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REPORT

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Catalysing Policy Improvement in Africa (CPIA)

Situation analysis of policy implementation for the Adolescents Sexual and Reproductive Health in Tanzania

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Disclaimer:

The opinions and the recommendations contained in this document are the responsibility of Ifakara Health Institute (IHI) researchers and stakeholders involved (see acknowledgement section) and do not necessarily reflect the views of the Government of Tanzania or any other individual or organization.

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EXECUTIVE SUMMARY

Background

Effective implementation of adolescent health policies and strategies that are holistic, evidence-based and context-specific is central to ensuring the attainment of adolescent sexual and reproductive health and rights (ASRHR), including their access to SRH services. Led by the Ifakara Health Institute in Tanzania, the Catalysing Policy Improvement in Africa project in Tanzania aimed to catalyse improved ASRH policy in Tanzania, using an approach that is considerate of the need to strengthen local research and policy making systems and institutions and be positively synergistic with other externally driven initiatives.

Methods

A situation analysis of the state of ASRH policy implementation was conducted between February and June 2003. A document review and consultations with policy makers and ASRH partners, including with adolescents and health workers, followed by a stakeholder's workshop to discuss emerging issues and challenges.

Findings

Despite the existence of multiple national ASRH strategic policies, adolescents sexual and reproductive health outcomes remain poor, with limited access to and use of SRHR information and services. Disparities prevail – geographically and by wealth status. Several systemic barriers prevent an adequate SRH response to the challenges facing adolescents, including: a fragmented ASRH information system with limited scope on ASRH indicators, limiting the presentation of current ASRH status and priority gap areas; inadequate budget allocation towards ASRH service provision; fragmentation of national and donor-funded SRH services and interventions; limited competencies and personal biases of healthcare workers to deliver ASRH services; sociocultural taboos; insufficient engagement of adolescents in ASRH planning; and poor coordination between different sectors and government levels, policymakers, funders, implementers and researchers.

Policies on adolescent health and well-being are not always evidence informed, aligned or updated. Most ASRH strategic objectives and targets are drawn from the international agenda, not responsive to the context.

Conclusion

Tanzania has made important progress in setting SRH strategic objectives, but its implementation is not comprehensive and responsive to the specific needs of adolescents. More evidence on SRHR with sustainable mechanisms toward strengthening the national research to policy interface and improved financing, coordination, monitoring and evaluation is needed to guide relevant strategic objectives and services for adolescents.

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

AFHS	Adolescent Friendly Health Service
ARHS	Adolescent Reproductive Health Strategy
AHDS	Adolescent Health and Development Strategy
AMREF	African Medical and Research Foundation
ASRH	Adolescent Sexual and Reproductive Health
ASRMH	Adolescent Sexual Reproductive and Maternal Health
AYFS	Adolescent Youth Friendly Services
AYSRH	Adolescent Youth Sexual Reproductive Health
BMGF	Bill and Melinda Gates Foundation
CHW	Community Health Worker
CPIA	Catalysing Policy Improvement in Africa
CSO	Civil Society Organisation
EMIS	Education Management Information System
ESRF	Economic and Social Research Foundation
FHI	Family Health International
FGM	Female Genital Mutilation
FP	Family Planning
FYDP	Five-Year Development Plan
GBV	Gender Based Violence
GFATM	Global Fund for AIDS, TB and Malaria
HMIS	Health Management Information System
HRH	Human Resources for Health
HSSP	Health Sector Strategic Plan
IHI	Ifakara Health Institute
INGOs	International Non-Governmental Organisations
KCMC	Kilimanjaro Christian Medical Centre
LGA	Local Government Authority
M&E	Monitoring and Evaluation
MCDGC	Ministry of Community Development Gender and Children
MoEST	Ministry of Education, Science and Technology
MoH	Ministry of Health
MNSRH	Maternal, Newborn, Sexual and Reproductive Health

MUHAS	Muhimbili University of Health and Allied Sciences
NACP	National AIDS Control Programme
NAIA-AHW	National Accelerated Action and Investment Agenda for Adolescent Health
NCD	Non-Communicable Disease
NHP	National Health Policy
NIMR	National Institute of Medical Research
NMNAP	National Multisectoral Nutrition Action Plan II (NMNAP
NGOs	Non-Governmental Organisations
NRP	National Research Priorities
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PORALG	President's Office Regional Administration and Local Government Authorities
RCH	Reproductive and Child Health
REPOA	Research for Poverty Alleviation
RMNCAH	Reproductive Maternal Neonatal Child and Adolescent Health
SDG	Social Development Goal
STI	Sexual Transmitted Infection
SWAP	Sector Wide Approach
SWAAT	Society for Women and AIDS in Africa-Tanzania
TDHS	Tanzania Demographic and Health Survey
TWG	Technical Working Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UNU	United Nations University
USAID	United States Agency for International Development
WASH	Water and Sanitation
WB	World Bank
WHO	World Health Organisation
YFS	Youth Friendly Services

LISTS OF TABLES

LISTS OF FIGURES

1 BACKGROUND

Figure 1: Adolescents closely follow proceedings at a dissemination meeting organized under the CPIA program in Tanzania

Despite many improvements in Maternal, New-born, Sexual and Reproductive Health (MNSRH) in Sub-Saharan Africa, the overall progress remains inadequate and uneven. Some of the reasons for this include inadequate investment and funding for health, fragmented and disorganized healthcare systems, gaps in evidence-based policy and guidelines, policy acceptance and ownership, and weaknesses in policy dissemination and implementation.

In response to these challenges, the International Development Research Centre (IDRC) of Canada and the United Nations University International Institute of Global Health (UNU-IIGH) agreed to co-fund an 18-month (October 2022 - April 2024) multi-country programme of work (Catalyze Policy Improvement in Africa - CPIA) aimed at promoting MNSRH policy improvement and development in five countries: Uganda, Senegal, Burkina Faso, Tanzania, and Mozambique.

CPIA seeks to promote maternal, newborn, sexual and reproductive health policy improvement using an approach that is nationally led and considerate of the need to strengthen local research and policymaking systems and institutions. It will also be positively synergistic with other externally driven initiatives and committed to prioritizing equity in terms of both processes and outcomes. CPIA adopts a context-specific approach and operates slightly differently in each country and is being led by the Ifakara Health Institute in Tanzania.

This report presents a situational analysis of Adolescent Sexual and Reproductive Health (ASRH) policy in Tanzania Mainland. It covers the adequacy of existing ASRH policies and guidelines; implementation challenges encountered and future priorities; a mapping of the major ASRH stakeholders and some of the initiatives and projects they support across the country; and the extent to which ASRH policy and practice is informed by relevant research evidence.

The primary purpose of this situation analysis is to understand the present adolescent sexual and reproductive health (ASRH) landscape in Tanzania's policy ecosystem; and inform the planning and design of interventions to catalyze ASRH policy formulation and implementation.

The specific objectives of this situation analysis are to:

i). Document ASRH policies and guidelines in place and their implementation status – challenges, gaps and achievements.
ii). Map the main ASRH policy stakeholders, including the major ASRH initiatives, projects and specific initiatives they support across the country.
iii). Explore the state of the national research to policy ecosystem.
iv). Identify challenges and opportunities in the current situation.
v). Provide recommendations for improvement based on analysis and stakeholder's view.
vi). Assess monitoring and evaluation of the existing interventions. The findings of the situation analysis can serve as baseline data against which the impact of future interventions can be measured. It provides a basis for monitoring progress and evaluating the effectiveness of policies and programs.

2 METHODS

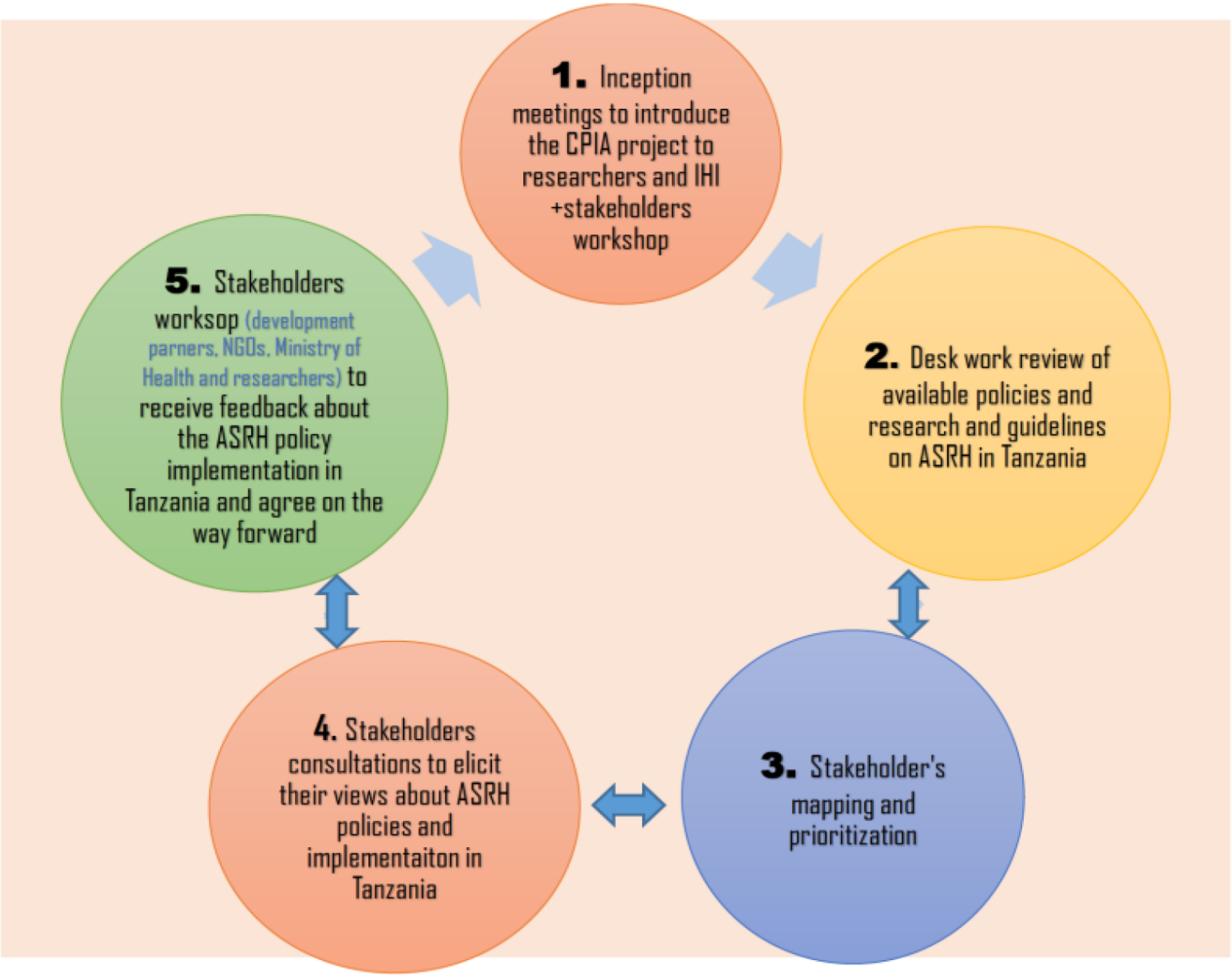


Figure 2: Steps taken in understanding the implementation of ASRH policies in Tanzania

The research team went through several steps in order to understand ASRH policy and implementation in Tanzania *(see Figure 2)*. The situation analysis is informed by four sources of data: document review; stakeholder meetings with policymakers and implementers at sub-national level; key informant interviews with a cross-section of external ASRH stakeholders, including representatives from the Ministry of Health; informal discussions with ASRH researchers.

The existing network between IHI and other partners was helpful in identifying appropriate stakeholders and policy documents related to ASRH. The process of understanding policy implementation was cyclical in nature to allow for reflection and synthesis of the emerging views.

The study was first introduced to IHI researchers, grant officers and administrative staff. The essence of this meeting was to introduce the CPIA project and receive preliminary support in terms of logistics and resources, in addition to insights from other related ongoing projects within the institution that this project can join hands with and be catalytic.

2.1 Document Review

We reached out to various sources of online literature. Existing national policies, strategic plans and guidelines were extracted from national websites and reviewed for necessary information regarding Adolescent Sexual and Reproductive Health in Tanzania Mainland. Draft documents, such as the National Health Policy (NHP), 2022 and National Health Policy Strategic Plan (2022) were reviewed to inform the position of ASRH countrywide. Websites of MoH and other ASRH stakeholders were visited to study relevant projects and activities in the ASRH arena. A number of reports from implementing partners were also studied during the process. Other documents including, published peer reviewed articles and grey literature that offered relevant information to inform the situation of the ASRH were reviewed.

2.2 Stakeholder Meetings

The situation analysis takes the Morogoro region as a case study to analyse the situation at the sub-national level. The research team introduced the CPIA project and engaged in a participatory process with several national and sub-national stakeholders, including officials from the Ministry of Health (MoH), President's Office Regional Administration and Local Government Authorities (PORALG), District and Regional representatives from Morogoro region, and national and international Non-Governmental Organisations (NGOs) working on ASRH and maternal health at large. An overall consensus was reached on the priority area of focus of Tanzania's CPIA project: adolescent's sexual, reproductive and maternal health. During this meeting, researchers were also informed of other ASRH stakeholders *(see Annex 1 for list of attending stakeholders).*

2.3 Key Informant Interviews

Stakeholder mapping using a snowballing technique[1] was employed to identify appropriate implementers of ASRH policies such as, NGOs, ministries, and development and implementing partners. Key informants were interviewed for information on ASRH policies and programmes and status of implementation – gaps, barriers, facilitators; ASRH financing; and level of coordination between various actors *(see Table 1).*

Informal key informant interviews were held with a few adolescents and health service providers from primary health care facilities in Morogoro Municipal (a CPIA case district) to better understand some of the challenges encountered in implementing adolescent friendly services.

[1] (https://www.questionpro.com/blog/snowball-sampling/).

Table 1: Category and number of key informants who informed the situation analysis

Government of Tanzania (N=11)	Multilateral and Bilateral Organizations (N=5)	Others (national/international NGOs, research institutions, consultant advisers) (13)
MoH (N=2) PO-RALG (N=2) Regional Level (N=7)	WHO (N=2) UNFPA (N=1) UNICEF (N=1) USAID (N=1)	AMREF (N=1) Family Health International (N=1) Femina (1) PATH INTERNATIONAL (N=1) RESTLESS DEVELOPMENT (N=2) BOTNAR FOUNDATION (N=1) Muhimbili University of Health and Allied Sciences (N=2) National Institute of Medical Research (N=1) Ifakara Health Institute (2) Independent public health advisers (N=1)

Informal discussions were also held with researchers from IHI, MUHAS and NIMR to learn more about ongoing ASRH related research nationally, and potential areas of working towards a more coordinated ASRH research platform and policy improvement areas.

2.4 Dissemination Workshop

A dissemination workshop was held on the 10th August 2023 in Morogoro Municipality. The event was attended by multiple stakeholders *(see Annex 2).* The dissemination workshop involved presentations and group discussions during which the different stakeholders got the opportunity to discuss the findings and share their immediate reflections.

Figure 3: Key presenters during the dissemination event in Morogoro, Tanzania [R-L] - The CPIA Project PI in Tanzania, Dr. Sally Mtenga, CPIA Project Research Scientist Irene Mashasi, and UNU-IIGH representative, Prof. David McCoy. PHOTO CREDIT: IFAKARA Communications

CPIA Tanzania's Principal Investigator (PI), Dr. Sally Mtenga, presented major findings from a systematic review and stakeholders' consultation meeting on adolescent sexual and reproductive health policy implementation challenges; Prof. David McCoy, CPIA overall PI and lead, presented an overview of International Institute for Global Health programme at the United Nations University, including an overview of CPIA multi-country programme of work, IHI researcher and CPIA Tanzania team member, highlighted program and policy implementation challenges in relation to the provision of adolescent friendly services in Tanzania.

The purpose of the dissemination meeting was to share and validate the findings from the situation analysis. A copy of the draft situation analysis was shared prior to the meeting with all the invited stakeholders. All their comments and feedback have been incorporated into this final report.

Figure 4: A group photo of the stakeholders who attended the stakeholders' workshop in Morogoro Region, Tanzania. PHOTO CREDIT: IFAKARA Communications

3 OVERVIEW

TANZANIA'S SOCIODEMOGRAPHIC AND HEALTH STATUS

3.1 Geographical Location

The United Republic of Tanzania lies on the east coast of Africa, just south of the equator. It shares borders with Kenya, Uganda, the Democratic Republic of the Congo, Rwanda, Burundi, Zambia, Malawi, Mozambique, and the Indian Ocean.

Tanzania is a union of two States, which was formed in April 1964: Tanganyika, which is commonly known as Mainland Tanzania, and Zanzibar. Each has its own ministry focusing on health and with separate administrative structures including policies and strategies.[2]

Tanzania Mainland has 26 administrative Regions, and 184 Councils (or Local Governments) which are the most important administrative and implementation units for delivery of public services.

Figure 5: The map of Tanzania.

3.2 Demographic Profile

Tanzania's population is unevenly distributed and rapidly urbanising, with close to two-thirds of the population living in rural areas and dependent on underdeveloped smallholder primary agriculture production.[3] Tanzania's estimated population stood at 65.7m in 2023, with a sex ratio of around 1 and with Zanzibar contributing some 1.7 million. The median age of the population is low, currently at around 17.0 years, with 42% the population under 15 years of age, 55.1% between 15 years and 64 years and 2.9% over the age of 64.

The overall life expectancy at birth is 52.9 years - 51.3 years for men and 54.4 years for women. [4] Adolescents between ages of 10 and 19 years make up to 23% of the population. The adolescent population increased from 10.2 million in 2010 to 14 million in 2020, by nearly 40%.

[2] https://www.afro.who.int/countries/united-republic-tanzania

[3] https://datareportal.com/reports/digital-2023-tanzania#:~:text=Tanzania's%20population%20in%202023,of%20the%20population%20is%20male

[4] https://countrymeters.info/en/Tanzania

5 Statista

3.3 Socioeconomic Profile

Tanzania is one of Africa's fastest growing economies. Following two decades of sustained growth of between 6% and 7% per annum between 2000 and 2018, the country reached an important milestone in July 2020 when it formally graduated to the status of lower-middle-income country, according to WB classification. Tanzania's GDP per capita was US$ 1099.3 in 2021, exceeding the threshold for lower-middle-income status. An estimated 28% of the population were living below the national poverty line in 2018, and some 44.9% of the population on less than USD2.15 a day.[5] However, with the recent COVID-19 pandemic, the annual GDP growth rate reportedly declined to 4.3% in 2021[6] . Working poverty remains a significant challenge. Unemployment and informal employment remain persistent. Youth unemployment rate reached 11.5% in 2016 (URT, MoHCDGEC, Jan 2021).

3.4 Health and Equity Profile

> *Having and maintaining a health system that can provide accessible, affordable, good quality, comprehensive and integrated care for universal health coverage and health equity in line with the 2030 Agenda for Sustainable Development remains a challenge: WHO CCS 2022-2027*

Tanzania has made significant progress towards achieving global and national targets in key areas of social well-being: with reductions in infant and child mortality and stunting; and an increase in school enrolment with near gender parity at the primary level. Levels of maternal mortality remain high at 238 deaths per 100,000 live births; and neonatal mortality stagnates, contributing to some 44% of under-five mortality (***see Table 2***). Persistent poverty, economic inequalities and social and geographic factors have become factors in the large differences in health status and the exclusion of some groups from health services (WHO CCS 2020-27). Malaria and HIV are amongst the primary causes of death for children and adults respectively in Tanzania. Non-communicable diseases (NCDs) - hypertension, diabetes, cardiovascular diseases, including mental health problems, are becoming the major causes of morbidity and mortality, straining the country's limited human and financial resources.[7]

Nationally, there is increasing concern for the health and development of adolescents (10-19 years) who constitute a significant proportion of the national population. Adolescents bear a huge and disproportionate burden of poor sexual and reproductive health (SRH) outcomes. This is not only threatening their immediate physical and mental health, but also has adverse long-term health and socioeconomic consequences. They are a major demographic force with significant potential to influence the future RMNCAH trends and social economic development of the country. Adolescent SRH and well-being is a national priority and a public health concern in Tanzania (MoHCDGEC, Dept of Reproductive and Child Health, April 2018; URT, MoHCDGEC, Jan 2021).

The country has a long-term goal to attain universal health coverage through major health financing reforms. While Tanzania's health system has improved with increasing health facilities and bringing health services closer to the people, the diversion of resources from routine health services to address emergencies, has strained the health system and has affected service delivery, limiting access to essential health services by vulnerable populations, including adolescents, who incur high out-of-pocket health expenditures.

Worker motivation is low coupled with severe shortages of staff which overburdens the health system, resulting in poor delivery of services. A gap of 53% exists in the health workforce at the health facility

[5] https://data.worldbank.org/country/tanzania?view=chart
[6] WHO Country Cooperation Strategy (CCS) 2022-2027. WHO Tanzania. (https://www.afro.who.int/countries/united-republic-tanzania)
[7] https://www.healthdata.org/tanzania

level and the skill mix is often inappropriate, with unequal distribution across the country (WHO CCS 2022-2027).

Tanzania has been repeatedly affected by health emergencies, which have impacted directly or indirectly on health. The cholera outbreak lasted for three years from 2015 to 2018, and affected all the 26 regions and 129 of the 139 districts in the country. Dengue fever outbreaks have been reported since 2010, with the largest outbreak occurring in 2019 in nine regions.

The COVID-19 pandemic, which was first detected in Tanzania in early 2020, has also impacted negatively, affecting the health, economy and social fabric of the Tanzanian population. It has put children, girls in particular, at greater risk of exploitation, child labour and gender-based violence. The rise in NCDs and the COVID-19 pandemic has reversed some of the hard-fought gains in health and development (WHO CCS 2022-27).

The health sector is resource constrained. In 2016/17 and 2017/18, the government earmarked about 7% of its national budget for the health sector, far less than The Abuja Declaration of 2001 which aimed at spending 15% of the budget on health expenditure. (URT, MoHCDGEC. Jan 2021, p5).

Table 2: Mortality and Equity, Tanzania

MORTALITY RATES			
Neonatal deaths, as % of all <5		44	2021
Neonatal mortality rate (per 1000 live births)		20	2021
		24**	2022**
Adolescent (10-19) mortality rate (per 1000 children aged 10)		11	2021
Adolescent (10-14) mortality rate (per 1000 children aged 10)		4	2021
Adolescent (15-19) mortality rate (per 1000 children aged 15)		8	2021
Lifetime risk of maternal deaths (1in N)		36	2017
Maternal mortality ratio (per 100,000 live births)		104	2022
Under 5 mortality rate (per 1000 live births)		47	2021
		43**	2022**
EQUITY			
Under 5 mortality rate (per 1000 live births)	Richest	73	2021
	Poorest	78	2021
Under 5 stunting (%)	Richest	19	2021
	Poorest	40	2021
CONTEXT			
Secondary completion rate, education (upper, female) (%)		27	2015
Population living below the national poverty line (%)		26	2017
		28*	2018*
Population with moderate to severe food insecurity (%)		58	2019-2021

*Source: Countdown to 2030 Country Profile. United Republic of Tanzania[8]; * WB country data; ** TDHS-MIS 2022[9]*

[8] https://data.unicef.org/countdown-2030/country/United-Republic-of-Tanzania/4/

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

4 STATUS OF ASRH IN TANZANIA

Figure 6: Reproductive health clipart. CREDIT: CLIPART LIBRARY

4.1 General Status

Available data from national surveys and small-scale research studies suggest that adolescents (aged 10–19 years) experience poor sexual and reproductive health outcomes in Tanzania (TDHS, 2022) as shown in *Table 3.* Contraception prevalence in adolescents and young women (15-24 years old) is at 12% (URT, MoHCDGEC Jan 2021); and condom use outside of marriage is low at 37% in adolescent girls and 35% in adolescent boys aged 15-19 years (MoHCDGEC April 2018).

Child and teenage marriages, early pregnancy and unsafe abortions remain high, while sexual coercion and transactional sex are frequent. On average, almost two out of five girls will be married before their 18th birthday. About 37% of the women aged 20-24 were married/in union before age 18 (TDHS 2012). Every year, about 8,000 girls drop out of school due to pregnancy (URT, MoHCDGEC Jan 2021) with limited work opportunities and poor livelihoods.

The Law of Marriage Act (1971) allows for boys to marry at 18 and girls to marry at 15. Girls under 18 need parental permission to marry. In addition, Customary Laws run parallel to Statutory Laws. Local Customary Law (Declaration) Order, GN 279 of 1963 allows each ethnic group to follow and make decisions based on its customs and traditions. Minimum age of marriage is not provided in the constitution. Violence is prevalent, including gender-based violence and physical violence in schools. As is substance abuse and mental health concerns (MoHCDGEC,RCH. April 2018; URT, MoHCDGEC. Jan 2021; Nkata et al, 2019). 11% of girls and 5.9% of boys reported experiencing at least one form of sexual violence and some 12.6% of girls and boys have experienced physical violence (URT, MoHCDGEC Jan 2021); 50% girls and boys aged 13-19 having reported experiencing physical violence at the hands of teachers (MoHCDGEC, April 2018)

Table 3: Adolescent Maternal and SRH status in Tanzania

Maternal context	Coverage (%)	Source
Proportion of women of reproductive age (age 15-49 years) who have their need for family planning satisfied with modern methods	53.1	TDHS-MIS 2022
ANC 4+ visits	48	UNICEF Global Database, Nov 2022
Proportion of births attended by skilled health personnel	85	TDHS-MIS 2022
PNC for mothers	36	UNICEF Global Database, Nov 2022
Adolescent birth rate (per 1000 women): Girls 10-14 years Girls 15-19 years	112 (132 per 1000 adolescent girls 15-19)	TDHS-MIS 2022 2015/16 Demographic Health Survey

Source: Adolescent health (https://data.unicef.org/resources/adolescent-health-dashboards-country-profiles/); THDS-MIS) 2022; UNICEF 2020; MoHCDGEC,RCH. April 2018; URT, MoHCDGEC. Jan 2021.

4.2 HIV/AIDs and STI

Over 98,000 adolescents aged 10 – 19 are currently living with HIV, in spite of HIV being the centre of majority of the adolescents' interventions[10]. This represents 5% of global adolescents living with HIV. As the population grows, the incidence of HIV/AIDS among adolescents is expected to increase (NAIA 2021/22-2024/25). There are several interventions are concerning HIV/AIDS preventions. The intention is to reduce the incidence of HIV. Approximately 10,000 (13%) out of 77,000 new HIV infections in Tanzania are among adolescents aged 10–19 year (UNICEF 2020). Adolescent girls and young women are increasingly vulnerable. However, only 42% and 38% of young people (15-24 years) have comprehensive knowledge of HIV prevention (TDHS-MIS 2022).

HIV/AIDS receives considerable attention from development partners and the government. More than 60% of programmes across the nation have HIV as part of their core focus that also include elements that address other areas such as teenage pregnancies and violence (NAIA-AHW p49).

4.3 Nutrition

Prevalence of stunting is very high, reaching about 70% at 13 years. Malnutrition is one of the common risk factors for ASRH (MoHCDGEC April 2018); 47% of girls aged 15-19 years were anaemic in 2015[11]. Since 2015, there are improvement on the prevalence of anaemia because there a lot of awareness interventions. Also, the MOEST has launched the school feeding programme since 2021, there are some valuable efforts are underway (URT, MoHCDGEC Jan 2021).

4.4 Education and Awareness

Education and awareness through school health programs on adolescent's reproductive and maternal health has been extensively implemented, specifically with regards to prevention of risk behaviours related to sexual transmitted infections (STIs) and HIV, prevention of teenage pregnancy, female genital mutilation and early marriages. Peer educators were considered as primary source of SRH education by 36.7% of adolescents, in particular by out of school children and HIV clients.

[10] UNICEF, HIV factsheet 2017
[11] Tanzania National Nutrition Survey 2015

5 POLICIES PLANS AND PROGRAMS

The current chapter focuses on national policies, plans and programs.

5.1 International and Regional Commitments

Tanzania is a signatory to the global and regional agendas as listed in *Table 4*.

Table 4: Global and regional treaties subscribed by Tanzania

International treaties	Descriptions
Global • Sustainable Development Goals by 2030; • Global Strategy for Women's, Children's and Adolescent Health 2016-2023; • the Global Accelerated Action for the Health of Adolescents 2017	aimed at catalysing the policy makers and programs implementers to address the needs for adolescent health in their nations through the establishment of definite priorities and specialized planning, implementation, and monitoring within governmental plans-(URT MoHCDGEC Nov 2021)
Regional • Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol), • Addis Ababa Declaration on Population and Development, • African Youth Charter, • African Union Campaign to End Child Marriage and • African Charter on the Rights and Welfare of the Child • Agenda 2063-the Africa we want	key transformational outcomes: attaining gender parity; reducing violence against women by a third in 2023; halting child marriages and exploitation; and reducing youth unemployment statuses by a quarter.

5.2 National Development and Health Policies, Strategies and Guidelines

Table 5: Policy documents in Tanzania relating to ASRH

Theme	Policy document	Descriptions
Development	**National Development Vision 2025**	- focuses on five characteristics: high quality livelihood; peace, stability and unity; good governance; a well-educated and learning society; and a semi-industrialised competitive economy capable of sustainable growth and shared benefits. - implementation was divided into three phases of the Five-Year National Development Plans - identifies RMNCAH as one of the priorities contributing to a higher-quality livelihood for all Tanzanians
Development	**Five Year Development Plan,** **FYDP II (2016/17 – 2020/21)** **FYDP III,** **2021/22 - 2025/26**	**Aim:** The third and final five-year plan focuses on establishing a sustainable framework that will enable to achieve the goals of the Tanzania Development Vision 2025; through numerous objectives including accelerating inclusive economic growth through poverty reduction and social development strategies, as well as productive capacity for youth, women and people with disabilities. **Key Strategic Areas;** The indicators include training 2 million youths on sexual and reproductive health by 2025/26. - target to improve quality of life and human wellbeing - achievements include improving access to social services for rural and urban residents where school enrolment increased at all levels of education, and access to health care services reached the villages level. The country made progress on human development indicators including, increase in life expectancy; increase in literacy rate; decline in gender inequality index; and decline in the basic needs and food poverty.
Health	**National Health policy, 2022. Draft**	**Aim:** The overall goal of the Policy is to have quality sexual and reproductive health, reducing maternal, newborns and under-five mortality through collaborative efforts with stakeholders towards improving reproductive health in all age groups at all levels. **Key Strategic Area**: Youth Friendly Services (YFS)
Health	**National Health Policy Implementation Strategy, 2022. Draft**	**Aim:** The overall goal of the Policy Implementation Strategy is to have quality sexual and reproductive health; for 90% of all levels of health facilities to provide youth friendly services by 2032. The Strategy emphasizes school and out of school health programs for wider coverage of YFS. **Key Strategic Area:** YFS - The **2022 draft National Health Policy and its Implementation Plan** have paved the way to nutrition interventions in the country; it states, "*the government will collaborate with the stakeholders to ensure nutrition and food security in the communities*", through fortification of food produced locally and by improving food availability.

Theme	Policy document	Descriptions
Health	**Health Sector Strategic Plan V, 2021-2026** **(HSSP IV) (2015-2020)** **(HSSP V) (2021–2026)**	**Aim:** Leaving no one behind, with the vision to have a healthy and prosperous society that contributes fully to the development of individuals and the nation. As its mission, the health sector will provide sustainable health services with standards that are acceptable to all citizens without financial constraints, based on geographical and gender equity. **Key Strategic Areas:** Adolescent Friendly Services and out of school programs, nutrition, equity, female cancers, - takes forward the unfinished agenda from the Millennium development Goals (MDGs) with more attention paid to maternal health (MDG5); sustaining gains made in child health indicators (MDG4), primary and secondary prevention gains in the high burden communicable diseases (malaria, TB, HIV) and a focus on prevention and management of NCDs with attention to addressing the social determinants of health in education, environment, economic, cultural and other sectors
Health	**Health Basket Fund (HBF)**	Tanzania already has a results-based health basket fund[12] that health funders support (not all), since 1999/2000, mainly to support primary health care at district level with priority areas spelled out in the Comprehensive Council Health Plan and Comprehensive Health Plans guidelines; it is part of the government effort to implement a sector-wide approach arrangement. Can ASRH funds be channeled in a similar manner or through the same basket? Some funders expressed strong reservations with pooling of ASRH funds, mainly due to the absence of relevant accountability systems to ensure appropriate use of their funds, and extent to which funded priorities would align with their headquarter priorities. For the Fiscal Year 2022/23, Seven Development Partners who support the Health Basket Fund (HBF) – Canada, Denmark, Ireland, Korea, Switzerland, UNFPA and UNICEF pledged a total of USD 42.2 million (approximately TZS 98 billion) to contribute to the implementation of the central, regional and health facilities plans. The funds will cover costs related to procurement of medicines, medical equipment and supplies and improvements to the delivery of quality health care to the Tanzanian population. Since its inception in 1999, over USD 1.2 billion (approximately TZS 2.8 trillion) has been disbursed through this pooled funding mechanism to contribute to the implementation of the Health Sector Strategic Plans.
Health	**Policy Guidelines on School Health Services in Tanzania 2018**	**Aim:** The policy guidelines complement the efforts of the health and education sector with the mission to "*Ensure that health and related services are planned, managed, and provided through the settings approach in order to achieve sustainable public health and educational development, it is possible to promote, protect, and restore the health and wellbeing of students and their communities*." **Key Strategic Areas:** Nutrition, WASH, mental health, substance abuse, communicable and non-communicable diseases, SRH, - Policy guidelines on School Health Services in Tanzania (National School Health Programme (2018) acknowledge the need for relevant interventions for both in and out of school children. This is well highlighted in the "**National Road Map Strategic Plan to Improve Reproductive Maternal Newborn Child and Adolescent Health in Tanzania (2016 - 2020)"**

[12] (https://www.dfa.ie/irish-embassy/tanzania/news-and-events/latestnews/ireland-to-provide-5-million-to-support-primary-health-care-facilities-in-tanzania-.html)

Theme	Policy document	Descriptions
Social	The Law of Marriage Act, 1971	**Aim:** The Act clearly states the legal basis of marriage in Tanzania, its procedures, restrictions and other mandates. The Act states that the minimum age to get married for is 18 years for boys and 15 years for girls. But when the court allows, one can be married at the age of 14 years. The status so far is the decision of the Court of appeal that declared this law to be un constitutional hence direct the parliament to amend the law. **Key Strategic Area:** Child marriage
Adolescent health	National Adolescent Health and Development Strategy, 2018-2022	-Builds on the previous National Adolescent Reproductive Health Strategies, HSSP IV and the One Plan II. -emphasize an expanded and holistic approach to addressing adolescent health and well-being; and aims for meaningful engagement of adolescents, as well as a broader range of ADHD stakeholders **Aim:** to address the overall health and development needs of adolescents by taking a broad and holistic understanding of the concept of health, with the vision "*To 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* " **Key Strategic Areas:** HIV and STIs, Family planning, Nutrition, Violence, Substance Abuse, Mental Health.
Adolescent health	National Accelerated Action And Investment Agenda for Adolescent Health And Wellbeing (NAIA-AHW), 2021/22 – 2024/25	**Aim:** The NAIA addresses gaps in adolescent health and wellbeing in the near to immediate term. It lays down catalytic and accelerated actions and investments. **Key Strategic Areas:** Preventing HIV, Preventing Teenage Pregnancies, Preventing Sexual, Physical and Emotional Violence, Improving Nutrition, Keeping Boys and Girls in School and Developing Soft Skills for Meaningful Economic Opportunities - builds on the National Adolescent Health and Development Strategy, The National Health Policy 2007; National Policy on HIV/AIDS 2001; HSSP IV; Tanzania National Multisectoral Strategic Framework for HIV and AIDS 2018/19 –2022/23; National Multisectoral Nutrition Action Plan 2016 – 2021; the One Plan II; and the National Family Planning Costed Implementation Plan 2019 – 2023 - development was an inclusive process, coordinated by a task force that brought together representatives from several Ministries and other stakeholders, incorporating inputs from government and non-government stakeholders, including from adolescents, development partners and various UN agencies. - explores adolescent programs / interventions being implemented across the country, drawing attention of stakeholders to increasing investments in some geographic areas and towards specific interventions (GBV and HIV), and other areas receiving little or no support.

Theme	Policy document	Descriptions
		- aimed at addressing the poor coverage of youth friendly services and capacitating health providers to deliver them. The NAIA-AHW outcomes includes increasing the number of the facilities providing AYFS; increasing community-based interventions that offer SRH services; and reducing HIV infections and teenage pregnancies. - documented interventions around demand, supply and an enabling environment for adolescents' development in the country. - six priority areas: preventing HIV; preventing teenage pregnancies; preventing sexual, physical and emotional violence; improving nutrition; keeping boys and girls in school; and developing skills for meaningful economic opportunities. - expected to impact on adolescent health and well-being in 13 priority regions and 89 District Councils, at an estimated cost of around TZS 1.338 trillion - Some reporting systems are in place; for example, the performance indicators based on HMIS and EMIS; and the basket funding structure. Presently, along with a few other partners, WHO and UNICEF are supporting the development of Terms of Reference for the larger NAIA-AHW Technical Working Group (TWG).
Adolescent health	National Adolescent Health and Development (ADHD) Strategy (2018-2022)	-builds on the previous National Adolescent Reproductive Health Strategies, HSSP IV and the One Plan II. -emphasize an expanded and holistic approach to addressing adolescent health and well-being; and aims for meaningful engagement of adolescents, as well as a broader range of ADHD stakeholders
Reproductive health	National Plan for Reproductive, Maternal, Newborn, Child and Adolescent Health & Nutrition, 2021/2022 - 2025/2026 (One Plan III)	**Aim:** The strategies in One Plan III address policy leverage, leadership, governance, accountability, improving service delivery and HMIS, in addition to detailing comprehensive adolescent health strategies **Key Strategic Areas:** HIV, Gender Based Violence (GBV), SRH
Reproductive health	National Family Planning Guidelines and Standards, 2013	-considers Adolescent Youth Friendly Services (AYFS) as a human right.
Adolescent Reproductive Health	National Adolescent Reproductive Health Strategy (2004-2008) (2011-2015)	- focused on extending the reach of adolescent friendly health services. - stressed the importance of addressing adolescent sexual and reproductive health needs in an integrated and holistic manner. -envisioned healthy adolescents living in an environment that enabled them to access quality information, services and life skills for the realisation of their full potential - second Strategy is built on the first Strategy, and other policy documents including the *National Standards for Adolescent-Friendly Sexual and Reproductive Health Services*

Theme	Policy document	Descriptions
		- **(copied from 4.3)** The National Adolescent Reproductive Health Strategy (2011 – 2015) stipulates clearly that Tanzania has a National School Health Programme
HIV/AIDS	National Multi-Sectoral Strategic Framework on HIV and AIDS	- Specifically seeks to address health challenges amongst key populations.
HIV/AIDS	National Guidelines for the management of HIV and AIDs 2019,	- recognizes adolescents as a demographic group in every aspect of diagnosis and management. The guidelines have outlined special considerations for adolescent's services. **Special considerations for adolescent services** • Arranging youth clinics on special days and times • Establishing clubs (pre-teen, teen, youth clubs) • Involving peer educators in providing services • Fast-tracking registration and retrieval of their (adolescent?) records • Guaranteeing privacy and confidentiality • Involving adolescents and youth in planning services and in deciding on their treatment choices • Encouraging adolescents to consult healthcare workers for health-related issues. • Ensuring availability of equipment and supplies (e.g. condoms or other family planning methods, fliers, job aides, posters, etc.) at clinics. **Source**: National Guidelines for the management of HIV and AIDs 2019:
Nutrition	National Multisectoral Nutrition Action Plan II (NMNAP II) 2021/2025/26	- developed to address nutrition challenges around all age groups; to carry forward the achievements, and address the implementation challenges of the NMNAP I 2016-2021c - according to NMNAP II, constraints to achieving the goals of NMNAP I, included inadequate funding to support nutrition interventions; reluctance to hire nutrition human resources; unavailability of nutritional data; poor collaboration with the private sector; and inadequate attention to adolescents and elders with special nutritional and health needs.
Violence	National Plan of Action to end Violence Against Women and Children in Tanzania 2017/18 – 2021/22	It emphasizes that actions are needed for both preventing and responding to violence and recognizes that investing in violence prevention initiatives has a positive impact on inclusive growth.

6 MAPPING OF STAKEHODERS AND PROGRAM

The current chapter focuses on the mapping of the ASRH stakeholders and program.

6.1 National Program

a) School Health Programmes

Since colonial era, Tanzania has school health programs targeting children and adolescents from three to 18 years of age (pre-school to secondary school). The current Policy Guidelines on School Health Services in Tanzania (2018) [13] aims at ensuring the physical, mental and social well-being of learners in order to maximize their learning capabilities. It considers a school premise as an avenue for reducing common health problems in learners and staff members thereby increasing their productivity and efficiency of the educational outcomes. It acknowledges that health is pivotal for children to benefit from education programme. The program was established by the Ministry of Health, Community Development, Gender, Elderly and Children in collaboration with the Ministry of Education, Science and Technology.

Youth Development is a division under the Prime Minister's Office Labour, Youth, Employment and Persons with Disability. This division is responsible to create conducive environment for promotion of youth involvement in social, economic and cultural development initiatives. The division also mobilize youth and ensure that their upbringing and socio-economic empowerment is enhanced. The division also acknowledge that youth development issues cut across many different areas including Employment, Sustainable Livelihoods, Education and Skills Development, Health, Youth Empowerment and Participation among others. However, there is still a need to create a synergy of health and development programs between the Youth division under the Prime Minister's Office, Community Development and Ministry of Health in order to maximize the benefits and progress.

b) Adolescent Youth Friendly Services (AYFS)

In 2017, the country committed itself to increasing the number of facilities providing the Adolescent and Youth Sexual and Reproductive Health (AYSRH) services[14], from 30% in 2016 to 80% in 2020; only 63% of the facilities were providing Adolescent Youth Friendly Services (AYFS) services in 2019[15]. Healthcare professionals play a crucial role in supporting and guiding adolescents in their sexual and reproductive health decisions.

[13] Policy guidelines on school health services in Tanzania 2018
[14] Available at https://www.advancefamilyplanning.org
[15] National Accelerated Investment Agenda for Adolescent Health and Wellbeing (2019-2022).

6.2 External-funded Program

ASRH initiatives in Tanzania are mainly funded through external support. Funds are channelled through an array of multilateral, bilateral, international, and national nongovernmental organizations that engage with different levels of the system. Partners work closely with the the Reproductive and Child Health (RCH) Department within the Ministry of Health which deals with ASRH services. *Table 6* below presents a summary of the ASRH support provided by some of the major stakeholders in Tanzania.

Annex 3 presents a preliminary mapping of ASRH stakeholders and the projects/initiatives being supported. We found that the implementation of ASRH programs is not on a par with all the strategic objectives. Not all ASRH services are being implemented. Financial barrier was commonly reported by implementers as hindering a comprehensive translation of the ASRH strategic objectives into services. Local funding is limited and fragmentation and duplication of effort is common, potentially minimising the cost effectiveness of ASRH programs being implemented. Stakeholders stressed the importance of prioritising and mobilising local funds to addressing ASRH needs; to align national ASRH priorities to investments.

Table 6. Major stakeholders supporting adolescent health programmes in Tanzania Mainland: some insights

	Area of support	No. of program	Example of programmes	Summary description of programmes	Year range	Focus regions
1.	Preventing HIV	13	USAID AFYA YANGU SOURTHEN PROGRAM USAID/Jhpiego:Sauti GFATM/AMREF: Global Fund HIV USAID/BMGF,MoH,AGPAHI: DREAMS	Provide HIV prevention awareness and provide HIV related services	2010-2026	Morogoro, Shinyanga, Mwanza, Kagera, Mara, Njombe, Mtwara, Lindi, Ruvuma,Njombe and Iringa.
2.	Preventing teenage pregnancy	8	PSI/BMGF, CIFF:Adolescent 360 USAID/FHI 360: Tulonge Afya USAID AFYA YANGU SOURTHEN PROGRAM, USAID KIZAZI HODARI	Promote SRH information awareness and provide access to contraceptives for adolescent girls	2013-2026	Geita, Iringa, Morogoro, Dar es Salaam, Zanzibar, Njombe, Mtwara, Lindi, Ruvuma and Njomba
3.	Preventing physical, sexual and emotional violence	5	USAID/Pact International: USAID Kizazi Kipya UK DFID/Intrahealth, PSI: Mwanamke Tunu Private Donations/World Vision: Development Programme, Gender Action Tanzania	Promote awareness on abusive practices and provide services related to violence (usually part of larger programmes to reduce HIV/teenage pregnancies) Prevent Physical and sexual violence in sports and through sports through the National GBV Prevention Marathon	2010-2025	Kigoma, Dar es Salaam, Mbeya, Mwanza
4.	Improving Nutrition	7	**UNICEF**: Anaemia reduction **EU**/*SC, WFP*: Support to food security and nutrition **Global Affairs Canada**/*Nutrition International*: Right Star Initiatives, USAID Kizazi Hodari	Provide technical and financial assistance of improved nutrition to adolescents	2010-2025	Singida, Pwani, Mbeya, Iringa, Njombe, Mwanza, Dar es Salaam

Source: URT, MoHCDGEC Jan 2021

7 STATE OF RESEARCH

The current chapter focuses on the state of research to the policy ecosystem.

7.1 National Research and Development Policy

Tanzania has a well-developed research policy framework that relies on long-term planning and underlines the connection between research and economic development. It was one of the first African countries to recognise the positive role of knowledge and research for development. It is noteworthy that Tanzania was one of the first countries in East Africa to develop a **science and technology policy**. In 1986, the **Tanzania Commission for Science and Technology Act** set up the institutional framework for research which remains in place today.

The **National Research and Development Policy 2010**[16] sets the overall direction of Tanzania's research policy. The Policy identified shortcomings in the national research system and laid out measures to address them. Among others, the policy includes:

- commitments to improve coordination between ministries, departments and agencies undertaking research and development (R&D) activities;
- increase the use of socio-economic research by establishing centres of research excellence;
- establish a human resource development programme and provide better remuneration and incentives for research.

9.2 Research Institutions in Tanzania Mainland

Tanzania's research system is dominated by publicly funded organisations. There are 27 universities, 15 university colleges, several research institutes, including 9 in human health, nutrition and medical sciences (see ***Table 7***). Consistent with the government's vision of universities as hubs for training and education, much of Tanzania's research happens in research institutes. Most research institutes are publicly funded or non-profit organisations.

A number of research institutions engage in health systems research, including the National Institute of Medical Research (NIMR), Muhimbili University of Health and Allied Sciences (MUHAS), Economic and Social Research Foundation (ESRF), Kilimanjaro Christian Medical Centre (KCMC) and the Ifakara Health Institute (IHI).

During a follow up conversation with some researchers at Ifakara Health Institute, it was noted that within NEST 360 project, there is Global Financing Facility analysis that is being carried out in Tanzania. One of the key picks from this project is that although maternal health has received much support, but little funding is invested on adolescent and neonatal health. One of the co-funders of this project is the Bill and Melinda Gates Foundation.

[16] http://www.tzonline.org/pdf/National_Research&DevPolicy.pdf

According to Mattia Fosci et al (2019) the national research institutional framework appears centralised, with all national bodies supporting research being directly or indirectly controlled by the **Ministry of Communication, Science and Technology (MoCST)** via the **National Commission for Science and Technology (COSTECH)**, with the exception of several sectoral ministries including the Ministry of Health that have distinct responsibilities for sectoral R&D.

COSTECH performs an intermediary role between research organisations and the national government, working closely with think tanks, such as Science, Technology and Innovation Policy Research Organisation (STIPRO), ESRF and Research for Poverty Alleviation (REPOA) which are being supported by the Think Tank Initiative. COSTECH relies heavily on think tanks for policy advice, some of which have a direct connection with the government to inform decision-making.

Table 7: Main health and social science research stakeholders in the country (non-exhaustive)

	Tanzania		International	
	Public	Private	Public	Private
Policymakers	• MoHSW • MoEST			
Intermediaries	• COSTECH • Environment for Development Initiative • International Growth Centre	• The Economic and Social Research Foundation	• African Economic Research Consortium • Council on Health Research for Development • East African Research and Innovation Research Management • Institute for Life Long Learning • International Growth Centre Tanzania	
Research funders	• Tanzania Commission for Science and Technology (COSTECH)		• Department for International Development • IDRC • Irish Aid • SIDA • UNESCO • USAID	• Bill and Melinda Gates Foundation • Comic Relief • Rockefeller Foundation • Wellcome Trust
Universities	• 11 public universities, including Muhimbili University of Allied and Health Sciences (MUHAS) • 4 public university colleges	• 16 private universities • 11 private university colleges, including Kilimanjaro Christian Medical University College		

	Tanzania		International	
	Public	Private	Public	Private
Think tanks & research institutes	• East Africa Centre for Research and Innovation in Social Work • Centre for Education & Development in Health (CEDHA) • National Institute for Medical Research (NIMR) • Economic and Social Research Foundation (ESRF) • Research for Poverty Alleviation (REPOA) • Tanzania Gender Networking Programme (TGNP) • Society for Women and AIDS in Africa-Tanzania (SWAAT) • National Social Welfare and Training Institute • Tanzania Bureau of Standards • Uongozi Institute • Twaweza • Ifakara Health Institute	• Ifakara Health Institute (IHI) • Primary Health Care Institute, Iringa	• International Growth Centre • World Bank	

Source: Mattia Fosci, et al. October 2019; Key informant interviews

7.2 National Research Priorities (NRP)

Research priorities are defined in research strategies published every 5 years, consistent with the objectives defined in **Development Vision 2025**. COSTECH is the main national institution responsible for implementing research and innovation policy. In drawing up the **National Research Priorities (NRP) for 2021/22-2025/26**, COSTECH engaged in a participatory and consultative approach drawing in stakeholders from the Government[17], private sector, academia and beneficiaries of R&D (URT COSTECH).

The NRP incorporates national and institutional policies and strategies that influence R&D, such as the **Tanzania Long Term Perspective Plan (2011/12-2025/26)**, the **CCM Ruling Party Manifesto 2020-2025**, and the **Integrated Industrial Development Strategy (IIDS) 2025**.

The NRP addresses international obligations and features its subscription to the **Sustainable Development Goals (SDGs)**, the **Science, Technology and Innovation Strategy for Africa**, the **Southern African Development Community (SADC) Vision 2050**, **East African Community Vision 2050**, **Paris Agreement on Climate Change** and **Addis Ababa Action Agenda on Financing for Development 2015**.

Source: URT COSTECH

The current NRP updates the research priorities from 2016, retaining and emphasising areas of relevance, and aims to "*build resilience in the sectors, producing wealth and sustainable jobs whilst developing and strengthening human capital*." [18] Amongst many health research priorities, the NRP draws attention to a focus on researching o the broader health needs of

[17] Including health, education, food quality, safety and nutrition, water and sanitation, land management and human settlements, energy, industry and manufacturing, trade, mining, transport and logistics, agriculture, national heritage, tourism, forestry and wildlife; as well as the private sector, academia and beneficiaries of R&D

[18] https://tawiri.or.tz/wp-content/uploads/2022/07/NATIONAL-RESEARCH-PRIORITIES2021-22-to2025-26final.pdf

adolescents, including mental health and reproductive needs. The NRP is expected to guide the formulation of institutional research priorities within specific sectors.

7.3 Research Culture

Researchers largely rely on international entities for research support and capacity strengthening rather than through internal research partnerships. The partnering countries are mainly USA, Belgium, Netherlands, Kenya and the UK; and more recently, China and other Asian countries who are entering the research sector both as funders and research partners.

> Over 80% of research publications come from international collaborations, and the country relies on international funding for over half of its research expenditure. While this gives international funders some leverage, the consultation has revealed frustration with international collaborations and internationally-set research priorities – with major tensions arising around the definition of research priorities and the management of international research funds.
>
> *Source: Mattia Fosci et al 2019*

For example, the Swedish International Development Cooperation Agency (SIDA) has a long-standing relationship with Tanzania and supports four Tanzanian institutions in research capacity: the University of Dar es Salaam, Muhimbili University of Health and Allied Sciences, Ardhi University and COSTECH. SIDA is noted to be one of the instrumental partners in building the National Research Priorities.

7.4 Uptake of Evidence in (ASRH) Policy Development

The "*gulf between policy and practice is especially large in Tanzania*", reported Mattia Fosci et al (2019). Thus, though the government commissions research from think tanks and research institutes (especially publicly funded ones), there is limited evidence that policy decisions are influenced by research.

Several factors are critical in shaping the extent to which research is used to influence policies - credible evidence; an influential leader/ champion; strategic alliances and coalitions between health and other "SDH" stakeholders, research and advocacy groups; informed citizens and public debate (communicating rather than disseminating); and an awareness of political priorities versus needs.

Stakeholder's interview:

"Research may be conducted during policy formulation, but there is limited evidence to suggest that findings inform the policy making and implementation process"

"Current ASRH policy components and targets are drawn from the international agenda, reflecting external interests; strong initiatives to explore the broader needs of adolescent's health are yet to be implemented"

"Research alone is of limited value in influencing policies, according to stakeholder views"

Tanzania has a core group of researchers engaged in health systems research, including on adolescent health and well-being, but there is limited interaction and consensus within the research community on some of the key research findings, and between researchers and policy makers with implications for informing policy making processes.

A prevailing concern amongst interviewed stakeholders is that research carried out across the country is not well coordinated. Externally funded research is often misaligned with national priorities and sensitivities, and it therefore remains unused in practice by policymakers [Mtenga et al, 2016].

8 CHALLENGES & OPPORTUNITIES

8.1 Specific Challenges in ASRH Data

Information system for ASRH is fragmented through the existence of multiple data systems such as below that gather data. The non-harmonised data collection with limited scope and indicators to each database, and sometimes non-disaggregated indicators on adolescent (10-19) limits the full representation of adolescent's sexual and reproductive health status which subsequently obscure the need for resource allocation to that area in Tanzania.

- Health Management Information System (HMIS) collects data at health facility
- National Demographic and Health Survey: only collects data on adolescent fertility rate
- National AIDS Control Programme (NACP)
- others: education and road accident information system

a) School Health Program

While there are interventions in place for out of school children, however well documented. According to estimates released by UNICEF and the Ministry of Education Science and Technology, there were around 3.6 million out of school children in 2015/16; 1.3 million were aged between 7 and 13 years, and 2.3 million were aged between 14-17 years (Policy Guidelines on School Health Services PGSHS 2018). Innovative approaches to reach out to adolescents via social media communication channels have not been considered.

b) Nutrition

There is limited available information regarding adolescent specific nutrition indicators, aside from prevalence of anaemia among women of reproductive age (15-49 years) which is noted to be on the decline.

c) HIV/AIDS

While policies have broadly addressed the importance of adolescent care in-terms of HIV/ AIDs, indicators to monitor progress are not well designed: adolescents are classified into two groups, children 0-14 years and young adults 15-24 years, impeding the harmonization of adolescent's information to make informed decisions.

d) Other factors including cultural, and logistical barriers.

8.2 Specific Challenges in ASRH Policies and Implementation

a) Health Policies

The **National Health Policy 2022 (draft)** broadly acknowledges the importance of, and constraints toward, achieving YFS. The Policy details the goals but does not include relevant strategies and the indicators; these are included in the National Health Policy Implementation Strategy

In the **National Health Policy Implementation Strategy, 2022 (draft)**, apart from YFS, the policy does not acknowledge the importance of adolescents as an important demographic group, and the need to address their overall health and wellbeing. Only ASRH is emphasized; other areas of gender-based violence, HIV services and prevention of communicable and non-communicable diseases are not highlighted.

It was noted in the **Health Sector Strategic Plan,** lack of funding for adolescent reproductive health services, poor integration of adolescent treatments into Comprehensive Council Health Plans (CCHPs), and sociocultural taboos impeding efforts to minimize teenage pregnancy are among the major gaps affecting the delivery of adolescent health. The health indicators adopted are not adolescent-specific except for nutritional assessment.

The **Policy Guidelines on School Health Services** in Tanzania 2018 recognizes a number of challenges limiting effective school programmes, such as poor integration of services and collaboration among stakeholders; limited technical capacity; unstructured priorities; poor nutrition interventions; inadequate coordination across schools, communities and health facilities; special needs children are not well covered (lack of inclusivity); uncoordinated resource mobilization and allocation; and the importance of operational research, monitoring, evaluation and knowledge management is not recognized.

b) Social Law

The **Law of Marriage Act, 1971 sets the marriage age for boys at 18 while allowing girls as young as 14 to get married with a court or parental consent.** The act also perpetuates child marriage. Child marriages contribute to teenage pregnancy. Prevalence of child marriage in Tanzania is estimated at 37% with the majority of victims in rural areas. Practically, this act violates girls' right to education given that at that age girls are not biologically ready to conceive, give birth and face the challenges of raising a child. So, far the law was reviewed and some amendments were recommended but have not been implemented. This poses continued challenges to child marriage and violence and early teenage pregnancy, especially to girls under the age of 18 years.

c) Adolescents' Health Policies

National Adolescent Health and Development Strategy, 2018-2022 highlights constraints in adolescent health and development services, including lack of quality services through schools and facility and community-based services; shortages of trained human resources both in numbers and skills to deliver AFHS; and inadequate commodities. However, it is unclear how well these constraints are being addressed, highlighting the need for proper coordination, monitoring and evaluation.

The National Accelerated Action and Investment Agenda for Adolescent Health and Wellbeing (NAIA-AHW), 2021/22 – 2024/25 -three years after NAIA was pulled together, the Investment plan is still to take off; donors have yet to fund the investment case study.

d) Reproductive Health Policies

In the **One Plan III,** a lot of data concerning adolescent indicators are missing (the Ones Plans, strategies and policies depend on national survey data)

Stakeholder's interview on National-Adolescent- Reproductive Health Strategy 2011-2015
Policy and legal environment to support provision of sexual reproductive health

"Multiple policies, guidelines and strategic plans guide the implementation of ASRH services, but it is hard to understand clearly the focus of these strategic objectives."

"Not everything is coordinated under the health sector. Most ASRH activities are managed under the Ministry of Community Development Gender and Children, mainly focusing on gender-based violence."

"Current policies do not monitor children's progress from 5 years to 18 years. There is currently no intervention program that are comprehensive enough to cover this age span. For example, how do we address the sexual health of children aged 6, 7, 8 and 9 years old? Should we assume that they do not have sex and health needs?"

e) School Health Program

Policy

Stakeholder's interview on National-Adolescent- Reproductive Health Strategy 2011-2015

Adolescents' access to, and utilization of integrated quality reproductive health services

"While various programs have been in place to increase access to ASRH, the provision of adolescent-friendly services remains limited, particularly comprehensive post abortion care."

Implementation

Adolescents have benefitted considerably from school health programmes, though their reach is limited to school going adolescents, and the inclusion of SRH issues is questionable. For example, to understand the coverage of knowledge about safe motherhood and HIV/AIDS, a study conducted among rural school children revealed that 80% believed it is safe for a girl to conceive before 18 years of age (PGSHS 2018). During the stakeholders meeting in Morogoro (Annex xx) we learned that while concrete guidelines exist to guide the provision of adolescent friendly services (AFHS), health care providers are not always adequately trained to apply these guidelines. Further, appropriate indicators are not in place to understand progress to implementation.

f) AYFS

Policy

While policies acknowledge the importance of youth and adolescent friendly services, they are not supported by relevant implementation plans. The country has a National Standards Mentorship guide and training package for provision of AYFS but the appropriate indicators to understand progress to its implementation is not implemented. Also, with the exception of contraceptive use and HIV, most AYFS components have received little attention. Besides, uncertainties about current laws among healthcare professionals is a barrier to adolescents' access to sexual and reproductive health services [Bylund et al 2020].

The current National Health Policy (2017) does not include any targets for adolescent health. Adolescent as a special group is not given an emphasise in the national health policy and this may constrain investments allocated towards addressing adolescent health needs.

Stakeholder's interview on National-Adolescent- Reproductive Health Strategy 2011-2015

Attitude and behaviour change

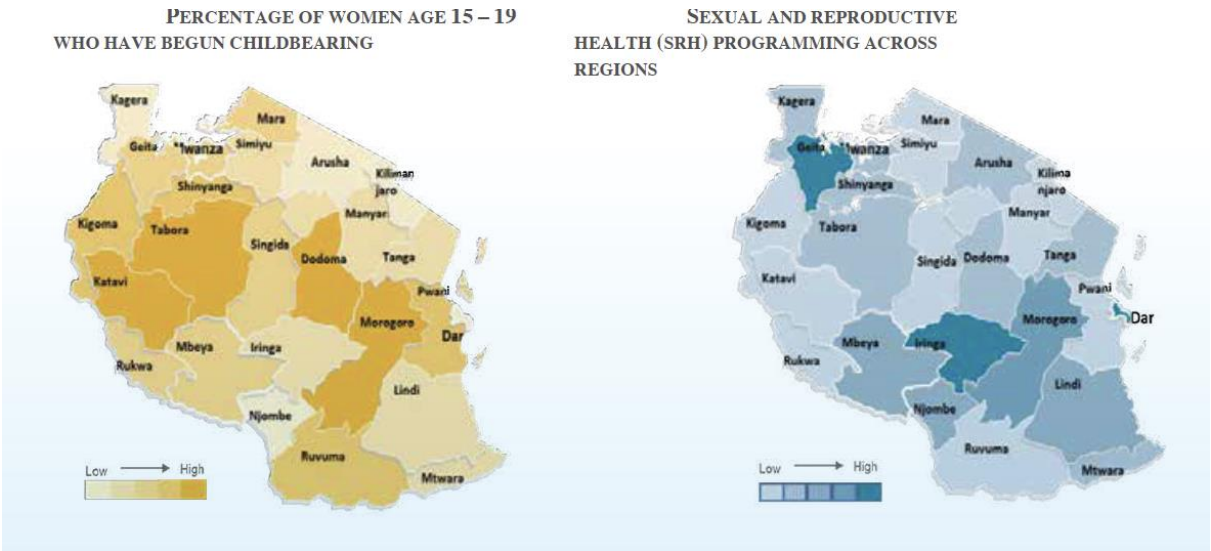
"The current national parenting strategy does not support children while they are young. Most parenting period is focused on 'adolescents'."

Implementation

The implementation of AYSRH services[19] in Tanzania is faced with enormous challenges like inadequately structured and poor quality of services; inadequate training and poor attitudes of healthcare providers and lack of knowledge regarding AYFS, especially at primary health care level; limited privacy and confidentiality (adolescents prefer not to be seen by family and community members when using ASRH services); scarce resources to provide the required services; and cultural and religious factors. Parents still perceive that ASRH services are meant for adults, and its provision motivates adolescents to engage in sexual behavioural activities at a young age.

The NAIA-AHW notes that SRH programmes are limited in regions like Tabora, Dodoma, and Katavi which have high rates of teenage pregnancy (see *Figure below*); less than 30% of schools in Katavi providing comprehensive SRH education.

Figure 7: Sexual and Reproductive Health Programming across regions



Source: URT, MoHCDGEC. Jan 2021 P49

[19] A range of services need to be provided during youth friendly services, including: information and counselling on reproductive health, sexuality and safe sex; VCT, STI and pregnancy testing services; management of STIs, VCT+, PMTCT+ and HIV/AIDS; focused ANC and post-natal care, and during child birth; post abortion care; contraception, including emergency contraception and condoms; promotion and provision of other health related issues such as substance abuse, violence, injuries, mental health, chronic diseases and referrals.

Healthcare professionals have limited knowledge about the sexual and reproductive health needs of adolescents. Coupled with their personal biases and negative attitudes which are influenced by social norms – such as "*it is inappropriate for girls aged 10–18 to access sexual and reproductive health services, especially contraceptives*". Unmarried women accessing sexual and reproductive health services are particularly vulnerable to stigma.

Stakeholder's interview on National-Adolescent- Reproductive Health Strategy 2011-2015

Attitude and behaviour change

"Provision of adolescent friendly services seems to be affected by negative attitude among health care providers towards providing SRH services to adolescents, as well as limited funds to support training of health care providers on the provision of adolescent friendly services."

"Most health care providers are not adequately trained to provide adolescent friendly services (AFS), according to interviewed stakeholders. They are not AGE sensitive to adolescents and their specific SRH needs. Their attitude and perception towards adolescents' use of sexual, reproductive and maternal health services, in particular to attending to the needs of un-married adolescents, girls in particular, remains negative. They are reluctant to do so."

"Although parents are the main gate keepers for adolescents' access to ASRH, they have not been fully involved in addressing adolescents' SRH needs."

In an effort to increase the coverage of such services, all diploma programmes were expected to incorporate an AYSRH component in their nursing and midwifery curriculum by 2022; however, its implementation is yet to be realized[20].

g) HIV/AIDS and STI

Implementation

The financing of HIV/AIDS programmes is donor dependent, limiting the scaling up and long-term sustainability of implemented interventions.

Njombe faces the highest rate of HIV prevalence for adults aged 15 and above, followed by Iringa and Mbeya, but "*have relatively little to medium programme concentration*", as shown in a *Figure* below. There is inconsistency in how resources are distributed; regions are not prioritised according to need.

Provision of HIV services to adolescents have not yielded to the target of 90% of adolescents aged 10-19 years to be under ART by 2020: only 56% of adolescents living with HIV were on ART by 2020; possibly because of limited enrolment and poor retention of adolescents in HIV care and treatment. Tanzanian adolescents living with HIV since infancy are not adequately engaged with home-based care; in part because they are afraid of disclosing their HIV status, but also because home-based care providers are perceived as health promoters rather than trusted counsellors by adolescents.

[20] Available at www.advancefamilyplanning.org

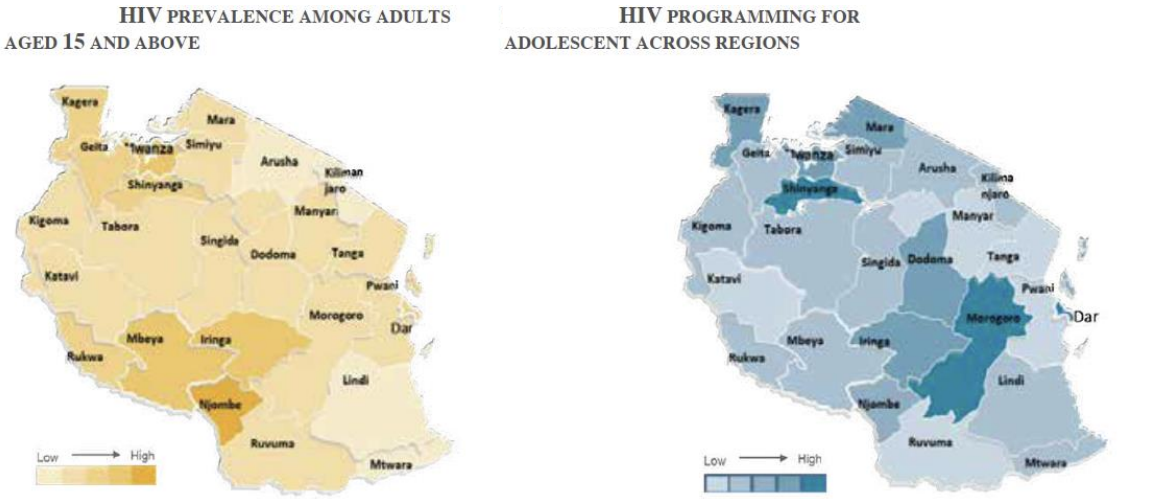


Figure 8: HIV Programming for Adolescent Across Regions - *Source: Source: URT, MoHCDGEC. Jan 2021, P49*

h) Nutrition

Policy

According to NMNAP II, constraints to achieving the goals of NMNAP I, included inadequate funding to support nutrition interventions; reluctance to hire nutrition human resources; unavailability of nutritional data; poor collaboration with the private sector; and inadequate attention to adolescents and elders with special nutritional and health needs

Implementation

While the prevalence of anaemia is reported to be highest in Shinyanga, Mwanza, Simiyu, and Kigoma, existing nutrition programmes for adolescents which are limited in number are concentrated in Singida, where the programmes reach up to 30% of the adolescent population (NAIA-AHW p51), as shown in the *Figure* below. While the nutrition component has been integrated with environment and health education, it has still yet to receive adequate attention.

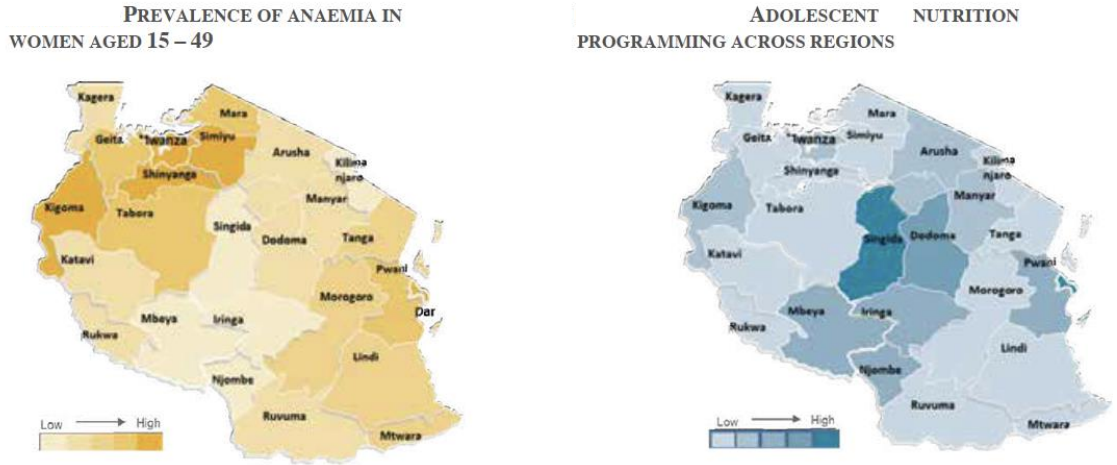


Figure 9: Adolescent Nutrition Programming Across Regions - Source: URT, MoHCDGEC. Jan 2021, p51

i) Education and Awareness

Policy

Many of the reviewed policies acknowledge the importance of creating SRH awareness among adolescents but do not detail specific SRH education related interventions. Apart from the **National Five-Year Development Plan (FYDP III) - 2021/22 – 2025/26** that plans to have 2 million adolescents being trained on health and well-being by 2025/26, no policies and guidelines or curriculum to do with sexual and reproductive health education and awareness have been found in this analysis. Besides notes that around half of the adolescents were not aware of policies, laws and regulations around SRH matters.

Stakeholder's interview on National-Adolescent- Reproductive Health Strategy 2011-2015

Attitudes and behavior change on adolescent friendly reproductive health services:

"Education and awareness on issues related to sexuality and use of family planning have been inadequately addressed."

Implementation

A study undertaken in 2007 in Mtwara showed that accessibly to SRH education remains a challenge where those living with HIV have more access to relevant information compared to others (Mushi L et al, 2007). The paper further found that peer educators were considered as primary source of SRH education; other sources of information were parents, teachers and mass media, though instructors believed they were ineffective in teaching their students about sexual and reproductive health. SRH discussions with parents/guardians have revolved mainly around sex, HIV, STIs, menstruation and drug use; little is discussed on adolescent concerns to do with homosexuality, family planning, pregnancies and reproduction. The bottlenecks to SRH discussions arise from cultural taboos and lack of awareness among parents and care takers[21]

Stakeholder's interview:
"Education programs have resulted in an increasing demand for ASRH services among adolescents which is not being met."

8.3 Specific Challenges in National Research-Policy Ecosystem

Cross-ministerial coordination in national research remains a challenge, resulting in fragmentation of research agenda with sectoral ministries having separate research policies and funding processes. The national research framework reportedly "*suffers from weak coordination between ministries and capacity gaps in national research bodies, especially COSTECH with its numerous functions (policymaking, funding, monitoring and evaluating*)", with implications for research to policy implementation" (Mattia Fosci et al 2019).

While COSTECH relies heavily on think tanks for policy advice, "*policy decisions are often perceived to be disconnected from the recommendations, in particular if research findings are not directly aligned with national research priorities*" (Mattia Fosci et al, 2019).

National funding remains grossly insufficient; gross expenditure in research and development (GERD) is only 0.5% of GDP, which is half of the objective stated in the 1996 Science and Technology Policy.

[21] Knowledge about safe motherhood and HIV/AIDS among school pupils in a rural area in Tanzania

Collaborative partnerships with external institutions lead to research capacity strengthening and international visibility, but increasing reliance on external funding in the longer run also create several problems such as research priorities being driven by international agendas, neglecting local expertise, expectations and policy priorities (Mattia Fosci et al 2019).

8.4 General Challenges in National ASRH Policies and Plans

Altogether, there is no shortage of good policies, strategies and programmes but these need to be effectively implemented. Whether the majority of the population benefits from such policies and programmes, depends ultimately on how available benefits and resources are allocated and distributed.

a) Lack of emphasis on adolescents in Policies

Policies and legislation often do not recognize adolescents as a unique demographic segment. For example, in the development policies such as the **Development Vision 2025** and the **Five Year Development Plan (FYDP)**, adolescents (10-19) are included within the youth group (10-24 years), with no specific interventions towards addressing their needs, as in many other national documents. Definition of adolescence "*have been lacking in the judiciary, rather they are submerged into broader categories like children and youth, which leaves the health needs for adolescents unrecognized*" (Bylund et al 2020).

An example for ASRH is the target for training adolescents, which is very small - 2 million adolescents, equivalent to only 14% of adolescents in the country. For a national level development plan, the number looks big but the proportion to see the impact is very small.

b) Outdated Policies and Standards

Many policies and standards are outdated and do not reflect the current and emerging needs of adolescents. For example, the **National Adolescent Reproductive Health Strategy (2011-2015)** grouped the basic needs of adolescents to seven thematic areas: information and advice, services, rights, providers' competence, policies and management systems, organization of service delivery points (SDPs), and community and parental support. These are not comprehensive and are not informed by current evidence and health needs, especially with regards to child and adolescent mental health in Tanzania [Okelo et al, 2022]. A scoping review indicated that 'there is a hole in the wall' [Clarke et al, 2020]. Available evidence suggests that while there are effective interventions to address mental health among adolescents, there is limited evidence on the effectiveness of school-based interventions designed to prevent suicide and self-harm.

c) Misalignment of Policies and Acts on adolescents

Most policies support adolescent health and wellbeing, but their emphasis varies, and this misalignment can potentially result in variations during implementation. For example, the **draft National Health Policy 2018** and the **National Plan of Action to end Violence Against Women and Children in Tanzania 2017/18 – 2021/22** place an emphasis on socio-economic considerations and health systems, whereas the **Health Sector Strategic Plan 2015 – 2020 (HSSP IV)** and other documents focus on promoting coordination (NAIA-AHW).

The **Adolescent Health and Development Strategy 2018–2022** endorses adolescents' access to sexual and reproductive health services, yet there is some confusion about how this is supported by the other policies and legislative frameworks are being implemented. For example, there exist some contradictions between Acts which can prevent adolescents from receiving certain rights and protection; such as permitting girls to be married as young as 15 years (18 years for boys), as well as

limited provision of comprehensive sex education in schools resulting in little awareness around HIV, AIDS, and SRH (URT, MoHCDGEC Jan 2021).

d) Policy-implementation gap

There is limited translation of policy strategic components/agenda into actual implementation programmes. Although some policies, such as the National Adolescent Health and Development Strategy 2018-2022 highlighted the need to promote a holistic approach to addressing adolescents needs, not all ARMH strategic components were being implemented.

For example, while adolescent sexual and reproductive health education is prioritized and some excellent programs have been implemented to educate adolescents on the importance of utilizing sexual and reproductive health services, this is not matched by the availability and quality of ASRH services. The setting at various health facilities is not conducive to provision of ARMH friendly programmes with limited training of healthcare providers (as described in the implementation of AYFS program).

e) Lack of monitoring and evaluation on ASRH program

There is limited available information available on the implementation and performance of adolescent programmes that are being funded by several partners which remain largely uncoordinated. Multiple data collection, evaluation systems and tools were used by different partners.

e) Limited integration of sexual health in current ASRH programs
The importance of addressing sexual health of adolescents is acknowledged, but the sexual component remains to be adequately embraced in most programmes, such as the School Health Program and AYFS.

f) Lack of involvement of parents in addressing adolescent health needs
The family is the core institution with a strong role to promote sexual and reproductive health among adolescents, but there has been very limited effort to engage families when planning for ASRH interventions, such as for family planning and sexual health education services for adolescents. The process is not inclusive - parents have not been prepared to provide SRH support to their children.

There are ad hoc programs with community health workers visiting households and educating families on ASRH matters, but these usually depend on external funds and have not been sustained over time. Empowering families and communities to address the sexual and reproductive health needs of their children is a prerequisite to promoting ASRH in a sustainable way.

g) Inadequate research focus on ASRH and concrete integration of research into policy formulation and programme development:
A recent systematic review in Tanzania indicated that only one research addressed pregnancy as an outcome and not a single study was retrieved describing the frequency of unsafe abortion [Nkata et al 2019]. In a recent scoping review of ASRH in Sub Saharan Africa (South Africa, Kenya, Nigeria, Tanzania, Uganda and Ethiopia), Ajayi et al (2021) note that research on ASRH is limited in focus:

"*While topics like HIV, access to contraceptives and sexual behaviours have received significant attention, issues like sexually transmitted infections, comprehensive sexuality education and adolescent and youth-friendly services, menstrual hygiene and gender norms, as well as studies focusing on early adolescents, received little attention*."

Stakeholder's interview

"… have never heard of a single forum where policy makers, implementers and researchers meet to review recent research findings, policies and programmes on ASRH needs. Though the MoH does hold ASRH technical group meetings and there are annual research dissemination forums with potential to provide a platform for a strong interface between researchers, implementing partners, funders and policy makers."

This is a missed opportunity towards having informed policies and activities that accommodate the realistic and emerging needs of adolescents in the country. At the same time, the policy strategic components and related implementation processes have not been adequately updated and informed by ongoing context specific research findings.

h) Externally driven ASRH agenda

The current strategic ASRH policies/guidelines are largely externally driven (for example, with respect to family planning), reflecting global priorities, with limited acknowledgement of the reality of the needs of adolescents within Tanzania; of what is acceptable, feasible and implementable within the Tanzanian context.

Gaps in general budget allocations and health insurance coverage negatively affect funding for adolescent health services. In the budget, financial resources are not dedicated to adolescent health and wellbeing; rather, funding for adolescent health and wellbeing is merged with other insufficiently funded programmes.

NAIA-AHW p5

Besides, externally funded programmes are time-bound and are limited in size and scale, targeting between 50,000-100,000 adolescents on average (URT, MoHCDGEC Jan 2021 p55). The national impact is limited. Most SRH programmes targeting adolescents are not always concentrated in regions facing the greatest burden as exemplified in the AYFS and HIV/AIDS program.

In implementing programmes, the choice of region is influenced by population spread, donor interest, and existing work. The objective of the programme is another important factor, but in some cases, there may be several competing programme objectives…There is a growing shift towards comprehensive programming and holistically addressing adolescents' issues, but programmes still disproportionately anchor on HIV as a central theme and cover other issues only lightly.

Source: URT, MoHCDGEC Jan 2021 p55

Stakeholder's interview on National-Adolescent- Reproductive Health Strategy 2011-2015

Resource mobilization

"There has been a decrease in resources to support adolescents sexual and reproductive health, partly due to changing external partner funding priorities."

"The decline in external support is for a number of reasons, including changing donor priorities; policy and political instability in recent years; and the recent COVID-19 pandemic which shifted funding priorities to emergency preparedness."

i) Fragmentations of donor-funded ARMH programs

Implementing partners are striving to address the same ARMH problems differently, even in the same geographical location. For example, adolescent friendly services or programmes for prevention of

teenage pregnancies have been implemented by numerous partners and sometimes within the same geographical region.

Consequently, progress on addressing adolescent needs is not harmonised and scaled across the country due to the different approaches taken and duration of program. Besides, implementers rarely share and reflect on challenges encountered, as well as best practices which can be scaled up.

Further, with funds being disbursed through various stakeholders, it is difficult for an already constrained health system to monitor how funds are being allocated and used across the country, and towards which specific programmes/initiatives.

j) Lack of sustainability in donor-dependent program
Close to 90 per cent of ASRMH programmes are reliant on external funding which has reportedly declined over the past few years. In most cases, programs is being supported by resources made available for a specific duration only, negatively impacting the continuity of some key ASRMH priorities and approaches implemented from one project to the next.

k) National fragmentations of ARMH programs and budget
A multiplicity of uncoordinated initiatives at national and local government levels further stretches the already weak/fragile institutions. There is fragmentation and a lack of coordinated approach at all levels:

- between government sectors addressing different adolescent needs;
- between development partners and the INGOs they support with little interaction between them;
- between different units within a single organization where adolescent needs are addressed.

Divided opinions on NAIA-AHW
Stakeholder opinions are divided over the **NAIA-AHW.** While some believe NAIA-AHW is the way forward for a more holistic approach to addressing adolescent needs, others think that the NAIA-AHW is "*lost*"; or "*too broad and complex*".

According to some of the interviewed stakeholders, the NAIA is a big step towards recognising that adolescent's health encompasses multiple vulnerabilities and stressing the need for an intersectional approach. It has the potential to influence health changes broadly since it has been adopted by the Government. It is an opportunity to push for a coordinated approach, to guide donor investments.

Though the NAIA-AHW impetus came from Gates Foundation/USAID from the perspective of their priorities, and may not comprehensively address all adolescent needs, it is a first step. Implementation research linked to its implementation can inform which adolescent needs are being met, and how and what needs to shift over time.

On the other hand, some stakeholders thought that the **National Adolescent Reproductive Health Strategy (ARHS)** is more focused, and is within the SWAP structure with a Technical Working Group. The Strategy is the right starting point to coordinate and help align the financing of priority activities, with an action plan for each of the main components.

There is tension between sectors regarding issues revolving around the alignment of sector strategies which were drawn up before NAIA -AHW came into being, with NAIA priorities. The health sector strategy, for example, is more focused with an implementation guide; however, some of its priorities are captured within NAIA, and others not. It is a fluid process.

Stakeholder's interview

"RMNCH in Tanzania has received "so much" money over the last decade, perhaps "too much", but this support has been distorted across the country, with some regions receiving considerable donor support – good weather, national parks, good infrastructure, etc., and other not so much. And yet, years down the line, the RMNCH performance indicators in the heavily supported districts have remained the same, or shown limited improvements."

Concern on capacity to lead NAIA

Some concerns have been raised regarding MoH/PMOs office capacity to lead the coordination of NAIA. The NAIA requires a "catalytic force", a champion, to pull together sectors and systems; to align TWG consultative processes with the overall NAIA TWG; to attract investments and guide equitable and need-based allocation of resources; to coordinate at subnational level with clear plans and priorities from sector ministries, and so on. The RCH unit within the Ministry of Health is now elevated to a department with its own resources, though remains understaffed and underfunded.

The health sector partnership is coordinated through the Health Sector-Wide Approach (SWAp) that was established in 1999. SWAp forms a dialogue structure bringing together the Government and other stakeholders. The current SWAp arrangement includes the Ministry of Health, the President's Office, Regional Administration and Local Government; the President's Office, Public Service Management and Good Governance; the Ministry of Finance and Planning; the Development Partners Group for Health (DPG-H); private service providers; civil society organizations; and health-related nongovernmental organizations. WHO serves as the secretariat for DPG-H. This forum ensures the alignment of partners' programmes with the Government's plans and budget cycle and funding accounting, disbursement, auditing and reporting at all levels.

Source: WHO CCS 2022-2027.

Stakeholder's interview

Accountability

"There has never been an expenditure report from the MoH/RCH unit: either a capacity issue or an accountability issue."

"Initiatives only move when linked to hefty per diems, though development partners are partly to blame for this practice, by supporting "anything without questioning"."

As noted earlier, three years after its adoption, NAIA is still to attract funds. The main funders are funding their respective own priorities, mostly directly via international NGOs to districts (USAID); few to MoH/MoHCDGEC, as well as via INGOs/ NGOs (UNICEF, Irish Aid). Other UN bodies act as technical support to Ministries of Health, Education, and to PORALG, a practice resulting in accountability and reporting issues. The central question is how to bring key development partners and financiers around the table and activate a multisectoral policy?

Stakeholder's interview

"*Can we carve out the country where partners can support a whole integrated package (basic support to youths) by districts*?"

"In sum, the core issue with addressing adolescent health, including ASRH, is one of "many ***partners, a fragmented approach and limited coordination".****"*

9 RECOMMENDATIONS

Here are the recommendations for improving ASRH policies and implementation:

1. Harmonisation of existing databases with key ASRH indicators in HMIS (routine data collection) to monitor progress over time.
2. Review expired policies and laws and increase sensitivity of current guidelines to the national context, and addressed the critical needs of adolescents to achieve effective and efficient policy implementation and outcomes with higher impacts.
3. Address discrepancies between the different policies.
4. Raise awareness of existing ASRH policies at various levels of the government (districts, regions) and within the communities. and address the fragmentation of ASRH policy documents.
5. Institutionalize a monitoring and evaluation plan to establish implementation challenges and success stories.
6. Work with parents, support groups, religious leaders, community leaders, media and adolescents themselves to ensure that adolescent challenges (e.g. sociocultural taboo) are addressed in a sustainable way. A parenting framework needs to be comprehensively implemented and applied in the various settings.

Some research priorities to inform the NAIA-stakeholder suggestions

- Out of school adolescents are reportedly the most vulnerable, in particular the "poor and smart" adolescents; they are not in school and have no money; what are they doing? Pilot an integrated district-based model for out of school youths, in partnership with the district council, civil society and the private sector. A package of services addressing basic health care including SRH/FP and another one or more NAIA pillar(s), such as education and income generation. Findings with respect to "*how to implement an integrated package of essential services and effect multisectoral coordination*" can be used towards informing policies at all levels, including the national multisectoral initiative (NAIA).
- A policy focused study addressing the central question of: what systems and structures need to be in place from national to sub national levels for NAIA to work? What reporting and accountability mechanisms need to be in place to ensure that adolescents benefit from this investment? Who are the key players one needs to bring around the table – who shapes the agenda?

7. Youth involvement and social mobilisation – social media needs to be extensively utilized for a wider reach to all adolescents with sexual and reproductive health education.
8. Build capacity (e.g. incorporation of AYSRH curriculum in diploma program) of facility- and community-based health care providers, and other volunteers to provide friendly ASRH services (quality, knowledge and attitude).
9. Leverage data and information through research to inform future approaches and guide the development of programmes and interventions. For example: (i) undertake implementation and policy focused research

to learn how to effect multisector coordination mechanisms to address adolescent health needs, at all levels of the system; (ii) commission research to address key gap areas towards informing the holistic and emerging needs of adolescents; use available evidence towards guiding and updating current ASRH policies in Tanzania.

10. Prioritise research in understudied areas of adolescent health and well-being. Most factors determining health are outside the health sector. **Available research needs to be synthesised for a better understanding of the current ASRH landscape and research gap areas. Overall, research needs to adequately explore the broader sexual, reproductive and maternal health needs of adolescents and evidence needs to be appropriately channelled to inform national-level policy debates.**

11. Strengthen partnerships between national researchers, policymakers and implementing partners working on ASRH, through National Institute of Medical Research (NIMR) or an established system for effective use of available scarce resources.
    a) As a government supported research wing, the National Institute of Medical Research (NIMR) maybe well-placed to coordinate adolescent health research, noted a few stakeholders. However, the Institute appears to be faced with constraints – human resource and financial, and there are some concerns regarding its capacity to do so.
    b) Mtenga et al (2016) suggest establishing a system to promote collaboration across sectors and strengthen collective research capacities of individuals and institutions researching in the social determinants of health (SDH). The process will augment existing SDH research initiatives, deepen contextualisation, and better inform appropriate intersectoral policies towards addressing prevailing health inequities across the country.

12. The NAIA-AHW paradox need to be resolved in order to achieve the intended ASRH policy initiatives. NAIA-AHW is an excellent policy platform that aims to address the many vulnerabilities of adolescents; it has much potential. It has been adopted by the Government. Health partners should focus on strengthening and spearheading the implementation of NAIA.

13. While NAIA has been introduced to sectors, to parliamentarians, to the media, it also needs to be clearly presented at subnational levels and bring on board bodies representing adolescents, and transition to an implementation plan. It requires a clearly defined coordination mechanism for its effective implementation; and a monitoring and evaluation plan to monitor the progress of its implementation.

14. Decrease reliance on external funding support and create sustainable domestic resource mobilization strategies to support ASRH; involve the private sector and raise local funds to address context specific and emerging needs of adolescents. Long term funding commitment is required to ensure that policies are implemented over a reasonable timeframe for optimal results.

Towards a coordinated approach: stakeholder recommendations

1st Model. Coordinated support from bilateral and multilateral funders to support the implementation of National ASRH priority components.
2nd Model. Implementing partners bid (fund application) for implementation of ASRH specific objectives.
3rd Model. External and national funding partners, including the private sector, coordinate to financing specific ASRH needs.

15. Create a single ASRH/ASRMH basket, pooling of resources to ease management of funds, facilitate a coordinated approach, ensure key priorities are addressed and help assess progress to implementation.

16. The focus should be on systems strengthening and not on single projects operating in SILOS. It is important for key actors to work through government system structures.

17. Government oversight and commitment is critical to achieving scale and coverage, reach consensus, coordinate responses, ensure effective use of resources and ensure sustainability.

18. Revive the review process of ASRH strategy.

10 CONCLUSIONS

Information gathered in this situation analysis suggests that adolescents (aged 10–19 years) experience poor sexual and reproductive health outcomes in Tanzania. Barriers that heighten adolescents' vulnerability to poor SRH outcomes are complex and multifaceted. Policies and guidelines covering most of ASRH components are in place; however, translating these into improved indicators has proved to be a challenge.

The implementation process is challenged by fragmentation at all levels – with limited coordination between the different sectors addressing adolescent health needs; and between development partner's and the INGOs they support. Policies are not always evidence informed. Research on adolescent health and well-being is inadequately coordinated with limited interaction within the research community, and with policy makers, funders and implementing partners.

The next phase of this project will focus on identifying sustainable mechanisms toward strengthening the national research to policy interface; and exploring models for improved coordination of ASRH support in one district.

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ANNEXES

Annex 1: CPIA Tz stakeholders meeting in Morogoro, 7th Dec 2022: List of attending stakeholders. President's Office, Regional Administration and Local Government (N=1)

- President's Office, Regional Administration and Local Government (N=1)
- Morogoro Regional Medical Officer (N=1)
- Morogoro Regional Reproductive and Maternal health coordinator (n=1)
- Morogoro Regional Social Welfare Officer (N=1)
- Morogoro Municipal District Reproductive and Maternal Health coordinator (N=1)
- Morogoro District Social Welfare Officer (N=1)
- Morogoro Acting District Medical Officer (N=1)
- Morogoro Council health management team member (N=1)
- Non-government Organization working on MNSRH (N=2)
- T-MARC
- AMREF
- Ifakara Health Institute researchers (2)

Annex 2: CPIA Tz dissemination meeting, Morogoro, 10th August 2023: List of attending stakeholders

The multi-stakeholders in Morogoro included representatives from the following:

- Adolescents' groups
- Ministry of Health
- President's Office–Regional Administration and Local Governments (PO-RALG)
- Members of Morogoro regional and district health management teams; and Morogoro Regional Medical Officer
- University of Mzumbe
- AMREF Dar es Salaam
- Engender Health, Dar es Salaam and Mwanza
- FHI
- TMARC

Annex 3: Preliminary mapping of stakeholders and the projects/initiatives supporting ASRH in Tanzania

Major ASRH stakeholder / Funder	Project/Initiative	Specific components/ area of focus	Who they work with/through	Where they work (National/regional/ district)
UNFPA /Italy	Zero tolerance for the practice of Female Genital Mutilation (FGM), time frame?	▪ Roundtable discussion on mobilizing investment and support to accelerate the elimination of FGM in Tanzania; hosted and funded by Residence of the ambassador of Italy	▪ Tanzania Police Force ▪ The Association for Termination of Female Genital Mutilation (ATFGM) Masanga, ▪ Tanzania Inter-faith Partnership, ▪ The Men Engage Tanzania Network ▪ UNICEF	National level
UNFPA	Youth Friendly Services (Wezesha Wasichana project) (Capacity building for girls); 2019-2023	▪ Improve sexual and reproductive health rights and well-being among vulnerable adolescent girls in Tanzania. ▪ Refurbishment of five Youth Friendly Service centers in Zanzibar • Supported SRH; and the development of guidelines, a training manual, and data management	▪ Ministry of Health, Zanzibar ▪ UNICEF	At ministerial level (Zanzibar). all 22 districts in Mbeya and Songwe regions and Zanzibar
UNFPA/Government of Finland	Chaguo langu Haki yangu programme (my choice my right); time frame?	▪ Adolescent girl and young women champions take the lead in ending GBV and child marriage; girls are trained to be champions in their communities to create awareness among their peers. ▪ Promote male participation to increase women's access to SRH services	▪ United Nations Sexual and Reproductive Health Agency (UNFPA) ▪ Women in Law and Development in Africa- WiLDAF ▪ Tanzania Men as Equal Partners in Development (TMEPiD)"	▪ Regional and local government ▪ Kahama-Shinyanga region; and Tarime and Butiama in Mara region

Major ASRH stakeholder / Funder	Project/Initiative	Specific components/ area of focus	Who they work with/through	Where they work (National/regional/ district)
UNFPA /Embassy of Switzerland	The Safeguard Young People (SYP) programme; time frame?	▪ The program was launched in Dar es salaam in 2021 with the overall aim of improving policy and legal environment for addressing young people's issues, policies, and programs at the national and sub-national levels. Specifically: increasing adolescents and young people's knowledge and skills towards the adoption of protective sexual behaviors; and integrated SRH and HIV services for adolescents and young people are of quality and scaled up.	• Government of Tanzania	• Regional and local governments of 5 selected regions in Tanzania Mainland- Kigoma, Shinyanga, Simiyu, Dodoma, Dar es Salaam; and in Zanzibar (Unguja and Pemba).
UNFPA / Irish Aid	The Ujana Wangu Nguvu Yangu Project (My youth, My power); 2018-2022	▪ Addresses SRH needs and challenges faced by adolescents and young people, both in the community and in refugee camps	▪ Ministry of Health, Community Development, Gender, Elderly and Children, the President's Office Regional and Local Government, Regional Administrative Secretaries, Local Government, and selected NGOs/Implementing Partners in Kigoma Region	▪ Kigoma community and refugee camps
UNICEF	MEET BINTI program (meet a daughter); 2022	▪ BINTI is a digital advocacy tool to end child marriage in Tanzania. It is a program which aggregates voices of young people and influential leaders, triggering conversations across society, with the key action of the campaign asking people to take a pledge – a pledge to not participate in the marriage of a child under the age of 18	▪ Dorris Mollel Foundation with funding support from UNFPA	Shinyanga
WOMEN FUND TANZANIA- WFT AND GENDER ACTION TANZANIA- GATA	BINTI MICHEZO PROGRAM	▪ Binti Michezo Program focuses on creating free and safe spaces for girls and women in addressing gender based violence, also advocating for a free and safe space for girls in sports arena.	▪ Gender Action Tanzania- GATA	Dar es Salaam

Major ASRH stakeholder / Funder	Project/Initiative	Specific components/ area of focus	Who they work with/through	Where they work (National/regional/ district)
UNICEF	NYP+ in Iringa; NGO started in 2005 supported by UNICEF	▪ Aimed to mobilise young people for HIV treatment and avoid discrimination	▪ District AIDS Control Coordinator (DACC) ▪ National Council of People Living with HIV (NACOPHA)	Iringa
	GRREAT initiative; April 2019-March 2024	▪ Provides a platform for vulnerable adolescents to get together, and discuss topics related to puberty, family planning, life skills, healthy eating, gender-based violence, sexually transmitted diseases, and HIV to improve their health. ▪ Youth peer educators lead the discussions and support adolescents through weekly sessions and provide referrals to access services from the nearest health facilities whenever necessary. ▪ Peer educators are supported by the CHWs in their villages; each youth peer educator is paired with a CHW for technical support, mentorship, and linkages to health facilities.	▪ GRREAT is implemented by UNICEF and UNFPA with financial support from Global Affairs Canada (GAC)	National level Mbeya Songwe Zanzibar
	Oky App for Tanzanian Girls	▪ A period tracking app tailored for girls in Tanzania	▪ Tai Tanzania ▪ R-Labs ▪ Mingati	Dar es Salaam
WHO / UK Aid from the Government of the United Kingdom of Great Britain and Northern Ireland	Report of an adolescent health services barriers assessment (AHSBA) in the United Republic of Tanzania with a focus on disadvantaged adolescents	▪ Based on a national assessment conducted between July and October 2018 as a standalone exercise to inform the review of the National Adolescent Reproductive Health Strategy (2011–2015) and the mid-term review of One Plan II ▪ Capacity building, resource mobilisation, technical support. (support the coordination of the development of evidence-based policies, strategies, guidelines and normative tools).	▪ MoH	National[22]

[22] Strengthening health systems to ensure universal access to quality RMNCAH and other essential health services, is one of the four strategic priorities through which WHO supports the Government in improving the health of its population over the 5 years, from 2022 to 2027. Overall, WHO partners with the Government, development partners, civil society, nongovernmental organizations, academia and research institutions in the implementation of the health and development agenda in the country. WHO also interacts with other sectors to address the social and environmental determinants of health within the current National Strategic Framework of Health in all Policies (2020–2025) (WHO CCS 2022-2027).

Major ASRH stakeholder / Funder	Project/Initiative	Specific components/ area of focus	Who they work with/through	Where they work (National/regional/ district)
PACT / USAID-PEPFAR	Pamoja Tuwalee project 'let's raise them together') (2010-2016)	• To improve the lives of vulnerable children and their caregivers	MoH, 43 local partners in districts.	National and district level Conrad Hilton Foundation, UNICEF
	Kizazi kipya project- ('the new generation'); 2016-2021	▪ To transform the lives of vulnerable Tanzanian children and young people, particularly those affected by HIV by creating access to better financial resources for parents and caregivers of orphans and vulnerable children (OVC), as well as improved access to health and HIV services for children and adolescents, including those who are hard to reach	▪ Elizabeth Glaser Pediatric AIDS Foundation ▪ Aga Khan Foundation ▪ Railway Children Africa ▪ The Ifakara Health Institute.	Covers 140 councils/sub-national units (SNUs)
Jpiego T-MARC, MDH and Deloitte /USAID	USAID Afya Yangu Southern and Northen Programs ;(2022-2026)	▪ Seeks to improve access to quality, client-centred RMNCAH services at facility and community levels. ▪ Works for an enhanced enabling environment, improved health-seeking behaviors, strengthened linkages between facility and community health services, improved positive gender norms in support of services uptake and increased community engagement in RMNCAH services.	▪ Ministry of Health ▪ Tanzania Communication and Development Center ▪ Benjamin Mkapa Foundation ▪ Amani Girls Home; ▪ Kenya-based AI-Fluence ▪ U.S.-based organizations ▪ Manoff Group ▪ Ona and D-tree International.	Iringa, Lindi, Morogoro, Mtwara, Njombe and Ruvuma
Jpiego / USAID	Moving Integrated, Quality Maternal, Newborn and Child Health and Family Planning and Reproductive Health Services to Scale (MOMENTUM)	▪ Projects aiming to accelerate reductions in maternal, newborn and child mortality and morbidity in high-burden countries by increasing host country commitment and capacity to provide high-quality, integrated health care	In collaboration with the Ministry of Health	Nationally , Ministry of health, IVAC
Jpiego	The Challenge Initiative (TCI) Next Gen; 2016-2022	▪ The goal of TCI Nex tGen, which builds on the previous TCI initiative, is to increase access to modern contraception for urban poor women. ▪ Provides technical assistance to local governments as they implement interventions in FP and AYSRH	Bill & Melinda Gates Institute for Population and Reproductive Health. In collaboration with the Ministry of Health	Nationally, MOH At the districts

Major ASRH stakeholder / Funder	Project/Initiative	Specific components/ area of focus	Who they work with/through	Where they work (National/regional/ district)
Jhpiego/ USAID	Sauti (2015-2020)	▪ HIV prevention and family planning services to key vulnerable populations	USAID	Dar es Salaam, Iringa, Njombe, Mbeya, Shinyanaga, Morogoro, Lindi, Dodoma, Tabora, Arusha, Kilimanjaro
Engender Health	Scaling Up Family Planning programme 2019-2024	▪ Access contraceptive care. ▪ GBV screening ▪ Referrals for post- abortion care services.	United Kingdom's Foreign Commonwealth Development Office	Arusha, Dar es Salaam, Dodoma, Geita, Kilimanjaro, Morogoro, Pwani, and Tanga) and all five regions of Zanzibar (North, Pemba South, Zanzibar Central/South, Zanzibar North, and Zanzibar Urban/West)
T- MARC, MDH and Deloitte	USAIDA AFYA YANGU SOURTHEN PROGRAM (C3HP-Client Centred health Program)'); 2022-2026	Improved access to high-quality gender-equitable and youth-friendly FP through integration with HIV and other health services in facilities and communities. Client centred HIV /TB program with the integration of FP, Gender and Youth and SBCC	Elizabeth Glaser Pediatric AIDS Foundation, Deloitte	Southern and North-Central zone
Engender Health/ USAID?	Post abortion Care Family Planning (PAC-FP); 2020-2022	This is the flagship program that sought to develop, test, and disseminate models for increasing informed and voluntary use of post abortion FP, particularly long-acting reversible contraceptives and permanent methods	Dodoma, Mara, Simiyu, Tanga, Kagera, Mbeya, Ruvuma, and Shinyanga	Zanzibar
Marie Stopes	SRH	Provides SRH services , post abortion care, contraception and family planning services (including mobile outreach and HRH initiatives to increase access to family planning services)	Ministry of health Maries Stopes International	Country-wide
AMREF	Ustawi wa Mwanamke Project ('woman's welfare'); 2018-2020	• Strengthening Community Based Health Program • Increasing access to quality RMNCAH services	Ireland Embassy	Misungwi district in Mwanza

Major ASRH stakeholder / Funder	Project/Initiative	Specific components/ area of focus	Who they work with/through	Where they work (National/regional/ district)
	Youth-friendly services;	Address or prevent early/unplanned pregnancies among young people including the realization of their SRH rights	Global Affair Canada	Mwanza and Simiyu
	ARP/ Water, Sanitation and Hygiene (WASH);	The program contributes to the reduction of FGM among small girls aged 5- 9 years, adolescents and young girls (10-24 yrs), and other adult women of reproductive age (25-49 yrs); implemented through improved and integrated Sexual Reproductive Health and Rights (SRHR) and WASH services Advocates for policy change and law amendments, related to child marriage and supporting schools and the surrounding communities	AMREF-Health Africa UK in support of the *Rabelais Trust*	Handeni District, Tanga Misungwi and Kwimba districts for Mwanza Region and Itilima District for Simiyu Region
	Together for SRH Project; 2018-2021	Improving access to HIV services and integrated quality SRHR information and services among adolescents and young people (including those living with disabilities and with HIV, key populations, and young mothers)	UNAIDS UNFPA UNICEF WHO.	Kigoma region
AMREF/ Global Fund	GB HIV/TB Grant (2018-2020)	Expand coverage for HIV services, testing, ART services and viral suppression	President's Emergency Plan for AIDS Relief (PEPFAR) and the Center for Disease and Prevention (CDC)	Singida, Morogoro, Dodoma

Major ASRH stakeholder / Funder	Project/Initiative	Specific components/ area of focus	Who they work with/through	Where they work (National/regional/ district)
World Vision	End child marriages; time frame?	Protect children from child marriage by advocating for: ▪ Families and communities to positively prevent and respond to child marriages and engage with duty bearers. ▪ Vibrant citizen movements to engage with duty bearers and mobilize rights holders to promote the rights of children. ▪ Increased access of adolescents and children to vocational and life skills training, quality education, health services, and livelihood opportunities ▪ Enactment and enforcement of laws and policies that protect children	Government of Tanzania, the Parliament and Judiciary; Local and National Coalitions/Networks/Alliances, Teachers, Development Partners, Community-Based Organizations, CSOs, Faith-Based Organizations, Religious and Traditional Leaders, Media, Influential people, Youth, Children, Parents/Guardians and Communities.	Shinyanga, Tabora, Simiyu, Dodoma, Morogoro, Singida, Kagera, Tanga, Arusha, Manyara, Kigoma, Dar es Salaam and Kilimanjaro
FEMINA / Swedish International Development Cooperation Agency (SIDA) and the Danish International Development Agency (DANIDA)	Cheza Salama campaigns ('play safely')	▪ Our Bodies: Puberty and Human Reproduction, Menstrual Hygiene Management ▪ Sex and Sexuality: Sexual Values, Masturbation, Abstinence, Safe Sexual Intercourse, Non-Vaginal Sex, Transactional Sex, Sexually Transmitted Infections and Harmful Sexual Practices ▪ Relationships: Types, Expectations, Rights and Responsibilities and Early Marriage ▪ Gender Based Violence (GBV): General Knowledge, Female Genital Mutilation and Corporal Punishment in School ▪ HIV and AIDS: General Knowledge and Living Positively ▪ Mental and Physical Health: General Well Being, Substance Abuse and Accessing Services	Marie Stopes, FHI 360 and UNICEF	Through the distribution of FEMA magazine

Major ASRH stakeholder / Funder	Project/Initiative	Specific components/ area of focus	Who they work with/through	Where they work (National/regional/ district)
Pathfinder / USAID	Tuungane project ('let's unite'); time frame?	▪ Strengthen health facilities and train community health workers so that more people in more places have access to contraceptive information and services. ▪ Implement behaviour change interventions to eliminate stigma and transform harmful gender and social norms through existing platforms and networks, such as community health workers, community radio, community group discussions, and dialogues. ▪ Train health providers to deliver the services young people need and deserve, including post abortion care that can save their lives. ▪ Pioneer the use of low-cost digital technology to transform the way health care is delivered in Tanzania, creating a lifeline for people who live far from a health facility. ▪ Advocate for community health workers to provide a wider range of contraceptives beyond condoms and pills, especially DMPA-SQ (Sayana Press), paving the way for an increase in self-care options.	John Snow, Inc.; Johnson & Johnson; individual donors; Carolyn Foundation; William H. Donner Foundation; Longview Foundation; Philip Stoddard and Adele Smith Brown Foundation; Swift Foundation; Trull Foundation	The regions are not specific (will be fixed)
Pathfinder/ Anonymous	Chaguo La Maisha (2015-2017)	▪ Aimed at improving access to quality youth friendly contraceptives and post abortion care services		Dar es Salaam
UMATI	The Umkoba Project (' BAG')	▪ Contribute towards improved SRH outcomes of women, men, adolescents, and youth in Kigoma, ultimately leading to healthy, productive and empowered women, men, and youth.	Bergstrom Foundation	Kigoma region Kasulu DC Kibondo DC Kakonko DC Uvinza DC Kasulu TC Buhigwe DC

Major ASRH stakeholder / Funder	Project/Initiative	Specific components/ area of focus	Who they work with/through	Where they work (National/regional/ district)
Family Health International (FHI 360)/USAID	National support: institutional/ systems strengthening. Program support Time frame?	▪ Support / capacity building- national strategies, guidelines and tools for improving the delivery of public sector programs. ▪ Addressing SRH needs of adolescents and young people through the Sitetereki ("I am unshakable") platform, including facilitating the use of modern contraceptive methods among sexually active adolescents.	Ministry of Health and Social Welfare	Iringa, Lindi, Morogoro, Mtwara, Njombe, Ruvuma
Ifakara Health Institute / International Development Research Centre (IDRC) Canada	Research project: Quality improvement for maternal and new-born health in Mtwara Region Tanzania (IMCHA). (time frame?)	▪ The project used the approach of collaborative quality improvement (QI), a bottom-up problem-solving method to strengthen health systems, towards improving both, the quality of, and demand for, MNH services.	LGAs	▪ Tandahimba and Newala districts in Mtwara region
Evangelical-Lutheran Church in Tanzania (ELCT)/ Church of Sweden	National adolescent sexual and reproductive health programme (2018–2020)	▪ Improve access to sexual and reproductive health information and to provide education and services to adolescents		▪ ten hospitals in ten districts in Tanzania[23]
BMGF/Population Service International	Adolescent 360 (2016-2020)	▪ Increase access to contraceptives for adolescent girls		▪ Kagera, Geita, Mwanza, Tabora, Mbeya, Tanga, Dar es Salaam, Iringa, Morogoro

[23] The ELCT is the second largest church in Tanzania, with 26 dioceses throughout the county. The church is responsible for several national programmes and interventions and provides several public health services such as health- and education services. By implementing a sexual and reproductive health programme for adolescents, the ELCT aims to complement the government's National Road Map Strategic Plan to Improve Reproductive, Maternal, New-born, Child & Adolescent Health in Tanzania (2016–2020)

Major ASRH stakeholder / Funder	Project/Initiative	Specific components/ area of focus	Who they work with/through	Where they work (National/regional/ district)
Nutrition International/ Global Affairs Canada	Right Star Initiative (2017-2020)	▪ Technical and financial assistance to TFNC and LGAs to improve nutrition of adolescent girls		▪ Mwanza and Simiyu
BRAC / NOVO Foundation	Empowerment and Livelihood for Adolescents (2013-2016)	▪ Safe space for adolescent girls to socialise and receive mentoring, life skills and financial literacy training		Not available
CSI Tanzania	Girl Talk Girl Power (2016-2018?)	▪ Engage adolescent girls in essential life skills and conversation on SRH topics		Dar es Salaam
Intrahealth/ PSI/ UK DFID	Mwanamke Tunu (2014-2018)	▪ Access to FP and GBV services		Geita
BMGF/MoH/AGPAHI/ USAID	DREAMS, 2014	▪ Reduce new HIV infections in vulnerable adolescent girls and young women		Shinyanga, Mbeya, Dar es Salaam
Restless Development/ UNICEF	Mabinti Tushike Hatamu (2013/2018?)	▪ Building leadership skills of out of school adolescent girls		Dar es Salaam, Iringa, Mbeya