

Operational Guidance

Implementation of innovative community health worker and youth peer educator approaches to promote Adolescent Sexual and Reproductive Health, HIV Prevention, Nutrition and Rights within the GRREAT Initiative

Mbeya and Songwe Regions

Dr Eric van Praag

Consultant for UNICEF Tanzania

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Abbreviations

ADDO	Accredited Drug Dispensing Outlet
AMREF	African Medical Research Education Foundation
BMF	Benjamin Mkapa Foundation
BRAC	Bangladesh Rural Advance Committee
BRAC	Bangladesh Rural Advance Committee
CBHP	Community based Health Programme
CHMT	Council Health Management Team
CHW/V	Community Health Worker/Volunteer
DMO	District Medical Officer
GAC	Global AIDS Coalition
GFATM	Global Fund AIDS, TB, and Malaria
GRREAT	Girls Reproductive Health, Rights and Empowerment Accelerated in Tanzania
HIV	Human Immunodeficiency Virus
HPS	Health Promotion Section of MOHCDGEC
HSSP	Health Sector Strategic Plan
MOEST	Ministry of Education, Science and Technology
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
NACP	National AIDS Control Programme
NAIA-AHW	National Accelerated Action and Investment Agenda for Adolescents Health and Wellbeing
NGO	Non-Governmental Organization
NSHP	National School Health Programme
PORALG	Presidents Office -Regional Administration and Local Government
RCHS	Reproductive Child Health Section of MOHCDGEC
RHS	Regional Health Secretary
RMO	Regional Medical Officer
SEED	Supplies Enabling Environmental Demand
SRH	Sexual and Reproductive Health
TASAF	Tanzania Social Action Fund

TAYOA	Tanzania Youth Alliance
TIE	Tanzania Institute of Education
TWG	Technical Working Group
UN	United Nations
UNESCO	United Nations Education Science and Cultural Organization
UNFPA	United Nations Populations Fund
UNICEF	United Nations Children Fund
VEO	Village Executive Officer
WASH	Water Sanitation and Hygiene
YPE	Youth Peer Educator

Background

Adolescents (10-19 years old) make 23% of the Tanzanian population with great potential to contribute to the development of the country (1). Adolescence is also the time with the greatest individual psychosocial and developmental changes occurring whereby many feel insecure, misunderstood or threatened by parents, schools or health authorities and feel best guided by their peers and the norms set by them seen as positive role models (2). In low income communities many adolescents come to terms with frequent household and care giver changes, discontinuity of schools, separations from siblings and family, poverty, violence, and broken dreams. All these lead to vulnerability to early pregnancies, HIV, malnutrition, petty crime and early drug and alcohol use.

Community based sexual reproductive health, activities for adolescents have been implemented by various Non-Governmental Organization (NGOs) in Tanzania such as UMATI, Amref Health Africa, Fhi360 and others since the nineties using the peer health education model (3). The Ministry of health Community Development Elderly and Children have developed the reference guide for established peer education groups in the communities. This model utilizes peer leaders identified among the older adolescents or youth and trained in health and social welfare aspects relevant to adolescents related to sexual health and HIV, family planning, nutrition, and income generation. Youth Peer Educators (YPE) work with groups of adolescents through meetings, events, bonanza's or sports clubs as well as in school platform through school health clubs as part of extracurricular activities. These gatherings of adolescents and their youth peers for social purposes, allow openings for YPEs to deliver health education, initiate behavioral change and address their sexual health needs. For adolescents living with HIV, peer models have shown to improve adherence to lifelong treatments and address stigma (2).

Community health care has been a cornerstone of Tanzanian's Health development since independence in 1961 using various models over time. Currently the Government of Tanzania is working with development partners to support community-based health workers/volunteers (CHW/V) to deliver multiple but targeted public health interventions at community level. The Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) developed policy and operational guidelines as well as sector specific guides, training and resource materials to support CHW/Vs to improve access to a package of promotive, preventive, basic curative and rehabilitative services including adolescent care, reproductive health, nutrition and HIV services (4,5). Based on the Tanzania Health Policy 2007 (updated 2021), CHW/Vs are imbedded in the community health structures and recognized at the village level. The CHW/Vs constitute of male and female volunteers who are selected by community members to support provision of community-based health interventions and strengthen the linkage between health facilities and their respective community hamlets. Part of their tasks specifically mentioned in the policy and operational guidelines is building linkages with other community-based development volunteers such as welfare assistants and youth peer educators, also initiating the formation of interest groups such as patient groups for HIV treatment or youth groups. CHW/Vs are trained through 6 modules developed by MOHCDGEC for the duration of 2-3 weeks each. Module 2 of the training manual covers 'Reproductive, Maternal, Newborn, Child and Adolescent Health' which includes adolescent health services including nutrition and

sexually transmitted diseases, Family Planning, and promoting adolescent reproductive health in an integrated manner.

Recognizing the potential of community based CHW/Vs in increasing access to integrated services instead of fragmented disease or issue specific CHW/Vs, the MOHCDGEC in collaboration with the President's Office Regional and Local Governance (PORALG) is currently finalizing the operationalization of a voluntary but supported CHW/V cadre based in the community at the hamlet (kitongoji) level who will be trained and certified under guidance from MOHCDGEC to deliver a package of integrated services (5).

It is understood that both CHW efforts and the YPE initiatives are not yet formalized. They operate often with support of Community Based Organizations (CBOs) or NGOs in close collaboration with Government bodies and structures.

In June 2021 the Government of Tanzania launched its Health Sector Strategic Plan V July 2021-June 2026 'Leaving No One Behind' with a clear emphasis on the promotion of adolescent health through a variety of community and facility-based activities. UNICEF stands ready to support the Government as an UN specialized agency on adolescent's health and the reproductive and sexual health vulnerabilities adolescents are facing as well as their nutritional, developmental, educational, and environmental health needs.

This operational guide outlines innovative ways to address adolescents needs at the community level by bringing together pairs of volunteer community health workers or school health teachers with selected and trained youth peer educators either in school or in the community. These pairs will meet with adolescents through their established social gatherings such as school clubs, sports or youth clubs, weekend social events to be involved in learning about their own health and sexual development as well as identifying those at risk and/or in need of further support at the Youth Friendly services of the nearest health facility.

This guide on the pairing approach is an effective tool which is being implemented through the GRREAT Initiative in Mbeya and Songwe. The successful implementation of Community Health Workers – Youth Peer Educators paring approach will be rolled out to other regions in Tanzania for effective and sustainable implementation of adolescent health and wellbeing programmes.

Facts about Adolescents in Tanzania

Based on latest census 2012 and estimates of continuing population growth there are 12,439,677 adolescents in Tanzania, representing about a fourth of the total population but the absolute number is rapidly growing reflecting a demographic shift (1,6). By age 15 one third of have left primary or secondary school due to social or economic reasons. Dropouts for girls is higher than for boys and early teen-age pregnancies are common (7). The adolescents birth rate is 132 per 1000 19-year-old girls and among the highest in the world (6). A large proportion is living in low income (peri) urban areas seeking opportunities usually following peer influence. More than one in four women aged 15-19 had begun childbearing and this trend is rising (6).

Young women continue to be twice as likely to get HIV compared to young men of the same age group. Gender inequalities drive excessive risks among adolescent girls. Although overall HIV prevalence has decreased in Tanzania, HIV prevalence among adolescents is still high. An estimated 99,000 adolescents aged 10-19 were living with HIV in 2019 and about 10,000 were newly infected with HIV in the same year (8).

Between 2010 and 2015, the prevalence of overweight/obesity among adolescent girls aged 15 – 19 years has increased from 9% to 11% while prevalence of undernutrition has remained unchanged at 18 %. Nevertheless, 47 per cent of adolescent girls aged 15-19 years in Tanzania are anemic (4).

At the regional level, percentage of teenagers who have begun childbearing is high in Mbeya region at 37.7% and in Songwe at 26.6%. There were 1,361 new HIV infections among 15-24-year old in Mbeya region, with nearly two-third infections among females. Among 421 new HIV infections among the same group in Songwe region, two-third infections were among females as well. Comprehensive knowledge about HIV is low –with 48.5% of young people (15-24 years) in Mbeya region and 32.6% in Songwe region having comprehensive knowledge of key HIV issues. Condom use has increased in Tanzania in general, but is still inadequate, with only 34.1% of young men, and 41.5% of young women using a condom in the last year (9).

Rationale

The Health Sector Strategic Plan V 2020-2025 (HSSP V) elaborates on the priority for adolescent health care and calls for implementation of NAIA and NSHSP guidance as follows:

“In collaboration with stakeholders, the Government will expand youth friendly services, not alone by improving infrastructure, supplies, etc. but also by reorienting health staff in compassionate care, patient charter and rights of adolescents. This will be attained by supporting the implementation of priorities identified in the National Agenda to Accelerate Investment for Adolescent Health and Wellbeing 2019 – 2022 (NAIA) and the National School Health Strategic Plan (2018 - 2023) (NSHSP). The two plans mainly prioritize school age and adolescent health, education, child protection, equity, gender, and inclusiveness, WASH, nutrition, HIV and AIDS. The use of private sector platforms such as Accredited Drug

Dispensing Outlets (ADDO) offer unique opportunities of reaching adolescents with services such as FP. These platforms are an important point of contact with the health system for adolescents and youth. Young people's affinity to ADDOs is due to the presence of ADDOs at the last mile, the proximity of ADDOs to their homes and other gathering points such as educational institutions" (10)

Also the National MultiSectoral Framework for HIV/AIDS 2018/9 -2022/3 calls for the enhancing of peer support, youth friendly services and adolescents clubs to establish a supportive environment for adolescents with HIV in- and out of school and enhance the capacity of CHW/Vs to address human rights and medical ethics for this vulnerable age group in particular girls (11).

It is with the above picture in mind that an adolescent's community focus with peer led efforts was felt timely, necessary, and relevant. UNICEF is implementing a joint UN initiative "*Girls' Reproductive Health, Rights and Empowerment Accelerated in Tanzania*" (**GRREAT**) in collaboration with UNFPA with support from Global Affairs Canada to assist the Government of Tanzania to improve Sexual Reproductive Health (SRH), HIV and nutrition outcomes for adolescents. GRREAT is aiming to facilitate integration, enhance sustainability and longer-term impact of interventions targeting vulnerable adolescent girls and boys in the communities in selected districts in Mbeya and Songwe regions. This multi-sectoral initiative focuses on strengthening supply and demand sides of adolescent reproductive health, HIV, and nutrition services provision through structural and behavioral interventions, combining livelihood improvements, reproductive health/ HIV and violence protection.

The Pairing defined

As part of this broad initiative it was realized that little is known how different cadres who are present in the same community can address common health issues as a pair and work together as a team in order to boost early recognition of health issues, counsel, manage and/or refer to the nearest health facility in a practical, affordable and effective way.

Adolescents will be linked to peers with educational skills, Youth Peer Educators (YPE), through formation of informal adolescent groups both out of school or in school and meet with health and social welfare trained volunteers in the community such as CHWs or teachers assigned with health and wellbeing tasks in schools. Together they can discuss and learn about sexual health issues of adolescents and if needed get referred or escorted to youth friendly services for health and social welfare at nearest facility. Also, adolescents will receive information and services on nutrition, WASH, and sexual transmitted diseases, reproductive health, family planning and reproductive and health rights. Adolescent or youth leadership is a temporary phase based on the transitional nature of adolescents in the community as adolescents graduate to young adulthood phase. Since the GRREAT initiative will be working with young people in a span of 5 years, there will be several youth peer educators who will transition out within the life span of the project. Therefore, CHW/Vs will serve to bear the mentorship role to youth peer educators across different cohorts. Youth peer educators will be an essential structure as peer leaders to identify adolescents in need for health or social welfare issues, and link them to the CHW/Vs who if

needed will facilitate effective referrals to nearby facilities where youth friendly services are operational and a social welfare department is staffed to address adolescent issues. This requires an intensive working together or teaming up between the CHW/V and the YPE, hence the concept of pairing of these 2 cadres.

Conceptual framework



Adapted from EngenderHealth (12)

Figure 1: Supply and Demand for pairs linked to the Enabling Environmental context (SEED)

The SEED programming model depicts an adolescent centered approach whereby as a result of all interventions their sexual health needs are met by community-based pairs of volunteers supported by the peripheral health and social welfare system. To achieve that there should be cadres of well-trained pairs available in their physical environment supervised by the village health administration and the nearest youth friendly health services (the SUPPLY side). Adolescents themselves should feel at ease with translating their health and welfare needs into demands based on knowledge and skills obtained (the DEMAND side). This linking of demand and supply will only happen if there is an enabling environment underlying this linking. Their families or guardians, the community itself, the school environment and the nearest health facility should all have attitudes, norms and values which respect, acknowledge and support adolescents with sexual health issues (the ENABLING ENVIRONMENT).

Supply and Demand can further be strengthened by emphasizing and ensuring quality in the interactions between adolescents and pairs. Demand and the Enabling Environment can be strengthened by a process of transforming social norms and addressing inequalities, roles and

respect between boys and girls, between younger adolescents and elder youth within the family and at school. Enabling Environment and the Supply can be strengthened by systems strengthening approaches whereby health and social welfare system strengthening is guided by a deep understanding of factors limiting positive attitudes of care and welfare providers and involving community structures in planning of service provision.

Methodology

In order to formulate concrete and practical operational guidance on how to implement a relatively new intervention such as the pairing concept it was felt essential to obtain the buy-in through in-depth consultations of relevant stakeholders at various levels with mandates to promote better Adolescent Sexual and Reproductive Health.

Therefore a methodology was developed to meet key informants of MOHCDGEC, PORALG, and the Ministry of Education, Science and Technology (MOEST) both at National and Regional (Mbeya) level together with facilitating and implementing partners such as UNICEF, Benjamin Mkapa Foundation (BMF), Restless Development and Pathfinder International at both national and regional levels. These meetings were either group meetings or individual follow up interviews using a structured questionnaire involving all involved departments dealing with adolescents and school health in MOHCDGEC such as the Reproductive Child Health Section (RCHS) and the Health Promotion Section (HPS) and as well the Regional Medical Officer (RMO), the Regional Educational Officer (REO), the Regional Health Secretary (RHS), the District Medical Officers (DMO) and various Regional Health Management Team (RHMT) and Council Health Management Team (CHMT) members of PORALG held over the period of February and April 2021. At community level, in depth group discussions were held at three sites with different contexts (urban site, rural site with facility, rural site without facility) in April 2021 whereby village leadership such as the Village Executive Officer (VEO) or Ward Executive Officer (WEO) and the pairs all together were met in the presence of a district coordinator for reproductive health or community health. The discussions centered around four different aspects of responsibility and influence all stakeholders have with regards to implementation of: 1. Policies and Guidelines in the area of CHWs, peer education and reproductive health for adolescents in- and out of school; 2. Coordination between various actors/stakeholders at the national, regional/district and village level; 3. Training of YPEs and CHWs, materials and modalities; 4. Operationalization of the pairing concept

Views from Government consultations on key elements to implement pairing

Policies and Guidelines:

The technical ministries such as MOHCDGEC and MOE are responsible for policy and technical guidance, while PORALG is responsible for the implementation through the Regional Offices and Councils. In the case of CHWs it is the guidance through the Community-based health care programme (CBHP) in the HPS of MOHCDGEC while the peer education on reproductive and sexual health for adolescents is guided by both MOHCDGEC and the (MOEST through the Tanzania Institute of Education (TIE).

MOHCDGEC through HPS is currently finalizing 2 documents: The National Policy Guideline of CBHP and the Operational Guideline for CBHP which guides the roles of CHWs. (3,4).

Two issues as part of the CBHP policy are currently being clarified before finalization of these guides: First the balance between the focus on intervention driven outreach to communities from health facilities on one side and the focus on community driven comprehensive health care by communities themselves on the other side. Secondly the lack of consensus within MOHCDGEC to give CHWs as government trained but lay workers a basic curative services package for which there is not yet a legislative framework. The final policy may have consequences for CHW services to adolescents in the community with acute medical needs who feel already stigmatized by the current facility staff and lack of privacy for reproductive and sexual health issues. The pairing of CHWs and YPEs in close coordination with a trained health worker to provide youth friendly services would follow the proposed policies and guidelines for CHWs and could be the appropriate measure to best manage adolescents' medical and social issues and learn from that. From both informants at National and Regional level, the implementation of the pairing model was very much welcomed and recommended for implementation by the partners through the GRREAT initiative.

With regards to adolescents, the main multisectoral policy and national guiding document is the National Accelerated Action and Investment Agenda for Adolescents Health and Wellbeing 20/21 – 23/24 (NAIA_AHW) which has been formally launched by the Prime Minister Hon. Kassim Majaliwa on April 17th 2021 (13).

The NAIA_AHW anchors on six pillars chosen as they disproportionately affect adolescents: 1. Preventing HIV; 2. Preventing Teenage Pregnancies; 3. Preventing Sexual, Physical and Emotional Violence; 4. Improving Nutrition; 5. Keeping Boys and Girls in School; and 6. Developing Soft Skills for Meaningful Economic Opportunities. Tanzanian Institute of Education (TIE) as the curriculum arm of MOEST together with TFNC, EGPAF and UNICEF have contributed technically to the development of this policy guide.

The more general school health related guidelines from the Government are the 2018 Policy guideline on School Health Services and the 5 years Strategic Plan 2018-2023 by the National School Health Program of HPS/MOHCDGEC in collaboration with MOEST (14). Both have

specific chapters on adolescents and their health needs. These two documents have not yet been translated in Kiswahili and have not yet been disseminated to all schools in Tanzania.

Adolescent Health priorities and its approaches for implementation are reflected clearly in One Plan 3 of RCHS and the HSSP V, both in final draft and officials at both national and regional level called on stakeholders for support in printing, dissemination and orientation (10 and 15).

More of direct practical importance of the training of YPEs is the 2020 Peer Educator Manual and its training package in Kiswahili ‘Rejea ya Muelimishaji Rika’ which has been printed in March 2021 with UNFPA, UNICEF, GAC and GFATM support and currently been used by Restless Development in their training of both out of school and in-school youth peer educators (16).

In addition, there are more topic specific guidelines for adolescents such as the school feeding guide to address nutritional issues, available from MOEST and used by many School Feeding programmes, although implementation of these programmes depends on external funding.

MOEST at regional level strongly recommended to implement and learn from a different pairing model for in-school adolescents. The REO Mbeya put forward as a policy guidance that the pairing of the in-school YPE at secondary schools should not be with the CHW but with the school health teacher (patron/matron) or the teacher identified by YPE as the favorite health teacher of adolescents to pair up as a team to identify health or developmental issues among in school adolescents, address them or refer to health facility directly, preferably escorted, where a youth friendly trained facility professional can address the issue. Pairing with CHW/Vs was not favored by REO as it was clearly indicated that as per policy that in school issues basically need to be addressed by in school staff.

Coordination

National level:

Responsibilities for adolescent’s health and development is divided among many departments and units among the technical and administrative Ministries such as MOHCDGEC, MOEST and PORALG. MOHCDGEC has at least three departments and several units dealing with adolescent’s health issues. These departments include; the RCHS with the Gender and Adolescents Health Unit, the MTCT - and the FP units; the HPS with its National School Health Programme and the Health Communication Unit; the NACP with its Care, Treatment and Support Unit as well as the Prevention Unit. All units are well-structured and coordinated in a vertical way for decision making, reporting and approvals but less clearly coordinated in a horizontal way among various units/departments for joint planning and guideline development. Only the formal Technical Working Groups (TWGs) and task forces have representation of all relevant units although meetings are ad hoc, lack equal representation from the different units/departments and depend on external support given to lead unit. All informants from these Ministries admitted openly that coordination in the sense of easy communication, joint planning and sharing of information is an issue. Partners who want to present, share, and discuss particular adolescent issues admit difficulties and delays in getting an all involved decision-making process in place. When it comes to technical aspects, the relevant ministry often initiates and develops

plans as per national and donor budget and only involves other ministries in advanced stages for reviews and approval, seldom following joint planning, development, and implementation. Trainings and workshops are good examples as being initiated by one unit without the necessary involvement of expertise of other units.

Several programs and approaches have been tested but all of them depend on the willingness of officers within different departments and units or even ministries to cooperate and team up often outside reporting lines. To build trust, to share information and documented results quickly is easier said than done. The NAIA_AHW strategic guide however is a good example which outlines the joint planning, coordination and collaboration which goes far beyond participating in technical working groups and calls for a functional formal multi-ministerial steering committee on adolescents issues which was presented during the launch by the Prime Minister on April 17th 2021(13).

WASH is another example where timely and good coordination and collaboration between government departments, UN agencies and development partners takes place.

At Regional level geographic proximity and overall coordination vested in one office being the office of the RMO with its well-established Regional Health Management Team allows easier sharing and decision making. Moreover, at this level coordination is more focused on actual implementation between and within districts. Equal distribution of partner support between districts was expressed repeatedly by regional CHMT members as a priority. It calls for better communication between partners, district councils and the Regional office which was admittedly seen as not optimal on who works where and how and for how long. Sustainability and equal support to all districts was an aspect of great concern and suggestion were made to ensure that all partner proposed projects are timely shared with both districts and region while actual activities and budgets are to be reflected in the annual CCHPs.

More frequent and more focused coordination meetings both formal and informal were suggested which may require some operational and financial support from partners to accomplish this.

At the community level however coordination for implementation takes place both formally and informally on a regular basis. Although primary and secondary schools at village or mtaa level operate under MOEST independently from structures under health but mechanisms are in place under the village leadership for coordination.

Village government structures (chairperson, village executive officer) are available to assist in the formation of adolescent peer groups and nomination of CHW to provide psychosocial and health support. Also, informants confirmed that the existing village government coordinates well with primary and secondary schools through village school meetings with regards to construction but less on school health, gender and social matters which was felt as an area for improvement. At day schools, the lack of a designated teacher for adolescent health limits easy coordination with staff from the health sector at village level.

Village school committees, village social service committees and the facility governing committees could all play a role in strengthening coordination for CHW/Vs however, it was not clear how coordination for social and developmental issues should be established with formal government Health or Community Developmental Officers at the ward level.

Training of YPEs and CHWs on adolescent health and development

Adolescent health is covered to an extent in the current national curricula for primary and secondary schools (O-level) but found by many stakeholders as insufficient regarding physical and mental health development for boys and girls. These curricula are currently under revision by MOEST. The National Policy Guidelines for School Health jointly published by MOHCDGEC and MOEST in 2018 covers policy guidance on adolescent health and could guide learning materials development but is yet to be disseminated and discussed at subnational level (11). Currently TIE is developing together with UN partners the Life Skills for primary and secondary schools covering all 6 pillar topics from the NAIA_AHW, expected to be ready by June 2021. Extracurricular activities such as health clubs in schools are an opportunity for additional learning and stimulated by MOEST although in practice many extracurricular activities are dormant as many officials admit. Learning booklets on Adolescent health does exist such as the 'Healthy Adolescence' for 15-19yrs and 'Growth and Changes' for girls 10-14 and 'To become a young man' for boys 10-14. (17). Specifically for YPEs, the peer leaders, the MOHCDGEC issued a training guide in October 2020 'Rejea ya muelimishaji rika' now widely used by partners to support peer education training such as Restless Development, AMREF, TAYOA, BRAC, TASAF, World Vision, UNICEF and others (16).

Training materials for CHWs are guided since 2020 by the HPS of MOHCDGEC and consists of 6 modules, each of one to three weeks training time. The CHW training module 1 for facilitators, 'Basics of Health Promotion', does have some content to teach communication skills, relationship- and trust building between a CHW and other key facility staff and as well for the formation of multidisciplinary Quality Assurance Village Health Teams including youth representatives.

Module 2 on Reproductive, Maternal, Infant, Child and Adolescent Health has some basics on adolescent health but HPS informants admit that these two modules need updating the six key pillars on adolescent health as mentioned in the NAIA. Team building within the community and hamlet structure, roles and responsibilities and referral mechanisms need to be specified.

Operationalization

Informants from all three Ministries agreed that putting in place pairing and implementation in a coordinated way between CHW and community youth peer leaders for both in- and out-of-school adolescents is welcomed and the efforts to implement these through BMF and Restless Development are appreciated. CHWs should have the responsibility for referrals to nearest health facility using the new updated referral forms. The current Pathfinder International initiated strengthening of Quality Adolescents and Youth Sexual Reproductive Health Services for facility staff to provide a youth friendly approach in a more respectful environment within the health facilities as part of the GRREAT initiative will benefit those adolescents in need of health and social interventions at the facility level. The tasks of a CHW in a village with a health

facility or in a remote village is basically the same although in the latter case, more emphasis will be on facilitating regular outreach services from the distant health facility. The task of the YPE according to the health and education officials is to identify adolescents with health or developmental issues within their health promotional clubs or groups, discuss these with the CHWs for next steps and ensure referral or escorting to either health facility or welfare officer.

It is appreciated that this project promotes the revival of identifying a school health teacher and the revival of school health clubs at both primary and secondary schools. That is in line with the Policy and Operational guides of the National School Health Programme but as dissemination of these documents is limited, support for this would be welcomed

It was stressed that pairs and their VEO/WEOs should involve village social service committees (although admittedly rather dormant) but the more active health facility governing committees. Psychosocial and nutritional support mechanisms identified by CHW/V-YPE pairs for adolescents need to be on the agenda of these committees and translated into action.

As indicated under Coordination section, working together with other partners also targeting adolescent health in the same catchment areas need to complement each other to avoid gaps in operational support. Jhpiego, FHI360, Boresha Afya Southern Zone, Care International, World Vision all have projects targeting Adolescents but with different scope as GRREAT and their operations need to be streamlined. PORALG facilitates operational support being responsible for implementation and does support councils and all staff to do what has been agreed upon in their annual council comprehensive plans (CCHP). It was therefore mentioned by all government stakeholders that all donor funded district activities such as those on adolescent health to be reflected in the CCHP with as much details as possible.

MOEST officials and R/CHMT members felt that operationalization of adolescent health activities for day schools should be on the agenda of the existing School Committees (for primary schools) and School Boards for secondary schools. That is where village leadership and parent bodies and youth bodies are all represented. Where the pairs are active, they could easily be nominated and participate on social and health aspects for adolescent and ensure these as agenda points. Too often these committees are too focused on constructions, coping with numbers and budgets but regarding quality, social affairs and health, these are easily falling of the agenda.

Key informant recommendations

Summary of key recommendations from officials from the various ministries:

Ministry of Education, Science and Technology (MOEST):

1. Consider pairing for in school adolescents and out of school as different. In school pairs are the YPE pupil with leadership capabilities to be paired with the nominated health teacher or patron/matron. Involvement of health teachers and heads of schools in the training for YPEs and pairing approach
2. The National Accelerated Action and Investment Agenda for Adolescents Health and Wellbeing 20/21 – 23/24 (NAAIA_AHW) is widely appreciated as key to the much-

needed adolescent health focus. There is a need for support now to disseminate printed versions, discuss at regional, district and school levels and translate into action plans to ensure all multisectoral needs for adolescent health to be covered.

3. Extracurricular school health clubs, school health committees, village social service committees and facility governing committees to be reactivated and coordinated with a focus on adolescent health and wellbeing.

Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC), including RCHS and HPS:

1. Modules for CHW in service training to be revised to reflect better the current competence needs in general and for adolescent health.
2. NSHP to be translated and disseminated, as content cannot yet be used for informing regional levels, councils, wards, and schools. UNESCO has shown interest in partial funding dissemination and orientation. MOHCDGEC is looking for additional partners and hopes to launch within 2021
3. The role of the dispensary in charge in supervising CHW/V technically as well as the role of the YF nurse currently retrained by Pathfinder in supervising the school health teacher and the CHW who refer adolescents to the YF nurse need to be specified, formalized and communicated through CHMT coordinators to field level
4. Community based health data are being recorded by CHW/V in the Mtuha book 3 as part of this project. This information needs to be transported at facility level in book 10 by facility data clerk. This needs to be put in place as soon as possible through rapid in-service trainings and availability of Mtuha Book 10. Eventually transporting these in the DHIS2 system to be considered through digital approaches using mobile technologies for CHWs as well.

PORALG including RMO and RHMTs and DMO and CHMTs:

1. Regular Health Coordination meeting under auspices of RMO at regional level and DMO at district level between authorities and implementing partners to be revived and to include Adolescents health and priority vulnerabilities such as HIV, nutrition and hygiene and hold as formal quarterly meetings. Smaller specific adolescent health issue meetings to be hold between CHMT/CHMT and implementing partners to be hold on an ad-hoc basis. Operational costs can rotate from partner to partner to complement efforts by the office of the RMO and DMO respectively.
2. Sustainability after project ends to be planned from now, addressed at coordination meetings and assuring project activities and budget reflection in CCHP, including incentive support for CHWs which should be channeled through direct health financing facilities

Observations from communities



Focus group discussions with pairs, their VEO or WEO, in the presence of CHMT member and partner representatives BMF and Restless Development.

Three community sites were chosen in Mbeya Region reflecting an urban mtaa, a village with a nearby health facility and a village without a facility. At all these sites a clear consensus was expressed that adolescent conditions in and out of school are an issue and an attempt to address these through the pairs was very welcomed. Among the pairs together with the VEO/WEO mutual respect, team spirit and trust were not an issue despite very different educational, age and social backgrounds.

Views on lessons learned and operational guidance were expressed through open and frank discussions with 9 different pairs recently established after their training.

The pairing concept for adolescent health was obviously new to all of them as their recent training focused heavily on technical aspects of maintaining health and preventing disease whereby the operational aspects on how to team up to address these as a pair of volunteers under guidance of village leadership and health facility in charges was less apparent from what the fresh volunteers had learned.

Key ingredients of team building such as respect and trust was already felt and facilitated by the shared same community background and age difference whereby the YPE are on average 10 yrs. younger than the CHWs. Gender balance worked out well as almost all pairs per village had around half of them being female and half male. Female adolescents can thus be linked to female YPEs and CHWs which was felt by all as important, similarly for male adolescents to male YPEs and CHWs. Enthusiasm, motivation, and commitment were clearly felt and expressed and working together was felt as natural and doable.

It was noted that CHWs have various other sets of responsibilities and tasks of which Adolescents Reproductive and Sexual Health including HIV prevention, ART adherence, and nutrition are important components while YPE are solely focusing on adolescent health but also focus on gender issues and social development including vulnerabilities to violence and sexual risks. The pairing approach to identify adolescents in need and possible referral was hardly addressed in the trainings of both cadres, so a need to cover this in supervisory visits and mentoring was expressed. Developing daily rosters and timetables will allow where and when the pairing activities will take place with a focus on identifying adolescents in need of intensified health education or medical - or health issues - or social follow up.

VEO/WEO expressed gratitude and promised all support in their power for this intervention. In their views this linking, up with peer educators/leaders using already established youth groups, Saturday morning togetherness events or bonanza's is very much needed to address the health and social issues among adolescents in particular for the out of school ones. The missing links are parents as so many youngsters stay with relatives or stepparents or even alone as in the more urban areas

VEO/WEO called for a reporting system to them as well to be put in place which should be simple, have examples of successes and achievements as well as numerical progress in coverage and male-female balances.

There was consensus that even after project ends, the knowledge and skills achieved by the YPEs and CHWs will benefit the community continuously as one of them mentioned. 'Elimu Haiishi' (Education never fades). This made sense as all pairs within the village or mtaa are connected to the same community and likely will be continuously available.

Several operational issues or challenges were mentioned by all pairs which needs to be addressed in the planning phase for any roll out:

- For both YPEs and CHWs a need was felt to be recognizable and identifiable through identity tags. CHWs do have uniforms.
- no education materials provided so far to assist and share in meeting/discussions with adolescents, households, and groups
- no condoms to be provided to adolescents at risk

- CHWs do not feel comfortable discussing often asked questions about potential side effects of hormonal contraceptives with women and adolescents. Lack of knowledge was identified as the underlying factor.
- YPEs expressed an area for which they demand more skills to help adolescents with job opportunities.
- Reporting formats by the pairs to authorities and partners as requested by the project focus heavily on quantifiable information (numbers of adolescents reached) but less on qualitative info such as comments on interactions or sessions, small narratives, case, or success stories etc. It would help if there are clear written tasks from the JDs for each cadre as a separate leaflet to be shared with VEO and supervisors.
- All participants of the FGDs requested regular visits by technical staff of partners and UNICEF for rapid learning, updates and motivation and eventually digital reporting or learning through mobile phones.

It was observed comparing the three sites that adolescent group forming in a rural setting is much easier than in an urban setting. Coherence, familiarity, and social cohesion were mentioned as contributing factors in rural areas

These FGDs obviously had their limitations as only 3 sites in one Region were visited which may not be representative and the pairs were only just formed but the learning and value from these FGDs was evident and calls for a more programmatic approach to have FGDs at all sites as part of regular supervisory visits and where needed focused mentoring at site.

The pairing between an identified school health teacher and the in school YPE could not be assessed as that was an additional approach just brought up during these first round of observations of regional and community stakeholders.

Operational Guidance for Pairing

Operational guidance on pairing per se being a social skill to enhance the possibility of identifying adolescents with specific needs as a pair together and develop a management plan to address these needs, requires the right volunteers, trained well, posted where they can perform, and with the right continuous guidance and supervision.

workforce

A pair of trained CHW- and YPE or in school Health teacher and pupil YPE are conditional for successful pairing to take place. In addition, they need to be posted in each village under the guidance of the VEO/WEO preferably at the office of the VEO/WEO or within the school under the guidance of the Headmaster. Pairing as an approach to meet adolescents in need of follow up education or referral needs to be explicitly covered in training of CHWs, health teachers and YPEs. As pairing is a skill to be performed, separate coaching visits by relevant CHMT members supported by the three IPs are needed. In summary:

- Each partner to ensure that the training includes the concept of pairing (BMF for CHWs, Restless Development for YPEs and health teachers with orientation for Heads of Schools and Pathfinder International for facility staff responsible for youth friendly services.
- VEO/WEO to ensure space and oversee that teamwork between the pairs take place
- CHMT member responsible for CBHP or RSH together with Restless Development district youth leader to regularly visit sites to supervise pairing activities and monitor staffing situation with a particular view on gender balance to ensure that girls needs can be addressed as well as boys needs by peers understanding these.

Service package

Services need to be provided because of pairing to reach the adolescents and identify who needs follow up information, care or referral. These tasks on what and when to do for each of the pairing members need to be clearly written and be handy available to them. Certain tools are essential for the pairing work to be done such as referral forms , educational leaflets, reporting forms, Mtuha book 3, functional mobile phones, list of people with contact details such the gender desk at police station, the YF clinician, the social welfare and community development offices, the trained ADDOs in the village, all pairing team members in the village per hamlet etc. Procedures need to be known how to address out of stock issues and where to find alternatives for items like condoms, emergency contraceptive supplies, hygiene items for girls, nutritional supplements etc. In summary:

- Partners to design a task list for pairing with roles and responsibilities for each pair member elaborating on where, when and with which youth group to meet, criteria for YPE when to involve CHW or health teacher, criteria for social and medical referral.
- UNICEF to facilitate availability of government materials such as Mtuha book, referral forms, educational materials
- VEO and pairs to design a contact list of essential people in the community to support adolescent health

Governance

The vision of pairing needs to be well understood by relevant national, regional and district authorities to obtain buy-in's for support and creating opportunities for expansion and continuity. As the approach involves multiple sectors within organizations and government, a mechanism for optimal coordination needs to be in place as an essential component of good governance. At the field level the offices of the Regional/District Medical Officer and its implementing staff as well as the offices of the R/D Educational Officer are key. For any innovative approach to be governed well, regular learning coordination meetings need to be held at regional level with all stakeholders involved while achievements and success stories needs to be collected and shared beyond those involved. Regular supportive Supervision and where necessary mentoring on the spot will need to be mainstreamed into overall health supervisory systems of community health care. In summary:

- Organizations and Ministries to promote interdepartmental coordination into the area of adolescent health and development bringing together sectors responsible for education, for health, for sexual health/HIV, for nutrition, for social welfare and for gender.
- Partners to ensure that their regional and district representation with supervisory ministry authorities like CHMT member and reps from district educational office to make quarterly joined visits to each site at village level to monitor progress, trouble shoot and discuss improvements at community and school level.
- The GRREAT Initiative to demonstrate results from the pairing approach to promote feasibility and effectiveness beyond the two regions if the model will be successful.

Essential elements of pairing

Pairing between cadres with a very different educational, age, career structures and social background to work together as a team requires attitudes, skills, and a thorough understanding of the social environment where this pairing takes place. Even more so, as these required tasks to work together for the benefits of adolescents' health are to be provided by volunteer community members. Social skills to perform these tasks are not specifically taught in each family and educational system but obtained by experience and positive social feedback. Key to pairing are the following needed skills and understanding of facilitative environmental conditions:

1. Thorough understanding by all pair members of adolescents physical and developmental phases, their health and social risks within current societal norms and values within families, schools, and communities. Understanding of vulnerabilities of girls of violence and HIV, discrimination due to gender and age biases in communities.
2. Team building between members of a pair given age, social and educational inequalities between them.
3. Earning Respect by showing commitment and delivering results
4. Listening and patience
5. Joined planning between pair members and direct administrative and technical supervisors
6. Clear tasks written and understood
7. Feeling of being supported

In summary:

- BMF, Restless Development and Pathfinder to review their training modules for resp. CHW, YPE, health teachers and facility staff if the above elements are sufficiently covered.
- BMF, Restless Development and CHMT member to orient the VEO/WEO on the necessary requirements for good pairing for adolescent issues to be managed.

Monitoring and Evaluation

The M&E plan for this GRREAT initiative is well outlined to each implementing partner and focusses heavily on numerical targets and coverages. For the pairing component to be specifically monitored more qualitative information is needed. These can easily be incorporated into the monthly reporting forms from pair members to the VEO/WEO and partner organizations by adding room for qualitative narrations, comments on the numbers and at least one monthly success story.

In summary:

- Implementing partners to redesign the monthly reporting format to allow qualitative information on the effects of pairing.
- VEO/WEO to add within their regular village health committee meeting, social welfare committee meetings and school meetings, an agenda point of progress with adolescent health using the pairing approach.

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