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

NATIONAL ADOLESCENT HEALTH AND DEVELOPMENT STRATEGY 2018 - 2022

REPRODUCTIVE AND CHILD HEALTH SECTION

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LIST OF ACRONYMS

AAT	Automobile Association of Tanzania
ADDO	Accredited Drug Dispensing Outlets
ADHD	Adolescent Health and Development
ADH	Adolescent Health
AFHS	Adolescent Friendly Health Services
AIDS	Acquired Immune Deficiency Syndrome
ARHWG	Adolescent Reproductive Health Working Group
ART	Antiretroviral therapy
ARV	Antiretroviral
ASDP	Agriculture Sector Development Programme
AYAS	Adolescents and Young Adult Stakeholders Group
BCC	Behavioural Change Communication
BRN	Big Results Now
CBO	Community-based organisation
CHF	Community Health Fund
CSE	Comprehensive Sexuality Education
CPD	Continuing Professional Development
CME	Continuing Medical Education
CTC II	Care and Treatment Clinic II
DHIS2	Demographic Health Information Service – 2
DHS	Demographic and Health Survey
DRC	Democratic Republic of the Congo
ECD	Early Childhood Development
EMIS	Education Management Information System
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
ESA	Eastern and Southern Africa
FBO	Faith-based Organisation
GBV	Gender-based Violence
GoT	Government of Tanzania
HEADSS	Home, Education and employment, Activities, Drugs, Sexuality and Suicide / depression
HFS	Health Financing Strategy
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPV	Human Papillomavirus
HSS	Health Systems Strengthening
HSSP	Health Sector Strategic Plan
HTC	HIV Testing and Counselling
IEC	Information, Education, and Communication
LGA	Local Government Authority
M&E	Monitoring and Evaluation
MKUKUTA	Swahili abbreviation for the National Strategy for Growth and Reduction of Poverty
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
MoLEYD	Ministry of Labour, Employment & Youth Development
MR4H	Mobile for Reproductive Health
NACP	National AIDS Control Programme
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
NGSRP	National Strategy for Growth and Reduction of Poverty
NHIF	National Health Insurance Fund
NPA-VAWC	National Plan of Action to end Violence against Women and Children in Tanzania
OOP	Out-of-Pocket
OP/IP	Outpatient-inpatient
PEPFAR	President's Emergency Plan for AIDS Relief
PLHA	People living with HIV/AIDS
PMO	Prime Minister's Office
PMTCT	Prevention of Mother-to-Child Transmission
PO-PSM	President's office, Public Service Management
PO-RALG	President's Office, Regional Administration and Local Government
PPP	Public Private Partnership
PSI	Population Services International
RAIS	Road Accident Information System
RCHS	Reproductive and Child Health Section
RH	Reproductive Health
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SADC	Southern Africa Development Community
SNHI	Single National Health Insurance
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TACAIDS	Tanzania Commission for AIDS
TASAF	Tanzania Social Action Fund
TC – SWAp	Technical Committee on Sector Wide Approaches
TECC	Tanzania Entrepreneurship Competitiveness Centre
TZ	Tanzania
TIKA	"TibakwaKadi"
UMASITA	Swahili abbreviation for Tanzania Informal Sector Community Health Fund
UNFPA	United Nations Population Fund
VAC	Violence Against Children
VIBINDO	Swahili abbreviation for association of small industries and small business owners
WHO	World Health Organization

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EXECUTIVE SUMMARY

CONTEXT

The National Adolescent Health and Development (ADHD) Strategy marks the first step of an expanded and holistic focus by the MoHCDGEC on the issues affecting adolescents in the country. Acknowledging the effect of socio-economic and cultural conditions on health outcomes, there is a shared understanding amongst stakeholders that focusing onholistic development outcomes for adolescents is critical. Furthermore, as part of its national agenda, Tanzania aims to be a middle-income country by 2025 through industrialisation; 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.[1] Among other investments, Tanzania therefore needs to pursue positive development and health outcomes for its adolescent population in order to ensure the demographic dividend is successfully leveraged.

The strategy builds on the foundation of the previous National Adolescent Reproductive Health Strategies and other relevant policy documents. The first strategy (2004-2008) focused on extending the reach of adolescent friendly health services and the second strategy (2011-2015) focused on sexual and reproductive health of adolescents. This strategy also draws on key policy documents such as the National Health Policy 2018 (in draft), the Health Sector Strategic Plan (HSSP) 2015 – 2020, and the One Plan II which recognize adolescents and call out the need to address adolescent health in the country. This strategy (2018-2022) aims to build on these efforts, through a comprehensive approach that equally addresses the demand and supply side, as well as critical enablers for adolescent health. In addition, this strategy also aims to ensure that there is continuous, active and meaningful engagement of adolescents. Thus, the strategy involves a broader range of stakeholders who play a part in ADHD.

As a signatory to the global Sustainable Development Goals, better ADHD will directly and indirectly contribute to Tanzania achieving severalof the internationally agreed goals.This ADHD strategy provides an opportunity for the country to gain some mileage in implementing the SDGs as the various components of the strategy is linked to six out of seventeen SDGs as shown in the figure below. Consequently, any success in implementing this strategy will improve the health and holistic development of adolescents, yield national gains for Tanzania and improve its positioning within the international development ecosystem.

SITUATION ANALYSIS

In this strategy, the state of ADHDhas been assessed from three lenses of demand, supply and enablers. The demand lens seeks to understand the socio-cultural and economic trends in the country and their influence on health outcomes, as well as the disease burden for adolescents. The supply lens assesses health services and other types of support needed to effectively address adolescent health and development needs in Tanzania. Lastly, enablersfocus on policies and legislations, financing, data systems including access to information and coordination that create the right environment and provide relevant tools to support ADHD. Policies, legislations and commitment reviews the various policies, legislations and commitments to determine if they are harmonized in addressing ADHD issues and if they support

[1]Tanzania Human Development Report (THDR) 2014: Economic Transformation for Human Development in Tanzania

ADHD. Financing examines the gaps in financing for ADHD activities, health insurance coverage and allocation of resources. Data and access to information assesses data systems for ADHD, communication and access to information for adolescents, monitoring and evaluation and research on adolescent outcomes. Finally, coordination examines coordination mechanism and collaboration between ministries, agencies and donor partners.

Currently, the greatest risk factors for adolescent health in Tanzania are:poor sexual and reproductive health including sexually transmitted infections, malnutrition and anaemia, substance abuse, mental health concerns, and violence including gender-based violence. These all contribute to increased morbidity and mortality not only during adolescence but also later in their lives.Adolescent Fertility Rate is currently at 128 pregnancies per 1,000 women compared to the target of less than 100 pregnancies per 1,000 women by 2020.[2]Sexually Transmitted Infections (STIs), including HIV/AIDS remain a great risk for adolescents where 40% of new infections occur, condom use outside marriage is as low as 37% in adolescent girls and 35% in adolescent boys ages 15-19.[3] In terms of nutrition,the prevalence of stunting is very high, reaching about 70% stunting rate at 13 years.[4]Adolescents in Tanzania are at a high risk for self-harm and interpersonal violencewith 50% of boys and girls aged 13-19 having reported experiencing physical violence at the hands of teachers.[5]

Given the current state of adolescent health issues in the country and taking into consideration anticipated population growth, it is critical that Tanzania puts in place measures to improve ADHD. According to the World Bank, Tanzania has sustained relatively high economic growth over the last decade, averaging 6 - 7% annually.[6]However, while the poverty rate has declined, the absolute number of poor people remains high due to population growth. Simple regression projections for the 15-19 age group show that HIV as a risk factor reduces while injuries increase. Thus, there is a need to focus interventions on the diverse health issues facing adolescents.

DEMAND

From a demographic perspective, adolescent population is a significant part of the Tanzanian population. Tanzania is home to 10 million adolescents in the age group of 10-19 years, accounting for 23% of the country's population. Further breaking this down, adolescents between ages 10-14 and ages 15-19 make up c.13% and c.10% of the total population respectively. Thus, adolescents represent a huge opportunity to transform the social and economic fortunes of the country if they are healthy educated, and empowered.

The combination of socio-cultural and economic factors such as low education levels, high poverty rates, discriminatory social norms and extreme religious practices can have adverse effects on adolescent health outcomes. Unless these factors change, there will continue to be negative implications for adolescents in Tanzania. HIV/AIDS, infectious diseases, teen pregnancies, nutritional deficiencies and violence are major issues faced by adolescents in part due to increased urbanization,

[2]MoHCDGEC, One Plan II, 2016
[3] TDHS-MIS, Tanzania Demographic and Health Survey and Malaria Indicator Survey, 2015-2016
[4] TDHS-MIS, Tanzania Demographic and Health Survey and Malaria Indicator Survey, 2015-2016

[5] UNICEF, Violence Against Children in Tanzania, 2011
[6] World Bank, Tanzania Country Overview, 2017

high dropout rates at the secondary school level, high poverty rates, discriminatory social norms and insufficient economic opportunities for youth.[7]

Supply

There is a need for health and development services and support to effectively respond to the ADHD outcomes. The packages of health services offered to adolescents should aim to be adolescent friendly. WHO defines adolescent friendly health services as those that are accessible, equitable, acceptable, appropriate, comprehensive, effective and efficient and consider the special needs of adolescents.[8]

However, limited service delivery points for adolescents, inadequate number of suitably trained human resources and weak supply chains threaten the availability of adolescent friendly services. Service delivery challenges include a dearth of appropriate health services for adolescents. Only 30% of health service delivery points meet the national standards for AFHS compared to the target of 80% by 2015.[9]Schools play a critical role for in-school adolescents and can help provide vital information and services to adolescents**.** Yet, there is limited classroom material on topics such as nutrition, substance abuse, violence, reproductive health, mental health and vocational preparation. Furthermore, community-based services provide access to both in-school and out-of-school adolescents, however, there is limited evidence showing the success of youth centres and drop-in centres.[10]

Human resources are the underpinning of service delivery in any system, however, there is a shortage of trained human resources for delivery of ADHD services in Tanzania. With 64,449 health workers against the target of 140,500, health workers are in short supply.[11]Additionally, majority of the health workforce are older which might constrain the availability of AFHS as adolescents are typically not comfortable with seeking services provided by health workers who are much older than themselves. This is illustrated by data showing that nurses above 39 years represent 56% of the nurse workforce and usually delivermost health services.[12]Likewise, according to the Tanzanian Teachers Union, over 50,000 teachers are needed to fill the gap in secondary schools.[13] As a result, many students are learning in difficult conditions as they lack qualified teachers. On the supply chain side, there isa limited number of drug dispensing outlets and inadequate teaching aids.[14]

Enablers

There is a need for policies and legislationsthat support and protect adolescents, and intervene across health financing, health data and access to information and coordination to unlock demand and supply of ADHD.

Policies have not fully recognized adolescents as a unique demographic segment while some legislations areunfriendlyto ADHD. These policiesdo not offer sufficient protection to adolescents,

[7] NBS, Tanzania HIV and Malaria Indicator Survey, 2011
[8] WHO, Adolescent Friendly Health Services, 2002
[9] UNICEF, Adolescence in Tanzania, 2011
[10] GHSP Journal, What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices, 2015
[11] Tanzanian MoHCDGEC, Human Resource for Health Country Profile, 2013
[12] Tanzanian MoHCDGEC, Human Resource for Health Country Profile, 2013
[13] Education Internationa l, Tanzania: Significant Move to Curb Teacher Shortage, 2013
[14] Tanzanian MoHCDGEC, Health Sector Strategic Plan 2015-2020, 2015

particularly for sexual and reproductive health issues. On the legislative side, some contradictions exist between Acts, most notably around the definition of a child. As an example, while the Law of the Child Act defines a child as a person below 18 years of age, the Marriage Act provides that young girls can contract marriage at 14 or 15, and the penal code suggests that parents and guardians will not be punished for deserting children above 14 years. These contradictions can prevent children from enjoying certain rights and protection under the Child Act, including protection from statutory rape and unjustifiable desertion. Tanzania has however committed to several national, regional and international conventions that could improve the operating environment for ADHD.

Gaps in general budget allocations and health insurance coverage negatively affect funding for ADHD services. The Government of Tanzania's (GoT) health expenditure has remained consistently lower than the 15% target in the Abuja declaration of 2001. For instance, in 2017⁄18, the GoT earmarked 7% of its national budget for the health sector, consistent with the year before.[15]Furthermore, within the budget, no financial resources are dedicated to ADHD, but rather, ADHD funding is submerged within other potentially insufficiently-funded programmes that are reflected in the budget. Given resource constraints, it is important to maximize existing budgets of all ministries and public institutions whose activities affect adolescents, effectively coordinate allocation of donor funds, and supplement these with private funding.In the absence of universal health care, adolescents are largely excluded from coverage of existing insurance schemes given that many of them are unemployed, cannot afford the premiums, and do not have parents who are enrolled in any of the schemes.In addition to insufficient funding and coverage, ADHD outcomes are worsened by suboptimal public health spending that consumes financial resources that could have otherwise been channeled to ADHD. These issues raise further questions for ADHD financing and broad coverage for health services needed by adolescents.

The data and access toinformation system for ADHD 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 and only cover basic adolescent indicators as part of broader indicator sets. On the access to information side,adolescents are often not aware of health or other services that are available to them (e.g. educational and vocational support, drug and alcohol counselling, legal and social support), where they are provided and how to obtain them. Most adolescents get information from unreliable sources and do not have access to appropriate information to prepare them to cope with changes that take place in their bodies, health and development.

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

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

approaches in the implementation of programmes. There is a glaring need for strong coordination mechanisms at the regional, district and community levels to build linkages and align partner approaches in the implementation of programmes.

Recognizing these needs and challenges, the government of Tanzania, donors and NGOs have undertaken initiatives to improve ADHD over the last several years. Actors in the ADHD space have implemented numerous programmes with a focus on SRH and HIV/AIDS and less focus on other issues such as drug and substance abuse, mental health, etc.There is a lack of clear mandate and scope of prioritized activities among coordinating bodies and implementing partners. This has resulted in some duplication of efforts and in implementers working in silos, with limited understanding of each other's efforts and outcomes.Divergent approaches to measuring outcomes and collecting and sharing data have resulted in limited shared learnings from different programmes on adolescent health.

STRATEGIC PRIORITIES

Immediate action is needed to address these challenges, this strategy sets six priority objectives around the various components that need to be implemented:

1. Demand: ***Engage adolescents to better understand their issues and develop effective and sustainable solutions while also strengthening schools and working with communities and adolescent gatekeepers to address negative socio-cultural norms and promote adolescent health and well-being*.** Key priorities to achieve this goal include creating strong linkages with economic plans such as the ASDP II and agencies such as the MoEST to empower adolescents; promoting interventions that build adolescent competence, confidence, connection, character and caring involving diverse approaches; creating strong linkages with community development groups, community-based organizations and faith-based organizations to promote positive socio-cultural norms; and promoting adolescent participation and decision making at all levels.
2. Supply: ***Ensure availability of holistic, appropriate and cost-effective adolescent friendly health services with a well-trained workforce and promote public-private partnerships to address the gap in public health service delivery.***Key priorities to achieve this goal include promoting leadership and accountability across the healthcare delivery system; introducing of performance incentives to improve service delivery; fostering PPP for adolescent health care delivery; expanding the use of community-based delivery models; promoting a comprehensive curriculum which includes courses such as SRH and life skills; investing in enhancing the skills and capabilities of doctors, nurses, community development officers and teachers; and strengthening the supply and management of priority drugs and medical products that are considered critical for AFHS.
3. Policies, legislations and commitments: ***Elevate adolescents as a critical demographic segment in policy and legislation, ensure policy and legislation alignment on ADHD and monitor and evaluate the implementation of policies and legislation.***Key priorities to achieve this goal include updating policy documents to fully recognize adolescents as a unique demographic segment; harmonizing policy intervention efforts; amending or withdrawing unfriendly ADHD legislations and national directives; tracking impact of policy and legislation implementation; and maintaining pro-ADHD national, regional and international commitments.
4. Financing: ***Increase the value and sustainability of funding for national health priorities, including ADHD, increase health insurance coverage and reduce inefficiencies in public***

spending. Key priorities to achieve this goal include increasing the value and sustainability of funding for national health priorities, including ADHD; increasing coverage and service offering of health insurance schemes; reducing inefficiencies in public health spending and channel savings to ADHD; and increasing household income.

5. Data and access to information:***Ensure efficient collection and use of national HMIS data to continuously improve the quality of care and service delivery to adolescents and improve access to relevant and standardized information to users.***Key priorities to achieve this goal include streamlining the data collection and dissemination process; harmonizing indicators used to collect adolescent data; enhancing increased access of information to adolescents, gate keepers, educators and service providers; conducting programmatic and operational research and studies
6. Coordination: ***Strengthen intersectoral coordination and cooperation among adolescent stakeholders and enhance their role in promoting adolescent health and wellbeing***. Key priorities to achieve this goal include establishinga functional coordination and implementation mechanism that takes into account a multi-sectoral structure, inclusive membership, top level leadership, effective governance, performance measurement, defined outcomes and resource mobilization.

IMPLEMENTATION

Over the next five years till 2022, implementation of the ADHD strategy will require coordinated efforts from all actors working in the ADHD space. A mid-term review will be conducted after the first two years of implementation.

Successful implementation of Tanzania's ADHD strategy will require strong leadership and coordinated multi-sectoral and multi-stakeholder participation. Activities will be executed at national, regional and district levels, with clear responsibilities vested on specific stakeholders. National stakeholders include the MoHCDGEC, and other ministries and national actors that should therefore set the direction, provide broad leadership and rally other stakeholders to support implementation.

BACKGROUND

OVERVIEW

Globally, adolescents represent a major demographic and socio-economic force, and are also a major influencer of public health trends. Adolescence is defined as a period of human growth and development that occurs after childhood and before adulthood involving multi-dimensional changes. According to WHO (2014), adolescents are persons between 10 and 19 years of age who during this period experience biological, psychological, mental and social changes. As a developmental phase in human life, adolescence is further divided into early adolescence (10-12 years), mid adolescence (13 to 15) years and late adolescence (16-19 years). Currently, adolescents are estimated at one fifth of the world's population and form a major proportion of the socially, economically and sexually active population.[16] 88% of the world's adolescents live in developing countries, and Sub-Saharan Africa is home to 18% of these adolescents.[17]

Although all adolescent changes occur simultaneously, they occur at different paces for each adolescent depending on gender, education, environmental and socio-economic factors. Biologically, adolescents experience pubertal changes and changes in brain structure while psychologically and mentally, adolescents' cognitive capacities mature and they develop critical thinking skills. As a result of the multiple roles they are expected to play at school, family and in the community, adolescents experience significant social changes. Due to the major biological and psychological transformations associated with this age group, adolescents are significantly exposed to risky behaviours, with significant consequences on their immediate and long-term health and socio-economic lives.[18]

In Tanzania, adolescents account for about a third of the total population. According to the National Bureau of Statistics Population Projections for 2017, Tanzania Mainland has a population of 52,554,628comprised of 25,687,154 males and 26,867,474 females. Tanzania's population has grown by 10,485,399 persons or 30.4% since 2002, translating into a rate of growth of 2.7% per annum. There are 5,625,848 Tanzanians between the ages of 10-14 years and 4,466,674 between the ages of 15-19 years.[19] This large cohort presents significant potential for the social and economic development of the country if the country makes the necessary investments to make them healthy and productive. It has been evidenced that investments in adolescent health can bring triple dividends i.e. (a) promotion of positive behaviours and prevention, early detection and treatment of problems could improve the current state of adolescents today; (b) enabling healthy habits during early stages will help set a pattern of healthy lifestyles and reduce morbidity, disability and premature mortality in their adult life, and (c) promoting their emotional well-being and healthy practices and prevention of risk factors could potentially protect the health of future offspring.[20]

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[16] WHO, Broadening the Horizon: Balancing Protection and Risk for Adolescents, 2002

[17] UNICEF, State of the World's Children, 2011

[18] NCBI, The Role of Puberty in the Developing Adolescent Brain, 2010

[19]Tanzania Human Development Report (THDR) 2014: Economic Transformation for Human Development in Tanzania

[20]http://www.who.int/maternal_child_adolescent/topics/adolescence/why-invest/en/

While the importance of this age group has been acknowledged in various national policy documents,the health of this population group has not been given the special attention that it deserves. Key policy documents like the National Health Policy 2018 (in draft), the Health Sector Strategic Plan (HSSP) 2015 – 2020, and the One Plan II recognize adolescents and call out the need to address adolescent health in the country. Furthermore, a number of surveys have provided evidence of continued high prevalence of health risk behaviours among adolescents and young adults. The ADH Situation Analysis, conducted by the MoHCDGEC in 2017 further highlights the current situation of adolescent health in Tanzania and calls out the need to strengthen adolescent health delivery in the country.

RATIONALE FOR THE STRATEGY

The National Adolescent Health and Development (ADHD) Strategy is the result of an effort by the MoHCDGEC to focus holistically on the issues affecting adolescents in the country. MoHCDGEC acknowledges the important role of government ministries and key stakeholders in adolescent health and development and has worked collaboratively with these institutions in the development of this strategy. This National Adolescent Health and Development Strategy 2018-2022 has been developed to address the overall health and development needs of adolescents by taking a broad and holistic understanding of the concept of health. The strategy builds on the foundation in the previous National Adolescent Reproductive Health Strategy and 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 MoHCDGEC acknowledges the effect of socio-cultural and economic conditions on health outcomes and is thus looking for a stategy that focuses on achieving holistic development outcomes for adolescents. Furthermore, Tanzania's goal is to be a middle-income country by 2025 which will be primarily driven by the youth population which represents c.70% of the total population. To achieve this goal, there is a need for Tanzania to be able to take advantage of its demographic dividend by utilizing the youth boom to drive economic transformation. According to UNFPA, improving the physical, sexual and mental health of adolescents aged 10-19 yearscould bring a tenfold economic benefit by averting adolescent deaths and preventing unwanted pregnancies among adolescents.[21] Tanzania can leverage these benefits through investing in adolescent population to drive positive development and health outcomes.

VISION OF THE STRATEGY

Tanzania will create an environment that promotes and supports the growth and development of healthy, educated and empowered adolescents who are empowered to transition into adulthood and contribute to the country's development vision. This will be accomplished through strong multi-stakeholder action

[21]https://www.unfpa.org/press/lancet-investing-adolescent-health-education-could-bring-tenfold-economic-benefit

DEFINITION OF KEY TERMS AND SCOPE

The overall scope of the ADHD strategy focuses on the holistic growth of adolescents and aims to address both health and non-health development aspects. On health, this strategy focuses on the health outcomes of adolescents including their physical, mental and social wellbeing while on the developmental side, the focus is on non-health issues that affect the overall development of adolescents including violence, substance abuse, nutrition, road accidents and mental health. The table below clarifies the definitions and scope of key concepts, as agreed upon through consultations with the MoHCDGEC, and based on national and international guidelines.

TABLE 1: DEFINITION OF KEY TERMS AND SCOPE

Term	Definition	Scope of key themes covered
Adolescent health and development (ADHD)	Adolescent health and development (ADHD) focuses on the holistic development of adolescents and covers two main components: a) Health – covers the health outcomes of adolescents including their physical, mental and social wellbeing in various areas b) Development – covers non-direct health related issues that touch on adolescents' welfare such as violence, substance abuse, etc.	• Sexual reproductive health including HIV • Nutrition • Substance abuse • Mental health • Violence
Demand	The demand side of healthcare looks at key factors that affect health seeking behaviours and patterns of utilization of existing services and interventions by adolescents.	• Socio-cultural norms • Economic situation • Education • Physical environment
Supply	The supply side looks into the wide ecosystem that provides various health and non-health services and interventions to adolescents. Particularly, this focuses on the delivery of youth friendly services, the development and support of a workforce that understands adolescents and the supply of commodities that facilitate effective dissemination of services.	• Service delivery • Human resources • Supply chain
Data and access to information	Data and access to information includes the demand and supply side of data collection, synthesis and dissemination. On the supply side, this looks at the collection, synthesis and sharing of data from interventions and programmes while the demand side focuses on information flows to adolescents and concerned parties to enhance health seeking behaviours and attitudes and improve uptake of adolescent services.	• Data systems • Monitoring and evaluation • Research • Communication and access to information
Financing	Financing focuses on the function responsible for mobilization, accumulation and allocation of money to cover the health and development needs of adolescents both individually and collectively, within the health system and other related areas e.g. education, social welfare, etc.	• Financial allocation • Health insurance and universal coverage • Development financing
Policies, legislation and commitments	Policies and legislation include national laws and regulations touching on adolescents that exist within Tanzania's constitutional framework and legal regime. It also includes global and regional commitments that Tanzania has made towards the advancement of adolescent health and development.	• National policies affecting adolescents such as health, education, social welfare • Country laws • Global/ regional commitments
Economic development	Economic development focuses on efforts that aim to improve the economic welfare and quality of life for adolescents by empowering them with skills and means through which they can gain and grow incomes, either through employment or entrepreneurship.	• Financial support • Education and skills • Economic productivity
Mental health	Mental health centres on the state of well-being in which adolescents can realize their potential, cope with the normal stresses of life, work productively, and make positive contributions to their communities.	• Mental disorders
Nutrition	Nutrition focuses on the intake of food, considered in relation to the body's dietary needs to ensure that adolescents access adequate, balanced achieve physical fitness.	• Anaemia in pregnancy
SRH and HIV/AIDS	Sexual reproductive health covers the physical, mental and social welfare of adolescents in all matters relating to the reproductive system with the goal of ensuring that they have satisfying and safe sex lives, and the capability and freedom to reproduce. It also looks at HIV/ AIDSs as a critical part of SRH	• Family planning • HIV/AIDS • Sexually transmitted diseases

Term	Definition	Scope of key themes covered
Substance abuse	Substance abuse focuses on the abusive use of harmful or hazardous psychoactive substances, including alcohol and illicit drugs that can lead to various behavioural, cognitive, and physiological phenomena that develop after repeated substance use and lead to a strong desire to take the drug and difficulties in controlling its use	• Alcohol abuse • Other drug and substance abuse
Violence	Violence focuses on the intentional use of physical or psychological force or power, threatened or actual, against oneself, another person, or against groups or communities, that could potentially result to injury, death, psychological harm, maldevelopment, or deprivation	• Gender-based violence • Inter-personal violence

METHODOLOGY

The strategy development process relied ona comprehensive review of key documents, research and analysis of relevant data and global best practice and extensive stakeholder engagement across all levels. The process was coordinated by the MoHCDGEC.

FIGURE 1: KEY COMPONENTS OF THE STRATEGY METHODOLOGY

PHASE I

INCEPTION REPORT AND PREPARATION OF THE SITUATIONAL ANALYSIS

This phase began with the preparation of an inception report which was presented to key stakeholders in a one-day meeting. An updated inception report was presented to an inclusive stakeholder meeting and approved. Thereafter, desk research was conducted which specifically focused on reviewing key national, regional and international policies, relevant to ADH. The team then developed a high level country ADHD profile and compiled the findings into a comprehensive situational analysis report which was presented to the RCH Section and the Technical Working Group involved in the process.

STRATEGIC PLANNING WORKSHOP

A five-day strategic planning workshop was held in Morogoro. This workshop attracted various adolescent health stakeholders including members of the Technical Working Group. During the

workshop, a situational analysis report was presented for discussion. Thereafter, the vision and mission statements were developed.

Finalization and Approval

To finalize Phase I, adolescent health stakeholders were re-engagedthrough one-on-one interviews to test and appraise various priorities and recommendations outlined in the strategy. A comprehensive review of key documents such as the WHO Global Accelerated Action for the Health of Adolescents (AA_HA!) and relevant data was conducted.The inputs gathered from these interviews were then incorporated into the final draft. Subsequently, a government roundtable meeting was held to discuss the recommendations and the cross-sectoral collaboration needed for successful implementation of these recommendations. This was followed by an inclusive stakeholder workshop in April 2018 that brought together key ADHD stakeholders to review the final draft of the strategy. Input and feedback from the government roundtable and stakeholder workshop were incorporated into the final report which was shared with the MOHCDGEC for final review and approval.

Phase II

In the second phase of this engagement, there will be a focus on three key activities: (a) develop a costing plan that will guide the implementation of this strategy; (b) develop a governance framework to support the coordination framework and outline a leadership and accountability structure that will steer the implementation of this strategy; and (c) prepare a monitoring and evaluation (M&E) plan that provides a mechanism for tracking progress in the implementation of the ADHD strategy at the national, regional and district levels. In addition, a comprehensive mapping of existing ADHD programs will be completed in this phase.

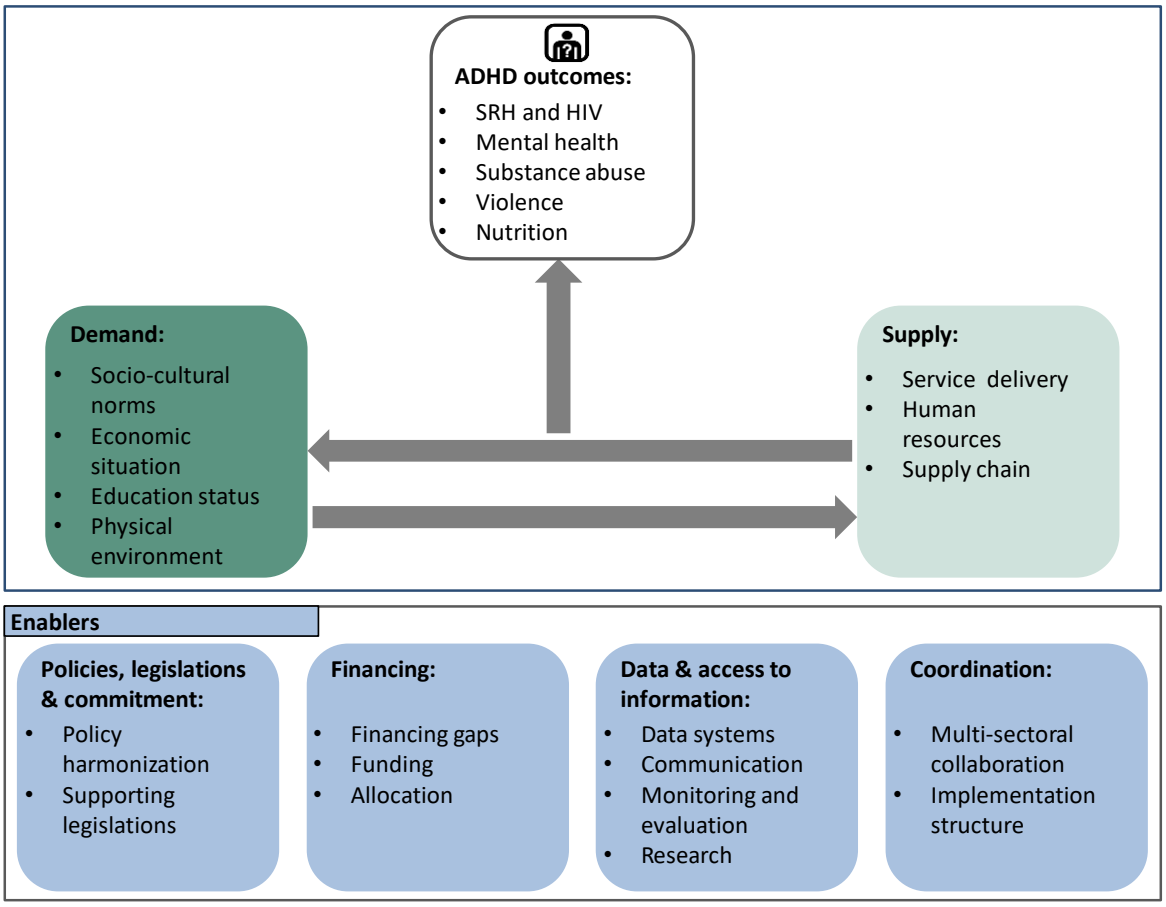
Although development of the strategy was coordinated by the MoHCDGEC (both on the health and community development sides), its successful implementation depends on close collaboration and partnership between different stakeholders under the guidance of the President's office – Regional Administration and Local Government (PO-RALG). Apart from the health ministry, other key sectors envisaged to play a major role in the implementation of the strategy are: the Ministry of Education, Science and Technology (MoEST) (especially in providing information, counselling and life skills training to adolescents); and the PMO – Ministry of Labour, Employment & Youth Development (MOLEYD) (in promoting livelihood skills).

SITUATION ANALYSIS

This section starts by taking stock of the key ADHD issues adolescents face in Tanzania. Subsequently, the section presents the state of ADHD from three lenses- demand, supply and enablers.The section presents the demand situation which seeks to understand the socio-cultural and economic trends in the country and their influence on ADHD outcomes. Thereafter, the supply lens assesses health services and other types of support needed to effectively address adolescent health and development needs in Tanzania.

Lastly, enablersfocus on policies, legislations and commitment, financing, data systems including access to information and coordination that create the right environment and provide relevant tools to support ADHD. Policies, legislations and commitment reviews relevant policies, legislations and commitments to determine if they are harmonized in addressing ADHD issues and if they support ADHD. Financing examines the gaps in financing for ADHD activities, health insurance coverage and allocation of resources. Data and access to information assesses data systems for ADHD, communication and access to information for adolescents, monitoring and evaluation and research on adolescent outcomes. Finally, coordinationexamines coordination mechanism and collaboration between ministries, agencies and donor partners for ADHD.

FIGURE 2: FRAMEWORK FOR ASSESSING THE ADHD SITUATION IN TANZANIA



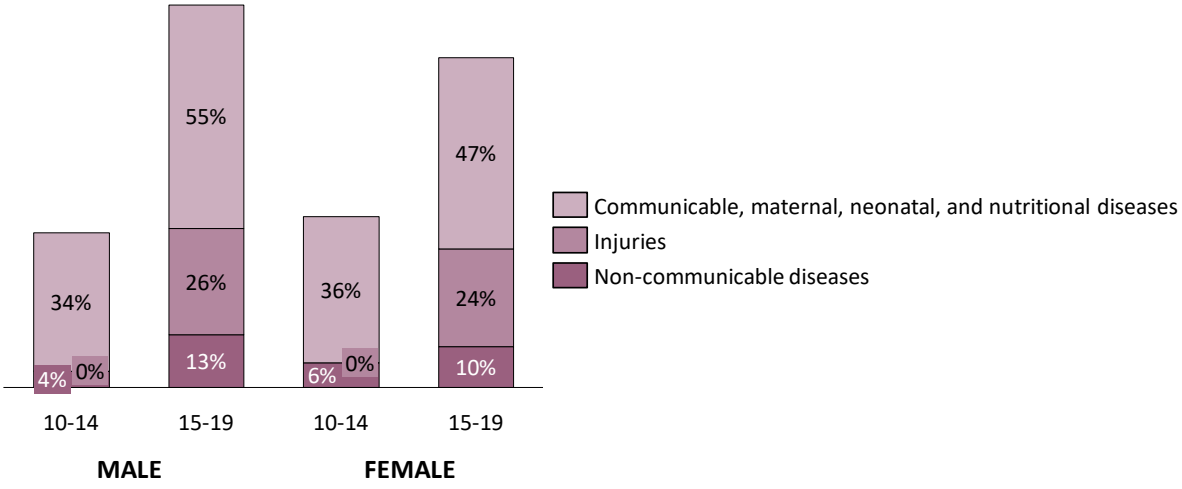
ADHD OUTCOMES

Adolescent health has long-term consequences for adulthood. More than 33% of the disease burden and almost 60% of premature deaths among adults can be associated with behaviour or conditions that

began or occurred during adolescence, for example, tobacco and alcohol use, poor eating habits, sexual abuse, and risky sex.[22]

The top risk factors for adolescents' health in Tanzania today span a range of issues, such as poor sexual and reproductive health including sexually transmitted infections, malnutrition and anaemia, substance abuse, mental health concerns and violence including gender-based violence. These all contribute to increased morbidity and mortality not only during adolescence but also later in their lives.

FIGURE 3: ISSUES THAT ADOLESCENTS ARE AT RISK FOR[23]



SEXUAL AND REPRODUCTIVE HEALTH

Sexual and reproductive health status of adolescents in Tanzania remains an area of concern for the country. Low levels of knowledge on SRH and STI/HIV, high prevalence of child marriage, correspondingly high levels of adolescent fertility and limited access to quality and age appropriate information and services are challenges which perpetuate poor sexual and reproductive health outcomes. Given that 57% of young women and 48% of young men report having had sex by age 18, it is important for adolescents to have access to comprehensive sexual education.[24]

Adolescent pregnancies are currently a major sexual and reproductive health concern in Tanzania. Among adolescents aged 15 to 19 years, 27% of them have begun child bearing (21% have given birth and 6% are pregnant with their first child). Mothers' age at birth is associated with maternal and childhood mortality hence, children born to mothers under 20 years have a high risk of dying. Although there are plans to reduce Adolescent Fertility Rate from the current 128 to less than 100 pregnancies

[22] WHO, World Health Report, 2002
[23] Institute of Health Metrics and Evaluation, Global Burden of Disease Statistics, 2017
[24] TDHS-MIS, Tanzania Demographic and Health Survey and Malaria Indicator Survey, 2015-2016

per 1,000 women by 2020, this target is unlikely to be achieved due to existing barriers including comprehensive knowledge on SRH.[25]

Additionally, adolescents' knowledge on family planning is much lower among youths in the country compared to the national average. Girls who are at primary school but not completed primary school are least likely to use a modern method of contraception at 9%. It is apparent that pregnant women who are younger than 18 years of age face increased risks of complications for both the mother and the new-born, compared to women between 20-24 years old. Even though the uptake of modern family planning methods is still low, measures have been defined in One Plan II to address this shortcoming. Consequently, Contraceptive Prevalence Rate needs to be increased from 27.4% to 45% by 2020.[26]

Sexually Transmitted Infections (STIs), including HIV/AIDS remain a great risk for adolescents. Condom use outside marriage is as low as 37% in adolescent girlsand 35% in adolescent boys between the ages of 15-19.[27]Youths in rural areas use condoms at a lower rate compared to their urban counterparts. Among unmarried young women, use of a condom at sexual intercourse is higher among adolescents aged 18-19 years. Older unmarried young men (age 20-24) are more likely to use a condom during sexual intercourse than younger unmarried men (age 15-19).

HIV/AIDS is a big risk factor for male and female ages 15-19 with 43% of new HIV infections in Tanzania occurring among youth below 24 years and with 70% of new adolescent infections occurring in girls. Of the new infections in 2016, 83% of these were in adolescent girls.[28] Among the 10-14 age group, 35% of females and 33% of males experience HIV as a risk factor for death. Stigma and discrimination related to HIV/AIDS is widespread among Tanzanian adults and adolescents. This creates challenges for adherence to treatment for adolescents living with HIV as they want to avoid the stigma that comes with being on ARV drugs.Additionally, poor disclosure of HIV status from parents and guardians to adolescents living with HIV/AIDS leads to poor adherence as well as depression when adolescents find out their HIV status.

Strategies in the One Plan II, 2016 and the Third Health Sector HIV and AIDS Strategic Plan, 2013 are being drawn on to implement recommendations in order to achieve national targets and goals. The proposed interventions in these documents are vital in improving adolescent sexual and reproductive health outcomes.

NUTRITION

Nutritional requirements before and during adolescence are significant and a key requisite to attain optimum growth in this important stage of life. Poor nutrition significantly impacts on the health and development of children and adolescents, leading to physical-stunting, poor mental development, delayed attainment of puberty, and susceptibility to infections. The nutritional status of adolescents depends on the foundation laid during childhood, particularly during the first two years of life, which is a

[25]MoHCDGEC, One Plan II, 2016
[26]MoHCDGEC, One Plan II, 2016
[27] TDHS-MIS, Tanzania Demographic and Health Survey and Malaria Indicator Survey, 2015-2016
[28] UNAIDS estimate, 2017

critical period for growth and development. Adolescents can gain 15% of their ultimate adult height and 50% of their adult weight in this time period.[29]

Additionally, in pregnant adolescent women, poor nutrition could lead to high mortalities and a higher likelihood of giving birth to underweight and unhealthy babies, with reduced chances of survival. In Tanzania, the prevalence of stunting is very high, reaching about 70% stunting rate at 13 years. This has a considerable impact on maternal nutrition as more than half of young women under the age of 19 are pregnant or are already mothers. In addition, 45% of women age 15-49 are anaemic, of which half of them are adolescents aged 15-19 years.[30]

Interventionsin the National Nutrition Strategy 2011-2015 and the National Multisectoral Nutrition Action Plan 2017-2022 are being implemented in order to achieve favorable adolescent nutrition outcomes.

VIOLENCE

Adolescents in Tanzania are at a high risk for self-harm and interpersonal violence with older adolescents more vulnerable to both. Levels of violence in school are very high, 50% of boys and girls aged 13-19 reported experiencing physical violence at the hands of teachers.[31] These levels of violence contribute to absenteeism in school for adolescent girls and boys. In the 15-19 age group, 12.7% of boys and 12.6% of girls have experienced physical violence. The Global Burden of Disease shows that self-harm and interpersonal violence is a 17% risk factor for 15-19 year olds compared to 0% for 10-14 year olds.[32]

Gender based violence (GBV) affects a large percentage of girls in Tanzania and predisposes girls to various sexual and reproductive problems. The 2015TDHS shows 11% of sexually experienced girls aged 15-19 reported that they have experienced sexual violence and shows that nearly one in four girls aged 15-19 have ever experienced physical violence. Additionally, the inability of women and girls to negotiate safe sex because of gender inequality and power dynamics within sexual relationships can lead to STI and HIV transmission. Also, women and girls living with HIV are isolated and discriminated against, leading them to face increased levels of violence and challenges to seeking treatment.

Currently, there is close collaboration with the National Plan of Action to End Violence Against Women and Children in Tanzania 2017-2022 so as to ensure that the proposed interventions are being implemented to address violence amongst adolescents.

SUBSTANCE ABUSE

There is a growing use of illicit drugs in addition to alcohol and tobacco amongst Tanzanian adolescents. Tanzania is a significant transit country for illicit drugs, most notably heroin originating in Southwest Asia and cocaine from South America, with a growing domestic user population. Tanzania also produces cannabis both for domestic consumption and international distribution. Reports show that 5-12% of 10- 24 years olds have experienced drug use such as alcohol, cigarette, cannabis and khat

[29] UNICEF, Adolescence in Tanzania, 2011
[30] TDHS-MIS, Tanzania Demographic and Health Survey and Malaria Indicator Survey, 2015-2016
[31] UNICEF, Violence Against Children in Tanzania, 2011
[32] IHME, Global Burden of Disease in Tanzania, 2017

and 2.1% have injected themselves with drugs such as heroin. Substance abuse is a cross-country problem with more heroin and cocaine cases in urban areas while the semi-urban and rural use more of weed and khat. Substance abuse results in poor health outcomes during the adult years as tobacco use and alcohol abuse are also known risk factors for NCDs such as cardiovascular diseases and stroke in adult life.

The Drug Control and Enforcement Act 2015 is a useful tool in the war against drugs. However, there is a need to develop a national substance abuse strategy with the Drugs Control and Enforcement Authority taking the lead in the development of the strategy.

MENTAL HEALTH

Like many other countries, awareness about mental health, mental illness and acceptance of treatment for mental health are very low in Tanzania, primarily due to social stigma. There is limited data in Tanzania on mental health issues in adolescents. However, issues such as HIV, reproductive health problems, gender-based violence, etc are associated with depressive symptoms.[33] There is a need for adolescent programmes to include mental health components as it is often a taboo that is not discussed. Adolescents in the country are also vulnerable to various forms of mental health problems: acute psychotic states and schizophrenia. It is also reported that a significant proportion are admitted for acute psychotic states due to alcohol and drug misuse.

Mental health is a key component of the National Health Policy with policy guidelines released for mental health care in Tanzania. The Mental Health Act 2008 emphasizes access to quality services and the rights of the mentally ill. These guidelines will be taken into cognizance during implementation of this strategy while efforts are being made to develop a dedicated national mental health policy for the country.

EFFECT OF POPULATION GROWTH ON ADOLESCENT HEALTH OUTCOMES

Given the current state of adolescent health issues in the country and taking into consideration anticipated population growth as well as economic growth levels, adolescent health outcomes will be exacerbated if concerted actions aren't taken. The current focus on SRH and HIV interventions with less focus on other issues such as injuries may lead to shifts in the highest risk factors rather than an overall decrease for adolescents.The graphs below show that HIV progressively declines for both age groups while injuries increase. Additionally, self-harm and interpersonal violence increases for 15-19 year olds. Thus, attention on ADHD issues needs to address the various risk factors affecting ADHD as neglect of some issues can result in negative consequences.[34] It is important to note that mental health and substance abuse doesn't show up in the graph below due to limited data. However, given globalization, and Tanzania's status as a transit country, there is a likelihood of increase in substance abuse as a risk factor.

[33] Stakeholder interviews

[34] A simple regression projection was done with population and GDP at base prices as the independent variables and each risk factor for health as the dependent variable. The percentage risk represents the risk for the population

FIGURE 4: CHANGES IN HEALTH RISK FACTORS FOR 10-14 YEAR OLDS[35]

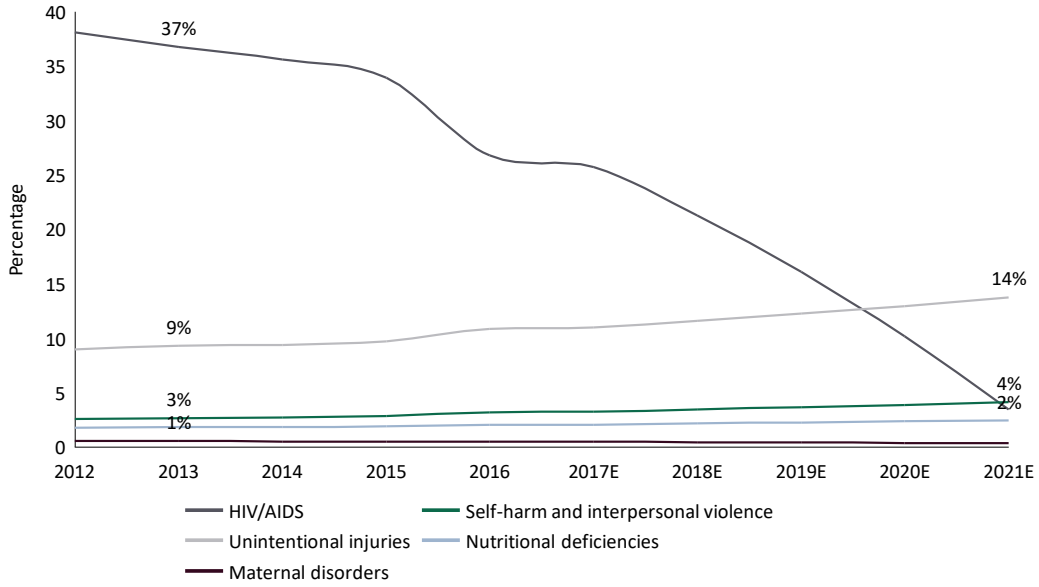
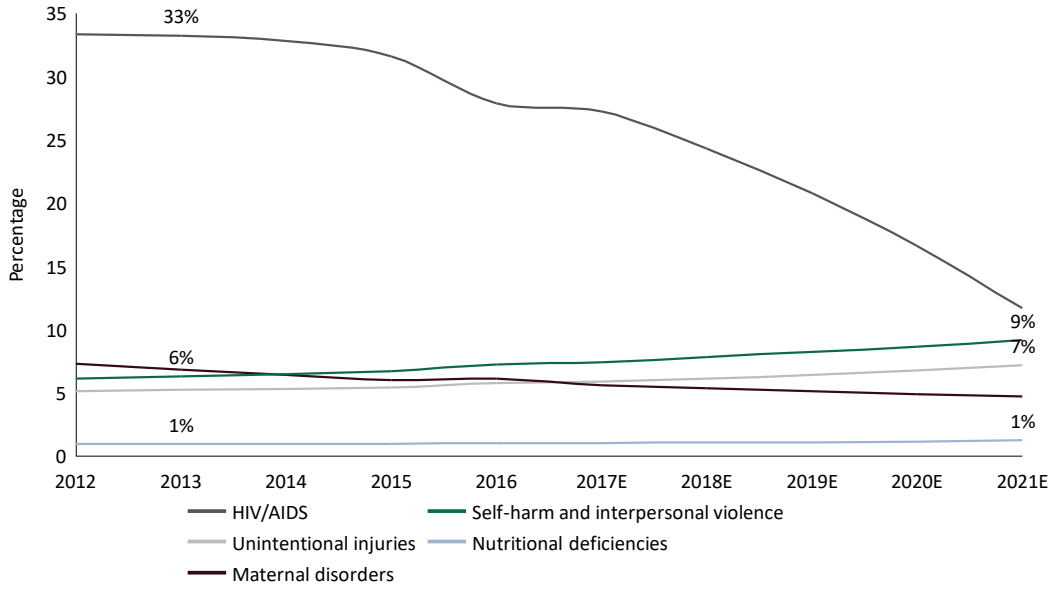


FIGURE 5: CHANGES IN HEALTH RISK FACTORS FOR 15-19 YEAR OLDS



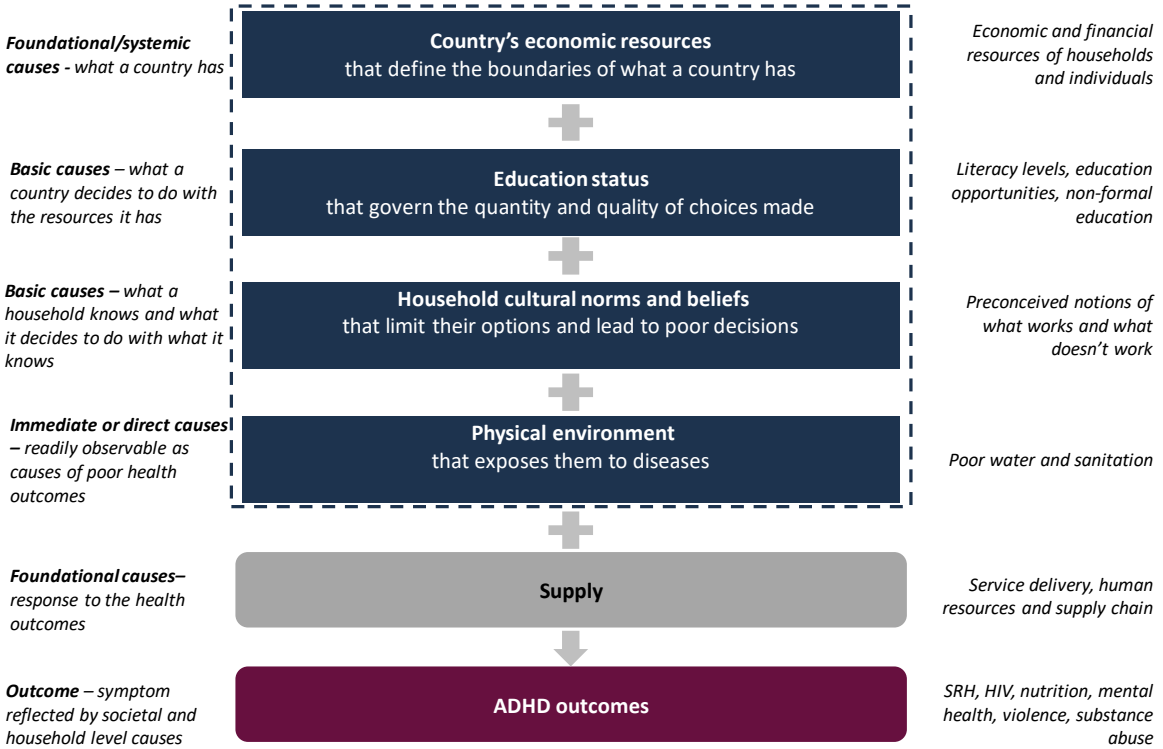
[35] Source: IHME, Global Burden of Disease in Tanzania, 2017. Years with E at the end are based on projections while years without E at the end are actuals

DEMAND

The socio-cultural fabric and economic context of a country is a contributing factor to ADHDoutcomes. The combination of socio-economic and cultural factors such as low education levels, high poverty rates, discriminatory social norms and some religious practices can adversely affect health outcomes.

Adolescents who are marginalized are even more vulnerable and have a set of more varied challenges which further distort their transitional process. Adolescents who are out of school, adolescents who live on the streets, adolescents with disability, adolescents who engage in sex work and adolescents in child labour cannot transition well into adulthood unless given special interventions to meet their overall health needs. Adolescent girls especially face gender-based discrimination, evident in the practice of child marriage. High rates of adolescent fertility, high prevalence of domestic violence, increasing incidence of sexual abuse, and, to some degree, a high drop-out rates from secondary education are all consequences of socio-cultural norms and practices that do not protector support adolescents. Adolescent boys also face pressure to comply with certain social norms around masculinity which drivessome of them to adopt risky behaviours such as unsafe sex, violence and substance use.

FIGURE 6: IMPACT PATHWAY OF SOCIO-CULTURAL AND ECONOMIC FACTORS ON ADHD OUTCOMES[36]



[36] Dalberg analysis

SOCIO-CULTURAL AND ECONOMIC TRENDS

Poverty leads to failure to meet basic needs and nutrition, and has significant implications on health, growth, morale and self-esteem of adolescents. Tanzania has experienced high economic growth rates of 6-7%, however, poverty is still high and estimated at c.50% of the population.[37] This high rate of poverty is primarily due to corresponding population growth which has reduced the per capita benefits from the growing economy. The high level of poverty also impacts negatively on the ability of families to support the educational needs of their children/adolescents and contributes to creating unsafe environments for adolescents.

Poverty exacerbates other factors that affect health. Low income levels increase the propensity for risky behaviour such as unprotected sexual relations, drug and substance abuse and different forms of exploitation.[38] The proportion of girls who are out of school is more than four times higher for the lowest income quintile than the highest income quintile, at 27% and 6%, respectively.[39] Additionally, a 2007 survey revealed 41% of school principals in the poorest schools reported teacher–pupil sexual harassment compared with 20% in the richest.[40]Additionally, some groups of adolescent girls use sex to obtain food, items, and finances beyond their families' means in order to survive as well as to gain status among their peers.[41]

Likewise, poverty drives rural to urban migration, particularly movements towards areas with economic activity such as lucrative trucking routes or mining areas which leads to adolescents succumbing to risky behaviour. According to the 2012 Tanzanian National Population Census, urbanization in Tanzania grew to 29.1% in 2012. This is a significant leap considering that only 5.7% of Tanzania's population lived in urban areas in 1967. Mining areas such as those inKagera, Mwanza, MusomaandShinyanga have experienced higher migrations rates which have been largely associated with artisanal mining activity in the regions.[42] Such migration is characterized by increased sexual behaviour driven by increased incomes among young miners and an influx of young women in the services industries e.g. hotel waiters and bar maids.[43] Similar occurrences have characterized major transport corridors such as the main highways to Rwanda, Zambia and DRC where urban pockets have gradually developed. Majority of these towns are often characterized by increased sexual activity and an influx of commercial sex workers which pose a significant risk to young adolescents.

EDUCATION

Education and literacy are important tools for understanding and interpreting information on adolescent health; both are strongly associated with improving health and fertility indicators.[44]They

[37] World Bank, Tanzania
[38]TDHS-MIS, Tanzania Demographic and Health Survey and Malaria Indicator Survey, 2015-2016
[39] No Ceilings, Out of School Children, http://noceilings.org/map/#OSCPFEIN&2010
[40] UNESCO, School-Related Gender-Based Violence Is Preventing The Achievement Of Quality Education For All, 2015
[41] Stakeholder interviews
[42] Journal of Contemporary African Studies, Unearthing Treasure And Trouble: Mining As An Impetus To Urbanization In Tanzania, 2012
[43] WIDER, Youth in Tanzania's urbanizing mining settlements, 2014
[44] UN Department of Economic and Social Affairs, Linkages Between Population and Growth, 1997

are also important tools for accessing better jobs and household wealth status by adolescents and their families.

Despite the high rate of primary school enrolment in the country, there is a high drop-out rate at the secondary school levels. Tanzania is making significant progress towards expansion of the education sector and enhancing literacy levels across the country. There is over 93% enrolment at primary schools, however, close to 60% of primary school leavers do not go on to secondary school.[45] This is often a result of economic issues as well as interruptions due to teenage pregnancies.

The high drop-out rate is worsened by teenage pregnancies as many girls drop out of school every year due to unplanned/unwanted pregnancies. Adolescent pregnancies are currently a major sexual and reproductive health concern in Tanzania. Among youth aged 15-19 years, 27% of them have begun child bearing (21% have given birth and 6% are pregnant with their first child).[46]In 2016 alone, a total of 3,700 girls were reported to have dropped out of school because of pregnancy.[47]One study estimates that 97% of married girls of secondary school age are out of school compared to 50% of unmarried girls.[48]Teenage pregnancy and the subsequent dropout of girls from school have a major negative impact on their education, health and development. Educational attainment is also associated with older age at first birth. Among women aged 25-49 who were surveyed for the 2010 DHS, the median age at first birth for those with no education was just under 19 years, versus 23 years for those with at least a secondary education.

Children with disabilities are more likely to drop out of school early due to challenges of access and stigma, as well as lack of trained staff and appropriate learning materials. While it is estimated that 7.9% of Tanzanians are living with disability, less than 1% of children in pre-primary, primary and secondary school have a disability.[49]Secondary schools in Tanzania are insufficiently equipped or well-resourced toaccommodate children with all types of disabilities, despite the government'scomprehensive inclusive education plan. Only 75 out of 3,601 public secondary schoolshave special needs units and specialized teachers, according to the MoEST Special NeedsEducation unit.[50] Children withdisabilities should be guaranteed equality in the entire process of their education,including by having meaningful choices and opportunities to be accommodated inmainstream schools if they choose, and to receive quality education on an equal basis alongside children without disabilities.

Alternative opportunities for formal learning, basic literacy, and vocational education are difficult to access and costly. Adolescents who drop-out of secondary school lack the accreditation (secondary school certificate) and studies needed to pursue an official vocational education and skills training degree.[51]Entry to vocationalschools is not straightforward for many. Students should be fluent in English

[45] EPDC, Tanzania National Education Profile, 2014
[46] TDHS-MIS, Tanzania Demographic and Health Survey and Malaria Indicator Survey, 2015-2016
[47] NBS, Basic Education Statistics in Tanzania, 2016
[48] FHI360, Most Vulnerable Children in Tanzania: Access to Education and Patterns of Non-attendance, 2012
[49] NBS, Basic Education Statistics in Tanzania, 2016
[50] Human Rights Watch, Barriers to Secondary Education in Tanzania, 2017
[51] TAMASHA, Education: Schooling or Fooling?, Undated

and must payfees amounting to TZS 60,000 (USD27) for official government colleges, which exclude manyadditional costs, or as high as TZS 600,000 (USD273) for nongovernmental colleges.[52]

There is a dire need to reduce drop-out rates in secondary schools and find alternative routes for out-of-school adolescents given the many long-term benefits of education. Education is key to breaking the transmission of poverty from one generation to the next, for both boys and girls, and for building stronger more robust economies. It is also particularly important for adolescent girls as it contributes to later marriage, reduced teenage pregnancies, lower infant mortality and improved child nutrition. Innovations such as multimedia platforms that provide easy access to content for students inside or outside schools or transitional models that connect adolescents to work can be alternative routes for out-of-school children.[53]

CULTURAL NORMS

Several cultural and religious practices contribute to adverse adolescent health outcomes. 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. Child marriage for instance presents numerous risks to adolescent girls, including early pregnancy, violence, abuse and exploitation. It also reduces girls' education, limits their social connections and potential earnings and thereby contributes to poverty.[54] Such norms also prohibitfrank parent-child discussions about sexual and reproductive health leading to lack of appropriate information and can result in adverse sexual behaviours and health outcomes.

Gender norms have an influence on the health of adolescents, which manifests through discrimination of both male and female adolescents, leading to marginalization. Tanzania has made progress towards promoting gender equality, one such area is the increase in secondary school enrolments for girls. Despite this, only 70% of girls who start secondary school finish four years of schooling compared to 85% of boys.[55] There are also more female domestic workers than male domestic workers, and this is a particularly vulnerable group that may be overlooked when it comes to adolescent rights and protections. Furthermore, girls experience higher rates of domestic violence than boys. Conversely, the financial pressure placed on boys can force them to start working at an early age which can expose them to economic exploitation and other vices.

These gender-defined roles become more entrenched in early adolescence. Boys are encouraged to demonstrate their virility and masculinity with little or no family supervision, whilst girls are taught to become ideal wives and mothers, to submit to a husband's wishes, and take up household

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[52] Vocational Education and Training Authority, Procedures for Joining Vocational Education and Training Centers in Tanzania, 2015

[53]Ubongo Media in Tanzania, http://www.ubongokids.com/; Harambee in Kenya, https://www.harambeeforkenya.org/

[54] Global Partnership for Education, Why Education Girls Makes Economic Sense, March, 2014

[55] Center for Reproductive Rights, Forced Out: Mandatory pregnancy testing and the expulsion of pregnant students in Tanzanian schools, 2013.

duties.[56]Contradictory gender norms from family and society can shape sexual expectations with implications on engagement in unsafe sexual behaviours.

PHYSICAL ENVIRONMENT

Poor access to safe water and sanitation, poor housing and unsafe food are among the key drivers of diseases which significantly affect the health of adolescents within the communities. In Tanzania, only 48% of rural households have access to improved sources of water. Households in urban areas are more likely to have access to improved sources of water than those in rural areas, nearly 90% of urban mainland households have access to an improved source of drinking water. Sanitation facilities are limited throughout Tanzania–35% of urban mainland households and only 10% of rural mainland households have access to an improved sanitation facility. Only six in ten households in Zanzibar have access to an improved sanitation facility.[57]

SUPPLY

There is a need for health and development services and support to effectively respond to the ADHD outcomes. There are various delivery channels of health and development services for adolescents- in-facility and out-of-facility. Facilities include clinics and hospitals while out-of-facilities include schools, community-based services and youth centres. The various providers of these services include health workers, teachers and community development officers, youth officers and social welfare officers.

The packages of health services offered to adolescents should aim to be adolescent friendly. This concept was introduced by WHO to help define packages of health services targeted at providing adolescents with appropriate and convenient health services, which consider their special needs.

Box 1: Adolescent Friendly Health Services, WHO[58]

According to the WHO, adolescent friendly health services need to be accessible, equitable, acceptable, appropriate, comprehensive, effective and efficient and require the following:

- **Adolescent friendly procedures to facilitate**
    - Easy and confidential registration of patients, and retrieval and storage of records
    - Short waiting times and (where necessary) swift referral
    - Consultation with or without an appointment
- **Adolescent friendly health care providers who**

[56]American Journal of Public Health, Tanzanian adolescent boys' transitions through puberty: the importance of context, 2014

[57] TDHS-MIS, Tanzania Demographic and Health Survey and Malaria Indicator Survey, 2015-2016

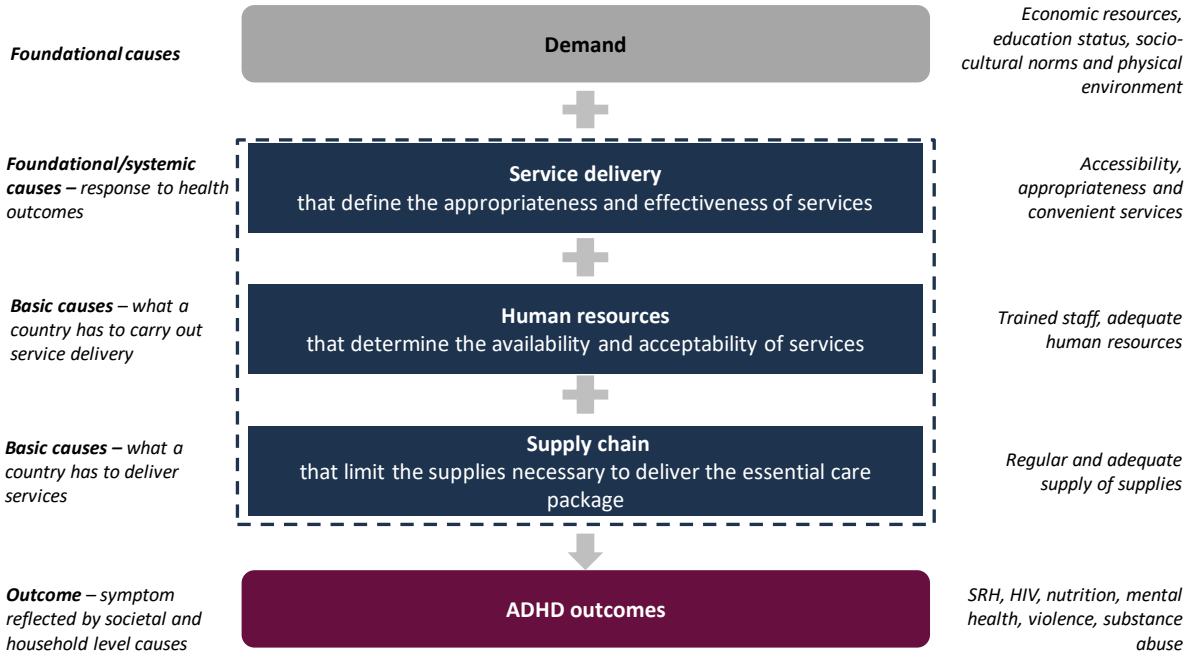
[58] WHO, Adolescent Friendly Health Services, 2002

- Are technically competent in adolescent specific areas, and offer health promotion, prevention, treatment and care relevant to each client's maturation and social circumstances
- Devote adequate time to clients or patients
- Are non-judgmental and considerate, easy to relate to and trustworthy provide information and support to enable each adolescent to make the right free choices for his or her unique needs
- Provide information and support to enable each adolescent to make the right free choices for his or her unique needs

- **Adolescent friendly support staff who are**
  - Understanding and considerate, treating each adolescent client with equal care and respect
  - Competent, motivated and well supported
- **Adolescent friendly health facilities that**
  - Provide a safe environment at a convenient location with an appealing ambience
  - Have convenient working hours
  - Offer privacy and avoid stigma
- **Community involvement and dialogue to**
  - Promote the value of health services
  - Encourage parental and community support
- **Community based, outreach and peer-to-peer services to increase coverage and accessibility**
- **Appropriate and comprehensive services that**
  - Address each adolescent's physical, social and psychological health and development needs
  - Provide a comprehensive package of health care and referral to other relevant services
- **Effective health services for adolescents**
  - That are guided by evidence-based protocols and guidelines
  - Having equipment, supplies and basic services necessary to deliver the essential care package

Three mutually reinforcing challenges present the most important barriers for achieving adolescent friendly servicesin Tanzania; lack of quality service delivery for adolescent health and development services through schools and facility and community-based services, shortages of trainedhuman resources both in numbers and skills to deliver AFHS and inadequate commodities for adolescent services.

FIGURE 7: IMPACT PATHWAY OF SERVICE DELIVERY, HUMAN RESOURCES AND SUPPLY CHAIN ON ADHD OUTCOMES[59]



SERVICE DELIVERY

There are limited health facilities which hinders the accessibility of adolescent health services especially as these services are often delivered through health facilities. 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. The limited availability of primary health care facilities means that adolescents do not have easy access to health facilities.

Given the limited public health facilities, private players in the healthcare industry have a significant role to play in bridging that gap and enabling a healthier future for adolescents. About two-thirds of all primary care is provided by the public health system; the remainder is supplied by non-profit organizations (typically faith-based or other humanitarian groups) or by private enterprises.

Additionally, there is a dearth of appropriate health services for adolescents. Studies show that only 30% of health service delivery points meet the national standards for AFHS.[60]This is compared to the

[59] Dalberg analysis
[60] UNICEF, Adolescence in Tanzania, 2011

target of having 80% health facilities providing AFHS by 2015. However, most service delivery points do not provide client centred comprehensive and integrated ADH services e.g. extended hours clinics or have special clinics for adolescents.

Furthermore, there is a need for adolescent facility services to be strongly integrated into the broader health system as facility-based services do not provide an integrated adolescent health package. The HEADSS assessment[61] (home, education and employment, activities, drugs, sexuality and suicide/depression) which is an instrument for finding out issues about adolescents and providing necessary support is usually not offered in facilities. Services such as malaria, tuberculosis, HIV prevention and control, STIs are increasingly delivered in an integrated way at the primary health care level ("one-stop-shop"). However, most service delivery points currently providing sexual and reproductive health services are not organized to meet the needs of adolescents. Currently only a few public health facilities are offering comprehensive packages of adolescent services. There is a need to also integrate social welfare officers into the delivery of adolescent services in order to provide psychosocial support as well as drive community engagement in the provision of adolescent services.

Community-based services provide access to both in-school and out-of-school adolescents, however, there is limited evidence showing the success of youth centres and drop-in centres.[62]Community-based services are often offered through peer-led youth clubs and community-based multiservice centres (e.g., drop-in centres, community clinics). The greatest strength of community-based services is their emphasis on outreach. The most vulnerable teenagers are often isolated, living either on their own or in dysfunctional family settings. Such youths are unlikely to engage the health system, through either a school or community clinics as such street-based outreach is the most effective means for reaching them. Additionally, youth clubs can serve as the entry points to the respective health facilities. Youths in these clubs are initially attended to by youth peer counsellors, who provide counsellingbefore referring them to the appropriate health workers. Nevertheless, there has been limited evidence demonstrating the effectiveness of youth clubs and drop-in centres.

Schools play a critical role for in-school adolescents and can help provide vital information and services to adolescents. Yet, there is limited classroom material on topics such as nutrition, substance abuse, violence, reproductive health, mental health and vocational preparation. In order to achieve this, it is essential to have a comprehensive curriculum offering both sexual and reproductive health services as well as life skills. However, even though there is a comprehensive sexual education as part of the curriculum in secondary schools in Tanzania, there is limited offering of these courses with teachers not prioritizing it.[63] In addition, there is no lifeskills course as part of the curriculum which can reduce the ability of adolescents to transition into the world of work and limit their economic empowerment opportunities.

HUMAN RESOURCES

[61] Cohen E, et al., HEADSS, A Psychosocial Risk Assessment Instrument: Implications for Designing Effective Intervention Programmes for Runaway Youth, 1991

[62] GHSP Journal, What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices, 2015

[63] Human Rights Watch, Barriers to Secondary Education in Tanzania, 2017

Human resources are in short supply in Tanzania which affects the accessibility of services for adolescents. The World Health Organization estimates that the country should have a workforce of about 127,650.[64]The government aspires to have a larger workforce of 140,500 by 2019, but at present, the country has only 64,449 health workers.[65] Health worker densities of less than 2.3 per 1000 population have been linked to poorer health outcomes; Tanzania has a health worker density of 1.2 per 1000 population. Healthcare supply is also skewed towards urban areas, with large variations in infrastructure across states. About 40% of the health workforce are in urban areas even though only 32% of the total population live in urban areas. This in turn affects the availability of health care providers who are technically competent in adolescent specific areas and can devote adequate time to patients.

There are various recruitment challenges that affect the ability to attract, retain and ensure equitable distribution of health personnel, as a result, health facilities often lack workers with the skills needed to meet basic standards of care. Recruitment in the health sector is a multisectoral function.[66] It involves the Civil Service arm of PoRALG which is charged with the responsibility of identifying new employment posts. Likewise, PO-PSM is charged with the responsibility of rationalisation, validation and approval of new employment posts. MoHCDGEC is responsible for advertising and posting of health workers to relevant authorities and the MoFP is responsible for financing new posts in form of salaries. Challenges of recruitment process include low human resource management capacity in the councils, limited allocations for personnel emoluments, poor working conditions (roads, communication network, electricity, recreation, water, and schools for children) especially in rural areas, limited ability of the health sector to meet the basic employee personal needs and brain drain within and outside the country. According to government guidelines, dispensaries should be staffed by eight health workers, but in practice most have only one or two.[67] Health centres are supposed to have about 30 staff members, but they typically have less than half that number. This has an impact on the effectiveness and equitable distribution of health services provided to adolescents. The inadequate number of staff often mean that available health care providers may not be competent, motivated and well supported to provide services to adolescents.

Too often, the health workers who staff these facilities do not have the appropriate training and are subject to inadequate quality controls which impacts their knowledge of adolescent friendly procedures. The output of training institutions has increased considerably over the past several years, but the quality of training is not yet consistent. Continuing Professional Development (CPD) has limited continuity for the programmes; the impact of CPD on the health system as a whole is insufficient as the approach is fragmented and ad-hoc. There is no system of accreditation and re-registration of professionals based on attending CPD. Furthermore, there is no system of quality assurance of competencies and procedures of health professionals. However, for ADH, there is also an additional dimension of inadequate training of all the health workers in the provision of AFHS, and the weak coordination structures for AFHS at facility level. Additionally, if health staff are not well trained, they

[64] WHO estimates that a minimum of 2.3 trained health workers per 1,000 people are needed to provide the basic standard of care required

[65]TanzanianMoHCDGEC, Human Resource for Health Country Profile, 2013

[66] Ibid

[67] Tanzanian MoHCDGEC, Staffing Establishment, 2005

would lack the knowledge and ability to offer AFHS which in turn affects the acceptability of these services by adolescents. Thus, this can result in unwillingness of adolescents to obtain the health services that are available.

Further, the age and attitude of the health workforce might serve as a deterrent to the availability of adolescent friendly health services. The nursing cadre delivers most health services given that they are often the most within the workforce, however, nurses above 39 years represent 56% of the nurse workforce.[68] This means that most of the health workforce are older and might be out of touch with issues facing adolescents. Adolescents might also feel uncomfortable discussing some issues with much older health personnel.

On the education side, Tanzania also faces a shortage of skilled educators. According to the Tanzanian Teachers Union, over 50,000 teachers are needed to fill the gap in secondary schools.[69] As a result, many students are learning in difficult conditions as they lack qualified teachers. This shortage also puts a constraint on the ability of available teachers to provide further services beyond classroom teaching to students.

While teachers are among the most important influences in the lives of school-aged children, they are ill-equipped to handle mental health, behavioural health and reproductive health problems.[70] There is a need for additional staff development workshops to address these needs. Teachers have to be trained to overcome socio-cultural norms-such as the view that abstinence is the most appropriate prevention strategy- and discomfort with teaching about sexuality.

SUPPLY CHAIN

In terms of supply chain, AFHS services are adversely affected by erratic supply of drugs and medical supplies. Key medicines are not readily available in drug outlets despite recent expansion in delivery points. The number of Accredited Drug Dispensing Outlets (ADDOs) has increased from 2,215 in 2010 to 3,591 in 2013, leading to better availability of some medicines and health products in rural areas.[71]However, given that the ADDOs are still too little to cover the needs of the country, there are still incidencesof stock-outs. Thus, this affects the availability of commodities that are necessary to deliver the essential care package to adolescents. Private pharmacies are commonly used by adolescents and should be provided with information to enable them deliver essential commodities to adolescents.[72]

Internal and external factors affect overall management of commodities in the sector. Internal factors include inadequate funding, poor planning and coordination, inadequate tracking mechanisms and tools, as well as inadequate pharmaceutical human resources at the facility level resulting in poor inventory management. External factors include a lack of coordination of externally fundedprogrammes' medicines, health products and donated supplies, and pilferage. This negatively affects the quality of

[68] Tanzanian MoHCDGEC, Human Resource for Health Country Profile, 2013
[69] Education Internationa l, Tanzania: Significant Move to Curb Teacher Shortage, 2013
[70] Human Rights Watch, Barriers to Secondary Education in Tanzania, 2017
[71] Tanzanian MoHCDGEC, Health Sector Strategic Plan 2015-2020, 2015
[72] Stakeholder interviews

care and performance of service provision in general. In instances when these occur, adolescents are unable to receive appropriate treatment and care.

Beyond the health system, other relevant sectors such as educationalso lack necessary materials. Many secondary schools lack the required materials to engage in basic education and to provide health services. Textbooks and learning materials are in short supply in secondary schools across Tanzania.[73] Additionally, schools lack the facilities and supplies to promote good menstrual hygiene management. Good menstrual hygiene management requires adequate access to water, accessible, private, and hygienic sanitation facilities so that girls can dispose of or change sanitary protection materials. However, key components of a good learning environment such as available and accessible learning materials and adequate sanitation facilities are absent in plenty secondary schools in Tanzania.[74]

ENABLERS

POLICIES, LEGISLATIONS AND COMMITMENTS

ADHD has received a fair amount of policy and legislative attention over the past decades, but adolescents have not been recognized as a unique demographic segment in most programming. Landmark policy documents like the National Health Policy 2018 (in draft) and Health Sector Strategic Plan (HSSP) 2015-2020 recognize adolescents and have built their health needs into overall policy programming, but do not call them out as a distinct demographic segment. For instance, the National Health Policy flagged adolescent fertility as an important health and social issue as teenage pregnancies can lead to adverse pregnancy outcomes, sicknesses and death. It also emphasized the need to provide adolescent-specific health services in areas like gender-based violence, female genital mutilation, violence and other harmful traditional practices. However, the policy only discusses adolescents in the broader context of Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH), and not as a distinct demographic group. The emphasis on adolescent health reflects in other policy documents like the National Adolescent Reproductive Health Strategy, and the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and child deaths (One Plan II). The draft Family Planning Costed Implementation Plan also has adolescents as a distinct demographic segment. Beyond emphasizing adolescent health, these additional policy documents go further to include specific targets and indicators to reduce some of the barriers to ADHD, and an implementation roadmap to guide execution. However, a few other important policies like the National Policy on HIV / AIDS, the Education and Training Policy and the National Strategy for Gender Development neither mention adolescents nor proffer solutions to mitigating the barriers to their health and overall development. In the legislation space, adolescents are hardly called out in documents, but are submerged in broader demographic categories like children and youth. This is the case in legislative pieces such as the Law of the Child 2009, the Law of Marriage 2002, Anti-trafficking in Persons Act 2008, and the Public Health Act 2009.

Generally, existing policies and legislation support ADHD, but the policies are not aligned in their prioritization of ADHD components, while some legislation is contradictory. Tanzania's policies are

[73] UNESCO, Global Education Monitoring Report, Every Child Should Have a Textbook, 2016
[74] Human Rights Watch, Barriers to Secondary Education in Tanzania, 2017

mostly pro-ADHD, but they place different levels of emphasis on the six components that collectively constitute an effective ADHD system (i.e Coordination, data, financing, health systems, policies, legislation and commitments, and socioeconomic considerations), potentially resulting in inconsistencies and variations during implementation. Most policies present socioeconomic considerations as the priority component for ADHD but are not aligned in the way they prioritize the other five components, resulting in varying policy focus across the ADHD system. 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. There is very little mention of monitoring and evaluation, and health financing in most of these documents, a gap that may have contributed to limited data and funding for ADHD activities as these policies get implemented. On the legislative side, some contradictions exist between Acts, most notably around the definition of a child. As an example, while the Law of the Child Act defines a child as a person below 18 years of age, the Marriage Act provides that young girls can contract marriage at 14 or 15, and the penal code suggests that parents and guardians will not be punished for deserting children above 14 years. These contradictions can prevent children from enjoying certain rights and protection under the Child Act, including protection from statutory rape and unjustifiable desertion.

Additionally, some legislation has proven unfriendly to ADHD. Few legislations have the potential to worsen ADHD outcomes. For example, within the marriage act, the age of consent to sexual activity is 18 for males and as early as 14 for females. This provision will continue to enable the high prevalence of early child marriages and teenage pregnancies, which are both barriers to ADHD in Tanzania. Also, the statutory age of consent for independently consenting to HIV/AIDS testing and counselling (HTC) and HIV treatment in Tanzania is 18, except for married minors. Given the provisions of this law, HIV prevalence among unmarried minors could remain high as they are not legally allowed to test for HIV, even though some of them are sexually active. Finally, the government's current position on adolescent pregnancy does not allow girls who get pregnant in secondary schools to continue with their formal education. This inevitably has implications for their continued development and contributions to society. As these legislations and national directives are reviewed, it is important to allow for direct adolescent participation in the process as they are uniquely positioned to provide input that elevates their interests in the existing legislative framework.

However, Tanzania has committed to several national, regional and international conventions that could improve the operating environment for ADHD. Over the past few decades, the GoT subscribed to several pro-ADHD conventions, committing itself to abide by their tenets. A few of these conventions include: i) the UN political declaration on HIV / AIDS, ii) the Eastern and Southern African (ESA) commitments on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people, iii) the convention on the rights of the Child, iv) the SADC protocol on child and adolescent health, v) the Ouagadougou declaration on primary health care, and vi) The UN Convention on the Elimination of all forms of Discrimination against Women (CEDAW). Collectively, these conventions commit to ensure the full health of all people in the member countries; pledge to strengthen social services, legal, health and educational systems to ensure the holistic development of all people; emphasize the need for gender equality and forbid any distinction, exclusion or restriction made on the basis of sex; protect the needs of women, children and other vulnerable groups; and elevate primary health care as a fulcrum for universal health coverage. It is important that the GoT

reflects on and maintains these commitments in the spirit of improving ADHD. It is also important that the ADHD coordination structure includes a thematic group that keeps stock of all national, regional and international commitments that could affect the health and development of Tanzanian adolescents.

Although the major ADHD barriers have been addressed in the policy and legislative framework, it is unclear how well these are being implemented, highlighting the need for proper coordination, monitoring and evaluation. Most barriers to ADHD are recognized in the present-day policies, legislations and commitments – these include issues around sexual and reproductive health, nutrition, violence, substance abuse, and mental health. However, as mentioned in the situation analysis on data, very little information exists on how well these policies and legislations are being implemented, and any impact from ongoing execution. Consequently, it has been difficult to conduct reviews, learn lessons or adapt the various policy and legislation components to the realities of ADHD in Tanzania.

TABLE 2: ANALYSIS OF POLICIES AFFECTING ADHD

Policy	Policy thrust	Components	Assessment
National Health Policy 2018 (in draft)	To reach all households with preventive and essential health services that meet the needs of the population, and adhere to quality standards	• **Health Systems:** Improve the quality and delivery of a range of health services including, but not limited to, RMNCAH, eye and oral health, rehabilitation services for people with disabilities, and immunization • **Policy and legislation:** Strengthen governing principles, acts, regulations and guidelines for the promotion of health services	Mentions adolescents as part of a section on Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH). Recognizes adolescent fertility as an important health and social issue as teenage pregnancies can lead to adverse pregnancy outcomes, sicknesses and death. Also recognizes the need for improved adolescent nutrition, and the provision of adolescent-specific health services. Policy components include health systems, and policy and legislation
Health Sector Strategic Plan IV (2015 to 2020)	To reach all households with essential health and social welfare services	• **Health systems:** Establish a multilevel Health Systems Strengthening (HSS) programme to measure quality improvement in primary health care services • **Socioeconomic considerations:** Ensure equitable access to health services (especially for vulnerable groups) • **Socioeconomic considerations**: Achieve active community partnership through intensified interactions with the population for improvement of health and social wellbeing • **Coordination:** Apply modern management methods and engaging in innovative partnerships to achieve a higher rate of return on investment • **Coordination:** Collaborate with other sectors, and advocate for the inclusion of health promoting and health protecting measures in other sectors' policies and strategies	Recognizes adolescents as a key demographic segment to be served by the health and social welfare sector, and includes a few adolescent-centric indicators (e.g. adolescent fertility rate) in its performance indices. Policy builds up on HSSP III programming and results from the Big Results Now (BRN) initiative (focused on injecting innovation into eight priority areas including energy, agriculture, water, transport, health, business environment, resource mobilization and education). Policy components are mostly demand strengthening, but also include health systems and coordination
National Adolescent Reproductive Health Strategy 2011 to 2015	To improve the reproductive health of all adolescents in Tanzania	• **Policy and legislation:** Strengthen policy and legal environment to support provision of sexual reproductive health information, education, life skills and services for adolescents • **Socioeconomic considerations:** Increase adolescents' access to, and utilization of integrated quality reproductive health services • **Socioeconomic considerations:** Promote positive attitudes and behavioral change among adolescents, parents and the community on adolescent friendly reproductive health services • **Health systems:** Strengthen capacity for more effective and efficient management, resource mobilization and scaling up of adolescent friendly SRH programmes	Very adolescent-centric policy document, built around four strategies and fourteen outputs (comprising targets, indicators and activities). Policy components are heavily hinged on socioeconomic considerations. It builds on the foundation laid by the 2004-2008 National Adolescent and Development Strategy, and other relevant policy documents including the National Standards for Adolescent Friendly Sexual and Reproductive Health Services. Identifies the need for multi-sectoral coordination (i.e. close collaboration and partnership between different stakeholders in driving implementation).

Policy	Policy thrust	Components	Assessment
Situation of Adolescent Health in Tanzania (not a policy)	Provide information on the situation of adolescent health within the political, demographic, socio-economic, educational and health system context of Tanzania as input for a strategic plan 2018 to 2020	• **Socioeconomic considerations:** Promote adolescent and youth friendly services in the service delivery points; promote family planning uptake among adolescent and young people; provide social –cultural value clarification on the use of family planning; ensure parents and other relatives take full responsibility for advocating for more appropriate ways of nurturing their children; provision of friendly corrective means of undesirable behaviors, such as drug use and sexual risk behaviors • **Health systems:** Provide comprehensive sexuality education at community and schools; strengthen linkage mechanisms for facility and community based services	Not a policy document or strategy. Only identifies barriers, and provides a few recommendations for improving ADHD outcomes, but with no implementation plan or timeline. Document advocates that the new adolescent health strategy reflect global and regional updates including priority needs such as GBV prevention and response, STIs and HIV, PMTCT, reproductive cancers, HPV vaccination, mental health and the like. Also flags the need to harmonize the One Plan II and other pro-ADH health strategies in the new strategy. Components of the situation report are a mix of demand strengthening and health systems.
The National Roadmap Strategic Plan to Improve reproductive, Maternal, New Born, Child and Adolescent Health in Tanzania 2016 - 2020 (One Plan II)	Improve reproductive, maternal, newborn, child and adolescent health in Tanzania in line with the National Developmental Vision 2025	• **Health systems:** Provision of quality and equitable RMNCAH services to be offered by skilled attendants • **Policy and legislation:** Advocates that services to be offered in an enabling environment • **Coordination:** Services to be delivered in an integrated manner along the continuum of care, taking into consideration of community and facility factors	Provides an elaborate plan for improving Reproductive, Newborn, Maternal, Child and Adolescent Health (RMNCAH), with a good emphasis on adolescent health and development. The One Plan II has five strategic objectives and several operational targets covering areas of Maternal Health; Newborn and Child Health; Adolescent Health; Family Planning; Prevention of Mother to Child Transmission; Immunization and Vaccine Development; Reproductive Health (RH) Cancer, Reproductive Health, Gender and cross-cutting programmes. Plan includes impact indicators, operational targets to be achieved by 2020, and implementation strategies. One Plan II was designed to build on its predecessor and sit within the context of a host of national and international plans (e.g. HSSP IV, National Health Policy, 2015 Global Strategy for Women's, Children's and Adolescents' health)
The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and child deaths (2008 to 2015)	To reduce maternal, neonatal and under-five mortality	• **Socioeconomic considerations / financing:** Promote advocacy and resource mobilization; mobilize and engage the community; inform, educate and communicate behavioral change • **Health systems:** Strengthen existing health systems and build capacity • **Coordination:** Foster partnerships among government, donors, NGOs, private sector and other stakeholders	Recognizes absence of adolescent-friendly services and other barriers to ADH. Policy also contains priorities, associated activities, and 14 operational targets to be achieved by 2015; but these are not ADHD-centric as the document has a broader thematic focus. It includes a strategic framework with operational targets (also not ADHD-centric --- as there are no mention of adolescents in the targets). Given its thematic focus, the implementation of this document might lead to positive ECD outcomes (which may trickle down to improved ADHD outcomes). The policy sits within the context of national and international policies and conventions including the erstwhile Millennium Development Goals, Tanzania Vision 2025, the National Strategy for Growth and Reduction of Poverty (NSGRP-MKUKUTA), and the Primary Health Services Development Program (PHSDP-MMAM). Policy components are mostly demand strengthening, but also include financing, health systems and coordination

Policy	Policy thrust	Components	Assessment
National plan of action to end violence against women and children in Tanzania 2018 to 2022	Aims to end violence against women and children in all its forms as part of an integrated agenda for investing in the protection and empowerment of women and children. Plan was developed by consolidating eight different action plans addressing violence against women and children to create a single comprehensive, National Plan of Action to eradicate violence against women and children in the country	• **Socioeconomic considerations:** Strengthening the households by empowering men, women, girls and boys in the pursuit of social economic opportunities; upholding norms and values that empower women and support non-violent, respectful, positive, nurturing and gender-equitable relationships • **Health Systems:** A comprehensive and integrated protection system delivering coordinated, quality and timely support to women, children, boys and girls affected by violence • **Health Systems:** A comprehensive and integrated protection system delivering coordinated, quality and timely support to girls and boys affected by violence • **Coordination:** A National comprehensive integrated, effective and efficient coordination mechanism and informs decision making on VAWC prevention and response intervention	Pro-ADHD plan as it includes nine sets of indicators to end violence against women and children
National five-year development plan 2016 to 2020	To enhance the pace of progress towards the Tanzania Development Vision 2025. Overall, the plan is themed "Nurturing Industrialization for Economic Transformation and Human Development"	-	Broad development plan, which builds off of the first-year development plan, and aims to propel the country towards its planned 2025 status. Includes an M&E Plan with targets and indicators for various sectors. Only mention of adolescent is in its health targets for reducing nutrition prevalence among women of child bearing age (15 to 49) and increasing mineral uptake in adolescents. Plan is pro-ECD as it includes relevant targets
Tanzania national development vision 2025	Aims to move Tanzania to middle income country status by 2025. Envisions a country with five key attributes: i) High quality livelihood; ii) Peace, stability and unity; iii) Good governance and the rule of law; iv) A well-educated and learning society; and v) A competitive economy capable of producing sustainable growth and shared benefits	• **Health systems:** Access to quality reproductive health services for all individuals of appropriate ages (but does not call out adolescents in this regard)	Broad development plan setting the tone for long-term development in Tanzania. Not a health plan or strategy, but includes three relevant health targets: i) Access to primary health care for all; ii) Access to quality reproductive health services for all individuals of appropriate ages; iii) Reduction in infant and maternal mortality rates. Overall, the plan advocates for a positive health environment, which can then enable ADHD interventions
Education and Training Policy (2014)	To help TZ navigate a rapidly evolving and tech-driven education landscape	-	Policy focuses exclusively on education, and does not reference ADHD
National Youth Development Policy (2007)	Provide direction to youth, partners and other stakeholders on youth development issues	-	Identifies adolescent reproductive health as a policy focus area. Policy does not contain strategies / activities to remedy issues; merely includes a set of priority "policy statements"
National Policy on HIV/AIDS (2001)	Provide a framework for the leadership and coordination of TZ's national multisector response to the HIV / AIDS epidemic	• **Socioeconomic considerations:** Targeted advocacy, information, education and communication for behavioral change • **Health systems:** HIV testing • **Health systems:** Care for PLHAs (people living with HIV/AIDS) • **M&E / Learning:** Research • **Health financing:** Financing	Introduces recommendations for preventing HIV transmission amongst several demographic segments: youths in and out of schools, adults, people with multiple partners and commercial sex workers, drug substance abusers, PLHAs; and across pathways: blood and bodily fluids, invasive and non-invasive skin penetration, mother-to-child transmission. Policy components are mostly health systems, but also includes demand strengthening, health financing, and M&E / Learning. Does not appear to have been set in the context of broader health plans (i.e. national health policy) or national strategic vision (e.g. Tanzania Development Vision 2025)
Child development policy (1996)	Promote the interests of the Tanzanian child by providing a set of guidelines for their upbringing, promoting their rights, and advocating for their holistic development	-	The document is essentially a set of recommendations for child upbringing. These include the role of various societal actors (i.e. parents, community etc) in ensuring the development of a child. The policy does not sit in the context of any current national or international plan, policy or convention

TABLE 3: ANALYSIS OF LEGISLATION AFFECTING ADHD

Legislation	Highlights	Implications
The Law of The Child Act 2009	This Act defines a child as a person below 18 years, which is inconsistent with other legislations. For instance, the Marriage Act allows a girl child to contract marriage at the age of 15, stopping them from enjoying the rights and protection under the Child Act. Also, by allowing girls aged 15 to contract marriages, the Marriage Act condones statutory rape as the penal code provides that a male person who has sexual intercourse with a female under 18 years of age commits rape	Inconsistencies in the definition of a "child" could lead to exclusion of children within certain age windows from the full rights and privileges of the Tanzanian child (e.g. exemption from marriage, rape, desertion by parents and / or guardians, provision of basic care, inheritances from parents, protection from child abuse, protection of children whilst in police custody) resulting in the partial protection of children rights in other aspects of life
Public Health Act 2009	The Act grants exemption to children and pregnant women from payment of immunizations or vaccination fees against tetanus and any other infectious immunizable diseases. It protects children's health by prohibiting a child from attending any primary school until there has been produced to the person in charge of that school an immunization card with respect to that child. Further, the Act prohibits a person from causing or suffering from a nuisance, likely to be injurious or dangerous to health, existing on any land, premises, air or water which may affect a child	Pro-ECD legislation as it protects the health of children, potentially driving ADHD outcomes as the children mature into adolescents
Persons with Disabilities Act 2010	Requires every child with a disability to have equal rights in relation to admission to the public or private schools and be provided with appropriate disability related support services or other necessary learning service from a qualified teacher or a teacher assigned for that purpose	This Act is pro-ADHD as it enables disabled children and adolescents to access holistic education
Anti-trafficking in Persons Act 2008	This law was established to suppress and punish trafficking in persons and children. Per the law, it is an offence for any person to recruit, transport, transfer, harbor, provide or receive a person by any means, including those done under the pretext of domestic or overseas employment, training or apprenticeship, for the purpose of prostitution, pornography, sexual exploitation, forced labor, slavery, involuntary servitude or debt bondage. The law protects a child victim of trafficking by concealing the identity of trafficked victims such that no person is allowed to publish the name of the victim	Sets a national tone for curbing instance of child and adolescent trafficking. Although trafficking has not been identified as a significant barrier to ADHD in Tanzania, it nonetheless has far-reaching negative effects on victims, particularly children and adolescents
The Law of Marriage Act 2002	The Law of Marriage Act allows a girl aged 15 years to enter into marriage, contradicting the Education Act that prohibits any person from marrying a primary or secondary student	Will likely deprive a married girl child of 15 years old her right to education as provided under the child act
The Drugs and Prevention of Illicit Traffic in Drugs Act 1995	The Act imposes fines or conviction to any person who found guilty of smoking, inhaling, sniffing or otherwise using any narcotic drug or psychotropic substances or found in any house, room or place for the purposes of smoking, inhaling, sniffing or otherwise using any narcotic drug or psychotropic substances	This Act sets the tone for curbing substance abuse – a major barrier to adolescent health and development in Tanzania
The Road Traffic Act 1973	Provides that any person who causes bodily injury to or the death of any person by driving a motor vehicle or trailer recklessly or at a speed or in a manner which is dangerous to the public or to any other person is guilty of an offence. The Act criminalizes the act of any person who is in charge or attempts to drive whilst under the influence of a drink or drug, and causes bodily injury or death. The law doesn't specifically address children and adolescent's protection as they are generally included in persons	The Act sets a national tone for curbing road accidents – an identified barrier to adolescent health and development
The Intoxicating Liquors Act 1968	The Act prohibits licensees to supply intoxicating liquor or employ any person under the apparent age of 16 years or sell or control or supervise the sale of intoxicating liquor on the premises. Also criminalizes such act of any licensee who permits a person under the apparent age of 16 years to be present while intoxicating liquor is being served or consumed in places other than restaurants, hotel dining rooms, hotel lounges and the like	This law presupposes that a person of 17 or 18 years old can be employed or be sold liquors and hence contradicts the protection of the said children as per the Law of the Child Act which provides for protection for persons below the age of 18 years old
Age of consent	The Age of Consent in Tanzania varies for males and females. At 18, males are only legally allowed to engage in sexual activity, but females are permitted (with the consent of the court) as from 14. Recent court rulings suggest that this law is discriminatory	This provision will continue to drive the high prevalence of early child marriages and teenage pregnancies – which are barriers to ADHD in Tanzania

Legislation	Highlights	Implications
Mental health care	In the National Health Policy of 2007, mental health was called out as an essential component of comprehensive healthcare, and as part of the national package of essential health interventions in primary, secondary and tertiary care. Target is to establish 20 mental health care beds in each district and a psychiatry rehabilitation facility in each region	The reflection of mental health care in a national document sets the tone for promoting mental health amongst all people, including adolescents. This will likely reduce prevalence of mental health issues amongst adolescents
HIV testing	The statutory age of consent for independently consenting to HIV/AIDS testing and counseling (HTC) and HIV treatment in Tanzania is 18. However, the National AIDS Control Programme guidelines permit minors who are married, parents or sexually active to independently consent to HTC	This legislation is inimical to ADHD as sexual activity in Tanzania begins before age 18. Given the provisions of this law, HIV prevalence amongst unmarried minors could remain high as they are not legally allowed to test for HIV
Abortion	In Tanzania, abortion is only permitted to save the life of the woman, to preserve physical health, and/or to preserve mental health. Under the Revised Penal Code of Tanzania (chapter 16, sections 150-152) the performance of abortions is generally prohibited, and results in imprisonment of the practitioner and woman, if the procedure was not done to preserve physical and mental health	This could enable high incidences of unwanted and teenage pregnancies – an identified barrier to ADHD
Contraception	Tanzania is pro-contraception having adopted a family planning policy in 1976. Broader Family Planning policies reflect in the Health Sector Strategic Plan. Contraception use has been increasing, unmet need for contraception is high at 25% suggesting that women may not be achieving their desired family size	Legislative stance on contraception is favorable to ADHD. However, access to contraceptive commodities (e.g. condoms) is sometimes stifled by frequent stock-outs
Minimum age for drinking, smoking and driving	The minimum age for drinking and purchasing alcohol, smoking and driving in Tanzania is 18. It is also an offence to sell tobacco products to persons under the age of 18	Favorable legislative stance as it protects early adolescents from the influence of alcohol and narcotics. Also allows an adolescent to sufficiently mature before driving a car, potentially resulting in less road accidents, which have been a barrier to ADHD

FINANCING

Financing for ADHD activities is acquired from multiple sources including government budgets, development assistance and households. Health-specific activities are financed from health systems, and individual and household funding, while the broader development activities are mostly funded from budgetary provisions within various ministries.To enable health-specific activities, health systems financing are provided by the government through taxes, and development partners through basket and other project funding. On the other hand, individual and household financing is derived from direct out-of-pocket payments (OOPs) for health services, or health insurance schemes. Shortly after Tanzania's independence, all health funding was acquired from health systems financing, with the government providing free care for all. However, government allocation eventually proved insufficient to meet the health needs of all Tanzanians, necessitating other sources of financing. In 1996, health insurance was introduced via the Community Health Fund (CHF) to provide universal coverage, reduce the burden on the government and generate a complimentary finance stream, while protecting households from catastrophic financing due to OOPs. Five years later, the CHF, which was targeted at the informal sector and rural areas, was supplemented with the National Health Insurance Fund (NHIF), targeting public sector workers. A third insurance scheme known as "TibakwaKadi" (TIKA) operates on a similar basis as the CHF and also targets informal workers but is implemented in urban councils.

GAPS IN HEALTH SYSTEMS FINANCING

Gaps in ADHD financing begin with insufficient generation of health systems funds for broader health priorities, resulting in insufficient funding for ADHD activities. The Government of Tanzania's (GoT) health expenditure has remained consistently lower than the 15% target in the Abuja declaration of 2001. For instance, in 2017/18, the GoT earmarked 7% of its national budget for the health sector which is consistent with the prior year.[75] Consequently, a greater proportion of Tanzania's total health funds comes from donors, rather than more sustainable government tax-based revenue. Furthermore, within the budget, no financial resources are dedicated to ADHD rather, ADHD funding is submerged within other potentially insufficiently-funded programmes that reflect in the budget. Given this trend, ADHD is not positioned to receive sustainable health systems financing. ADHD is instead financed from other programmes which mostly derive their own financing from donors whose interests may not always be ADHD-aligned. Finally, the GoT's heavy reliance on donors to finance the provision of basic health services is risky for ADHD financing given the decline in the contribution of external aid to the national budget over the past decade from 40% in 2008/9 to less than 30% in 2013/14, and the projection that this trend will continue into the next decade.[76] This trend raises further sustainability questions for ADHD financing given its suboptimal positioning in the budget and its dependency on development assistance.

Given resource constraints, it is important to maximize existing budgets of all ministries and public institutions whose activities affect adolescents, effectively coordinate allocation of donor funds, and supplement these with private funding. In the National Plan of Action to end Violence against Women and Children in Tanzania (NPA-VAWC), 38.5% of the Community Development budget is dedicated to strengthening the economic situation of households, supporting positive parenting, and teaching life skills in schools. Also, the largest share of education sector spending is usually dedicated to providing basic education – which has the potential to significantly improve ADHD outcomes – and followed closely by higher education and secondary education.[77] It is important to identify similar budgetary provisions across other MDAs as these resources can be consolidated into a bigger pool of funds dedicated to improving ADHD in Tanzania. Further, it is important to amplify the impact of development assistance on the priority ADHD needs of the country. This can be achieved by aligning the objectives of general

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

[76] World Bank, Tanzania Economic Update, 2015

[77] UNICEF, Education Budget Brief, 2016

budget support / basket funding with program-specific funding (e.g. from the likes of PEPFAR) to generate more funds that can then be used to tackle specific ADHD issues instead of having both sets of funds allocated to different priorities. Additionally, it is necessary to tap additional funds from other stable sources, most notably the private sector. Public-Private Partnerships (PPPs) can play a key role in providing additional financing and service delivery capabilities, thus reducing the financial burden on the government and allowing for private sector participation in remedying ADHD issues, which typically results in equitable risk sharing, innovation and improved service delivery.

GAPS IN INDIVIDUAL AND HOUSEHOLD FUNDING

Individual and household financing is fragmented, and consequently unable to scale to meet the health and development needs of adolescents. In addition to CHF, NHIF, TIKA, and private insurance schemes, several micro insurance schemes exist in Tanzania. These include UMASITA (Swahili abbreviation for Tanzania Informal Sector Community Health Fund) and VIBINDO (Swahili abbreviation for association of small industries and small business owners). This fragmented structure does not encourage universal access as the various schemes target different demographic segments and have separate risk pools with little potential for cross-subsidization and risk equalization. Consequently, a greater portion of the population is not covered by these schemes. In 2016, health insurance coverage stood at 25.8%[78], significantly less than the projected 45%[79] enrolment by 2015. Given the limited coverage, OOP payments have remained a significant individual and household financing source, accounting for as much as a fifth of total health funds in 2014, comparable with government spending.[80] This trend constitutes a barrier to ADHD as most adolescents cannot afford to make OOP payments for health services.

Individual and household financing is also limited by household income as up to a quarter of Tanzania's population could be living below the poverty line[81]. While the formal sector typically enjoys good health insurance coverage, there have been gaps in implementing health insurance arrangements for the informal sector, mostly due to poor enrolment rates and early drop outs in membership. Despite incentives like waivers and exemptions, enrolment rates have remained low due to affordability, implying that the majority of Tanzanians do not have sufficient income to pay the necessary insurance premiums, and consequently continue to have limited access to health care and face the possibility of catastrophic out-of-pocket payments (OOPs) for health services. Consequently, it is necessary to increase household income by accelerating economic growth, improving the standard of living and social welfare of Tanzanians and implementing other directives in the National Strategy for Growth and Reduction of Poverty (MKUKUTA II). Similarly, it is important to scale up programs like the Tanzanian Social Action Fund (TASAF) to enable poor households to increase their income and economic opportunities while improving consumption of services like health insurance. Activities to increase household income should be tracked in the ADHD coordination secretariat as these are critical to improving overall ADHD outcomes.

Finally, although successful to some degree, existing health insurance schemes do not cover all adolescents, and do not always provide the essential ADHD health services. The insurance schemes cover either employed residents (or their dependents) who are enrolled in the NHIF or private insurance schemes, or informal sector workers who can afford the premiums for the CHF/TIKA. Adolescents are largely excluded from coverage given that many of them are unemployed, cannot afford the premiums, and do not have parents who are enrolled in any of the schemes. Additionally, there are inequities in access to health care as the insurance schemes are variant in the health services they cover. Whilst CHF and TIKA are limited to primary health care, NHIF and private insurance schemes are more robust and typically cover a range of in- and outpatient services, basic diagnostic

[78] Health Policy Project, Prospects for Sustainable Health Financing in Tanzania, 2016
[79] Tanzania MoHCDGEC, Health Financing in Tanzania, 2010
[80] Institute for Health Metrics and Evaluation Website, 2014
[81] World Bank Website, 2018

tests, and minor surgeries. Consequently, ADHD services are covered by these schemes in varying degrees – sexual and reproductive health services are usually covered by the schemes, but there is little coverage of other services like nutrition, violence, substance abuse, and mental health.

Going forward, it is important to generate more financing for health services by harmonizing existing health insurance schemes to create a bigger pool of funds to serve the health needs of all Tanzanians, including adolescents. Tanzania's recent Health Financing Strategy (HFS) seeks to harmonize the current fragmented health financing architecture by combining existing insurance schemes to achieve cross-subsidization and scale efficiencies. Particularly, the HFS aims to create and fund a standard minimum benefit package of primary and secondary health care services that will be fully accessible to all Tanzanians, with a focus on the poor and vulnerable groups. It acknowledges that the various insurance schemes have not scaled to serve the entire country; as such, it proposes a Single National Health Insurance (SNHI) which will be compulsory for all Tanzanians. The SNHI will be formed by harmonizing existing schemes and supplementing them with resources from government revenue (including tax levies) and development partner funding.[82] To ensure affordability, the SNHI will provide full subsidization for the poor and vulnerable, based on the national socio-economic targeting mechanism applied by the Tanzania Social Action Fund (TASAF). It is imperative that the implementation of the SNHI be encouraged and, where possible, expedited.

Inefficient public health spending

In addition to insufficient funding and coverage, ADHD outcomes are worsened by suboptimal public health spending that consumes financial resources that could have otherwise been channelled to ADHD. Most government spending (about 60 to 65%) on health is on recurrent items like salaries and commodities. While these items are necessary for programmatic delivery, the government also needs to prioritise financing for non-recurrent but critical items like capital additions, systems improvements or other priorities like ADHD.[83] Also, due to a weak health management information system, resource distribution within the health sector is more arbitrary than data-driven, resulting in inefficiencies that waste resources that could potentially be channelled to ADHD activities. For instance, according to a past audit report of the Controller and Auditor General, allocation of resources for primary health care did not align with demand (number of visitors) and performance (quality and efficiency of service) of the facilities. Also, because operational indicators were not monitored, and relevant data was not collected, remedial actions could not be taken on time, leading to low-productivity, staff absenteeism and other inefficiencies.[84] Given already identified resource constraints, it is imperative that resource allocation is both effective and efficient. It is important to migrate to an evidence-based financing model where funding is allocated on the basis of proven impact of services and initiatives. This will entail strengthening M&E systems to collect data on the results of all ongoing initiatives, analysing the data to understand which initiatives deliver the greatest impact, and increasing funding to the high-impact initiatives while reducing or eliminating funding to the less effective initiatives.

Data and Access to Information

Health information systems are a critical component of adolescent health and are an important factor in driving better health outcomes in this age-group. Information flowing to adolescents and concerned parties enhances health seeking behaviours and attitudes and improves uptake of adolescent services. On the other hand, collection, synthesis and sharing of data from interventions and programmes is critical in determining the

[82] Tanzania Health Sector Strategic Plan IV (2015 to 2020)
[83] World Bank, Tanzania Economic Update, 2015
[84] Ibid

outcomes of existing programmes. Data and information can be leveraged through research to inform future approaches and guide development of programmes and interventions.

Health Management Information System

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, PEPFAR, United Nation agencies, etc. run their own data tracking systems to monitor their 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 outside health; e.g. the education management information system (EMIS), road accident information system (RAIS) among others. However, majority of these systems lack any fully dedicated information on adolescents as they do not specifically mark out adolescents through the indicators used.

Lack of clearly defined adolescent indicators to guide collection of adolescent data is a key limitation to the rigour of adolescent data collected through the existing systems. With the exception of 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 outside health including issues such as deaths and injuries due to accidents and violence, school attendance, cases of gender-based violence, etc.

Existing adolescent health data is not adequately disaggregated, and often categorizes adolescents as one large demographic group. For instance, 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 touch on 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.

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.

Monitoring and Evaluation

Insufficient tracking of progress and results, and a siloed approach in assessment of adolescent programme outcomes result in limited information on programme performance. Adolescent programmes are not always comprehensive at the point of 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 the different organizations. Such programmatic evaluations focus on programme outputs resulting in information gaps in correlating outputs to long-term health outcomes. Consequently, this has led to limited understanding of the long-term outcomes and collective impact of ADHD programmes in Tanzania. Furthermore, information on the funding of these programmes is poorly tracked hence resulting in very limited data on the investment that goes into different areas within adolescent health.

There exists multiple monitoring and evaluation tools among various partners, however these data collection and evaluation systems are fragmented. Information sharing across the different platforms is very limited, mainly 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 theportal 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 programmes and interventions going forward.

Access to Information

Health literacy and information is critical to empowerment of adolescents and includes, among other things, the timely recognition of the need for health or other services; the ability to seek advice and care; and the ability to successfully utilize existing services. However, adolescents are often not aware of health or other services that are available to them (e.g. educational and vocational support, drug and alcohol counselling, legal and social support), where they are provided and how to obtain them. Most adolescents get information from unreliable sources and do not have access to appropriate information to prepare them to cope with changes that take place in their bodies, health and development.

A range of channels and approaches such as peer education, parent-child communication, adult-youth communication, in and out of school youth clubs and media outreach are currently being used to raise awareness among adolescents and their communities. Programmes have traditionally used facilities to deliver information to adolescents. While most adolescents in Tanzania live within reach (less than 5km) of a health facility, evidence available from studies conducted in adolescent health confirm that majority of adolescents do not receive quality health services of their choice. This is particularly due to service providers lacking adequate orientation on the provision of health information, including counselling and psychosocial services to adolescents in a non-judgmental and friendly manner. In addition, most of the service delivery points do not have adequate and appropriate IEC/BCC messages and materials that are specific for adolescent health issues and needs. Implementing partners have also utilized community-based platforms including youth clubs, media outreach including radio and text messaging and institution-based interventions. For instance, mobile-based information sharing has taken off significantly among adolescents, taking advantage of the rising phone penetration in the country. With advancement in internet connectivity, On the other hand, institution-based interventions still need some more work, particularly in entrenching comprehensive sexuality education within school curriculums.

Key areas have focused on social behaviour change, particularly touching on sexual reproductive health and HIV/ AIDS. However, there has been very little focus on delivering information on other non-health areas such as accidents and trauma, drug and substance abuse and violence Inadequate communication with parents and gatekeepers has been a major constrain in the uptake of adolescent health. Misinformation among gatekeepers is a potential drawback to adolescents' access to health services as parents, guardians and local leaders are critical

information channels for adolescents. For instance, stereotypes and stigmatization of adolescents who are seen going to facilities by older adults could potentially dissuade them from visiting these facilities. By empowering families and the community in general, demand for adolescent friendly health services can be significantly improved.

Standardization of adolescent information that is passed on to adolescents is important in order to ensure that a common approach and communication objectives are aligned. Specifically, current communication interventions are largely dependent on the implementers focus areas and programme's approach. There is need for the government to ensure that information is regularly standardized and updated in order to align with existing adolescent health objectives and priorities.

Research

Research on adolescent outcomes in Tanzania is still quitelimited and has focused heavily on sexual reproductive health and HIV/AIDS. Research is critical in informing the general direction and future focus on interventions as well as drawing learnings from previous efforts. Limited focus on guiding research initiatives within adolescent health drives an urgent need to address the existing gap and consequently leverage research to draw learnings from existing efforts and inform future adolescent initiatives.

Coordination

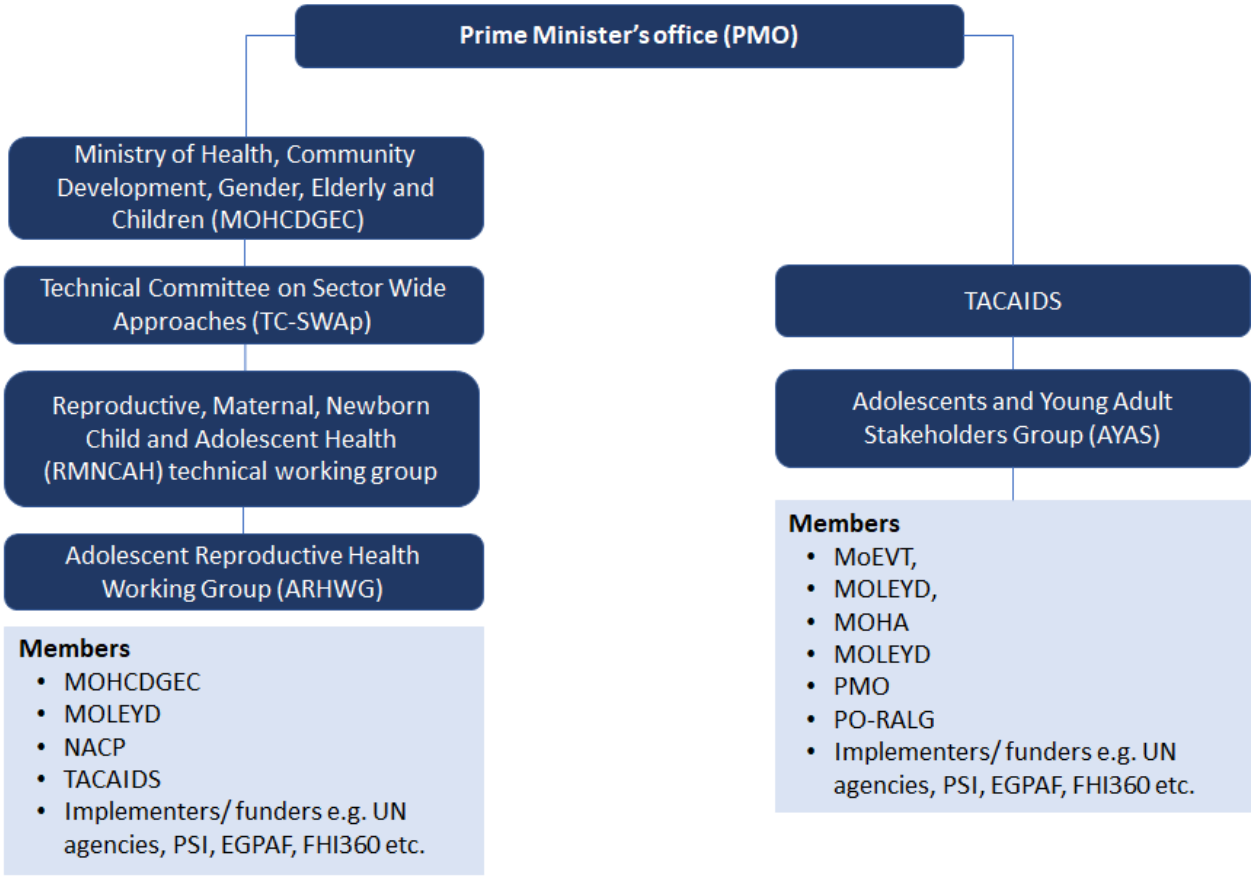
As currently structured, coordination of adolescent health in Tanzania is overseen by the MoHCDGEC , through the Reproductive and Child Health Section (RCHS). In this role, MoHCDGEC works with multiple government ministries including the Ministry of Education, Science and Technology (MoEST), Ministry of Labour, Employment & Youth Development (MOLEYD), Ministry of Home Affairs (MOHA), the Prime Minister's Office (PMO) and the President's Office - Regional Administration and Local Government (PO – RALG). Other stakeholders include implementing partners, funders, other non-state actors and adolescents themselves.

Coordination of adolescent health stakeholders is done through existing coordination mechanisms established within PoRALG, PMO, MOHCDGEC and TACAIDS.MOHCDGEC's Reproductive and Child Health Section (RCHS) coordinates adolescent health stakeholders through the Adolescent Reproductive Health Working Group (ARGWG).The ARHWG brings together representatives from implementing partners, funders, directorates within MOHCDGEC and other relevant ministries. Its role includes implementing adolescent policies, coordinating programmes, developing annual workplans and monitoring and evaluating progress. ARHWG reports to the Reproductive, Maternal, Newborn Child and Adolescent Health (RMNCAH) technical working group, a higher group formed under the Technical Committee on Sector Wide Approaches (TC-SWAp) to coordinate and provide technical guidance in the implementation of the RMNCAH priorities as stipulated in the HSSP IV, the One Plan II and other sector strategies. TC-SWAp is the main forum for government, development Partners and civil Society to discuss technical issues and monitor the goals and activities of the health sector.

The Adolescents and Young Adult Stakeholders Group (AYAS) is a multi-sectoral working group that exists under TACAIDS to coordinate a multi-sectoral national response to reduce adverse SRH outcomes amongst 10-24-year olds. Stakeholders that sit within AYAS include the MoEST, MOLEYD, MOHA, MOHCDGEC, PMO and PO-RALG, implementing partners and funders including the UN agencies. The ministries of health and education jointly co-chair AYAS while UNFPA serves as the current secretariat. AYAS's focus has been particularly focused on fulfilling the ESA commitmentshence pivoting its efforts on HIV/AIDS and sexual reproductive health.[85]

[85] The ESA commitments is a set of targets on adolescents and young Africans agreed upon by Ministers of Education and Health from 20 countries in Eastern and Southern Africa (ESA). The ministers agreed to work collaboratively towards a vision

FIGURE 8: ADOLESCENT HEALTH COORDINATION MECHANISMS IN TANZANIA



While these multiple coordination mechanisms exist, they work in parallel, have limited cross-collaboration and are poorly aligned in their approaches to coordinating adolescent health activity. The entities work in silos and have limited understanding of the progress achieved within each entity's work. For instance, while AYAS continues to focus on HIV/AIDS and SRH, the ARGWG plays a very limited role within AYAS despite being the focal point from MOHCDGEC. ARGWG's work should be strongly aligned to AYAS's work to ensure that there is collaboration in approaches, data collection and work planning as the two bodies work to address common issues in RHS and HIV/AIDS.

Implementation of programmes is poorly coordinated, particularly at the grassroot level due to the absence of a functional implementation structure. As such, weak linkages between MOHCDGEC, PO-RALG and implementing partners at regional and district levels have led to poor alignment and siloed approaches in the implementation of programmes. Programme implementers continue to experience duplication of effort, particularly in the selection of project areas, selection of implementation approaches, execution of adolescent programmes and collection of outcome data. While Technical Working Groups coordination only takes place at national level, there is limited participation of communities, civil societies and youth associations at district and community level. Coordination at lower levels is often dependent on existing programmes which are often time-based and inadequately spread

across the country. Strong coordination mechanisms should be developed at regional, district and community level to build linkages and align partner approaches in the implementation of programmes.

Poor coordination of data collection and sharing has resulted in weak and fragmented data collection and management. Different implementing partners have internal data collection and synthesis mechanisms which are barely shared across the sector. Partners often rely on their internal data systems to inform decision making and monitor the progress of their programmes. Partners should make a strong investment in developing data sharing mechanisms to promote sharing of data and learnings among various players in the sector.

EFFORTS IN IMPROVING ADOLESCENT HEALTH

Stakeholders in adolescent health have responded to the recommendations of the HSSP to improve adolescent healthby working under the leadership of PO-RALG and the MOHHCDGEC to implement programmes that aim to improve health outcomes among 10-19 year olds. These programmes are executed by implementing partners in partnership with government ministries including the MOHCDGEC, MoEST, MOLEYD and the prime minister's office (PMO).

Implementation partners rely on government policy and strategy for direction of their activities and programmes; however, majority have cited weak articulation of the government's strategy as a major bottleneck. Funders and implementing have previously relied on government strategies such as the previous adolescent health strategy (2011-2015), Health Sector Strategic Plan (HSSP) 2015-2020 and the One Plan II to provide guidance on the governments priorities on adolescent health. Stakeholders have highlighted the need to align these policies and strategies into one overarching framework that guides their activities in Tanzania. The development of an adolescent health strategy will be critical in providing guidance on the government's key priority areas and overall direction in developing adolescent health interventions.

While majority of these programmes do not exclusively target adolescents, adolescents form a significant share of the target population for child and youth programmes. For instance, programmes that target young children cover children between the ages of 5-14, consequently covering younger adolescents who sit between ages 10-14. On the other hand, programmes targeting young adults focus on populations between the ages of 15-35, hence capturing adolescents within the ages of 15-19. Few programmes have been exclusively dedicated to adolescents within the 10-19 age group. Further, implementing partners have also developed tailored programmes that target specific adolescent populations based on factors such as gender and levels of risk – this is particularly important in reaching vulnerable and marginalized groups. For instance, partners have designed programmes that target girls who experience early teenage pregnancies as they are considered more prone to risk than other adolescent groups. Adolescents experience different changes and hence have unique needs during this developmental stage. As such, it is important to develop programmes that specifically address these needs. Further, adolescents sit within different contexts such as rural vs. urban, in-school vs. out-of-school, etc. which define their unique needs within their respective settings. It is critical for stakeholders to tailor programmes to ensure that they reach adolescents within these different contexts.

Adolescent programmes in Tanzania have mostly focused on SRH and HIV/AIDS and focused less on emerging adolescent issues such as accidents and injuries, drug and substance abuse, mental health, road safety, etc. These areas have been consistently overlooked by funders as they are considered less critical to adolescent health outcomes. However, as outlined in the demand section of this strategy, data shows that these areas are significantly becoming issues of concern for adolescents and warrant increased programmatic and intervention attention. Some implementing partners have moved to providing services in the form of packages which embed economic empowerment, life skills, financial skills and socio-cultural interventions such as GBV into health programmes as a way of addressing socio-economic and cultural challenges among adolescent populations. Economic and socio-cultural factors have been identified as critical factors that determine health seeking behaviour among adolescents hence building a strong case to integrate them into health-based adolescent programmes.

Lack of clear mandate and scope among coordinating bodies and implementing partners has resulted in duplication of efforts and implementers working in silos, with limited understanding of each other's priorities and outcomes. Development partners face poor coordination in prioritization of intervention areas and lack of alignment in implementation of programmes. This has limited the effectiveness of adolescent health interventions as implementing partners seldom benefit from the synergies of working collaboratively.

Divergent approaches to measuring outcomes and collecting and sharing data have resulted in limited learnings from different programmes on adolescent health. Implementing partners have varying data collection and synthesis mechanisms and rarely have cross-learning platforms that can allow them to learn from each other. This limits the efficient utilization of data and information that could potentially inform future priority areas and guide approaches for players in the space.

Youth friendly services is an emerging priority area and has been a significant priority for majority of players in the market – however it is yet to be adopted fully by all actors. Programme implementers have especially used facility-based models for sexual reproductive health and HIV/AIDS programmes, as this allows them to utilize already existing infrastructure to reach out to adolescents seeking health interventions. As such, programmes have developed youth-friendly corners in health facilities and trained workers to be more approachable to adolescents. However, the approach has not been fully mainstreamed across the country and only exists in specific areas where such programmes exist. The government alongside implementing partners should consider expanding youth friendly services across the entire country while factoring specific regional contexts for different areas.

Poor coordination and alignment of community-based programmes has resulted in decreased access to services and information among young adolescents who do not visit health facilities. If effectively coordinated, community-based programmes such as teen clubs, youth ambassadors, peer-to-peer learning initiatives can be very effective in delivering services and information especially to adolescents and youth who may not be able to access facilities. Evidence has shown that adolescents can be too shy or fear visiting a health facilitydue to stereotypes, stigmatization and misinformation, hence limiting their access to health services and information. It is critical to ensure better coordinationas a way ofstrengthening community-based programmes to enable them reach out to this section of adolescents in the community.

While various programmes have given attention to marginalized and vulnerable groups, there is need to invest more in addressing their continuously evolving needs. For instance, pregnant adolescent girls have increasingly become more vulnerable and increasingly marginalizedas a result ofthe government's current position which does not allow girls who get pregnant in secondary schools to continue with their formal education.This leaves them with limited options, hence making them even more vulnerable. Future programmes targeted at this group should identify specific ways of building capabilities among such girls by offering them alternative learning and economic empowerment opportunities that enable them to continue learning and also empower them economically as most of them lack financial means to support their families and also to access healthcare.

Existing evaluation mechanisms provide little information on how much funding goes into specific thematic areas, hence resulting in a significant information gap on funding patterns in adolescent health. Partners such as PEPFAR, The UN agencies and The Global Fund are key funders of adolescent health programmes in Tanzania. There also exists other funding sources including the government which fund various programmes that cover adolescents within the targeted populations. Funders and implementers should develop mechanisms to track how much funding goes into various thematic areas, and consequently map out any areas that might be neglected.

This strategy comes at a right time when there is broad recognition of these needs and gaps in the ADHD space and when stakeholders have shown deliberate and concerted efforts to address them going forward. As such, the strategy is well positioned to highlight critical issues and identify strategic priorities and develop recommendations that will guide interventions to address these gaps.

STRATEGIC PRIORITIES FOR ADHD

This section providesstrategic prioritiesto lead to the achievement of the vision for ADHDin Tanzania. The section outlines the objective of each component, the recommendations and the interventions required to achieve the recommendations.The strategic priorities have been sequenced into three levels based on the feasibility of implementation and highest potential of the respective priorities towards creating significant impact and transformation of the ADHD space. First order priorities are those that have highest feasibility and highest impact potential while third order priorities are less feasible to implement and have lower potential for impact. The table below shows the various priorities and the proposed sequencing:

FIGURE 9: PROPOSED SEQUENCING FOR PRIORITIES

	First-order priorities	Second-order priorities	Third-order priorities
Demand	Create strong linkages to other economic plans such as ASDP II and agencies e.g. MoEST, PoRALG Create strong linkages with community groups, CBOs and FBOs to promote positive socio-cultural norms	Promote interventions that build adolescent competence, confidence, connection, character, etc. Promote adolescent participation and decision making at all levels	
Supply	Promote leadership and accountability across the healthcare delivery system Expand the use of community-based delivery models	Foster public and private partnerships for adolescent health care delivery Promote a comprehensive curriculum which integrates SRH, nutrition, life skills, etc. into formal and non-formal education Enhance the skills and capabilities of doctors, nurses, community development officers and teachers	Strengthen the supply and management of priority drugs and medical products that are critical for AFHS Introduction of performance incentives to improve service delivery
Policies, legislations and commitments	Update policy documents to fully recognize adolescents as a unique demographic segment Harmonize policy intervention efforts	Amend or withdraw unfriendly ADHD legislations and national directives Maintain pro-ADHD national, regional and international commitments	Track impact of policy and legislation implementation
Financing	Increase the value and sustainability of funding for national health priorities, including ADHD Increase coverage and service offering of health insurance schemes	Reduce inefficiencies in public health spending and channel savings to ADHD	Increase household income
Data and Information	Streamline the data collection and dissemination process Harmonize indicators used to collect adolescent data Enhance increased access of information to adolescents, gate keepers, educators, etc.	Regularly conduct programmatic and operational research and studies	
Coordination	Develop and implement a comprehensive coordination and governance framework to coordinate all ADHD players		

STRENGHENING COMMUNITIES AND EMPOWERINGADOLESCENTSTHROUGH DEMAND SIDE INTERVENTIONS

Strategic objective:Engage adolescents to better understand their issues and develop effective and sustainable solutions while also strengthening schools and working with communities and adolescent gatekeepers to address negative socio-cultural norms and promote adolescent health and well-being.

Strategic recommendations:

- **Create strong linkages to other economic plans such as ASDP II and the national industrialization plan and agencies such as the MoEST and PoRALG to empower adolescents and promote economic empowerment programmes for adolescents.**Given that high poverty levels, lack of education, and a lack of income generating skills are high risk factors for behaviours associated with negative health outcomes, it is imperative that adolescents are linked with programmes that can offer quality education, training, employment or access to markets. Additionally, schools and implementing agencies need to make a firm and public commitment to support ADHD
- **Promote interventions that build adolescent competence, confidence, connection, character and caring involving diverse approaches for 10-14 year olds and 15-19 year olds**. These approaches can include those focused on (a) increasing adolescent resilience (e.g. mentoring); (b) building knowledge, skills and resources (e.g. educational programmes for at-risk youth; vocational training), and (c) improving parenting and caregiving as stipulated by the evolving national parenting strategy. Such interventions are required to promote confidence and skill development which are key for social and behavioural empowerment
- **Create strong linkages with community development groups, community-based organizations and faith-based organizations to promote positive socio-cultural norms in the communities and in families.** These programmes should be used to strengthen the capacity of parents and guardians to respond positively to the needs of young people through a combination of dialogue, engagement and information, education and communication (IEC) approaches
- **Promote adolescent participation and decision making at all levels.** In additionto serving adolescents, it is important to include adolescents in decision making and implementation as they can provide invaluable insights into their unique challenges, and serve as change agents by championing the strategy amongst their peers

Interventions and activities:

- **Sensitisation and education within schools.** There is a need to build the capacity of teachers to enable them to provide a supportive environment that keeps kids in school in order for them to reach their highest educational potential. This will entail better coordination with the MoEST and PoRALG. Adolescents should also be engaged in defining the issues they face and designing the solutions
- **Sensitisation in the broader community:** Besides schools, it is important to mobilise the community in distributing the key messages of this strategy to a wider audience, possibly through a PPP model. The audience should include high risk areas including key logistical routes in Tanzania and large infrastructure sites comprising mining communities, present and upcoming infrastructure projects (e.g. the Hoima – Tanga oil pipeline, and the Standard Gauge Railway connecting Dar es Salaam to Morogoro)
- **CBOs and FBOs should work with parents and gatekeepers to promote positive, stable emotional connections with their adolescent children**. There is a need to promote connection, regulation, psychological autonomy, modelling and provision/protection of adolescents. Thus, CBOs and FBOs should support parents and guardians to communicate with their children about issues such as sexual and reproductive health as a complement to school-based comprehensive and sexual education. CBOs and FBOs should also address gender norms, roles and relationships that may be harmful

- **Explore linkages of adolescents to the Ministries of Agriculture and Livestock and Fisheries**. Activities relate to collaborating in economic opportunities that adolescents may be interested in engaging in such as horticulture
- **Incorporate life skills and financial skills training in adolescent programmes as much as possible.** Behavioural and biomedical adolescent programmes should include packages on financial literacy, savings and lending and skills training
- **Promote economic empowerment interventions such as microcredits to start businesses or cash transfer interventions.** Microcredit interventions should not be done in isolation of other approaches to strengthen their vocational skills while cash transfer interventions can particularly help adolescent girls to take fewer risks in their sexual relationships
- **Support safe spaces for adolescents.** The lack of a confidential and judgement-free environment can be a barrier to adolescents obtaining SRH information and learning skills. Safe spaces can be physical spaces where adolescent girls and boys meet regularly with an older or peer mentor who provides life skills training and health information
- **Engage in continuous consistent messaging and dialogue**. In order for socio-cultural norms to evolve, parents and gatekeepers need to receive similar information that disproves discriminatory norms from various sources over and again as such perceptions are difficult to change. Such sources should include religious leaders, traditional leaders, village meetings, culturally acceptable IEC materials as well as radio programmes
- **Collaborate with companies to reach gatekeepers and provide incentives to adolescents.**Companies, particularly large companies such as mining companies or FMCGs, should be encouraged to educate employees about socio-cultural norms and their impact on health outcomes. Companies can also donate items to adolescent programmes that can serve as incentives to encourage adolescents participate and complete such programmes

SYSTEM STRENGTHENING FOR SUPPLY SIDE INTERVENTIONS

Strategic objective:To ensure availability of holistic, appropriate and cost-effective adolescent friendly health services with a well-trained workforce and promote public-private partnerships to address the gap in public health service delivery.

Strategic recommendations:

- **Promote leadership and accountability across the healthcare delivery system.**To ensure that quality and effective AFHSs are delivered in a sustainable manner, it is important to promote strong leadership and accountability at all levels of the healthcare delivery system, starting from the facility level. Reward systems should be established to reinforce appropriate behaviours and ensure the right targets are met
- **Introduction of performance incentives to improve service delivery**. To enhance performance within the public-sector dispensaries and health centres, the health system could offer incentives to the workforce. Tanzania has begun to move in this direction, for example, it has started to offer pay-for-performance bonuses to health workers who can meet infant and maternal care objectives. This can be extended to include adolescent care objectives
- **Foster public and private partnerships for adolescent health care delivery.** Push for a greater role for non-profit and private organizations in service delivery – these could include running advocacy initiatives, holding the various ADHD actors accountable, contributing to strengthening health systems (e.g. health insurance), and providing technological tools to enable ADHD delivery across the country
- **Expand the use of community-based delivery models**. Although community health workers have limited training, they can perform health promotion activities and serve as liaisons to more highly trained colleagues. If every village has its own community health worker, the basics of health care delivery can

beextended to all. Furthermore, youth involvement and participation in the delivery of AFHS should be strengthened

- **Promote a comprehensive curriculum which makes sexual and reproductive health, nutrition, life skills and empowerment compulsory topics to be included in secondary school and non-formal education packages.** Adolescent health and life skills should be integrated into the regular curriculum and tested like other subjects are tested
- **Invest in enhancing the skills and capabilities of doctors, nurses, community development officers and teachers through training, career progression and CME in the provision of AFHS.** This is required toincrease capacity of the workforce to deliver quality adolescent services. There is a need to identify training needs and develop a training plan to close the knowledge and skill gaps
- **Strengthen the supply and management of priority drugs and medical products that are considered critical for AFHS.** The essential minimum package should include HIV test kits, STI test kits, family planning methods, pregnancy testing,iron supplements and immunizations such as TT and HPV**.** There is a need to develop and implement an appropriate system for priority drugs and products to reduce commodity stock-outs in facilities

Interventions and activities:

- **Create an enabling ecosystem that provides incentives for health service delivery beyond metropolitan cities and in rural areas**. This should include incentives for the private sector to expand to far-to-reach areas and financial incentives for working in remote areas including local recruitment and placement in home towns
- **Promote the establishment of community-based youth centres and strengthen community involvement in ADHS**. Community mobilization and participation to improve key adolescent care practices will help generate demand for services and increase access to services within the community
- **Review and update the curriculum for training and retraining of health workers, community health workers, community development officers and teachers to emphasize the special needs for the adolescent cohort**. This should include the adoption of minimum quality standards to improve delivery
- **Establish innovative continuing education and training models**. Use technology to scale and accelerate teaching and training at lower costs as well as overcome access barriers
- **Develop and implement an appropriate drugs inventory management system for essential ADH drugs and supplies**. Strengthen coordination with the pharmaceuticals and procurement units and dispensaries

IMPROVING ENABLERS OF ADHD

POLICIES, LEGISLATIONS AND COMMITMENTS

Strategic objectives: To elevate adolescents as critical demographic segment in policy and legislation, ensure policy and legislation alignment on ADHD and monitor and evaluate the implementation of policies and legislation

Strategic recommendations:

- **Update policy documents to fully recognize adolescents as a unique demographic segment**. Given the unique needs of adolescents, their size (about a third of Tanzania's total population) and their importance to the future of Tanzania, it is important that they are called out as a distinct demographic segment in policy and legislative programming, and not bundled into a broader category of youths or children. Particularly, landmark policy and legislative pieces like the National Health Plan, Public Health Act, and the Law of the Child Act should elevate adolescents and factor their needs into the design of these documents to produce output that better caters to ADHD

- **Harmonize policy intervention efforts**. Tanzania can maximize ADHD outcomes by synchronizing the prioritization of interventions from all policy documents. Additionally, the implementation of the prioritized interventions should be properly coordinated within the government. These would ensure that policy pressure is laser-focused on the most critical areas per time, rather than being scattered in different directions
- **Amend or withdraw unfriendly ADHD legislations and national directives**. Contradictions in the country's legislative framework can stifle or cancel implementation progress towards ADHD. To progress with improving the enabling environment, it is imperative that anti-ADHD legislations and national directives are amended or otherwise withdrawn from the public domain. In amending these, it is important to allow for direct adolescent input and engagement all through the process
- **Track impact of policy and legislation implementation**. Data on policy and legislation impact helps to uncover improvement opportunities in current programming and inform future design efforts. As Tanzania's ADHD plans are implemented, it will be important to conduct periodic reviews to check implementation progress, verify that the policies and legislation are making the intended impact, and learn lessons from ongoing execution
- **Maintain pro-ADHD national, regional and international commitments.** As noted in the situation analysis, the GoT has already subscribed to several pro-ADHD conventions that can significantly improve the operating environment for ADHD activities. It is important that the government reflects on and maintains these commitments as a quick win for improving the health and development of Tanzania's adolescents

Interventions and activities:

- **Call out adolescents in policies and legislations.** This can be achieved by disaggregating youth into children, adolescents and young adults, incorporating the unique needs of adolescents into policy and legislation programming, and establishing a clear line of sight between ADHD and the actualization of policy and legislation objectives
- **Develop one plan for all ADHD intervention efforts.** Bundle all ADHD policies into one comprehensive plan with priorities, targets and performance indices. This would enable efficiencies in execution as policy pressure is consistently applied on the critical ADHD areas
- **Increase the age of consent to marriage for females from 14/15 to 18** to reduce prevalence of early marriages and teenage pregnancies. Reducing these two barriers can have the triple impact of improving ADHD outcomes, reducing unsafe abortions, and keeping the total fertility rate within favourable limits, leading to natural / organic population control
- **Reduce age of consent to HTC to allow sexually active but unmarried minors access these services**. If amended, this can reduce HIV prevalence as young adolescents access counselling services early on and can then modify behaviours that are likely to transmit the virus to other people
- **Track and coordinate the GoT's adherence to its pro-ADHD commitments.** Establish a thematic group within the ADHD coordination structure to track all national, regional and international commitments that could affect the health and development of Tanzanian adolescents, provide periodic updates on how well the government is keeping these commitments, and coordinate government activity to maintain these commitments

FINANCING

Strategic objective:To increase the value and sustainability of funding for national health priorities, including ADHD, increase health insurance coverage and reduce inefficiencies in public health spending.

Strategic recommendations:

- **Increase the value and sustainability of funding for national health priorities, including ADHD.**The health sector will require more funding as the adolescent population increases and ADHD new and improved activities are meet their health priorities. Consequently, it is important to increase government allocation to the health sector, and earmark financial resources for executing ADHD activities. Also, the GoT needs to identify additional sources of funds to reduce its reliance on donors given their contributions to the budget may not be sustainable in the long term. This can be achieved by improving domestic revenue mobilisation (i.e. tax collection), establishing a national trust fund, maximizing the utilization of pro-ADHD resources in the various MDA budgets, tapping funds from the private sector, and amplifying the impact of development assistance on ADHD by aligning the objectives of basket and programmatic funding
- **Increase coverage and service offering of health insurance schemes.** Given that health insurance schemes are an effective vehicle for driving access to universal health but have not scaled to cover all Tanzanians (resulting in significant out-of-pocket payments for health services), it is important to invest in a platform, such as the Single National Health Insurance, that caters to the health needs of all Tanzanians, including adolescents. As more people are covered by the scheme, their dependents (i.e. children and adolescents) are likely to also be served. It is equally important to ensure that the SNHI covers essential ADHD health services that address historic and present-day barriers to ADHD (i.e. sexual and reproductive health, nutrition, violence, substance abuse, mental health etc)
- **Reduce inefficiencies in public health spending and channel savings to ADHD.** Inefficiencies in public health spending consume resources that would otherwise be available to potentially finance ADHD activities. Consequently, it is important to increase efficiencies through improved public financial management. In particular, it is important to achieve cost efficiency, which procures a maximum amount of health inputs per Tanzanian shilling spent; technical efficiency, which uses the least amount of inputs to provide optimal health services; and allocative efficiency, which allocates available resources in accordance with, and in proportion to, need. Central to achieving these efficiencies is an evidence-based financing model where funding is allocated based on proven impact of services and initiatives. As stated in the situation analysis, this will entail strengthening M&E systems to collect data on the results of all ongoing initiatives, analysing the data to understand which initiatives deliver the greatest impact and increasing funding to the high-impact initiatives while reducing or eliminating funding to the less effective initiatives. As cost savings are realised, these should then be invested in improving ADHD outcomes
- **Increase household income.**As notedin the situation analysis, given that individual and household financing is limited by household income, it is important to increase household income by accelerating economic growth, improving the standard of living and social welfare of Tanzanians and implementing other directives in the National Strategy for Growth and Reduction of Poverty (MKUKUTA II). Similarly, it is important to scale up programs like the Tanzanian Social Action Fund (TASAF) to enable poor households to increase their income and economic opportunities while improving consumption of services like health insurance

Interventions and activities:

- **Increase budgetary allocation to the health sector, including dedicated resources for ADHD**. Double budgetary allocation from present-day average of 7% to the Abuja declaration target of 15% to provide more funding for national health priorities, including ADHD, and reduce reliance on development assistance. Consider other innovative financing approaches such as introducing levies and taxes for foreign

transactions, diaspora bonds, and potentially harmful substances like Tobacco. Include a line item in the national budget to dedicate some financial resources to ADHD implementation

- **Utilize pro-ADHD resources in the budgets of other ministries.** Create a thematic group within the ADHD Coordination team to identify pro-ADHD line items in other budgets, and tap these funds to increase the fiscal space for ADHD activities
- **Tap private funding.**In allowing for private sector participation, the government can adopt one of two configurations, both of which will attract some private funding:
    - **Partial funding, no service delivery**: Allow private market actors to provide care and shift the government role to that of a steward by only paying for results delivered (e.g. through a public health insurance system), and ensuring the providers meet national quality standards. This frees up government resources currently invested in service delivery to be reallocated to resolving other ADHD issues
    - **Partial funding, partial service delivery**: Share the financial burden of providing ADHD services with the private sector (e.g. by paying only for basic services, and having the private sector cover other services), and leverage the management capabilities, efficiency and innovation potential of the private sector in transforming the quality of care and other operations. As an example, the government can allow for the provision of low-cost but paid services to help reduce the need for government funding
- **Align basket and programmatic funding objectives.** As noted in the situation analysis, it is important to amplify the impact of development assistance on the priority ADHD needs by aligning the objectives of general budget support / basket funding with programmatic funding and using the collective funds to tackle specific ADHD issues
- **Implement the Health Financing Strategy and Health Sector Strategic Plan IV.** Encourage the implementation of the Health Financing Strategy and Health Sector Strategic Plan IV given its focus on ensuring equitable access to health services. Importantly, expedite the creation and roll-out of the SNHI scheme to improve health coverage across Tanzania, serve more adolescents (either solo or through their parents' insurance packages), and reduce catastrophic out-of-pocket payments for households. Whilst rolling out, ensure the SNHI covers ADHD services around sexual and reproductive health, nutrition, violence, substance abuse, and mental health
- **Establish efficient procurement systems and processes.** Reduce procurement expenses by entering into long-term supply contracts with vendors and other value chain actors, incorporating appropriate service level agreements to incentivize cost effectiveness and product quality. Cost savings from this area should be invested in ADHD activities
- **Strengthen Health Management Information Systems to improve overall monitoring and evaluation.** Improve allocative efficiencyby collecting and analysing performance datato aid decision making on resource allocation. This will minimize allocation mismatches, ensuring that areas with poorer ADHD indicators receive a larger allocation of resources and vice versa
- **Implement the NGSRP and scale up TASAF.** Boost household income byimplementing the directives in the National Strategy for Growth and Reduction of Poverty (MKUKUTA II) and scale up programs like the Tanzanian Social Action Fund (TASAF) to enable poor households to increase their income and, consequently, consumption

Data and Access to Information

***Strategic objective*:** Firstly, to ensure efficient collection and use of national health management information system (HMIS) data to continuously improve the quality of care and service delivery to adolescents. Secondly, to improve access to relevant and standardized information to adolescents, gate keepers, educators and service

providers to drive better health behaviours and attitudes. Lastly, to ensure timely and reliable research on adolescent health to inform policy development and programme planning and implementation.

Strategic recommendations:

- **Streamline the data collection 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
- **Harmonize indicators used to collect adolescent data** under various data systems and ensure that health data under the national health management information system is disaggregated along key areas such as age, gender, geography, health facility and education level, etc.
- **Enhance increased access of information to adolescents, gate keepers, educators and service providers**through multiple channelsto equip them with knowledge on various issues affecting adolescents and impart parenting skills among parents and guardians. It should also ensure engagement of marginalized and vulnerable groups. This should include adolescents where relevant to allow them to play a leading role in steering communication processes related to their needs
- **Conduct programmatic and operational research and studies** on various thematic areas in adolescent health regularly. To achieve this, there is need to assess research gaps and develop relevant guidelines, promote collaboration with various stakeholders to undertake adolescent research, and encourage the use of research in measuring programme impact and effectiveness and to guide the development of future policies and programmes

Interventions and activities:

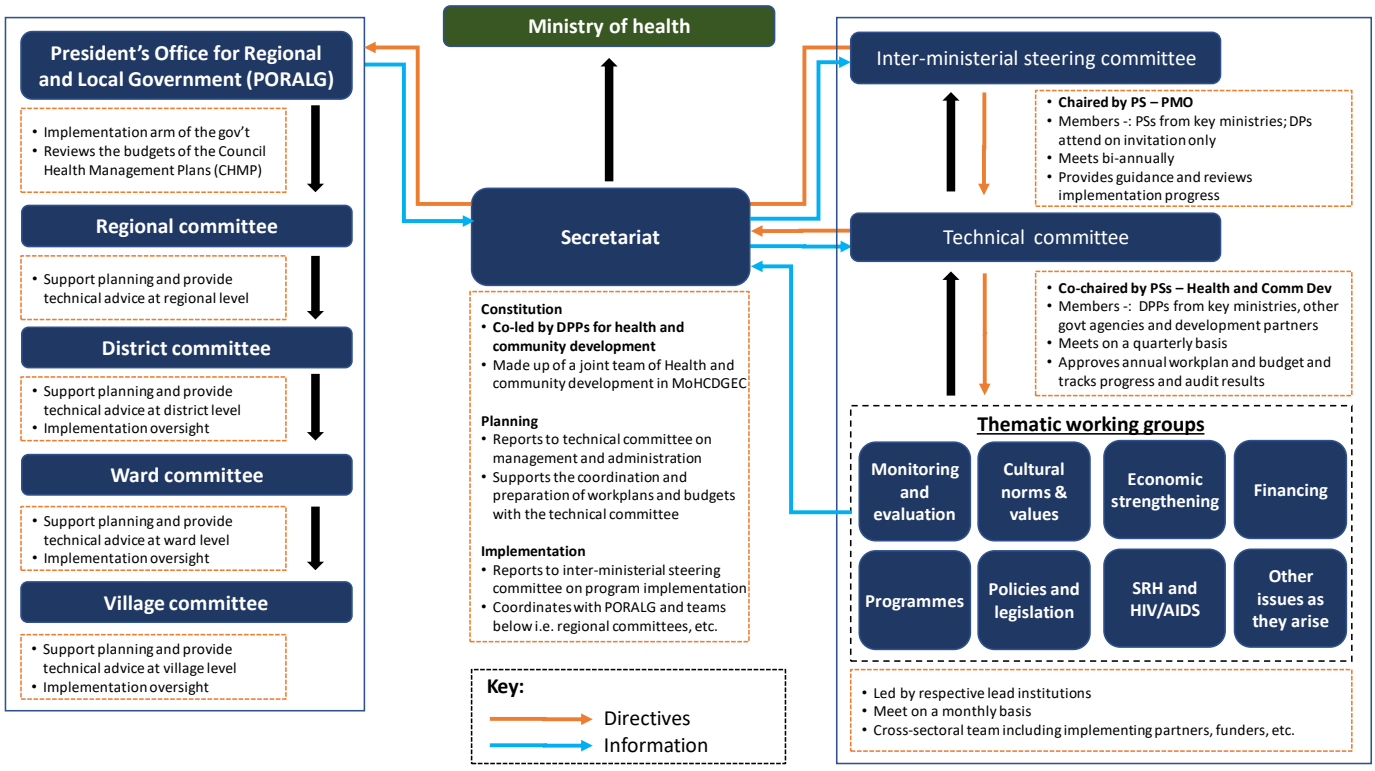
- **Develop standardized adolescent information packs** that provide information to each relevant group. This will include reviewing current IEC communication material to ensure that they use language and methods deemed as appropriate by adolescents
- **Integrate the comprehensive sexuality education into the national education curriculum** to ensure widespread access to information on sexuality among adolescents in learning institutions across the country
- **Develop specialized programmes to engage marginalized adolescents** to enhance their knowledge and skills on the issues facing them. Such programmes could target out-of-school adolescents, those with physical and mental disabilities and adolescents in remote areas
- **Provide training on skills and communication to service providers and educators** to equip them with the skills to deliver quality information to adolescents on areas such as life skills, economic empowerment, etc.
- **Review existing indicators in the HMIS and CTC II data systems** 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
- **Advocate for disaggregation of data in the HMIS system** 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
- **Train service providers in order to improve their capacity to collect, synthesize and use adolescent data** to improve service delivery to adolescents at facility and community level
- **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 within districts and facilities
- **Assess and prioritize adolescent research needs and develop guidelines on key focus areas** where research on adolescent health should be conducted. This will guide practitioners and funders on where to concentrate adolescent research

- **Disseminate research through relevant channels to reach various stakeholders** e.g. policy makers, programme managers. This will ensure that they incorporate research findings into government policies, planning documents and programmes designs

COORDINATION

Strategic objective: Strengthen intersectoral coordination and cooperation among adolescent stakeholders and enhance their role in promoting adolescent health and wellbeing.

FIGURE 10: PROPOSED COORDINATION STRUCTURE FOR ADOLESCENT HEALTH IN TANZANIA



Strategic recommendations:

To ensure that the coordination mechanisms outlined above is functional, it is critical to ensure it takes into account key critical coordination factors that will ensure the efficient execution of various functions across the coordination structure. Below are number of recommendations that should be considered:

- **Structure.**The coordination entity shall be multi-sectoral and will bring multiple members under the guidance and direction of the prime ministers' office –to ensure seamless cross-ministerial collaboration and supervision. This will facilitate swift discussion and execution of identified interventions. The coordination frameworkwillclearly articulate the role of each entity involved to ensure that they collectively address the diverse needs that adolescents have. Furthermore, the coordination framework will incorporate an implementation arm, through PO-RALG that stretches to grassroot level to ensure that identified interventions can be implemented at lower levels. This implementation arm will be extended to the grassroots through regional, district, ward and village committees. 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 government. This will ensure easier integration into government functions and easily capitalize on existing resources

- **Membership.**The coordination mechanism will be inclusive in nature and should bring both government actors and non-government stakeholders on board. The framework includes 13 key ministries and government agencies that are involved in adolescent health and development. These include the Prime Minister's Office (PMO), President's Office - Regional Administration and Local Government (PO-RALG), Ministry of Home Affairs (MoHA - Police, Prisons and Immigration - Human trafficking), Ministry of Finance and Planning (MoFP - Commissioner of Budget), Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC), Ministry of Constitution and Legal Affairs (MoCLA), Ministry of Education, Science and Technology (MoEST), Ministry of Agriculture (MA), Ministry of Livestock Development and Fisheries (MLF), Ministry of Industry, Trade and Investment (MITI), the Ministry of Energy (ME), Ministry of Minerals (MM), Tanzania Commission for AIDS (TACAIDS), Tanzania Social Action Fund (TASAF), Commission for Human Rights and Good Governance (CHRAGG), Registration, Insolvency, and Trusteeship Agency (RITA), Tanzania Food and Nutrition Centre (TFNC), National Bureau of Statistics (NBS). On the other hand, non-government actors should include implementing partners, funders, civil society organizations (CSOs), Faith based organizations (FBOs) and special groups e.g. people with disabilities as well as adolescents and their families through district and ward-level representatives. Representation at local levels will be through the regional, district, ward and village committees. These structures will bring together local government leadership, implementing partners on the ground, adolescents themselves and other relevant stakeholders.

- **Leadership.The MOHCDGEC shall provide overall leadership to the coordination entity.**The inter-ministerial committee will be chaired by the permanent secretary at PMO, since they have the mandate to convene and oversee all government ministries. This inter-ministerial committee will be responsible for overall guidance of the adolescent health and development work while providing oversight and monitoring of progress. The technical committee which sits under the inter-ministerial committee will be co-chaired by the permanent secretaries for health and community development. This entity will bring together all the DPPs from all the ministries that sit in the inter-ministerial steering committee. Further, this committee will also include development partners. The committee will be responsible for developing workplans to guide the implementation of the ADHD strategy, and tracking of implementation progress and auditing results. On the other hand, PO-RALG will be responsible for overseeing the implementation of ADHD activities. PO-RALG will oversee this through a implementation structure that moves down from the regional level all the way to the village level.
- **Governance.**Governance of an effective coordination entity should be at two levels – **(a)High level representation:**The inter-ministerial steering committee will be composed of permanent secretaries from key ministries that is responsible for overall guidance, direction and tracking of progress in the execution of adolescent health policies and strategies. **(b) Lower level representation**: (technical committee) where DPPs of different Ministries can meet to discuss and drive technical elements of the sector including implementation and day-to-day coordination. Members of the technical committee will sit within various thematic working groups that will be responsible for addressing issues and driving activities within specific thematic areas. The entity will also include a secretariat that is tasked with the role of documenting discussions and following up activities that arise from the meetings. The secretariat will sit within the ministry of health and will include a joint team from the health and community development departments, led by the DPPs from both departments.
- **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 ensures that members dedicate their resources distribution towards the coordination functions, and also align resourcing of various programmes and interventions that sit under the coordination entity

Interventions and activities:

- **Establish the coordination and implementation mechanism outlined above** whose mandate is to bring all stakeholders together for regular meetings to discuss adolescent matters and take stock of progress while collaboratively planning the way forward
- **Task a specific organization within the coordination entity, preferably a government ministry,** to host the coordination secretariat and dedicate funding to the adolescent working group. Dedicated funding will enable critical working group activities
- **Ensure regular reports and monitoring and evaluation of progress.** Through a defined set of indicators, stakeholders will be tasked with the responsibility of filing regular reports to the coordination entity outlined above. These regular reports will enable informed-decision making within the implementation organ
- **Appoint adolescent and youth focal points within health departments at regional and district level** to oversee adolescent matters. These focal points should sit in the DAC and RAC committees to ensure that adolescent matters receive attention at regional/ district levels

CONTRIBUTIONS OF THE STRATEGIC PRIORITIES TO THE SDGS

Faced with common global economic, social and environmental challenges, the international community defined a set of Sustainable Development Goals (SDGs) in 2015. These goals, which were formulated by the United Nations and a wide range of stakeholders, are intended to galvanize global action through concrete targets for the 2015–2030 period for poverty reduction, food security, human health and education, climate change mitigation, and a host of other objectives across the economic, social and environmental pillars.[86] As such, the ambitious Sustainable Development Goals (SDGs) envision a world profoundly transformed for the better.

Tanzania is a signatory to the SDGs as former President Kikwete met with various world leaders in 2015 to evaluate the preceding Millennium Development Goals (MDGs) and endorse the SDGs.[87] This ADHD strategy provides an opportunity for the country to gain some mileage in implementing the SDGs as the various components of the strategy is linked to six out of seventeen SDGs as shown in the figure below. Consequently, any

86 UNCTAD, Investing in Sustainable Development Goals, 2015

87http://nbs.go.tz/nbstz/index.php/english/events/605-tanzania-starts-preparations-on-implementation-and-monitoring-of-the-global-sustainable-development-goals-sdgs

success in implementing this strategy will improve the health and holistic development of adolescents, yield national gains for Tanzania and improve its positioning within the international development ecosystem.

TABLE 4: THE PATH TO ACHIEVING THE SDGS THROUGH ADHD

SDG	Indicator	Adolescent-focused activities to achieve the goal	Rationale
Goal 1: End poverty in all its forms everywhere	• Proportion living on less than $1 a day • Proportion of people who suffer from hunger	• Provide life skills for adolescents • Improve broader economic development and implement directives in MKUKUTA II • Scale up TASAF	• Interventions such as providing microcredit to promote economic empowerment under the demand component will give adolescents access to finance and opportunities to increase household income. This will in turn reduce the proportion of people living in extreme poverty and hunger
Goal 3: Ensure healthy lives and promote well-being for all at all ages	• Infant death rate	• Preventing high-risk pregnancies to young mothers and reducing adolescent malnutrition	• Preventing both high-risk pregnancies and adolescent malnutrition by improving service delivery on the supply side results in healthier mothers who are then able to nurture healthy babies
	• Maternal mortality ratio (to the extent that young mothers are at higher risk of pregnancy-related death and disability) • Proportion of births attended by skilled health personnel • Contraceptive prevalence rate	• Improving quality and access to reproductive and maternal care services • Expanding youth access to information and services for pregnancy prevention	• Leveraging PPPs to provide access to relevant reproductive knowledge and services is a supply-side intervention that can reduce maternal mortality and contribute to healthy living. Improved access to information can also improve health seeking behavior in adolescents
	• HIV prevalence among 15–24-year old pregnant women • Prevalence and death rates associated with tuberculosis (TB) and malaria	• Expanding youth-specific HIV prevention and care efforts • Educating youth on how to identify the symptoms of TB and get care for themselves, friends, and family members • Preventive malaria treatment for all adolescents	• Providing access to HIV and malaria preventive and care services, and knowledge to identify TB symptoms is a supply-side intervention that will reduce HIV prevalence and incidences of malaria and TB
Goal 4: Ensure inclusive and equitable quality education and promote life-long learning opportunities for all	• Secondary school completion rates • Participation rate in non-formal education	• Improve access to quality education for all adolescents • Pursuing alternative forms of education for out-of-school adolescents (i.e. technical and vocational training)	• Providing access to all forms of education, including technical and vocational education, life and financial skills etc., is a demand-side intervention that will increase school completion rates and go further to position adolescents for economic opportunities
Goal 5: Achieve gender equality and empower all women and girls	• Ratio of girls to boys in primary, secondary, and tertiary education • Among 15–24-year-olds, ratio of literate females to literate males	• Educating girls • Changing social norms to promote gender equity	• Collaborating with CBOs and FBOs to resolve anti-gender socio-cultural norms is a demand-side intervention that will reduce gender imbalances that constrain girls from enrolling in schools, or seeking economic empowerment opportunities
Goal 8: Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all	• Unemployment rate of 15–24-year-olds	• Carrying out policies and programs to expand youth employment	• Implementing policies (e.g. MKUKUTA II) and programs to create employment opportunities for youth is an enabler for reducing unemployment rates
Goal 11: Make cities and human settlements inclusive, safe, resilient and sustainable	• Proportion of population with sustainable access to an improved water source	• Investing in the human capital of young people, leading to lower fertility and less pressure on natural resources	• Investments in education as well as SBCC approaches will quip adolescents with the knowledge to pursue better environments

ACTION PLAN

Successfully implementing Tanzania's ADHD strategy will require strong leadership and coordinated multi-sectoral and multi-stakeholder participation including adolescents. Activities will be executed at national, regional and district levels, with clear responsibilities vested on specific stakeholders. National stakeholders include the MoHCDGEC, and other ministries and national actors who will set direction, provide broad leadership and rally other stakeholders to support implementation. Specifically, their roles will be:

- **Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC)**: Champion the strategy and serve as a focal point for driving onward implementation and rallying other stakeholders. Within MoHCDGEC, the Directorate of Reproductive and Child Health Services (RCHS) will take the lead in convening stakeholders, whilst the Directorate of Community Development will oversee the use of community platforms (e.g. local clubs, peer groups etc) in promoting ADHD
- **Ministry of Education, Science and Technology (MoEST):** Introduce relevant ADHD content into curricula, allow schools to teach ADHD content in classes, and empower teachers to train and be trained on ADHD issues
- **President's Office, Regional Administration and Local Government (PO-RALG):**Lead nation-wide implementation, coordinating with regional and district-level PO-RALG offices
- **Ministry of Finance and Planning (MoFP):** Provide financial resources for implementing the ADHD strategy
- **Ministry of Justice and Constitutional Affairs:** Review legislations to ensure the necessary enabling environment for ADHD
- **Ministry of Home Affairs:** Rally relevant departments, especially the police force, in providing child protection services
- **PMO – Ministry of Labour, Employment and Youth and Development:** Support implementation particularly around the resolution of socioeconomic issues that pose a serious barrier to ADHD, and help facilitate inter-ministerial discussions and coordination
- **Other ministries:** Ensure complementary and supporting policies and interventions
- **Development partners:** Provide financing and other technical support for ADHD activities
- **Implementation partners:** Support the delivery of ADHD programmes and interventions
- **Civil Society Organizations:** Run continuous advocacy efforts to promote ADHD awareness and hold the government accountable
- **Faith Based Organizations:** Implement community-based programmes to improve ADHD, and correct conflicting notions (i.e. ADHD practices being anti-religious)
- **Private Sector:** Support implementation efforts by contributing to strengthening health systems (e.g. health insurance), mainstreaming efficient practices across the health sector, and providing technological tools to enable ADHD delivery across the country

In addition to the national stakeholders, regional and district stakeholders will play an important role in ensuring the strategy trickles down to the grass roots. In particular, the participation of youth groups, districts, wards and villages is crucial to successful ADHD implementation as these stakeholders are the closest to the grassroots. In addition to other roles, district stakeholders will help manage gate keepers (i.e. parents), and work with PO-RALG to ensure implementation at the grass roots. Finally, adolescents themselves will play a critical role in

championing and implementing various aspects of this strategy. As such they should be continuously engaged all through the implementation period.

MONITORING AND EVALUATION

The Monitoring and Evaluation (M&E) plan provides a mechanism for tracking the implementation of the ADHD strategy at the national, regional and district levels. M&E will be a continuous effort all through the implementation horizon, and will consist of four key activities:

- **Data collection**: Specific indicators will be agreed and continuously monitored to generate performance data
- **Data analysis**: Collected data will be analysed to gauge implementation progress
- **Data dissemination**: As findings emerge from data analysis, these will be disseminated widely to all stakeholders across national, regional and district levels
- **Data utilization**: Findings from data analysis will be used in constructive ways, i.e. to either reinforce successful ADHD activities or make the case for modifications

The key ADHD indicators to be collected and monitored will be clearly defined in the next phase of the project. There are however targets from commitments and conventions that Tanzania is a signatory to that can guide current work in ADHD.

TABLE 5: TARGETS FOR KEY HEALTH AND DEVELOPMENT OUTCOMES FROM COUNTRY COMMITMENTS

Convention	Area	Targets
The Eastern and Southern African (ESA) commitments on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people	Sexual and reproductive health	• By the end of 2015, decrease by 50% the number of adolescents and young people who do not have access to equitable, accessible, acceptable, appropriate and effective youth-friendly SRH services, including HIV • By 2020, Consolidate recent and hard-won gains in the reduction of HIV prevalence in East and Southern Africa (ESA), and push towards eliminating all new HIV infections among adolescents and young people aged 10-24 • By 2020, increase to 95% the number of adolescents and young people aged 10-24 who demonstrate comprehensive HIV prevention knowledge levels • By 2020, Reduce early and unintended pregnancies among young people by 75% • By 2020, Increase the number of schools and teacher training institutions that provide comprehensive sexuality education (CSE) to 75%
	Gender-based violence	• By 2020, Eliminate gender-based violence
	Child marriage	• By 2020, eliminate child marriage