



National Accelerated Investment Agenda for Adolescent Health & Wellbeing

2019 – 2022

DAR ES SALAAM, TANZANIA

February 2019



Table of Contents

LIST OF ABBREVIATIONS AND ACRONYMS	3
LIST OF FIGURES	5
FOREWORD	7
ACKNOWLEDGEMENTS	8
EXECUTIVE SUMMARY	9
Situation Analysis.....	9
Interventions and Activities	10
Overview	10
Summary of Interventions and Activities.....	10
Enablers.....	13
A Roadmap for Activation of the agenda.....	14
PART I - SITUATION ANALYSIS	15
Rationale and Overview of the AGENDA	15
Combined Pillar Mapping	17
Existing Adolescent Programs	18
Constraints Across Demand, Supply, and Enabling Environment.....	19
PART II - DETAILED INTERVENTIONS AND SUGGESTED ACTIVITIES	22
METHODOLOGY.....	22
Pillar 1 – Preventing HIV	25
Pillar 2 – Preventing Teenage pregnancies.....	29
Pillar 3 – Preventing Pyphysical, sexual and emotional violence	32
Pillar 4 – Improving Nutrition	35
Pillar 5 – Keeping boys and girls in school	36
Pillar 6 – Developing Skills For Meaningful Economic Opportunities	39
Cross-Cutting	42
PART III - ENABLERS	45
Coordination	46
Data, monitoring and evaluation.....	49
Costing	53
PART IV - A ROADMAP FOR ACTIVATION OF AGENDA	57
Key Considerations.....	57

Next Steps	58
PART V - ANNEX	59
Regional programming analysis	59
Combined Pillar Mapping	59
Pillar 1 – Preventing HIV	60
Pillar 2 – Preventing Teenage Pregnancies.....	61
Pillar 3 – Preventing Physical, Sexual, and Emotional Violence	61
Pillar 4 – Improving Nutrition	62
Pillar 5 – Keeping Boys and Girls in School.....	63
Pillar 6 – Developing Skills for Meaningful Economic Opportunities	63
High level overview of Adolescent Programs.....	65
Emerging and Supporting Interventions	67
Pillar 1 – Preventing HIV	67
Pillar 2 – Preventing Teenage pregnancies	68
Pillar 3 – Preventing Physical, Sexual, and Emotional Violence	68
Pillar 4 – Improving Nutrition	68
Pillar 5 – Keeping Boys and Girls in School.....	68
Pillar 6 – Developing skills for meaningful economic opportunities	68
Cross-Cutting Interventions	69
Coordination Deep-dive	69
Structure and Membership	69
National Level Coordinating Units	69
Sub-National Level Coordinating Units	72
Performance Measurement	74
Defined outcomes	74
Resource Mobilization	74
Activities and Funding	74
Data, M&E Deep Dive	76
Data, M&E Results Framework Matrix.....	76
Activities and Funding	85
Stakeholder Engagement.....	86



LIST OF ABBREVIATIONS AND ACRONYMS

ADDO	Accredited Drug Dispensing Outlets
ADHD	Adolescent Health and Development
AFHS	Adolescent Friendly Health Services
AIDS	Acquired Immune Deficiency Syndrome
ARHWG	Adolescent Reproductive Health Working Group
AYAS	Adolescents and Young Adult Stakeholders Group
BCC	Behavioural Change Communication
CHMT	Council Health Management Teams
CHRAGG	Commission for Human Rights and Good Governance
CHW	Community Health Worker
CSE	Comprehensive Sexuality Education
CMAC	Council Multisectoral AIDS Committee
CSO	Civil Society Organization
CTC II	Care and Treatment Clinic II
Data, M&E	Data, Monitoring and Evaluation
DHIS2	Demographic Health Information Service – 2
DHS	Demographic and Health Survey
DED	District Executive Director
DEO	District Educational Officer
EAC	East Africa Community
EMIS	Education Management Information System
ESA	Eastern and Southern Africa
ESDP	Education Sector Development Plan
FBO	Faith-based Organization
FDC	Folk Development Colleges
GBV	Gender-Based Violence
HCD	Healthcare Delivery
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
HSHP	Health Sector HIV/AIDS Strategic Plan
IAE	Institute of Adult Education
IEC	Information, Education, and Communication
IPOSA	Integrated Program for Out-of-School Adolescents
LGA	Local Government Authority
mCPR	Modern Contraceptive Prevalence Rate
MITI	Ministry of Industry, Trade and Investment
MoA	Ministry of Agriculture
MoJCA	Ministry of Justice and Constitutional 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 & People with Disabilities
MoW	Ministry of Water
NACP	National AIDS Control Program
NCD	Non-Communicable Disease
NEEC	National Economic Empowerment Council
NGO	Non-Governmental Organization
NMNAP	National Multisectoral Nutrition Action Plan
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	President's Emergency Plan for AIDS Relief
PMO	Prime Minister's Office
PO-RALG	President's Office, Regional Administration and Local Government
PPTC	Post-Primary Training Centres
R/CCMAC	Regional/City Council Multisectoral AIDS Committee
RCHS	Reproductive and Child Health Section
RITA	Registration Insolvency and Trusteeship Agency
RMNCAH	Reproductive, Maternal, New-born, Child and Adolescent Health
SADC	Southern Africa Development Community
SBCC	Social and Behaviour Change Communication
SDG	Sustainable Development Goals
STI	Sexually Transmitted Infection
SWASH	School Water, Sanitation and Hygiene
TACAIDS	Tanzania Commission for AIDS
TASAF	Tanzania Social Action Fund
TC – SWAp	Technical Committee on Sector Wide Approaches
TDHS	Tanzania Demographics and Health Survey
TECC	Tanzania Entrepreneurship Competitiveness Centre
TFNC	Tanzania Food and Nutrition Centre
THIS	Tanzania HIV Impact Survey
TIE	Tanzania Institute of Education
TIKA	"Tiba kwa Kadi"
VAC	Violence Against Children
VEO	Village Executive Officer
VETA	Vocational Education and Training Authority
VMMC	Voluntary Medical Male Circumcision
WEO	Ward Executive Officer
WGs	Working Groups
WHO	World Health Organization
WIFAS	Weekly Iron Folic Acid Supplementation
WMAC	Ward Multisectoral AIDS Committee

LIST OF FIGURES

FIGURE 1: OVERVIEW OF SIX PILLARS	16
FIGURE 2: COMBINED ISSUE MAP FOR ALL PILLARS	17
FIGURE 3: COMBINED PROGRAMS MAP FOR ALL PILLARS	17
FIGURE 4: SUMMARY OF EXISTING ADOLESCENT PROGRAMS IN TANZANIA.....	18
FIGURE 5: OVERVIEW OF DEMAND, SUPPLY, AND ENABLING ENVIRONMENT	19
FIGURE 6: SUMMARY OF INTERVENTIONS ACROSS PILLARS	24
FIGURE 7: PROPOSED SOFT SKILLS FOR INTERVENTION 6.1.....	39
FIGURE 8: PROPOSED COORDINATION STRUCTURE.....	46
FIGURE 9: PROPOSED IMPLEMENTATION STRUCTURE	48
FIGURE 10: ILLUSTRATIVE RESULTS FRAMEWORK MATRIX.....	52
FIGURE 11: M&E DATA FLOW	53
FIGURE 12: ESTIMATED TOTAL COST ACROSS 43 DISTRICTS	55
FIGURE 13: HIGH LEVEL IMPLEMENTATION OF NAIA_AHW	57
FIGURE 14: COMBINED ISSUE MAP FOR ALL PILLARS	59
FIGURE 15: COMBINED PROGRAMS MAP FOR ALL PILLARS	59
FIGURE 16: HIV PREVALENCE AMONG ADULTS AGED 15 AND ABOVE.....	60
FIGURE 17: HIV PROGRAMMING FOR ADOLESCENT ACROSS REGIONS	60
FIGURE 18: PERCENTAGE OF WOMEN AGE 15-19 WHO HAVE BEGUN CHILDBEARING	61
FIGURE 19: SEXUAL AND REPRODUCTIVE HEALTH (SRH) PROGRAMMING ACROSS REGIONS	61
FIGURE 20: PERCENTAGE OF WOMEN WHO HAVE EXPERIENCED PHYSICAL/SEXUAL VIOLENCE IN THE PAST 12 MONTHS.....	61
FIGURE 21: VIOLENCE PREVENTION AND RESPONSE PROGRAMMING FOR ADOLESCENTS ACROSS REGIONS.....	61
FIGURE 22: PREVALENCE OF ANEMIA IN WOMEN AGED 15-49	62

FIGURE 23: ADOLESCENT NUTRITION PROGRAMMING ACROSS REGIONS	62
FIGURE 24: TOTAL MALE AND FEMALE DROPOUT RATE.....	63
FIGURE 25: PROGRAMS FOR KEEPING ADOLESCENTS IN SCHOOL ACROSS REGIONS.....	63
FIGURE 26: UNEMPLOYMENT RATES ACROSS THE REGIONS	63
FIGURE 27: ADOLESCENT SKILLS BUILDING PROGRAMMING ACROSS REGIONS.....	63
FIGURE 28: HIGH-LEVEL OVERVIEW OF EXISTING ADOLESCENT PROGRAMS IN TANZANIA	65
FIGURE 29: TOTAL COORDINATION COSTS ACROSS FOUR YEARS AT THE NATIONAL LEVEL	74
FIGURE 30: TOTAL COORDINATION COSTS ACROSS FOUR YEARS IN ONE DISTRICT.....	75
FIGURE 31: PILLAR 1 – PREVENTING HIV RESULTS FRAMEWORK MATRIX.....	76
FIGURE 32: PILLAR 2 – PREVENTING TEENAGE PREGNANCIES RESULTS FRAMEWORK MATRIX.....	78
FIGURE 33: PILLAR 3 – PREVENTING PHYSICAL, SEXUAL AND EMOTIONAL VIOLENCE RESULTS FRAMEWORK MATRIX.....	79
FIGURE 34: PILLAR 4 – IMPROVING NUTRITION RESULTS FRAMEWORK MATRIX.....	81
FIGURE 35: PILLAR 5 – KEEPING BOYS AND GIRLS IN SCHOOL RESULTS FRAMEWORK MATRIX.....	82
FIGURE 36: PILLAR 6 – DEVELOPING SKILLS FOR MEANINGFUL ECONOMIC OPPORTUNITIES RESULTS FRAMEWORK MATRIX	83
FIGURE 37: CROSS-CUTTING RESULTS FRAMEWORK MATRIX	84
FIGURE 38: TOTAL NATIONAL DATA, M&E COSTS ACROSS FOUR YEARS	85
FIGURE 39: TOTAL DISTRICT DATA, M&E COSTS ACROSS FOUR YEARS.....	85
FIGURE 40: STAKEHOLDERS LIST	86

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. The strategy focuses on adolescents as being pivotal in achieving the Sustainable Development Goals (SDGs). Within the East African Community (EAC) and Southern African Development Community (SADC) blocs, the Eastern and Southern Africa (ESA) commitments are implemented to ensure adolescents' and young people's access to youth-friendly Sexual and Reproductive Health (SRH) services in the region. This presents an opportune time for Tanzania to further build up on these global and regional commitments, and its commitment to the burgeoning adolescent population who are key to driving industrialization.

Despite this global momentum and significant evidence to argue for adolescent-specific interventions, there has been slow progress in developing such programs. Implementing adolescent-specific interventions that are at scale, multisectoral, integrated, resourced and monitored can be challenging with limited capacity. To address this, the Government, particularly Ministry of Health, Community Development, Gender, Elderly and Children, called for the development of the National Accelerated Investment Agenda for Adolescent Health and Wellbeing (NAIA_AHW 2019 – 2022). 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. It builds on the National Adolescent Health Development Strategy 2018 – 2022, 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 & Emotional Violence, Improving Nutrition, Keeping Boys & Girls in School, and Developing Meaningful Employment Opportunities. Although each pillar has a very 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 also outlines enabling interventions and an activation road map. Enablers 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 also goes beyond a national strategy and provides an activation road map to achieving 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). Development partners can support the vision of the agenda by ensuring program alignment with the prioritized activities, and by closely working 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 stakeholder.

Hon. Samia Hassan Suluhu

Vice President of the United Republic of Tanzania.

ACKNOWLEDGEMENTS

The development of the National Accelerated Investment Agenda for Adolescent Health and Wellbeing was an expansive multi-sectoral consultation process, that brought together stakeholders across government, development organizations and communities, including adolescents. I would first like to acknowledge the management team 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 team brought together government stakeholders towards an exercise of prioritizing adolescents' needs and identifying potential solutions to these challenges. In partnership with other ministries and government agencies, the management team 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 ministries and government bodies. I would like to acknowledge the significant contribution of Mr. Atupele Mwambene, the Director of Policy and Planning at MoHCDGEC – Community Development, who chaired the task force, and was instrumental in coordinating all aspects of the document development. Further acknowledgement goes to the MoHCDGEC – Community Development who coordinated workshops, meetings and interviews. 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), and the Tanzanian Institute of Education (TIE). I would also like to acknowledge the significant role played by Dalberg Advisors, who steered the development of the document, from conceptualization to the creation of an implementation roadmap.

Development stakeholders were also key in providing input and helping steer the vision of the document. The team consulted several development partners including various UN agencies, Faith-Based Organizations, Non-Governmental Organizations and civil societies. I would like to particularly acknowledge the Elizabeth Glassier Paediatrics AIDS Foundation and Population Service International for funding the initial phase of the project – the development of the National Adolescent Health Development Strategy, which laid a critical foundation in developing the NAIA_AHW. Similarly, I would like to acknowledge the UNICEF Tanzania office for additional support, not only as a thought partner, but as facilitators of a country-wide adolescent workshop and survey, in partnership with TFNC.

The Bill and Melinda Gates Foundation funded the development of the agenda. We would like to thank the foundation for their generosity in spearheading health progress in Tanzania as the country furthers its inclusive and universal health access agenda.

Hon. Ummu Mwalimu (MP)

Minister of Health, Community Development, Gender, Elderly and Children

EXECUTIVE SUMMARY

SITUATION ANALYSIS

Adolescents, aged 10-19, account for about a fourth of the total population in Tanzania, the country needs to support the growth and development of a healthy, educated and empowered adolescent population as it transitions into adulthood to ensure the demographic dividend is successfully leveraged. Tanzania Mainland has an adolescent population of about 12,439,677.¹ This large cohort presents significant potential for the country's social and economic development if the necessary investments to improve health and productivity are carried out. Evidence shows that investments in adolescent health, particularly reproductive health, can triple dividends². Specific to Tanzania, the Ministry of Finance and Planning has established that the potential demographic dividend from a combined investment approach in economics, education and family planning is USD 3,877 per capita, which is more than triple the current GDP per capita.³

The National Accelerated Investment Agenda for Adolescent Health and Wellbeing has been developed to focus the country on gaps in adolescent health and wellbeing that need to be addressed in the immediate to near term. Adolescents have not been prioritized as a unique segment of the population; while the importance of this age group has been acknowledged, the health and wellbeing of this group has received very little special attention. Youth represent the promise and potential of Tanzania's future development, so there is an unprecedented opportunity to begin addressing 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.⁴ The NAIA_AHW builds on the efforts to define the National Adolescent Health and Development Strategy (still in draft form) with a focus on developing an agenda solely focused on catalytic and accelerated action and investments to help reverse what is potentially already, or soon-to-be, a dire state for adolescents.

The NAIA_AHW anchors on six pillars, which represent issues where adolescents are disproportionately affected, and areas where interventions are limited in their specific targeting of adolescents, and/or have adolescent programs which are not at scale. The pillars also outline priority areas where investments can be made to ensure a productive cohort and ultimately productive nation. The six pillars are (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. Although each pillar has a very specific objective, they are interconnected and should be viewed as one comprehensive agenda; they should therefore not be implemented in silo. In the short to medium-term, it is the combined effect of all six pillars that will make a positive and lasting impact on adolescent health and wellbeing.


While there have been some efforts to address challenges impacting adolescent health and wellbeing, programming is timebound, limited in size and scale, and the focus is highly variable. Many programs operate within a limited time period of two to five years, and only address one or two areas. At the LGA level, there are too few efforts to bring programs together using a more comprehensive approach. Programs currently operating in Tanzania Mainland reach about a total of 3.4 million adolescents – a quarter of the adolescent population. Although the number appears substantial, the national impact is limited because each program, with different goals, targets on average, only 50,000 – 100,000 adolescents. Furthermore, most

¹ Tanzania National Bureau of Statistics (NBS)

² http://www.who.int/maternal_child_adolescent/topics/adolescence/why-invest/en/

³ Ministry of Finance and Planning, Population Dynamics and Demographic Dividend in Tanzania, 2017

⁴ http://www.who.int/maternal_child_adolescent/topics/adolescence/why-invest/en/



programming for adolescents has focused primarily on Sexual and Reproductive Health (SRH). There are only a limited number of programs which specifically address challenges in improving nutrition, preventing violence, enhancing access to education, or improving economic opportunities in this age group.

The underlying drivers of adolescent health and wellbeing are well recognized and span across demand, supply, and enabling environment; while some can be addressed in the immediate term, others are more systemic, and require long-term investment. On the demand side the combination of socio-economic and cultural factors such as low education levels, high poverty rates, discriminatory social norms, and some religious practices drive adverse behavioural outcomes among adolescents. Similarly, on the supply side, the lack of 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, while some policies are not aligned in their prioritization of adolescent development components.

INTERVENTIONS AND ACTIVITIES

OVERVIEW

The National Accelerated Investment Agenda for Adolescent Health and Wellbeing focuses on identifying priority interventions that can increase urgency and action towards improving adolescent health and wellbeing. Interventions fall across three categories; priority, supporting, and evolving/emerging. Priority interventions are those which have some momentum and have the potential for high impact in the short to medium term. While there is some work being done in these areas, there is a need to continue advancing current efforts to achieve intended objectives for adolescent health and wellbeing. Each pillar outlines the interventions, and characterizes them based on target age range, constraint addressed, intended outcome, and suggested activities to operationalize the intervention.


Supporting and emerging/evolving interventions are complementary interventions that are not the focus of the NAIA_AHW but are important in the medium to long-term. Supporting interventions are those with substantial momentum amongst several stakeholders who are implementing programs to address these issues. Some of these interventions are already achieving their intended outcomes, while others are anticipated to see outcomes in the long-term. In contrast, emerging/evolving interventions are those that are new with very limited momentum yet show some promise. Although not a focus of the NAIA_AHW, both supporting and emerging/evolving interventions are important to sustain; it is therefore essential for stakeholders to continue implementing interventions in these categories.

Both adolescent participation and stakeholder engagement were instrumental in defining the interventions. The final set of priority interventions is therefore the result of a process that incorporated input from a wide range of stakeholders in relevant government ministries and agencies, implementing partners including Non-Governmental Organizations (NGOs), and the donor community. To gather feedback and refine the interventions, we conducted various stakeholder workshops and one-on-one meetings. Furthermore, given that adolescent participation is critical to helping define issues and determining how to best reach adolescents, we leveraged various consultation mechanisms to ensure adequate adolescent participation. These mechanisms included multiple focus groups, an adolescent workshop, and online surveys to gather opinions from a diverse set of youth, including marginalized and most vulnerable groups.

SUMMARY OF INTERVENTIONS AND ACTIVITIES

The NAIA_AHW identifies interventions that are selected based on their potential to achieve the objectives of each pillar. These interventions include:


- **Pillar 1 (Preventing HIV) – increasing access to community-based HIV testing and linkages to prevention and care, empowering adolescent boys and girls, and male partners of AGYW increasing access to use protective measures against HIV/AIDS infection, and promoting access and usage of voluntary medical male circumcision (VMMC) for adolescent boys, as well as male partners of Adolescent Girls and Young Women (AGYWs).** In addition to these interventions, is the role of Social and Behaviour Change Communication (SBCC) in ensuring long-term behaviour change among adolescents and the wider community, by countering negative social norms. The strategic objective of this pillar is to reduce HIV new infections by 50% for adolescents aged 10-19 years as defined in the Health Sector HIV and AIDS Strategic Plan (HSHSP IV 2017-2022). While HIV testing does not directly prevent HIV, targeted testing increases the opportunity for action to decrease risk for those who are HIV negative and provides a link to services for those identified as positive. Reproductive health protective measures and information services are also proven to be highly effective in preventing HIV. VMMC reduces the risk of female-to-male sexual transmission of HIV by up to 70%.
- **Pillar 2 (Preventing Teenage Pregnancies) – expanding access to comprehensive Sexual and Reproductive Health (SRH) information combined with expanding access and promoting the use of evidence-based methods for teenage pregnancy prevention to community-based settings.** Cognizant of the role of parents and caregivers, the agenda also seeks to promote parenting and family care skills within the community, particularly by enhancing parents' role in the gender and sexual socialization of their children. The strategic objective of this pillar is to lower the fertility rate to 80/1000 live births by 2020 for AGYW as defined in The National Road Map Strategy Plan to Improve Reproductive, Maternal, New-born, Child & Adolescent Health in Tanzania (2016-2020) (One Plan II). Evidence, both within, and outside of Tanzania, supports the need to implement both supply and demand activities to increase the use of evidence-based methods for teenage pregnancy prevention. For example, a systemic review of five developing countries (Mali, Nigeria, Tanzania, South Africa, Vietnam) demonstrated that young women's use of modern contraceptive methods was limited due to a lack of knowledge and access, suggesting that increasing knowledge and availability can boost usage.
- **Pillar 3 (Preventing Sexual, Physical, and Psychological Violence) – scaling and strengthening peer support groups to serve as platform for peer-to-peer support, and strengthening the protection systems to increase awareness on violence and to improve response and support services.** The objective of the pillar is to reduce incidence of physical, sexual and emotional violence. At its very root, preventing violence requires a long-term change in socio-cultural norms and behaviour but in the short-term, building systems will increase reporting and also support prevention. In 2014, the prevalence of both sexual and physical violence significantly reduced, partially due to the development of child protection systems which focused on training frontline workers to effectively respond to violence. This plan therefore advocates for scaling-up such training and support. Furthermore, evidence from Arumeru, which supports peer clubs, shows the effectiveness of peer-to-peer networks, with an increase in the number of students who sought support from their peers.
- **Pillar 4 (Improving Nutrition) – scaling Weekly Iron Folic Acid Supplementation (WIFAS) to adolescent girls.** To ensure long-term sustainable change, nutritional education and counseling are central SBCC activities that will be implemented concurrent with the WIFAS intervention, to improve individual behaviours and household practices, promote collective action, and enhance the overall



enabling environment for good nutrition outcomes. The strategic objective of the intervention is to reduce iron deficiency anaemia among adolescents. According to evidence from an assessment of a WIFAS program in Gujarat India, the study showed a 21.5% reduction in the prevalence of anemia among girls and a 25% reduction among boys. The provision of nutrition education coupled with WIFAS can thus ensure that the short-term benefits can also extend to the long-term.

- **Pillar 5 (Keeping Boys and Girls in School) – improving WASH infrastructure in schools, and supporting and strengthening the Institute of Adult Education (IAE) & President’s Office – Regional Administration and Local Government (PO-RALG) to implement Integrated Program for Out of School Adolescents (IPOSA).** The strategic objective of this pillar is to lower drop-out rates in schools, building on the Education Sector Development Programme I (ESDP I). WASH is a proven mechanism to reduce absenteeism around the world with a strong focus on menstrual hygiene management (MHM) and national hygiene campaigns. In Kenya’s Nyanza province there was a reduction of 58% in girls’ absenteeism resulting from the Water Treatment and Hygiene Promotion interventions. Furthermore, there is a need to also target vulnerable populations with a focus on developing alternative education pathways. IPOSA is already underway and can be further strengthened through the agenda.
- **Pillar 6 (Developing Skills for Meaningful Economic Opportunities) – strengthening the Vocational Educational and Training Authority (VETA) and Post Primary Technical Centre (PPTC) soft skills programs and strengthening the "Stadi za Kazi" subject.** Given that the adolescent population covers ages 10-19, the strategic objective of this pillar is to improve adolescents’ readiness for employment and/or future entrepreneurial activities. Deloitte’s Access Economics forecasts in a May 2017 report that soft skill-intensive occupations will account for two-thirds of all jobs by 2030, compared to half of all jobs in 2000 globally, signifying the importance of focusing on soft skills. This pillar therefore focuses on improving soft skills for youth both in-and-out of school such as subject knowledge and competence, communication, and general knowledge & commercial awareness. The current “Stadi za Kazi” program has already launched in a few schools in Tanzania, as an initiative to improve life skills. It is low-cost and is relatively easy to strengthen and scale. VETA and PPTC soft skills programs can reach students who are out-of-school. The impact of these interventions can be extended further by ensuring that youth are equipped with critical financial literacy skills and linked to self-help groups so that they can effectively take advantage of existing financial and other business development support services.

A select number of interventions are cross-cutting with the potential to achieve objectives of more than two pillars; these are (1) expanding and improving ‘adolescent-friendly services’ and (2) offering cash transfers to cover indirect costs of schooling for in and out-of-school adolescents from disadvantaged communities. Several studies show that adolescent-friendly services are critical to increasing use of health services. Success is dependent on ensuring that services are implemented in a holistic manner, leveraging both the community and facilities, while ensuring that there is demand from adolescents themselves. While Tanzania is making some headway in increasing the provision of adolescent friendly services, there is a need to increase the scale and scope of current efforts particularly to support pillars 1, 2, and 3. Similarly, cash transfers have shown to be very successful around the world in lowering absenteeism, improving sexual reproductive health outcomes, and lowering probability of early marriage and teenage pregnancy. As of 2007, 29 developing countries had some type of conditional cash transfer program in place. For example, Malawi's Zomba Conditional Cash Transfer Program is an ongoing conditional cash transfer intervention targeting young women in Malawi that provides incentives (in the form of school fees and cash transfers) to




current schoolgirls and recent dropouts to stay in or return to school. Early results show that this program has led to significant declines in early marriage, teenage pregnancy, and self-reported sexual activity among program beneficiaries after just one year of program implementation. For program beneficiaries who were out of school at baseline, the probability of getting married and becoming pregnant declined by more than 40% and 30% respectively.

Finally, SBCC and gender-responsive programming are critical to sustaining interventions and are integrated as activities within the interventions. The quality and effectiveness of SBCC will be expanded to promote positive social and cultural norms within each pillar. For example, interventions 1.1 and 1.2 under Preventing HIV and intervention 3.2 under Preventing Sexual, Physical & Emotional violence include SBCC activities to counter negative practices. Similarly, gender will be mainstreamed into programming by considering the specific needs of men, women, girls, and boys with respect to both biological/sex differences and sociocultural gender. Evidence shows that SBCC campaigns are highly effective in countering social norms using media (e.g. radio was widely cited) and leveraging influencers (e.g. religious and community leaders) and celebrities. The effectiveness of SBCC can be extended when combined with other activities. In doing so we can ensure that the SBCC campaigns are specific, targeted, and are able to contribute to the overarching objective. Furthermore, gender-responsive programming helps to ensure that the effectiveness of the program is realized by tailoring messages to boys and girls.

ENABLERS

The success of the agenda is dependent on an optimized coordination and implementation structure to streamline and operationalize interventions. Coordination will operate both on a national and a sub-national level. While the national level focuses on country-wide efforts including coordination with the development partners, the sub-national level will focus on the region, district, ward, and village. At the national level, the Prime Minister's Office (PMO) will coordinate the National Steering Committee (NSC), the National Technical Committee (NTC), and existing working groups that map to the six pillars. The NSC will provide guidance and review implementation progress, the NTC will track progress and approve annual workplan and budget, and the working groups will focus on driving expert content. The National Secretariat will conduct day-to-day operationalization of the NAIA_AHW and will be under the co-chairmanship of the Director of Government Business from PMO – Policy and Coordination and the Director of Policy and Planning at MoHCDGEC – Community Development. At the sub-national level, PO-RALG will guide implementation of the agenda. The regional administrative secretary, the district executive director, ward executive officer, and the village executive officer will each provide technical assistance and support planning at their respective levels. Adolescent engagement will be sought through youth representation at the Council Multisectoral AIDS Committee (CMAC) for the sub-national level, and through the NTC for the national level.

A strong data, monitoring and evaluation framework and structure are also critical to continuously monitor progress. At the start of implementation phase of the agenda, data and data systems should be reviewed and adjusted to ensure adolescent age-disaggregated, reliable and consistent data is available. Monitoring of program performance will occur on an activity (output), intervention (outcome) and pillar (impact) level. An M&E Coordination Committee will be set up under the NTC and will oversee annual data collection, M&E work-planning, report on progress. Data and information will flow from village, ward, district, regional up to the national level. Primary source of data will be collected and analysed on the district and regional levels using existing government data systems such as Health Management Information System (HMIS) and Education Management Information System (EMIS). Where relevant, district and regional M&E officers will be supported by implementing partners' M&E officers to provide secondary data.



Implementing the core national elements of the NAIA_AHW over the next four years will cost an estimated TZS 12B/=. Core national elements of the agenda are those activities that require the same quantity of resources, dependent of the reach of the program. This includes activities such as reviewing national training curriculum, advocating for public-private partnerships and developing the coordinating units. The cost of the core national elements of is separated from the district-level cost to allow for model adaptability in the targeted number of districts.

On average, it is estimated that implementing programmatic activities will cost TZS 15B/= per district within the four-year period. Our analysis shows that there are 43 priority districts in 7 regions based on high-level of vulnerability to adolescent health and wellbeing and momentum of existing programming. Implementing the agenda over four years in these 43 priority districts alone will cost an estimated TZS 644B/=. The greatest costs will be incurred in year three, where it will cost an estimated TZS 207B/= due to the escalation of activities. Across the pillars, Pillar 1 requires the most resources given that it has the largest number of interventions and activities. The greatest cost driver in this pillar and the agenda overall is provision of VMMC. Finally, for nation-wide district-level implementation, the estimated cost is TZS 1.8T/=, adding TZS 1.7T/= to programmatic costs.

The costing model is useful in providing a high-level indicative costing for fundraising purposed. It is also flexible and can be adjusted to match different implementation priorities. Therefore, once these choices have been made, an additional budgeting exercise will need to be conducted during program design to supplement this model and guide implementation.

A ROADMAP FOR ACTIVATION OF THE AGENDA

To maximize the impact of the NAIA_AHW, appropriate interventions should be rolled out as a comprehensive package of services. This will ensure a holistic view of adolescent health and wellbeing by integrating services across the agenda as well as other supporting activities that help achieve the overarching vision. Rather than blindly roll-out all interventions, the program design phase 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 will ensure that the agenda is tailored to both the LGA and the population it serves. Other considerations on region of choice, adaptations to meet the needs of marginalized populations, and adolescent participation during implementation, are critical.

After the review of the agenda is complete and the action plan is approved, the following activities are necessary for effective implementation:

1. Develop the National Secretariat that will lead day-to-day operationalization and coordination
2. Conduct regional and resource mapping to confirm priority districts for implementation and determine funding needs
3. Design a comprehensive set of programs as guided by choice of regions and districts
4. Develop an operational guideline including a set of tools to support implementation
5. Design and formalize the Data, Monitoring & Evaluation system
6. Launch the approved action plan

PART I - SITUATION ANALYSIS

RATIONALE AND OVERVIEW OF THE AGENDA

Adolescents, age 10-19, are a key segment of the population in Tanzania, currently accounting for about a fourth of the total population, and continuing to grow.⁵ According to the National Bureau of Statistics, Tanzania Mainland has a population of 6,743,218 between the ages of 10-14 years and 5,696,459 between the ages of 15-19 years.⁶ At an average projected population growth of 3.1% from 2018 to 2022, Tanzania Mainland is projected to have a population of 7,370,648 between the ages of 10-14 years and 6,854,452 between the ages of 15-19 years by 2022.⁷ This large cohort presents significant potential for the country's social and economic development if the necessary investments are made now to improve their health and productivity.

Several global actors are also calling for increased investment 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) in support of the 2030 Agenda for Sustainable Development. The Global Strategy envisions a world in which every woman, child and adolescent realizes their rights to physical and mental health and wellbeing, has social and economic opportunities, and can participate fully in shaping prosperous and sustainable societies. This new strategy identifies adolescents as central to achieving the Sustainable Development Goals (SDGs) of the 2030 Agenda, including those related to poverty, hunger, education, gender equality, water and sanitation, economic growth, human settlement, climate change and peaceful and inclusive societies.⁸

Investing in adolescents also has the potential to result in growth of the economy. Tanzania aims to be a middle-income country by 2025 through industrialization; given that youth account for c.70% of the population (c.23% of total population are adolescents), this agenda will be primarily driven by youth.⁹ To achieve this goal, there is a need for Tanzania to take advantage of its demographic dividend by utilizing the youth boom to drive economic transformation. The economy's productivity is dependent on the reduction in fertility rate and child dependency burden to encourage a boost in the working-age population. Additionally, households and nations have more resources per child to invest in their health and education, thus enhancing overall human capital.¹⁰ Evidence shows that investments in adolescent health, particularly reproductive health, can triple dividends.¹¹ Similarly, for investments in education, evidence shows that a one-year increase in average tertiary education levels would eventually yield up to a 12% increase in GDP¹². Further, as evidenced by Ministry of Finance and Planning, the potential demographic dividend from a combined investment approach in economics, education and family planning is USD 3,877 per capita, which is more than triple the current GDP per capita.¹³

⁵ Tanzania Human Development Report (THDR), Economic Transformation for Human Development in Tanzania, 2014

⁶ 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

⁷ 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

⁸ http://www.who.int/maternal_child_adolescent/topics/adolescence/why-invest/en/

⁹ Tanzania Human Development Report (THDR), Economic Transformation for Human Development in Tanzania, 2014

¹⁰ Ministry of Finance and Planning, Population Dynamics and Demographic Dividend in Tanzania, 2017

¹¹ http://www.who.int/maternal_child_adolescent/topics/adolescence/why-invest/en/

¹² The Africa-America Institute, State of Education in Africa Report, 2015

¹³ Ministry of Finance and Planning, Population Dynamics and Demographic Dividend in Tanzania, 2017

The National Accelerated Investment Agenda for Adolescent Health and Wellbeing 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 prioritized as a unique segment of the population; while the importance of this age group has been acknowledged, the health and wellbeing of this group has received very little special attention. Youth represent the promise and potential of Tanzania's future development, so there is an unprecedented opportunity to begin addressing adolescent health. Globally, there is an increasing sense of urgency that something different must be done to respond more effectively to the needs of adolescents.¹⁴ The NAIA_AHW agenda outlines 'what needs to be done' to increase action for adolescents in the near to immediate term. Instead of building another long-term strategy, the agenda focuses on developing an action plan that is solely focused on catalytic and accelerated action and investments to help reverse what is potentially already, or soon-to-be, a dire state for adolescents. It builds on other relevant policy documents such as the National Health Policy 2018 (in draft), the Health Sector Strategic Plan (HSSP) 2015-2020, the One Plan II and the National Family Costed Plan that is currently being developed.

The agenda anchors on six pillars; targeting these pillars will help accelerate improvements in adolescent health and wellbeing.

The pillars also outline priority areas where investments can be made to ensure that we have a productive cohort and ultimately productive nation. The six pillars are (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.

Each of the six pillars represent areas where adolescents are disproportionately affected.

Over 98,000 adolescents¹⁵ aged 10-19 are currently living with HIV in Tanzania, and as the population grows, the incidence of HIV/AIDS is expected to increase among adolescents. Similarly, about 8,000¹⁶ girls in Tanzania drop out of school every year due to pregnancy. On violence, 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.¹⁷ While nutrition has been largely ignored, anemia disproportionately affects adolescent girls. 47% of adolescent girls aged 15-19 are anemic in Tanzania in 2015.¹⁸ Significant headway has been made on education but only 40% of Tanzanian students proceed to secondary school, and of students enrolled, 1.5 million adolescents are dropping out at lower secondary.¹⁹ Furthermore, despite

FIGURE 1: OVERVIEW OF SIX PILLARS



¹⁴ http://www.who.int/maternal_child_adolescent/topics/adolescence/why-invest/en/

¹⁵ UNICEF, HIV factsheet, 2017

¹⁶ <https://www.hrw.org/news/2017/02/14/tanzania-15-million-adolescents-not-school>

¹⁷ TACAIDS, The Adolescent Experience In-Depth: Using Data to Identify and Reach the Most Vulnerable Young People, 2014

¹⁸ Tanzania Demographic and Health Survey

¹⁹ <https://www.hrw.org/news/2017/02/14/tanzania-15-million-adolescents-not-school>

Tanzania's economy growing on average by 7% since 2016²⁰, the rate of youth unemployment has been rising steadily over the past decade and as of 2016 is at 11.5%.²¹

Tanzania's regional performance across each of the pillars is variable, with regions in the lake zone facing the highest disease burden; in contrast, programs for adolescents are primarily 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 had poor performance across most pillars. There are a few cases where the trend is inconsistent, such as the case for Njombe. When taking a wholistic view Njombe appears to be doing well, and while that is the case for most of the indicators, the situation is very different for pillar 1 (preventing HIV), where Njombe has the highest rate of HIV prevalence across the country. When looking at the spread of programs across the country, we found that programs targeting adolescents are mainly concentrated in the southern zones with regions like Iringa, Morogoro, Ruvuma and Mtwara reaching the greatest number of adolescents. In contrast, Katavi, has the least number of adolescents targeted by programs; regions like Manyara and Rukwa also reach a limited number of adolescents. The annex contains an initial mapping exercise which shows which regions experience the highest burden for each pillar based on proxy indicators.

COMBINED PILLAR MAPPING

FIGURE 2: COMBINED ISSUE MAP FOR ALL PILLARS

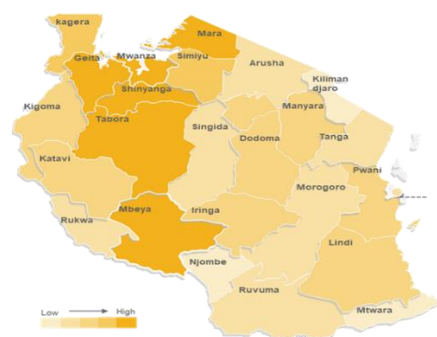
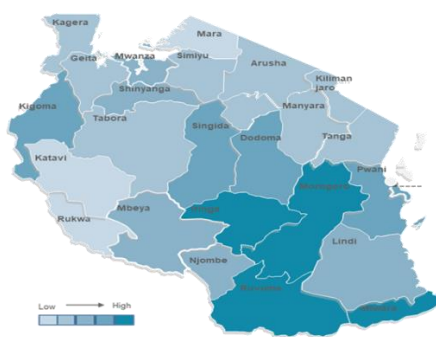


FIGURE 3: COMBINED PROGRAMS MAP FOR ALL PILLARS



Although each pillar has a very specific objective, they are interconnected and should be viewed as one comprehensive agenda, which should not be implemented in silo. In the short to medium-term, it is the combined effect of all six pillars that will make a positive and lasting impact on adolescent health and wellbeing. The potential benefits of integrated health services are well known, they 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 focusing separately on just one health problem²². While this document presents 'what needs to be done' to achieve the objective of each pillar, taking a very pillar-centric view, the next step is program design, where there is an opportunity to shift to a comprehensive view of the pillars, and leverage synergies ensuring that funding and thus programs are stretched as far as possible.

²⁰ <https://af.reuters.com/article/africaTech/idAFL5N1RI4YN>

²¹ https://www.ilo.org/addisababa/countries-covered/tanzania/WCMS_511334/lang--en/index.htm

²² WHO

EXISTING ADOLESCENT PROGRAMS

While there have been some efforts to address challenges impacting adolescent health and wellbeing, programming is limited in size and scale. We conducted a mapping exercise of adolescent programs in Tanzania, taking stock of where programs operate, how many adolescents are reached, and what each program achieves. Figure 4 gives a summary of the existing programs; the full list is found in the annex. While this provides an indicative sense of existing adolescent programs, the picture is incomplete, given that, it does not capture ongoing government programs. While recognizing the extent of government programs, capturing the impact specifically on adolescents is difficult given that most government initiatives are not adolescent-specific. In general, the adolescent segment is not a major programming focus in the country, with existing programs being very limited in number. Programs currently operating in Tanzania reach about a total of 3.4 million adolescents. Although the number is holistically substantial, the national impact is limited because each program targets, on average, only 50,000 – 100,000 adolescents. Time limits and financial restrictions constrain programs from scaling and reaching the number of targeted adolescents.

FIGURE 4: SUMMARY OF EXISTING ADOLESCENT PROGRAMS IN TANZANIA²³

Pillars	Number of Programs	Examples of Programs	Summary Description of Programs	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 Pregnancies)	8	Adolescent 360 (by PSI/ BMGF, CIFF), Tulonga Afya , Boresha Afya (by USAID/FHI360)	Promote SRH information awareness and provide access to contraceptives for adolescent girls	2013-2022	Geita, Iringa, Morogoro, Dar	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 programs with key objectives to reduce HIV and/or teenage pregnancies)	2010-2025	Kigoma, Dar, Mbeya, Mwanza	1,171,086
4 (Improving Nutrition)	7	Anemia Reduction (by UNICEF), Support to Food Security and Nutrition (by EU/Save the Children/WFP), Right Star Initiative (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	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 (programs are limited and usually focus on agriculture and out-of-school adolescents)	2013-2022	Mbeya, Iringa, Arusha, Kilimanjaro, Manyara, Mtwara, Dar	208,864

When taking a regional view, existing programs, are concentrated in Dar es Salaam, Morogoro, Iringa, and Mtwara; the focus of programs is highly variable. The choice in regions for program implementation is complicated. Various factors influence the choice including the population spread, donor interest, and existing work. The objective of the program is also an important driving factor, but in some cases, there may be several competing program objectives. Given these complexities, regions like Katavi and Rukwa, have

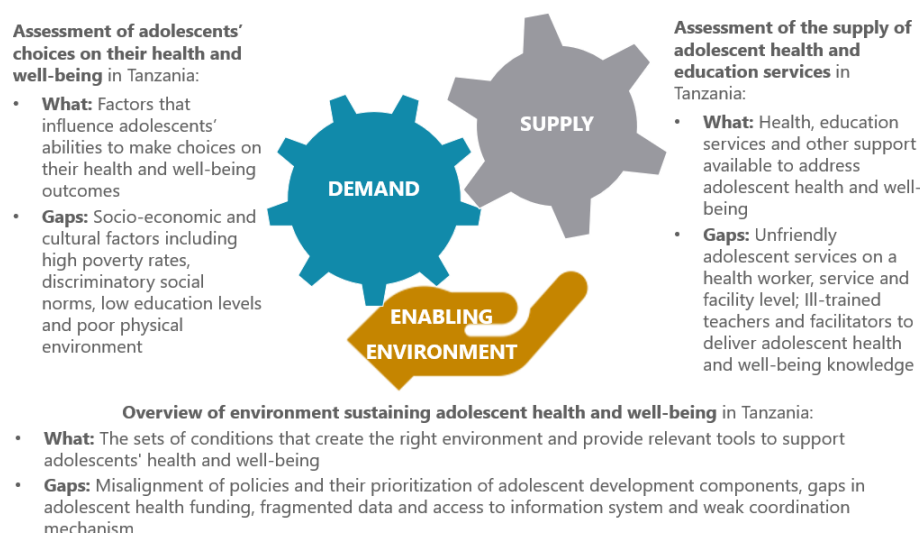
²³ Some programs' target population are unclear while some programs' target population impact across a few pillars.

received little focus. There is a growing shift towards comprehensive programming which aims to holistically address issues faced by adolescents. However, programs still disproportionately anchor on HIV as a central theme and only lightly cover other issues. When only considering timebound programs which were identified during the mapping, current HIV programs in the country reach 1,508,518 adolescents. Violence programs also reach many adolescents, with programs targeting 1,040,653 adolescents across the country.²⁴ In contrast areas like nutrition, and skills development have received very little attention.

CONSTRAINTS ACROSS DEMAND, SUPPLY, AND ENABLING ENVIRONMENT

There are several underlying drivers that span across demand, supply, and enabling environment that continue to undermine adolescent health and wellbeing despite on-going efforts. The demand lens seeks to understand the factors that influence adolescents' abilities to take concrete positive actions related to their health and wellbeing. Several factors including the combination of socio-economic and cultural factors such as high poverty rates, discriminatory social norms, low education levels, and poor physical environment drive adverse outcomes among adolescents—preventing them from achieving their full potential. Adolescents can make the right choices if they are given the right information, tools, and agency. The supply lens assesses the whole spectrum of services available to effectively address adolescent health and wellbeing. Adolescents' health-seeking behaviours are deterred by the lack of adolescent friendly services which encompasses the attitudes, availability, amount, and quality of the space and/or the service providers. Lastly, enablers focus on the sets of conditions that create the right environment and provide relevant tools to support adolescents. The misalignment of policies and their lack of prioritization of adolescent development components, gaps in adolescent health funding, fragmented data and access to information, and inefficient coordination mechanisms all inhibit the ability to unlock demand and supply.

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



DEMAND

Issues of awareness prevent adolescents from being able to access health services. Adolescents do not fully understand issues that impact their health and wellbeing and are also not aware of services that are available to them. Small scale studies on HIV awareness among youth and found that while youth know of HIV, their knowledge is not comprehensive. Although many know the name of the disease (in both Kiswahili and

²⁴ Dalberg analysis

English), they do not perceive themselves to be at risk of infection²⁵. Furthermore, several adolescents are unaware of existing services (e.g. educational and vocational support, drug and alcohol counselling, legal and social support) lacking information where services are provided and how to access them.

Various systemic and inter-related issues like poverty, cultural and religious practices, and education and literacy rates hinder both awareness and positive health-seeking behaviour. Tanzania has experienced high economic growth rates of 6-7%, and while the national poverty rate is declining, it is still high, estimated to be 26.9% in 2016.²⁶ The high level of poverty negatively impacts the ability of families to support the educational needs of their children and contributes to creating an unsafe environment for adolescents. Education and literacy are strongly associated with improving health and fertility indicators. The high drop-out rates in the country therefore lead to an uneducated population who do not seek out 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 difficult to access and are costly. Furthermore, cultural practices such as early marriages for the girl child and gender-based discrimination and violence hinder adolescents' demand of health services and perpetuate gender disparities.²⁷ Such norms also prohibit frank parent-child discussions about sexual and reproductive health that can result in adverse sexual behaviours and health outcomes due to a lack of appropriate information.

SUPPLY

On the supply side there is overall a shortage of trained health workers, and facilities to provide adolescent friendly health services (AFHS). Given that there are only 64,449 health workers against the target of 140,500, health workers are in short supply.²⁸ Over the period 2009 to 2014, the Government has expanded the number of health institutions with around 500 mainly primary health care facilities. However, a significant gap remains, given that many of these facilities are not adolescent-friendly. Studies show that only 30% of health service delivery points meet the national standards for AFHS.²⁹ This is compared to the target of having 80% health facilities providing AFHS by 2015. Most service delivery points do not provide client centred comprehensive and integrated adolescent services, such as having exclusive days/hours clinics for adolescents. On a community level, there are also limited community-based services to provide access to sexual reproductive health services to both in and out-of-school adolescents.

Availability of healthcare/education materials and commodities is often also an issue across delivery sites. Key commodities such as contraceptives are not readily available outside health facilities despite recent expansion in delivery points. Given that the Accredited Drug Dispensing Outlets (ADDOs) are still too few to cover the needs of the country, there are still incidences of stock-outs. Similarly, textbooks and learning materials are in short supply in secondary schools.³⁰ Schools also lack the facilities and supplies to promote good menstrual hygiene management, which requires adequate access to water as well as accessible, private, and hygienic sanitation facilities.

Furthermore, the friendly attitude, awareness, and ability to deliver services is lacking among service providers. On the education side, teachers are not trained to deliver content on health and wellbeing as they are not trained to deliver such content. Further, there is limited incentive in teaching this subject area since

²⁵Williams, Increasing Access to Youth Sexual & Reproductive Health Services in Tanzania: Recommendations to Higher Learning Institutions, 2015

²⁶ World Bank, Tanzania

²⁷ Thomas Bisika "Cultural Factors that affect sexual and reproductive Health in Malawi. Journal of Family Planning Reproductive Health Care, 2008

²⁸ Tanzanian MoHCDGEC, Human Resource for Health Country Profile, 2013

²⁹ UNICEF, Adolescence in Tanzania, 2011

³⁰ UNESCO, Global Education Monitoring Report, Every Child Should Have a Textbook, 2016

it is often not examinable.³¹ On the health side, most service providers do not know how to effectively meet the needs of adolescents. This can manifest in unfriendly attitudes of the health workforce towards adolescents which is a deterrent to adolescents seeking health services. Adolescents highlighted unapproachable and inaccessible healthcare professionals as one of the key reasons for not seeking healthcare support, especially with regards to teenage pregnancies. This was particularly emphasized among youth in rural areas where healthcare professionals are seen to be intimidating and lacking in understanding³². Specifically, there is a dimension of inadequate training of all health workers in the provision of AFHS – health workers have not received adequate training on AFHS provision before becoming professionals, and therefore need additional training when they start working as licensed professionals.³³

ENABLERS

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, potentially resulting in inconsistencies and variations during implementation. For instance, the draft National Health Policy 2018 and National Plan of Action to end Violence against Women and Children in Tanzania 2018-2022 equally emphasize socioeconomic considerations and health systems, while others like the Health Sector Strategic Plan 2015-2020 focus on promoting coordination. On the legislative side, some contradictions exist between Acts, which 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 government's health expenditure has remained consistently lower than the 15% target in the Abuja declaration of 2001. For instance, in 2017/18, the government earmarked 7% of its national budget for the health sector, consistent with the year before.³⁴ Furthermore, within the budget, no financial resources are dedicated to adolescent health and wellbeing, but rather, adolescent health and wellbeing funding is merged with other potentially insufficiently-funded programs that are reflected in the budget.

The data for adolescent health and wellbeing outcomes is fragmented, coupled with a lack of clearly defined indicators and limited access to information by adolescents. There are several data systems that seldom share information across different platforms, mainly due to poor coordination and lack of a streamlined data-sharing mechanism. Data systems such as HMIS and the CTC II collect general health data for all populations across the country, based on the HSSP IV guidelines but only cover basic adolescent indicators as part of broader indicator sets. Disaggregated data on 10-14 and 15-19-year old adolescents is a high priority for decision makers at all levels to have a clear sense of the problems faced by adolescents and whether they are being sufficiently addressed.

On the coordination side, the adolescent health and wellbeing space in Tanzania is characterized by multiple coordination mechanisms that work in parallel and have limited cross-collaboration. These mechanisms are poorly aligned in their approaches to coordinating adolescent health and wellbeing activities. The entities work in silos and have limited understanding of the progress achieved within each entity's work. Additionally, implementation of programs is poorly coordinated. Weak linkages between MoHCDGEC, PO-RALG and implementing partners at regional and district levels have led to poor alignment

³¹ Dalberg stakeholder interviews

³² Empower, Adolescent Engagement Report, 2018

³³ Dalberg stakeholder interviews

³⁴ Health Policy Plus Brief, Analysis of the Government of Tanzania's Budget Allocation to the Health Sector for Fiscal Year 2017/18, 2018

and siloed approaches in the implementation of programs.

PART II - DETAILED INTERVENTIONS AND SUGGESTED ACTIVITIES

METHODOLOGY


To address above-mentioned issues, the National Accelerated Investment Agenda for Adolescent Health and Wellbeing focuses on priority interventions which have the potential to increase urgency and action.

Interventions fall across three categories; 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. While there is some work being done in these areas, there is a need to continue advancing current efforts to achieve intended objectives for adolescent health and wellbeing. In defining interventions, we build on existing work and structures ensuring that there will be seamless integration with what is already being done. Each pillar outlines the interventions, and characterizes them based on target age range, constraint addressed, intended outcome, and suggested 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 amongst several stakeholders who are implementing programs to address these issues. Some of these interventions are already achieving their intended outcomes, while others are anticipated to see outcomes in the long-term, e.g. interventions around policy change are included in the list of support interventions. In contrast, emerging/evolving interventions are those that are new with very 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, both supporting and emerging/evolving interventions are important for long-term sustainability. It is essential for stakeholders to continue implementing interventions in these categories. A comprehensive list of supporting and emerging/evolving interventions is included in the annex. While this primarily focuses on pillar-specific and cross-cutting interventions, supporting system-building activities such as data management and coordination will also have long-term impact beyond the 4 years.

The final set of priority interventions is a result of a process that incorporated input from a wide range of stakeholders, that was achieved through the support of the taskforce. At the inception of document development, a taskforce was created, which included members from MoEST, MoHCDGEC – CD, MoHCDGEC/RCHS, PO-RALG, PMO, and TIE. The taskforce was instrumental in socializing the agenda across various ministries and leading efforts to convene stakeholders. Stakeholder engagement took place in several instances. Throughout the four-month development process, there were one-on-one meetings with over 70 stakeholders, and several working sessions. This includes a broad stakeholder meeting held on August 2018, with both government and development partners to prioritize interventions across metrics of feasibility and impact with a focus on interventions that have high feasibility and high impact. These interventions were further validated in smaller working sessions and one-on-one meetings. In total there were over 150 consultations with various 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. In the development process, there were several mechanisms of consultation including focus groups, an adolescent workshop, and online surveys which included opinions from a diverse set of adolescents, including marginalized and most vulnerable groups. During this initial phase, adolescents provided input into 1) the



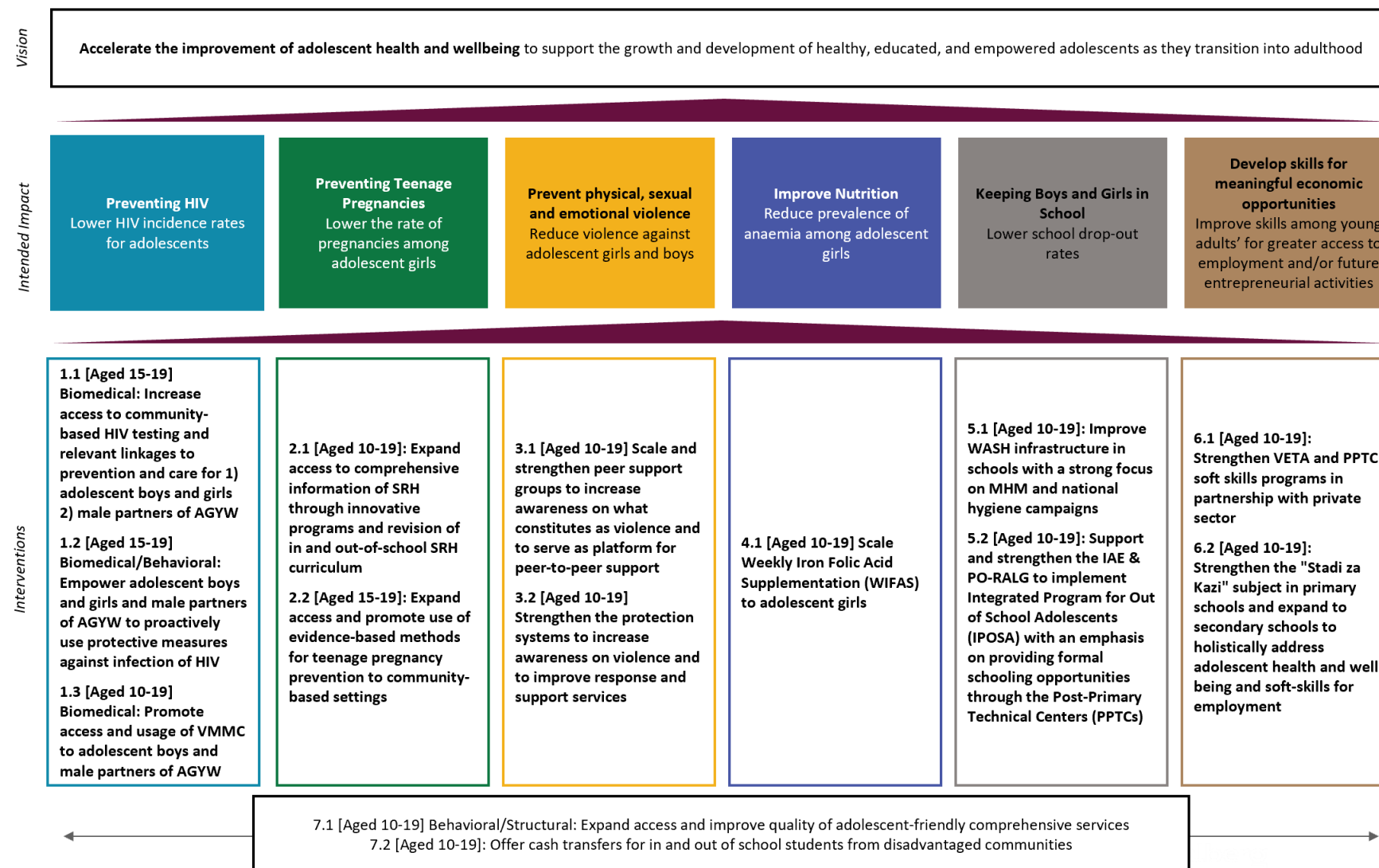
design of the agenda specifically by confirming the issues that hinder adolescent health and wellbeing, and 2) determining how they can be optimally reached through the interventions to ensure that there this is maximum impact. Following the design phase, adolescents will continue to be meaningfully 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 youth will vary. At the program design level, it is critical to introduce adaptive measures to reach various populations.

The remaining sub-sections elaborate on the interventions and critical themes or concepts, which are characterized as either pillar specific or cross cutting. Each of the prioritized interventions are characterized by the target age range, gap addressed, intended outcome, and suggested activities to operationalize the intervention. Figure 6 shows a summary of all the interventions across all the pillars.

- *Target age range* – Intended target population for each intervention
- *Gap addressed* – Overview of the gap or constraint that will be addressed by the intervention
- *Intended outcome* – Anticipated result from implementing the intervention, tied to the overall objectives of the pillar
- *Suggested activities* – List of what needs to be done to help achieve each intervention, while this section lists activities at a high level the full detailed list is included in the annex



FIGURE 6: SUMMARY OF INTERVENTIONS ACROSS PILLARS



PILLAR 1 – PREVENTING HIV

Prioritized interventions for Preventing HIV include:

- 1.1 [Aged 15-19³⁵] 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
- 1.2 [Aged 15-19] Biomedical/Behavioural: Empower adolescent boys and girls and male partners of AGYW to proactively use protective measures against infection of HIV
- 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 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 stop the spread of HIV. Today, HIV testing is mostly available in health facilities. However, there is evidence to suggest that adolescents experience unfriendly services and stigma when seeking HIV testing services at health facilities. This poses a major barrier to adolescents' participation in facility-based testing, and consequently linkages to preventive services and treatment. Facility-based testing, while essential, is unlikely to meet Tanzanian national targets on its own. Increased attention to community-based testing³⁶, which has led to higher uptake in sub-Saharan Africa³⁷, is therefore needed.

While an increase in HIV testing services coverage and uptake was evident during the implementation of HSHSP III, programs that provide not only testing but also ensure comprehensive pre and post-test counselling and complete linkages to prevention, or linkages to care after testing are needed. Generally, HIV prevention services programs 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 programs currently running. In contrast, regions with low prevalence rates including Kilimanjaro and Arusha have made notable efforts in public sensitization to drive improvements in testing and services such as ART.³⁸

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 2) male partners of AGYW
Target age range	15 – 19
Gap addressed	HIV testing is mostly available in health facilities, but unfriendly services and stigma towards adolescents seeking HIV services at health facilities pose a major barrier to adolescents' participation in facility-based testing, and consequently linkages to preventive services and treatment

³⁵ While the focus of this program is up to age 19 years, there is an opportunity to extend to age 24 years and align with work being done by DREAMS and the Global Fund

³⁶ UNAIDS, Tanzania HIV Investment Case, 2016

³⁷ Nature, "Systematic review and meta-analysis of community and facility-based HIV testing to address linkage to care gaps in sub-Saharan Africa", 2015

³⁸ Dalberg analysis

Intended Outcome³⁹	<ul style="list-style-type: none"> • Increase testing for HIV among 1) adolescent boys and girls 2) male partners of AGYW • Reduce new HIV infections for 1) adolescent boys and girls 2) male partners of AGYW
Suggested Activities	
1.1.1	Map and identify high-risk geographical locations/groups among 1) adolescent boys and girls 2) male partners of AGYW 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 leaders (e.g. young celebrities, political, community, religious), mass media, jogging clubs, bonanza, mentors/peer educators, and social media to promote and increase demand for HIV community-based testing, education and provision of protective measures, sexual reproductive health information and services, cervical cancer screening and post-violence care
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
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 2) male partners of AGYW
1.1.5	Provide facilitated referrals and linkages for identified HIV positive adolescent boys and girls, male partners of AGYW to care and treatment services (e.g. ART treatment)
1.1.6	Provide facilitated referrals and linkages for adolescent boys and girls, 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
1.1.8	Capacitate community members, i.e. parents/caregivers, community and religious leaders to effectively and frankly communicate with adolescents on issues related to sexual and reproductive health (SRH)

Intervention 1.2 – Empowering adolescents and male partners of AGYW to proactively use protective measures is important in preventing new HIV infections. Condoms have 98% effectiveness when used consistently and correctly⁴⁰, provided access to condoms is feasible. WHO and UNAIDS state that condoms use is therefore a key component of combination HIV prevention approach.⁴¹ Today, access to protective measures is limited due to inadequate availability of such measures at the community level, unaffordability of available protective measures and stigma towards adolescents who access such measures. Furthermore, lack of knowledge on effects and usage of protective measures limits uptake among adolescents.⁴² This intervention addresses access to, use, and awareness of protective measures to prevent HIV.

³⁹ Specific targets are included in the M&E annex section

⁴⁰ http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2016/february/20160212_condoms

⁴¹ http://www.unaids.org/en/resources/presscentre/featurestories/2016/october/20161002_condoms;
<http://www.who.int/hiv/topics/condoms/en/>


⁴² South African Journal of HIV Medicine, "Knowledge and practice of condom use as well as perceived barriers among street adolescents in Cameroon", 2016

While programs to increase distribution of protective measures against HIV infection in public health facilities and in the private sector through social marketing appears to have improved their accessibility, more programs are needed to continue strengthening the forecasting, promotion and distribution of protective measures. For example, during the implementation of HSHSP III, Tanzania made progress in ensuring availability and accessibility of HIV protective measures in public and private outlets. To sustain this progress, greater efforts should be placed to ensure more effective distribution to reach all populations in need, especially adolescents and male partners of AGYW. General HIV services programs, which typically include 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-concentration of programs running. 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.⁴³

Intervention	
Intervention	1.2 Biomedical/Behavioural: Empower adolescent boys and girls and male partners of AGYW to proactively use protective measures against infection of HIV
Target age range	15 – 19
Gap addressed	<ul style="list-style-type: none"> Limited access to protective measures against HIV infection at the community level, stigma towards 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 ⁴⁴	<ul style="list-style-type: none"> Increase use of protective measures against HIV infection among adolescent boys and girls and male partners of AGYW Reduce new HIV infections for adolescent boys and girls and male partners of AGYW
Suggested Activities	
1.2.1	Map and identify high-risk geographical locations/groups where there is unmet need for protective measures against HIV infection among 1) adolescent boys and girls 2) male partners of AGYW 3) sexual networks of adolescent boys and girls
1.2.2	Conduct demand-creation activities using influential leaders (e.g. young celebrities, political, community) to address the negative social stigma of parents and community leaders towards boys and girls using protective measures through pop-up events, mass media and social media

⁴³ Dalberg analysis

⁴⁴ Specific targets are included in the M&E annex section

- 
- 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 2) male partners of AGYW
 - 1.2.4** Promote social marketing of government-branded protective measures against HIV infection
 - 1.2.5** Build capacity of health and non-health providers (e.g. parents, caregivers and religious leaders) and retailers on usage and distribution of protective measures against HIV infection
 - 1.2.6** Train recordkeeping and forecasting skills of workers at health facility and community levels to ensure consistent supply of protective measures
 - 1.2.7** Procure and distribute vending machines of protective measures in all high-risk areas. Appropriate places include areas near shopping malls, sports grounds, guesthouses, bars, nightclubs etc.
 - 1.2.8** Advocate for public-private partnership to subsidize private sector protective measures and ensure their affordability and accessibility in pharmacies, private hospitals, communities
 - 1.2.9** Advocate for policy change to ensure government-branded protective measures are easily available from the national to community level
 - 1.2.10** Strengthen youth representatives on the village/ward/council multisectoral HIV committees as a spokesperson for adolescents' SRH needs

Intervention 1.3 – Promoting access and uptake of VMMC reduces the risk of female-to-male sexual transmission of HIV by up to 70%⁴⁵; while Tanzania has traditionally had high male circumcision at 72% of men aged 15-49 years (2011/2012 survey), VMMC coverage varied by age with the lowest levels among 15 – 19 years (66.2%), rising to 74.4% among 30 – 39 years.⁴⁶ A VMMC modelling exercise for thirteen selected regions of Tanzania mainland indicated that scaling up male circumcision among 10 – 29 year-olds would avert substantial level of HIV infections. This modelling exercise also indicated that the optimal long-term effectiveness of VMMC by 2050 would best be achieved through circumcision of men aged 15 - 29 years⁴⁷. WHO and UNAIDS recommended 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 that ethnic values and religious beliefs are 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, which have been almost exclusively funded from external sources, started in 2009 in thirteen priority regions (Kagera, Mwanza, Tabora, Shinyanga, Simiyu, Njombe, Geita, Rukwa, Mbeya, Songwe, Ruvuma, Iringa, Katavi and Rorya district in Mara region) with low coverage of male circumcision and high burden of HIV. The national targets were to circumcise 2.8 million by 2017 that was required to meet the coverage saturation target of 80% in all regions of the country. By the end of 2016, 2.2 million (78.6%) had been circumcised, and only two regions (Iringa and Njombe) out of thirteen had attained VMMC saturation coverage level of 80%. VMMC services, however, appear not to be adequately focused on high risk locations/groups such as mines and fish landing sites.⁴⁸


Intervention

⁴⁵ <https://www.jhpiego.org/what-we-do/hiv-aids-infectious-diseases/hiv-testing-prevention-care-and-treatment-copy/>

⁴⁶ HSHSP IV 2017-2022

⁴⁷ Kripke K, Perales N, Lija J, Fimbo B, Mlangi 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)

⁴⁸ HSHSP IV 2017-2022



Intervention	1.3 Biomedical: Promote access and uptake of VMMC to adolescent boys and male partners of AGYW
Target age range	10 – 19
Gap addressed	Limited access of VMMC to adolescent boys; programs typically target older males, but not adolescent boys
Intended Outcome⁴⁹	<ul style="list-style-type: none"> • Increase male circumcision among adolescent boys and male partners of AGYW • Reduce new HIV infections for adolescent boys and girls and male partners of AGYW
Suggested Activities	
1.3.1	Train healthcare workers to provide VMMC services to 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 information of SRH through innovative programs and revision of in and out-of-school SRH curriculum
- 2.2 [Aged 15-19]: Expand access and promote use of evidence-based methods for teenage pregnancy prevention to community-based settings

Intervention 2.1 – Expanding access to comprehensive SRH information equips adolescents with the necessary information to help them make responsible decisions for their sexual and reproductive health, including measures to prevent teenage pregnancies. While the decline in adolescent pregnancy and childbirth rates is most marked among older adolescents, especially those aged 19 years, where the rate dropped from 52% in 2004 to 44% in 2010, trends of increased childbearing among girls aged 15 from 3.7% in 2004 to 5.2% in 2010⁵⁰ is alarming. With most adolescent empowerment and reproductive health programs focused on older adolescents today, innovative healthcare delivery programs and improved SRH curriculum will ensure both adolescent boys and girls are well-equipped with SRH knowledge, within a broader scope of health and well-being education, from the age of 10.

SRH programs reach the largest number of adolescents in Dar, Morogoro and Geita. Notable programs include Sauti, Boresha Afya, Tulonge Afya and Mwanamke Tunu. Although Mara, Dodoma and Katavi have high rates of teenage pregnancies, programs in these regions do not reach a substantial number of

⁴⁹ Specific targets are included in the M&E annex section

⁵⁰ UNICEF, Adolescence in Tanzania, 2011

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 CSE, while regions such as Katavi have less than 30% of schools providing CSE.⁵¹

Intervention	
Intervention	2.1 Expand access to comprehensive information of SRH through innovative programs and revision of in and out-of-school SRH curriculum
Target age range	10 – 19
Gap addressed	<ul style="list-style-type: none"> • Limited comprehensive knowledge of sexual reproductive health and sensitivities about open discussion of sex • Most adolescent empowerment and reproductive health programs focus on older adolescents • Existing CSE curriculum is not fully integrated with the existing secondary school curriculum, Teachers Diploma curriculum and teaching methods
Intended Outcome ⁵²	<ul style="list-style-type: none"> • Increase the number of adolescents reached with comprehensive SRH information • Reduce teenage pregnancies among adolescent girls
Suggested Activities	
<p>2.1.1 Scale up existing innovative healthcare delivery (HCD) programs to better target and engage adolescents to raise awareness of SRH issues and rights</p> <p>2.1.2 Use mobile technology to increase demand, awareness and linkages to SRH services</p> <p>2.1.3 In-school: Conduct analytical review in terms of CSE integration with the existing secondary school curriculum, Teachers Diploma curriculum and teaching methods</p> <p>2.1.4 In-school: Develop guidelines for integrating CSE content in the existing secondary school curriculum, Teachers Diploma curriculum and teaching methods</p> <p>2.1.5 In-school: Revise textbook developers' content of CSE within the existing secondary school curriculum, Teachers Diploma curriculum and teaching methods</p> <p>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 Teachers Training Colleges</p> <p>2.1.7 In-school: Review Education Policy Guideline (2004) for implementing life skills and HIV programs in primary schools, secondary schools and Teachers Training Colleges to incorporate the delivery of CSE as a standalone non-examinable subject in form of extra-curricular activities</p> <p>2.1.8 In-school: Develop curriculum and modules for a standalone CSE non-examinable subject in form of extra-curricular activities in primary, secondary schools and Teachers Training Colleges</p>	

⁵¹ Dalberg analysis

⁵² Specific targets are included in the M&E annex section

- 2.1.9** In-school: Train teachers to deliver CSE as a non-examinable subject in form of extra-curricular activities in primary schools, secondary schools and Teachers Training Colleges
- 2.1.10** Out-of-school: Harmonize out-of-school CSE programs for adolescents
- 2.1.11** Out-of-school: Train facilitators on teaching CSE for adolescents who are out of school
- 2.1.12** Out-of-school: Facilitators (facilitators can be peers) train out-of-school adolescents on CSE through teen clubs, online learning etc.

Intervention 2.2 – Expanding access and promoting use of evidence-based methods for teenage pregnancy prevention to community-based settings is critical, particularly when limited access to and stigma towards uptake of certain measures are barriers for adolescents. For example: While awareness of modern contraceptive methods is at 96%⁵³, modern contraceptive prevalence rate (mCPR) for both married and all women aged 15-49 years fall short of national goals (mCPR for married women at 34.8% in 2017 vs national goal of 45%; mCPR for all women at 29.2% in 2017 vs national goal of 39%).⁵⁴ Increased availability of a range of evidence-based methods for teenage pregnancy prevention outside of health facilities, reduced stigma towards access of evidence-based methods by adolescents, and subsidized private sector evidence-based methods will accelerate reduction in fertility rate.

SRH programs that reach many adolescents focus on Dar, Morogoro and Geita. While Mara, Dodoma and Katavi have high rates of teenage pregnancies, programs in these regions do not reach a substantial number of adolescents.⁵⁵


Intervention	
Intervention	2.2 Expand access and promote use of evidence-based methods for teenage pregnancy prevention to community-based settings
Target age range	15 – 19
Gap addressed	<ul style="list-style-type: none"> Limited access to evidence-based methods for teenage pregnancy prevention outside health facilities Stigma towards access of evidence-based methods for teenage pregnancy prevention by adolescents Unaffordable price of private sector evidence-based methods for teenage pregnancy prevention
Intended Outcome ⁵⁶	<ul style="list-style-type: none"> Increased usage of evidence-based methods to prevent teenage pregnancy Reduce teenage pregnancies among adolescent girls
Suggested Activities	

⁵³ MoHCDGEC, One Plan II, 2016

⁵⁴ Tanzania National Family Planning Costed Implementation Plan 2018-2023, 2018

⁵⁵ Dalberg analysis

⁵⁶ Specific targets are included in the M&E annex section

- 
- 2.2.1** Use youth influencers, mass media, mobile technology, social media, traditional media, public campaigns, community meetings to address negative social cultural norms and religious beliefs regarding use of evidence-based methods for teenage pregnancy prevention by targeting adolescents and their influencers, i.e. parents, religious and community leaders
 - 2.2.2** Scale up positive parenting programs to address negative attitudes from parents/caregivers
 - 2.2.3** Integrate sexual reproductive health programs as a component of holistic programs that address developing wider skillsets such as life skills and entrepreneurship in efforts to garner adolescents' attention towards evidence-based methods for teenage pregnancy prevention
 - 2.2.4** Increase access to evidence-based methods for teenage pregnancy prevention in and out of health facilities, e.g. through holding outreach programs, mobile clinics, engaging CHWs and peer healthcare providers
 - 2.2.5** Advocate for public-private partnerships to subsidize private sector evidence-based methods for teenage pregnancy prevention and ensure their affordability and accessibility in pharmacies, private hospitals, communities
 - 2.2.6** Build capacity of health workers to provide evidence-based methods for teenage pregnancy prevention and address norms, values and bias towards provision of services to adolescents

In addition to prioritized interventions, 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. Parent-child sexuality communication has been identified as a protective factor for adolescent sexual and reproductive health, including HIV infection. Adolescent sexual decision-making and behaviour are influenced by several different factors and individuals including peers, family, community and the broader society. Parents, in particular, play a substantial role in the gender and sexual socialization of their children. Globally, evidence shows that discussions with adolescents on sexuality have been associated with a range of important psychosocial attributes including increased knowledge, better interpersonal communication skills, including sexual negotiation skills, and self-efficacy. While the specific impact of positive parenting interventions in Tanzania is mixed, a supporting intervention on positive parenting is recognized as critical to achieving the pillar's objectives in the long-term. Some of the recommended activities include: educating parents/caregivers, religious leaders on how to talk with the adolescents regarding issues of prevention of teenage pregnancies; and developing and distributing IEC material with SRH messages of prevention of teenage pregnancies.

PILLAR 3 – PREVENTING PHYSICAL, SEXUAL AND EMOTIONAL VIOLENCE

Prioritized interventions for violence include:

- 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
- 3.2 [Aged 10-19] Strengthen the protection systems to increase awareness on violence and to improve response and support services

Intervention 3.1 – Promoting positive social and cultural norms and increasing the demand for support services by survivors of violence has the potential to prevent new and repeated cases of violence. Evidence from the TDHS 2015 shows that c.60% of adolescent girls aged 15-19 believe wife beating is justifiable⁵⁷. Such deep-rooted practices, coupled with limited knowledge on adolescents' rights, and inadequate service

⁵⁷ NBS, Tanzania Demographics Health Survey, 2015

provision to survivors, limit help-seeking behaviour from survivors of violence. Through the peer support groups, education on adolescents' rights and positive social and cultural norms will be promoted to prevent new and repeated cases of violence. In addition, the peer support groups will also act as support platforms to survivors, thus increasing demand for support services. This has shown to be effective as the case of the peer support groups in Arumeru where a total of 70 cases of child labor and early marriage were reported through the peer support groups⁵⁸.

Peer support groups have previously been used as a tool to provide training on violence, which can be leveraged but need to be scaled. Fhi360 implemented a safe schools program in Dar es Salaam, Morogoro, Iringa and Tabora that provided training to students and whole communities on violence prevention and response⁵⁹. However, such initiatives remain program-driven with little sustainability after donor funding is terminated. There have been efforts by the government to expand the intervention under the NPA-VAWC's thematic area of safe schools and life skills. Given limited funding, the intervention is yet to be implemented. The current number of peer support groups is 398, and existing target under NPA-VAWC is to develop c.12,800 more by 2022⁶⁰.

Intervention	
Intervention	3.1 Scale and strengthen peer support groups to increase awareness on what constitutes as violence and to serve as platform for peer-to-peer support
Target age range	10 – 19
Gaps addressed	<ul style="list-style-type: none"> Limited awareness and knowledge on 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 ⁶¹	<ul style="list-style-type: none"> Increase adolescents' awareness on and understanding of violence and their rights Increase the number of survivors seeking help or support from either formal or informal channels
Suggested Activities	
3.1.1	Review and adopt the peer groups training manual on adolescents' violence prevention and response
3.1.2	Develop a directory poster that maps out the formal reporting mechanisms and support channels for services related to violence close to area where violence 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 adolescents
3.1.5	Conduct awareness campaigns targeting parents, religious leaders, influential, traditional leaders, service providers, government and political officials on violence against adolescents

⁵⁸ <http://www.thecitizen.co.tz/magazine/soundliving/1843780-4640806-kkdi5s/index.html>

⁵⁹ Dalberg stakeholder interviews

⁶⁰ MoHCDGEC, NPA-VAWC 2017-2022, 2018

⁶¹ Specific targets for outcomes are included in the M&E Annex section

Intervention 3.2 – This intervention can improve the supply and quality of support services as it scales 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 c.90% gap in social welfare officers⁶². This intervention strengthens the existing women and child protection systems to ensure sustainable impact in the supply of services to survivors of violence. It also seeks to increase community awareness on adolescent protection issues by increasing dialogue involving frontline workers, community members (particularly caregivers) and adolescents. For example, while adolescents are aware that corporal punishment administered by a teacher is not permissible by law, there is little they can do to object given unmatched understanding from the teachers and wider community. 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?”*⁶³ Consequently, providing awareness to both community members and adolescents will have potential to create a common understanding on violence, and provide a pathway on how violence can be prevented.

Women and child protection systems are currently implemented in several councils through the NPA-VAWC. UNICEF has been involved in developing these protection teams in the country and scaling the training of frontline workers such as the Police Gender and Children Desks (PGCDs) in Kigoma⁶⁴. Despite this, current efforts have limited reach in connecting frontline workers and the community as training is primarily focused on response rather than prevention⁶⁵. This intervention seeks to provide training on both prevention and response to frontline workers, which will consequently increase confidence in the community seek help or support during an incident. The intervention also seeks to scale to other councils that are yet to be reached under the NPA-VAWC.

Intervention	
Intervention	3.2 Strengthen the protection systems to improve response and support services on violence against adolescents
Target age range	10 – 19
Gaps addressed	<ul style="list-style-type: none"> • Inadequate service provision to survivors of violence • A culture of silence associated with stigma, fear and alienation
Intended Outcome ⁶⁶	<ul style="list-style-type: none"> • Increase the number of appropriate services provided by frontline workers • Increase community’s awareness on and understanding of violence and adolescents’ rights
Suggested Activities	

⁶² Dalberg stakeholder interviews

⁶³ Quote from the 2018 National Adolescent Conference in Dodoma

⁶⁴ Dalberg stakeholder interviews

⁶⁵ Dalberg stakeholder interviews

⁶⁶ Specific targets for outcomes are included in the M&E Annex section

- 3.2.1** Review and adopt the training manual for training frontline workers on violence prevention and response
- 3.2.2** Conduct national and sub-national level joint training workshop to frontline 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

PILLAR 4 – IMPROVING NUTRITION

Prioritized interventions for nutrition include:

- 4.1 [Aged 10-19] Scale Weekly Iron Folic Acid Supplementation (WIFAS) to adolescent girls

Intervention 4.1 – Scaling WIFAS to adolescent girls has the potential to reduce the prevalence of anaemia in both the short- and medium-term. The TDHS 2015 reports that 47% of adolescent girls aged 15-19 are anaemic⁶⁷. Scaling WIFAS can reduce this prevalence as an assessment of a WIFAS program in Gujarat, India has shown significant reduction in anemia prevalence by c.22%⁶⁸. WIFAS also has the potential to improve outcomes on absenteeism and drop-out rates as it increases school participation by reducing fatigue.

This intervention is currently implemented in Mwanza and Simiyu, where 94,000 adolescents are scheduled to receive IFA pills on a weekly basis by 2020 through the Right Start Initiative program under Nutrition International⁶⁹. The TDHS 2015 shows high prevalence of anaemia in the Lake Zone, which is where the current program is being implemented⁷⁰. However, there still exists a gap in reach as only a small fraction of the total adolescent population is targeted in this high area of need⁷¹. In other regions, nutrition programs have primarily focussed on providing school meals or as components of programs seeking to increase food productivity⁷². This is evidenced by the significant gap in funding micronutrients interventions, which has a deficit of 80% according to the NMNAP⁷³. The government and development partners have also committed funding towards anaemia prevention, but a deficit of 40% exists⁷⁴. The gap is most salient for adolescent nutrition programs which has a funding deficit of 62%⁷⁵.

Intervention	
Intervention	4.1 Scale Weekly Iron Folic Acid Supplementation (WIFAS) to adolescent girls
Target age range	10 – 19
Gaps addressed	<ul style="list-style-type: none"> • Limited awareness on nutritional needs • Small-scale and time-limited interventions

⁶⁷ NBS, Tanzania Demographics Health Survey, 2015

⁶⁸ Shobha P. Shah et al., Effectiveness and Feasibility of Weekly Iron Folic Acid Supplementation in Gujarat, India, 2016

⁶⁹ https://www.nutritionintl.org/content/user_files/2017/06/NI_FactSheet_RS-Tanzania-ENG-Ltr-FINAL-WEB.pdf

⁷⁰ NBS, Tanzania Demographics Health Survey, 2015

⁷¹ Dalberg analysis

⁷² Dalberg analysis

⁷³ PMO, NMNAP 2016 – 2021, 2018

⁷⁴ PMO, NMNAP 2016 – 2021, 2018

⁷⁵ PMO, NMNAP 2016 – 2021, 2018

Intended Outcome⁷⁶	<ul style="list-style-type: none"> • Increase awareness on nutritional needs to whole communities • Scale proportion of adolescent girls aged 10 – 19 who receive WIFAS pills
Suggested Activities	
4.1.1	Design WIFAS roll-out platform for in-school and out-of-school adolescents
4.1.2	Conduct training on WIFAS and nutritional education and counseling to teachers and CHWs
4.1.3	Conduct public awareness campaigns on the importance of the WIFAS, while providing community-wide nutritional education and counseling
4.1.4	Distribute the IFA pills to adolescent girls aged 10-19 through identified locations

Nutritional education and counselling is also critical to achieving set objectives of Pillar 4 and includes critical activities such as engaging communities on culturally-appropriate diets and creating awareness on consumption of fortified foods. Promoting nutritional education and counselling supports the prevention of malnutrition as well as the promotion and maintenance of good nutrition. It builds community-wide awareness and political, social and financial commitment to nutrition improvement. It also enhances individual behaviours and household practices, promotes collective actions in communities, improves the delivery of nutrition counselling services and the demand for these services, and enhances the overall enabling environment for good nutrition outcomes. While the direct impact of nutritional education and counselling activities is often difficult to capture, it remains necessary to achieving long-term change. Some of the recommended activities include: design nutritional messaging around NCD prevention, engage communities on feasible means of food preparation, and advocate for advertisement regulation of alcohol, tobacco and unhealthy foods. These activities will be conducted concurrently and in parallel with intervention 4.1 to ensure behavioural change that has potential to translate to long-term impact.

PILLAR 5 – KEEPING BOYS AND GIRLS IN SCHOOL

Prioritized interventions for pillar 5 include:

- 5.1 [Aged 10-19]: Improve WASH infrastructure in schools with a strong focus on MHM and national hygiene campaigns
- 5.2 [Aged 10-19]: Support and strengthen the IAE & PO-RALG to implement Integrated Program for Out of School Adolescents (IPOSA) with an emphasis on providing formal schooling opportunities through the Post-Primary Technical Centres (PPTCs)

Intervention 5.1 – Improving WASH infrastructure is proven to substantially increase school attendance particularly among girls. Evidence from a randomized trial of a school-based SWASH project conducted in Nyanza Province, Kenya found that a combined water treatment (WT) and hygiene promotion (HP) intervention reduced absenteeism by 39% in selected geographic areas. The impact was greater on girls, with a reduction of 58% in girls' absenteeism⁷⁷. Furthermore, there is evidence to show that this intervention can also have a positive impact on other pillars. For example, evidence suggests that improved SWASH facilities

⁷⁶ Specific targets for outcomes are included in the M&E Annex section

⁷⁷ UNICEF; The Impact of Water, Sanitation and Hygiene on Key Health and Social Outcomes, 2016

can also impact nutrition (especially lowering the need for deworming), and potentially certain forms of violence⁷⁸. This intervention focuses on constructing WASH facilities and promoting appropriate use.

While there are some existing commitments to fund WASH infrastructure in schools, the gap is still very large. There is a substantial need for WASH facilities in schools; more than 60% of Tanzanian schools do not have proper WASH facilities. Currently, the government has allocated less than 1% of its national budget to SWASH facilities in 500 primary schools. However, beyond government budget allocation, there are some existing commitments, the largest coming from the World Bank, who has agreed to a payment for results (P4R) model with the Government of Tanzania to build more WASH facilities in schools. The payment model requires the government to build the facilities, with payment dependent on whether each infrastructure meets the basic requirements. Additionally, several NGOs are interested in supporting the hygiene behavioural campaigns (e.g. UNICEF and Water Aid). Given this existing momentum there is an opportunity to increase the impact.

Intervention	
Intervention	5.1 Improve WASH infrastructure in schools with a strong focus on MHM and national hygiene campaigns
Target age range	10 – 19
Gap addressed	<ul style="list-style-type: none"> • High rate of abstenteeism • Limited number of schools with WASH facilities • High dropout rates (particularly among girls)
Intended Outcome ⁷⁹	Reduced abstenteeism and dropouts
Suggested Activities	
5.1.1	Train District Home Economic Education Officers and or Healthy Workers to train teachers (male and female) on Menstrual Hygiene Management in schools
5.1.2	Construct and rehabilitate 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
5.1.3	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
5.1.4	Conduct campaigns in schools to promote hand-washing and MHM
5.1.5	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 NBS and BEMIS
5.1.6	Create enabling environment for local industries to produce affordable sanitary pads

⁷⁸ Dalberg stakeholder Interviews

⁷⁹ Specific targets for outcomes are included in the M&E Annex section


5.1.7 Sensitize engagement of communities in construction of new schools

Intervention 5.2 – Alternative education pathways are critical to reach vulnerable and marginalized youth who are unable to pursue or continue with formal schooling opportunities. There are many marginalized populations who are unable to enter the formal schooling system, or enter and dropout due to various circumstances. The 2016 Basic Education Statistics of Tanzania (BEST) indicated that about 2,256,940 children between 14 to 17 years were out of school. Based on this, MoEST has introduced an educational program which 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 program has the potential to achieve the objectives of pillar 5 by increasing the number of youth in the system. It also has the potential to achieve the objectives of other pillars by integrating various health education and life skills trainings within the program.

IPOSA is currently being developed for implementation and can be effectively strengthened and scaled over the next four years. IPOSA is a recent program which 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 with the support of UNICEF in select regions. The program integrates four skills: literacy, entrepreneurship, life skills and prevocational skills. While this program already exists in select districts and regions, the reach has been limited since it is new. There is a need to scale the program to reach more adolescents and ensure that its impact is realized.

Intervention	
Intervention	5.2 Support and strengthen the IAE & PO-RALG to implement Integrated Program for Out of School Adolescents (IPOSA) with an emphasis on providing formal schooling opportunities through the Post-Primary Technical Centres (PPTCs) and FDCs
Target age range	10 – 19
Gap addressed	<ul style="list-style-type: none"> Limited education opportunities for those who are unable to pursue/continue with formal education pathways High drop-out rates
Intended Outcome ⁸⁰	<ul style="list-style-type: none"> Increase net enrollment Lower drop-out rates
Suggested Activities	
5.2.1 Conduct a baseline study for the IPOSA program 5.2.2 Develop competency based short courses for PPTCs certified by NECTA 5.2.3 Refurbish PPTCs and FDCs to effectively deliver vocational and formal school education for OOS adolescents in locations of greatest need	

⁸⁰ Specific targets for outcomes are included in the M&E Annex section

- 
- | |
|--|
| <p>5.2.4 Provide one free exam re-sit for students who dropped out and want to write their O-level core courses at a VETA, FDC or PPT centre</p> <p>5.2.5 Conduct annual career days in partnership with private sector players once a year for students to identify work opportunities post qualification</p> |
|--|

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 programs in partnership with private sector
- 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 programs in VETA and PPTCs will ensure that youth are better equipped to enter the workforce. Given the age bracket 10-19, the primary focus is on building critical skills for future employment and/or meaningful economic activities that improve the standard of living of Tanzanians, which is the aspiration of Tanzania’s vision 2025. Evidence in other countries shows some success with private TVETs working with private sector to design new curriculums and programs. For example, in Mali and Senegal it appears that private TVETS have been more successful in adapting to offer skills demanded by private sector⁸¹. Tailoring the program to meet the needs of the market, ensures that youth are receiving skills that employers need. Engagement with private sector is critical to identify those needs. Incorporating critical skills around financial literacy is key to supporting economic empowerment, ensuring that youth will be able to take advantage of mobile bank accounts and other digital financial services. Furthermore, there is an opportunity to create linkages to self-help groups so that youth not only have 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.

FIGURE 7: PROPOSED SOFT SKILLS FOR INTERVENTION 6.1⁸²

⁸¹ Dunbar, Engaging the Private Sector in Skills Development, 2013

⁸² Business Education Journal, “[Factors contributing to lack of employable skills among technical and vocational education \(TVET\) graduates in Tanzania](#)”, 2016



Soft Skill	Definition
Subject knowledge and competence	Knowledge and ability to critically apply about one's specialisation to their profession
Effective communication	An ability to express ideas clearly and confidently in writing and speech
General knowledge & commercial awareness	An understanding of the commercial realities affecting an organisation
Investigative & analytical skills	Gather information systematically to establish facts and principles
Initiative/self-motivation	An ability to act on initiative, identify opportunities and proactive in putting forward ideas & solutions
Drive/Grit	An ability to see tasks through to completion, deliver through to the end product & constantly looking for better ways of doing things.
Planning and organising	An ability to plan activities & carry them out effectively
Flexibility	An ability to adapt successfully to changing situations and environments
Time management	An ability to manage time effectively, prioritising tasks and able to meet deadlines

Although no specific stakeholders are working with VETAs and PPTCs on building a soft skills program, several development partners have programs that provide different types of skills trainings for out-of-school youth. The Youth Health Sport Initiative which is currently being implemented by DSW 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. Additionally, the Cash Plus program operates in Iringa and Mbeya provides cash transfers, intensive life skills training, mentoring, and coaching on livelihood enhancement. PEPFAR and DREAMS are also conducting a soft skills program in Mbeya city for caregivers of most vulnerable adolescents and select adolescent girls who are mothers. The program, Worth, targets women aged 15-19 and provides them with training in financial literacy skills, marketing, and SRH. While these types of programs can provide an anchor for what does and does not work, 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 programs in partnership with private sector
Target age range	10 – 19
Gap addressed	Lack of skills for effective employability or entrepreneurship
Intended Outcome⁸³	Increased number of adolescents who receive soft skills training
Suggested Activities	
6.1.1 Assess VETA centres and PPTCs to determine the current soft/life skills curricular available	

⁸³ Specific targets for outcomes are included in the M&E Annex section


- 6.1.2** Conduct annual labour force surveys to inform the vocational skills demanded and complementary soft skills required within these careers
- 6.1.3** Conduct a soft skills demand assessment annually with private sector actors to inform program curricular
- 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 select educators in VETAs selected to pilot the soft skills program

Intervention 6.2 – Integrating life skills training into the school system provides a systemic solution which has the potential to reach all in-school students and result in an overall improvement in wellbeing. The evidence shows that a comprehensive life skills training for adolescents results in improved wellbeing. In South Africa, The National Department of Education, Health and Welfare in collaboration with support organizations initiated a life skills training in schools, to address some of the most challenging psychosocial problems that young people face, such as HIV/AIDS, substance and child abuse. The rationale was to embed HIV/AIDS education within a broad series of skills relating to self-esteem, interpersonal relationships, citizenship and health. Results of a 2012 qualitative study showed an overall high psychosocial benefit for wellbeing demonstrating the importance of a holistic approach to health and wellbeing. A life skill training not only improves economic empowerment, but also 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 was introduced to primary schools in 1995 and revised in 2005, covers 11 skills which are considered essential for ‘work’ life. However, despite the existence of this manual it receives very little utilization because of the complexity in the instructions. It is also currently limited to primary schools. Capacity building for trainers can help bridge this gap with a subject that has long been ignored.

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	<ul style="list-style-type: none"> Limited opportunity for soft skills training in secondary schools Lack of skills for effective employability or entrepreneurship
Intended Outcome ⁸⁴	Increased number of adolescents who receive soft skills training
Suggested Activities	
6.2.1	Educate school management, parents and the community on the significance of this subject

⁸⁴ Specific targets for outcomes are included in the M&E Annex section

- 
- 6.2.2** Training teachers on "Study za Kazi" extracurricular program in primary and secondary schools to comprehensively address adolescent health, soft-skills for employment and wellbeing
- 6.2.3** Select teachers to train to head up the "Study za Kazi subject" in schools and: train teachers on using the life skills manual, and/or addressing stigmatisation of adolescent issues, managing assessment of delivery of the life skills program and assessing the performance of students on the program (annually) and final reporting of school-level outcomes to WEOs and DEOs, CHWs and MoHCDGEC

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
- 7.2 [Aged 10-19]: Offer cash transfers for in and out of school students from disadvantaged communities

Intervention 7.1 – Expanding access and improving quality of “adolescent-friendly comprehensive services”, in areas of need, will support adolescents’ uptake of SRH services, thereby increasing likelihood of preventing HIV and teenage pregnancies. Adolescents require access to quality sexual and reproductive services to meet their development needs. However, adolescents often face barriers – such as community and provider stigma, social and cultural norms, lack of privacy and confidentiality, and legal and policy barriers – to quality SRH services. As a result, adolescents are often unable to exercise their right to healthy sexual and reproductive lives.⁸⁵ Studies show that only 30% of health service delivery points meet the national standards for AFHS in Tanzania. This is much lower than the national target which aimed to have 80% of health facilities providing AFHS by 2015.⁸⁶ Emerging global guidance suggests that, to reach youth in a sustainable and scalable way, youth-friendly services must be mainstreamed in the community and health systems.⁸⁷ Improved “adolescent-friendly comprehensive services” along various levels of health facility, community, health service, and health worker will therefore encourage adolescents to seek SRH services.

Overall, there is a need to scale the provision of adolescent-friendly health services.⁸⁸ Today, HIV and SRH programs usually also include a component of adolescent-friendly services. Thus, programs with adolescent-friendly health services are likely, similarly, focused on regions including Morogoro, Shinyanga, Mwanza, Kagera, Mara, Geita and Dar es Salaam⁸⁹ aligning with the provision of HIV and SRH services. Although there is interest to increase the provision of AFHS, the number of AFHS facilities in the country is small demonstrating the need to extend resources.

Intervention


⁸⁵ Pathfinder International, Mainstreaming youth-friendly sexual and reproductive health services in the public sector in Mozambique and Tanzania, 2017

⁸⁶ UNICEF, Adolescence in Tanzania, 2011

⁸⁷ Pathfinder International, Mainstreaming youth-friendly sexual and reproductive health services in the public sector in Mozambique and Tanzania, 2017

⁸⁸ HSSP IV 2017-2022

⁸⁹ Dalberg analysis



Intervention	7.1 Behavioural/Structural: Expand access and improve quality of adolescent-friendly comprehensive services
Target age range	10 – 19
Gap addressed	<ul style="list-style-type: none"> Limited services that meet national standards for AFHS (only 30% of service delivery points meet the national standards) Health workers lack knowledge and have unfriendly attitudes towards adolescents
Intended Outcome	<ul style="list-style-type: none"> Increase RCH facilities with youth-friendly services Increase community based outlets offering comprehensive sexuality education & SRH services Reduce new HIV infections among adolescent boys and girls and young women Reduce teenage pregnancies among adolescent girls
Suggested Activities	
<p>7.1.1 Conduct orientation to RHMT, CHMT members, facility staff (including guards), gender desk workers, social welfare officers on adolescent-friendly services</p> <p>7.1.2 Train healthcare workers on adolescent-friendly health services as per national standards for provision of SRH services</p> <p>7.1.3 Perform random check-ins on healthcare workers' service provision and behaviours towards adolescents</p> <p>7.1.4 Integrate adolescent-friendly comprehensive SRH services into the existing facility star rating national program for clients to indicate service quality, supporting supervision needs</p> <p>7.1.5 Develop a facility feedback mechanism where adolescents can rate the facilities' service quality regularly by SMS every time after a visit</p> <p>7.1.6 Advocate for inclusion of adolescent health program in supervision and council budgets</p> <p>7.1.7 Advocate to health facilities so they have specific adolescent-friendly days/hours in pilot regions</p> <p>7.1.8 Renovate facility infrastructure 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 in every health facility)</p> <p>7.1.9 Set up community-based mobile clinics operated by young workers where adolescents can access services freely as an option outside of health facilities</p> <p>7.1.10 Integrate AFHS into Antenatal, Postnatal and New-born Care Services (e.g. train midwives to attend adolescent mothers in a friendly and non-judgmental way, conduct specific adolescent training on ANC, PNC and new-born care)</p> <p>7.1.11 Engage community in supporting adolescents with special needs on professional and assistive devices</p>	

Intervention 7.2 - Offering cash transfers for in and out of school students from disadvantaged communities can support improved school attendance, reduced new HIV infections and reduced fertility rate for adolescents. 60% of primary school age out-of-school children live in 20% of the poorest households

by standard of per capita household consumption.⁹⁰ Most boys and girls are taken out of formal schooling at 15-16 years old and drawn to informal employment to support families with household expenses.⁹¹ Financial constraints also encourage risky sexual behaviour such as transactional sex among adolescents. By providing cash assistance at regular intervals to adolescents from disadvantaged communities conditional cash transfers can bring improved outcomes for adolescents' education as well as reduce their risk-taking sexual behaviours. Cash transfers can be tied to pre-determined conditions, such as having beneficiaries be part of a school club where they receive SRH education.

Today, the main conditional cash transfer program implemented by TASAF/PSSN, Cash Plus, focuses on the Southern regions in Iringa and Mbeya and is under review to scale up the program to other regions. There are also other cash transfer programs; for example, there is a program currently being run by DREAMS/PEPFAR that focus on Kahama, Mbeya city, Shinyanga, Kyela and Temeke, and aims to target c.65,000 AGYW⁹². Intervention 7.2 can build on existing programs, working with current implementing partners and scaling to other regions.


Intervention	
Intervention	7.2 Offer cash transfers for in and out of school students from disadvantaged communities
Target age range	10 – 19
Gap addressed	Financial constraints contribute to lowered school attendance, and increased propensity of risky sexual behaviour that leads to an increase in HIV infection and fertility rate among adolescents
Intended Outcome	<ul style="list-style-type: none"> • Improve school attendance for adolescents • Reduce new HIV infections for adolescents • Reduce adolescent fertility rate for women
Suggested Activities	
7.2.1 Fundraise for CCTs 7.2.2 Identify and register program participants 7.2.3 Determine product conditions, structure and disbursement with MoEST, PO-RALG, TASAF & MoHCDGEC 7.2.4 Market the CCT to community stakeholders (parents, headmasters and DEOs) and educate stakeholders on the intended outcomes 7.2.5 Disburse CCTs to adolescents in and out of school	

SBCC and gender mainstreaming are critical elements which are difficult to measure on their own but are integrated as concepts or activities under several interventions. Effective and high-quality SBCC has the

⁹⁰ UNICEF, Tanzania Country Report, 2018

⁹¹ <http://www.thecitizen.co.tz/News/Alarm-as-more-boys-than-girls-drop-out-of-school/1840340-3385772-15r0hhwz/index.html>

⁹² <https://www.pepfar.gov/documents/organization/253960.pdf>



potential to impact long-term change as it influences positive social and cultural norms. While such long-term effect is typically difficult to measure, there are some studies that show that it 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. SBCC has shown to be effective in promoting nation-wide conversations that may precipitate desired long-term change. In particular, evidence shows that SBCC campaigns are highly effective in countering social norms using media (e.g. radio which is widely cited), and leveraging influencers such as religious and community leaders, and celebrities. The agenda integrates SBCC in the different interventions as activities. For example, interventions 1.1 and 1.2 under Preventing HIV and intervention 3.2 under Preventing Sexual, Physical & Emotional violence include SBCC campaigns as key activities. These SBCC activities are particularly important to interventions that seek to change deep-rooted practices. For example, SBCC campaign is critical in intervention 3.2 to address the culture of silence that is associated with stigma, fear and social alienation which discourage reporting of violence. Parents and caregivers, as adolescents' significant gatekeepers, are also important actors to consider in terms of influencing behaviours and are key targets in SBCC campaigns.

Gender mainstreaming is also another key cross-cutting element integrated into the agenda. It considers the specific needs of men, women, girls, and boys with respect to both biological/sex differences and sociocultural gender. Emerging evidence and program 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 is a promising intervention towards improving maternal and child health. This was substantiated by adolescents, as one reasoned, *"We also need to educate them [boys] to be healthy husbands and fathers in the future"*⁹³. 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 both adolescent boys and girls in PPTCs, while intervention 1.3 will scale voluntary male circumcision. Gender mainstreaming also provides room for adolescent boys and girls, men and women to become allies. This is particularly important to increase demand for products and services whose direct beneficiaries are only adolescent girls, such as in intervention 2.2 that provides evidence-based methods for teenage pregnancy prevention and in intervention 4.1 that provides iron-folic acid supplements.

PART III - ENABLERS

An improvement in the enablers is necessary to support the success of the prioritized interventions. Enablers are concepts that do not directly impact the outcome of the pillar-specific interventions, but that are necessary in fostering the momentum and feasibility of the interventions, and in promoting evidence-based learning to improve practices. Critical enablers considered include data, monitoring and evaluation (Data, M&E) and coordination.

Both Data, M&E and coordination are critical to ensure that the agenda is effectively implemented, managed and tracked. Data, Monitoring and Evaluation (Data, M&E) ensures effective and efficient planning, implementation and reporting of interventions. This will inform whether changes need to be made during implementation of interventions and their respective activities. The Data, M&E system will provide room for dialogue and decision-making based on the evidence emerging from the data to ensure learnings are quickly incorporated in implementation. Similarly, coordination of activities helps to identify and leverage synergies between implementing partners as well as creating alignment with international targets and government

⁹³ Quote from the 2018 National Adolescent Conference in Dodoma

policies. This has the potential to streamline resources towards achieving similar targets for adolescent health and wellbeing. The specific considerations for Coordination and Data, M&E are elaborated below.

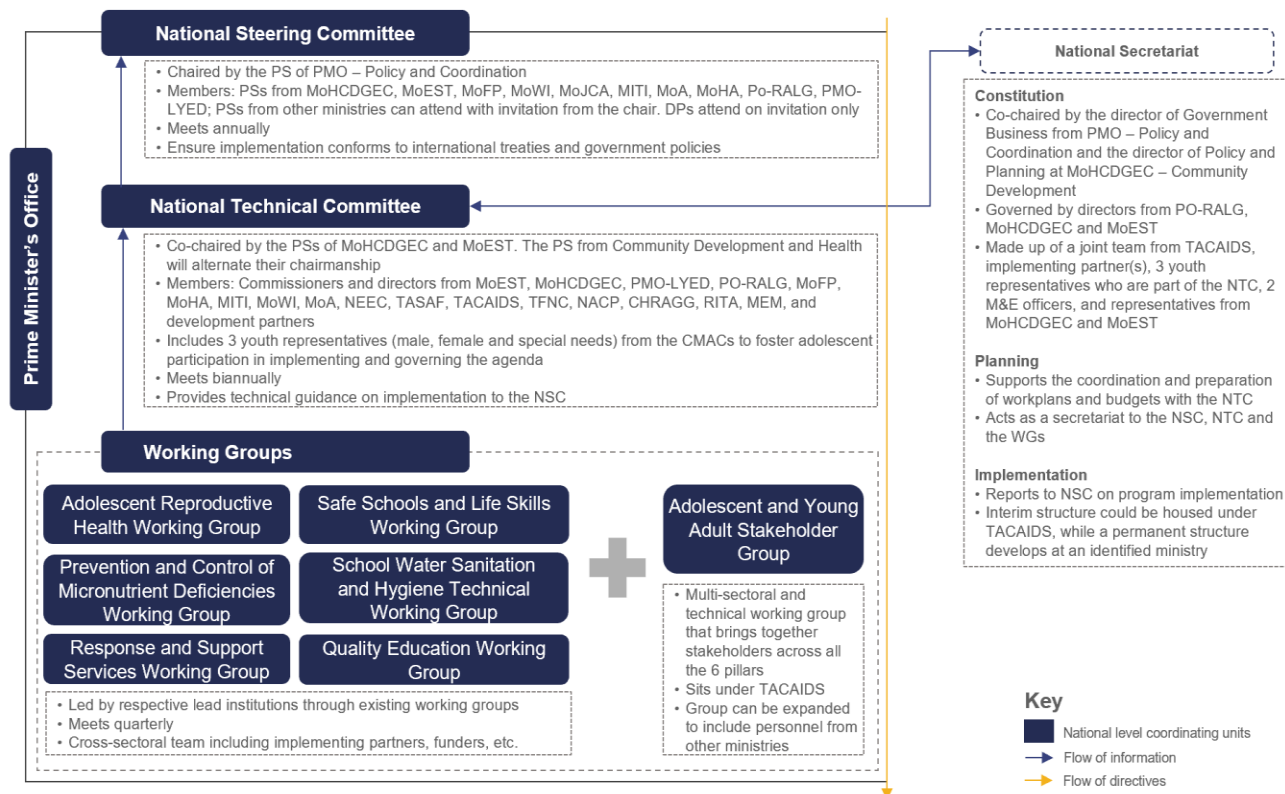
COORDINATION

OVERVIEW


The agenda recommends an optimized coordination and implementation structure to streamline and operationalize interventions, utilizing existing structures. The proposed mechanism will leverage the TACAIDS and the National Plan of Action to End Violence Against Women and Children in Tanzania (NPA-VAWC 2017/18 – 2021/22) coordination mechanisms given existing capacity of the structures, overlapping membership structure with adolescent stakeholders, thus reducing operational costs. The purpose of these proposed mechanisms is to ensure that all activities are aligned with international and national targets and government policies, enhance synergies between implementing partners, and develop opportunities for sharing knowledge and best practices. These mechanisms also seek to strengthen intersectoral coordination and cooperation among adolescent stakeholders and enhance their role in implementation of the NAIA_AHW. To achieve these objectives, the proposed mechanisms will leverage existing ministerial structures that will be supported by a National Secretariat to oversee the day-to-day operationalization of the NAIA_AHW.

COORDINATION STRUCTURE

FIGURE 8: PROPOSED COORDINATION STRUCTURE



The coordination structure will operate at both the national and the sub-national levels given that implementation is multi-sectoral and cross-jurisdictional. At the national level, the coordinating units will ensure that NAIA_AHW plans are aligned with national targets and government policies and develop best practices and instruments for knowledge sharing that will be streamlined to the sub-national level



coordinating units. At the sub-national level, coordinating units will enhance synergies between implementing partners, ensure 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 proposed coordination structure will sit within PMO – Policy and Coordination and will be supported by the National Steering Committee (NSC), the National Technical Committee (NTC) and the Working Groups (WGs). The NSC will be chaired by the Permanent Secretary of PMO – Policy and Coordination, who has the mandate to bring together sectoral stakeholders. The NSC will be composed of permanent secretaries from MoHCDGEC, MoEST, PMO-LYED, MoFP, MoW, MITI, MoHA, MoJCA, MoA and country directors of identified development partner organizations and CSOs. Permanent Secretaries from other ministries can attend upon request from the chair. The NSC will meet annually to discuss the agenda of the NAIA_AHW. The National Protection Steering Committee under the NPA-VAWC will be leveraged to facilitate the meeting of the NSC given overlapping membership structures. 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.

The Working Groups (WGs) are thematic working sessions under existing strategy and ministerial bodies that will push the NAIA_AHW agenda. The Adolescent and Young Adult Stakeholder Working Group (AYAS), which is under TACAIDS is a multi-sectoral adolescent-specific working group. It brings together technical personnel from MoHCDGEC, MoEST, PMO-LYED, PO-RALG, MoHA, PMO – Policy and Coordination, youth representatives and implementing partners. Additional members could be co-opted into AYAS such as those from TFNC, TASAF, MoW, TIE and NEEC. AYAS will advocate for the NAIA_AHW agenda at the national level, and directly liaise with the NTC to provide information on the progress of program implementation.

In addition to AYAS, the following existing working groups will be leveraged:

- Preventing HIV and Preventing Teenage Pregnancies – *Adolescent Reproductive Health Working Group* under the MoHCDGEC
- Preventing Teenage Pregnancies and Keeping Boys & Girls in school – *Adolescent Reproductive Health Working Group* under the MoHCDGEC
- Preventing Sexual, Physical & Emotional Violence – *Safe Schools and Life Skills Working Group and Response and Support Services* under NPA-VAWC
- Improving Nutrition – *Prevention and Control of Micronutrient Deficiencies Working Group* under the NMNAP
- Keeping Boys & Girls in School – *School Water Sanitation and Hygiene Technical Working Group* under the Water Sector Development Plan and *Quality Education Working Group* under the ESDP
- Developing Soft Skills – *Quality Education Working Group* under the ESDP⁹⁴

The membership structure and meeting frequency of these WGs and AYAS is provided under the Annex section.

IMPLEMENTATION STRUCTURE

The PO-RALG is responsible for the day-to-day implementation of all identified NAIA_AHW activities at the regional, district, ward and village/street levels. To avoid duplication of efforts and resources, and to enhance service delivery to adolescents, it is important to utilize existing structures at various levels of

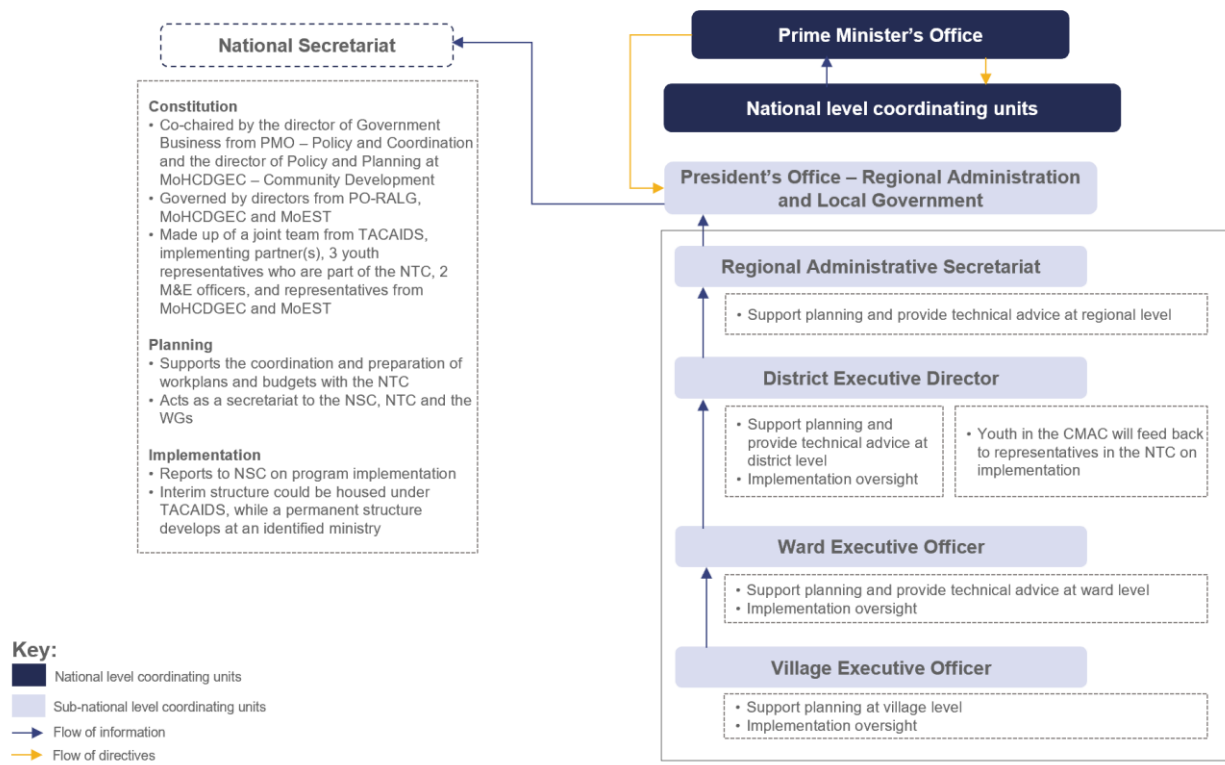
⁹⁴ The Skills Development Working Group is currently going through formalization process. The group could be more relevant in coordinating NAIA_AHW interventions once it is recognized in formal government dialogue


government. This will ensure easier integration into government functions and will capitalize on existing resources. The Regional Administrative Secretariat (RAS), the District Executive Director (DED), the Ward Executive Officer (WEO) and the Village Executive Officer (VEO) will support planning, provide technical advice and implementation oversight at their respective regional, district, ward and village/street levels.

The National Secretariat will serve as a link between the national and sub-national level and will implement daily coordination activities and operationalization of the NAIA_AHW. The Secretariat will be co-chaired by the Director of Government Business from PMO – Policy and Coordination and the Director of Policy and Planning from MOHCDGEC – Community Development. It will be governed by directors and commissioners from PO-RALG, PMO, MoEST and MoHCDGEC. Members of the secretariat will include 2 M&E officers, personnel from TACAIDS, 3 youth representatives that are part of the NTC, MoHCDGEC, MoEST and coordination units from PMO and PO-RALG. The National Secretariat will be housed by an organization that has a track record in coordinating different adolescent sectors and has existing capacity to carry out the responsibilities of the Secretariat. Potential interim National Secretariat could be housed in TACAIDS while a permanent structure develops under an identified ministry given existing capabilities in coordinating multisector actors of adolescent activities.

Coordination will primarily occur through meetings and virtual sharing of data/information among adolescent stakeholders. Progress updates on implementation of prioritized activities will flow from the village/street, ward, district, regional 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 done virtually or through meetings such as the Full Council and the District Council Committee meetings.

FIGURE 9: PROPOSED IMPLEMENTATION STRUCTURE





The National Secretariat will collate information from the PO-RALG and share with the NTC for technical advice. In addition to this, the NTC will also receive information from the WGs who 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. Through the annual NSC meetings, NAIA_AHW activities will be reviewed to ensure that they are aligned with international treaties, government policies and set national targets. In consultation with the NTC, the NSC will have the mandate to advise adolescent stakeholders, particularly PO-RALG, on how to improve implementation of activities.

ACTIVITIES

Key activities of the coordination structure include developing operationalization guidelines, supporting the meeting of the NSC, the NTC and the some of the working groups, advocating for funding of the agenda, and conducting operational research on emerging issues. The national level budget will go towards compensation benefits, purchase of technical equipment and building capacity for sitting members of the nation-level coordinating structures such as officers in the National Secretariat. District-level cost includes activities such as conducting supportive supervision in councils and building capacity of council officials to implement program activities. A more detailed set of activities with relevant costing is provided in the coordination annex section.


DATA, MONITORING AND EVALUATION

DATA AND DATA SYSTEMS

Health and education information systems are a critical component and important factor in driving better health and wellbeing outcomes. Information flow to adolescents and concerned parties can positively influence health-seeking behaviours and attitudes, and thereby improve uptake of adolescent services. On the other hand, collection, synthesis and sharing of basic demographic, health as well as programmatic data is critical in planning for and determining the outcomes of existing programmes. Finally, data and information can also be leveraged through research to inform future approaches and guide development of programmes and interventions.

Tanzania has multiple data systems that gather data and provide information on the state of adolescents in the country; however most of these systems focus on health. The MoHCDGEC's main health management information system – HMIS (managed through DHIS-2, a web-based software that allows for real-time data entry, control and feedback) is the main system that collects information on adolescent health. Additionally, different players in the adolescent health sector also run their own information management systems. For instance, NACP runs the Care and Treatment Clinic II (CTC-2) data system which mainly tracks data on HIV/AIDS treatment and care; implementing agencies such as UNICEF and PEPFAR run their own data tracking systems to monitor program performance, and local governments also collect data separately as part of their internal evaluation activities. There are other data systems that partly provide information on adolescents beyond the health spectrum; e.g. the education management information system (EMIS) and road accident information system (RAIS) among others. However, majority of these systems lack comprehensive adolescent-specific data as they do not specifically target adolescents through the indicators used.

Lack of clearly defined adolescent indicators to guide the collection of adolescent data is a key limitation to rigorous data collection through existing systems. Apart from implementing agencies, data systems such as HMIS and the CTC II collect general health data for all populations across the country based on the HSSP IV guidelines. As such, these systems only cover basic adolescent indicators as part of broader indicator sets. For instance, the HMIS indicators only cover adolescents in specific intervention and programmatic areas such as family planning, gender-based violence and VAC, tracer medicine and antenatal care. On the other hand, indicators measuring infectious diseases, nutrition and malaria do not account for adolescents despite



these being key issues that affect them. Furthermore, these systems do not collect adolescent data on areas other than health, including issues such as deaths and injuries due to accidents and violence, school attendance, and cases of gender-based violence.

Further, existing adolescent health and wellbeing data is not adequately age disaggregated, and often categorizes adolescents as one large demographic group. For instance, Outpatient-Inpatient (OP/IP) data collected through the routine HMIS system only contains three categories i.e. '5 and below', '5-60 years old' and 'above 60 years'. Consequently, this results in the lack of disaggregated information for 10-19-year-old populations. Where datasets cover adolescents (e.g. within the HMIS), they are categorized into either 'under 20-year-old' or '10-24 years' and do not disaggregate this data further by age or other demographic parameters. This creates information gaps in the evaluation systems as there is a limited understanding of specific variances that may exist within various demographics of the adolescent bracket e.g. based on age, gender, socio-economic status, geography, etc.

Finally, lack of capacity and demanding workloads among health workers results in poor motivation to invest in data collection consequently compromising the accuracy, completeness and timeliness of the data collected. In addition to low capacity to collect data, officials at health facilities and district level lack the capacity to analyse and utilize data to guide daily operations and management at facility level and inform strategic decision making at district level. Furthermore, there is a general lack of appreciation of data analysis and utilization at local levels that is driven by a perception that data is only relevant at the national levels. This drives the need for performance metrics and dashboards at district (LGA) level that can allow workers at these levels to track performance and ensure accountability.

To address the critical issues around having divergent approaches to collecting and synthesizing data, as well as lacking adequately age disaggregated health and wellbeing data, the following strategic priorities are recommended:

Strategic recommendations and activities:

1. **Recommendation: 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 activity: Advocate to key ministries to request data-driven reports** to drive collection and analysis of proper data from the village, ward, district, regional up to the national level
 - **Suggested activity: Set up performance metrics/commitments that are aligned with NAIA_AHW targets for government staff** to support performance management and maintain accountability
 - **Suggested activity: Train service providers to improve their capacity to collect, synthesize and use adolescent data** to improve service delivery to adolescents at a facility and community level
 - **Suggested activity: Develop and roll out data dashboards at district (LGA) level** that can allow workers at these levels to track performance and ensure accountability on adolescent health and wellbeing within districts and facilities
2. **Recommendation: 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 and education level, etc.

- Suggested activity: **Review existing indicators in data systems such as HMIS and EMIS** and develop recommendations on additional indicators that will enable collection of adolescent data. Current system lacks integral data indicators that are crucial in understanding adolescent health
- Suggested activity: **Advocate for disaggregation of 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 uniform adolescent related data is collected across the entire country on a regular basis

While the above data and data systems-related priorities are recommended, only certain activities that are directly within the scope of NAIA_AHW agenda's M&E program are included in the costing model. Detailed monitoring and evaluation activities and funding costs are included in the annex section.

MONITORING AND EVALUATION

Insufficient tracking of progress and results, and a siloed approach in assessment of adolescent program outcomes result in limited information on program performance. Adolescent programs are not always comprehensive during implementation and have fragmented activities that could be better coordinated to feed into shared metrics. While national data systems focus on broader health metrics, funders and implementing partners conduct their internal monitoring and evaluation which follow varied methodologies across different organizations. Such programmatic evaluations focus on program outputs resulting in information gaps in correlating outputs to long-term health and wellbeing outcomes. Consequently, this has led to limited understanding of the long-term outcomes and collective impact of adolescent health programs in Tanzania. Furthermore, information on the funding of these programs is poorly tracked hence resulting in very limited data on the investment that goes into different areas within adolescent health and wellbeing.

Though there exists multiple monitoring and evaluation tools among various partners, these data collection and evaluation systems are fragmented. Information sharing across the different platforms is very limited, primarily due to poor coordination and lack of a streamlined data and progress sharing mechanism. Implementing agencies for instance rely on their internal data systems to guide decision making despite the existence of elaborate data systems that are collected through the HMIS. Despite the provision of a HMIS web portal where partners and players in adolescent health can access data to monitor health outcomes, the data presented on the portal is often limited to specific indicators. Access to more detailed information is requested on an ad-hoc basis and requires direct outreach to specific teams across the sector. This process can often be bureaucratic and tedious due to the lack of clear data dissemination processes and mandate for sharing data from the ministry. Fast-tracking this process could yield benefits as this could potentially inform programs and interventions going forward.

To ensure NAIA_AHW tracks not only programmatic outputs but also long-term health and wellbeing outcomes and impact, and data collection and evaluation systems are streamlined across government and implementing partners, the following monitoring and evaluation framework is proposed.

AGENDA MONITORING AND EVALUATION OVERVIEW

Data, Monitoring and Evaluation (Data, M&E) of NAIA_AHW ensures effective and efficient planning, implementation and reporting, and will inform whether changes need to be made throughout and potentially beyond implementation to strategic areas of intervention and their respective activities. The general objective of monitoring is to provide room for dialogue and decision-making based on data collected from interventions/activities.

The specific objectives of monitoring include:

- i. To ensure timely availability of reliable and adequate data on NAIA_AHW activities
- ii. To carry out research, studies and reviews to provide more data and information
- iii. To enhance storage, retrieval, access, and use of data by government and stakeholders
- iv. To promote evidence-based planning, implementation and reporting

For these objectives to be realized, the existing monitoring systems need to be adjusted to collect reliable, consistent and age-aggregated data. Systems also need to be aligned with Ministries, Departments and Agencies (MDAs) and LGA strategic plans and monitoring, including harmonization with sectoral monitoring and evaluation frameworks. The coordination team and technical ministry will ensure efficiency and effectiveness in monitoring through:

- i. Development of monitoring guidelines
- ii. Provision of capacity building to key stakeholders in implementation and data collection, processing, analysis, and reporting
- iii. Facilitation of joint monitoring and evaluation of activities implementation
- iv. Consolidation of monitoring and evaluation 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 an impact (pillar), and outcome (intervention) level (activity output is not included here as activities are not defined as part of a program yet). The suggested framework can act as a draft for M&E experts to further develop on a pillar, intervention and activity level during the development of the M&E plan at the start of implementation. For each specific pillar, intervention and activity, information including indicators, the baseline information, targets, data source, frequency of data collection and reporting, and responsible agency or agencies for data collection will be detailed. M&E officers will collect information based on both quantitative and qualitative indicators, depending on the subject nature and data availability. Baseline surveys will be conducted to establish missing data for indicators with no baseline data. An illustrative NAIA_AHW Results Framework is shown below, and a detailed NAIA_AHW Results Framework is shown in the annex section.

FIGURE 10: ILLUSTRATIVE 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 10-24 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

FIGURE 11: M&E DATA FLOW



COSTING

Page | 53



the four year-period based on assumptions for when the proposed activities will be implemented. The costs presented below are indicative of a ‘worst case scenario’ considering the total costs to implement 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 as either district level or national level depending on how it is likely to be implemented, and to allow for mode adaptability in the targeted number of districts. National level costs are costs of activities that require the same quantity of resources, regardless of the reach of the program. This includes activities such as reviewing national training curriculum, advocating for public-private partnerships and developing the NAIA_AHW coordinating units. District level costs are associated with those activities that are dependent on the targeted number of districts. This includes activities such as developing comprehensive WASH packages for schools or conducting training workshops for teachers across schools. Implementing the core national elements over the next four years will cost an estimated TZS 12B/=-, while the cost of implementing in one district over four years is TZS 15B/=-.

Assuming the NAIA_AHW will be implemented in a total of 43 districts, it is estimated to cost TZS 644B/=- over four years (figure 12). In this initial costing exercise, selected regions include Mwanza, Simiyu, Geita, Tabora, Mara, Shinyanga, and Mbeya, and assumes that we are implementing in all the districts of these regions. These regions were selected because, relatively, they face some of the greatest burden across majority of the pillars. The greatest costs are anticipated in Pillar 1 given that it has the greatest number of interventions compared to the other pillars. More specifically VMMC significantly drive up the cost of implementation. Implementation of all activities excluding the VMMC interventions will cost TZS 11B/=- per district within four years, which is an estimated TZS 485B/=- in 43 districts over a four-year period. Comparatively, implementation with VMMC interventions costs TZS 15B/=- per district within four years, which is an estimated TZS 644BT/=- in 43 districts over a four-year period. Finally, for nation-wide district-level implementation, the estimated cost is TZS 1.8T/=-, adding TZS 1.7T/=- to programmatic costs. This considers implementation across all 162 districts of Tanzania Mainland.



FIGURE 12: ESTIMATED TOTAL COST ACROSS 43 DISTRICTS

Pillar	Interventions	2019	2020	2021	2022
Preventing HIV	Total	TZS 10,770,858,493.50	TZS 16,926,094,955.59	TZS 11,094,632,239.08	TZS 17,111,249,219.79
	National Level	TZS 393,750,000.00	TZS 303,187,500.00	TZS 549,871,875.00	TZS 91,162,968.75
	District Level	TZS 10,377,108,493.50	TZS 16,622,907,455.59	TZS 10,544,760,364.08	TZS 17,020,086,251.04
Preventing Teenage Pregnancy	Total	TZS 14,479,089,492.90	TZS 31,804,399,714.50	TZS 47,912,435,342.10	TZS 31,102,460,156.49
	National Level	TZS 588,107,622.90	TZS 1,059,882,862.50	TZS 530,823,155.63	TZS 314,263,063.41
	District Level	TZS 13,890,981,870.00	TZS 30,744,516,852.00	TZS 47,381,612,186.48	TZS 30,788,197,093.08
Preventing Physical, Sexual and Psychological Violence	Total	TZS 4,075,911,073.50	TZS 4,924,454,062.50	TZS 5,590,565,875.13	TZS 5,303,770,358.91
	National Level	TZS 220,643,325.00	TZS -	TZS 217,790,937.00	TZS -
	District Level	TZS 3,855,267,748.50	TZS 4,924,454,062.50	TZS 5,372,774,938.13	TZS 5,303,770,358.91
Improving Nutrition	Total	TZS 4,587,247,407.79	TZS 2,345,659,714.43	TZS 2,507,742,787.65	TZS 2,586,089,835.16
	National Level	TZS 10,500,000.00	TZS 2,778,300.00	TZS 2,917,215.00	TZS 3,063,075.75
	District Level	TZS 4,576,747,407.79	TZS 2,342,881,414.43	TZS 2,504,825,572.65	TZS 2,583,026,759.41
Keeping Boys and Girls in School	Total	TZS 16,234,924,125.00	TZS 18,449,682,063.75	TZS 24,125,953,229.44	TZS 25,312,195,037.78
	National Level	TZS -	TZS 18,191,250.00	TZS 19,100,812.50	TZS -
	District Level	TZS 16,234,924,125.00	TZS 18,431,490,813.75	TZS 24,106,852,416.94	TZS 25,312,195,037.78
Developing Meaningful Employment Opportunities	Total	TZS 6,398,794,605.00	TZS 28,425,571,287.75	TZS 34,637,934,318.75	TZS 36,624,395,845.68
	National Level	TZS 11,844,000.00	TZS 307,818,000.00	TZS -	TZS 60,775,312.50
	District Level	TZS 6,386,950,605.00	TZS 28,117,753,287.75	TZS 34,637,934,318.75	TZS 36,563,620,533.18
Cross Cutting	Total	TZS 14,492,874,897.90	TZS 32,091,248,070.00	TZS 32,136,596,100.00	TZS 7,092,600,519.38
	National Level	TZS 1,144,277,397.90	TZS 946,890,945.00	TZS -	TZS -
	District Level	TZS 13,348,597,500.00	TZS 31,144,357,125.00	TZS 32,136,596,100.00	TZS 7,092,600,519.38
Monitoring & Evaluation	Total	TZS 1,001,059,500.00	TZS 91,743,435.00	TZS 180,837,231.75	TZS 192,553,208.30
	National Level	TZS 548,656,500.00	TZS 35,423,325.00	TZS 121,701,116.25	TZS 130,460,287.03
	District Level	TZS 452,403,000.00	TZS 56,320,110.00	TZS 59,136,115.50	TZS 62,092,921.28
Sector Coordination	Total	TZS 1,859,235,000.00	TZS 1,604,688,750.00	TZS 1,684,923,187.50	TZS 1,769,169,346.88
	National Level	TZS 1,364,842,500.00	TZS 1,085,576,625.00	TZS 1,139,855,456.25	TZS 1,196,848,229.06
	District Level	TZS 494,392,500.00	TZS 519,112,125.00	TZS 545,067,731.25	TZS 572,321,117.81
Total National Level Costs		TZS 4,282,621,345.80	TZS 3,759,748,807.50	TZS 2,582,060,567.63	TZS 1,796,572,936.50
Total District Level Costs		TZS 69,617,373,249.79	TZS 132,903,793,246.02	TZS 157,289,559,743.77	TZS 125,297,910,591.86
TOTAL ANNUAL COSTS (VMMC Excluded)		TZS 73,899,994,595.59	TZS 136,663,542,053.52	TZS 159,871,620,311.40	TZS 127,094,483,528.36
Preventing HIV	Total	TZS 42,428,177,400.00	TZS 44,549,586,270.00	TZS 47,200,177,521.00	TZS 24,335,825,664.15
	Intervention 1.3 (VMMC)	TZS 42,428,177,400.00	TZS 44,549,586,270.00	TZS 47,200,177,521.00	TZS 24,335,825,664.15
TOTAL ANNUAL COSTS (VMMC Included)		TZS 116,328,171,995.59	TZS 181,213,128,323.52	TZS 207,071,797,832.40	TZS 151,430,309,192.51



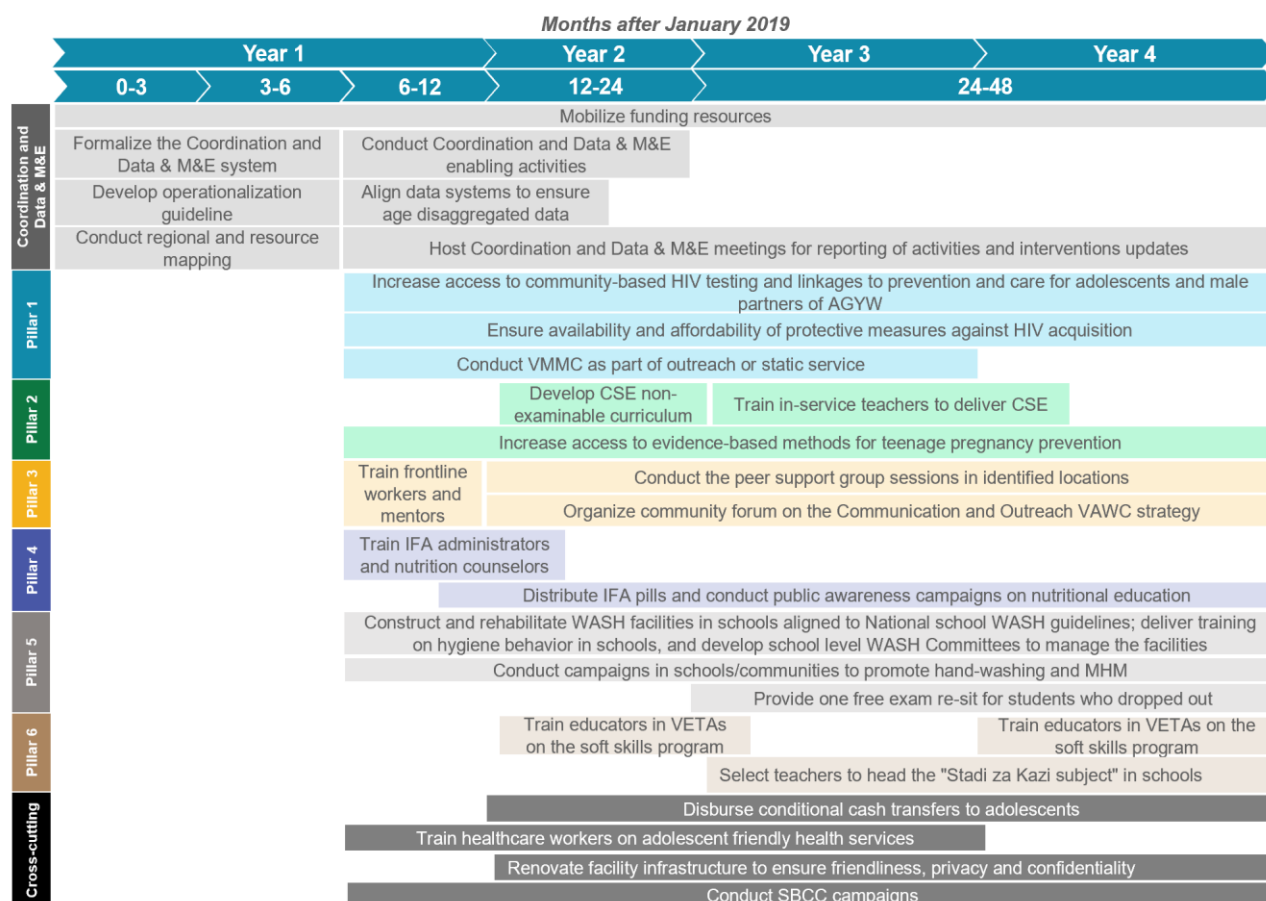
Coordination and Data, M&E account for an estimated 45% of the total national-level cost, and an estimated 0.4% of the total district-level cost. The total cost of implementing coordination activities at the national level is TZS 4.8B/= while implementation at a per district level is TZS 50M/=. This accounts for 39% of the total national level cost, and 0.3% of the total district level cost. The total cost of implementing data, M&E activities at the national level is TZS 836M/= while implementation at the district level is an estimated TZS 38M/= ⁹⁵. This accounts for 6.7% of the total national level cost, and 0.1% of the total district level cost.

While the costing model is useful in providing a high-level picture that is indicative for fundraising purposes, it is designed to be flexible and can adjust to match different implementation priorities. Therefore, once program priorities are identified, and the program is fully developed, an additional budgeting exercise will need to be conducted during program design 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.

⁹⁵ This includes cost to coordinate joint multi-sectoral monitoring visits and reviews to LGAs annually, which will be conducted on a few districts based on random sampling. The model currently assumes 25% of total districts targeted. Cost incurred without this activity per district is TZS 15M/=

PART IV - A ROADMAP FOR ACTIVATION OF AGENDA

FIGURE 13: HIGH LEVEL IMPLEMENTATION OF NAIA_AHW⁹⁶



To maximize the impact of the NAIA_AHW, interventions should be rolled out as a comprehensive package of services. Comprehensive program design will ensure a holistic view of adolescent health and wellbeing by integrating services across the agenda, as well as considering other supporting activities that help achieve the overarching vision. The program design should not include every intervention across all pillars in each of the selected regions and districts, instead, a comprehensive program 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 ensure that while maintaining its overarching vision, NAIA_AHW is adapted to both the region and the population that it serves.

KEY CONSIDERATIONS

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

⁹⁶ Figure 13 includes key activities across the 6 pillars and the Coordination and Data, M&E systems. Detailed activities for each intervention are included in the pillars section, while detailed activities for coordination and data, M&E systems are in the annex sections

- **Region(s) and districts of implementation:** Given that NAIA_AHW is a comprehensive agenda that does not target pillars in silo, the choice of regions should be driven by both the combined burden across pillars as well as the existing programs in that region. This ensures that selected regions and districts are those which are most vulnerable to adolescent health and wellbeing holistically. It should also consider existing programming in those regions to ensure that efforts are complementary and not duplicative of what already exists. Pillar-specific nuances should also be considered, especially in select cases where the intervention only applies to a very 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 specifically meet the needs and capabilities of all adolescent demographics and their specific needs. Some of the marginalized adolescent population that should be considered in program design include those living with HIV/AIDS, pregnant and parenting adolescents, those with special needs (this includes those who are physically disabled, visually or hearing impairment, cognitive and psychiatric disability etc.), survivors of violence and adolescents from poor households. In considering these populations it is important to think about adaptations at all levels including program design and roll-out.
- **Involving youth in program design and governance:** Continuing to involve adolescents in a meaningful way, is critical to the success of the NAIA_AHW. In this document, there are suggestions for adolescent participation during coordination. Adolescents can participate in decision-making from the district level as members of the Council Multisectoral AIDS Committees (CMACs) and continue to govern the NAIA_AHW at the national-level through youth representatives appointed to the National Technical Committee (NTC) and the National Secretariat. The role of marginalized adolescents in these governing bodies should also be considered. Beyond coordination there is an opportunity to further involve adolescents in other areas such as in 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 enjoy⁹⁷.”* Involving youth in program design will ensure that activities are geared to address their needs in an effective manner.

NEXT STEPS

After the review of the NAIA_AHW is complete and the action plan is endorsed, the following activities are necessary for effective implementation:

- Develop the National Secretariat that will lead the day-to-day operationalization and coordination of the NAIA_AHW
- Conduct regional and resource mapping to identify appropriate district for implementation and determine funding needs. The Lake Zone and Mbeya region are potential regions for implementation given the burden of vulnerability across the pillars and momentum of existing programming
- Design a comprehensive set of programs (program design can be guided by choice of regions or vice versa). This could also include resource mobilization campaigns from both government and development partners
- Develop an operational guideline including a set of tools
- Design and formalize the Data, Monitoring & Evaluation systems

⁹⁷ Quote from the 2018 National Adolescent Conference in Dodoma

- Launch the approved NAIA_AHW action plan
- Implementation of program interventions in identified districts

PART V - ANNEX

REGIONAL PROGRAMMING ANALYSIS

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

While the mapping exercise can provide a high-level indicative view of issue areas and programs; a more detailed mapping exercise is needed during the program design phase to fill current gaps. The current maps provide a high-level regional overview of 'problem areas' across the country, indicate where programs are concentrated on a regional level, and provide an indication of where the programmatic gaps. However, there are several limits to the maps due to limitations in data. The maps are therefore unable to provide a detailed overview of both programs and issue areas at the district level, describe the overview of resource allocation for adolescents, or provide a complete overview of actors including non-timebound programs.

COMBINED PILLAR MAPPING

FIGURE 14: COMBINED ISSUE MAP FOR ALL PILLARS

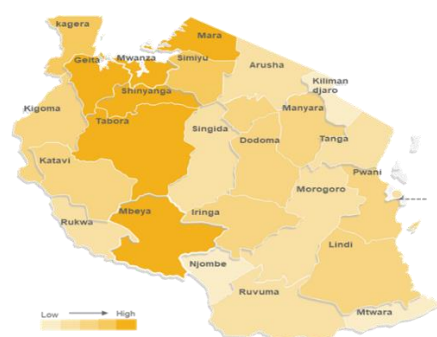
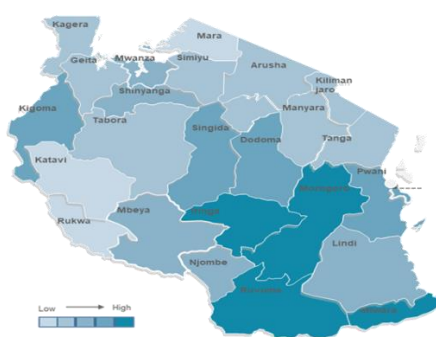


FIGURE 15: COMBINED PROGRAMS MAP FOR ALL PILLARS



Across all pillars, regions in the lake zone face the highest disease burden; in contrast, programs for adolescents are primarily 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 had poor performance across most pillars. There are a few cases where the trend is inconsistent, such as the case of Njombe. When taking a wholistic view, Njombe appears to be performing well across pillar indicators, and

while that is the case for most of the indicators, the situation is very different for pillar 1 (preventing HIV), where Njombe has the highest rate of HIV prevalence in the country. When looking at the spread of programs across the country, we found that programs targeting adolescents are mainly concentrated in the southern zones with regions like Iringa, Morogoro, Ruvuma and Mtwara reaching the greatest number of adolescents. In contrast, Katavi, has the least number of adolescents targeted by programs; regions like Manyara and Rukwa also reach a limited number of adolescents.

PILLAR 1 – PREVENTING HIV

FIGURE 16: HIV PREVALENCE AMONG ADULTS AGED 15 AND ABOVE



FIGURE 17: HIV PROGRAMMING FOR ADOLESCENT ACROSS REGIONS



As noted above, Njombe faces the highest rate of HIV prevalence for adults age 15 and above, followed by Iringa and Mbeya, in contrast most programming is concentrated in Morogoro. Regions which face the highest burden of HIV such as Njombe, Iringa and Mbeya are economic regions which are 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 Antiretroviral Therapy (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 programs 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 programs 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 program concentration.

PILLAR 2 – PREVENTING TEENAGE PREGNANCIES

FIGURE 18: PERCENTAGE OF WOMEN AGE 15-19 WHO HAVE BEGUN CHILDBEARING

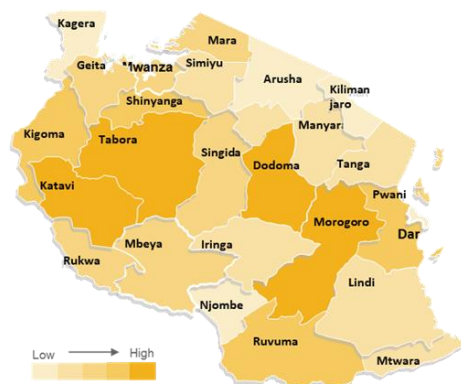


FIGURE 19: SEXUAL AND REPRODUCTIVE HEALTH (SRH) PROGRAMMING ACROSS REGIONS



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 socio-cultural norms. Select regions like Arusha, Kilimanjaro and Njombe have low rates of teenage pregnancies, 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. In contrast, 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, programs in these regions do not reach a substantial percent of adolescents.

PILLAR 3 – PREVENTING PHYSICAL, SEXUAL, AND EMOTIONAL VIOLENCE

FIGURE 20: PERCENTAGE OF WOMEN⁹⁸ WHO HAVE EXPERIENCED PHYSICAL/SEXUAL VIOLENCE IN THE PAST 12 MONTHS

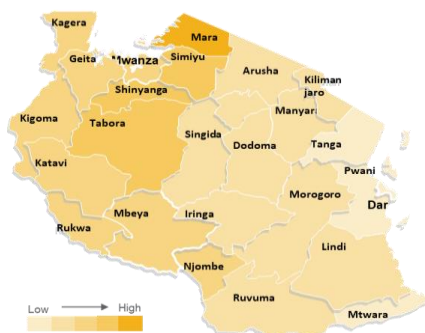
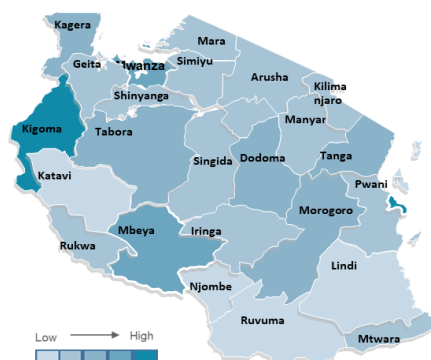


FIGURE 21: VIOLENCE PREVENTION AND RESPONSE PROGRAMMING FOR ADOLESCENTS ACROSS REGIONS



⁹⁸ Available data that is segmented by region uses prevalence of violence among women as an indicator. This indicator from the TDHS was used as a proxy for adolescents given limitations in region segmentation for the adolescent demographic

Rates of Gender-based violence (GBV) and violence against children (VAC) are particularly pronounced in Mara, Shinyanga and Tabora, but programs are mostly concentrated in Kigoma. In regions with high rates of violence, cultural norms such as wife beating perpetuate the cycle of violence; the weak linkages among police, health facilities and judicial systems also affect reporting. Although Pwani, Tanga and Mtwara experience fewer cases of violence compared to other regions, violence in these regions is still relatively high compared to 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, programs to counter violence in Kigoma reach the largest percent of the adolescent population across the country.

PILLAR 4 – IMPROVING NUTRITION

FIGURE 22: PREVALENCE OF ANEMIA IN WOMEN AGED 15-49

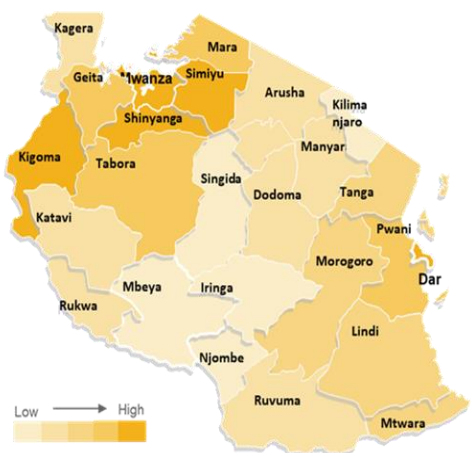


FIGURE 23: ADOLESCENT NUTRITION PROGRAMMING ACROSS REGIONS



Prevalence of anaemia is highest in Shinyanga, Mwanza, Simiyu and Kigoma, but programming is highly concentrated in Singida. Poor provision of maternal health services contributes to the high rates of anaemia around the lake zone. Coastal regions like Dar es Salaam also have rising rates of anaemia due to the malaria epidemic which can increase anaemia prevalence. In contrast, regions like Iringa, Njombe, Mbeya, Singida and Kilimanjaro are relatively performing well; three of these regions are found in the country’s agricultural corridor and are therefore more likely to be food secured leading to improved nutritional outcomes. Programs for adolescent girls are limited in number given that research on nutrition within the adolescent population is limited. Existing programs are concentrated in Singida where the programs reach up to 30% of the adolescent population in the region. Other regions such as Pwani, Mbeya, Iringa, Njombe, Mwanza, and Dar es Salaam reach about 9% of adolescents.

PILLAR 5 – KEEPING BOYS AND GIRLS IN SCHOOL

FIGURE 24: TOTAL MALE AND FEMALE DROPOUT RATE

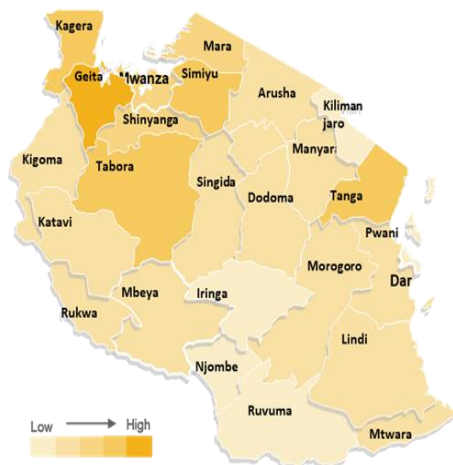
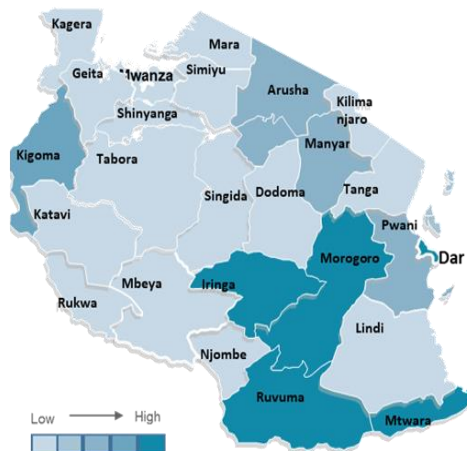


FIGURE 25: PROGRAMS FOR KEEPING ADOLESCENTS IN SCHOOL ACROSS REGIONS



Dropout rates are highest in Geita, followed by Tanga, Tabora and Simiyu; in contrast programming is primarily 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. Inadequacy of classrooms and latrines is also another major challenge. Regions which performed well – Njombe, Kilimanjaro and Dar es Salaam – have invested in WASH infrastructure and quality of facilities. This is demonstrated by their above average pupil-pit latrine ratios and pupil-classroom ratios. Similar to other pillars, programs and issue areas are largely misaligned; while programs are concentrated in the southern regions, regions in the north such as Geita have the highest dropout rates. Nonetheless, programs are limited in number.


PILLAR 6 – DEVELOPING SKILLS FOR MEANINGFUL ECONOMIC OPPORTUNITIES

FIGURE 26: UNEMPLOYMENT RATES ACROSS THE REGIONS



FIGURE 27: ADOLESCENT SKILLS BUILDING PROGRAMMING ACROSS REGIONS





The unemployment rate in Dar es Salaam is significantly high compared to other regions; while programming is low across the country, existing programs are mainly concentrated in Mbeya and Iringa. In addition to Dar es Salaam, regions like Mwanza, Pwani and Shinyanga also have high rates of unemployment. In contrast, Njombe and Tabora have some of the lowest unemployment rates followed by Tanga, Kagera and Rukwa. Urbanization as well as the size of the adolescents' population are 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 very small percentage of adolescents across the regions. Moreover, most of these programs have a very specific target which typically consists of out-of-school adolescents with a focus on helping youth find jobs and create businesses especially in agriculture. While skills building is a component of these programs, it is often not the primary objective.

HIGH LEVEL OVERVIEW OF ADOLESCENT PROGRAMS

FIGURE 28: HIGH-LEVEL OVERVIEW OF EXISTING ADOLESCENT PROGRAMS IN TANZANIA⁹⁹

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 PROFFECT	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	177,088
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	1,000,000

⁹⁹ Programs 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	8,798
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	Pillar 2 Pillar 3	Geita	43443
SCHOOL MEALS PROGRAM	FEED THE FUTURE	2016-2018	Provides technical and financial assistance to primary schools on healthy eating (e.g. provide fortified flour)	Pillar 4	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	Pillar 6	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	Pillar 1 Pillar 2	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	Pillar 1	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

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 amongst several stakeholders who are implementing programs to address these issues. Some of these interventions are already achieving their intended outcomes, while others are anticipated to see outcomes in the long-term. In contrast, emerging/evolving interventions are those that are new with very limited momentum yet show some promise. Although not a focus of the NAIA_AHW, both supporting and emerging/evolving interventions are important to sustain; it is therefore essential for stakeholders to continue implementing interventions in these categories. The full list of 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 multi-sectoral programs 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]** Scale up community-based programs, especially in high prevalence regions, leveraging social workers, educated mentors and peers to create mindset shift
- 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 regarding the legal age of marriage for girls

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 training of officers on data monitoring system and response.
- iii. **[Emerging/Evolving]** Scale apprenticeship programs to students who do not pass Primary School Leaving Examination and those who are already employed as a protective means against child labour

PILLAR 4 – IMPROVING NUTRITION


- i. **[Supporting]** Expand provision of deworming pills to the mass adolescent population
- ii. **[Supporting]** Promote industrial and community fortification
- iii. **[Supporting]** Expand school feeding programs
- iv. **[Emerging/Evolving]** Disaggregate nutrition indicators in national statistics studies to include the adolescents age group
- v. **[Emerging/Evolving]** Conduct research on food systems and adolescents to identify underlying issues in this age group
- vi. **[Emerging/Evolving]** Include gardening projects as part of the curriculum to provide adolescents with knowledge on their nutritional needs

PILLAR 5 – KEEPING BOYS AND GIRLS IN SCHOOL

- i. **[Supporting]** Work with local government and communities to build school dormitories at school
- ii. **[Emerging/Evolving]** Drive policy around the benefits of Kiswahili and English becoming formal mediums of instruction at 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 accessibility and capacity of youth development funds to target youth aged 12 and above to access financial services for entrepreneurial activities, with support from local government, PMO-LYED and NEEC

- 
- ii. **[Emerging/Evolving]** Improve NEEC's ability to partner with development partners to develop youth incubation hubs, targeting 15 - 19-year old's with the skills to produce market-driven goods and services across districts. Incubation hubs should provide BDS support services, access to market, mentorship and finance in partnership with private sector and government youth development funds at 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 counseling
- ii. **[Emerging/Evolving]** Launch a positive parenting campaign to equip parents with holistic skills promoting health and wellbeing

COORDINATION DEEP-DIVE

The coordination structure will consider critical factors that will ensure the efficient execution of various functions. Below are number of recommendations that should be considered:

STRUCTURE AND MEMBERSHIP

The coordination entity shall be multi-sectoral and will bring multiple members under the guidance and direction of the Prime Minister's Office – Policy and Coordination, to ensure seamless cross-ministerial collaboration and supervision. This will facilitate 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. The coordination structure builds on what already exists to avoid being duplicative. While the following provides suggestions, the actual structure will be finalized during the implementation phase. There are several entities which will be critical in coordinating the activities of the AGENDA at both the national and sub-national levels which include:

NATIONAL LEVEL COORDINATING UNITS

National Steering Committee (NSC)

The NSC will provide overall policy guidance on the NAIA_AHW to ensure alignment with international treaties and government policies. The NSC will be chaired by the Permanent Secretary of PMO – Policy and Coordination, and will include Permanent Secretaries from MoHCDGEC, MoEST, PMO-LYED, MoFP, MoW, MITI, MoHA, MoJCA, MoA and country directors of identified development partner organizations and CSOs. Permanent Secretaries from other ministries can attend upon request from the chair. The NSC will leverage the existing meeting of the National Protection Steering Committee to discuss the NAIA_AHW agenda annually.

The roles of the NSC will include:

- Provide policy guidance in overall implementation of the NAIA_AHW
- Ensure the NAIA_AHW is mainstreamed into government plans and strategies at all levels
- Provide oversight on reaching set targets
- Ensure adequate resources are allocated for activities
- Liaise with development partners for fund raising to support the implementation activities

National Technical Committee (NTC)

The NTC will provide technical assistance to the NSC and review annual plans and progress reports from AYAS and the working groups. The NTC will be co-chaired by the Permanent Secretaries of MoHCDGEC and MoEST.

The Permanent Secretaries from MoHCDGEC – Health and MoHCDGEC – Community Development will rotate their chairmanship on the NTC. Members of the NTC will include Commissioners/Directors and heads of government departments and units from PMO-LYED, PO-RALG, MoHCDGEC, MoEST, MoW, TACAIDS, MoFP, MoHA, MITI, TASAF, TFNC, MoA, MEM, RITA, CHRAGG, 3 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 agenda biannually.

The roles of the NTC will include:

- Analyze the implementation of activities and recommend on the integration of positive lessons learnt into various sectoral plans for scale up
- Ensure regional and international treaty obligations related to adolescents are integrated into national development plans and programs
- Advocate for the allocation of resources to prioritized interventions in coordination with the NSC
- Liaise with development partners and other stakeholders on resource mobilization for implementation
- Report quarterly to the NSC on the implementation of the NAIA_AHW

Adolescent and Young Adult Stakeholder Group (AYAS)

The Adolescent and Young Adult Stakeholder Working Group (AYAS) is a multi-sectoral adolescent-specific working group under TACAIDS. It brings together technical personnel from MoHCDGEC, MoEST, PMO-LYED, PO-RALG, MoHA, PMO – Policy and Coordination, 2 youth representatives (male and female) and implementing partners. Additional members could be co-opted into AYAS such as those from TFNC, TASAF, MoW, TIE, and NEEC. AYAS will advocate for the NAIA_AHW agenda at the national level and directly liaise with the NTC to provide relevant information on the implementation of activities.

The roles of AYAS will include:

- Collate progress updates across the working groups on adolescent-specific activities
- Support the working groups and the NTC on technical guidance on issues related to adolescents
- Advocate for funding prioritization towards interventions

Working Groups (WGs)

The Working Groups are thematic working sessions under existing strategy and ministerial bodies that will push forward the NAIA_AHW agenda. The membership structure and frequency meeting of each of the groups include:

i.) Adolescent Reproductive Health Working Group (ARHWG)

The ARHWG includes MoHCDGEC, PMO-LYED, NACP, TACAIDS and implementing partners. The working group sits under the mandate of MoHCDGEC – Health, and directly reports to the Reproductive, Maternal, New-born Child and Adolescent Health Working Group (RMNCAH) which is under the Technical Committee for sector-wide approaches (TC-SWAp). The ARHWG quarterly and could be leveraged to discuss and coordinate interventions under pillars 1 and pillar 2.

ii.) Safe Schools and Life Skills Working Group

This working group was formed through the NPA-VAWC under the thematic area of Safe Schools and Life Skills under the leadership of MoEST. The working group includes personnel from MoHCDGEC, MoHA, PO-RALG, and CSOs. The group meets quarterly, but funding challenges have limited the frequency of meetings. This group could be used to discuss the NAIA_AHW agenda 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 incorporates the IDD, Vitamin A supplementation, Anaemia and Food Fortification Alliance, and is formed under the National Multisectoral Nutrition Action Plan (NMNAP). The group reviews progress on the implementation of the operational plans of the NMNAP. This group could be leveraged to discuss the NAIA_AHW agenda as it relates to intervention 4.1 that addresses micronutrients deficiencies by scaling WIFAS programs. The group meets every quarter of the year.

v.) School Water Sanitation and Hygiene Technical Working Group


This group brings together coordinators of the national sanitation campaign under MoHCDGEC, SWASH coordinator under MoEST, PO-RALG, MoW sector coordination, rural and urban water committee member(s), development partners and CSOs. It is co-chaired by the director of policy and planning under MoEST and the director of environmental health at MoHCDGEC. The group is under the guidance of MoW as it was developed through the Water Sector Development Program. This group could be leveraged to discuss the NAIA_AHW agenda 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 working group is made of personnel from MoEST, PO-RALG Education, development partners (UNICEF, UNESCO, 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 agenda as it relates to intervention 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. The skills development working group could also be leveraged to coordinate pillars 5 and 6 once the formalization process is finalized.

National Secretariat

The secretariat will serve as a link between the national and sub-national 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. The secretariat will be governed by the directors from MoHCDGEC, MoEST and PO-RALG Sector Coordination. Members of the secretariat will include representatives from MoHCDGEC, MoEST, TACAIDS, coordination units of PMO and PO-RALG, 3 youth representatives who are part of the NTC, 2 M&E officers and implementing partner(s). The National Secretariat will be housed by an organization that has a track record in coordinating different adolescent sectors and has existing capacity to carry out the



responsibilities of the Secretariat. We propose an interim National Secretariat housed in TACAIDS while a permanent structure develops under an identified ministry given existing capabilities in coordinating multisector actors of adolescent activities.

The roles of the secretariat will include:

- Consolidate and prepare reports to be tabled before the NSC, NTC and the Working Groups
- Coordinate reviews, joint monitoring and evaluation, studies and research
- Provide progress reports received from the PO-RALG to the NSC and the NTC
- Supports the preparation of workplans and budgets with the NTC
- Prepare guidelines to facilitate operation and implementation at all levels

SUB-NATIONAL LEVEL COORDINATING UNITS

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

The PO-RALG will implement and coordinate the NAIA_AHW agenda at the sub-national levels. The director of PO-RALG Sector Coordination will chair the activities 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 include:

- Strengthen the reporting and communication mechanism at the sub-national level
- Consolidate progress reports through the council directors and submit to the National Secretariat
- Ensure integration of interventions into LGAs and implementing partners' plans and budget
- Liaise with development partners and other stakeholders on resource mobilization and utilization
- Conduct joint monitoring and evaluation visits at LGA level

Regional Administrative Secretariat (RAS)


The Regional Commissioner's office will support planning, provide technical advice and implementation oversight at the regional level. The Regional Administrative Secretariat (RAS) will lead the implementation and coordination of the NAIA_AHW at the regional level. 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 Labor 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 include:

- Raise the profile of the NAIA_AHW within the regional leadership and other key stakeholders
- Ensure interventions are integrated into regional development plans and budgeted for
- Consolidate regional progress reports through the council directors, and submit to the PO-RALG for further consolidation
- Adopt revised implementation plan from the PO-RALG and support the beneficiaries and implementing partners to adjust accordingly

District Executive Director (DED)

The District Commissioner's office will support planning, provide technical advice and implementation oversight at the district 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 NGOs, special needs, Council Elders' Committee, District Labor 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 coordinators at the district level will include:

- Raise the profile of the NAIA_AHW within the council leadership and other key stakeholders
- Ensure interventions are integrated into council development plans and are budgeted for
- Submit monthly progress reports to the RAS
- Adopt revised implementation plan from the PO-RALG and support beneficiaries and implementing partners to adjust accordingly

Ward Executive Officer (WEO)

The Ward Executive Officer (WEO) will support planning, provide technical advice and implementation oversight at the ward level. The WEO will steer the implementation and coordination of activities at the ward level, with the support of the Community Development Officer, identified teachers from primary and secondary schools, health centres or dispensary in-charge, Ward Education Officer, Social welfare officer and extension officers, People Living with HIV/AIDS (PLHIV), religious institutions, youth groups, champions in the response to HIV and AIDS, a community health provider, HIV-related CSO, informal private sector, 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 include:

- Raise the profile of the NAIA_AHW within the ward and village leadership and with other key stakeholders
- Submit monthly progress reports to the CMAC. This can be compiled in consultation with the programmatic officers and implementing partners
- Review and track progress reports of the program by liaising with the programmatic officer, government personnel, development partners, beneficiaries and village officers

Village Executive Officer (VEO)

The Village Executive Officer (VEO) will support planning, provide technical advice and implementation oversight at the village level. The VEO will drive the implementation and coordination of the NAIA_AHW at the village level, with the support of extension officers, health centre or dispensary in-charge, 2 primary school teachers and 2 secondary school teachers, People Living with HIV/AIDS (PLHIV), religious institutions, youth groups, champions in the response to HIV and AIDS, a community health provider, HIV-related CSO, informal private sector, from the Most Vulnerable Children Committee, Village Education Coordinator, Clinical Officer(s), and Community Development Officer. The village-level coordinating unit will bring together the Village Multisectoral AIDS Committee (VMAC) 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 include:

- Identify high risk areas in the village and develop strategies or plans
- Submit monthly reports on progress of the NAIA_AHW to the WEO. This can be compiled in consultation with the programmatic officers and implementing development partners
- Review and track progress reports of the program by liaising with the programmatic officer, government personnel, implementing partners and beneficiaries

PERFORMANCE MEASUREMENT

The entity should develop agreed action plans, responsibilities and timelines for each party, and reliable performance measures to track progress. The establishment of performance metrics will ensure mutual accountability amongst all adolescent stakeholders and guide them towards a common set of objectives. This process will give the coordination process greater value and incentivizes 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 participants will need to have a clear understanding of both the goals and agreed timelines towards which they are working. This will ensure 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

To implement the suggested coordination structure and ensuing activities will cost 49% of total cost (TZS 4.8B/=) at the national level, and 0.3% of total cost (TZS 50M/=) for one district. Key activities of the coordination structure include developing operationalization guidelines, supporting the meeting of the NSC, the NTC and the some of the working groups, advocating for funding, conducting supportive formative and operational research on emerging issues. The national level budget will go towards compensation benefits, purchase of technical equipment and building capacity for sitting members of the nation-level coordinating structures such as officers of the National Secretariat. District-level cost includes activities such as conducting supportive supervision in councils and building capacity of council officials to implement the NAIA_AHW.

FIGURE 29: 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 2019/20	FY 2020/21	FY 2021/22	FY 2022/23			
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	296,100,000	-	-	-	296,100,000	National Secretariat	External Consultant

	coordination structures at all levels							
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 Sub-National 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 30: 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 2019/20	FY 2020/21	FY 2021/22	FY 2022/23			
1	Socialization of the AGENDA at the sub-national level	2,625,000	2,756,250	2,894,063	3,038,766	11,314,078	National Secretariat	PO-RALG and all sub-national level coordinating units
2	Build capacity to plan, budget, manage and advocate for strong and effective activities at the sub-national level	8,872,500	9,316,125	9,781,931	10,271,028	38,241,584	National Secretariat and PO-RALG	All sub-national level coordinating units
Total Cost		11,497,500	12,072,375	12,675,994	13,309,794	49,555,662		

DATA, M&E DEEP DIVE


DATA, M&E RESULTS FRAMEWORK MATRIX

The Results Framework Matrix contains information on result areas at an impact (pillar) and outcome (intervention) level. The below is a suggested framework that 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 program yet) level at the start of implementation.

FIGURE 31: 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 10-19 years	Number of adolescents aged 15-19 who are newly infected with HIV/number of adolescents aged 15-19 years	TBD ¹⁰⁰ 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	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 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 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

¹⁰⁰ 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 implementation phase	Girls and boys aged 15-19 years: 85% by 2022 ¹⁰¹ (HSHSP IV 2017-2022)	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 practiced VMMC	Number of adolescent boys aged 10-19 years and male partners of AGYW that have practiced VMMC/number of adolescent boys aged 10-19 years and male partners of AGYW	TBD at the start of implementation phase	90% by 2022 ¹⁰² (HSHSP IV 2017-2022)	TBD at the start of implementation phase	Annually	MoHCDGEC/NACP	MoHCDGEC

¹⁰¹ Assuming the target of 85% of women and men engaged in multiple sexual partnerships reporting use of condom at last sexual intercourse also applies to women and men aged 15-24 years specifically.

¹⁰² Assuming the target of 90% of male circumcision rate attained by all regions applies to men aged 10-19 years and male partners of AGYW.



FIGURE 32: 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	Fertility rate among women aged 10-19 years	Number of live births per 1000 women aged 10-19 years	TBD at the start of implementation phase	80/1000 live births for women aged 10-19 years by 2020 ¹⁰³ ; to be updated at the start of implementation for 2022 target (One Plan II)	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 programs and revision of in and out-of-school SRH curriculum	Outcome	Percentage of adolescent boys and girls aged 10-19 years reached with comprehensive ¹⁰⁴ 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 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 ¹⁰⁵ ; 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

¹⁰³ Assuming the target of 80/1000 live births for women aged 15-19 years applies to women aged 10-19 years


¹⁰⁴ Definition of 'comprehensive' will be defined at the start of implementation phase

¹⁰⁵ Assuming the targets of mCPR for women aged 15-49 years applies to women aged 10-19 years



FIGURE 33: 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 34: 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 iron deficient anaemia	Number of adolescent girls aged 10-19 who have any form of iron deficient anaemia/number of adolescent girls surveyed aged 10-19	TBD at the start of implementation phase	< 20% (Acceptable levels according to WHO guidelines ¹⁰⁶)	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 nutritional education and counselling to all adolescents, and scale Weekly Iron Folic Acid Supplementation (WIFAS) to adolescent girls	Outcome	Percentage of individuals who have received nutritional education and counselling in the past 12 months	Number of individuals who have received nutritional education and counselling in the past 12 months/number of individuals 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
		Number of adolescent girls aged 10-19 who have received at least 24 IFA pills in the past 12 months	Number of adolescent girls aged 10-19 who have received at least 24 IFA pills in the past 12 months	TBD at the start of implementation phase	TBD at the start of implementation phase	Tally sheets ¹⁰⁷	Annually over 4 years	IFA recorder ¹⁰⁸	TBD at the start of implementation phase

¹⁰⁶ http://www.who.int/nutrition/publications/en/ida_assessment_prevention_control.pdf


¹⁰⁷ WHO guidelines for IFA pills requires a recorder to be present during the administration of the pills to record the number of pills taken weekly on tally sheets. To determine total number of pills taken by adolescents would require aggregation of the tally sheets

¹⁰⁸ The recorder is oftentimes the administrator of the pills, i.e. teacher or community health worker



FIGURE 35: 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 drop-out rates	Impact	School drop-out 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	Basic Education Statistics in Tanzania (BEST), 2017	Annual	BEMIS (Basic Education Management Information System)	MOE
Intervention 5.1 [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	Basic Education Statistics in Tanzania (BEST), 2017	Annual	BEMIS (Basic Education Management Information System)	MOE
Intervention 5.2 [Aged 14 - 19]: Support and strengthen the IAE & PO-RALG to implement Integrated Program for Out of School Adolescents (IPOSA) with an emphasis on providing formal schooling opportunities through the Post-Primary Technical Centres for 14 – 19	Outcome	Gross enrolment ratio	Percentage of students aged 14 to 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	Basic Education Statistics in Tanzania (BEST), 2017	Annual	BEMIS (Basic Education Management Information System)	MOE
Intervention 5.3 [Aged 10 -19]: Establish and strengthen school feeding programs	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	Basic Education Statistics in Tanzania	Annual	BEMIS (Basic Education Management Information System)	MOE



						(BEST), 2017		Information System)	
--	--	--	--	--	--	-----------------	--	------------------------	--

FIGURE 36: 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 ¹⁰⁹ training programs nationally	Percentage of education facilities with teaching curriculum approved life and soft skills programs for 10 to 19-year olds	TBD at the start of implementation phase	70% of schools (NPA-VAWC)	Basic Education Statistics in Tanzania (BEST)	Every two years	BEMIS (Basic Education Management Information System)	MOE
Intervention 6.1 [Aged 10-19]: Strengthen VETA and PPTC soft skills programs in partnership with private sector	Outcome	Improved soft and life skills training programs nationally	Percentage of education facilities with teaching curriculum approved life and soft skills programs for 10 to 19-year olds	TBD at the start of implementation phase	70% of VETA and PPTCs (based on NPA-VAWC target)	Basic Education Statistics in Tanzania (BEST)	Every two years	BEMIS (Basic Education Management Information System)	MOE
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 well-being and soft-skills for employment	Outcome	Improved soft and life skills training programs nationally	Percentage of education facilities with teaching curriculum approved life and soft skills programs for 10 to 19, year olds	TBD at the start of implementation phase	70% of schools (based on NPA-VAWC target)	Basic Education Statistics in Tanzania (BEST)	Every two years	BEMIS (Basic Education Management Information System)	MOE

¹⁰⁹ Soft skills are defined to include the following: 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)



FIGURE 37: 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 ¹¹⁰ 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 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, MoE, PMO-LYED

¹¹⁰ ‘Adolescent-friendly’ services are defined as services that are accessible, acceptable, equitable, appropriate and effective for different adolescent subpopulations (WHO)

ACTIVITIES AND FUNDING

To implement the suggested Data, M&E structure and ensuing activities will cost 7% of total cost (TZS 836M/=) at the national level, and 0.1% of total cost (TZS 38M/=) for one district. Key activities of the Data, M&E section include developing the M&E plan and aligning data systems and collection tools to reflect adolescent age disaggregation and capturing of reliable and consistent data. Activities at the national level include developing the M&E plan (including developing Results Framework Matrix, conducting baseline, midline and endline studies etc.), reviewing data collection and analysis systems to identify sources of data and gaps, supporting documentation and dissemination of data reports and best practices material, and coordinating National M&E Coordination Committee meetings. Activities at the district level include monitoring visits to LGAs as well as rolling out of data systems and tools.

FIGURE 38: 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 2019/20	FY 2020/21	FY 2021/22	FY 2022/23			
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	24,673,950	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 39: TOTAL DISTRICT DATA, M&E COSTS ACROSS FOUR YEARS

No.	Activities	Total Cost Per Year (TZS)						
-----	------------	---------------------------	--	--	--	--	--	--

		FY 2019/20	FY 2020/21	FY 2021/22	FY 2022/23	Total Cost per Activity (TZS)	Lead M&E Unit	Collaborating Coordinating Units
1	Support the piloting and rolling 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	¹¹¹ Coordinate joint multi-sectoral monitoring visits and reviews to the LGAs annually	6,804,000	7,144,200	7,501,410	7,876,481	29,326,091	M&E Coordination Committee	MoHCDGEC, MoEST, MoFP, PMO-LYED, PO-RALG
Total District Level Cost		15,624,000	7,144,120	7,501,410	7,876,481	38,146,091		


STAKEHOLDER ENGAGEMENT

Below is a list of stakeholders that were engaged in the development of the NAIA_AHW:

FIGURE 40: STAKEHOLDERS LIST

Stakeholders	
Development Partners	Bill and Melinda Gates Foundation
	Elizabeth Glassier Paediatrics AIDS Foundation
	Jhpiego
	FEMINA HIP
	PACT International
	Restless Development
	Save the Children
	Population Service International
	Salama Foundation
	USAID
	CDC – DREAMS
	Interreligious Peace Council of Tanzania
	Danish Embassy
	Pathfinder International

¹¹¹ This activity will only be conducted in 25% of total districts targeted in implementation on a random sampling basis



Development Partners	Nutrition International
	SANKU
	US – PEPFAR
	COUNSENUTH
	IntraHealth
	TAYOA
	GAIN
	UMATI
	HAKIELIMU
	REPOA
	Raleigh Tanzania
	ONA – LISHE YANGU
	Feed the Future
	UN Agencies – UNESCO, UNICEF, UNAIDS, UNFPA, ILO, World Bank, IOM, UNWOMEN
Development Partners	Water Aid
	HAKIELIMU
	Tanzania Private Sector Foundation, TPSF
	ICAP
	Engender Health
	Marie Stoppes
	DOYODO
	AMREF
	Netherlands Development Organization, SNV
	TAWASANET
	C-SEMA
	Benjamin Mkapa Foundation



Government Stakeholders	Ministry of Health, Community Development, Gender, Elderly and Children
	Ministry of Education
	Ministry of Home Affairs
	President's Office – Regional Administration and Local Government
	Ministry of Water
	Tanzania Institute of Education
	Health Promotion Services
	National AIDS Control Program, NACP
	TACAIDS
	TASAF
	Prime Minister's Office – Ministry of Labor, Employment, Youth and People with Disabilities, PMO – LYED
	National Economic Empowerment Council, NEEC
	Economic and Social Research Foundation
Government	Tanzania Food and Nutrition Center, TFNC
	SIDO
	RAS, Dodoma
	TFDA