHWG	Adolescent Reproductive Health Working Group
ART	Antiretroviral Therapy
AYAS	Adolescents and Young Adults Stakeholders Group
BCC	Behaviour Change Communication
BEMIS	Basic Education Management System
CC	City Council
CDO	Community Development Officer
CHMT	Council Health Management Team
CHW	Community Health Worker
CSE	Comprehensive Sexuality Education
CMAC	Council Multisectoral AIDS Committee
CSO	Civil Society Organization
CTC II	Care and Treatment Clinic II
DC	District Council
DCDO	District Community Development Officer
DED	District Executive Director
DEO	District Educational Officer
DFID	Department for International Development
DHEEO	District Home Economic Education Officer
DHIS2	District Health Information System 2
DSW	Deutsche Stiftung Weltbevoelkerung
DSWO	District Social Welfare Officer
EMIS	Education Management Information System
EPforR	Tanzania Education Programme for Results
ESDP	Education Sector Development Plan
EQUIP-Tanzania	Education Quality Improvement Programme Tanzania
FBO	Faith-based Organization
FDC	Folk Development Colleges
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
HSHSP	Health Sector HIV and AIDS Strategic Plan
IAE	Institute of Adult Education
IDD	Iodine Deficiency Disorder
IEC	Information, Education and Communication
IPOSA	Integrated Programme for Out-of-School Adolescents
LGA	Local Government Authority
mCPR	Modern Contraceptive Prevalence Rate
MC	Municipal Council
MDAs	Ministries Department and Agencies
M&E	Monitoring and Evaluation
MHM	Menstrual Hygiene Management
MIT	Ministry of Industry and Trade
MoA	Ministry of Agriculture

MoCLA	Ministry of Constitutional and Legal Affairs
MoEST	Ministry of Education, Science and Technology
MoFP	Ministry of Finance and Planning
MoHA	Ministry of Home Affairs
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
PMO-LYED	Prime Minister's Office-Ministry of Labour, Youth, Employment and People with Disabilities
MoW	Ministry of Water
NACP	National AIDS Control Programme
NEEC	National Economic Empowerment Council
NGO	Non-Governmental Organization
NAIA-AHW	National Accelerated Action and Investment Agenda for Adolescent Health and Wellbeing
NBS	National Bureau of Statistics
NMNAP	National Multisectoral Nutrition Action Plan
NMSF	National Multisectoral Strategic Framework for HIV and AIDS
NPA-VAWC	National Plan of Action to End Violence Against Women and Children in Tanzania
NSC	National Steering Committee
NTC	National Technical Committee
OP/IP	Outpatient-Inpatient
PEPFAR	United States President's Emergency Plan for AIDS Relief
PGCD	Police Gender and Children Desk
PMO	Prime Minister's Office
PO-RALG	President's Office, Regional Administration and Local Government
PPTC	Post-Primary Training Centre
PSSN	Productive Social Safety Net
P4R	Payment for Results
RAS	Regional Administrative Secretary
R/CCMAC	Regional/City Council Multisectoral AIDS Committee
RCDO	Regional Community Development Officer
RCHS	Reproductive and Child Health Section
RHMT	Regional Health Management Teams
RITA	Registration Insolvency and Trusteeship Agency
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RSWO	Regional Social Development Officer
SBCC	Social and Behaviour Change Communication
SDGs	Sustainable Development Goals
STI	Sexually Transmitted Infection
SWA	Social Welfare Assistant
SWAp	Sector Wide Approach
SWASH	School Water, Sanitation, and Hygiene
SWO	Social Welfare officer
TACAIDS	Tanzania Commission for AIDS
TASAF	Tanzania Social Action Fund
TC-SWAp	Technical Committee on Sector-Wide Approaches
TDHS	Tanzania Demographic and Health Survey
TDHS-MIS	Tanzania Demographic and Health Survey and Malaria Indicator Survey
TECC	Tanzania Entrepreneurship Competitiveness Centre
TFNC	Tanzania Food and Nutrition Centre
THIS	Tanzania HIV Impact Survey
TIE	Tanzania Institute of Education
TVET	Technical and Vocational Education and Training
UNAIDS	Joint United Nations Programme on HIV/AIDS

UNICEF	United Nations Children's Fund
VAC	Violence Against Children
VEO	Village Executive Officer
VETA	Vocational Education and Training Authority
VMMC	Voluntary Medical Male Circumcision
WEO	Ward Executive Officer
WG	Working Group
WHO	World Health Organization
WIFAS	Weekly Iron Folic Acid Supplementation
WMAC	Ward Multisectoral AIDS Committee

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FOREWORD

Globally, there is an increasing sense of urgency to recognize adolescents as a unique demographic. The United Nations launched the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) in support of The 2030 Agenda for Sustainable Development and the Global Accelerated Action for the Health of Adolescents 2017. The strategy focuses on adolescents as being pivotal in achieving the Sustainable Development Goals. Within the East African Community and Southern African Development Community blocs, the Eastern and Southern Africa Commitments are implemented to ensure the access of adolescents and young people to youth-friendly sexual and reproductive health services in the region. This presents an opportune time for Tanzania to build upon these global and regional commitments and upon its commitment to the rapidly increasing adolescent population who are crucial to driving industrialization.

Despite this global momentum and significant evidence to argue for adolescent-specific interventions, there has been slow progress in developing such programmes. Implementing adolescent-specific interventions that are at scale, multisectoral, integrated, resourced, and monitored can be challenging with limited capacity. To address this, the Government called for the development of the National Accelerated Action and Investment Agenda for Adolescent Health and Wellbeing 2021/22 – 2024/25 (NAIA-AHW). The Agenda was developed in consultation with multiple stakeholders, including adolescents. It focuses on opportunities in adolescent health and wellbeing by prioritizing areas of high impact potential, and those with existing momentum in addressing challenges. Also, the Agenda builds on the National Adolescent Health and Development Strategy 2011 – 2015, focusing on catalytic and accelerated action and investments for adolescent health and wellbeing.

The vision of the Agenda is to 'accelerate the improvement of adolescent health and wellbeing to support the growth and development of healthy, educated, and empowered adolescents as they transition into adulthood'. To achieve this vision, the Agenda is anchored on six pillars: Preventing HIV; Preventing Teenage Pregnancy; Preventing Sexual, Physical, and Emotional Violence; Improving Nutrition; Keeping Boys and Girls in School; and Developing Meaningful Employment Opportunities. Although each pillar has a specific objective, the NAIA-AHW should be viewed as one comprehensive Agenda, with the combined effect of all prioritized and enabling interventions compounding positive and lasting impact. In addition to prioritized interventions, the NAIA-AHW outlines enabling interventions and an activation road map. Enabling interventions are necessary to monitor and coordinate interventions to iterate and improve the implementation process. This supports a long-term vision on adolescent health and wellbeing, thus achieving a long-lasting impact beyond the four-year implementation period. The Agenda goes beyond a national strategy and provides an activation road map to making the vision of a healthy, educated, and empowered adolescent in the country.

Stakeholder efforts and resources need to be devoted toward ensuring that interventions are implemented to accelerate the country's progress as envisioned in the National Five-Year Development Plan II (2016/17 – 2020/21) and the Tanzania Development Vision 2025. Development partners can support the vision of the Agenda by ensuring programme alignment with the prioritized activities and working closely with the government. Furthermore, allocating resources, not only in financial terms but in human capital as well, will be critical for the success of the NAIA-AHW.

It is the responsibility of duty bearers to ensure that all adolescents can access their rights; this requires strong partnerships and commitment within the community and between stakeholders.

Hon. Kassim Majaliwa Majaliwa (MP)
Prime Minister

ACKNOWLEDGEMENTS

The development of the National Accelerated Action and Investment Agenda for Adolescent Health and Wellbeing (NAIA-AHW) was an expansive multisectoral consultation process that brought together stakeholders across government, development organizations and communities, including adolescents. I would like to acknowledge the management teams at the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC), who realized the need for immediate action on adolescent health and wellbeing and called for the development of the Agenda. The management teams under the leadership of Permanent Secretaries brought together government stakeholders towards an exercise of prioritizing adolescents' needs and identifying potential solutions to these challenges. In partnership with other Ministries, Departments and Agencies (MDAs), the management teams converged stakeholder interest to propel the vision of the Agenda.

The development of the NAIA-AHW was coordinated by a Task Force that brought together personnel from different MDAs and other stakeholders. I would like to acknowledge the significant contribution of the MoHCDGEC – Community Development, for chairing the Task Force and coordinating all aspects of the document development. Members of the Task Force were critical in pushing the vision of the NAIA-AHW in their respective ministries and organizations. Task Force members were from the Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC), President's Office-Regional Administration and Local Government (PO-RALG), Prime Minister's Office-Policy and Coordination, Ministry of Education, Science and Technology (MoEST), Tanzania Institute of Education (TIE), Tanzania Commission for AIDS (TACAIDS), and Tanzania Food and Nutrition Centre (TFNC). I also acknowledge the significant role played by Dalberg Tanzania, who steered the development of the document, from conceptualization to the creation of an implementation roadmap.

Development stakeholders were key in providing inputs and helping steer the vision of the document. The Task Force consulted several development partners including various UN agencies, faith-based organizations (FBO), non-governmental organizations (NGO), and civil society organizations (CSO). I would like to particularly acknowledge the Elizabeth Glaser Pediatrics AIDS Foundation and Population Service International for funding the initial phase of the project—the development of the National Adolescent Health and Development Strategy, which laid a critical foundation in developing the NAIA-AHW. Similarly, I acknowledge the UNICEF Tanzania Office for their support not only as a thought partner but as facilitators of a countrywide adolescent workshop and survey, in partnership with TFNC.

I would like to extend my sincere thanks to the Bill and Melinda Gates Foundation, who funded the development of the Agenda, for their generosity in spearheading health progress in Tanzania as the country furthers its inclusive and universal health access agenda.

Hon. Ummy Mwalimu (MP)
Minister for Health, Community
Development, Gender, Elderly and Children

STATEMENT OF COMMITMENT

We, the Permanent Secretaries from the Line Ministries forming the National Steering Committee (NSC) which is the highest governing body for the National Accelerated Actions and Investment Agenda for Adolescent Health and Wellbeing (NAIA-AHW):

Recognize that adolescents present significant potential for the country's social and economic development, and that targeted investments to improve adolescent health and productivity can harness the demographic dividend and triple the country's GDP per capita;

Confident that this NAIA-AHW translates well the National policies and guidelines on adolescent health and wellbeing into an evidence-based strategic action plan that also contextualizes adoption of the global Sustainable Development Goals (SDGs) and regional adolescent relevant strategies that Tanzania is a state party to;

Accept that it is possible to make significant progress in addressing adolescent needs including adolescents with disability during the Five-Year Development Plan II of 2016/17 – 2020/21 as an important step towards making Tanzania a middle-income country by 2025;

THEREFORE, THROUGH OUR SIGNATURES ATTACHED HERETO, WE COMMIT OURSELVES TO THE FOLLOWING:

We shall take practical steps to ensure our sector policies, strategies, programmes, and budgets are sensitive to the needs of adolescents;

We shall actively participate in the implementation of the NAIA-AHW through the National Steering Committee; and

We shall take the necessary leadership in the implementation of the pillars interventions that our sectors have been assigned by the NAIA-AHW.

Eng. Joseph Nyamhanga
Permanent Secretary,
President's Office, Regional Administration and Local Government

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Dorothy Mwaluko
Permanent Secretary (Policy, Coordination and Investment)
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Andrew Massawe
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Dr. John K. Jingu
Permanent Secretary (Community Development)
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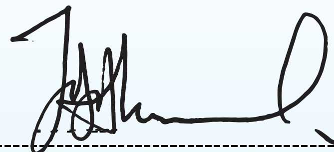

Dr. Leonard Akwilapo
Permanent Secretary
Ministry of Education, Science and Technology

EXECUTIVE SUMMARY

Tanzania Mainland has an adolescent population of about 12,439,677, accounting for about a fourth of Tanzania's population.[1] This large cohort presents significant potential for social and economic development. A combined investment approach in the economy, education, and family planning will have a potential demographic dividend of USD 3,877 per capita, more than triple the current GDP per capita.[2] Tanzania can harness this demographic dividend if it invests in education, health, governance, accountability, and productivity, and in creating quality jobs in adequate number.[3] Investments in adolescent health, particularly reproductive health, can triple dividends.[4] To leverage this demographic dividend, Tanzania needs to keep its adolescent population healthy, support their education, and empower them to develop successfully into adulthood.

The underlying drivers of adolescent health and wellbeing are well recognized; these span demand, supply, and an enabling environment. While some can be addressed in the immediate term, others are more systemic, and these require long-term investment. On the demand side, the combination of socio-economic and cultural factors—low education levels, high poverty rates, discriminatory social norms, and some religious practices—drive adverse behavioural outcomes among adolescents. Similarly, on the supply side, inadequate adolescent-friendly services and delivery channels prevent improvements in health-seeking behaviour. Within the enabling environment, policies and legislation do not often recognize adolescents as a unique demographic segment, and some policies are not aligned in their prioritization of adolescent development components.

Some efforts have been made to address challenges impacting adolescent health and wellbeing; however, programming is time-bound and limited in size and scale, and the focus varies. Many programmes operate within a limited time frame—of two to five years—and address only one or two areas. Few efforts are made at the level of the Local Government Authority (LGA) to use a more comprehensive approach and bring programmes together. Programmes currently operating in Tanzania Mainland reach about 3.4 million adolescents—a quarter of the adolescent population. Although the number appears substantial, the national impact is limited, because each programme has a specific goal and targets on average only 50,000 – 100,000 adolescents. Most programming for adolescents focuses on sexual and reproductive health (SRH); only a few programmes address the challenges in improving nutrition, preventing violence, enhancing access to education, or improving economic opportunities. The importance of adolescents is acknowledged, but this group is not considered a unique segment of the population or prioritized, and their health and wellbeing has received little attention. The youth represent the promise and potential of Tanzania's development, and there is an unprecedented opportunity for beginning to address adolescent health and wellbeing. Globally, there is an increasing sense of urgency that something different must be done to respond more effectively to the needs of adolescents.[5]

To improve the condition of adolescents in Tanzania, several gaps in health and wellbeing programmes need to be addressed immediately or in the near term. The National Accelerated Action and Investment Agenda for Adolescent Health and Wellbeing 2021/22 – 2024/25 (NAIA-AHW) builds on the National Adolescent Health and Development Strategy and lays down catalytic and accelerated actions and investments. The NAIA-AHW anchors on six pillars: (1) Preventing HIV; (2) Preventing Teenage Pregnancies; (3) Preventing Sexual, Physical and Emotional Violence; (4) Improving Nutrition; (5) Keeping Boys and Girls in School; and (6) Developing Skills for Meaningful Economic Opportunities. These pillars represent issues that affect adolescents disproportionately; areas where interventions are limited in their targeting of adolescents; and/or adolescent

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[1] National Bureau of Statistics (NBS), Population Census, 2012
[2] Ministry of Finance and Planning, Population Dynamics and Demographic Dividend in Tanzania, 2017
[3] African Institute for Development Policy, Opportunities for Harnessing the Demographic Dividend In Tanzania, 2014
[4] http://www.who.int/maternal_child_adolescent/topics/adolescence/why-invest/en
[5] http://www.who.int/maternal_child_adolescent/topics/adolescence/why-invest/en

programmes that are not at scale. The pillars outline priority areas for investments that can ensure a productive cohort and, ultimately, a productive nation. Besides, there are cross-cutting interventions, which have the potential to achieve more than two pillars. None of these pillars should be implemented separately; although each pillar has a particular objective, the pillars are interconnected, and form one comprehensive agenda, and the combined effect of all six pillars will in the short to medium term have a positive, lasting impact on adolescent health and wellbeing.

Priority interventions are those that have momentum and potential for high impact in the short to medium term; these can increase urgency and action towards achieving the objectives of improving adolescent health and wellbeing. The NAIA-AHW focuses on these priority interventions. Complementary interventions important in the medium to long term are *supporting* and *emerging/evolving* interventions; the NAIA-AHW does not focus on these. *Supporting* interventions are those with substantial momentum among several stakeholders that are implementing programmes to address these issues. Some of these interventions are already achieving their intended outcomes, while others are expected to see outcomes in the long term. *Emerging/evolving* interventions are those that are new, and have limited momentum, yet show some promise. Although not a focus of the NAIA-AHW, both supporting and emerging/evolving interventions are important to sustain, and it is essential for stakeholders to continue implementing interventions in these categories.

The existing programming has little momentum in the 13 priority regions and 89 District Councils. The coordination and implementation structure of the NAIA-AHW is optimized to operationalize and streamline interventions at the national and subnational level. At the national level, coordination will focus on countrywide efforts, including of development partners; at the subnational level, it will focus on the region, district, ward, and village. The success of the NAIA-AHW depends on the efficient operation of this structure and on adolescent engagement and participation. The NAIA-AHW focuses on 89 District Councils of 13 Regions. It aims, among other things, to construct or rehabilitate 670 classrooms in primary and secondary schools; construct or rehabilitate 201 hostels or dormitories for adolescent boys and girls in public and private secondary schools; construct or rehabilitate 402 water, sanitation and hygiene (WASH) facilities; and renovate 12 health facilities per district and establish Child Protection Desks in schools. Implementing programmatic activities will cost TZS 12.1 billion per District Council in the four-year period; national elements will require TZS 257 billion; and implementing all the interventions envisaged under the NAIA-AHW over the next four years will cost an estimated TZS 1.338 trillion.

PART I
INTRODUCTION

1.1 GLOBAL SITUATION OF ADOLESCENTS

Globally, there are 1.2 billion adolescents aged 10 – 19 years. More than half the adolescents live in Asia. South Asia has nearly 350 million adolescents, followed by East Asia and the Pacific with over 300 million adolescents. The adolescent population of either of these regions dwarfs that of any other region in the world.[6] In sub-Saharan Africa, adolescents aged 10 – 19 years make up 23% of the population. These numbers are expected to rise through 2050, and several global actors are calling for increased investments in adolescents. The global community is responding to this call for action.

In September 2015, the United Nations Secretary-General launched the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) (Global Strategy) in support of the 2030 Agenda for Sustainable Development (2030 Agenda). The Global Strategy envisions a world in which every woman, child, and adolescent realizes their rights to physical and mental health and wellbeing. This new strategy identifies adolescents as being central to achieving the Sustainable Development Goals (SDGs) of the 2030 Agenda.[7] To support and guide the implementation of the Global Strategy, a tool was developed: the Global Accelerated Action for the Health of Adolescents (AA-HA!). It provides the comprehensive information that countries need to decide what to do for adolescent health and how to do it. The AA-HA! brings about a paradigm shift in how we think about and plan for adolescent health.

1.2 SITUATION OF ADOLESCENTS IN TANZANIA

In Tanzania, adolescents are a key segment of the population; the 10 – 19 age group accounts for about a fourth of the population, and this number is growing.[8] The adolescent population of Tanzania Mainland is 12,439,677, of which 6,743,218 are aged 10 – 14 and 5,696,459 aged 15 – 19.[9] The population is projected to grow at 3.1% per annum on average from 2018 to 2022, when the adolescent population of Tanzania Mainland is projected to be 14,225,100 (7,370,648 aged 10 – 14 and 6,854,452 aged 15 – 19).[10] Tanzania aims to be a middle-income country by 2025 through industrialization; given that 70% of the population is 25 or younger (and 23% aged 10 – 19 years), this goal will be driven by the youth.[11] To achieve this goal and drive economic transformation, Tanzania needs to take advantage of its demographic by investing now in improving adolescent health and productivity.[12] Investments in adolescent health, particularly reproductive health, can triple dividends,[13] and a one-year increase in average tertiary education levels would eventually yield up to a 12% increase in GDP.[14] The potential demographic dividend from a combined investment approach in the economy, education, and family planning is USD 3,877 per capita, more than triple the current GDP per capita.[15]

1.3 RATIONALE OF THE NAIA-AHW

The NAIA-AHW has been developed to focus the country on gaps in adolescent health and wellbeing that need to be addressed in the near to immediate term. Adolescents have not been well prioritized as a unique segment

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[6] https://data.unicef.org/topic/adolescents/demographics/
[7] http://www.who.int/maternal_child_adolescent/topics/adolescence/why-invest/en/
[8] Tanzania Human Development Report (THDR), Economic Transformation for Human Development in Tanzania, 2014
[9] National Population Projections 2018: National Bureau of Statistics, Ministry of Finance, Dar es Salaam; and Office of the Chief Government Statistician, Ministry of State, President's Office, State House and Good Governance Zanzibar
[10] National Population Projections 2018: National Bureau of Statistics, Ministry of Finance, Dar es Salaam; and Office of the Chief Government Statistician, Ministry of State, President's Office, State House and Good Governance Zanzibar
[11] Tanzania Human Development Report (THDR), Economic Transformation for Human Development in Tanzania, 2014
[12] Ministry of Finance and Planning, Population Dynamics and Demographic Dividend in Tanzania, 2017
[13]http://www.who.int/maternal_child_adolescent/topics/adolescence/why-invest/en/
[14] The Africa-America Institute, State of Education in Africa Report, 2015
[15] Ministry of Finance and Planning, Population Dynamics and Demographic Dividend in Tanzania, 2017

of the population; while the importance of this age group is acknowledged, their health and wellbeing receives little attention. The youth of Tanzania represent its development potential, and there is an opportunity for comprehensively addressing adolescent health issues. The need to respond effectively to adolescents' needs is urgent, and the sense of urgency is growing worldwide.[16] The NAIA-AHW outlines 'what needs to be done' to increase actions and investments for adolescents in the near to immediate term. Instead of building another long-term strategy, the agenda focuses on catalytic and accelerated actions and investments to help reverse what is potentially already, or is soon to be, a dire situation for adolescents. It builds on several other relevant policy documents: The National Health Policy 2007; National Policy on HIV/AIDS 2001; Health Sector Strategic Plan 2015 – 2020 (HSSP IV); Tanzania National Multisectoral Strategic Framework for HIV and AIDS 2018/19 – 2022/23 (NMSF IV); National Multisectoral Nutrition Action Plan 2016 – 2021 (NMNAP); The National Road Map Strategic Plan to improve Reproductive, Maternal, Newborn, Child and Adolescent health in Tanzania 2016 – 2020 (One Plan II); and the National Family Planning Costed Implementation Plan 2019 – 2023.

1.4 OVERVIEW OF THE NAIA-AHW

The NAIA-AHW anchors on six pillars: (1) Preventing HIV; (2) Preventing Teenage Pregnancies; (3) Preventing Sexual, Physical and Emotional Violence; (4) Improving Nutrition; (5) Keeping Boys and Girls in School; and (6) Developing Soft Skills for Meaningful Economic Opportunities. Targeting these pillars will help accelerate improvements in adolescent health and wellbeing. The pillars outline priority areas where investments can be made to ensure that this cohort is productive and, ultimately, this nation is productive.

FIGURE 1: OVERVIEW OF SIX PILLARS

Each pillar represents an area where adolescents are disproportionately affected. Over 98,000 adolescents[17] aged 10 – 19 are currently living with the human immunodeficiency virus (HIV); as the population grows, the incidence of HIV/AIDS among adolescents is expected to increase. The Tanzania HIV Impact Survey 2016 – 2017 (THIS) reports the incidence of HIV infection at 0.07% in the 15 – 24 age group; 0.11% in the 15 – 19 age group; and 0.03% in the 20 – 24 age group. The disparity in HIV prevalence between males and females is most pronounced among young adults: in the 15 – 19 age group, 1.0% of females are HIV-positive (HIV+), but only 0.4% of males; and in the 20 – 24 age group, 3.4% of females are HIV-positive but only 0.9% of males.[18]

Every year, about 8,000[19] girls drop out of school due to pregnancy; this could fuel new HIV infections. Sexual, physical, and psychological violence are the most common forms of violence affecting adolescents; 11.2% of girls and 5.9% of boys reported experiencing at least one form of sexual violence, while 12.7% of boys and 12.6% of girls have experienced physical violence.[20] Adolescent girls are disproportionately affected by

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[16] http://www.who.int/maternal_child_adolescent/topics/adolescence/why-invest/en/
[17] UNICEF, HIV Factsheet, 2017
[18] Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC). Tanzania HIV Impact Survey (THIS) 2016–2017: Final Report. Dar es Salaam, Tanzania. December 2018
[19] https://www.hrw.org/news/2017/02/14/tanzania-15-million-adolescents-not-school
[20] TACAIDS, The Adolescent Experience In-Depth: Using Data to Identify and Reach the Most Vulnerable Young People, 2014

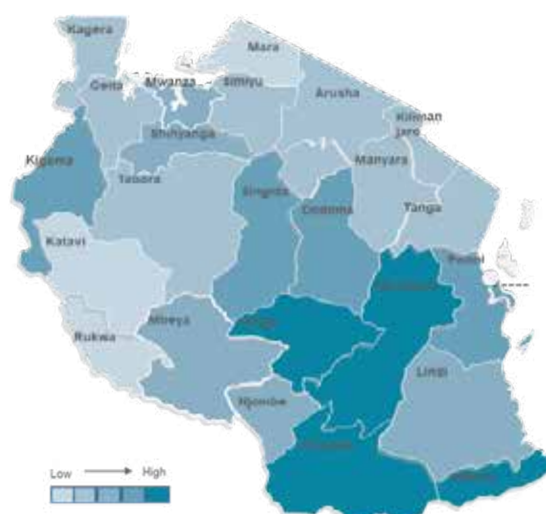
anaemia; 47% of girls aged 15 – 19 were anaemic in 2015.[21] Significant headway has been made on education, but only 40% of students proceed to secondary school, and 1.5 million drop out at the lower secondary level.[22] Since 2016, the economy has grown at 7% per annum on average,[23] but the youth unemployment rate rose steadily over the past decade and reached 11.5% in 2016.[24]

The performance on each pillar varies by region. The burden of disease is highest in regions in the Lake Zone, and a comparison of burden across all six pillars shows that the regions in the Lake Zone face the greatest burden. Shinyanga performs poorly on most pillars. The trend is inconsistent in a few cases, such as of Njombe. Njombe appears to be doing well on most indicators, but not on Pillar 1 (preventing HIV)—the HIV prevalence rate in Njombe is the highest in the country. Programmes for adolescents are concentrated in the southern zones and—in regions like Iringa, Morogoro, Ruvuma, and Mtwara—reach the greatest number of adolescents. Programmes target the fewest adolescents in Katavi and only a limited number in regions like Manyara and Rukwa. An initial mapping exercise based on proxy indicators shows the regions that experience the highest burden for each pillar (Annex 2).

COMBINED PILLAR MAPPING

Figure 2: combined issue map for all pillars

Figure 3: combined programme map for all pillars



Although each pillar has a specific objective, these should not be implemented in silos, as these are interconnected, and make up one comprehensive agenda; and the combined effect of all six pillars in the short to medium term will have a positive and lasting impact on adolescent health and wellbeing. The potential benefits of integrated health services are well known: these can be cost-effective, client-oriented, equitable, and locally owned. It is more effective to deal with the collective challenges of an individual (including their family, sexual contacts, etc.) rather than focus separately on only one health problem.[25] This document takes a pillar-centric view to present 'what needs to be done' to achieve the objective of each pillar. The next step, programme design, provides an opportunity to shift to a comprehensive view of the pillars and leverage synergies to ensure that funding and, thus, programmes are stretched as far as possible.

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[21] Tanzania Demographic and Health Survey
[22] https://www.hrw.org/news/2017/02/14/tanzania-15-million-adolescents-not-school
[23] https://af.reuters.com/article/africaTech/idAFL5N1RI4YN
[24] https://www.ilo.org/addisababa/countries-covered/tanzania/WCMS_511334/lang--en/index.htm
[25] WHO

1.5 EXISTING ADOLESCENT PROGRAMMES

Some efforts have been made to address challenges in adolescent health and wellbeing; however, programming is limited in size and scale. A mapping exercise identifies where adolescent health and wellbeing programmes operate, how many adolescents are reached, and what each programme achieves (Figure 4 and Annex 5). This exercise indicates the existing adolescent programmes, but not the ongoing government programmes; most government initiatives are not adolescent-specific, and capturing the impact on adolescents is difficult. The few adolescent-focused programmes operating in Tanzania reach about 3.4 million. This number seems substantial, but the national impact is limited, because each programme targets only 50,000 – 100,000 adolescents on average. Time limits and financial restrictions constrain programmes from scaling up.

FIGURE 4: SUMMARY OF EXISTING ADOLESCENT PROGRAMMES IN TANZANIA[26]

Pillars	Number of Programmes	Examples of Programmes	Summary Description of Programmes	Year Range	Focus Regions	Total Target Population
1 (Preventing HIV)	13	**Sauti** (by USAID/Jhpiego), **Global Fund HIV** (by Global Fund/AMREF), **DREAMS** (By USAID/BMGF, MDH, AGPAHI)	Promote HIV prevention awareness and provide HIV related services	2010 – 2025	Morogoro, Shinyanga, Mwanza, Kagera, Mara	1,623,027
2 (Preventing Teenage Pregnancy)	8	**Adolescent 360** (by PSI/BMGF, CIFF), **Tulonge Afya, Boresha Afya** (by USAID/FHI360)	Promote SRH information awareness and provide access to contraceptives for adolescent girls	2013 – 2022	Geita, Iringa, Morogoro, Dar Es Salaam	339,015
3 (Preventing Physical, Sexual and Emotional Violence)	5	**USAID Kizazi Kipya** (by USAID / Pact International), **Mwanamke Tunu** (by DFID/Intrahealth/PSI) **Muhe Development** Program (by private donations/ World Vision)	Promote awareness on abusive practices and provide services related to violence (usually part of larger programmes with key objectives to reduce HIV and, or teenage pregnancy)	2010 – 2025	Kigoma, Dar Es Salaam, Mbeya, Mwanza	1,171, 086
4 (Improving Nutrition)	7	Anaemia Reduction (by UNICEF) **Support to Food Security and Nutrition** (by EU, Save the Children, WFP), **Right Star Initiatives** (by Global Affairs Canada/Nutrition International)	Provide technical and financial assistance of improved nutrients to adolescents	2010 – 2025	Singida, Pwani, Mbeya, Iringa, Njombe, Mwanza, Dar Es Salaam	547,702
5 (Keeping Boys and Girls in School)	8	**Buhoma Development Program** (by private Donations/World Vision), **Tusome Pamoja** (by USAID/Pact International) **Cash Plus** (by UNICEF/TASAF)	Improve learning outcomes, enhance parental and community support of adolescents' education	2010 – 2025	Morogoro, Iringa, Ruvuma, Mtwara	1,723,945
6 (Developing Skills for Meaningful Economic Opportunities)	9	Advancing Youth Activity (by USAID/SNV), **Jiandalie Ajira Program** (by Mastercard Foundation/IYF/VETA) **Invest** (by Lutheran World Relief)	Focus on building skills of adolescents for employment (programmes are limited and usually focus on agriculture and out of school adolescents)	2013 – 2022	Mbeya, Iringa, Arusha, Kilimanjaro, Manyara, Mtwara, Dar Es Salaam	208,864

Existing programmes are concentrated in the regions of Dar es Salaam, Morogoro, Iringa, and Mtwara, and their focus varies. In implementing programmes, the choice of region is influenced by population spread, donor interest, and existing work. The objective of the programme is another important factor, but in some cases there may be several competing programme objectives. Given these complexities, regions like Katavi and Rukwa have received little focus. There is a growing shift towards comprehensive programming and holistically addressing adolescents' issues, but programmes still disproportionately anchor on HIV as a central theme and cover other issues only lightly. Current, time-bound HIV programmes reach 1,508,518 adolescents, and violence programmes target 1,040,653 adolescents,[27] but nutrition and skills development receive little attention.

1.6 CONSTRAINTS

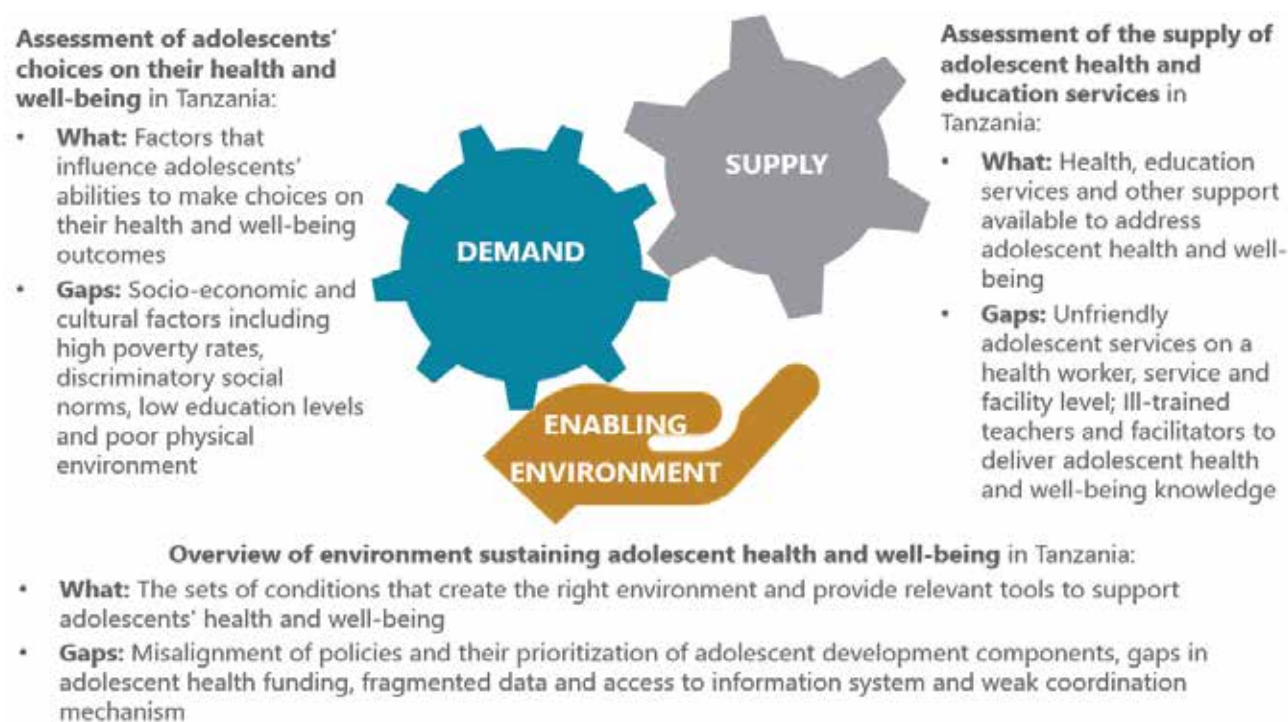
Adolescent health and wellbeing is undermined by drivers spanning demand, supply, and an enabling environment. The demand lens seeks to understand the factors that influence the ability of adolescents to take concrete, positive actions to improve their health and wellbeing. Socio-economic and cultural factors—high

[26] The target population of some programmes is unclear. Some other programmes target population impact across a few pillars

[27] Dalberg analysis

poverty rates, discriminatory social norms, low education levels, a poor physical environment—constrain adolescents from attaining their potential, but they can make the right choices if given the right information, tools, and agency. The supply lens assesses the spectrum of services available to effectively address adolescent health and wellbeing issues. Adolescent-friendly health services encompass the quality and attitudes of service providers, their availability and number, and the quality of the space. The lack of these services, or poor services, deters adolescents' health-seeking behaviour. Enablers focus on the sets of conditions that create the right environment and provide adolescents the appropriate support tools. However, the ability to unlock demand and supply is inhibited by policies that are misaligned or do not prioritize adolescent development components, and by gaps in adolescent health funding, inefficient coordination mechanisms, fragmented data, or inadequate access to information.

FIGURE 5: OVERVIEW OF DEMAND, SUPPLY, AND ENABLING ENVIRONMENT



DEMAND

Both awareness and positive health-seeking behaviour are hindered by inter-related systemic issues like poverty, cultural and religious practices, and poor education and literacy rates. Adolescents do not access health services because they do not fully understand issues that impact their health and wellbeing and because they are not aware of the services available. Small-scale studies on HIV awareness find that while the youth know of HIV, their knowledge is not comprehensive; many know the name of the disease (in both Kiswahili and English), but they do not perceive themselves to be at risk of infection.[28] Many adolescents do not know that services—educational and vocational support, drug and alcohol counselling, legal and social support—exist, or they do not know where these services are provided or how to access them.

Tanzania has experienced high economic growth rates of 6 – 7%, but while the national poverty rate is declining, it is still high—estimated at 26.9% in 2016.[29] High poverty constrains families in supporting their

[28] Williams, Increasing Access to Youth Sexual & Reproductive Health Services in Tanzania: Recommendations to Higher Learning Institutions, 2015
[29] World Bank, Tanzania

children's educational needs and contributes to creating an unsafe environment for adolescents. Education and literacy are strongly associated with improving health and fertility indicators. The high dropout rates in the country lead to an uneducated population who do not seek healthcare services. Children with disabilities are more likely to drop out of school early due to challenges of access and stigma. Alternative opportunities for formal learning, basic literacy, and vocational education are costly and difficult to access. Cultural practices—such as early marriage of girl children, and gender-based discrimination and violence—hinder adolescents' demand of health services and perpetuate gender disparities.[30] Such norms prohibit frank parent–child discussions about SRH, and this lack of appropriate information results in adverse sexual behaviours and health outcomes.

SUPPLY

There is a shortage of AFHS provision and facilities. The government targets 140,500 trained health workers, but there are only 64,449 health workers.[31] From 2009 to 2014, the government added around 500 healthcare facilities—mainly primary healthcare facilities—but few of these facilities are adolescent-friendly, and a significant gap remains. Studies show that only 30% of health service delivery points meet the national AFHS standards,[32] though the target was to have 80% of health facilities providing AFHS by 2015. Few service delivery points provide client-centred, comprehensive, and integrated adolescent services such as exclusive days/hours clinics. Community-based services that provide in-school and out-of-school adolescents access to SRH services are limited.

The availability of healthcare/education materials and commodities at delivery sites is often an issue. Key commodities such as contraceptives are not readily available outside health facilities, despite the recent expansion in delivery points. There are still too few Accredited Drug Dispensing Outlets (ADDOs) to cover the needs of the country, and stock-outs occur often. Textbooks and learning materials are in short supply at secondary schools.[33] Schools lack the facilities and supplies to promote good menstrual hygiene management (MHM), which requires adequate access to water and accessible, private, and hygienic sanitation facilities.

Teachers are not trained to deliver content on health and wellbeing; since the subject is often not examinable, teachers have limited incentive to teach it.[34] Few service providers know how to meet adolescents' needs effectively or have the awareness, ability, or friendly attitude necessary to deliver AFHS. Unfriendly health workers deter adolescents from seeking health services. Adolescents highlight that a key reason for not seeking healthcare support, especially with regard to teenage pregnancies, is that healthcare professionals are unapproachable and inaccessible. In rural areas, particularly, healthcare professionals are seen by the youth to be intimidating and lacking in understanding.[35] There is a dimension of inadequate training: health workers do not receive adequate training in providing AFHS; therefore, they need additional training before they start working as licensed professionals.[36]

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[30] Thomas Bisika 'Cultural Factors that affect sexual and reproductive Health in Malawi. Journal of Family Planning Reproductive Healthcare, 2008
[31] MoHCDGEC, Human Resource for Health Country Profile, 2013
[32] UNICEF, Adolescence in Tanzania, 2011
[33] UNESCO, Global Education Monitoring Report, Every Child Should Have a Textbook, 2016
[34] Dalberg stakeholder interviews
[35] Empower, Adolescent Engagement Report, 2018
[36] Dalberg stakeholder interviews

ENABLING ENVIRONMENT

Policies and legislation do not often recognize adolescents as a unique demographic segment, and some policies are not aligned in their prioritization of adolescent development components. While most policies support adolescent health and wellbeing, they place different levels of emphasis on components of adolescent development, causing inconsistencies and variations during implementation. For instance, socio-economic considerations and health systems are emphasized in the draft National Health Policy 2018 and the National Plan of Action to end Violence Against Women and Children in Tanzania 2017/18 – 2021/22, but the Health Sector Strategic Plan 2015 – 2020 (HSSP IV) and other documents focus on promoting coordination. On the legislative side, some contradictions between Acts can prevent adolescents from receiving certain rights and protection.

Gaps in general budget allocations and health insurance coverage negatively affect funding for adolescent health services. The Abuja Declaration of 2001 aimed at spending 15% of the budget on health expenditure, but the spending has been far less: in 2016/17 and 2017/18, for example, the government earmarked about 7% of its national budget for the health sector.[37] In the budget, financial resources are not dedicated to adolescent health and wellbeing; rather, funding for adolescent health and wellbeing is merged with other insufficiently funded programmes.

There are several data systems and platforms, such as the Health Management Information System (HMIS) and Care and Treatment Clinic II (CTC II). The data-sharing mechanism is not streamlined, however, and coordination is poor; therefore, information is seldom shared. The HMIS and CTC II collect general health data for all populations across the country, based on the guidelines of the Health Sector Strategic Plan IV (HSSP IV), but these cover only basic adolescent indicators, as part of the broad indicator sets. The indicators are not defined clearly, and access to information by adolescents is limited. The data available on adolescent health and wellbeing outcomes is fragmented, therefore, and disaggregating data on the 10 – 14 and 15 – 19 age groups is a priority, because decision makers at all levels need a clear sense of adolescents' problems and whether these are being sufficiently addressed.

Adolescent health and wellbeing activities are coordinated by multiple mechanisms. These work in silos and in parallel, and do not collaborate. The linkages are weak between the prime implementing entities: Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC); President's Office, Regional Administration and Local Government (PO-RALG); and the implementing partners at the regional and district levels. The weak linkage has led to poorly aligned and coordinated implementation of adolescent health and wellbeing programmes, and these entities have a limited understanding of the progress in each entity's work.

[37] Health Policy Plus Brief, Analysis of the Government of Tanzania's Budget Allocation to the Health Sector for Fiscal Year 2017/18, 2018

PART II
DETAILED INTERVENTIONS AND ACTIVITIES

2.1 METHODOLOGY

The NAIA-AHW focuses on priority interventions which have the potential to increase urgency and action. The interventions are categorized into priority, supporting, and evolving/emerging.

Priority interventions are those which have some momentum and have the potential for high impact in the near to immediate term. Some work is being done in these areas, and the current efforts need to be advanced to achieve the intended objectives for adolescent health and wellbeing. In defining interventions, we build on the existing work and structures to ensure that the integration with what is already being done is seamless. Each pillar outlines the interventions by target age range, constraint addressed, intended outcome, and activities to operationalize the intervention.

Supporting and *emerging/evolving* interventions are complementary interventions that are not the focus of the accelerated agenda but are important in the medium to long term. *Supporting* interventions are those with substantial momentum among several stakeholders that are implementing programmes to address these issues. Some of these interventions are already achieving their intended outcomes. For others, outcomes are expected in the long term. Interventions around policy change are support interventions.

Emerging/evolving interventions are those that are new with limited momentum, yet show some promise, e.g. interventions to expand research to address issues of nutrition among adolescents. Although not a focus of the agenda, supporting and emerging/evolving interventions both are important for long-term sustainability. It is essential for stakeholders to continue implementing interventions in these categories (Annex 6). The emerging/evolving interventions focus on pillar-specific and cross-cutting interventions; supporting system-building activities such as data management and coordination will have long-term impact beyond the four years.

The final set of priority interventions is the result of a process that incorporated inputs from a range of stakeholders. The process was supported by the Task Force created at the inception of document development. The Task Force included members of the Ministry of Education, Science and Technology (MoEST); the Community Development (CD) Department and the Reproductive and Child Health Section (RCHS) of the Ministry of Health Community Development, Gender, Elderly and Children (MoHCDGEC); the President's Office, Regional Administration and Local Government (PO-RALG); the Prime Minister's Office (PMO); and the Tanzania Institute of Education (TIE).

The Task Force was instrumental in socializing the agenda across ministries and in leading efforts to convene the stakeholders. Stakeholder engagement took place on several instances. Throughout the four-month development process, several working sessions and one-on-one meetings were held with over 70 stakeholders. In August 2018, a broad stakeholder meeting was held with government and development partners; it prioritized interventions across feasibility and impact metrics and focused on high-feasibility, high-impact interventions. These interventions were validated in smaller working sessions and one-on-one meetings. Over 150 consultations were held with government and non-government stakeholders.

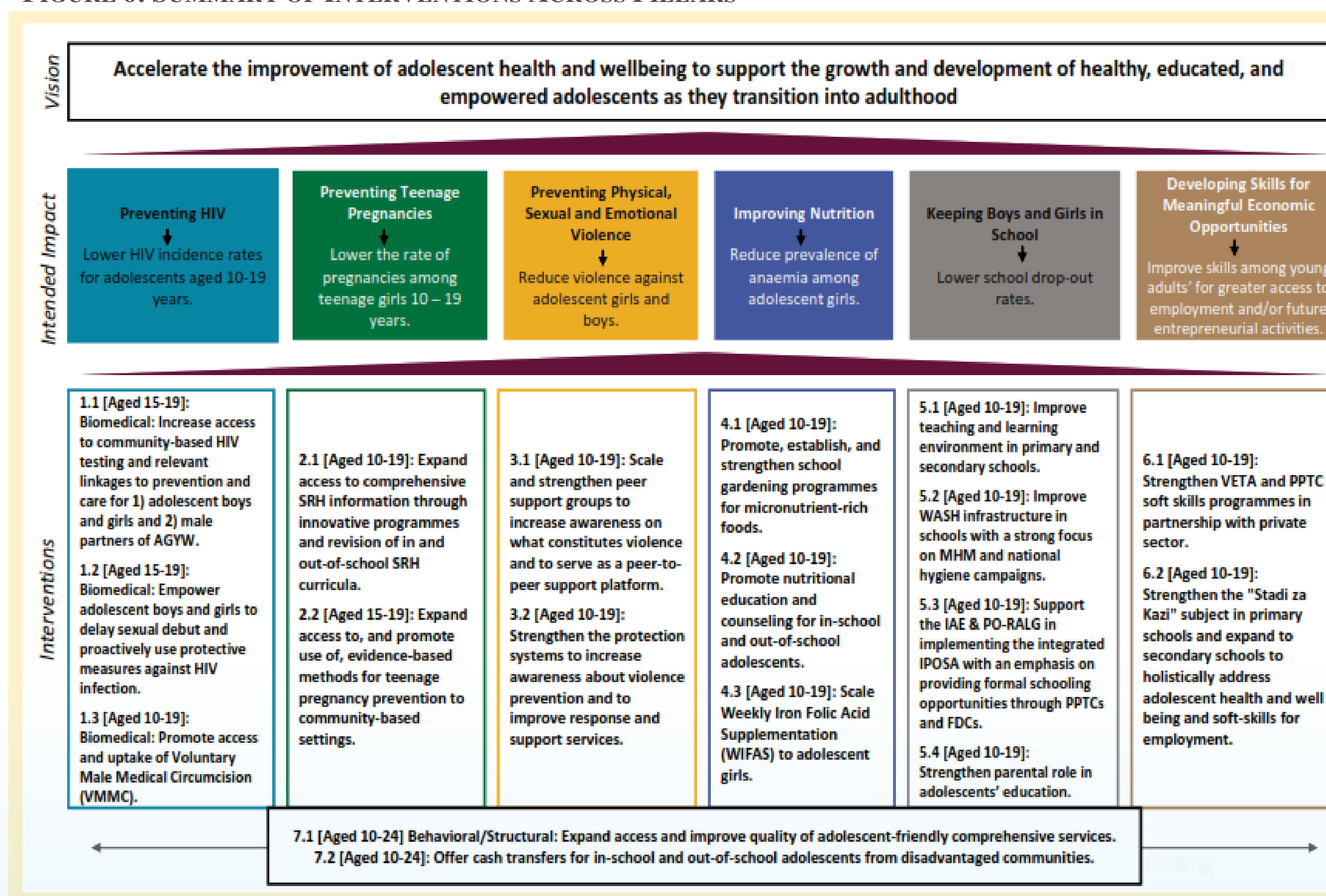
Adolescent participation is central to the success of the agenda; meaningful consultations with adolescents started in the design phase and will continue throughout implementation. Given the focus on the adolescent population, it is critical to ensure that adolescents are meaningfully consulted and engaged. The development process made use of several consultation mechanisms: focus groups; an adolescents' workshop; and online surveys. The online surveys elicited opinions from a diverse set of adolescents, including the marginalized and

the most vulnerable groups. During this initial phase, adolescents provided input into 1) the design of the agenda, specifically by confirming the issues that hinder adolescent health and wellbeing; and 2) determining how they can be optimally reached through the interventions to ensure maximal impact. Following the design phase, adolescents will continue to be meaningfully engaged through established, relevant, and appropriate governance mechanisms. While each of the fundamental issues affect all adolescents regardless of status (e.g. vulnerable and marginalized), the mechanisms of reaching specific youth groups will vary. To reach these various populations, it is critical to introduce adaptive measures into the programme during the design phase.

The following subsections elaborate on the interventions and critical themes or concepts, which are characterized as either pillar-specific or cross-cutting, and by the target age range, gap addressed, intended outcome, and activities needed to operationalize the intervention (Figure 6).

- *Target age range* – Target population
- *Gap addressed* – The gap or constraint that the intervention will address
- *Intended outcome* – Expected result, tied to the pillar objective
- *Activities* – What needs to be done

FIGURE 6: SUMMARY OF INTERVENTIONS ACROSS PILLARS



PILLAR 1 – PREVENTING HIV

Prioritized interventions for Preventing HIV include:

- 1.1 [Aged 15 – 19[38]] Biomedical: Increase access to community-based HIV testing and relevant linkages to prevention and care for 1) adolescent boys and girls and 2) male partners of adolescent girls and young women (AGYW);
- 1.2 [Aged 15 – 19] Biomedical/Behavioural: Empower adolescent boys and girls to delay sexual debut and proactively use protective measures against HIV infection; and
- 1.3 [Aged 10 – 19] Biomedical: Promote access and uptake of Voluntary Male Medical Circumcision (VMMC) to adolescent boys and male partners of AGYW.

Intervention 1.1 – Improving access to community-based HIV testing, with a strong social and behaviour change (SBCC component), is necessary to ensure that adolescent boys and girls and male partners of AGYW know their HIV status and take preventive measures to prevent new HIV infections using the combination prevention approach. HIV testing is available mostly at health facilities, but unfriendly services and stigma constrain sexually active adolescents' participation in facility-based testing and, consequently, their interaction with health systems and linkages to preventive services and treatment. Therefore, the coverage and uptake of HIV-testing services is low.[39] Facility-based testing, while essential, is unlikely to meet Tanzanian national targets. Increased attention to community-based testing,[40] which has improved uptake in sub-Saharan Africa,[41] is therefore needed.

The coverage and uptake of HIV testing services has improved, as became evident during the implementation of the Health Sector HIV and AIDS Strategic Plan III (HSHSP III). However, there is a need for programmes that provide not only testing but also ensure comprehensive pre- and post-test counselling and complete linkages to prevention or to care after testing. HIV prevention services and programmes are concentrated mostly in Morogoro and Shinyanga, followed by Mwanza, Kagera, and Mara. While Mbeya, Njombe, and Iringa have high HIV prevalence rates, they currently only have a mid-level concentration of programmes. In contrast, regions with low prevalence rates, including Kilimanjaro and Arusha, have made notable efforts in public sensitization to drive improvements in testing and in services such as antiretroviral therapy (ART).[42] HIV testing services will be scaled up to reach adolescents through community-based testing in accordance with the NMSF IV.

Intervention	
Intervention	**1.1 Biomedical: Increase access to community-based HIV testing and relevant linkages to prevention and care for 1) adolescent boys and girls and 2) male partners of AGYW**
Target age range	15 – 19
Gap addressed	HIV testing is mostly available in health facilities, but inadequately youth-friendly services, and stigma towards adolescents seeking HIV services at health facilities, constrain adolescents' participation in facility-based testing and, consequently, linkages to preventive services and treatment
Intended Outcome[43]	• Increased referrals to prevention and care post testing • Reduced new HIV infections for 1) adolescent boys and girls and 2) male partners of AGYW

[38] While the focus of this programme is up to age 19 years, there is an opportunity to extend it up to age 24 years and align it with the work being done by DREAMS and the Global Fund
[39] Tanzania National Multisectoral Strategic Framework for HIV and AIDS 2018/19–2022/23
[40] UNAIDS, Tanzania HIV Investment Case, 2016
[41] Nature, 'Systematic review and meta-analysis of community and facility-based HIV testing to address linkage to care gaps in sub-Saharan Africa', 2015
[42] Dalberg analysis
[43] Specific targets are included in the M&E Annex (Annex 9)

Activities	
1.1.1	Map and identify high-risk geographical locations/groups among 1) adolescent boys and girls, 2) male partners of AGYW, and 3) sexual networks of adolescent boys and girls
1.1.2	Conduct comprehensive demand-creation activities and sensitization campaigns for identified high-risk groups using influential people (e.g. young celebrities and political, community, religious leaders), mass media, jogging clubs, bonanza, mentors/peer educators, and social media to promote and increase demand for HIV community-based testing, HIV self-testing, education and provision of protective measures, SRH information and services, cervical cancer screening, and post-violence care
1.1.3	Conduct index testing for sexual networks of adolescent boys and girls and male partners of AGYW, and facilitate linkages to care for positives and preventive services for negatives
1.1.4	Implement combination prevention initiatives through pop-up/sports/music community events that include HIV community-based testing and linkages to care among 1) adolescent boys and girls and 2) male partners of AGYW
1.1.5	Provide facilitated referrals and linkages for identified HIV-positive adolescent boys and girls and male partners of AGYW to care and treatment services (e.g. ART)
1.1.6	Provide facilitated referrals and linkages for adolescent boys and girls and male partners of AGYW tested as HIV-negative to prevention services
1.1.7	Build capacity of healthcare providers to conduct community-based HIV testing as per national guidelines and to effectively communicate with adolescents on means of HIV/AIDS prevention by building strategic partnerships with non-state actors
1.1.8	Capacitate community members—parents/caregivers and community and religious leaders—to effectively and frankly communicate with adolescents on SRH issues

Intervention 1.2 – Empowering adolescents to delay sexual debut and proactively use protective measures is important in preventing new HIV infections. Behavioural interventions to delay sexual debut coupled with sexual reproductive health education can help reduce the transmission of HIV. Condoms have 98% effectiveness when used consistently and correctly,[44] provided access to condoms is feasible. Therefore, the World Health Organization (WHO) and Joint United Nations Programme on HIV/AIDS (UNAIDS) state that condom use is a key component of the combination HIV prevention approach.[45] Today, access to protective measures is limited, because such measures are not adequately available at the community level and adolescents cannot afford the protective measures available; adolescents who access such measures are stigmatized. The uptake of protective measures is limited because adolescents do not know their effects or usage.[46] To prevent HIV infection, this intervention aims to improve adolescents' awareness of protective measures and their access to and use of these measures.

Programmes using social marketing to increase the distribution of protective measures against HIV infection in public health facilities, the community, and in the private sector appears to have improved access to these measures. More programmes are needed to continue to strengthen the forecasting, promotion, and distribution of protective measures. During the implementation of the HSHSP III, Tanzania made progress in ensuring the availability of, and access to, HIV-protective measures in public and private outlets. To sustain this progress, greater efforts should be emphasized to ensure more effective distribution to

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[44] https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2016/february/20160212_condoms
[45] http://www.unaids.org/en/resources/presscentre/featurestories/2016/october/20161002_condoms
https://www.who.int/hiv/topics/condoms/en/
[46] South African Journal of HIV Medicine, 'Knowledge and practice of condom use as well as perceived barriers among street adolescents in Cameroon', 2016

reach all populations in need (except for boys and girls in a school setting), especially adolescents and male partners of AGYW. General HIV services programmes—which typically include the promotion and provision of protective measures against HIV infection—are concentrated in Morogoro and Shinyanga, followed by Mwanza, Kagera, and Mara. While Mbeya, Njombe, and Iringa have high HIV-prevalence rates, they currently only have a mid-level concentration of programmes. On the contrary, regions with low prevalence rates including Kilimanjaro and Arusha have made notable efforts in public sensitization, through development partners and NGOs, to drive improvements in using protective measures against HIV infection.[47]

Intervention	
Intervention	**1.2 Biomedical/Behavioural: Empower adolescent boys and girls to delay sexual debut and proactively use protective measures against infection of HIV**
Target age range	15 – 19
Gap addressed	• Limited access to protective measures against HIV infection at the community level, stigma against adolescents accessing such measures, and unaffordable price of private-sector protective measures • Limited usage of protective measures against HIV infection due to inadequate knowledge of correct usage
Intended Outcome[48]	• Increased use of protective measures against HIV infection among adolescent boys and girls and male partners of AGYW • Reduced new HIV infections for adolescent boys and girls and male partners of AGYW
Activities	
1.2.1	Implement combination prevention initiatives through sports/music/community events to empower adolescent girls and boys delay sexual initiation
1.2.2	Map and identify high-risk geographical locations/groups where there is an unmet need for protective measures against HIV infection among adolescent boys and girls; male partners of AGYW; and sexual networks of adolescent boys and girls
1.2.3	Conduct demand-creation activities through pop-up events, mass media, and social media and by using influential people (e.g. young celebrities, and political and community leaders) to persuade parents and community leaders against stigmatizing boys and girls using protective measures
1.2.4	Implement combination prevention initiatives through pop-up/sports/music community events that include HIV community-based testing and linkages to care among 1) adolescent boys and girls and 2) male partners of AGYW
1.2.5	Promote social marketing of government-branded protective measures against HIV infection
1.2.6	Build the capacity of health and non-health providers (e.g. parents, caregivers, and religious leaders) and retailers on the usage and distribution of protective measures against HIV infection
1.2.7	Train health facility and community workers in record-keeping and forecasting to ensure that the supply of protective measures is consistent
1.2.8	Procure and distribute vending machines of protective measures in all high-risk areas; appropriate

[47] Dalberg analysis
[48] Specific targets are included in the M&E Annex (Annex 9)

	places include areas near markets, shopping malls, sports grounds, guest houses, bars, nightclubs, colleges, and universities
1.2.9	Advocate for public–private partnership to subsidize private-sector protective measures and ensure access to these measures in pharmacies, private hospitals, and communities
1.2.10	Advocate for policy change to ensure government-branded protective measures are easily available from the national level to the community level
1.2.11	Strengthen youth representatives on the village/ward/council multisectoral HIV committees as spokespersons for adolescents' SRH needs

Intervention 1.3 – Promoting access to, and the uptake of, VMMC reduces the risk of female-to-male sexual transmission of HIV by up to 70%.[49] Traditionally, male circumcision has been high in Tanzania; 72% of men aged 15 – 49 years were circumcised, according to the 2011/2012 survey. The coverage of VMMC varies by age, from 66.2% (15 – 19 years) to 74.4% (30 – 39 years).[50] A VMMC modelling exercise for 13 selected regions of Tanzania Mainland indicated that scaling up male circumcision in the 10 – 29 age group would substantially avert HIV infection. This exercise indicated that the optimal long-term effectiveness of VMMC by 2050 would best be achieved through circumcision of men aged 15 – 29 years.[51] WHO and UNAIDS recommend VMMC as an additional important strategy for HIV prevention, particularly in settings with high HIV prevalence and low levels of male circumcision. The success of this intervention will require ethnic values and religious beliefs to be overcome. This one-off, permanent protection will effectively avert new HIV infections and reduce the number of people needing HIV treatment and care.

VMMC services started in 2009 in 13 priority regions where male circumcision is low and the burden of HIV high. These regions are Kagera, Mwanza, Tabora, Shinyanga, Simiyu, Njombe, Geita, Rukwa, Mbeya, Songwe, Ruvuma, Iringa, Katavi, and Rorya district in Mara region. Funding has been almost exclusively external. The national coverage saturation target was 80% by 2017, and 2.8 million men were to be circumcised to meet this target. By the end of 2016, 2.2 million (78.6%) had been circumcised, and only two regions (Iringa and Njombe) out of 13 had attained the target. However, VMMC services do not appear to be adequately focused on high-risk locations/groups such as mines and fish landing sites.[52]

Intervention	
Intervention	**1.3 Biomedical: Promote the access to, and uptake of, VMMC among adolescent boys and male partners of AGYW**
Target age range	10 – 19
Gap addressed	Limited access of VMMC to adolescent boys; programmes typically target older males, not adolescent boys
Intended Outcome[53]	• Increased male circumcision among adolescent boys and male partners of AGYW

[49] https://www.jhpiego.org/what-we-do/hivaids-infectious-diseases/hiv-testing-prevention-care-and-treatment-copy
[50] Tanzania Health Sector HIV and AIDS Strategic Plan IV, 2017–2022 (HSHSP IV) Monitoring and Evaluation Plan https://www.measureevaluation.org/resources/publications/tr-18–302/at_download/document
[51] Kripke K, Perales N, Lija J, Fimbo B, Mlanga E, Mahler H, *et al*. (2016) The Economic and Epidemiological Impact of Focusing Voluntary Medical Male Circumcision for HIV Prevention on Specific Age Groups and Regions in Tanzania. PLoS ONE 11(7)
[52] Tanzania Health Sector HIV and AIDS Strategic Plan IV, 2017–2022 (HSHSP IV) Monitoring and Evaluation Plan https://www.measureevaluation.org/resources/publications/tr-18–302/at_download/document
[53] Specific targets are included in the M&E Annex (Annex 9)

	• Reduced new HIV infections for adolescent boys and girls and male partners of AGYW

Activities	
1.3.1	Train healthcare workers to provide VMMC services among adolescent boys and male partners of AGYW in and out of health facilities
1.3.2	Conduct consultation meetings to integrate VMMC services as part of SRH services for adolescent boys and male partners of AGYW in and out of health facilities
1.3.3	Conduct VMMC as part of outreach or static services

PILLAR 2 – PREVENTING TEENAGE PREGNANCIES

Prioritized interventions for teenage pregnancies include:

- 2.1 [Aged 10 – 19]: Expand access to comprehensive SRH information through innovative programmes and revision of in-school and out-of-school SRH curricula; and
- 2.2 [Aged 15 – 19]: Expand access to, and promote the use of, evidence-based methods for teenage pregnancy prevention to community-based settings.

Intervention 2.1 – Access to comprehensive SRH information gives adolescents the information they need to make responsible SRH decisions, including delaying sexual debut and postponing age at first pregnancy as measures to prevent teenage pregnancies. Teenage childbearing has been steady over the past decade. About 26% of teenagers had a child or were pregnant in 2004/05; this percentage fell to 23% in 2010 and rose to 27% in 2015/16.[54] Most adolescent empowerment and reproductive health programmes focus on older adolescents. Innovative healthcare delivery programmes and an improved SRH curriculum will equip boys and girls from the age of 10 with SRH knowledge within the broad scope of health and wellbeing education.

Sexual and reproductive health programmes reach the largest number of adolescents in Dar es Salaam, Morogoro, and Geita. Notable programmes include Sauti, Boresha Afya, Tulonge Afya, Tuseme Clubs, and Mwanamke Tunu. Although Mara, Dodoma, and Katavi have high rates of teenage pregnancies, programmes in these regions do not reach a substantial number of adolescents. Regions including Arusha, Kilimanjaro, and Njombe have relatively lower rates of teenage pregnancies, which may be attributed to the wide reach of SRH education in these regions. Over 50% of the schools in these regions provide comprehensive sexuality education (CSE), while less than 30% of schools provide CSE in regions like Katavi.[55]

Intervention	
Intervention	**2.1 Expand access to comprehensive SRH information through innovative programmes and revision of in-school and out-of-school SRH curricula**
Target age range	10 – 19
Gap addressed	• Limited comprehensive knowledge of SRH and sensitivities over open discussion of sex • Most adolescent empowerment and reproductive health programmes focus on older adolescents • Existing CSE curriculum is not fully integrated with the existing secondary school curriculum, Teachers Diploma curriculum, or teaching methods

[54] TDHS-MIS 2015/16
[55] Dalberg analysis

Intended Outcome[56]	• Increased number of adolescents reached with comprehensive SRH information • Reduced teenage pregnancies among adolescent girls
Activities	
2.1.1	Scale existing innovative healthcare delivery programmes and target and engage adolescents better to raise their awareness of SRH issues and rights
2.1.2	Use mobile technology to increase demand, awareness, and linkages to SRH services
2.1.3	In-school: Conduct analytical review in terms of integrating CSE into the existing secondary school curriculum and into the curricula and teaching methods of the Teachers' Certificate and Diploma programmes
2.1.4	In-school: Develop guidelines for integrating CSE content into the existing secondary school curriculum and into the curricula and teaching methods of the Teachers' Certificate and Diploma programmes
2.1.5	In-school: Integrate the textbook CSE content into the existing secondary school curriculum and into the curricula and teaching methods of the Teachers' Certificate and Diploma programmes
2.1.6	In-school: Train in-service teachers and tutors to deliver CSE as an integrated concept within existing primary schools, secondary schools, and Teacher Colleges
2.1.7	In-school: Review the Education Policy Guideline (2004) to incorporate CSE as an integrated subject and deliver and implement life skills and HIV programmes in primary schools, secondary schools, and Teacher Colleges
2.1.8	In-school: Train schoolteachers and guardians on the Guidance, Counselling and Child Protection Guideline
2.1.9	Out-of-school: Harmonize out-of-school CSE programmes for adolescents
2.1.10	Out-of-school: Train facilitators on teaching out-of-school adolescents CSE
2.1.11	Out-of-school: Facilitators (peers can be facilitators) train out-of-school adolescents on CSE through teen clubs, online learning, etc.

Intervention 2.2 – Expanding access to evidence-based methods for preventing teenage pregnancy and promoting the use of these methods in community-based settings is critical, particularly when adolescents' access to certain measures is limited and the stigma against uptake is a barrier. The awareness of modern contraceptive methods is at 96%.[57] However, the modern contraceptive prevalence rate (mCPR) falls short of national goals. In 2017, the mCPR among married women in the 15 – 49 age group was 34.8%, against the national goal of 45%; among all women aged 15 – 49 years, the mCPR was 29.2%, against the national goal of 39%.[58] Several measures can reduce the fertility rate: improving the availability of evidence-based methods of preventing teenage pregnancy outside health facilities; removing the stigma against adolescents who access evidence-based methods; and subsidizing private-sector evidence-based methods.

SRH programmes that reach many adolescents focus on Dar es Salaam, Morogoro, and Geita. While Mara, Dodoma, and Katavi have high rates of teenage pregnancies, programmes in these regions do not reach a substantial number of adolescents.[59]

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[56] Specific targets are included in the M&E Annex (Annex 9)
[57] MoHCDGEC, One Plan II, 2016
[58] Tanzania National Family Planning Costed Implementation Plan 2018–2023, 2018
[59] Dalberg analysis

Intervention	
Intervention	**2.2 Expand access to evidence-based methods in community-based settings and promote the use of these methods to prevent teenage pregnancy**
Target age range	15 – 19
Gap addressed	• Limited access to evidence-based methods outside health facilities • Stigma against adolescent boys and girls who access evidence-based methods • Private-sector evidence-based methods unaffordable for most teenagers
Intended Outcome[60]	• Increased usage of evidence-based methods among teenagers and reduced incidence of pregnancy • Reduced incidence of pregnancy among adolescent girls
Activities	
2.2.1	Address negative social cultural norms and religious beliefs of adolescents' use of evidence-based methods to prevent pregnancy by targeting them and influencers (parents, and religious and community leaders) through community meetings and public campaigns (by means of mobile technology and mass, social, and traditional media)
2.2.2	Scale up positive parenting programmes to address the negative attitudes of parents/caregivers
2.2.3	Integrate SRH programmes as a component of holistic programmes that develop wider skill sets such as life skills and entrepreneurship to garner adolescents' attention towards evidence-based methods for preventing pregnancy
2.2.4	Improve access to evidence-based methods for teenage pregnancy prevention in and out of health facilities, e.g. by engaging Community Health Workers (CHW) and through outreach programmes, mobile clinics, and peer healthcare providers
2.2.5	Advocate for public–private partnerships to subsidize private-sector evidence-based methods for preventing pregnancy and ensure access in pharmacies, private hospitals, and communities
2.2.6	Train health workers on AFHS norms and values and address their bias against providing adolescents services so that they provide adolescents evidence-based methods for preventing pregnancy

Improving parenting and family care skills among parents, guardians, teachers, peer groups, community leaders, and religious leaders is a critical supporting activity for Pillar 2. Frank parent–child communication on sexuality improves adolescent SRH outcomes and prevents HIV infection. An adolescent's peers, family, community, and society at large influence their sexual decision-making and behaviour, and parents affect their children's gender and sexual socialization substantially. Globally, discussions with adolescents on sexuality are associated with important psychosocial attributes such as self-efficacy and improved knowledge and interpersonal communication skills, including sexual negotiation skills. In Tanzania, the impact of positive parenting interventions is mixed; however, a supporting intervention on positive parenting is recognized as being critical to achieving the pillar's objectives in the long term. Some of the activities recommended are educating parents, caregivers, and religious leaders on talking to adolescents about preventing pregnancy and developing and distributing information, education and communication (IEC) material with SRH messages.

PILLAR 3 – PREVENTING PHYSICAL, SEXUAL AND EMOTIONAL VIOLENCE

Prioritized interventions for violence include:

[60] Specific targets are included in the M&E Annex (Annex 9)

- 3.1 [Aged 10 – 19] Scale and strengthen peer support groups to increase awareness on what constitutes violence and to serve as a peer-to-peer support platform; and
- 3.2 [Aged 10 – 19] Strengthen protection systems to increase awareness about violence and to improve response and support services.

Intervention 3.1 – Promoting positive social and cultural norms and increasing violence survivors' demand for support services has the potential to prevent new and repeated cases of violence. Evidence from the Tanzania Demographic and Health Survey 2015 (TDHS 2015) shows that 60% of adolescent girls aged 15 – 19 believe wife-beating is justifiable.[61] Help-seeking behaviour is limited by such deep-rooted beliefs, coupled with the limited knowledge of and awareness about adolescents' rights and inadequate provision of services to violence survivors. The peer support groups will promote education on adolescents' rights and positive social and cultural norms, which will help prevent new and repeated cases of violence. These groups will act as support platforms for survivors, thus increasing demand for support services. In Arumeru, 70 cases of child labour and early marriage were reported through peer support groups.[62]

Peer support groups have been used to provide training on violence. This training can be leveraged, but it needs to be scaled. FHI 360 implemented a safe schools programme in Dar es Salaam, Morogoro, Iringa, and Tabora that trained students and communities in violence prevention and response.[63] However, such initiatives remain programme-driven; there is little sustainability after donor funding is terminated. The government has made efforts to expand the intervention under the 'Safe schools and life skills' thematic area of the National Plan of Action to End Violence Against Women and Children in Tanzania 2017/18 – 2021/22 (NPA-VAWC). Given limited funding, the intervention is yet to be implemented. The current number of peer support groups is 398, and the existing target under the NPA-VAWC is to develop 13,200 more by 2022.[64]

Intervention	
Intervention	**3.1 Scale and strengthen peer support groups to increase awareness on what constitutes violence and to serve as a peer-to-peer support platform**
Target age range	10 – 19
Gaps addressed	• Limited awareness of and knowledge about the social, economic, and legal rights of adolescents • A culture of silence associated with stigma, fear, and alienation • Myth on the utilization of response and support services for survivors
Intended Outcome[65]	• Increased awareness and understanding among adolescents of violence and their rights • Increase in the number of survivors seeking help or support from formal or informal channels
Activities	
3.1.1 Review and adopt the peer group training manual on preventing and responding to violence against adolescents	
3.1.2 Develop a directory poster that maps the formal reporting mechanisms and support channels for services related to violence close to areas where violence has occurred	
3.1.3 Train mentors on the training manual to lead training sessions with youth	
3.1.4 Conduct the peer support group sessions in schools and in identified locations for out-of-school	

[61] NBS, Tanzania Demographics Health Survey, 2015
[62] http://www.thecitizen.co.tz/magazine/soundliving/1843780–4640806-kkdi5s/index.html
[63] Dalberg stakeholder interviews
[64] MoHCDGEC, NPA-VAWC 2017 – 2022, 2018
[65] Specific targets for outcomes are included in the M&E Annex (Annex 9)

	adolescents
3.1.5	Conduct awareness campaigns targeting parents, religious leaders, influential, traditional leaders, service providers, government, and political officials on violence against adolescents
3.1.6	Establish and strengthen Junior and Youth Councils to enhance child participation rights in development activities

Intervention 3.2 – This intervention can improve the supply and quality of support services as it scales up the training of frontline workers in response and support services. Inadequate services to survivors of violence discourages the reporting of cases. This is driven by the limited capacity and number of frontline workers, e.g. there is a 90% gap in the requirement of social welfare officers.[66] This intervention strengthens the existing women and child protection systems and ensures that the supply of services to violence survivors has a sustainable impact. It seeks to improve community awareness on the issues of adolescent protection by facilitating a dialogue among adolescents, frontline workers, and community members (particularly caregivers). The law prohibits teachers from administering corporal punishment, but teachers and the community choose to ignore it, and adolescents are powerless to object. As one adolescent said, *If physical violence is against the law, why then can teachers beat us at school? That is physical violence isn't it?*[67] Consequently, making both community members and adolescents aware of violence has the potential to create a common understanding and provide a pathway towards preventing violence.

Women and child protection systems are currently implemented in several councils through the NPA-VAWC. The Government in collaboration with stakeholders has been developing these protection teams in the country and scaling the training of frontline workers, such as the Police Gender and Children Desks (PGCDs), in Iringa, Njombe, Mbeya, and Kigoma.[68] Social Welfare Officers (SWO) have been trained almost countrywide on case management, including on children/adolescents facing violence. The Protection Committees form the core of the response part of the protection system and connect the community with the formal response system (SWO, PGCD, health facilities). However, community norms and values constrain the reporting of violence. Many school clubs were formed in different parts of Tanzania to enhance peer-to-peer communications to defend children's rights and for protecting them from any form of Violence. For instance, with support from UNICEF, schools have set up Tuseme Clubs. In Mbeya, Iringa, and Njombe, more than 1,000 schools have Tuseme Clubs. These clubs empower boys and girls to voice their concerns on issues that affect them; they become aware of their rights, and they learn how to identify violence and protect themselves and where to go if they experience violence. The Education Quality Improvement Programme (EQUIP-Tanzania) of the Department of International Development (DFID) has set up similar school clubs in the regions they support. Training focuses on response, rather than prevention, however; and the current efforts at connecting frontline workers and the community have limited reach.[69] The EQUIP-Tanzania intervention seeks to provide frontline workers training on both prevention and response, and it will improve the community's confidence in seeking help or support during an incident. The intervention aims to scale to other councils that are yet to be reached under the NPA-VAWC.

Intervention	
Intervention	**3.2 Strengthen protection systems to improve response and support services on violence against adolescents**

[66] Dalberg stakeholder interviews
[67] Quote from the 2018 National Adolescent Conference in Dodoma
[68] Dalberg stakeholder interviews
[69] Dalberg stakeholder interviews

Target age range	10 – 19
Gaps addressed	• Inadequate provision of services to survivors of violence • A culture of silence associated with stigma, fear, and alienation
Intended Outcome[70]	• Increase the number of appropriate services provided by frontline workers • Increase community awareness and understanding of violence and adolescents' rights
Activities	
3.2.1	Review and adopt the training manual for training frontline workers on violence prevention and response
3.2.2	Conduct national- and subnational-level joint training workshop for frontline workers (Community Development Workers (CDOs), SWOs, health workers, law enforcers, Protection Committees)
3.2.3	Organize community forums and use the media to communicate issues of violence based on the Communication and Outreach strategy on VAWC
3.2.4	Establish Child Protection Desks in schools as a platform for empowering girls and boys and educating them about their rights, CSE, and Violence Against Children (VAC)
3.2.5	Conduct regular school check-ins by SWOs, CHWs, and CDOs to ensure that schools provide a safe environment for students
3.2.6	Establish and strengthen One-Stop Centres for VAC response and support in 67 District Hospitals (one per district)
3.2.7	Construct or rehabilitate 13 safe houses (one in each priority region)

PILLAR 4 – IMPROVING NUTRITION

Prioritized interventions for nutrition include:

- 4.1 [Aged 10 – 19] Promote, establish, and strengthen school gardening programmes for micronutrient-rich foods;[71]
- 4.2 [Aged 10 – 19] Promote nutritional education and counselling for in-school and out-of-school adolescents; and
- 4.3 [Aged 10 – 19] Scale Weekly Iron Folic Acid Supplementation (WIFAS) for adolescent girls.

Intervention 4.1 Promote, establish, and strengthen gardening programmes for micronutrient-rich foods in schools. School-based nutrition programmes—production of fruits and vegetables, and small animal–keeping—make meals available and give students an opportunity to learn good nutritional practices. By providing meals, schools reduce malnutrition—pre-existing in most adolescents—and, in turn, improve educational outcomes.[72] Improving school-based nutrition education, and school and home gardening, can significantly improve the dietary diversity of adolescents in interventional schools. By improving access to education and social protection, these programmes make possible returns on investment beyond health.

[70] Specific targets for outcomes are included in the M&E Annex (Annex 9)

[71] The target micronutrient-rich foods will depend on the geographical location. These may include orange sweet potatoes and locally available green vegetables

[72] Drake L, Woolnough A, Burbano C, Bundy D (Editors) (2016). Global School Feeding Sourcebook: Lessons from 14 Countries (2016). Imperial College Press, ISBN 9781783269112: New Jersey. https://openknowledge.worldbank.org/handle/10986/24418 License: CC BY-NC

Intervention	
Intervention	**4.1 Promote, establish, and strengthen school gardening programmes for micronutrient-rich foods**
Target age range	10 – 19
Gaps addressed	• Limited access to micronutrient-rich foods • Low consumption of micronutrient-rich foods
Intended Outcome[1]	• Increased access to micronutrient-rich food to in-school adolescents • Improved healthy eating habits for in-school adolescents • Increased dietary diversity among in-school adolescents
Activities	
4.1.1	Establish school gardens and small animal–keeping in primary and secondary schools
4.1.2	Train adolescents, teachers, and community on modalities of cultivating micronutrient-rich foods
4.1.3	Create awareness on production and cultivation of micronutrient-rich foods in schools
4.1.4	Conduct quarterly supportive supervision of gardening and small animal–keeping programmes in schools
4.1.5	Provide farm inputs and extension service support to prioritized schools implementing gardening programmes

Intervention 4.2 Nutritional education and counselling for in-school and out-of-school adolescents. This component is key to achieving the set objectives of Pillar 4. It includes critical activities such as engaging communities on locally available and culturally appropriate diets, creating awareness on the consumption of fortified and diversified foods from five groups of foods to meet nutritional requirements, and focusing on non-communicable diseases. Promoting nutritional education and counselling supports the prevention of malnutrition; promotes and maintains proper nutrition; builds community-wide awareness and political, social, and financial commitment to improving nutrition; and enhances individual positive nutritional behaviours and household practices. The direct impact of nutritional education and counselling activities is often challenging to capture; however, it remains necessary to achieving long-term change. In regions like Njombe, Mara, Kilimanjaro, and Simiyu, school feeding programmes enhance nutrition education and counselling among in-school adolescents.

Intervention	
Intervention	**4.2 Promote nutritional education and counselling for in-school and out-of-school adolescents**
Target age range	10 – 19
Gaps addressed	• Limited knowledge of nutritional needs during adolescence
Intended Outcome[73]	• Improved awareness of nutritional needs among communities • Healthy eating habits among adolescents and the community at large

[73] Specific targets for outcomes are included in the Annex on M&E (Annex 9)

Activities	
4.2.1	Establish and identify platforms to conduct nutritional education and counselling to adolescents
4.2.2	Review and update guidelines for conducting nutritional education and counselling
4.2.3	Train adolescents on nutrition, healthy eating, and lifestyle through school-based programmes and through youth and peer clubs
4.2.4	Create public awareness on healthy diets, including consumption of iron-rich foods, and lifestyle behaviours among adolescents through mass media, campaigns, and clubs
4.2.5	Promote consumption of locally available and culturally acceptable diversified foods
4.2.6	Establish community demonstration plots for micronutrient-rich foods by engaging agricultural extension officers in community settings
4.2.7	Leverage existing clubs for in-school and out-of-school adolescents to create food recipes using locally available foods through cooking demonstrations and competitions
4.2.8	Promote physical activities for adolescent boys and girls in and out of school.

Intervention 4.3 – Scale WIFAS for adolescent girls. Iron-deficiency anaemia is now recognized as being the primary cause of lost Disability Adjusted Life Years in adolescent girls worldwide. In adolescent girls, anaemia impairs cognitive functioning and deteriorates school performance, reduces productivity, and affects current and future reproductive health. WHO estimates that 27% of adolescents in developing countries are anaemic, and the TDHS 2015 reports that 47% of adolescent girls in Tanzania aged 15 – 19 are anaemic.[74] A WIFAS programme in Gujarat, India reduced the prevalence of anaemia by 22%.[75] **WIFAS has the potential to reduce the prevalence of anaemia in the short and medium term.** It can improve concentration in class and participation in other school activities.

This intervention is being implemented in Mwanza and Simiyu, where 94,000 adolescents are scheduled to receive iron folic acid (IFA) supplements on a weekly basis by 2020 through the Right Start Initiative.[76] The TDHS 2015 finds a high prevalence of anaemia in the Lake Zone, where the current programme is being implemented.[77] Only a small fraction of the adolescent population is targeted in this area of high need, however, and there is still a gap in reach,[78] evidenced by the significant gap in funding micronutrient interventions. In other regions, nutrition programmes provide school meals, or they function as components of programmes that seek to increase food productivity; according to the NMNAP, these programmes have a funding deficit of 80%.[79] The government and development partners have committed funding towards anaemia prevention, but a deficit of 40% exists.[80] The gap is most salient for adolescent nutrition programmes, which have a funding deficit of 62%.[81] This intervention will be carried out in priority regions where the prevalence of anaemia is high (more than 40%).

[74] NBS, Tanzania Demographics Health Survey, 2015
[75] Shobha P. Shah et al., Effectiveness and Feasibility of Weekly Iron Folic Acid Supplementation in Gujarat, India, 2016
[76] https://www.nutritionintl.org/content/user_files/2017/06/NI_FactSheet_RS-Tanzania-ENG-Ltr-FINAL-WEB.pdf
[77] NBS, Tanzania Demographics Health Survey, 2015
[78] Dalberg analysis
[79] PMO, NMNAP 2016–2021, 2018
[80] PMO, NMNAP 2016–2021, 2018
[81] PMO, NMNAP 2016–2021, 2018

Intervention	
Intervention	**4.3 Scale Weekly Iron Folic Acid Supplementation (WIFAS) for adolescent girls**
Target age range	10 – 19
Gaps addressed	• High prevalence of anaemia among adolescent girls • Limited awareness among adolescent girls on the prevalence of anaemia • Inadequate consumption of iron-rich foods leading to anaemia
Intended Outcome[82]	• Increased awareness on preventing anaemia among adolescent girls • Increased proportion of nutrition interventions targeting adolescent girls • Reduced prevalence of anaemia via consumption of recommended dosage of WIFAS
Activities	
4.3.1 Design models for implementing WIFAS	
4.3.2 Orient primary and secondary schoolteachers, CHWs, CDOs, and other community mobilizers on implementing the designed WIFAS model	
4.3.3 Conduct public awareness campaigns on the importance of WIFAS while providing community-wide nutritional education and counselling	
4.3.4 Distribute IFA supplements to adolescent girls at identified locations	

PILLAR 5 – KEEPING BOYS AND GIRLS IN SCHOOL

Prioritized interventions for Pillar 5 include:

- 5.1 [Aged 10 – 19] Improve teaching and learning environment in primary and secondary schools;
- 5.2 [Aged 10 – 19] Improve WASH infrastructure in schools with a strong focus on MHM and national hygiene campaigns;
- 5.3 [Aged 10 – 19] Support the Institute of Adult Education (IAE) and PO-RALG in implementing the Integrated Programme for Out-of-School Adolescents (IPOSA) with an emphasis on providing formal schooling opportunities through Post-Primary Technical Centres (PPTCs) and Folk Development Colleges (FDCs); and
- 5.4 [Aged 10 – 19] Strengthen parental role in adolescents' education.

Intervention 5.1 – Improving the teaching and learning environment in primary and secondary schools is crucial to improving school completion rates. Tanzania has made improvements in ensuring that basic education for all becomes a reality at the primary level, but the data shows that more efforts are needed. Completion rates in secondary schools is 11.3%, compared to 71.1% in primary schools for the same year.[83] Truancy is the leading cause of high dropout rates in both primary and secondary schools. Schools lack basic facilities:[84] classrooms are inadequate in number and in poor condition; there are too few textbooks; and the number of pit latrines for students is limited. Several ongoing initiatives support the improvement of the teaching and learning environment. The Tanzania Education Programme for Results (EPforR) allocated USD 437.5 million from 2014 to 2018 to improve the quality of education. The programme sought to deliver

[82] Specific targets for outcomes are included in the M&E Annex (Annex 9)
[83] NBS Population Data
[84] MoEST (2018) National Basic Education Statistics in Tanzania (BEST) National Data, 2018

capitation grants timely to schools, improve teaching conditions, and supply an adequate number of textbooks. To address these challenges adequately, however, more investment is needed.

Intervention 5.2 – Improving WASH infrastructure is proven to substantially increase school attendance, particularly among girls. Evidence from a randomized trial of a school water, sanitation, hygiene (SWASH) project conducted in selected geographic areas in Nyanza Province, Kenya found that a combined water treatment and hygiene promotion intervention reduced absenteeism overall by 39% and among girls by 58%.[85] This intervention can positively impact other pillars; for example, evidence suggests that improved SWASH facilities can also improve nutrition (by lowering the need for deworming) and, potentially, certain forms of violence.[86] This intervention focuses on constructing WASH facilities and promoting appropriate use.

Some commitments exist towards funding WASH infrastructure in schools, but the gap is still large. Over 60% of schools lack proper WASH facilities. The government allocates less than 1% of its national budget to SWASH facilities in 500 primary schools. There are other commitments; the largest, from the World Bank, is a payment for results (P4R) model with the Government of Tanzania to build more WASH facilities in schools. The model requires the government to build the facilities and the World Bank to pay if the facilities meet the basic requirements. Several development and implementing partners (e.g. United Nations Children's Fund (UNICEF) and WaterAid) are interested in supporting the hygiene behavioural campaigns. Given this momentum, there is an opportunity to increase the impact.

Intervention	
Intervention	**5.1 Improve teaching and learning enviroment in primary and secondary schools**
Target age range	10 – 19
Gap addressed	• Inadequate number of classrooms in schools • Inadequate teaching and learning material • High absenteeism and dropout • Limited access to dormitories, particularly for girls
Intended Outcome[87]	• Reduced incidence of absenteeism and dropout among adolescent boys and girls • Improved secondary school completion rates • Increased attendance in schools • Reduced incidence of school dropout due to teenage pregnancy
Activities	
5.1.1 Construct and rehabilitate 670 classrooms in primary and secondary schools (at least 7 per council) ***5.1.2*** Provide teaching and learning materials ***5.1.3*** Construct or rehabilitate 201 hostels or dormitories (at least two per council) in public and private secondary schools for adolescent girls and boys	

[85] UNICEF; The Impact of Water, Sanitation and Hygiene on Key Health and Social Outcomes, 2016
[86] Dalberg stakeholder Interviews
[87] Specific targets are included in the M&E Annex (Annex 9)

Intervention	
Intervention	**5.2 Improve WASH infrastructure in schools with a strong focus on MHM and national hygiene campaigns**
Target age range	10 – 19
Gap addressed	• High rate of absenteeism • Limited number of schools with WASH facilities • High dropout rate, particularly among girls
Intended Outcome[88]	Reduced absenteeism and dropouts
Activities	
5.2.1	Train District Home Economic Education Officers (DHEEO) and/or Health Workers to train teachers (male and female) on MHM in schools
5.2.2	Construct and rehabilitate 402 (at least four per council) WASH facilities (gender-separated and accessible child-friendly toilets with MHM facilities, water supply systems, and hand-washing facilities) in schools aligned to national school WASH guidelines; deliver training and workshops to change hygiene behaviour at schools; and develop school-level WASH Committees to manage the facilities
5.2.3	Conduct capacity-building of institutions (district WASH teams and school management committees) on good governance for appropriate planning, implementation, monitoring, and maintenance of WASH services in selected schools
5.2.4	Conduct campaigns in schools to promote hand-washing and MHM
5.2.5	Strengthen the WASH focus of the Education Management Information System (EMIS), ensuring that the necessary SWASH survey questionnaire responses are integrated into quarterly surveys conducted by the National Bureau of Statistics (NBS) and BEMIS
5.2.6	Create an environment that enables local industries to produce affordable sanitary pads
5.2.7	Sensitize and engage communities in constructing new schools with WASH facilities

Intervention 5.3 – Alternative education pathways are critical to reach vulnerable and marginalized youth who are unable to pursue or continue with formal schooling opportunities. Many marginalized populations cannot enter the formal schooling system, or they drop out. The 2016 Basic Education Statistics in Tanzania (BEST) indicated that about 2,256,940 children (14 – 17 years) were out of school. The MoEST has introduced an educational programme that will enable these youths to access education as their basic human right in a conducive environment. Given that formal schooling is not an option for many who have dropped out or never entered the school system, this programme has the potential to achieve the objectives of Pillar 5 by increasing the number of youth in the system. By integrating health education and life skills trainings, it can also achieve the objectives of other pillars.

The IPOSA is being developed for implementation. It can be strengthened and scaled over the next four years. The IPOSA aims to reach those who are currently not in the school system by targeting adolescents who never attended school, dropped out of either primary or secondary school, or completed primary school but did not transit to secondary education. It is currently being implemented by the Government in collaboration with UNICEF in selected regions. The programme integrates four skills: literacy, entrepreneurship, life skills, and pre-vocational skills. While this programme already exists in selected districts and regions, the reach has been limited since it is new. There is a need to scale the programme to reach more adolescents and ensure that its impact is realized.

[88] Specific targets for outcomes are included in the M&E Annex (Annex 9)

Intervention	
Intervention	**5.3 Support the IAE and PO-RALG in implementing the IPOSA with an emphasis on providing formal schooling opportunities through PPTCs and FDCs**
Target age range	10 – 19
Gap addressed	• Limited education opportunities for those unable to pursue or continue with formal education pathways • High dropout rates
Intended Outcome[89]	• Increased net enrolment • Lower dropout rates
Activities	
5.3.1 Conduct a baseline study of the IPOSA ***5.3.2*** Develop and implement short, competency-based courses for PPTCs certified by the National Examinations Council of Tanzania (NECTA) ***5.3.3*** Refurbish and construct 335 PPTCs (five per district) to deliver vocational and formal school education for out-of-school adolescents in locations of greatest need ***5.3.4*** Refurbish and construct eight Zonal Centres to effectively deliver vocational, entrepreneurship and formal school education for AGYW and their children ***5.3.5*** Implement voucher scheme for AGYW who attend Zonal Centres ***5.3.6*** Provide one free exam re-sit for students who dropped out and want to write their O-level core courses at a PPTCs, Zonal Centres, FDCs, or Vocational Education and Training Authority (VETA) centres ***5.3.7*** Conduct annual career days in partnership with private sector players once a year for students to identify work opportunities post qualification	

Intervention 5.4 – Strengthening the role of parents in adolescents' education improves student achievement, reduces absenteeism, and restores parents' confidence in their children's education. The level of involvement depends on the parents' education level and economic wellbeing, and it is also influenced by cultural and societal norms. Sociocultural norms and taboos in countries such as Tanzania make parents or guardians reluctant to support their children, especially adolescent girls, on academic issues, because they do not see any value in being educated. Several initiatives focus on changing the cultural and societal norms of education, and these have produced positive outcomes. Programmes like EQUIP-Tanzania aim to involve the community in improving education outcomes. Recently, the Government conducted sensitization meetings to strengthen school committees where parents are members. Intervention 5.4 can build on existing programmes and school committees to implement activities that will improve the role of parents in adolescents' education.

[89] Specific targets for outcomes are included in the M&E Annex (Annex 9)

Intervention	
Intervention	**5.4 Strengthen parental role in adolescents' education**
Target age range	10 – 19
Gap addressed	Parental and community involvement is crucial in enhancing adolescents' education, but few parents and guardians follow up on the academic progress of their children
Intended Outcome[90]	Increased engagement of parents and guardians in adolescents' learning
Activities	
5.4.1 Build capacity of Parent-Teacher Associations in following up on the learning of adolescents in school ***5.4.2*** Conduct campaigns in communities to promote parental and community involvement in adolescents' learning	

PILLAR 6 – DEVELOPING SKILLS FOR MEANINGFUL ECONOMIC OPPORTUNITIES

Prioritized interventions for Pillar 6 include:

- 6.1 [Aged 10 – 19]: Strengthen VETA and PPTC soft skills programmes in partnership with communities and the private sector; and
- 6.2 [Aged 10 – 19]: Strengthen the 'Stadi za Kazi' subject in primary schools and expand to secondary schools to holistically address adolescent health and wellbeing and soft skills for employment.

Intervention 6.1 – Strengthening soft skills programmes in VETA and PPTCs will ensure that the youth are better equipped to enter the workforce. The primary focus is on building critical skills among adolescents in the 10 – 19 age group to create opportunities for employment and/or meaningful economic activities in the future. That will improve the standard of living, which is the aspiration of Tanzania's Vision 2025. Private technical and vocational education and training (TVET) institutions in countries such as Mali and Senegal have designed new curricula and programmes that offer skills demanded by the private sector.[91] Engaging with the private sector is critical to identifying market and employer needs and to ensuring that the programmes develop the appropriate skills in the youth. Incorporating critical financial literacy skills is key to supporting economic empowerment and ensuring that the youth will be able to take advantage of mobile bank accounts and other digital financial services. There is an opportunity to create linkages to self-help groups (SHG) so that the youth have not only the necessary skills but also the confidence and the ability to access financial resources once they finish school. Figure 7 below provides a summary of appropriate soft skills that could be provided in this intervention.

[90] Specific targets are included in the M&E Annex (Annex 9)
[91] Dunbar, Engaging the Private Sector in Skills Development, 2013

FIGURE 7: PROPOSED SOFT SKILLS FOR INTERVENTION 6.1[92]

Soft Skills	Definition
Subject knowledge and competence	The knowledge and ability to critically apply one's specialization to their profession
Effective communication	The ability to express ideas clearly and confidently in writing and speech
General knowledge and commercial awareness	The ability to gather understanding of the commercial realities affecting an organization
Investigative and analytical skills	The ability to gather information systematically to establish facts and principles
Initiative/self-motivation	The ability to act on initiative, identify opportunities and proactive in putting forward ideas and solutions
Drive/grit	The ability to see tasks through to completion, deliver the end product and constantly look for better ways of doing things
Planning and organizing	The ability to plan activities and carry them out effectively
Flexibility	The ability to adapt successfully to changing situations and environment
Time management	The ability to manage time, prioritize tasks and meet deadlines

Although there are no stakeholders working with VETAs and PPTCs to build a soft skills programme, the programmes of several development partners provide skills trainings for out-of-school youth. The Youth Health Sport Initiative, being implemented by DSW Tanzania, mobilizes young people to engage in productive activities to enhance talents and education on health and economic empowerment in Dar es Salaam, Kilimanjaro, Arusha, and Manyara. The Cash Plus programme operates in Iringa and Mbeya and provides cash transfers, intensive life skills training, and mentoring and coaching on livelihood enhancement. WORTH is a soft skills programme in Mbeya City for caregivers of the most vulnerable adolescents and selected adolescent girls who are mothers. The programme targets women aged 15 – 19 and trains them in financial literacy skills, marketing, and SRH. WORTH is conducted by the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the DREAMS partnership. These types of programmes can provide an anchor for what works and does not work, and building these elements into VETA and PPTC has the potential to have a wider reach.

Intervention	
Intervention	**6.1 Strengthen VETA and PPTC soft skills programmes in partnership with the private sector**
Target age range	10 – 19
Gap addressed	Lack of skills for effective employability or entreprenurship
Intended outcome[93]	Increased number of adolescents who receive soft skills training
Activities	
6.1.1	Assess VETA centres and PPTCs to determine the current soft/life skills curricula available
6.1.2	Conduct annual labour force surveys/assessment in collaboration with the PO-RALG to understand the vocational skills demanded and complementary soft skills required
6.1.3	Assess soft skills demand with private sector actors annually to inform programme curricula
6.1.4	Conduct national career services drives in VETAs and PPTCs to improve employment outcomes for final-year VETA graduates
6.1.5	Identify and train educators in VETAs selected to pilot the soft skills programme

[92] Business Education Journal, 'Factors contributing to lack of employable skills among technical and vocational education (TVET) graduates in Tanzania', 2016
[93] Specific targets for outcomes are included in the M&E Annex (Annex 9)

Intervention 6.2 – Integrating life skills training into the school system provides a systemic solution that has the potential to reach all in-school students and improve wellbeing overall. The evidence shows that comprehensive life skills training for adolescents improves wellbeing. In collaboration with support organizations in South Africa, the National Department of Education, Health and Welfare initiated a life skills training programme in schools. The programme addresses some of the most challenging psychosocial problems young people face, such as HIV/AIDS, child abuse, and substance abuse. The rationale was to embed HIV/AIDS education within a broad series of skills relating to self-esteem, interpersonal relationships, citizenship, and health. Life skills training programmes improve economic empowerment and has the potential to promote an overall healthy lifestyle, also helping to achieve the objective of the other five pillars.

While Stadi za Kazi exists in primary schools, it is currently not practical, and the complexity of the subject limits its effectiveness—demonstrating the need to strengthen the subject. Stadi za Kazi, which translates to 'work skills', is a subject that covers 11 skills considered essential for 'work' life. It was introduced to primary schools in 1995 and revised in 2005. However, the instructions are so complex that it is rarely utilized. It is also currently limited to primary schools. Capacity-building for trainers can help in teaching this long-ignored subject.

Intervention	
Intervention	**6.2 Strengthen the 'Stadi za Kazi' subject in primary schools and expand to secondary schools to holistically address adolescent health and wellbeing and soft skills for employment**
Target age range	10 – 19
Gap addressed	• Limited opportunity for soft skills training in secondary schools • Lack of skills for effective employability or entreprenurship
Intended outcome[94]	Increased number of adolescents who receive soft skills training
Activities	
6.2.1 Educate school management, parents, and the community on the significance of this subject ***6.2.2*** Training teachers on 'Stadi za Kazi' extracurricular programme in primary and secondary schools to comprehensively address adolescent health, soft skills for employment, and wellbeing ***6.2.3*** Select teachers to train and head the 'Stadi za Kazi subject' in schools, and train them in using the life skills manual and/or addressing the stigmatization of adolescent issues, assessing the assessment of the delivery of the life skills programme, annually assessing student performance, and in reporting final school-level outcomes to Ward Executive Officers (WEO), DEOs, CHWs, and the MoHCDGEC ***6.2.4*** Provide life skills training with seed money or start-up capital for adolescents to initiate entrepreneurial activities	

[94]Specific targets for outcomes are included in the M&E Annex (Annex 9)

CROSS-CUTTING

A select number of interventions are cross-cutting with the potential to achieve objectives of more than two pillars, which include:

- 7.1 [Aged 10 – 19]: Behavioural/Structural: Expand access and improve quality of adolescent-friendly comprehensive services; and
- 7.2 [Aged 10 – 19]: Offer cash transfers for in-school and out-of-school adolescents from disadvantaged communities.

Intervention 7.1 – Expanding the access to adolescent-friendly comprehensive services and improving quality in areas of need will support adolescents' uptake of SRH services and, thereby, improve the likelihood of preventing HIV and teenage pregnancies. Adolescents have the right to healthy sexual and reproductive lives.[95] To meet their development needs, they require access to quality SRH services, but access is constrained by community and provider stigma, social and cultural norms, the lack of privacy and confidentiality, and legal and policy barriers. Studies show that only 30% of health service delivery points meet the national AFHS standards, much lower than the national target—80% of health facilities providing AFHS by 2015.[96] The emerging global guidance suggests that youth-friendly services must be mainstreamed in the community and health systems to reach the youth in a sustainable and scalable way.[97] Adolescents will feel encouraged to seek SRH services if 'adolescent-friendly comprehensive services' are improved along the level of health facility, community health service, and health workers.

Overall, AFHS provision needs to scale.[98] Today, HIV and SRH programmes usually include an adolescent-friendly services component. Programmes with an AFHS component are aligned with the provision of HIV and SRH services and are concentrated in Morogoro, Shinyanga, Mwanza, Kagera, Mara, Geita, and Dar es Salaam.[99] There is an interest in improving the provision of AFHS, but there are too few facilities in the country. There is a need to extend resources.

Intervention	
Intervention	**7.1 Behavioural/Structural: Expand access to adolescent-friendly comprehensive services and improve their quality**
Target Age Range	10 – 19
Gap Addressed	• Services that meet national AFHS standards limited (only 30% of service delivery points meet national standards) • Health workers not trained in delivering AFHS, unfriendly to adolescents
Intended Outcome	• Increased reproductive and child health (RCH) facilities with youth-friendly services • Increased community-based outlets that offer CSE and SRH services • Reduced new HIV infections among adolescent boys and girls and young women • Reduced teenage pregnancies among adolescent girls
Activities	
7.1.1	Conduct orientation on adolescent-friendly services to members of the Regional Health Monitoring

[95] Pathfinder International, Mainstreaming youth-friendly sexual and reproductive health services in the public sector in Mozambique and Tanzania, 2017
[96] UNICEF, Adolescence in Tanzania, 2011
[97] Pathfinder International, Mainstreaming youth-friendly sexual and reproductive health services in the public sector in Mozambique and Tanzania, 2017
[98] MOHCDGEC, Health Sector Strategic Plan IV 2015 – 2020
[99] Dalberg analysis

	Team (RHMT) and Council Health Management Teams (CHMT), facility staff (including guards), gender desk workers, and SWOs
7.1.2	Train healthcare workers on the national AFHS standards of SRH services provision
7.1.3	Perform random check-ins on healthcare workers' service provision and behaviours towards adolescents
7.1.4	Integrate adolescent-friendly comprehensive SRH services into the existing facility star rating national programme for clients to indicate service quality, supporting supervision needs
7.1.5	Develop a facility feedback mechanism where adolescents can rate the facilities' service quality regularly by short message service (SMS) every time after a visit
7.1.6	Advocate for the inclusion of an adolescent health programme in supervision and council budgets
7.1.7	Advocate specific adolescent-friendly days/hours at health facilities in pilot regions
7.1.8	Renovate 12 health facilities per district to ensure friendliness, privacy, and confidentiality (e.g. creating signboards of youth-friendly messages, holding wellbeing events regularly, and establishing an adolescent-friendly information desk at every health facility)
7.1.9	Set up community-based mobile clinics (as an alternative to health facilities), operated by young workers, where adolescents can access services freely
7.1.10	Integrate AFHS into antenatal care (ANC), postnatal care (PNC), and newborn care services (e.g. train midwives to attend to adolescent mothers in a friendly, non-judgemental way and conduct training programmes on ANC, PNC, and newborn care for adolescents
7.1.11	Sensitize community to support adolescents with special needs

Intervention 7.2 – Offering cash transfers for in-school and out-of-school adolescents from disadvantaged communities can reduce the incidence of new HIV infections and the adolescent fertility rate. About 60% of children of primary school age who are out of school live in 20% of the poorest households by the standard of per capita household consumption. Financial constraints encourage risky sexual behaviour such as transactional sex. Conditional cash transfers (CCTs) at regular intervals to adolescents from disadvantaged communities can improve their education outcomes and reduce risky sexual behaviour. Cash transfers can be tied to predetermined conditions; for example, beneficiaries may be required to enrol in a school club and receive SRH education or attend a skills training programme for out-of-school adolescents.

Cash Plus is the main CCT programme. Implemented by the Tanzania Social Fund (TASAF) III/Productive Social Safety Net (PSSN) Programme, it focuses on the southern regions in Iringa and Mbeya. It is being reviewed for scaling up to other regions. DREAMS/PEPFAR runs another CCT programme. It focuses on Kahama, Mbeya City, Shinyanga, Kyela, and Temeke, and it aims to target 65,000 AGYW.[100] The NMSF IV recommends cash transfers, incentives, parenting programmes, and parental monitoring to keep AGYW in school. Cash transfers and other financial incentives have the potential to increase school attendance and reduce teenage pregnancy and child marriage. Livelihood support should be considered for girls and young women not in school, including female household heads. Cash transfers can also be used for livelihood support.[101] Intervention 7.2 can build on existing programmes, working with current implementing partners and scaling to other regions.

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[100] Wambura M, Drake M, Kuringe E, Majani E, Nyato D, Casalini C, Materu J, Mjungu D, Nnko S, Mbita G, Kalage E, Shao A, Changalucha J, Komba ACash Transfer to Adolescent Girls and Young Women to Reduce Sexual Risk Behavior (CARE): Protocol for a Cluster Randomized Controlled Trial
JMIR Res Protoc 2019;8(12):e14696
URL: https://www.researchprotocols.org/2019/12/e14696
[101] NMSF IV Page 31

Intervention	
Intervention	**7.2 Offer cash transfers for in-school and out-of-school adolescents from disadvantaged communities**
Target age range	10 – 19
Gap addressed	Financial constraints contribute to increasing adolescents' propensity of risky sexual behaviour that leads to an increase in HIV infection and fertility rate among adolescents
Intended outcome	• Reduced new HIV infections for adolescents • Reduced adolescent fertility rate for women
Activities	
7.2.1 Fundraise for CCTs ***7.2.2*** Identify and register programme participants ***7.2.3*** Determine product conditions, structure, and disbursement with the MoEST, PO-RALG, TASAF, and the MoHCDGEC ***7.2.4*** Market the CCTs to community stakeholders (parents, headmasters, and DEOs) and educate stakeholders on the intended outcomes ***7.2.5*** Disburse CCTs to in-school and out-of-school adolescents	

Gender mainstreaming and SBCC are integrated as concepts or activities under several interventions. These are critical elements, but difficult to measure on their own. Effective, high-quality SBCC influences positive social and cultural norms and has the potential to bring about long-term change. Such long-term effects are difficult to measure, but some studies show that SBCC is effective. For example, a study by Wakefield *et al*. on the effect of mass media campaigns on tobacco smoking and road safety shows compelling evidence that SBCC contributed towards reducing deaths. Social and behaviour change communication has been shown to be effective in promoting nation-wide conversations that may precipitate desired long-term change; SBCC campaigns are effective in countering social norms using media (e.g., radio, which is widely cited), and leveraging influencers such as celebrities and religious and community leaders. The Agenda integrates SBCC into several interventions; SBCC campaigns are incorporated as key activities into Interventions 1.1 and 1.2 under Preventing HIV and into Intervention 3.2 under Preventing Sexual, Physical and Emotional Violence. These SBCC activities are particularly important to interventions that seek to change deep-rooted practices. Intervention 3.2 addresses the culture of silence that is associated with stigma, fear, and social alienation, which discourage the reporting of violence. Parents and caregivers serve adolescents as gatekeepers, and they are important actors and key targets in SBCC campaigns.

Gender mainstreaming is another key cross-cutting element integrated into the agenda. It considers the specific needs of men, women, girls, and boys with respect to biological/sex differences and sociocultural gender. Emerging evidence and programme experience indicate that gender mainstreaming can have considerable health benefits for both genders. A study by Tokhi *et al*. shows that engaging men in low- and middle-income countries can help improve maternal and child health. This was substantiated by adolescents; one reasoned, *We also need to educate them [boys] to be healthy husbands and fathers in the future*.[102] Gender mainstreaming is incorporated as elements of some activities or as stand-alone interventions in the agenda. For example, Intervention 6.1 seeks to provide life skills to adolescent boys and girls in PPTCs, and Intervention 1.3 will scale voluntary male circumcision. Gender mainstreaming provides adolescent boys and girls, men, and women room for becoming allies. This is particularly important in increasing the demand for products and services that directly benefit only adolescent girls. Examples of such interventions are Intervention 2.2, which provides evidence-based methods for preventing teenage pregnancy, and Intervention 4.1, which provides IFA supplements.

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[102] Quote from the 2018 National Adolescent Conference in Dodoma

PART III
COORDINATION STRUCTURE

3.1 INTRODUCTION

The coordination entity will be multisectoral. It will bring multiple members together under the guidance and direction of the PMO (Policy and Coordination) to facilitate seamless cross-ministerial collaboration and supervision and swift discussion and execution of identified interventions. The coordination framework will articulate the role of each entity involved to ensure that they collectively address the diverse adolescent needs. To avoid being duplicative, the coordination structure builds on what already exists. While the following provides suggestions, the actual structure will be finalized during the implementation phase. Several entities will be critical in coordinating the activities of the Agenda at the national and subnational levels.

3.2. NATIONAL-LEVEL COORDINATING UNITS

Implementation will be multisectoral and cross-jurisdictional, and the coordination structure will operate at the national and subnational levels. The national-level coordinating units will ensure that the NAIA-AHW plans are aligned with national targets and government policies; develop best practices and instruments for knowledge-sharing; and streamline these practices and instruments to the coordinating units at the subnational level. The subnational-level coordinating units will enhance synergies between implementing partners; ensure that the implementation of prioritized activities at the regional, district, ward, and village levels are in line with the NAIA-AHW operational guidelines; and report on the progress of activities. The national coordination structure will sit within the PMO (Policy and Coordination). The structure will be supported by the NSC, the National Technical Committee (NTC), and the Working Groups (WG).

National Minister's Forum

The National Ministers' Forum will have a high-level mandate to oversee that the implementation conforms to the government policies and international treaties. The forum will be chaired by the Minister for Health, Community Development, Gender, Elderly and Children. The participants will be Ministers from MoEST, MoFP, PO-RALG, PMO-LYED, MoW, MoCLA, MIT, and MoA. The forum will meet annually.

National Steering Committee (NSC)

The mandate of the NSC is to provide overall policy guidance on the Agenda to ensure alignment with international targets and government policies and to mobilize resources for the financing of Agenda activities. This coordination structure will link closely with the National Ministers Forum, which supports the NSC in facilitating inclusion and resource mobilization within and outside the government for implementing the agenda. This Forum will also ensure alignment with government policies and international treaties. The NSC will be chaired by the Permanent Secretary of the PMO (Policy and Coordination). The Permanent Secretary of the PMO (Policy and Coordination) has the mandate to bring together sectoral stakeholders.

The NSC will be composed of the Permanent Secretaries of several government ministries: Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC); Ministry of Education, Science and Technology (MoEST); Ministry of Finance and Planning (MoFP); Ministry of Water (MoW); Ministry of Industry and Trade (MITI); Ministry of Home Affairs (MoHA); Ministry of Constitutional and Legal Affairs (MoCLA); Ministry of Agriculture (MoA); Prime Minister's Office - Labour, Youth, Employment and People with Disabilities (PMO-LYED); and the PO-RALG. Permanent Secretaries from other ministries can attend upon request from the chair. The NSC will also be composed of the country directors of identified development partner organizations and civil society organizations (CSO).

The NSC will meet annually to discuss the agenda of the NAIA-AHW. Given the overlapping membership structures, the National Protection Steering Committee under the NPA-VAWC will be leveraged to facilitate the meeting of the NSC.

The roles of the NSC will be to:

i. Provide policy guidance in the overall implementation of the NAIA-AHW;
ii. Ensure the NAIA-AHW is mainstreamed into government plans and strategies at all levels;
iii. Provide oversight on reaching set targets;
iv. Ensure adequate resources are allocated for activities; and
v. Liaise with development partners for fund raising to support the implementation activities.

National Technical Committee (NTC)

The NTC will provide the NSC technical assistance, and review annual plans and progress reports from the AYAS and Working Groups. The NTC will be co-chaired by the Permanent Secretaries of the MoHCDGEC and the MoEST. The Permanent Secretaries of the Health and Community Development departments of the MoHCDGEC will rotate their chairmanship of the NTC.

Members of the NTC will include government ministers (from the MoHCDGEC, MoEST, MoFP, MoHA, MITI, MoW, and MoA) and heads of government departments (PMO-LYED and PO-RALG). It will include also the heads of TACAIDS; TASAF; Tanzania Food and Nutrition Centre (TFNC); Registration, Insolvency and Trusteeship Agency; and the Commission for Human Rights and Good Governance. There will also be three youth representatives (male, female, and special needs) and representatives of development partners, CSOs, and FBOs.

The NTC will leverage the existing meeting of the National Protection Technical Committee to discuss the NAIA-AHW biannually.

The roles of the NTC will be to:

i. Analyse the implementation of activities and recommend on the integration of positive lessons learnt into various sectoral plans for scale-up;
ii. Ensure regional and international treaty obligations related to adolescents are integrated into national development plans and programmes;
iii. Advocate for the allocation of resources to prioritized interventions in coordination with the NSC;
iv. Liaise with development partners and other stakeholders on resource mobilization for implementation; and
v. Report quarterly to the NSC on the implementation of the NAIA-AHW.

Adolescent and Young Adult Stakeholder (AYAS) Working Group

The Adolescent and Young Adult Stakeholder (AYAS) Working Group (WG) is a multisectoral, adolescent-specific working group under the TACAIDS. The AYAS WG brings together technical personnel from the MoHCDGEC, MoEST, PMO-LYED, PO-RALG, MoHA, PMO (Policy and Coordination); two youth representatives (male and female); and representatives of implementing partners. Additional members could be co-opted from the TFNC, TASAF, MoW, TIE, and the National Economic Empowerment Council (NEEC). The AYAS WG will advocate for the NAIA-AHW at the national level and directly liaise with the NTC to provide relevant information on the implementation of activities.

The roles of AYAS will be to:

i. Collate progress updates across the WGs on adolescent-specific activities;
ii. Support the WGs and the NTC on technical guidance on issues related to adolescents; and
iii. Advocate for funding prioritization towards interventions.

Working Groups (WG)

The WGs are thematic working sessions under the existing strategy and ministerial bodies that will push the NAIA-AHW. The AYAS WG, which is under TACAIDS, is a multisectoral, adolescent-specific WG. It brings together technical personnel from the MoHCDGEC, MoEST, PMO-LYED, PO-RALG, MoHA, PMO (Policy

and Coordination); youth representatives; and representatives of implementing partners. Additional members could be co-opted into AYAS such as those from TFNC, TASAF, MoW, TIE, and NEEC. The AYAS WG will advocate for the NAIA-AHW at the national level, and directly liaise with the NTC to provide information on the progress of programme implementation.

In addition to AYAS, the following existing Working Groups will be leveraged:

i. Preventing HIV and Preventing Teenage Pregnancies – *Adolescent Reproductive Health Working Group* under the MoHCDGEC;
ii. Preventing Teenage Pregnancies and Keeping Boys and Girls in School – *Adolescent Reproductive Health Working Group* under the MoHCDGEC;
iii. Preventing Sexual, Physical, and Emotional Violence – *Safe Schools and Life Skills Working Group* and *Response and Support Services* under NPA-VAWC;
iv. Improving Nutrition – *Prevention and Control of Micronutrient Deficiencies Working Group* under the NMNAP;
v. Keeping Boys and Girls in School – *School Water Sanitation and Hygiene Technical Working Group* under the Water Sector Development Plan and *Quality Education Working Group* under the Education Sector Development Plan (ESDP); and
vi. Developing Soft Skills – *Quality Education Working Group* under the ESDP.[103]

The membership structure and frequency of meetings of each of the groups include:

i.) Adolescent Reproductive Health Working Group (ARHWG)

The Adolescent Reproductive Health Working Group (ARHWG) includes the MoHCDGEC, PMO-LYED, PO-RALG, National AIDS Control Programme (NACP), TACAIDS, and implementing partners. The ARHWG sits under the mandate of the MoHCDGEC (Health) and reports directly to the Reproductive, Maternal, Newborn, Child and Adolescent Health Working Group (RMNCAH) under the Technical Committee of the Sector Wide Approach (TC-SWAp). The ARHWG meets quarterly and could be leveraged to discuss and coordinate interventions under Pillars 1 and 2.

ii.) Safe Schools and Life Skills Working Group

This WG was formed through the NPA-VAWC under the thematic area of Safe Schools and Life Skills under the leadership of the MoEST. The WG includes personnel from the MoHCDGEC, MoHA, PO-RALG, and CSOs. The WG meets quarterly, but funding challenges have limited the frequency of meetings. This WG could be used to discuss the NAIA-AHW as it relates to Intervention 3.2, which seeks to develop a safe school environment.

iii.) Response and Support Services Working Group

This was formed through the NPA-VAWC under the thematic area of Response and Support Services. It includes personnel from MoHCDGEC, MoHA, PO-RALG, FBOs, and CSOs. The group meets quarterly, but funding challenges have limited the frequency of meetings. This group could be leveraged to discuss intervention 3.2 that addresses the supply of response and supply services to survivors of violence.

iv.) Prevention and Control of Micronutrient Deficiencies Working Group

This WG incorporates the IDD, Vitamin A supplementation, Anaemia and Food Fortification Alliance, and it is formed under the NMNAP. The group reviews the progress of the implementation of the NMNAP operational plans. This group could be leveraged to discuss the NAIA-AHW as it relates to

[103] The Skills Development Working Group is being formalized. Once this WG is recognized in formal government dialogue, it could be more relevant in coordinating NAIA-AHW interventions

Intervention 4.1, which addresses micronutrient deficiencies by scaling WIFAS programmes. The group meets every quarter of the year.

v.) School Water Sanitation and Hygiene Technical Working Group

This WG brings together the coordinators of the National Sanitation Campaign under the MoHCDGEC; the SWASH coordinator under the MoEST; PO-RALG; MoW sector coordination; rural and urban water committee member(s); development partners; and CSOs. This WG is co-chaired by the Director of Policy and Planning under the MoEST and the Director of Environmental Health at the MoHCDGEC. This group is under the guidance of the MoW, as it was developed through the Water Sector Development Programme. This group could be leveraged to discuss the NAIA-AHW as it relates to Intervention 5.1 that seeks to improve WASH infrastructure in schools. The School Water Sanitation and Hygiene Technical Working Group meets every quarter of the year.

vi.) Quality Education Working Group

This WG is made up of personnel from MoEST, PO-RALG Education, development partners (UNICEF, UNESCO) and NGOs, private sector actors, and religious organizations that offer educational services. The group meets every quarter before the ESDP committee convenes to discuss the quality of education, including inclusive education, and learning opportunities for out-of-school adolescents. This group could be leveraged to discuss the NAIA-AHW as it relates to Interventions 5.2 and 6.1 that improve skills to adolescents and broaden opportunities for out-of-school adolescents. A Skills Development Working Group exists; however, the Group is not recognized in formal government channels, although there are efforts towards formalization. Once formalized, the Skills Development Working Group could also be leveraged to coordinate Pillars 5 and 6.

National Secretariat

The Secretariat will serve as a link between the national- and subnational-level coordinating units and lead the day-to-day operationalization of the NAIA-AHW. It will be co-chaired by the Director of Government Business from PMO (Policy and Coordination) and the Director of Policy and Planning at the MoHCDGEC (Community Development).

Members of the Secretariat will include representatives of the MoHCDGEC, PMO, PMO-LYED, MoEST, TACAIDS, TIE, TFNC and PO-RALG; three youth representatives who are part of the NTC; two officers from Monitoring and Evaluation (M&E) section from MoHCDGEC and MoEST; and implementing partner(s).

The roles of the Secretariat will be to:

i. Consolidate and prepare reports to be tabled before the NSC, NTC and the WGs;
ii. Coordinate and review monitoring and evaluation (M&E) studies and research;
iii. Provide progress reports received from the PO-RALG to the NSC and the NTC;
iv. Supports the preparation of work plans and budgets with the NTC; and
v. Prepare guidelines to facilitate operation and implementation at all levels.

3.3 SUBNATIONAL LEVEL COORDINATING UNITS

President's Office – Regional Administration and Local Government (PO-RALG)

The PO-RALG will implement and coordinate the NAIA-AHW at the subnational levels. The responsible Director of the PO-RALG will chair the meetings of the NAIA-AHW in the PO-RALG and will appoint technical representatives who will also sit in the National Secretariat.

The roles of the PO-RALG will be to:

i. Strengthen the reporting and communication mechanism at the subnational level;
ii. Consolidate progress reports through the council directors and submit these to the National Secretariat;

iii. Ensure the integration of interventions, and of implementing partners' plans and budgets, into LGAs;
iv. Liaise with development partners and other stakeholders on resource mobilization and utilization; and
v. Conduct joint M&E visits at LGA level.

Regional Secretariat Level

At Regional Secretariat level, the Regional Administrative Secretariat (RAS) will lead the implementation and coordination of the NAIA-AHW.

This role will be supported by the Regional Community Development Officer, Regional Local Government Officer, Regional Education Officer, Regional Medical Officer, Regional Nursing Officer, Regional Planning Officer, Regional Labour Officer, Regional Social Welfare Officer, Regional Nutrition Officer, Regional Water Engineer, and Regional AIDS Coordinator.

The regional-level coordinating unit will bring together the Regional/City Council Multisectoral AIDS Committee (R/CCMAC) and members of the Child Protection Team at the regional level. This group will meet quarterly.

The roles of coordinators at the regional level will be to:

i. Raise the profile of the NAIA-AHW within the regional leadership and other key stakeholders;
ii. Ensure interventions are integrated into regional development plans and budgeted for;
iii. Consolidate regional progress reports through the Council Directors and submit these reports to the PO-RALG for further consolidation; and
iv. Adopt the revised implementation plan from the PO-RALG and support beneficiaries and implementing partners in adjusting accordingly.

Council level

At Council level, the District Executive Director (DED) will steer the implementation and coordination of NAIA-AHW activities at the district level.

This role will be supported by the Council HIV and AIDS coordinator, District AIDS Control Coordinator, District Community Development Officer, District Medical Officer, District Human Resource Officer, District Education Officers, Cultural Officer, Social Welfare Officer, PGCD, District Planning Officer, People living with HIV/AIDS (PLHIV), religious institutions, youth groups, HIV-related CSOs, People with Disabilities, Council Elders' Committee, District Labour Officer, District Water Engineer, Nutrition Officer, and Council Legal Officer.

The district-level coordinating unit will bring together the Council Multisectoral AIDS Committee (CMAC) and members of the Child Protection Team at the council level. This group will meet quarterly.

The roles of the coordinators at the district level will be to:

i. Raise the profile of the NAIA-AHW within the council leadership and among the other key stakeholders;
ii. Ensure interventions are integrated into council development plans and budgeted for;
iii. Submit monthly progress reports to the RAS; and
iv. Adopt the revised implementation plan from the PO-RALG and support beneficiaries and implementing partners in adjusting accordingly.

Ward level

The Ward Executive Officer (WEO) will support planning at the ward level and provide technical advice and implementation oversight. The WEO will steer the implementation and coordination of activities at the ward level with the support of the CDO; identified teachers from primary and secondary schools; health centre or dispensary in-charge; Ward Education Officer; Social Welfare Officers and extension officers; PLHIV; religious institutions; youth groups; champions in the response to HIV and AIDS; a Community Health Provider; HIV-related CSOs; informal private sector representatives; the Ward Elders' Committee; Clinical Officers; and identified influential people. The ward-level coordinating unit will bring together the Ward Multisectoral AIDS Committee (WMAC) and members of the Child Protection Team at the ward-level. This group will meet quarterly.

The roles of the coordinators at the ward level will be to:

i. Raise the profile of the NAIA-AHW within the ward and village leadership and with the other key stakeholders;
ii. Submit monthly progress reports to the CMAC, which can be compiled in consultation with programme officers and implementing partners; and
iii. Track programme progress by reviewing reports and liaising with the programmatic officer, government personnel, development partners, beneficiaries, and village officers

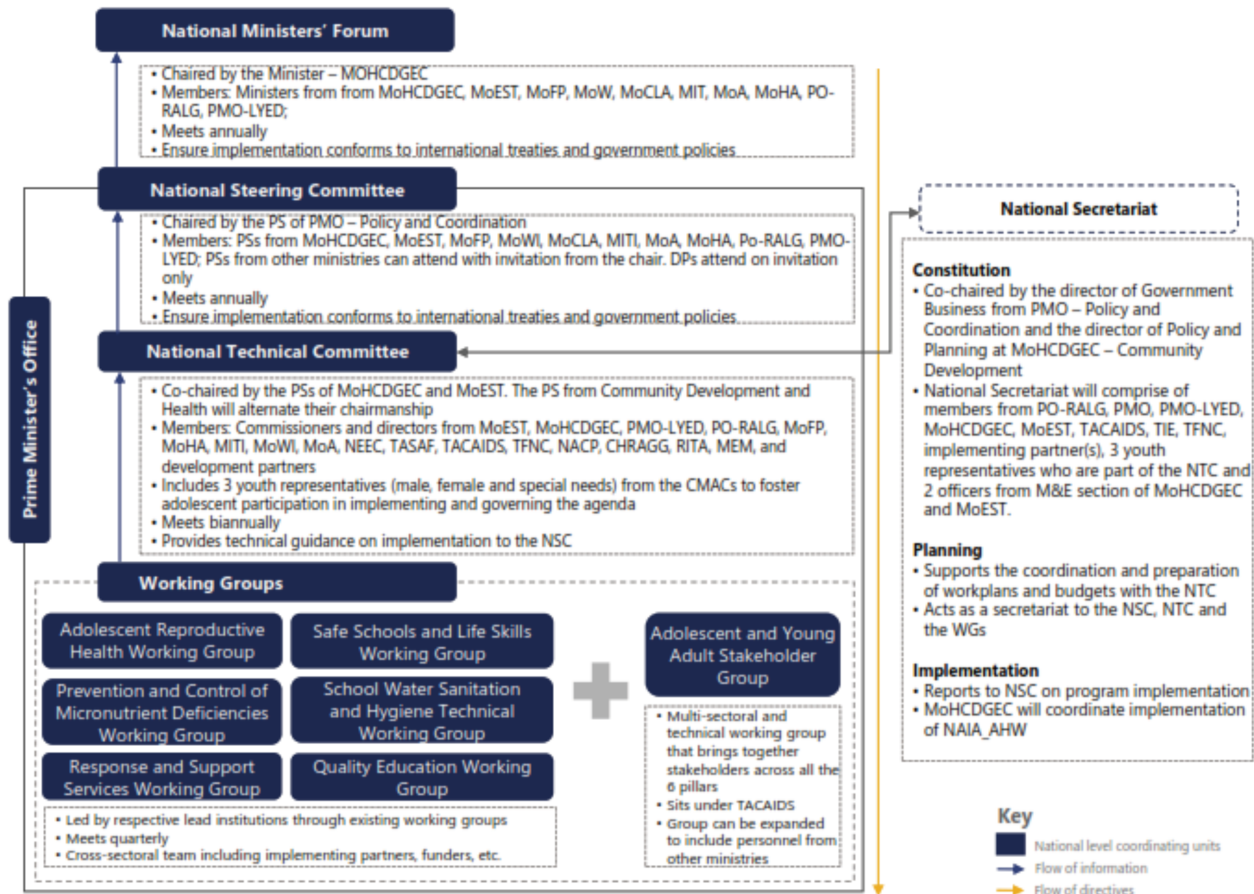
Village level

The Village Executive Officer (VEO) will support planning at the village level and provide technical advice and implementation oversight. The VEO will drive the implementation and coordination of the NAIA-AHW at the village level. The VEO will be supported by extension officers; the health centre or dispensary in-charge; two teachers from primary and secondary school; PLHIV; religious institutions; youth groups; champions in the response to HIV/AIDS; a Community Health Provider; HIV-related CSOs; informal private sector representatives; Women and Children Committees; the Village Education Coordinator; Clinical Officer(s); the CDO; a Community Case Worker; and a Social Welfare Assistant. The village-level coordinating unit will bring together the Village Multisectoral AIDS Committee and members of the child protection team at the village-level. This group will meet quarterly.

The roles of the coordinators at the village level will be to:

i. Identify high-risk areas in the village and develop strategies or plans;
ii. Submit monthly reports on progress of the NAIA-AHW to the WEO, which can be compiled in consultation with the programmatic officers and implementing development partners; and
iii. Track programme progress by reviewing reports and liaising with the programmatic officer, government personnel, implementing partners, and beneficiaries.

FIGURE 8: COORDINATION STRUCTURE



IMPLEMENTATION STRUCTURE

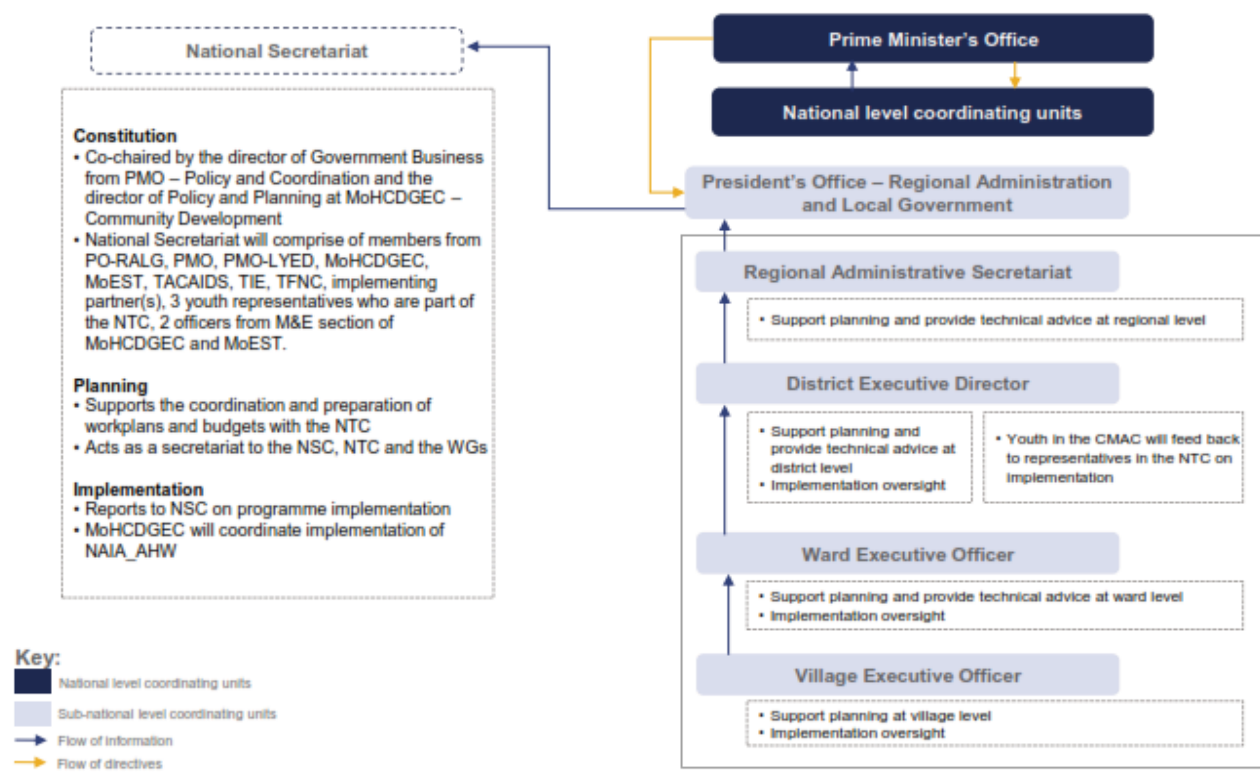
The PO-RALG is responsible for the day-to-day implementation of all identified NAIA-AHW activities at the regional, council, ward, and village/street levels. Utilizing the structures existing at the various levels of the government will avoid duplicating efforts or resources and capitalize on existing resources; facilitate integration with government functions; and enhance the delivery of services to adolescents. Technical advice and planning and implementation oversight will be provided by the RAS at the region, the DED at the district council, the WEO at the ward, and by the VEO at the village and street.

The National Secretariat will serve as a link between the national and subnational level. The National Secretariat will implement the daily coordination activities of the NAIA-AHW and conduct operationalization activities. The Secretariat will be co-chaired by the Director of Government Business of the PMO (Policy and Coordination) and the Director of Policy and Planning of the MoHCDGEC (Community Development).

The members of the Secretariat will be from the MoHCDGEC, MoEST, PMO, PMO-LYED, PO-RALG, TIE, TACAIDS, TFNC, three youth representatives who are part of the NTC and two officers from M&E section of MoHCDGEC and MoEST.

Coordination will occur through meetings and virtual sharing of data/information among the stakeholders. Progress updates on the implementation of prioritized activities will flow to the national level from the village/street, ward, district, and regional level to the national level through the VEO, WEO, DED, RAS, and PO-RALG Coordination for each respective level. The flow of this information could be virtual or through meetings such as the Full Council and the District Council Committee meetings.

FIGURE 9: IMPLEMENTATION STRUCTURE



The National Secretariat will collate information from the PO-RALG and share it with the NTC for technical advice. In addition, the NTC will receive information from the WGs, which will collect progress updates on adolescent activities through established channels. Insights from the WG meetings and technical advice developed by the NTC will then be shared by the NSC. The NAIA-AHW activities will be reviewed at the annual NSC meetings to ensure that they are aligned with international treaties and government policies, and then used to set national targets. The NSC will have the mandate—in consultation with the NTC—to advise stakeholders, particularly the PO-RALG, on improving implementation.

ACTIVITIES

The key activities of the coordination structure include developing operationalization guidelines; supporting the meetings of the NSC, NTC, and some of the WGs; advocating for the funding of the Agenda; and conducting operational research on emerging issues. The national-level budget will be used towards compensation benefits, purchase of technical equipment, and building capacity for sitting members of the national-level coordinating structures such as officers in the National Secretariat. District-level costs include activities such as conducting supportive supervision in councils and capacity-building of council officials to implement programme activities. A detailed set of activities, with the relevant costing, is provided in Annex 8.

MONITORING AND EVALUATION

DATA AND DATA SYSTEMS

Health and education information systems are a critical component of, and important factor in, improving health and wellbeing outcomes. The flow of information to adolescents and concerned parties can positively influence health-seeking behaviours and attitudes and, thereby, improve the uptake of adolescent services. In planning existing programmes and determining their outcomes, it is crucial to collect, synthesize, and share basic demographic, health, and programmatic data. Data and information can be leveraged through research to inform future approaches and guide the development of programmes and interventions.

Tanzania has multiple data systems that gather data and provide information on the state of adolescents; however, most of these systems focus on health. The HMIS of the MoHCDGEC is the main system that collects information on adolescent health. The HMIS is managed through the District Health Information System 2 (DHIS2), a web-based software application that allows for data entry, control, and feedback in real time. The players in the adolescent health sector run their own information management systems. For instance, the NACP runs the CTC II data system, which tracks data on HIV/AIDS treatment and care; implementing agencies such as UNICEF and PEPFAR run their own data tracking systems to monitor programme performance; and local governments collect data as part of their internal evaluation activities. Other data systems, such as the EMIS and road accident information system, provide information on adolescents beyond the health spectrum. These systems do not target adolescents, however, and lack comprehensive adolescent-specific data.

The existing systems do not define indicators to guide the collection of data on adolescents. That limits rigorous data collection. Data systems such as the HMIS and CTC II collect health data for all populations based on the HSSP IV guidelines, and cover only basic adolescent indicators as part of broader indicator sets. For instance, the HMIS indicators cover adolescents only in specific intervention and programmatic areas such as family planning, gender-based violence (GBV) and VAC, tracer medicine, and antenatal care (ANC). Infectious diseases, nutrition, and malaria are the key issues that affect adolescents, but the indicators that measure these do not account for adolescents. These systems do not collect adolescent data on areas other than health such as deaths and injuries due to accidents and violence, school attendance, and GBV.

The existing data on adolescent health and wellbeing is not adequately disaggregated by age; often, it categorizes adolescents as one large demographic group. For instance, outpatient-inpatient (OP/IP) data collected through the routine HMIS contains only three categories: '5 and below', '5 – 60 years old', and 'above 60 years'. Where datasets cover adolescents (e.g. within the HMIS), the data is categorized into 'under 20-year-old' and '10 – 24 years', but not disaggregated further by age or other demographic parameters. These gaps in the evaluation systems limit the understanding of specific variances within demographics of the adolescent bracket based on age, gender, socio-economic status, or geography.

Finally, health workers have demanding workloads, and they lack the capacity and motivation to invest in data collection. That compromises the accuracy, completeness, and timeliness of the data. The officials at health facilities and the district level lack the capacity to analyse or utilize data to guide daily operations and management at the facility or inform strategic decision-making at the district level. The importance of analysing or utilizing data is not appreciated at local levels; the perception is that data is relevant only at the national level. Performance metrics and dashboards at the district (LGA) level, along with training, would enable workers to track performance and ensure accountability.

There are many, divergent approaches to collecting and synthesizing data on health and wellbeing, but it is not adequately disaggregated by age. To address these issues, these strategic priorities are recommended.

Strategic recommendations and activities:

Recommendation 1: **Streamline the data collection, analysis, and dissemination process** to ensure the collection and synthesis of timely data and seamless dissemination to relevant stakeholders. Collection of accurate, complete, and timely data will help identify problems and needs and enable evidence-based decision-making. Suggested activities include:

i. **Advocate to key ministries to request data-driven reports** to drive collection and analysis of proper data from the village, ward, district, and regional level up to the national level;
ii. **Set performance metrics/commitments aligned with NAIA-AHW targets for government staff** to support performance management and maintain accountability;
iii. **Train service providers to improve their capacity to collect, synthesize, and use adolescent data** to improve service delivery to adolescents at the facility and community level; and
iv. **Develop and roll out Management Information Systems at Council level** that will enable workers to track performance and ensure accountability on adolescent health and wellbeing in districts and facilities.

Recommendation 2: **Harmonize indicators used to collect adolescent data** under various data systems and ensure that health and wellbeing data under the relevant management information systems are disaggregated along key areas such as age, gender, geography, health facility, education level, etc. Suggested activities include:

i. **Review existing indicators in data systems such as HMIS and EMIS** and develop recommendations on additional indicators that will enable the collection of adolescent data. The current system lacks integral data indicators that are crucial in understanding adolescent health; and
ii. **Advocate for disaggregating data in the HMIS, EMIS, and other relevant data systems** by age, gender, education level, and geography on programmes and interventions that involve adolescents. This will ensure that the adolescent-related data collected countrywide on a regular basis is uniform.

While the above data and data systems-related priorities are recommended, only certain activities that are directly within the scope of NAIA-AHW's M&E programme are included in the costing model. The M&E activities, and funding costs, are detailed in Annex 9.

MONITORING AND EVALUATION (M&E)

The progress and results of adolescent programmes are insufficiently tracked, and the approach used to assess outcomes is siloed. The information available on programme performance is limited, therefore. Adolescent programmes are not always comprehensive during implementation and have fragmented activities that could be better coordinated to feed into shared metrics. National data systems focus on broad health metrics, but the internal M&E systems of funders and implementing partners use their own methodology. Such programmatic evaluations focus on programme outputs and cause gaps in correlating outputs to long-term health and wellbeing outcomes. The understanding of the long-term outcomes and collective impact of adolescent health programmes in Tanzania is limited, therefore. The information on programme funding is poorly tracked, and the data on the investment into the different areas in adolescent health and wellbeing is limited.

There are multiple M&E tools among various partners, but these data collection and evaluation systems are fragmented. Information sharing across the different platforms is limited, primarily due to poor coordination and the absence of a streamlined mechanism for sharing data and progress. Implementing agencies, for instance, rely on their internal data systems to guide decision-making, although elaborate data systems are collected through the HMIS. Partners and players in adolescent health can access the data at the HMIS web portal and monitor health outcomes, but the data is often limited to specific indicators. Access to more detailed information is requested ad hoc, and it requires direct outreach to specific teams across the sector. This process can often be bureaucratic and tedious, as there is no clear data dissemination process or mandate for sharing data from the ministry. Fast-tracking this process would yield benefits by informing programmes and interventions.

An M&E framework is proposed to ensure that the NAIA-AHW tracks not only programmatic outputs but also long-term health and wellbeing outcomes and impact and that data collection and evaluation systems are streamlined across government and implementing partners.

NAIA-AHW MONITORING AND EVALUATION (M&E) OVERVIEW

Monitoring and Evaluation (M&E) will ensure that the planning, implementation, and reporting of the NAIA-AHW is efficient and effective. Data and M&E of the strategic intervention areas and their activities will identify whether changes need to be made during implementation and, potentially, beyond. Monitoring provides room for dialogue and decision-making based on data collected from interventions/activities.

The specific objectives of monitoring are to:

i. Ensure that the data on NAIA-AHW activities is timely, reliable, and adequate;
ii. Ensure data collection facilities;
iii. Carry out research, studies, and reviews to provide more data and information;

iv. Enhance storage, retrieval, access, and use of data by government and stakeholders; and
v. Promote evidence-based planning, implementation, and reporting.

To realize these objectives and collect reliable, consistent, and age-aggregated data, the existing monitoring systems need to be adjusted and aligned with the strategic plans and monitoring systems of MDAs and LGAs and harmonized with sectoral M&E frameworks. The coordination team and technical ministry will ensure that monitoring is efficient and effective by:

i. Developing monitoring plan;
ii. Building the capacity of key stakeholders in implementation and data collection, processing, analysis, and reporting;
iii. Facilitating joint M&E of activity implementation; and
iv. Consolidating M&E reports to be tabled and discussed at the national level and annual consultative meetings.

THE RESULTS FRAMEWORK MATRIX

The NAIA-AHW Results Framework Matrix contains information on result areas at the level of impact (pillar) and outcome (intervention).[104] M&E experts can use this matrix to develop on a pillar, intervention, and activity level when they develop the M&E Plan at the beginning of implementation**.** Information will be detailed for each specific pillar, intervention, and activity. The information will include the indicators, baseline information, targets, data source, frequency of data collection and reporting, and the agency or agencies responsible for collecting data. Officers from M&E sections of sector Ministries in collaboration with some implementing partners will collect information based on quantitative and qualitative indicators depending on the subject and on the availability of data. Baseline surveys will be conducted for indicators that do not have any baseline data. An illustrative NAIA-AHW Results Framework is shown below, and a detailed NAIA-AHW Results Framework is shown in Annex 9.

Pillar 1	Indicator Type	Indicator	Indicator Definition	Baseline	Target	Data Source	Frequency	Responsibility	Reporting
Pillar 1 Preventing HIV – Lower HIV incidence rates for adolescents aged 10-24 years	Impact	HIV incidence rate among adolescents aged 15-24 years	Number of adolescents aged 15-24 who are newly infected with HIV/number of adolescents aged 15-24 years	TBD at the start of implementation phase	Reduce new infections by 50% by 2022 (HSHSP IV 2017-2022)	TBD at the start of implementation phase	Annually over 4 years	NBS	MoHCDGEC /TACAIDS
Intervention 1.1 [Aged 15-24] Biomedical: Increase access to community-based HIV testing, and relevant linkages to prevention and care for 1) adolescent boys and girls 2) male partners of AGYW	Outcome	Percentage of 1) adolescent boys and girls aged 15-24 years 2) male partners of AGYW tested in a community setting and linked to services	Number of 1) and 2) tested in a community setting/number of 1) and 2); Number of 1) and 2) linked to services/number of 1) and 2)	TBD at the start of implementation phase	Testing for girls and boys aged 15-24 years: 60% by 2020; to be updated at the start of implementation for 2022 targets (One Plan II) Linked to services: If tested negative: TBD at the start of implementation; If tested positive – 100% of those tested positive are linked to services by 2022 (HSHSP IV 2017-2022)	TBD at the start of implementation phase	TBD at the start of implementation phase	TBD at the start of implementation phase	MoHCDGEC

Illustrative

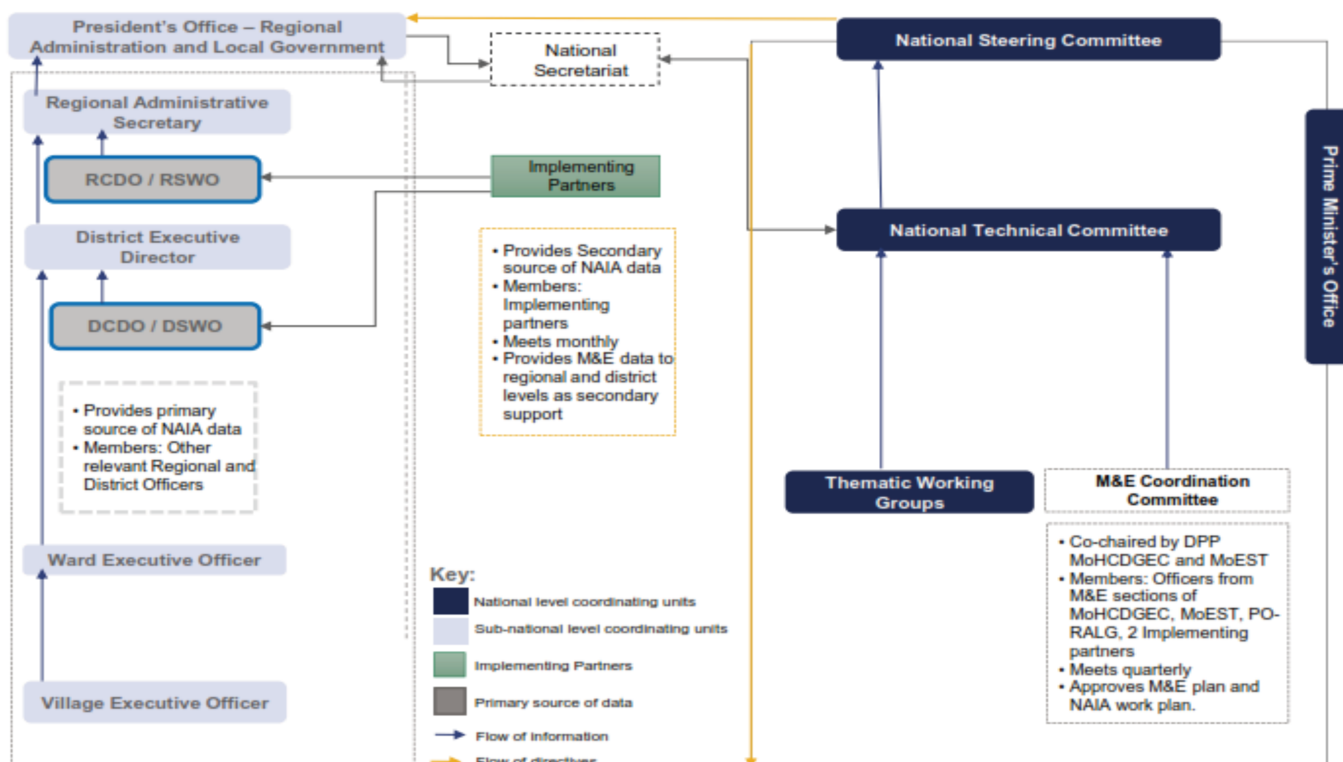
DATA FLOW

Data and information will flow from the village, ward, council, and regional level up to the national level. To create data reports for the NAIA-AHW, primary data will be collected and analysed at the district and regional levels using existing government data systems such as the HMIS and EMIS. If secondary data is required, the M&E Officers of implementing partners will appoint M&E Officers at the district and regional level. At the national level, the M&E Coordination Committee oversees and approves the annual NAIA-AHW

[104] Activity output is not included here as activities are not yet defined as part of a programme.

work plan and budget; it also tracks progress by monitoring data reports. The Committee is co-chaired by DPP of the MoHCDGEC and MoEST, and it is supported by the Officers from M&E sections of other existing multisectoral government partners and of implementing partners.

FIGURE 10: M&E DATA FLOW



ACTIVITIES

The key activities of the M&E Section are to develop the M&E Plan and align data systems and collection tools to capture reliable, consistent, age-disaggregated data on adolescent health and wellbeing. The Section's national-level activities are to develop the M&E Plan (and develop a Results Framework Matrix, conduct baseline, midline, and endline studies, etc.); review data collection and analysis systems to identify data sources and gaps; facilitate the integration of key indicators into periodic studies and surveys; support the documentation and dissemination of reports and best practices material; and coordinate the meetings of the National M&E Coordination Committee. The Section's district-level activities are to monitor visits to LGAs and roll out data systems and tools. The detailed M&E activities, along with the relevant costing, is shown in the M&E Annex (Annex 9).

PART IV
COSTING THE NAIA-AHW

4.1 COSTING

The NAIA-AHW has been costed to provide individual costs for each proposed intervention and the total cost across the six pillars over four years. A dynamic costing model was developed to calculate each of the costs. The model uses a bottom-up approach, starting at the activity level and leveraging inputs from government and development partners. The model also determines when the costs of implementation will be incurred over the four-year period based on assumptions of when the proposed activities will be implemented. The costs presented below are indicative of a 'worst case scenario' considering the total cost of implementing each intervention. This will largely be driven by the choice in districts and regions of implementation overlaid with the selected interventions. Users will be able to vary zones, regions, and districts of implementation to determine total implementation costs. The full costing model includes all the assumptions for each activity and sub-activity.

Each cost is presented at the national or District Council level, depending on how it is likely to be implemented and to allow for adaptability in the targeted number of District Councils. Activities that require the same quantity of resources regardless of programme reach are national-level costs, such as reviewing the National Training Curriculum, advocating for public–private partnerships, and developing the NAIA-AHW coordinating units. Activities that depend on the number of District Councils targeted, such as developing comprehensive WASH packages for schools or conducting training workshops for teachers across schools, are costed at the level of the District Council. Implementing the core national elements over the next four years will cost an estimated TZS 257 billion, while the cost of implementing in one District Council over four years is TZS 12.1 billion.

The regions selected for this initial costing exercise are Mwanza, Simiyu, Geita, Tabora, Mara, Shinyanga, Kigoma, Tanga, Katavi, Mbeya, Rukwa, Lindi, and Songwe. These regions were selected because, relatively, they face some of the greatest burden across the majority of the pillars. Assuming that the NAIA-AHW will be implemented in all the District Councils of these regions (89 District Councils), it is estimated to cost TZS 1.338 trillion over four years (Figure 12). The greatest costs are expected in Pillar 1, as it has the greatest number of interventions.

Implementing all the interventions will cost TZS 12.1 billion per district over four years; excluding the VMMC intervention will reduce the cost to TZS 9.38 billion per district over four years. Implementing VMMC will raise the cost significantly. Finally, implementing the NAIA-AHW in all 185 District Councils of Tanzania Mainland is estimated to cost TZS 2.25 trillion over four years.

FIGURE 11: ESTIMATED TOTAL COST FOR IMPLEMENTATION

Pillar	Interventions	2021/22	2022/23	2023/24	2024/25
Preventing HIV	Total	TZS 82,572,751,511.79	TZS 88,798,710,247.24	TZS 90,350,327,761.41	TZS 57,159,462,172.69
	National Level	TZS 454,059,897.90	TZS 303,187,500.00	TZS 549,871,875.00	TZS 161,261,211.76
	LGA Level	TZS 82,118,691,613.89	TZS 88,495,522,747.24	TZS 89,800,455,886.41	TZS 56,998,200,960.93
Preventing Teenage Pregnancy	Total	TZS 22,497,419,462.85	TZS 49,091,992,867.87	TZS 74,712,014,077.95	TZS 48,715,508,586.74
	National Level	TZS 444,467,622.90	TZS 807,189,862.50	TZS 530,823,155.63	TZS 314,263,063.41
	LGA Level	TZS 22,052,951,839.95	TZS 48,284,803,005.37	TZS 74,181,190,922.33	TZS 48,401,245,523.34
Preventing Physical, Sexual and Psychological Violence	Total	TZS 235,857,037,348.18	TZS 46,734,080,331.89	TZS 46,474,661,108.80	TZS 46,244,115,764.37
	National Level	TZS 234,872,079,091.40	TZS 1,212,167,250.00	TZS 1,502,142,799.50	TZS 933,080,478.75
	LGA Level	TZS 984,958,256.78	TZS 45,521,913,081.89	TZS 44,972,518,309.30	TZS 45,311,035,285.62
Improving Nutrition	Total	TZS 7,211,496,352.99	TZS 5,936,048,842.21	TZS 6,157,586,261.28	TZS 6,392,312,466.03
	National Level	TZS 10,500,000.00	TZS 2,228,072,175.00	TZS 2,194,541,133.75	TZS 2,304,268,190.44
	LGA Level	TZS 7,200,996,352.99	TZS 3,707,976,667.21	TZS 3,963,045,127.53	TZS 4,088,044,275.59
Keeping Boys and Girls in School	Total	TZS 37,584,736,742.90	TZS 40,427,193,223.47	TZS 43,063,205,348.27	TZS 44,247,011,703.91
	National Level	TZS -	TZS 1,447,031.25	TZS 911,629.69	TZS 638,140.78
	LGA Level	TZS 37,584,736,742.90	TZS 40,425,746,192.22	TZS 43,062,293,718.58	TZS 44,246,373,563.13
Developing Meaningful Employment Opportunities	Total	TZS 12,663,614,544.24	TZS 43,781,677,598.71	TZS 53,866,233,244.16	TZS 56,921,686,640.72
	National Level	TZS 11,844,000.00	TZS 55,125,000.00	TZS -	TZS 60,775,312.50
	LGA Level	TZS 12,651,770,544.24	TZS 43,726,552,598.71	TZS 53,866,233,244.16	TZS 56,860,911,328.22
Cross Cutting	Total	TZS 21,842,891,075.68	TZS 21,708,132,804.96	TZS 20,920,692,546.30	TZS 11,408,295,207.91
	National Level	TZS 1,084,185,900.00	TZS 1,009,987,017.80	TZS 66,250,876.43	TZS 69,563,420.26
	LGA Level	TZS 20,758,705,175.68	TZS 20,698,145,787.16	TZS 20,854,441,669.86	TZS 11,338,731,787.65
Monitoring & Evaluation	Total	TZS 2,833,839,374.02	TZS 1,495,905,372.97	TZS 572,102,655.20	TZS 607,490,312.84
	National Level	TZS 577,870,501.05	TZS 58,278,150.00	TZS 61,192,057.50	TZS 71,034,185.25
	LGA Level	TZS 2,255,968,872.97	TZS 1,437,627,222.97	TZS 510,910,597.70	TZS 536,456,127.59
Sector Coordination	Total	TZS 2,573,700,064.86	TZS 2,156,427,068.11	TZS 2,264,248,421.51	TZS 2,377,460,842.59
	National Level	TZS 1,633,537,500.00	TZS 1,169,256,375.00	TZS 1,227,719,193.75	TZS 1,289,105,153.44
	LGA Level	TZS 940,162,564.86	TZS 987,170,693.11	TZS 1,036,529,227.76	TZS 1,088,355,689.15
Total National Level Costs		TZS 239,088,544,513.25	TZS 6,844,710,361.55	TZS 6,133,452,721.25	TZS 5,203,989,156.58
Total LGA Level Costs		TZS 186,548,941,964.27	TZS 293,285,457,995.88	TZS 332,247,618,703.62	TZS 268,869,354,541.23
TOTAL ANNUAL COSTS		TZS 425,637,486,477.52	TZS 300,130,168,357.43	TZS 338,381,071,424.87	TZS 274,073,343,697.80
Intervention 1.3 (VMMC)	National Level	TZS 78,750,000.00	TZS 82,687,500.00	TZS 86,821,875.00	TZS 91,162,968.75
	LGA Level	TZS 65,981,016,042.16	TZS 69,280,066,844.27	TZS 73,402,061,107.77	TZS 37,845,191,614.23
TOTAL ANNUAL COSTS (without VMMC Included)		TZS 359,577,720,435.36	TZS 230,767,414,013.16	TZS 264,892,188,442.10	TZS 236,136,989,114.82

Coordination and M&E account for an estimated 2.3% of the total national-level cost, and an estimated 0.8% of the total district-level cost. Implementing coordination activities will cost TZS 5.3 billion at the national level and TZS 45.5 million per District Council. This accounts for 2% of the total national level cost and 0.37% of the total district-level cost. Implementing M&E activities at the national level is estimated to cost TZS 768 million and per District Council TZS 53 million.[105] This accounts for 0.3% of the total national level cost and 0.44% of the total district-level cost.

The costing model is useful provides a high-level picture that is indicative for fundraising purposes. It is designed to be flexible and can be adjusted to match different implementation priorities. Therefore, once the programme priorities are identified, and the programme is fully developed, an additional budgeting exercise will need to be conducted during the design of the programme to supplement this model and guide implementation. Since the model is dynamic, these assumptions can be changed during the budgeting exercise to arrive at precise costs.

[105] This includes the cost of coordinating annual joint multisectoral monitoring visits and reviews to LGAs. These will be based on random sampling and conducted in a few district councils

PART V
ANNEXES

ANNEX 1: KEY CONSIDERATIONS

There are key considerations and learnings that can guide decision-making prior to launch and implementation. These considerations include:

- **Region(s) and District Councils of implementation**: Given that the NAIA-AHW is comprehensive and does not target pillars in silos, the choice of regions should be driven by the combined burden across pillars and the existing programmes in that region. This ensures that the regions and District Councils most vulnerable to adolescent health and wellbeing are selected. The programming existing in those regions should be considered to ensure that efforts are complementary and not duplicative of what already exists. Pillar-specific nuances should be considered, especially in cases where the intervention applies to a specific population type.

- **Adapting to adolescent population segments:** Regardless of the area of choice, the implementation of the NAIA-AHW should be equitable and adapted to meet the specific needs and capabilities of all adolescent demographics. Some of the marginalized adolescent populations that should be considered in programme design include ALHIV/AIDS, pregnant and parenting adolescents, survivors of violence, adolescents from poor households, and those with special needs (physically disabled, visually or hearing impaired, suffering cognitive or psychiatric disability, etc.). In considering these populations, it is important to think about adaptations at all levels, including programme design and roll-out.

- **Involving youth in programme design and governance:** Continuing to involve adolescents in a meaningful way is critical to the success of the NAIA-AHW. This document suggests ways to foster adolescent participation during coordination. Adolescents can participate in decision-making from the district level as members of the CMACs and continue to govern the NAIA-AHW at the national level through youth representatives appointed to the NTC and the National Secretariat. The role of marginalized adolescents in these governing bodies should be considered. Adolescents can be involved in areas such as the design and roll-out of activities. Adolescents can identify effective means to engage them. As one said, *The government should organize regional seminars, road shows, and fun events across the country. They should speak our language, have competitions, and make it fun with sports, music, and dancing so that young people become more engaged and enjoy.*[106] Involving youth in programme design will ensure that activities are geared to address their needs in an effective manner.

To maximize the impact of the NAIA-AHW, interventions should be rolled out as a comprehensive package of services. Comprehensive programme design will ensure a holistic view of adolescent health and wellbeing by integrating services across the agenda and considering other supporting activities that help achieve the overarching vision. The programme design should not include every intervention across all pillars in each of the selected regions and District Councils; instead, a comprehensive programme package should prioritize interventions and activities based on the area of implementation to optimize existing resources and ensure it can meet the specific needs of the adolescent populations in that region. This ensures that while maintaining its overarching vision, the NAIA-AHW is adapted to both the region and the population that it serves.

[106] Quote from the 2018 National Adolescent Conference in Dodoma

ANNEX 2: REGIONAL PROGRAMMING ANALYSIS

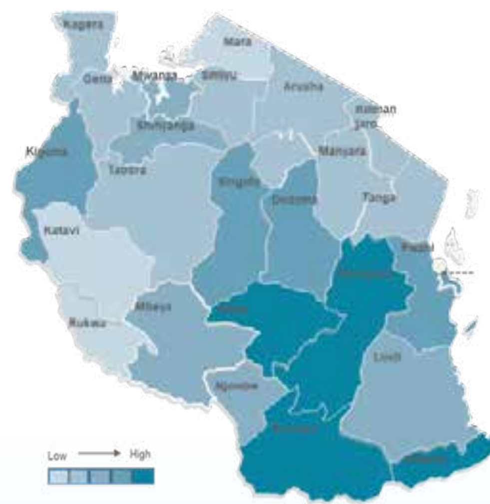
We mapped the programmes by region to identify the spread of (1) issues and (2) programmes for adolescents across the country to pinpoint regions that may require additional focus. One map was created for each of the two pillars, and the combined map is an overlay of all the indicators. The issue areas in the maps are in yellow, and the programme mapping is in blue. The darker the colour in a map, the greater the burden in the region, or the larger the number of adolescents reached in that region relative to other regions in the country. The burden of each issue in the first map was characterized using proxy target indicators. These indicators were selected by their ability to represent the pillar's performance. The combined map was a relative comparison across all the pillars. The programme mapping was based on the percentage of adolescents reached by programmes in that region. Regions with less than 1% of their adolescents being targeted by current programmes are characterized as being on the low end of the spectrum, while regions with at least 20% of their adolescents being targeted are characterized as being on the high end of the spectrum.

This mapping exercise provides a high-level, indicative view of issue areas and programmes. However, a more detailed mapping exercise is needed during the programme design phase to fill current gaps. The current maps provide a high-level regional overview of 'problem areas' across the country, indicate where programmes are concentrated on a regional level, and provide an indication of where the programmatic gaps. However, there are limits to the maps, due to limitations in data: the maps do not provide a detailed overview of programmes and issue areas at the district level, describe the overview of resource allocation for adolescents, or provide a complete overview of actors including programmes that are not time-bound.

Combined Pillar Mapping

Figure 12: combined issue map for all pillars

Figure 13: combined programmes map for all pillars

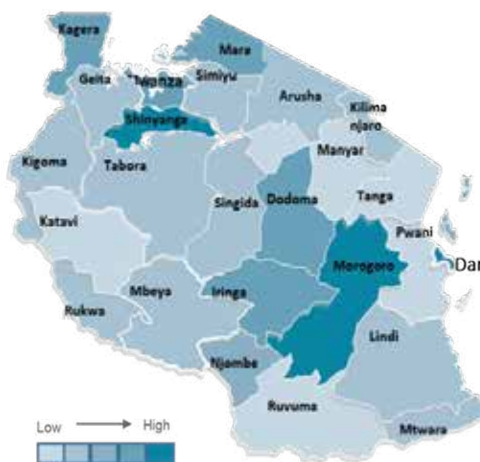


Across all pillars, regions in the Lake Zone face the highest disease burden, but programmes for adolescents are concentrated in the southern zone. A relative comparison of burden across all six pillars shows that regions clustered in the Lake Zone face the greatest burden. In particular, Shinyanga performed poorly on most pillars. There are a few cases where the trend is inconsistent, such as the case of Njombe. Njombe appears to be performing well on most indicators, but on Pillar 1 (preventing HIV), it has the highest rate of HIV prevalence in the country. Programmes targeting adolescents are concentrated in the southern zones, with regions like Iringa, Morogoro, Ruvuma, and Mtwara reaching the greatest number of adolescents. Katavi has the least number of adolescents targeted by programmes, and regions like Manyara and Rukwa reach a limited number of adolescents.

PILLAR 1 – PREVENTING HIV

FIGURE 14: HIV PREVALENCE AMONG ADULTS AGED 15 AND ABOVE

FIGURE 15: HIV PROGRAMMING FOR ADOLESCENT ACROSS REGIONS



Njombe faces the highest rate of HIV prevalence for adults age 15 and above, followed by Iringa and Mbeya, but most of the programming is concentrated in Morogoro. Regions such as Njombe, Iringa, and Mbeya face the highest burden of HIV. These are economic regions, frequented by traders who are more likely to engage in unprotected sex. Regions with low HIV prevalence include Arusha, Lindi, Mtwara, and Kilimanjaro. This may be attributed to ongoing efforts to fight HIV. Kilimanjaro and Arusha have been working on public sensitization to drive improvements in testing, condom use, and ART. Prevalence rates in these regions have declined significantly from 2002. When looking at programming, HIV has received the most attention. More than 60% of programmes across the nation have HIV as part of their core focus, but also include elements that address other areas such as teenage pregnancies and violence. Most of these programmes are concentrated in Morogoro, followed by Shinyanga, Mwanza, Kagera, and Mara. Dar es Salaam also has several actors focusing on HIV/AIDS, while regions like Njombe and Iringa with some of the highest HIV/AIDS prevalence rates have relatively little to medium programme concentration.

PILLAR 2 – PREVENTING TEENAGE PREGNANCIES

FIGURE 16: PERCENTAGE OF WOMEN AGE 15 – 19 WHO HAVE BEGUN CHILDBEARING

FIGURE 17: SEXUAL AND REPRODUCTIVE HEALTH (SRH) PROGRAMMING ACROSS REGIONS

Teenage pregnancies are highest in Katavi, Tabora, Dodoma, and Morogoro while SRH programming is more pronounced in Geita and Iringa. Regions with high rates of teenage pregnancies are more likely to have high rates of early marriage due to sociocultural norms. Select regions like Arusha, Kilimanjaro, and Njombe have low rates of teenage pregnancy, which may be attributed to the high coverage of SRH education. Over 50% of all the schools in these regions provide comprehensive SRH education, while regions like Katavi have less than 30% of schools providing comprehensive SRH education. Since SRH programming is often tied to other issues like HIV and keeping boys and girls in school, region selection is likely a combination of factors across pillars. Regions like Dar es Salaam, Morogoro, and Geita reach the largest number of adolescents through SRH programming. Although Mara, Dodoma, and Katavi have high rates of teenage pregnancy, programmes in these regions do not reach a substantial percentage of adolescents.

Pillar 3 – Preventing Physical, Sexual and Emotional Violence

Figure 18: Percentage of women[107] who have experienced physical/sexual violence in the past 12 months

Figure 19: Violence prevention and response programming for adolescents across regions

The rates of GBV and VAC are particularly pronounced in Mara, Shinyanga, and Tabora, but programmes are mostly concentrated in Kigoma. In regions with high rates of violence, cultural norms such as wife-beating perpetuate the cycle of violence, and the weak linkages between the police, health facilities, and judicial system affect reporting. Pwani, Tanga, and Mtwara experience fewer cases of violence than other regions, but the incidence of violence is higher than in some other regions. In comparison to other pillars, the programmatic gaps for violence is much larger given that choice of region is driven by other factors which are integrated with violence programming (e.g. preventing HIV). Often, violence is a secondary or tertiary objective in HIV programming. Given the existing data, programmes to counter violence in Kigoma reach the largest percentage of the adolescent population across the country.

[107] The available data is segmented by region; it uses the prevalence of violence among women as an indicator. This indicator from the TDHS 2015 was used as a proxy for adolescents, given the limitations in region segmentation for the adolescent demographic

Pillar 4 – Improving Nutrition

Figure 20: Prevalence of anaemia in women aged 15 – 49

Figure 21: Adolescent nutrition programming across regions

The prevalence of anaemia is highest in Shinyanga, Mwanza, Simiyu, and Kigoma, but programming is highly concentrated in Singida. The poor provision of maternal health services in the Lake Zone contributes to the high rates of anaemia. The incidence of malaria can increase the prevalence of anaemia; the malaria epidemic in coastal regions like Dar es Salaam have raised the prevalence rate of anaemia. The performance is better in regions like Iringa, Njombe, Mbeya, Singida, and Kilimanjaro. Three of these regions are found in the country's agricultural corridor; therefore, these are more likely to be food-secure, and their nutritional outcome is likely to be good. Programmes for adolescent girls are limited in number, as research on nutrition among the adolescent population is limited. Existing programmes are concentrated in Singida, where the programmes reach up to 30% of the adolescent population. Programmes in regions such as Pwani, Mbeya, Iringa, Njombe, Mwanza, and Dar es Salaam reach about 9% of the adolescents.

Pillar 5 – Keeping Boys and Girls in School

Figure 22: Total male and female dropout rate

Figure 23: Programmes for keeping adolescents in school across regions

Dropout rates are highest in Geita, followed by Tanga, Tabora and Simiyu, but programming is concentrated in the south. Dropout rates are complicated, making it difficult to find strong associations in regional performance. Some of the factors leading to dropouts include truancy (peer pressure, lack of basic needs, livestock keeping, mining works and domestic works) as well as pregnancies, which account for 7% of

the dropout rates. The inadequacy of classrooms and latrines is another major challenge. Regions which performed well—Njombe, Kilimanjaro, and Dar es Salaam—have invested in WASH infrastructure and the quality of facilities. This is demonstrated by their above-average pupil-to-pit latrine and pupil-to-classroom ratio. Similar to other pillars, programmes and issue areas are largely misaligned; while programmes are concentrated in the southern regions, regions in the north such as Geita have the highest dropout rates. Nonetheless, programmes are limited in number.

PILLAR 6 – DEVELOPING SKILLS FOR MEANINGFUL ECONOMIC OPPORTUNITIES

FIGURE 24: UNEMPLOYMENT RATES ACROSS THE REGIONS

FIGURE 25: ADOLESCENT SKILLS BUILDING PROGRAMMING ACROSS REGIONS

The unemployment rate across the country is significantly high, but programming is low.

People in the 15 – 24 age group make up more than 30% of the national labour force, but most of them are unemployed. The overall youth labour force participation rate is 84.5% (89.3% rural and 81.3% urban). The gender differential shows that males have a slightly higher labour force participation rate than that of females with 86.3 and 82.8% respectively. Comparing the rates in 2006 and 2014, the unemployment rate declined—from 11.7% in 2006 to 10.3% in 2014—but the female unemployment rate (12.3%) exceeded that of males (8.2%). Young people aged 15 – 24 years are more vulnerable to unemployment (13.7%); the incidence was greater among males (15.2%) than females (12.8%) (ILFS 2014). The unemployment rate is highest among young people with secondary school education (13.8%) and primary school education (10%)**.** Urbanization and the size of the adolescent population are the primary drivers of both high and low unemployment. Larger cities tend to have higher rates of unemployment because they tend to attract the youth population; however, the supply of jobs is limited and cannot absorb this growing population in urban areas. Adolescent-specific programming with a focus on building skills only reach a small percentage of adolescents. Most programmes have a specific target, typically out-of-school adolescents, and focus on helping youth find jobs and create businesses, especially in agriculture. Skills-building is a component of these programmes, but it is often not the primary objective.

ANNEX 3: GEOGRAPHICAL LOCATION OF PRIORITY REGIONS AND COUNCILS

ZONE	REGIONS	COUNCILS		
Lake	1. Geita	Bukombe DC	Geita DC	Mbogwe DC
		Chato DC	Geita TC	Nyang'wale DC
	2. Shinyanga	Kishapu DC	Kahama TC	Shinyanga DC
		Msalala DC	Shinyanga MC	Ushetu DC
	3. Mwanza	Ilemela MC	Mwanza CC	Ukerewe DC
		Kwimba DC	Buchosa DC	Misungwi DC
		Sengerema DC	Magu DC	
	4. Simiyu	Bariadi DC	Itilima DC	Busega DC
		Bariadi TC	Maswa DC	Meatu DC
	5. Mara	Musoma MC	Serengeti DC	Tarime DC
		Bunda DC	Rorya DC	Tarime TC
		Bunda MC	Butiama DC	Musoma DC
Western Zone	6. Tabora	Nzega DC	Sikonge DC	Urambo DC
		Nzega TC	Tabora MC	Tabora/Uyui DC
		Kaliua DC	Igunga DC	
	7. Kigoma	Buhigwe DC	Kigoma Ujiji MC	Kibondo DC
		Kakonko DC	Kigoma DC	Uvinza DC
		Kasulu DC	Kasulu TC	
	8. Katavi	Mlele DC	Mpimbwe DC	Mpanda TC
		Mpanda DC	Nsimbo DC	Busokelo DC
Southern Highlands	9. Mbeya	Chunya DC	Rungwe DC	Mbarali DC
		Kyela DC	Mbeya DC	Mbeya CC
	10. Songwe	Songwe DC	Tunduma TC	Mbozi DC
		Ileje DC	Momba DC	
	11. Rukwa	Sumbawanga MC	Kalambo DC	Nkasi DC
		Sumbawanga DC		
Southern	12. Lindi	Kilwa DC	Liwale DC	Ruangwa DC
		Lindi DC	Nachingwea DC	Lindi MC
Northern	13. Tanga	Tanga CC	Pangani DC	Bumbuli DC
		Korogwe	Mkinga DC	Kilindi DC
		Korogwe TC	Handen Mji	Lushoto DC
		Muheza DC	Handeni DC	

ANNEX 4: STATUS OF KEY INDICATORS IN SELECTED REGIONS

No.	Region	Total Population	Adolescent Population	Preventing HIV	Preventing Teenage Pregnancy	Preventing Violence	Improving Nutrition	Keeping Boys and Girls in School
				Prevalence Of HIV In The 15 – 49 Age Group	Percentage of women aged 15 – 19 who have begun childbearing	Percentage Of Ever Married Women Aged 15 – 49 Who Have Experienced Physical, Sexual, Or Emotional Violence Committed By Their Partner	Percentage of Women Aged 15 – 49 with Anaemia	Secondary School Dropout Rate
1	Geita	2,335,134	584,637	5.2	30	63%	52.8	7.0
2	Katavi	771,287	184,060	5.4	45	50%	44.9	7.0
3	Kigoma	2,706,831	678,944	3.0	32	61%	55.1	3.4
4	Lindi	1,004,439	234,100	0.3	28	37%	48.9	4.5
5	Mara	2,298,317	568,235	3.3	37	78%	50.9	2.8
6	Mbeya	2,136,614	470,628	9.2	33	45%	25.3	2.3
7	Mwanza	3,676,300	856,817	6.5	28	60%	55.4	4.1
8	Rukwa	1,231,959	338,775	4.1	29	46%	31.7	5.1
9	Shinyanga	1,933,768	486,872	5.5	34	78%	59.8	4.2
10	Simiyu	2,196,449	546,557	3.5	30	62%	54.1	6.1
11	Songwe	1,239,970	307,633	5.6	Part of Mbeya	Part of Mbeya	Part of Mbeya	7.4
12	Tabora	2,974,427	740,596	4.8	43	71%	52.6	4.0
13	Tanga	2,391,791	611,230	5.4	21	25%	43.7	3.4

ANNEX 5: HIGH-LEVEL OVERVIEW OF ADOLESCENT PROGRAMMES

FIGURE 26: HIGH-LEVEL OVERVIEW OF EXISTING ADOLESCENT PROGRAMMES IN TANZANIA[108]

Program Name	Funder/ Implementer	Year	Description	Pillars Impacted	Regions Implemented	Target population
BUHOMA DEVELOPMENT PROGRAM	PRIVATE DONATIONS/ WORLD VISION	2010-2025	Provides awareness trainings for parents and community on importance of girl child education; also provides equipment to schools (e.g. desks)	Pillar 5	Kigoma	943
MUHE DEVELOPMENT PROGRAM	PRIVATE DONATIONS/ WORLD VISION	2010-2025	Works with adolescents to improve well being by focusing on meeting basic needs (e.g. water, food, and healthcare); also provide education and awareness on abusive practices	Pillar 1 Pillar 3 Pillar 4	Kigoma	542
ADVANCING YOUTH ACTIVITY	USAID/ SNV	2017-2022	Teaches youth various skills around employability, business, and leadership skills	Pillar 6	Iringa and Mbeya	33,000
JIANDALIE AJIRA PROGRAM	MasterCard Foundation/ IYF, VETA	2018-2022	Provides training for youth on skills required for the industrial economy	Pillar 6	Mtwara, Dodoma and Dar es Salaam	22550
TULONGE AFYA	USAID/ FHI 360	2017-2022	Generates awareness through community sensitization, outreach and radio campaigns on positive health practices including HIV prevention	Pillar 1 Pillar 2	Iringa, Njombe, Mwanza, Shinyanga and Tabora	Unclear
ANEMIA REDUCTION	UNICEF	2016-2021	Provides technical and financial assistance for micronutrients supplementation and fortification	Pillar 4	Mbeya, Iringa, Njombe and Songwe	112,570
BORESHA AFYA	USAID/ FHI360	2016-2021	Works to integrate various HIV services into existing family planning services	Pillar 1 Pillar 2	Iringa, Lindi, Morogoro, Mtwara, Njombe and Ruvuma	64000
EAST AFRICAN YOUTH INCLUSION PROFECT	MasterCard foundation/ Heifer International	2016-2021	Equips youth with various technical (e.g. financial literacy) and leadership skills	Pillar 6	Iringa and Mbeya	10000
KIGOMA JOINT PROGRAM	16 UN AGENCIES	2017-2021	Cuts across various sectors including youth economic empowerment, girl child education and WASH	Pillar 3 Pillar 5 Pillar 6	Kigoma	120,000
SUPPORT TO FOOD SECURITY AND NUTRITION	EU/ Save the Children& WFP	2017-2021	Aims to contribute to reduced malnutrition in the target districts through improved food and nutrition security	Pillar 4	Dodoma and Singida	177,038
TOHARA PLUS	US CDC/ INTRAHEALTH	2016-2021	Strengthens voluntary medical male circumcision including for adolescent boys	Pillar 1	Mwanza, Kagera, Shinyanga and Mara	231,600
USAID KIZAZI KIPYA	USAID/ Pact International	2016-2021	Works to transform lives of vulnerable children and young people by improving access to health and HIV services	Pillar 1 Pillar 3	Across the nation	1,300,000

[108] Programmes highlighted in yellow have ended, will end soon, or have an end date that is unclear

Program Name	Funder/ Implementer	Year	Description	Pillars Impacted	Regions Implemented	Target population
ADOLESCENT 360	**PSI/** BMGF, CIFF	2016-2020	Use human-centered design to increase access to contraceptives for adolescent girls	Pillar 2	Kagera, Geita, Mwanza, Tabora, Mbeya, Tanga, Dar, Iringa and Morogoro	66751
INVEST	**LUTHERAN WORLD RELIEF**	2017-2020	Provide funding for a select number of entrepreneurs for students (those who are currently in school)	Pillar 6	Morogoro	814
SAUTI	**USAID/** Jhpiego	2015-2020	Provides a combination of HIV prevention and family planning services to key vulnerable populations	Pillar 1 Pillar 2	Dar es Salaam, Iringa, Njombe, Mbeya and Shinyanga, Morogoro, Lindi, Dodoma, Tabora, Arusha and Kilimanjaro	143,550
RIGHT STAR INITIATIVE	**GLOBAL AFFAIRS CANADA/** Nutrition International	2017-2020	Provides technical and financial assistance to TFNC and LGAs to improve nutrition of adolescent girls	Pillar 4	Mwanza and Simiyu	94000
TUSOME PAMOJA	**USAID/** Plan International	2016-2020	Improving early grade learning outcomes for primary school children	Pillar 5	Mtwara, Iringa, Morogoro and Ruvuma	1400000
GF HIV/TB GRANT	**GLOBAL FUND/** AMREF	2018-2020	Expand coverage of HIV services, testing, ART, and viral suppression	Pillar 1	Singida, Morogoro and Dodoma	162064
CASH PLUS	**UNICEF/** TASAF	2017-2019	Provides intensive life skills training, mentoring and coaching on livelihood enhancement	Pillar 5 Pillar 6	Iringa and Mbeya	2500
CHILD FOCUSED COMM. DVPT. PROGRAM	**TOMS SHOES, PRIVATE DONATIONS/** FEED THE CHILDREN	2012-2019	Provides daily meals for students in schools as well as refurbishing school buildings	Pillar 4 Pillar 5	Pwani and Dar es Salaam	140,704
MAISHA BORA	**DGD/** WFP	2015-2019	Improves capacity of schools to provide school meal programs and improved WASH practices	Pillar 4 Pillar 5	Arusha and Manyara	8,796
ACCELERATING CHILDREN'S HIV TREATMENT INITIATIVE	**PEPFAR, CIFF/** EGPAF, ICAP	2016-2018	Focuses on increasing HIV testing and treatment among adolescents by promoting youth friendly services	Pillar 1	*Unclear*	*Unclear*
EMPOWERMENT AND LIVELIHOOD FOR ADOLESCENTS	**NOVO FOUNDATION/** BRAC	2013-2018	The program provides safe spaces for young adolescent girls to socialize and receive mentoring and life skills training combined with financial literacy training	Pillar 6	*Unclear*	*Unclear*
GIRL TALK GIRL POWER	**CSI Tanzania**	2016-2018	Engages adolescent girls to provide essential life skills linked with conversation on taboo SRH topics	Pillar 1 Pillar 2 Pillar 6	Dar es Salaam	4000
HEALTH AND WATER	**FEED THE FUTURE**	2017-2018	Provides technical and financial assistance on WASH facilities	Pillar 5	Pwani	50,000

Program Name	Funder/ Implementer	Year	Description	Pillars Impacted	Regions Implemented	Target population
MWANAMKE TUNU	**DFID**/ IntraHealth/ PSI	2014-2018	Improves access to family planning and services related to gender based violence	Pillar2 Pillar3	Geita	41443
SCHOOL MEALS PROGRAM	**FEED THE FUTURE**	2016-2018	Provides technical and financial assistance to primary schools on healthy eating (e.g. provide fortified flour)	Pillar4	Pwani	14,000
YOUTH HEALTH SPORT INITIATIVE	**DSW**	2018	Mobilizes young people to engage in productive activities leveraging individual talents; also educates youth on health and economic empowerment	Pillar6	Dar, Kilimanjaro, Arusha and Manyara	16000
CHAGUO LA MAISHA	**ANONYMOUS/** PATHFINDER	2015-2017	Aimed at improving access to quality youth friendly contraceptive and Post abortion care services	Pillar1 Pillar2	Dar es Salaam	10170
YOUTH AND HELPLINE	**TAYOA**	2010-2016	Provides various services including mobile HIV testing services, and outreach combined with free helpline and text messages	Pillar1	Helpline (Nation wide) Outreach services (Dar es Salaam, Pwani and Tanga)	*Unclear*
DREAMS	**USAID, BMGF/** MDH, AGPAHI	2014	A partnership where individual partners design and implement programs with an aim to reduce new HIV/AIDS infections in vulnerable adolescents girls and young women	Pillar 1	Shinyanga, Mbeya and Dar es Salaam	*Unclear*
MABINTI TUSHIKE HATAMU	**UNICEF/** RESTLESS DEVELOPMENT	2013	Works on reducing the vulnerability of adolescent out of school girls by building their leadership skills	Pillar 1 Pillar 2 Pillar 3	Dar es Salaam Iringa and Mbeya	7101
LYRA AFRICA	**PRIVATE DONATIONS/** LYRA	2011-	Builds dormitories for girls	Pillar 5	Iringa	1000

ANNEX 6: EMERGING AND SUPPORTING INTERVENTIONS

Supporting and emerging/evolving interventions are complementary interventions that are not the focus of NAIA-AHW but are important in the medium to long term. Supporting interventions are those with substantial momentum among several stakeholders that are implementing programmes to address these issues. Some of these interventions are already achieving their intended outcomes, while others are expected to see outcomes in the long-term. Emerging/evolving interventions are those that are new, with limited momentum, yet show some promise. Although not a focus of the NAIA-AHW, supporting and emerging/evolving interventions are important to sustain; it is therefore essential for stakeholders to continue implementing interventions in these categories. The supporting and emerging/evolving interventions are categorized below by pillar.

Pillar 1 – Preventing HIV

i. **[Supporting]** Promote a supportive policy environment for accelerated HIV testing by removing age-related barriers to testing for adolescents
ii. [**Supporting**] Increase government allocation and fund disbursement for HIV interventions related to adolescents
iii. [**Supporting**] Strengthen linkages of HIV interventions with other priority multisectoral programmes for adolescents in hotspots
iv. [**Emerging/Evolving**] Promote self-testing usage and access for adolescents
v. [**Emerging/Evolving**] Promote stigma reduction through targeted district-level SBCC multimedia and linking HIV+ adolescents and young people to existing PLHIV groups for psychosocial support

Pillar 2 – Preventing Teenage pregnancies

i. **[Supporting]** Create a shift in the mindset by scaling community-based programmes, especially in high-prevalence regions, and leveraging social workers, educated mentors, and peers
ii. **[Supporting]** Increase community-based advocacy against social norms to counter stigma against the use of family planning methods for adolescent girls
iii. **[Supporting]** Review the Marriage Act and Constitution to address discrimination against girls on the legal age of marriage

Pillar 3 – Preventing Physical, Sexual and Emotional Violence

i. **[Supporting]** Increase the number of social welfare officers to support response to violence
ii. **[Supporting]** Support the Police Gender and Children's Desk by scaling the training of officers on data monitoring system and response
iii. **[Emerging/Evolving]** Scale apprenticeship programmes to students who do not pass the Primary School Leaving Examination and those who are already employed as a protective means against child labour

Pillar 4 – Improving Nutrition

i. **[Supporting]** Expand the provision of deworming pills to the entire adolescent population
ii. **[Supporting]** Promote industrial and community fortification
iii. [**Supporting**] Expand school feeding programmes
iv. **[Emerging/Evolving]** Disaggregate nutrition indicators in national statistics studies to reflect the data for adolescents
v. **[Emerging/Evolving]** Conduct research on food systems and adolescents to identify underlying issues in this age group
vi. **[Emerging/Evolving]** Include gardening projects in the curriculum to teach adolescents about their nutritional needs

Pillar 5 – Keeping Boys and Girls in School

i. **[Supporting]** Work with local government and communities to build dormitories at schools
ii. **[Emerging/Evolving]** Drive policy around the benefits of Kiswahili and English becoming formal mediums of instruction at the primary school level
iii. **[Emerging/Evolving]** Train teachers in evidence-based pedagogies appropriate to early-grade reading, writing, and arithmetic

Pillar 6 – Developing skills for meaningful economic opportunities

i. **[Emerging/Evolving]** Improve access to and capacity of youth development funds to target youth aged 12 and above to access financial services for entrepreneurial activities, with the support of local government, PMO-LYED, and NEEC
ii. **[Emerging/Evolving]** Improve the ability of the NEEC to collaborate with development partners and develop youth incubation hubs, targeting 15 – 19-year-olds with the skills to produce market-driven goods and services across districts. Incubation hubs should provide the youth access to markets, mentorship, finance, and business development services in partnership with private sector and government youth development funds at the local government level

Cross-Cutting Interventions

i. **[Supporting]** Develop/optimize one-stop centres for youth to integrate delivery channels to offer multiple services, e.g. access to information, treatment, reporting, and counselling
ii. **[Emerging/Evolving]** Launch a positive parenting campaign to equip parents will holistic skills promoting health and wellbeing

ANNEX 7: TOTAL COORDINATION COSTS

FIGURE 27: TOTAL COORDINATION COSTS ACROSS FOUR YEARS AT THE NATIONAL LEVEL

No.	Activities	Total Cost Per Year (TZS)				Total Cost per Activity (TZS)	Lead Coordinating Units	Collaborating Coordinating Units/Agencies
		FY 2021/22	FY 2022/23	FY 2023/24	FY 2024/25			
1	Purchase of office equipment	25,830,000	-	-	-	**25,830,000**	National Secretariat	n/a
2	Support the operationalization of the National Secretariat	567,000,000	595,350,000	625,117,500	656,373,375	**2,443,840,875**	National Secretariat	n/a
3	Develop guidelines on the operationalization of the coordination structures at all levels	296,100,000	-	-	-	**296,100,000**	National Secretariat	External Consultant
4	Support the meeting of the National Steering Committee, the National Technical Committee, and the Working Groups	176,557,500	185,385,375	194,654,644	204,387,376	**760,984,895**	National Secretariat	National Steering Committee, National Technical Committee, Working Groups
5	Advocate for prioritization of public financing in national budgeting instruments	9,030,000	-	-	-	**9,030,000**	National Steering Committee	All Coordinating Units
6	Build capacity to plan, budget, manage, and advocate for strong and effective activities at the national level	59,850,000	62,842,500	65,984,625	69,283,856	**257,960,981**	National Secretariat	National Technical Committee, Working Groups, All Subnational Level Coordinating Units
7	Carry out public expenditure reviews	230,475,000	241,998,750	254,098,688	266,803,622	**993,376,059**	National Secretariat	National Technical Committee, External Consultant
	Total Cost	**1,364,842,500**	**1,085,576,625**	**1,139,855,456**	**1,196,848,229**	**4,787,122,810**		

FIGURE 28: TOTAL COORDINATION COSTS ACROSS FOUR YEARS IN ONE DISTRICT

No.	Activities	Total Cost Per Year (TZS)				Total Cost per Activity (TZS)	Lead Coordinating Units	Collaborating Coordinating Units
		FY 2021/22	FY 2022/23	FY 2023/24	FY 2024/25			
1	Socialization of the Agenda at the subnational level	2,625,000	2,756,250	2,894,063	3,038,766	**11,314,078**	National Secretariat	PO-RALG and all subnational level coordinating units
2	Build capacity to plan, budget, manage, and advocate for strong and effective activities at the subnational level	8,872,500	9,316,125	9,781,931	10,271,028	**38,241,584**	National Secretariat and PO-RALG	All subnational level coordinating units
Total Cost		**11,497,500**	**12,072,375**	**12,675,994**	**13,309,794**	**49,555,662**		

Performance Measurement

The entity should develop action plans, responsibilities, and timelines for each party and agree on these, and develop reliable performance measures to track progress. Establishing performance metrics will ensure mutual accountability among all adolescent stakeholders; guide them towards a common set of objectives; give the coordination process greater value; and incentivize agencies and individuals towards greater participation and accountability.

Defined outcomes

The coordination entity will work towards clearly defined and mutually agreed joint outcomes. The leadership of the entity should engage members in identifying and agreeing on a common set of outcomes that the team will aim to achieve over a defined period. All the participants will need a clear understanding of their goals and timelines. This will ensure that the members remain motivated and targeted in their individual and overall goals within the coordination framework.

Resource Mobilization

Resources are critical for a coordination initiative to be sustainable and prove value for its existence. The coordinating entity should develop a collective resource mobilization and alignment mechanism that will ensure that members dedicate their resources distribution towards the coordination functions and align resourcing of various programmes and interventions that sit under the coordination entity.

Activities and Funding

Implementing the suggested coordination structure and performing the ensuing activities will cost 2% of the total cost (TZS 5.3 billion) at the national level and 0.3% of the total cost (TZS 45 million) for one district. The key activities of the coordination structure include developing operationalization guidelines; supporting the meetings of the NSC, the NTC, and some of the WGs; advocating for funding; and conducting supportive, formative, and operational research on emerging issues. The national-level budget will go towards compensation benefits; the purchase of technical equipment; and the capacity-building of sitting members of the national-level coordinating structures such as officers of the National Secretariat. The district-level cost includes activities such as conducting supportive supervision in councils and building the capacity of council officials to implement the NAIA-AHW.

ANNEX 8: DETAILED ACTIVITY COSTING

PILLAR 1: PREVENTING HIV

INTERVENTION	ACTIVITY	FY 2021/22	FY 2022/23	FY 2023/24	FY 2024/25
1.1 Biomedical: Increase access to community-based HIV testing and relevant linkages to prevention and care for 1) adolescent boys and girls 2) male partners of AGYW	**1.1.1** Map and identify high-risk geographical locations/groups among 1) adolescent boys and girls, 2) male partners of AGYW, and 3) sexual networks of adolescent boys and girls	TZS 1,263,848,108.11	TZS 0.00	TZS 0.00	TZS 0.00
	1.1.2 Conduct comprehensive demand-creation activities and sensitization campaigns for identified high-risk groups using influential people (e.g. young celebrities and political, community, religious leaders), mass media, jogging clubs, mentors/peer educators, and social media to promote and increase demand for HIV community-based testing, education and provision of protective measures, SRH information and services, cervical cancer screening, and post-violence care	TZS 4,374,318,729.73	TZS 4,593,034,666.22	TZS 4,822,686,399.53	TZS 5,063,820,719.50
	1.1.3 Conduct index testing for sexual networks of adolescent boys and girls, male partners of AGYW, and facilitate linkages to care for positives and preventive services for negatives	TZS 3,001,639,256.76	TZS 3,151,721,219.59	TZS 3,309,307,280.57	TZS 3,474,772,644.60
	1.1.4 Implement combination prevention initiatives through pop-up/sports/music community events that include HIV community-based testing and linkages to care among 1) adolescent boys and girls and 2) male partners of AGYW	TZS 2,106,413,513.51	TZS 2,211,734,189.19	TZS 2,322,320,898.65	TZS 2,438,436,943.58
	1.1.5 Provide facilitated referrals and linkages for identified HIV-positive adolescent boys and girls and male partners of AGYW to care and treatment services (e.g. ART)	TZS 0.00	TZS 0.00	TZS 0.00	TZS 0.00
	1.1.6 Provide facilitated referrals and linkages for adolescent boys and girls and male partners of AGYW tested as HIV-negative to prevention services	TZS 0.00	TZS 0.00	TZS 0.00	TZS 0.00
	1.1.7 Build the capacity of healthcare providers to conduct community-based HIV testing as per national guidelines and to effectively communicate with adolescents on the means of HIV/AIDS prevention through building strategic partnerships with non-state actors	TZS 0.00	TZS 1,870,083,642.61	TZS 0.00	TZS 2,061,767,215.98
	1.1.8 Capacitate community members—parents/caregivers, and community and religious leaders—to effectively and frankly communicate with adolescents on SRH issues	TZS 0.00	TZS 935,041,821.30	TZS 0.00	TZS 1,030,883,607.99
1.2 Biomedical/ Behavioural: Empower adolescent boys and girls to delay sexual debut and proactively use protective measures against HIV infection	**1.2.1** Implement combination prevention initiatives through sports/music/community events to empower adolescent girls and boys delay sexual initiation	*[this is included in 1.1.4]*			
	1.2.2 Map and identify high-risk geographical locations/groups where there is an unmet need for protective measures against HIV infection among 1) adolescent boys and girls, 2) male partners of AGYW, and 3) sexual networks of adolescent boys and girls				
	1.2.2 Conduct demand-creation activities through pop-up events, mass media, and social media and by using influential people (e.g. young celebrities, and political and community leaders) to persuade parents and community leaders against stigmatizing boys and girls using protective measures	TZS 4,374,318,729.73	TZS 4,593,034,666.22	TZS 4,822,686,399.53	TZS 5,063,820,719.50
	1.2.3 Implement combination prevention initiatives through pop-up/sports/music community events that include HIV community-based testing and linkages to care among 1) adolescent boys and girls and 2) male partners of AGYW				
	1.2.4 Promote social marketing of government-branded protective measures against HIV infection	TZS 210,000,000.00	TZS 0.00	TZS 231,525,000.00	TZS 0.00

	1.2.5 Build capacity of health and non-health providers (e.g. parents, caregivers, and religious leaders) and retailers on the usage and distribution of protective measures against HIV infection	TZS 35,106,891.89	TZS 0.00	TZS 38,705,348.31	TZS 0.00
	1.2.6 Train health facility and community workers in record-keeping and forecasting to ensure that the supply of protective measures is consistent	TZS 982,030,342.00	TZS 0.00	TZS 1,082,688,452.05	TZS 0.00
	1.2.7 Procure and distribute vending machines of protective measures in all high-risk areas; appropriate places include areas near markets, shopping malls, sports grounds, guesthouses, bars, nightclubs, colleges, and universities	TZS 19,722,972.97	TZS 20,709,121.62	TZS 21,744,577.70	TZS 22,831,806.59
	1.2.8 Advocate for public – private partnership to subsidize private-sector protective measures and ensure access in pharmacies, private hospitals, and communities	TZS 52,500,000.00	TZS 110,250,000.00	TZS 115,762,500.00	TZS 0.00
	1.2.9 Advocate for policy change to ensure that government-branded protective measures are easily available from the national level to the community level	TZS 52,500,000.00	TZS 110,250,000.00	TZS 115,762,500.00	TZS 0.00
	1.2.10 Strengthen youth representatives on the village/ward/council multisectoral HIV committees as a spokesperson for adolescents' SRH needs	TZS 0.00	TZS 17,693,873.51	TZS 0.00	TZS 19,507,495.55
1.3 Biomedical: Promote access and uptake of VMMC to adolescent boys and male partners of AGYW	**1.3.1** Train healthcare workers to provide adolescent boys and male partners of AGYW VMMC services in and out of health facilities	TZS 596,817,162.16			
	1.3.2 Conduct consultation meetings to integrate VMMC services into SRH services for adolescent boys and male partners of AGYW in and out of health facilities	TZS 78,750,000.00	TZS 82,687,500.00	TZS 86,821,875.00	TZS 91,162,968.75
	1.3.3 Conduct VMMC as part of outreach or static services	TZS 65,384,198,880.00	TZS 68,653,408,824.00	TZS 72,086,079,265.20	TZS 37,845,191,614.23

PILLAR 2: PREVENTING TEENAGE PREGNANCIES

INTERVENTION	ACTIVITY	FY 2021/22	FY 2022/23	FY 2023/24	FY 2024/25
2.1 Expand access to comprehensive information of SRH through innovative programmes and revision of in and out-of-school SRH curriculum	***2.1.1*** Scale existing innovative healthcare delivery programmes to raise awareness of SRH issues and rights by targeting adolescents and engaging them better	TZS 2,106,413,513.51	TZS 4,423,468,378.38	TZS 4,644,641,797.30	TZS 2,438,436,943.58
	2.1.2 Use mobile technology to improve the awareness and demand of SRH services and linkages to these	TZS 758,308.86	TZS 1,592,448.62	TZS 1,672,071.05	TZS 1,755,674.60
	2.1.3 In-school: Conduct analytical review in terms of CSE integration with the existing secondary school curriculum, Teachers' Certificate, and Diploma curriculum and teaching methods	TZS 0.00	TZS 150,822,000.00	TZS 0.00	TZS 0.00
	2.1.4 In-school: Develop guidelines for integrating CSE content into the existing secondary school curriculum and into the curricula and teaching methods of the Teachers' Certificate and Diploma programmes	TZS 60,091,497.90	TZS 76,673,451.89	TZS 80,507,124.49	TZS 84,532,480.71
	2.1.5 In-school: Integrate the textbook CSE content into the existing secondary school curriculum and into the curricula and teaching methods of the Teachers' Certificate and Diploma programmes	TZS 144,460,475.68	TZS 861,499.46	TZS 904,574.43	TZS 949,803.15
	2.1.6 In-school: Train in-service teachers and tutors to deliver CSE as an integrated concept in existing primary schools, secondary schools, and Teacher Colleges	TZS 0.00	TZS 0.00	TZS 22,363,950,253.99	TZS 0.00
	2.1.7 In-school: Review the Education Policy Guideline (2004) to incorporate CSE as an integrated subject and deliver and implement life skills and HIV programmes in primary schools, secondary schools, and Teacher Colleges	TZS 0.00	TZS 150,822,000.00	TZS 0.00	TZS 0.00

	2.1.8 In-school: Train schoolteachers and guardians on the Guidance, Counselling, and Child Protection Guideline	TZS 451,647,000.00	TZS 474,229,350.00	TZS 497,940,817.50	TZS 522,837,858.38
	2.1.9 Out-of-school: Harmonize CSE programmes for out-of-school adolescents	TZS 143,640,000.00	TZS 0.00	TZS 0.00	TZS 0.00
	2.1.10 Out-of-school: Train facilitators on teaching out-of-school adolescents CSE	TZS 1,014,238,106.76	TZS 0.00	TZS 1,118,197,512.70	TZS 0.00
	2.1.11 Out-of-school: Facilitators (peers can be facilitators) train out-of-school adolescents on CSE through teen clubs, online learning etc	TZS 0.00	TZS 13,270,405,135.14	TZS 13,933,925,391.89	TZS 14,630,621,661.49
2.2 Expand access and promote use of evidence-based methods for teenage pregnancy prevention to community-based settings	***2.2.1*** Address negative social cultural norms and religious beliefs of adolescents' use of evidence-based methods to prevent pregnancy by targeting them and influencers (parents, and religious and community leaders) through community meetings and public campaigns (by means of mobile technology and mass, social, and traditional media)	TZS 5,763,370,895.27	TZS 12,103,078,880.07	TZS 12,708,232,824.07	TZS 13,343,644,465.27
	2.2.2 Scale up positive parenting programmes to address the negative attitudes of parents/caregivers	TZS 6,319,240,540.54	TZS 6,635,202,567.57	TZS 6,966,962,695.95	TZS 7,315,310,830.74
	2.2.3 Integrate SRH programmes into holistic programmes that address the development of wider skill sets, such as life skills and entrepreneurship, to garner adolescents' attention towards evidence-based methods for preventing pregnancy	TZS 2,068,297,459.46	TZS 4,343,424,664.86	TZS 4,560,595,898.11	TZS 2,394,312,846.51
	2.2.4 Improve access to evidence-based methods for teenage pregnancy prevention in and out of health facilities, e.g. by engaging Community Health Workers (CHW) and through outreach programmes, mobile clinics, and peer healthcare providers	TZS 2,359,183,135.14	TZS 4,954,284,583.78	TZS 5,201,998,812.97	TZS 5,462,098,753.62
	2.2.5 Advocate for public – private partnerships to subsidize private-sector evidence-based methods for preventing pregnancy and ensure access in pharmacies, private hospitals, and communities	TZS 105,000,000.00	TZS 220,500,000.00	TZS 231,525,000.00	TZS 0.00
	2.2.6 Train health workers on AFHS norms and values and address their bias against providing adolescents services so that they provide adolescents evidence-based methods for preventing pregnancy	TZS 2,106,413,513.51	TZS 2,211,734,189.19	TZS 2,322,320,898.65	TZS 2,438,436,943.58

PILLAR 3: PREVENTING PHYSICAL, SEXUAL, AND EMOTIONAL VIOLENCE

INTERVENTION	ACTIVITY	FY 2021/22	FY 2022/23	FY 2023/24	FY 2024/25
3.1 Scale and strengthen peer support groups to increase awareness on what constitutes violence and to serve as platform for peer-to-peer support	***3.1.1*** Review and adopt the peer group training manual on adolescents' violence prevention and response	TZS 23,100,525.00	TZS 23,100,525.00	TZS 23,100,525.00	TZS 23,100,525.00
	3.1.2 Develop a directory poster that maps the formal reporting mechanisms and support channels for services related to violence close to areas where violence has occurred	TZS 256,248,243.24	TZS 0.00	TZS 11,576,250.00	TZS 10,500,000.00
	3.1.3 Train mentors on the training manual to lead training sessions with youth	TZS 739,210,013.54	TZS 0.00	TZS 0.00	TZS 0.00
	3.1.4 Conduct peer support group sessions in schools and in identified locations for out-of-school adolescents	TZS 0.00	TZS 5,838,978,259.46	TZS 6,130,927,172.43	TZS 6,437,473,531.05
	3.1.5 Conduct awareness campaigns on violence against adolescents targeting parents, influential religious and traditional leaders, service providers, and government and political officials	TZS 0.00	TZS 353,877,470.27	TZS 371,571,343.78	TZS 390,149,910.97
	3.1.6 Establish and strengthen Junior and Youth Councils to enhance child participation rights in development activities	TZS 109,200,000.00	TZS 114,660,000.00	TZS 120,393,000.00	TZS 126,412,650.00
3.2 Strengthen protection systems to	***3.2.1*** Review and adopt the training manual for training frontline workers on violence prevention and response	TZS 233,832,435,766.40	TZS 233,832,435,766.40	TZS 233,832,435,766.40	TZS 233,832,435,766.40

improve response and support services on violence against adolescents	*3.2.2* Conduct national- and subnational-level joint training workshop for frontline workers (Community Development Workers (CDOs), SWOs, health workers, law enforcers, Protection Committees)	TZS 197,542,800.00	TZS 476,260,095.41	TZS 717,864,037.18	TZS 525,076,755.18
	3.2.3 Organize community forums and use the media to communicate issues of violence based on the Communication and Outreach strategy on VAWC	TZS 0.00	TZS 280,152,997.30	TZS 294,160,647.16	TZS 308,868,679.52
	3.2.4 Establish Child Protection Desks within Schools as platform to empower girls and boys, educate about their rights, CSE, and Violence Against Children (VAC)	TZS 0.00	TZS 7,372,447,297.30	TZS 4,644,641,797.30	TZS 3,251,249,258.11
	3.2.5 Conduct regular school check-ins by SWOs, CHWs, and CDOs to ensure that schools provide a safe environment for students	TZS 0.00	TZS 31,200,196,962.16	TZS 32,760,206,810.27	TZS 34,398,217,150.78
	3.2.6 Establish and strengthen One-Stop Centres for VAC response and support in 67 District Hospitals (one per district)	TZS 562,800,000.00	TZS 886,410,000.00	TZS 930,730,500.00	TZS 651,511,350.00
	3.2.7 Construct or rehabilitate 13 safe houses (one in each priority region)	TZS 136,500,000.00	TZS 211,097,250.00	TZS 221,652,112.50	TZS 155,156,478.75

PILLAR 4: IMPROVING NUTRITION

INTERVENTION	ACTIVITY	FY 2021/22	FY 2022/23	FY 2023/24	FY 2024/25
4.1 Promote, establish, and strengthen school gardening programmes for micronutrient-rich foods	*4.1.1* Establish school gardens and small animal – keeping within primary and secondary schools	TZS 0.00	TZS 844,882,460.27	TZS 887,126,583.28	TZS 931,482,912.45
	4.1.2 Train adolescents, teachers, and community on modalities of cultivating micronutrient-rich foods	TZS 0.00	TZS 6,523,141,368.65	TZS 6,849,298,437.08	TZS 7,191,763,358.94
	4.1.3 Create awareness on production/cultivation of micronutrient-rich foods in schools	TZS 0.00	TZS 2,087,393,175.00	TZS 2,191,762,833.75	TZS 2,301,350,975.44
	4.1.4 Conduct quarterly supportive supervisions gardening and small animal – keeping programmes in schools	TZS 0.00	TZS 132,704,051.35	TZS 139,339,253.92	TZS 146,306,216.61
	4.1.5 Provide farm inputs and extension service support to prioritized schools implementing gardening programmes	*[this is included in 4.1.1]*			
4.2 Promote nutritional education and counselling for in-school and out-of-school adolescents	*4.2.1* Establish and identify platforms to conduct nutritional education and counselling to adolescents	TZS 0.00	TZS 69,016,500.00	TZS 0.00	TZS 0.00
	4.2.2 Review and update guidelines for conducting nutritional education and counselling	TZS 0.00	TZS 69,016,500.00	TZS 0.00	TZS 0.00
	4.2.3 Train adolescents on nutrition, healthy eating, and lifestyle through school-based programmes, youth, and peer clubs	TZS 0.00	TZS 3,911,899,214.70	TZS 6,845,823,625.73	TZS 2,875,245,922.81
	4.2.4 Create public awareness on healthy diets, including consumption of iron-rich foods, and lifestyle behaviours among adolescents through mass media, campaigns, and clubs	TZS 0.00	TZS 47,994,632,052.85	TZS 50,394,363,655.50	TZS 52,914,081,838.27
	4.2.5 Promote consumption of locally available and culturally acceptable diversified foods	TZS 0.00	TZS 195,369,853.38	TZS 123,083,007.63	TZS 86,158,105.34
	4.2.6 Establish community demonstration plots for micronutrient-rich foods through engaging agricultural extension officers in community settings	TZS 0.00	TZS 164,553,023.68	TZS 103,668,404.92	TZS 72,567,883.44
	4.2.7 Leverage on existing clubs for in-school and out-of-school adolescents to create food recipes using locally available foods through cooking demonstrations and competitions	TZS 0.00	TZS 99,417,451.80	TZS 62,632,994.64	TZS 43,843,096.25

INTERVENTION	ACTIVITY	FY 2021/22	FY 2022/23	FY 2023/24	FY 2024/25
	4.2.8 Promote physical activities for adolescent boys and girls in and out of school	TZS 245,748,243.24	TZS 258,035,655.41	TZS 270,937,438.18	TZS 284,484,310.08
4.3 Scale Weekly Iron Folic Acid Supplementation (WIFAS) to adolescent girls	***4.3.1*** Design models for WIFAS implementation	TZS 822,765,118.38	TZS 0.00	TZS 0.00	TZS 0.00
	4.3.2 Orient primary and secondary schoolteachers, CHWs, CDOs, and other community mobilizers on the designed WIFAS model for implementation	TZS 1,755,456,936.65	TZS 0.00	TZS 0.00	TZS 0.00
	4.3.3 Conduct public awareness campaigns on the importance of the WIFAS, while providing community-wide nutritional education and counselling	TZS 266,812,378.38	TZS 280,152,997.30	TZS 294,160,647.16	TZS 308,868,679.52
	4.3.4 Distribute the IFA supplements to adolescent girls through identified locations				
	4.3.4a Review and adopt existing training materials on WIFAS and nutritional education and counselling	TZS 0.00	TZS 2,646,000.00	TZS 2,778,300.00	TZS 2,917,215.00
	4.3.4b Develop and print behaviour change communication (BCC) materials for WIFAS and nutritional education and counselling	TZS 10,500,000.00	TZS 0.00	TZS 0.00	TZS 0.00
	4.3.4c Train community mobilizers	TZS 1,089,612,603.65			
	4.3.4d Engage out-of-school adolescents through CHWs and peers	TZS 63,192,405.41	TZS 0.00	TZS 69,669,626.96	TZS 0.00
	4.3.4e Bulk procure and distribute IFA supplements (for in and out-of-school)	TZS 2,697,617,667.29	TZS 2,832,498,550.65	TZS 2,974,123,478.18	TZS 3,122,829,652.09
	4.3.4f Support IFA administrators to provide IFA supplements to out-of-school adolescents	TZS 505,539,243.24	TZS 530,816,205.41	TZS 557,357,015.68	TZS 585,224,866.46

PILLAR 5: KEEPING BOYS AND GIRLS IN SCHOOL

INTERVENTION	ACTIVITY	FY 2021/22	FY 2022/23	FY 2023/24	FY 2024/25
5.1 Improve teaching and learning environment in primary and secondary schools	***5.1.1*** Construct and rehabilitate 670 classrooms in primary and secondary schools (at least 7 per council)	TZS 0.00	TZS 1,404,977,813,513.51	TZS 1,475,226,704,189.19	TZS 1,548,988,039,398.65
	5.1.2 Provide teaching and learning materials.	TZS 1,672,592,635,135.14	TZS 1,756,222,266,891.89	TZS 1,844,033,380,236.49	TZS 1,936,235,049,248.31
	5.1.3 Construct or rehabilitate 201 hostels or dormitories (at least two per council) in public and private secondary schools for adolescent girls and boys	TZS 52,660,338,048.48	TZS 55,293,354,950.90	TZS 58,058,022,698.45	TZS 60,960,923,833.37
5.2 Improve WASH infrastructure in schools with a strong focus on MHM and national hygiene campaigns	***5.2.1*** Train District Home Economic Education Officers (DHEEO) and or Health Workers to train teachers (male and female) on Menstrual Hygiene Management in schools	TZS 0.00	TZS 82,829,445.39	TZS 86,970,917.65	TZS 91,319,463.54
	5.2.2 Construct and rehabilitate 402 (at least four per council) WASH facilities (gender-separated and accessible child-friendly toilets with MHM facilities, water supply systems, and hand-washing facilities) in schools aligned to national school WASH guidelines; deliver training and workshops to change hygiene behaviour at schools; and develop school-level WASH Committees to manage the facilities	TZS 35,106,892,313.17	TZS 36,862,236,928.83	TZS 38,705,348,775.28	TZS 40,640,616,214.04
	5.2.3 Conduct capacity building of institutions (District WASH teams and school management committees) on good governance for appropriate planning, implementation, monitoring, and maintenance of WASH services in selected schools	TZS 1,087,611,510.81	TZS 1,087,611,510.81	TZS 1,087,611,510.81	TZS 1,087,611,510.81
	5.2.4 Conduct campaigns in schools to promote hand-washing and MHM	TZS 1,123,420,540.54	TZS 1,179,591,567.57	TZS 1,238,571,145.95	

	5.2.5 Strengthen the WASH focus of the EMIS, ensuring that the necessary SWASH survey questionnaire responses are integrated into quarterly surveys conducted by NBS and BEMIS	TZS 0.00	TZS 18,191,250.00	TZS 19,100,812.50	TZS 0.00
	5.2.6 Create enabling environment for local industries to produce affordable sanitary pads	TZS 0.00	TZS 3,493,391,025.60	TZS 3,668,060,576.88	TZS 1,925,731,802.86
	5.2.7 Sensitize and engage communities in constructing new schools with WASH facilities	TZS 266,812,378.38	TZS 280,152,997.30	TZS 294,160,647.16	TZS 308,868,679.52
5.3 Support and strengthen the IAE and PO-RALG to implement IPOSA with an emphasis on providing formal schooling opportunities through PPTCs and FDCs	***5.3.1*** Conduct a baseline study for the IPOSA	TZS 157,500,000.00	TZS 0.00	TZS 0.00	TZS 0.00
	5.3.2 Develop and implement short, competency-based courses for PPTCs certified by the National Examinations Council of Tanzania (NECTA)	TZS 240,660,000.00	TZS 0.00	TZS 0.00	TZS 0.00
	5.3.3 Refurbish PPTCs to effectively deliver vocational and formal school education for out-of-school adolescents in locations of greatest need	TZS 0.00	TZS 2,211,734,189.19	TZS 3,870,534,831.08	TZS 1,625,624,629.05
	5.3.4 Refurbish and construct eight Zonal Centres to effectively deliver vocational, entrepreneurship and formal school education for AGYW and their children	TZS 0.00	TZS 51,962,400.00	TZS 89,288,724.00	TZS 36,822,669.78
	5.3.5 Implement voucher scheme for AGYW who attend Zonal Centres	TZS 0.00	TZS 79,380,000.00	TZS 83,349,000.00	TZS 87,516,450.00
	5.3.6 Provide one free exam re-sit for students who dropped out and want to write their O-level core courses at a PPTCs, Zonal Centres, FDCs, or Vocational Education and Training Authority (VETA) centres	TZS 0.00	TZS 3,686,223,648.65	TZS 3,870,534,831.08	TZS 4,064,061,572.64
	5.3.7 Conduct annual career days in partnership with private sector players once a year for students to identify work opportunities post qualification	TZS 0.00	TZS 0.00	TZS 3,522,186,696.28	TZS 3,698,296,031.10
5.4 Strengthen parental role in adolescents' education	***5.4.1*** Build the capacity of Parent-Teacher Associations in following up on in-school adolescents' learning	TZS 0.00	TZS 1,447,031.25	TZS 911,629.69	TZS 638,140.78
	5.4.2 Conduct campaigns in communities to promote parents and community's involvement in adolescents' learning	TZS 0.00	TZS 878,943,166.78	TZS 1,538,150,541.87	TZS 646,023,227.59

PILLAR 6: DEVELOPING SKILLS FOR MEANINGFUL ECONOMIC OPPORTUNITIES

INTERVENTION	ACTIVITY	FY 2021/22	FY 2022/23	FY 2023/24	FY 2024/25
6.1 Strengthen VETA and PPTC soft skills programmes in partnership with private sector	***6.1.1*** Assess VETA centres and PPTCs to determine the current soft/life skills curricula available	TZS 114,405,273.97	TZS 0.00	TZS 0.00	TZS 0.00
	6.1.2 Conduct annual labour force surveys/assessment in collaboration with PO-RALG to understand the vocational skills demanded and complementary soft skills required	TZS 0.00	TZS 107,689,337.67	TZS 0.00	TZS 118,727,494.78
	6.1.3 Assess soft skills demand with private sector actors annually to inform programme curricula	TZS 0.00	TZS 55,125,000.00	TZS 0.00	TZS 60,775,312.50
	6.1.4 Conduct national career services drives in VETAs and PPTCs to improve employment outcomes for final-year VETA graduates	TZS 0.00	TZS 0.00	TZS 1,683,682,651.52	TZS 1,767,866,784.10
	6.1.5 Identify and train educators in VETAs selected to pilot the soft skills programme	TZS 0.00	TZS 165,658,890.77	TZS 0.00	TZS 182,638,927.07
6.2 Strengthen the 'Stadi za Kazi' subject in primary schools and expand to secondary schools to holistically	***6.2.1*** Educate school management, parents, and the community on the significance of this subject	TZS 9,829,929,729.73	TZS 10,321,426,216.22	TZS 0.00	TZS 0.00
	6.2.2 Training teachers on 'Stadi za Kazi' extracurricular programme in primary and secondary schools to comprehensively address adolescent health, soft skills for employment, and wellbeing	TZS 0.00	TZS 33,131,778,154.05	TZS 34,788,367,061.76	TZS 36,527,785,414.84

address adolescent health and wellbeing and soft skills for employment	***6.2.3*** Select teachers to train and head the 'Stadi za Kazi subject' in schools, and train them in using the life skills manual and/or addressing the stigmatization of adolescent issues, assessing the assessment of the delivery of the life skills programme, annually assessing student performance, and in reporting final school-level outcomes to Ward Executive Officers (WEO), DEOs, CHWs, and the MoHCDGEC	TZS 0.00	TZS 0.00	TZS 17,394,183,530.88	TZS 18,263,892,707.42
	6.2.4 Provide life skills training with seed money or start-up capital for adolescents to initiate entrepreneurial activities	TZS 2,721,285,810.81	TZS 2,857,350,101.35	TZS 3,000,217,606.42	TZS 3,150,228,486.74

CROSS-CUTTING PILLAR

INTERVENTION	ACTIVITY	FY 2021/22	FY 2022/23	FY 2023/24	FY 2024/25
7.1 Behavioural/Structural: Expand access and improve quality of adolescent-friendly comprehensive services	***7.1.1*** Conduct orientation on adolescent-friendly services to members of the Regional Health Monitoring Team (RHMT) and Council Health Management Teams (CHMT), facility staff (including guards), gender desk workers, and SWOs	TZS 84,256,540.54	TZS 84,256,540.54	TZS 84,256,540.54	TZS 84,256,540.54
	7.1.2 Train healthcare workers on AFHS as per the national SRH services provision standards	TZS 263,301,689.19	TZS 276,466,773.65	TZS 580,580,224.66	TZS 0.00
	7.1.3 Perform random check-ins on healthcare workers' service provision and behaviours towards adolescents	TZS 421,282,702.70	TZS 442,346,837.84	TZS 464,464,179.73	TZS 487,687,388.72
	7.1.4 Integrate adolescent-friendly comprehensive SRH services into the existing facility star rating national programme for clients to indicate service quality, supporting supervision needs	TZS 180,180,000.00	TZS 0.00	TZS 0.00	TZS 0.00
	7.1.5 Develop a facility feedback mechanism where adolescents can rate the facilities' service quality regularly by short message service (SMS) every time after a visit	TZS 901,800,900.00	TZS 946,890,945.00	TZS 0.00	TZS 0.00
	7.1.6 Advocate for the inclusion of an adolescent health programme in supervision and council budgets	TZS 7,021,378,378.38	TZS 0.00	TZS 0.00	TZS 0.00
	7.1.7 Advocate for specific adolescent-friendly days/hours at health facilities in pilot regions	TZS 7,021,378,378.38	TZS 0.00	TZS 0.00	TZS 0.00
	7.1.8 Renovate 12 health facilities per district to ensure friendliness, privacy, and confidentiality (e.g. creating signboards of youth-friendly messages, holding wellbeing events regularly, and establishing an adolescent-friendly information desk at every health facility)	TZS 0.00-	TZS 8,846,936,756.76	TZS 9,289,283,594.59	TZS 0.00-
	7.1.9 Set up community-based mobile clinics (as an alternative to health facilities), operated by young workers, where adolescents can access services freely	TZS 0.00	TZS 36,862,236,486.49	TZS 38,705,348,310.81	TZS 0.00
	7.1.10 Integrate AFHS into antenatal care (ANC), postnatal care (PNC), and newborn care services (e.g. train midwives to attend to adolescent mothers in a friendly, non-judgemental way and conduct training programmes on ANC, PNC, and newborn care for adolescents	TZS 0.00	TZS 63,096,072.80	TZS 66,250,876.43	TZS 69,563,420.26
	7.1.11 Sensitize the community to support adolescents with special needs	TZS 0.00	TZS 280,152,997.30	TZS 294,160,647.16	TZS 308,868,679.52
7.2 Offer cash transfers for in-school and out-of-school adolescents from disadvantaged communities	***7.2.1*** Fundraise for CCTs	TZS 2,205,000.00	TZS 0.00	TZS 0.00	TZS 0.00
	7.2.2 Identify and register programme participants	[Costs included in 7.2.1 above]			
	7.2.3 Determine product conditions, structure, and disbursement with the MoEST, PO-RALG, TASAF, and the MoHCDGEC	[Costs included in 7.2.1 above]			
	7.2.4 Market the CCTs to community stakeholders (parents, headmasters, and DEOs) and educate stakeholders on the intended outcomes	TZS 0.00	TZS 1,201,708,909.46	TZS 0.00	TZS 0.00
	7.2.5 Disburse CCTs to in-school and out-of-school adolescents	TZS 0.00	TZS 3,317,601,283.78	TZS 3,483,481,347.97	TZS 3,657,655,415.37

ANNEX 9: DATA AND M&E FRAMEWORK

DATA AND M&E RESULTS FRAMEWORK MATRIX

The Results Framework Matrix contains information on result areas at an impact (pillar) and outcome (intervention) level. This framework can act as a draft for M&E experts to further develop on a pillar, intervention, and activity (activity output is not included here as activities are not defined as part of a programme yet) level at the beginning of implementation).

FIGURE 29: PILLAR 1 – PREVENTING HIV RESULTS FRAMEWORK MATRIX

Pillar 1	Indicator Type	Indicator	Indicator Definition	Baseline	Target	Data Source	Frequency	Responsibility	Reporting
Pillar 1 Preventing HIV – Lower HIV incidence rates for adolescents aged 10 – 19 years	Impact	HIV incidence rate among adolescents aged 10 – 19 years	Number of adolescents aged 15 – 19 who are newly infected with HIV/number of adolescents aged 15 – 19 years	TBD[109] at the start of the implementation phase	Reduce new infections by 50% by 2022 (HSHSP IV 2017 – 2022)	TBD at the start of implementation phase	Annually	NBS	TACAIDS / MoHCDGEC
Intervention 1.1 [Aged 15 – 19] Biomedical: Increase access to community-based HIV testing and relevant linkages to prevention and care for 1) adolescent boys and girls 2) male partners of AGYW	Outcome	Percentage of 1) adolescent boys and girls aged 15 – 19 years and 2) male partners of AGYW tested for HIV in a community setting and linked to services	Number of 1) and 2) tested in a community setting/number of 1) and 2); Number of 1) and 2) linked to services/number of 1) and 2)	TBD at the start of the implementation phase	Testing: TBD at the start of implementation phase Linked to services: If tested negative – TBD at the start of implementation; If tested positive – 100% of those who tested positives are linked to services by 2022 (HSHSP IV 2017 – 2022)	TBD at the start of implementation phase	Annually	MoHCDGEC	MoHCDGEC

[109] TBD is defined as to be determined

Pillar 1	Indicator Type	Indicator	Indicator Definition	Baseline	Target	Data Source	Frequency	Responsibility	Reporting
Intervention 1.2 [Aged 15 – 19] Biomedical/Behavioural: Empower adolescent boys and girls and male partners of AGYW to proactively use protective measures against infection of HIV	Outcome	Percentage of girls and boys aged 15 – 19 using condoms during last sex	Number of girls and boys aged 15 – 19 using condoms/number of girls and boys aged 15 – 19 during last sex	TBD at the start of the implementation phase	Girls and boys aged 15 – 19 years: 85% by 2022[110] (HSHSP IV 2017 – 2022)	Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS)	Annually	NBS	TACAIDS/ MoHCDGEC
Intervention 1.3 [Aged 10 – 19] Biomedical: Promote access and uptake of VMMC to adolescent boys and male partners of AGYW	Outcome	Percentage of adolescent boys aged 10 – 19 years and male partners of AGYW that has practised VMMC	Number of adolescent boys aged 10 – 19 years and male partners of AGYW that have practised VMMC/number of adolescent boys aged 10 – 19 years and male partners of AGYW	TBD at the start of the implementation phase	90% by 2022[111] (HSHSP IV 2017 – 2022)	TBD at the start of implementation phase	Annually	MoHCDGEC/NACP	MoHCDGEC

[110] Assuming that the target of 85% of women and men engaged in multiple sexual partnerships reporting use of condom at last sexual intercourse applies to women and men aged 15–24 years

[111] Assuming that the target of 90% male circumcision attained by all regions applies to men aged 10–19 years and male partners of AGYW

FIGURE 30: PILLAR 2 – PREVENTING TEENAGE PREGNANCIES RESULTS FRAMEWORK MATRIX

Pillar 2	Indicator Type	Indicator	Indicator Definition	Baseline	Target	Data Source	Frequency	Responsibility	Reporting
Pillar 2 Preventing Teenage Pregnancies – Lower the rate of pregnancies among teenage girls aged 10 – 19 years	Impact	Teenage child bearing rate among adolescents aged 10 – 19 years	Percentage of women age 15-19 who have given birth or are pregnant with their first child	TBD at the start of the implementation phase	Reduce teenage pregnancy from 27% to 5% by 2022[112]	TDHS	TBD at the start of implementation phase	NBs/ MoHCDGEC	MoHCDGEC
Intervention 2.1 [Aged 10 – 19]: Expand access to comprehensive information of SRH through innovative programmes and revision of in-school and out-of-school SRH curricula	Outcome	Percentage of adolescent boys and girls aged 10 – 19 years reached with comprehensive[113] information of SRH	Number of adolescents aged 10 – 19 years reached with comprehensive information of SRH/number of adolescents aged 10 – 19 years	TBD at the start of the implementation phase	TBD at the start of implementation phase	TBD at the start of implementation phase	Annually	MoHCDGEC TBD at the start of implementation phase	MoHCDGEC TBD at the start of implementation phase
Intervention 2.2 [Aged 15 – 19]: Expand access and promote use of evidence-based methods for teenage pregnancy prevention to community-based settings	Outcome	Modern contraceptive prevalence rate among women aged 10 – 19 years who are sexually active	Number of women aged 10 – 19 years who are currently using at least one method of contraception/number of women aged 10 – 19 years who are sexually active	30.2% for all women and 35.7% for married women aged 15 – 49 years (2018) (Tanzania National Family Planning Costed Implementation Plan)	40% for all women and 47% for married women aged 10 – 19 years by 2023;[114] to be updated at the start of implementation phase for 2022 targets (Tanzania National Family Planning Costed Implementation Plan)	TDHS	TBD at the start of implementation phase	NBS/ MoHCDGEC	MoHCDGEC

[112] Government of Tanzania, National Plan of Action to end Violence Against Women and Children 2017/18 – 2021/22, 2018

[113] 'Comprehensive' will be defined at the start of the implementation phase

[114] Assuming that the targets of mCPR for women aged 15–49 years applies to women aged 10–19 years

FIGURE 31: PILLAR 3 – PREVENTING PHYSICAL, SEXUAL AND EMOTIONAL VIOLENCE RESULTS FRAMEWORK MATRIX

Pillar 3	Indicator Type	Indicator	Indicator Definition	Baseline	Target	Data Source	Frequency	Responsibility	Reporting
Pillar 3 Preventing Physical, Sexual, and Emotional Violence – Reduce violence against adolescent girls and boys	Impact	Percentage of adolescents aged 10 – 19 who experienced any incidents of physical violence in the past 12 months preceding the survey	Number of adolescents aged 10 – 19 who experienced any incidents of physical violence in the past 12 months/number of adolescents aged 10 – 19	TBD at the start of implementation phase	TBD at the start of implementation phase	CPMIS	Annually over 4 years	District officials	MoHCDGEC
		Percentage of adolescents aged 10 – 19 who experienced any incidents of sexual violence in the past 12 months preceding the survey	Number of adolescents aged 10 – 19 who experienced any incidents of sexual violence in the past 12 months/number of adolescents aged 10 – 19	TBD at the start of implementation phase	TBD at the start of implementation phase	CPMIS	Annually over 4 years	District officials	MoHCDGEC
		Percentage of adolescents aged 10 – 19 who experienced any incidents of emotional violence in the past 12 months preceding the survey	Number of adolescents aged 10 – 19 who experienced any incidents of emotional violence in the past 12 months/number of adolescents aged 10 – 19	TBD at the start of implementation phase	TBD at the start of implementation phase	CPMIS	Annually over 4 years	District officials	MoHCDGEC

Pillar 3	Indicator Type	Indicator	Indicator Definition	Baseline	Target	Data Source	Frequency	Responsibility	Reporting
Intervention 3.1 [Aged 10 – 19] Scale and strengthen peer support groups to increase awareness on what constitutes as violence and to serve as platform for peer-to-peer support	Outcome	Percentage of adolescents aged 10 – 19 surveyed that demonstrate appropriate awareness on and understanding of violence and their rights	Number of adolescents aged 10 – 19 surveyed that demonstrate appropriate awareness on and understanding of violence and their rights/number of adolescents aged 10 – 19 surveyed	TBD at the start of implementation phase	TBD at the start of implementation phase	Survey	Annually over 4 years	TBD at the start of implementation phase	TBD at the start of implementation phase
		Percentage distribution of adolescents aged 10 – 19 who have ever experienced any form of violence and sought help from either formal or informal channels	Number of adolescents aged 10 – 19 who have experienced any form of violence and sought help from either formal or informal channels /number of adolescents aged 10 – 19 surveyed that have experienced any form of violence	TBD at the start of implementation phase	TBD at the start of implementation phase	Survey	Annually over 4 years	TBD at the start of implementation phase	TBD at the start of implementation phase
Intervention 3.2 [Aged 10 – 19] Strengthen the protection systems to increase awareness on violence and to improve response and support services	Outcome	Percentage of frontline workers surveyed that demonstrate appropriate knowledge and skills on adolescent protection according to national standards	Number of frontline workers surveyed that demonstrate appropriate knowledge and skills on adolescent protection according to national standards/number of frontline workers surveyed	TBD at the start of implementation phase	TBD at the start of implementation phase	Frontline workers survey	Annually over 4 years	TBD at the start of implementation phase	MoHCDGEC
		Percentage of individuals surveyed that demonstrate appropriate awareness on and understanding of adolescent protection	Number of individuals surveyed that demonstrate appropriate awareness on and understanding of adolescent protection/number of individuals surveyed	TBD at the start of implementation phase	TBD at the start of implementation phase	Survey	Annually over 4 years	District officials	MoHCDGEC

Figure 32: Pillar 4 – Improving Nutrition Results Framework Matrix

Pillar 4	Indicator Type	Indicator	Indicator Definition	Baseline	Target	Data Source	Frequency	Responsibility	Reporting
Pillar 4 Improving Nutrition – Reduce prevalence of anaemia among adolescent girls	Impact	Percentage of adolescent girls aged 10 – 19 with any form of anaemia	Number of adolescent girls aged 10 – 19 who have any form of anaemia/number of adolescent girls surveyed aged 10 – 19	TBD at the start of implementation phase	< 20% (Acceptable levels according to WHO guidelines[115])	Survey	Annually over 4 years	TBD at the start of implementation phase	TBD at the start of implementation phase
Intervention 4.1 [Aged 10 – 19] Promote, establish, and strengthen school gardening programmes for micronutrient-rich foods	Outcome	Percentage of Schools with established school gardening programmes	Number of schools with established school gardening programmes /number of Schools per LGA	TBD at the start of implementation phase	TBD at the start of implementation phase	Survey	Annually over 4 years	TBD at the start of implementation phase	TBD at the start of implementation phase
Intervention 4.2 [Aged 10 – 19] Promote nutritional education and counselling for in-school and out-of-school adolescents	Outcome	Percentage of Adolescents who have received nutritional education and counselling in the past 12 months	Number of adolescents who have received nutritional education and counselling in the past 12 months/number of adolescents surveyed	TBD at the start of implementation phase	TBD at the start of implementation phase	Survey	Annually over 4 years	TBD at the start of implementation phase	TBD at the start of implementation phase
Intervention 4.3 [Aged 10 – 19] Scale Weekly Iron Folic Acid Supplementation (WIFAS) for adolescent girls	Outcome	Number of adolescent girls aged 10 – 19 who have received at least 24 IFA supplements in the past 12 months	Number of adolescent girls aged 10 – 19 who have received at least 24 IFA supplements in the past 12 months	TBD at the start of implementation phase	TBD at the start of implementation phase	Tally sheets[116]	Annually over 4 years	IFA Recorder	TBD at the start of implementation phase

[115] http://www.who.int/nutrition/publications/en/ida_assessment_prevention_control.pdf
[116] WHO lays down guidelines for administering IFA pills: a recorder must be present, and they must record the number of pills taken weekly on tally sheets. Aggregating the tally sheets would determine the total number of pills taken by an adolescent

Figure 33: Pillar 5 – Keeping Boys and Girls in School Results Framework Matrix

Pillar 5	Indicator Type	Indicator	Indicator Definition	Baseline	Target	Data Source	Frequency	Responsibility	Reporting
Pillar 5 Keeping Boys and Girls in School – Lower school dropout rates	Impact	School dropout rates	Percentage of students from a cohort enrolled in a given grade in one year who are no longer enrolled in the following school year	TBD at the start of implementation phase)	To be defined by the Ministry of Education	BEST, 2017	Annual	BEMIS	MoEST
Intervention 5.1 [Aged 10 – 19] Improve teaching and learning environment in primary and secondary schools	Outcome	Percentage of schools with built/rehabilitated classrooms	Number of schools with built/rehabilitated classrooms in LGA/total number of schools in the LGA	TBD at the start of implementation phase	To be defined by the Ministry of Education	TBD	Annual	BEMIS	MoEST
Intervention 5.2 [Aged 10 – 19]: Improve WASH infrastructure in schools with a strong focus on MHM and national hygiene campaigns	Outcome	Truancy rate	Number of students who have not attended a day of school without credible reason	TBD at the start of implementation phase)	TBD at the start of implementation phase	BEST, 2017	Annual	BEMIS	MoEST
Intervention 5.3 [Aged 10 – 19]: Support and strengthen the IAE and PO-RALG to implement the IPOSA with an emphasis on providing formal schooling opportunities through PPTCs for adolescents aged 14 – 19	Outcome	Gross enrolment ratio	Percentage of students aged 14 – 17 who are enrolled in Form 1 to 4 in relation to the total in the country that qualify to be enrolled	TBD at the start of implementation phase	TBD at the start of implementation phase	BEST, 2017	Annual	BEMIS	MoEST
Intervention 5.4 [Aged 10 - 19]: Strengthen parental role in adolescents' education	Outcome	Improved parents' participation in adolescents' education	Number of parents reached with parenting educational programmes in past 12 months	TBD at the start of implementation phase	TBD at the start of implementation phase	BEST, 2017	Annual	BEMIS	MoEST

Figure 34: Pillar 6 – Developing Skills for Meaningful Economic Opportunities Results Framework Matrix

Pillar 6	Indicator Type	Indicator	Indicator Definition	Baseline	Target	Data Source	Frequency	Responsibility	Reporting
Pillar 6 Developing Skills for Meaningful Economic Opportunities – Improve skills among young adults for greater access to employment and/or future entrepreneurial activities	Impact	Improved soft and life skills[117] training programmes nationally	Percentage of education facilities with teaching curriculum approved life and soft skills programmes for 10 to 19- year olds	TBD at the start of implementation phase	70% of schools (NPA-VAWC)	BEST	Every two years	BEMIS	MoEST
Intervention 6.1 [Aged 10 – 19]: Strengthen VETA and PPTC soft skills programmes in partnership with private sector	Outcome	Improved soft and life skills training programmes nationally	Percentage of education facilities with teaching curriculum approved life and soft skills programmes for 10 to 19- year olds	TBD at the start of implementation phase	70% of VETA and PPTCs (based on NPA-VAWC target)	BEST	Every two years	BEMIS	MoEST
Intervention 6.2 [Aged 10 – 19]: Strengthen the 'Stadi za Kazi' subject in primary schools and expand to secondary schools to holistically address adolescent health and wellbeing and soft skills for employment	Outcome	Improved soft and life skills training programmes nationally	Percentage of education facilities with teaching curriculum approved life and soft skills programmes for 10 to 19, year olds	TBD at the start of implementation phase	70% of schools (based on NPA-VAWC target)	BEST	Every two years	BEMIS	MoEST

FIGURE 35: CROSS-CUTTING RESULTS FRAMEWORK MATRIX

Cross-cutting Intervention	Indicator Type	Indicator	Indicator Definition	Baseline	Target	Data Source	Frequency	Responsibility	Reporting
Intervention 7.1 [Aged 10 – 24] Behavioural/Structural: Expand access and improve quality of 'adolescent-friendly comprehensive services'	Outcome	Percentage of health facilities providing adolescent-friendly[118] reproductive health services	Number of health facilities providing adolescent-friendly reproductive health services/number of health facilities	TBD at the start of implementation phase	80% by 2020; to be updated at the start of implementation phase for 2022 target (Tanzania National Family Planning Costed Implementation Plan)	TBD at the start of implementation phase	TBD at the start of implementation phase	TBD at the start of implementation phase	TBD at the start of implementation phase
Intervention 7.2 [Aged 10 – 24]: Offer cash transfers for in-school and out-of-school students from disadvantaged communities	Outcome	To be defined when the terms of the conditional cash transfer are agreed upon	To be defined when the terms of the conditional cash transfer are agreed upon	To be defined when the terms of the conditional cash transfer are agreed upon	To be defined when the terms of the conditional cash transfer are agreed upon	TBD at the start of implementation phase	Annual over four years	TASAF	MoHCDGEC, MoEST, PMO-LYED

[117] Soft skills include subject knowledge and competence, effective communication, general knowledge, and commercial awareness, investigative and analytical skills, initiative/self-motivation, drive/grit, planning and organizing, flexibility, and time management (Business Education Journal, 'Factors contributing to lack of employable skills among technical and vocational education (TVET) graduates in Tanzania', 2016)

[118] 'Adolescent-friendly' services are accessible, acceptable, equitable, appropriate, and effective for different adolescent subpopulations (WHO)

ANNEX 10: M&E ACTIVITIES AND FUNDING

Implementing the suggested Data and M&E structure and ensuing activities will cost 4% of the total cost (TZS 768 million) at the national level and 0.4% of the cost (TZS 70 million) for one district. The key activities of the Data and M&E Section are to develop the M&E Plan and align data systems and collection tools to capture reliable, consistent, age-disaggregated data on adolescent health and wellbeing. The Section's national-level activities are to develop the M&E Plan (and develop a Results Framework Matrix, conduct baseline, midline, and endline studies, etc.); review data collection and analysis systems to identify data sources and gaps; facilitate the integration of key indicators into periodic studies and surveys; support the documentation and dissemination of data reports and best practices material; and coordinate the meetings of the National M&E Coordination Committee. The Section's district-level activities are to monitor visits to LGAs and roll out data systems and tools.

FIGURE 36: TOTAL NATIONAL DATA, M&E COSTS ACROSS FOUR YEARS

No.	Activities	Total Cost Per Year (TZS)				Total Cost per Activity (TZS)	Lead M&E Unit	Collaborating Coordinating Units
		FY 2021/22	FY 2022/23	FY 2023/24	FY 2024/25			
1	**National level:** Develop M&E plan (including M&E framework, baseline, midline, and endline studies) to facilitate monitoring and reporting	141,907,500	10,749,375	95,793,469	100,340,042	**348,790,386**	M&E Coordination Committee	MoHCDGEC, MoEST, MoFP, PMO-LYED, PO-RALG
2	**National level:** Develop/align data capturing system and data collection tools to reflect adolescent age disaggregation and capturing of reliable and consistent data for monitoring and reporting	383,250,000	-	-	-	**383,250,000**	M&E Coordination Committee	MoHCDGEC, MoEST, MoFP, PMO-LYED, PO-RALG
3	**National level:** Support documentation and dissemination of M&E products and materials, including lessons and best practices in the implementation of interventions	23,499,000	24,673,95 0	25,907,648	30,120,245	**104,200,842**	M&E Coordination Committee	MoHCDGEC, MoEST, MoFP, PMO-LYED, PO-RALG
Total National Level Cost		**548,656,500**	**35,423,325**	**121,701,116**	**130,460,287**	**836,241,228**		

FIGURE 37: TOTAL DISTRICT DATA, M&E COSTS ACROSS FOUR YEARS

No.	Activities	Total Cost Per Year (TZS)				Total Cost per Activity (TZS)	Lead M&E Unit	Collaborating Coordinating Units
		FY 2021/22	FY 2022/23	FY 2023/24	FY 2024/25			
1	Support the piloting and roll-out of the developed data systems and tools, including training	8,820,000	-	-	-	**8,820,000**	M&E Coordination Committee	MoHCDGEC, MoEST, MoFP, PMO-LYED, PO-RALG
2	Coordinate joint multisectoral monitoring	6,804,000	7,144,200	7,501,410	7,876,481	**29,326,091**	M&E Coordination	MoHCDGEC, MoEST, MoFP,

ANNEX 11: STAKEHOLDER ENGAGEMENT

Figure 39 lists the stakeholders engaged in the development of the NAIA-AHW.

FIGURE 38: STAKEHOLDERS' LIST

STAKEHOLDERS		
GOVERNMENT	**DEVELOPMENT PARTNERS**	
MoHCDGEC	Bill and Melinda Gates Foundation	ONA – LISHE YANGU
	Elizabeth Glaser Pediatrics AIDS Foundation	Feed the Future
PMO – Policy and Coordination	Jhpiego	WaterAid
	FEMINA HIP	TPSF
PMO-LYED	PACT International	ICAP
PO-RALG	Restless Development	Engender Health
MoEST	Save the Children	Marie Stopes
MoHA	Population Service International	DOYODO
MoW	Salama Foundation	AMREF
MoA	USAID	Netherlands Development Organisation, SNV
TIE	CDC – DREAMS	TAWASANET
TACAIDS	IRCPT	C-SEMA
TASAF	Danish Embassy	Benjamin Mkapa Foundation
NEEC	Pathfinder International	**UN AGENCIES**
TFNC	Nutrition International	
SIDO	SANKU	WHO
TMDA	US – PEPFAR	UNESCO
RAS – DODOMA	COUNSENUTH	UNICEF
RESEARCH INSTITUTIONS	IntraHealth	UNFPA
	TAYOA	UNAIDS
ESRF	GAIN	ILO
	UMATI	World Bank
REPOA	HAKIELIMU	IOM
	Raleigh Tanzania	UN Women

BILL & MELINDA GATES *foundation*

Dalberg