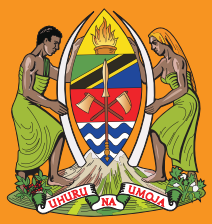

United Republic of Tanzania
Ministry of Health and Social Welfare

NATIONAL ADOLESCENT REPRODUCTIVE HEALTH STRATEGY

2011-2015

February 2011

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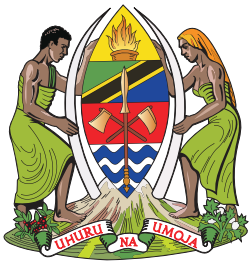

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NATIONAL ADOLESCENT REPRODUCTIVE HEALTH STRATEGY

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ACRONYMS AND ABBREVIATIONS

AFHS	Adolescent Friendly Health Services
AHD	Adolescent Health and Development
AIDS	Acquired Immuno Deficiency Syndrome
AYA	African Youth Alliance
BCC	Behaviour Change Communication
CBOs	Community Based Organizations
CDP	Child Development Policy
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CHMT	Council Health Management Team
CMT	Council Management Team
CORPs	Community Own Resource Persons
CRC	Convention on the Right of the Child
CSWs	Commercial Sex Workers
FDCs	Folk Development Centres
FGM	Female Genital Mutilation
FLE	Family Life Education
HIV	Human-Immuno Virus
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IPC	Interpersonal Communication
IRC	International and Regional Convention
KABP	Knowledge, Attitude, Behaviour and Practice
M & E	Monitoring and Evaluation
MAFS	Ministry of Agriculture and Food Security
MCDWAC	Ministry of Community Development, Women Affairs and Children
MLDW	Ministry of Livestock Development and Water
MOEC	Ministry of Education and Vocational Training
MOF	Ministry of Finance
MOH	Ministry of Health and Social Welfare
MOHA	Ministry of Home Affairs
MOIT	Ministry of Industries and Trade
MOJCA	Ministry of Justice and Constitutional Affairs
MOLYDS	Ministry of Labour, Youth Development and Sports
MORALG	Ministry of Regional Administration and Local Government
MPs	Members of Parliament
MSD	Medical Store Department

MSTHE	Ministry of Science, Technology and Higher Education
NACP	National Aids Control Programme
NBS	National Bureau of Statistics
NGOs	Non-Governmental Organizations
NPP	National Population Policy
NSHP	National School Health Programme
NYP	National Youth Policy
PLAs	Participatory Learning Approaches and Actions
PMO-RALG	Prime Minister's Office-Regional and Local Government
POPP	President's Office Planning and Privatisation
PRSP	Poverty Reduction Strategy Paper
PSI	Population Services International
RCHS	Reproductive and Child Health Section
SDP	Sports Development Policy
SDPs	Service Delivery Points
STIs	Sexually Transmitted Infections
TAs	Teacher Associations
TFR	Total Fertility Rate
TOR	Terms of Reference
TOTs	Training of Trainers
TRCHS	Tanzania Reproductive and Child Health Survey
UMATI	Chama cha Uzazi na Malezi Bora Tanzania
VCT	Voluntary Counselling and Testing
VDC	Village Development Committee
VETA	Vocational Education Training Authority
VPO	Vice President's Office
WDC	Ward Development Committees
WHO	World Health Organization
YEGs	Youth Economic Groups
YSOs	Youth Serving Organizations

FOREWORD

Adolescence is a period of great opportunity and hope. It is the period between childhood and adulthood when young people undergo major physical, emotional and social development, with significant impact on their sexual and reproductive health. The period can be very difficult and even confusing to some adolescents. While some of them successfully go through this transition into adulthood, others fail to overcome the challenges of this important stage and eventually miss the opportunity to realise their full potential in life. The decisions, behaviours, skills and knowledge of adolescents regarding their reproductive health have a major impact on their future health and development.

Consequently, one of the most important commitments a country can make for its future economic, social and political progress as well as stability, is to invest in growth and development needs of young people including their sexual and reproductive health. In Tanzania, young people aged between 10 and 24 years constitute 32 percent of the total population, out of which a third are adolescents aged between 10 and 19 years. Their high population makes it inevitable to develop and invest in programmes which address adolescent health and development.

Apart from being a signatory to various international and regional conventions that promote adolescent sexual and reproductive health, Tanzania has developed a number of policies documents in which young people's needs are addressed. These include the National Health Policy (2007), Health Sector Strategic Plan III; The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths; National Policy on HIV/AIDs; National Youth Policy; National Strategy for Growth and Reduction of Poverty (NSGRP), and the National Adolescent Health and Development Strategy (2004 -2008).

Adolescents, if well empowered with relevant knowledge and skills, can be very helpful in promoting the health and wellbeing of their families and communities. Economically, having healthy adolescents can lead to improved productivity, returns on investments and prevention of various health risks and associated costs. From a human rights perspective, adolescents have the right to access information, skills and services regarding their sexual and reproductive health (SRH), the right to participate in health and development programmes that affect their lives, and the right to grow up in a safe and supportive environment.

Subsequently, this strategy provides a sound framework for streamlining multisectoral efforts towards implementation of policies and programmes which promote and protect the health and development of adolescents. The Strategy envisages a coordinated multi-disciplinary and multi-level approach in addressing the needs of adolescents in a holistic manner. Thus, the strategy will serve as a guiding tool the Government, Non-Governmental Organisations, the private sector, development agencies, and other stakeholders, in implementing programmes and interventions relevant to adolescent sexual and reproductive health, over the next five years (2011 -2015).

Dr. Deo Mtasiwa
Chief Medical Officer
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ACKNOWLEDGEMENT

The National Adolescent Reproductive Health Strategy (2011 – 2015) is a product of collaborative efforts by different stakeholders. The Ministry of Health and Social would like to acknowledge all those individuals and institutions which contribute in one way or another to the successful development of the strategy.

Special thanks go to the Technical Working Group consisting of members drawn from various government departments, the civil society and multilateral agencies. The team included representatives from the Reproductive and Child Health Section of the Ministry of Health and Social Welfare (RCHS-MoHSW); the National AIDS Control Programme (NACP); Prime Minister's Office, Regional Administration and Local Government (PMO-RALG); Kinondoni Municipal Council; Africa Medical Research Foundation (AMREF); Mario Stopes Tanzania; Health Scope Tanzania; Family Health International (FHI); *Chama cha Uzazi na Malezi Bora Tanzania* (UMATI); the World Health Organization (WHO) and the United Nations Population Fund (UNFPA).

The Ministry would also like to acknowledge the contribution of the adolescents who volunteered their views through interviews and focus group discussions conducted at the initial stage of development of the strategy.

Over and above, the technical and financial support from WHO Tanzania Country Office, WHO Head Quarter and the United Nations Population Fund, cannot go unmentioned.

Thank you all very much for your invaluable contributions and participation.

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EXECUTIVE SUMMARY

The National Adolescent Reproductive Health Strategy (2011 – 2015) is an important guiding document in addressing the various sexual and reproductive health needs of adolescents in the ever changing social environment. The needs include information and advice; services; rights; providers' competence; policies and management systems; organization of service delivery points (SDPs); as well as community and parental support.

The strategy envisions healthy adolescents living in an environment that enables them to access quality information, services and life skills for the realisation of their full potential. It builds on the foundation laid by the 2004-2008 National Adolescent and Development Strategy, and other relevant policy documents including the National Standards for Adolescent Friendly Sexual and Reproductive Health Services. It also brings together various shades of opinion and experiences from different stakeholders to bear on the fundamental needy to address adolescent sexual and reproductive health needs an integrated and holistic manner.

Thus, the process of developing the strategy was highly participatory. It involved review of the previous strategy (National Adolescent Health and Development Strategy of 2004 - 2008) to identify gaps in its implementation, and see how best they could be addressed in a more creative and result-driven way in order to realise the desired outcomes. The process was informed by findings from a qualitative study conducted as part of development of the strategy, with a focus on availability and access to adolescent friendly sexual and reproductive health services. These were followed by a series of workshops involving different stakeholders to identify relevant information to be included in the strategy, and to build consensus on various issues of interest to different stakeholders. Subsequently, the strategy can be best described a "consensus document" one which integrates various priorities of different stakeholders committed to promoting adolescent sexual and reproductive health.

The primary objective of the strategy is to contribute to improvement of sexual and reproductive health status of adolescents and their general wellbeing. The specific objectives are:-

i. To create an enabling policy environment and legal framework that facilitates successful implementation of interventions which make it possible for adolescents to exercise their sexual and reproductive health rights;
ii. To provide an implementation framework for essential interventions that are geared towards increasing adolescents' access to participation and utilisation of friendly sexual and reproductive health information, education and services;
iii. To promote positive attitudes and practices among adolescents, parents, guardians and other key actors at the household and community levels regarding adolescent sexual and reproductive health needs;
iv. To strengthen coordination under the government's leadership by providing a framework for fostering partnerships with all relevant stakeholders both in the public and private sectors, as well as the adolescents, their parents and guardians.

The strategy outlines the following key principles which will guide implementation of various interventions and activities to promote adolescent sexual and reproductive health:

i. Adolescents are a heterogeneous group with different sexual and reproductive health needs;
ii. Reproductive health services are a basic human right for all people including adolescents;
iii. Participation and involvement of adolescents in planning, implementation, monitoring and evaluation of programmes that focus reproductive health and development, is critical to ensuring that their needs are fully addressed;
iv. Community involvement and parental support are crucial for sustainable adolescent reproductive health programmes;
v. Adolescent reproductive health services should encompass preventive, curative and rehabilitative care;
vi. Adolescent reproductive health services must promote gender equity and equality;
vii. Effective and sustainable adolescent reproductive health services require human resources development, strategic leadership, knowledge management and dissemination of lessons learnt alongside institutional capacity development;
viii. Given the diverse reproductive health needs of adolescents, effective mechanisms for networking and collaboration among various stakeholders are essential in addressing the needs holistically.

In line with the above principles, various complementary approaches will be adopted to address the diverse needs of adolescents including those most vulnerable such as rural adolescents, orphans, street children, commercial sex workers, adolescents with disabilities, younger adolescents (10-14yrs), adolescent girls, adolescents living in high STI/HIV transmission areas, and adolescents living with HIV/AIDS, among others.

Although development of the strategy was coordinated by the Ministry of Health and Social Welfare, its successful implementation depends on close collaboration and partnership between different stakeholders. Apart from the health ministry, other key sectors envisaged to play a major role in the implementation of the strategy include, among others: the Ministry of Education and Vocational Training (especially in providing information, counselling and life skills training to adolescents); Ministry of Community Development Gender and Children (in promoting active participation of community including parents and guardians in ensuring adolescents' access to quality reproductive health services); and Ministry of Labour, Employment and Youth Development (in promoting livelihood skills.

CHAPTER ONE

INTRODUCTION

1.1 Background and Context

The World Health Organization (WHO) defines reproductive health is a state of complete physical, mental and social wellbeing in matters related to the reproductive system including its functions and processes. Tanzania is a signatory to various international and regional conventions that promote adolescent sexual and reproductive health. These conventions include the Rights of the Child, Elimination of all Forms of Discrimination against Women, the 1994 International Conference on Population and Development (ICPD) Programme of Action, and the Millennium Development Goals, among others.

In Tanzania, young people's concerns are addressed in several policy documents such as the National Health Policy (2007), Health Sector Strategic Plan III; The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths; National Policy on HIV/AIDs; National Youth Policy; and the National Strategy for Growth and Reduction of Poverty (NSGRP) commonly known by its Kiswahili acronym - *MKUKUTA*; among others.

Despite existence of these supportive policies, there are still a number of obstacles to young people's access to quality reproductive health services. Recent studies have shown that adolescent pregnancy is still a major challenge. According to the 2004-5 Tanzania Demographic Health Survey (TDHS 2004-5), two-thirds of women are married before their 20th birthday and about a quarter (23%) of girls aged 15-19 have began childbearing. The situation is a reflection of limited access to sexual and reproductive health information, among other factors.

Teenage pregnancies have a major negative impact on the education of young girls in school and their lives in general. Other consequences include complications arising from early child bearing, unsafe abortion, and spread of HIV and other sexually transmitted infections (STIs). These problems are exacerbated by existence of negative socio-cultural factors such as gender norms, early marriage, forced marriage and female genital mutilation (FGM), which constrain young people's access to their sexual and reproductive health rights.

1.2 Rationale of the Strategy

Adolescence is a period of great opportunity and hope. While some adolescents successfully go through this transition into adulthood, others fail to overcome the challenges of this important stage and eventually miss the opportunity to realise their full potential in life. The decisions, behaviours, skills and knowledge of adolescents regarding their reproductive health have a major impact on their future health and development. Consequently, one of the most important commitments a country can make for its future economic, social and political progress as well as stability, is to invest in growth and development needs of young people including their sexual and reproductive health.

In Tanzanian, one out of three young persons aged 10 – 24 years are adolescents aged between 10 and 19 years. Their high population makes it inevitable to develop and invest in programmes which address adolescent health and development. The adolescents, if well empowered with relevant knowledge and skills, can be very helpful in promoting the health and wellbeing of their families and communities. Economically, having healthy adolescents can lead to improved productivity, returns on investments and prevention of various health risks and associated costs. From a human rights perspective, adolescents have the right to access information, skills and services regarding their sexual and reproductive health (SRH), the right to participate in health and development programmes that affect their lives, and the right to grow up in a safe and supportive environment.

1.3 Objectives of the Strategy

The primary objective of the strategy is to contribute to improvement of sexual and reproductive health status of adolescents and their general wellbeing. The following are the specific objectives of the strategy:

(a) To create an enabling policy environment and legal framework that facilitates successful implementation of interventions which make it possible for adolescents to exercise their sexual and reproductive health rights;
(b) To provide an implementation framework for essential interventions that are geared towards increasing adolescents' access to participation and utilisation of friendly sexual and reproductive health information, education and services;
(c) To promote positive attitudes and practices among adolescents, parents, guardians and other key actors at the household and community levels regarding adolescent sexual and reproductive health needs;
(d) To strengthen coordination under the government's leadership by providing a framework for fostering partnerships with all relevant stakeholders both in the public and private sectors, as well as the adolescents, their parents and guardians.

1.4 The Process of Development

Development of the strategy involved review of the previous strategy (the 2004-2008 National Adolescent Health and Development Strategy) to identify gaps in its implementation and see how best they could be addressed in the new strategy, taking into account the changing sexual and reproductive health needs of adolescents. The process was highly participatory and involved a number of stakeholders including relevant government ministries, UN agencies, local and international NGOs, and faith-based organisations.

The process was co-ordinated by the Ministry of Health and Social Welfare (MoHSW) and carried out in three phases. The first phased involved assessment of availability and access to adolescent friendly SRH services. It was a qualitative study involving policy and decision makers, providers of reproductive health services, as well as young people in school and out of school. Findings from the study informed revision of the previous strategy and provided useful insights in defining the focus of the new strategy.

The second phase involved consensus building on various issues emerging from the assessment and

review of the previous strategy, and how best they could be addressed in the new strategy. The process was conducted through a workshop involving all key stakeholders. Among the issues addressed in the second phase were the vision, goal and strategic objectives of the new strategy. This was followed by another workshop involving a much smaller team of technical experts tasked with drafting the strategy. The experts were drawn from the relevant government ministries, UN agencies, the civil society and other development partner organisations. The team also reviewed various reports to indentify relevant information to be included in the strategy. The major output from the process was the Draft National Strategy on Adolescent Reproductive (2010 -2015).

The third phase involved dissemination of the draft strategy and incorporation of comments from different stakeholders towards its finalisation. This was followed by final editing, design and layout of the document and its mass reproduction for use at different levels.

1.5 Institutional Ownership

Although development of the strategy was coordinated by the Ministry of Health and Social Welfare, its successful implementation depends on close collaboration and partnership between different stakeholders. Apart from the health ministry, other key sectors envisaged to play a major role in the implementation of the strategy are: the Ministry of Education and Vocational Training (especially in providing information, counselling and life skills training to adolescents); Ministry of Community Development Gender and Children (in promoting active participation of community people including parents and guardians in ensuring adolescents' access to quality reproductive health services); and the Ministry of Labour, Employment and Youth Development (in promoting livelihood skills).

CHAPTER TWO

SITUATION OF ADOLESCENT HEALTH IN TANZANIA

Delivery of comprehensive health services to adolescents is a major priority to the Government of Tanzania. The commitment is reflected in various policy documents including the National Healthy Policy (2007); Policy Guidelines for Reproductive and Child Health Services (2003); Standards for Adolescents Friendly Reproductive Health Services (2005); the Third National Health Sector Strategic Plan; and the National Roadmap to Accelerate Reduction of Maternal; Newborn and Child Deaths; among others. This commitment has been of great impetus to implementation of various adolescent reproduction health programmes in the country.

However, a lot more needs to be done in order to respond fully to the needs of adolescents. This group still faces significant challenges including limited knowledge regarding their sexual and reproductive health, inadequate access to adolescent friendly SRH services, poor attitude of parents and guardians towards adolescent sexual and reproductive health issues, poor attitudes of reproductive health service providers, and inadequate resources for equitable delivery of adolescent friendly SRH services.

2.1 Demographic Situation

According to the National Bureau of Statistics estimates based on the population and Housing Census of 2002, the population of Tanzania in year 2010 was 40,63,291. This includes 20,685.769 females (50.8%) and 19,997,522 males (49.2%). About 64% are below 25 years of age. Those aged between 10 and 24 years constitute 32% of the total population. The Total Fertility Rate (TFR) is 5.4 children per woman, with 6.1 in rural areas and 3.7 in urban areas (TDHS 2009/10). The age-specific fertility rates were 119 children per 1,000 women among those aged 15 to 19 years, and 262 children per 1,000 women among those aged 20 to 24 years, an indication that young women contribute significantly to maternal and newborn morbidity and mortality.

2.2 Socio-economic Context

Tanzania has achieved significant macro economic growth in the recent years. In 2005, the country recorded an average annual Gross Domestic Product (GDP) growth rate of 6.8 percent but declined slightly to 5.8 percent in 2006 (*MoHSW-MMAM, 2007*). However, this growth has not been felt at the household and individual levels. Moreover, there is still unequal distribution of economic gains compounded by limited capacity of the social and economic systems to respond to the needs of the population. This situation has contributed to the high unemployment rate among young people and exposed them to high-risk situations such as unwanted pregnancies, spread of STIs including HIV/AIDS, drug and substance abuse and different forms of exploitation (*THMIS, 2007/08*).

2.3 Education

Tanzania has made significant progress towards achievement of the Millennium Development Goals (MDG) 2 and 3, with over 90 percent of boys and girls being enrolled in primary schools. However, almost two thirds (63.9 percent) of primary school leavers do not join secondary education and are forced into adult life when they are still too young (*MOEVT-BEST, 2008*).

Recent data show that there are many girls who drop out of school every year due to unplanned/unwanted pregnancies. In 2007 alone, a total of 3,195 girls were reported to have dropped out of school because of pregnancy (*MoEVT- Basic Education Statistics 2007*). Teenage pregnancy and the subsequent dropout of girls from school have a major negative impact on their education, health and development.

Subsequently, the Ministry of Health and Social Welfare and the Ministry of Education and Vocational Training through the National School Health Programme, are jointly promoting health education in schools. The programme provides young people in school with a number of health care services including information on their sexual and reproductive health as well as counselling support. The Ministry of Education and Vocational training (*MoEVT*) has also mainstreamed HIV education in schools. These are among the initiatives to improve both the health and education status of young people in school especially adolescents.

2.4 Adolescent Reproductive Health

Adolescents are at risk of early and unwanted pregnancy, sexually transmitted infections including HIV/AIDS. Adolescents are also vulnerable to the dangers of substance abuse and gender based violence which predisposes them to various sexual and reproductive problems. In response to this, the government in collaboration with different stakeholders is making the necessary efforts to provide adolescent friendly SRH services in an integrated manner. To this end, national standards for adolescent friendly sexual and reproductive health services have been developed to guide national response to basic sexual and reproductive health needs of adolescents.

The basic needs of adolescents are grouped in seven thematic areas namely information and advice, services, rights, providers' competence, policies and management systems, organization of service delivery points (SDPs), and community and parental support.

The national standards further outline a range of adolescent friendly SRH services to be delivered in line with the Essential Reproductive Health Package developed by the Ministry of Health and Social Welfare. The services include prevention, promotion, curative and rehabilitation activities undertaken at different levels and settings within the health sector. The range of services includes the following:

- Information and counselling on reproductive health, sexuality and safe sex
- Testing services (VCT, STI and pregnancy)
- Management of STIs, VCT+, PMTCT+
- Focused ante-natal care
- Care during child birth
- Postnatal care
- Post abortion care
- Contraception including emergency contraception
- Condom promotion and provision
- Referrals

The majority of the services are provided through static facilities and linked to appropriate outreach activities. The service delivery points (SDPs) include hospitals, health centres and dispensaries - all owned and managed by different stakeholders including the government, faith-based organisations, NGOs and other private sector players. Other SDPs include community outlets such as youth centres, pharmacies and community outreach centres for peer education and paraprofessional counselling.

Addressing the needs of adolescents is a challenge that goes beyond the health sector. Despite the efforts being made to respond to the sexual and reproductive health needs of this population group, studies conducted in the country show that adolescents and youth are still at risk of STIs/HIV and AIDS and significantly contribute to maternal and newborn deaths. Below are some of the research findings regarding the situation of adolescents in Tanzania:

2.4.1 Adolescent Sexual Behaviour

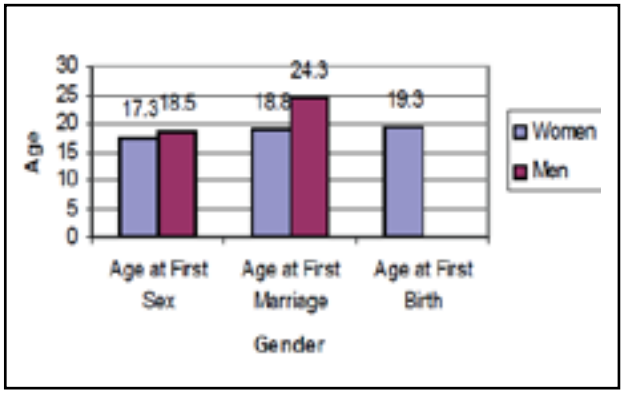
Adolescents develop interest in sex as their bodies change and mature. According to Tanzania Health Management Information System Reports (*THMIS 2007/08*), the first sex intercourse usually occurs before marriage for both women and men. The median age at first intercourse for women is 17.3 and 18.5 years for men. Women are married at medium age of 18.8 and men at 24.3 years. Ten percent of adolescents had had sex by age 15 and 43 percent by age 18. About one-quarter of youth who have ever had sex report that they used a condom the first time they had sex. Condom use at first sex increases dramatically with education.

Many girls are coerced into having sex as they lack the power, confidence and skills to refuse unwanted sex or to negotiate for safer sex. Poverty often forces girls into commercial sex work. Economic hardships can force both girls and boys to leave home and seek out a livelihood in the informal sector, thereby increasing their vulnerability to sexual exploitation.

Generally, adolescents have only patchy in-depth knowledge of issues related to sexual and reproductive health and other risk behaviours like drug and substance abuse, which predispose them to early sexual activities that may lead to unplanned/unwanted pregnancies and sexually transmitted infections including HIV and AIDS.

2.4.2 Contraceptive Knowledge and Use

Almost all young women (more than 90 percent) know about family planning methods (*TDHS, 2004-05*). Pills and condoms are the most commonly known methods. About 60 percent of young women and 77 percent of young men know where to get condoms. Knowledge of condom source increases with age, but is higher among men than women at all ages. Condom use increases dramatically with education (*THMIS 2007/08*).



Use of family planning is higher in urban areas than rural areas (19 percent of women aged 15-24 compared to 9 percent respectively). The National average concerning use of modern family planning methods among youth (15-24 years) is 12 percent. Almost 20 percent of married women aged 15-19 have an unmet need for family planning, compared to 23 percent of married women age 20-24 (*TDHS 2004/05*).

Majority of young women approve of family planning (85 percent of women aged 15 – 19 and 88 percent of women aged 20 – 24). Just over half of young women aged 15 – 19 and two – third of young women aged 20 – 24 believe that their husbands approve of family planning (*TDHS 2004/05*). However, many misconceptions and negative feelings exist among young men. About one third of young men believe that family planning is women's business and are bothered less about the services.

Induced abortion is illegal in Tanzania hence the actual magnitude of the problem is not known. However, several attempts have been made to provide Comprehensive Post Abortion Care (CPAC) which includes family planning as one of the key elements.

2.4.3 Adolescent Pregnancy and Childbearing

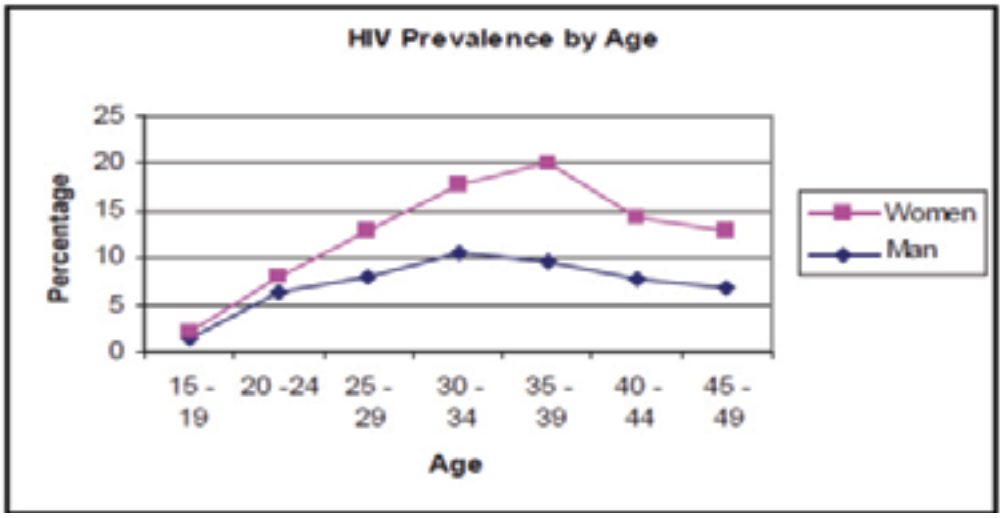
Adolescent pregnancies are currently a major sexual and reproductive health concern in Tanzania. Early childbearing, particularly among adolescents has negative demographic, socio-economic and socio-cultural implications. More than half of young women under the age of 19 are pregnant or already mothers, and prenatal mortality rate is significantly higher for young women under the age of 20 (at 56 per 1000 pregnancies) than for women aged 20 – 29 (at 39 per 1000 pregnancies). Adolescent pregnancy rate is higher in rural areas (29 percent) than urban (20 percent) and only half of young mothers under the age of 20 are assisted by medical professionals (*TDHS 2004-05*).

2.4.4 Sexually Transmitted Infections (STI)

Sexually transmitted infections including HIV pose serious health problems among adolescents. Untreated STIs may increase the risk of contracting and transmitting HIV, as well as infertility. According to National AIDS Control Programme and the Tanzania HIV and Malaria Indicator Survey (*NACP THMIS 2007-2008*), six percent of young women and seven percent of young men reported that they had STI or STI symptom in the year before the survey. Distribution of STIs by age group and sex revealed that three times as many boys as girls under 15 years had contracted a curable sexually transmitted disease. For the age group 15 - 19, twice as many female adolescents were reported with STIs by age group and sex revealed that three times as many boys as girls under 15 years had contracted a curable sexually transmitted disease.

2.4.5 Prevalence of HIV/AIDS

Youth aged 15 – 24 years account for 60 percent of the new HIV infections in the country. While young men and women are equally infected in the age group of 15-19 (1.3 percent), women aged 20-24 (1.4 percent) are more likely to be infected than men of the same age group. The HIV epidemic is largely driven by unsafe sexual behaviour by males on one hand, and female subordination and lack of economic independence on the other. For example, more than 70 percent of sexually active out of school girls reported granting sexual favours for basic needs, having relationships with older men (*NACP, HEALTH Sector HIV and AIDS Strategic Plan –II 2008-2012*).



Young women aged 15 - 19 years are 4 times more likely to contract HIV than their male counterparts. Although HIV/AIDS awareness is high among young people (95 percent girls and 97 percent boys), there is disparity between levels of knowledge and corresponding changes in behaviour towards safe sex practices. About 18 percent of young women (15 - 19) and 36 percent of young men (15 - 19) had ever used condom for either family planning purposes or for STI prevention (*THMIS 2007-2008*).

Sexual relations during adolescence are often unplanned and sporadic and sometimes occur as a result of pressure, coercion or force. A report by the World Health Organisation showed that about 10 percent of girls who had their first sexual intercourse before the age of 15 were coerced into the activity (*WHO, 2008*). Adolescents start sexual activity typically before they gain experience and skills in self-protection, adequate information on STIs and how to avoid contracting such infections by utilising the available preventive services.

2.4.6 Adolescents and HIV Testing

Among sexually active youth, one in four young women and one in five young men have been tested for HIV and received the results. Testing is much more common in urban than in rural areas i.e. 28 percent and 18 percent respectively for men (*THMIS, 2007/08*). Among young women who gave birth, 29 per cent were counselled, tested for HIV and received results. Generally, there is an increase in the number people testing for HIV, from 11 percent in the (*TDHS 2004/05*) to 20 percent (*THMIS 2007/08*).

2.4.7 Nutritional Status of Adolescents

While studies on adolescent nutritional status in Tanzania are scanty, available statistics reveal a considerable degree of chronic malnutrition. Adolescents are exposed to under nutrition, micronutrient malnutrition and obesity. In Tanzania, data show that the prevalence of stunting is very high, reaching about 70 percent at 13 years (*PRSP, 2000*). This has a considerable impact on maternal nutrition as more than half of young women under the age of 19 are pregnant or are already mothers. Maternal nutrition during the pre and postnatal periods is extremely important for the outcome of pregnancy as well as infant feeding.

2.5 Generating Demand and Community Support for Adolescent Sexual and Reproductive Health Services

Adolescents complete their physical, emotional and psychological journey to adulthood in a changing world that contains both opportunities and risks. Most adolescents are full of optimism and represent a positive force in society, as they grow up into adulthood. Globalization has accelerated changes while the structures that protect previous generations of young people are being eroded.

Adolescents are at risk of early and unwanted pregnancy, sexually transmitted infections including HIV, and other dangers such as drug/substance abuse. Adolescents need sexual and reproductive health information, education and counselling services. This would help them to understand and cope with the physical, psychological and emotional changes and make informed decisions. Provision of Information, Education and Communication (IEC) materials including counselling services need to be comprehensive and tailored to their developmental stages, environments and needs.

Families and communities have an important role to play in promoting adolescent health. However, little has been done to achieve meaningful community participation in promoting adolescent friendly SRH services. Experience has shown that training of health care providers, changes in the health facility settings and involvement of the community in implementation of adolescent programmes can significantly increase young people's use of the health services (*World Health Organisation*).

Thus, in order to generate demand for the services, adolescents need to be informed about availability their availability through a range of channels including parents, youth groups, schools, religious groups and the media. Government and various organisations are supporting this initiatives through different approaches including peer education, parent-child communication, adult-youth communication, in and out of school youth clubs and awareness-raising through the media. For quality control, stakeholders are encouraged use national standards and guidelines in working with the approaches.

2.5.1 Role of Parents and Guardians

Parents are those who provide significant and/or primary care for adolescents over a significant period of the adolescent's life without being paid as an employee. They include biological parents, foster parents, adoptive parents, grandparents, other relatives and fictive kin such as godparents. In times of pandemic, war, genocide and natural disasters, families are often headed by surviving children. The social environment of adolescents can either protect them from negative health outcomes or put them at greater risk.

Parents have major roles to play in influencing health outcomes of adolescents. Such roles include connection (love), behaviour control (limit), respect for individuality (respect), modelling of appropriate behaviour (model) and provision and protection (provide). However, their role in supporting sexual and reproductive health of adolescents has been constrained by inadequate communication with the adolescents. This is partly because parents are not empowered to discuss deeply intimate issues with their children, and partly because they do not fully understand their obligations to the adolescents.

2.5.2 Support to Adolescents at the Community Level

Community encompasses individuals living within geographical vicinity of adolescents. They include community leaders, religious leaders, teachers and healthcare workers, among others.

Involvement of these groups as well as the adolescents in the design, planning, implementation and evaluation of interventions that target adolescents can be very helpful in creating as sense of ownership necessary for sustainability of the interventions.

Experience has shown that programmes that deal with adolescents in isolation from the rest of the community many a time fail to make meaningful impact due to lack of support systems at the household and community levels. Thus, successful implementation of adolescent sexual and reproductive health interventions requires clear definition of roles of the family and other community's own resource persons (e.g. religious leaders, village health workers, community development officers, teachers, etc) in the implementation process. Areas in which the family and community's own resource persons could be involved include dissemination of information to the adolescents, counselling support and life skills training.

5.2.3 Peer Education

Peer education is a process whereby a well trained and motivated individual undertakes informal or organised educational activities with persons who belong to the same social group. The social group may be based on age, sex, gender, occupation, socio-economic or health status, educational level or marital status. It is one of the potential strategies in promoting positive adolescent sexual reproductive health and HIV behaviour.

Peer education activities are generally flexible and can be implemented in diverse settings in combination with other activities and programs. The activities mainly focus on sharing ideas and building skills for informed decision-making.

However, peer education should be complemented with other strategies in addressing sexual and reproductive health needs of adolescents. This is because some young people do not always prefer to receive health information from their peers on certain topics. In addition, some peer educators also tend to use familiar and non-participatory methods despite being trained in participatory peer education skills. Experience has also shown that peer education often has a larger positive long-term effect on the peer educators themselves than the peers they reach.

2.5.4 Support to Adolescents in School

School setting is one of the best environments to reach adolescents with sexual and reproductive health services including life skills training. It also provides an avenue for screening and treating young people for common illnesses.

Ministry of Education and Vocational Training in collaboration with the Ministry of Health and Social Welfare and other partners have developed policy and guidelines on school HIV education, life skills training and counselling for young people. Some of the schools have also trained peer educators and formed school health clubs as a strategy for ensuring young people's access to information. Teaching and learning materials on sexual reproductive health have also been developed and approved by Education Material Approval Committee (EMAC) to be used by teachers as reference materials and some by pupils during peer education sessions. However, these services are not available in most schools due to shortage of teachers trained to provide the services.

2.5.4 Role of the Media

Media is one the means to reach many people including adolescents. Due to globalisation, adolescents are exposed to various types of media including television, radio, websites and print media. However, most adolescents in rural areas are not easily reached through these channels.

Government sectors and various organisations are making efforts to reach adolescent through multimedia mainly television programme (e.g. talk show), radio, magazines which are distributed to some of secondary schools and community and theatre performances. Currently few websites have been introduced to deliver sexual reproductive health services to adolescents.

2.6 Accessibility of Adolescent Friendly Reproductive Health Services

Access to adolescent friendly reproductive health services (AFRHS) is still a major challenge in Tanzania. A study conducted by UMATI in 2008 showed that only 30 percent of service delivery points (SDPs) in the country meet the national standards for AFRHS. At the time the study, 60 percent of health care providers had not received orientation on provision of information and counselling to adolescents, and only 11 percent had been trained on sexual and reproductive health rights of the adolescents and AFRHS. Moreover, less than 40 percent of the SDPs had IEC materials for adolescents and those with guidelines and procedures for serving adolescents were about 39 percent. The study further showed that only 16 percent of the SDPs had designated areas for adolescents and 52 percent had no information management system for adolescent health. About 47.8 percent used special registers to capture information on adolescents, 34 percent used HMIS tools (MTUHA) and 13 percent used special forms.

The findings indicate the need for continued training of health care providers on adolescent sexual and reproductive health; distribution and sensitisation of the service providers on the use of IEC materials with specific messages for adolescents; and use of standard operating procedures for delivery of AFRHS.

2.7 Support to Most-Vulnerable Adolescents

Adolescents are neither equally vulnerable nor homogenous group; their needs for health information and services depend on their age, stage of development and circumstances. Due to their circumstances, some adolescents tend to be more vulnerable than others to health and social problems. Thus, most vulnerable adolescents are some specific groups that need urgent attention and those living in difficult conditions. These groups include rural adolescents, orphans, street children, commercial sex workers (CSWs), adolescents with disabilities, younger adolescents 10-14 years, adolescent girls, adolescents living in high STI/HIV transmission areas e.g. mining sites, and adolescents living with HIV/AID.

Tanzania has implemented a number of programmes that provide support to most vulnerable adolescents. The programmes mainly for awareness raising on the entitlement and sexual and reproductive health rights of the adolescents, provision of psychosocial support and referral care for adolescents affected by HIV. Other priorities include sensitisation of health care providers, home-based care providers, teachers and pupils on adolescent sexual and reproductive health concerns; and involvement of these groups in community projects that target most vulnerable adolescents.

Most of the programmes are supported by different donors in line with the Tanzania National Costed Plan of Action (NCPA) for Vulnerable Children. The NCPA calls for establishment of most vulnerable children (MVC) committees at the community level and collaboration with civil society organizations (CSOs) to identify the children and provide them with the needed support including sexual and reproductive health services.

Despite the existence of programmes targeting most vulnerable adolescents, this group is still faced with a number of challenges such as inadequate knowledge about availability of adolescent sexual and reproductive health services, limited access to AFRHS and poor attitude of some health care providers leading to poor quality of services. Other challenges include gender barriers especially to adolescent girls who often feel reluctant to be examined by male care providers and male adolescents who find it difficult to discuss intimate symptoms with female health services providers. Moreover, some the services delivery points are not friendly to adolescents with disabilities in terms of infrastructure, and many lack psychosocial support interventions for HIV/AIDS orphans ravaged by the social and economic impact of the pandemic. Such children need support that bridges between sexual reproductive health needs and their social environments, more so if they come from severely dysfunctional families, are homeless and/or physically neglected.

2.8 Policy and Legal Environment

Tanzania has ratified international and regional conventions that promote adolescent reproductive health. The following conventions are of particular relevance to young peoples' sexual reproductive health and rights, as they influence the existing policies and laws that promote adolescents sexual reproductive health and rights.

(a) The Convention on the Rights of the Child (*UNICEF 1990*)
(b) The UN Convention on the Elimination of all forms of Discrimination against Women (CEDAW)
(c) The Organisation of African Unity Charter on the Right and Welfare of the Child
(d) The International Conference on Population and Development (ICPD), Programme of Action (UN, 1994)
(e) The fourth World Conference on Women UN 1995 Platform for Action and Beijing Declaration
(f) The SADC Protocol Article 17 on Child and Adolescent Health

The table below highlights some of the supportive national policies and laws.

Policies	Laws and Legal Frameworks
• The National Health Policy (2007) • The National Policy on HIV and AIDS (2001) • The National Population Policy (200) • The Education and Training Policy (1995) • The National Youth Policy (1996) • The Community Development Policy (1996) • The Cultural Policy (1997) National Policy Guideline for Reproductive and Child Health Services (2003)	• Constitution of the United Republic of Tanzania • Marriage Act 1971 • National Education Act 1978 • Penal Code • Vocational Education and Training Act 1994 • Employment Act • Sexual Offenses Special Provisions Act 1998

These policies and laws are generally supportive of the health and development of adolescents in Tanzania. However, there are some challenges in their operationalisation to effectively promote delivery of sexual and reproductive health information, education and services to adolescents. For example, Tanzania Marriage Act of 1971 states that sexual relations and pregnancy become legally acceptable only if they occur within marriage. Further, a boy can get married at the age of 17 years or older while a girl can get married at the age of 15 years if parents/guardians give consent. Customary laws also allow adolescent below 18 years to get married. But the Sexual Offences Special Provisions Act of 1998 makes it an offence of rape for a male person to have sexual intercourse with a girl who is below 18 years with or without her consent.

CHAPTER THREE

DESCRIPTION OF THE STRATEGY

3.1 Vision

The National Strategy on Adolescent Reproductive Health (2010 – 2015) envisions health adolescents living in an environment that enables them access to quality information, services and life skills for the achievement of their full potential.

3.1 Goal

The goal is to improve reproductive health of all adolescents in Tanzania.

3.2 Strategic Objectives

The strategic objectives are as follows:

(a) Strengthened policy and legal environment to support provision of sexual reproductive health information, services and life skills for adolescents;
(b) Increased adolescent's access to and utilisation of quality reproductive health services;
(c) Positive attitudes and behaviours promoted among parents, adolescents and the community towards improvement of adolescent sexual and reproductive health;
(d) Strengthened capacity of key stakeholders to deliver effective and efficient adolescent sexual and reproductive health programmes.

The strategic objectives are based on gender equality and equity, participatory decision making, respect for adolescents' human rights, efficiency and effectiveness.

3.3 Guiding Principles

The five-year strategy addresses adolescent sexual and reproductive health needs based on the following guiding principles:

(a) Adolescents are a heterogeneous group with different sexual and reproductive health needs;
(b) Reproductive health services are a basic human right for all people including adolescents;
(c) Participation and involvement of adolescents in planning, implementation, monitoring and evaluation of programmes that focus reproductive health and development, is critical to ensuring that their needs are fully addressed;
(d) Community involvement and parental support are crucial for sustainable adolescent reproductive health programmes;
(e) Adolescent reproductive health services should encompass preventive, curative and rehabilitative care;
(f) Adolescent reproductive health services must promote gender equity and equality;
(g) Effective and sustainable adolescent reproductive health services require human resources development, strategic leadership, knowledge management and dissemination of lessons learnt alongside institutional capacity development;

(h) Given the diverse reproductive health needs of adolescents, effective mechanisms for networking and collaboration among various stakeholders are essential in addressing the needs holistically.

In line with the above principles, various complementary approach will be used to address the diverse needs of adolescents, including those most vulnerable such as rural adolescents, orphans, street children, commercial sex workers, adolescents with disabilities, younger adolescents (10-14yrs), adolescent girls, adolescents living in high STI/HIV transmission areas, adolescents living with HIV/AIDS.

3.4 Reaching the Target Population

Adolescent sexual and reproductive health interventions will be implemented in different social settings where the adolescents are found. These include schools, homes, health facilities, streets, workplaces, community organisations, refugee camps, remand homes, youth centres, media institutions, and criminal justice and rehabilitation institutions. The process will require proactive participation of all relevant stakeholders including government officials drawn from the relevant ministries (policy makers, programme managers, health care providers, teachers, etc) development workers from various civil society organisations, media personnel, parents and other community members.

The strategy seeks to enhance delivery of adolescent sexual and reproductive health interventions in line with the National Standards for Adolescent Friendly Reproductive Health Services, which envisage an environment in which:-

- All adolescents are able to obtain sexual and reproductive health information and advice relevant to their needs, circumstances and stage of development;
- All adolescents are able to obtain sexual and reproductive health services that include preventive, promotive, rehabilitative and curative services that are appropriate to their needs
- All adolescents are informed of their rights on sexual and reproductive health information and services whereby these rights are observed by all service providers and significant others
- Service providers in all delivery points have the required knowledge, skills and positive attitudes to provide sexual and reproductive health services to adolescents effectively and in a friendly manner
- Policies and management systems are in place in all service delivery points in order to support the provision of adolescent friendly sexual and reproductive health services
- All service delivery points are organised for the provision of adolescent friendly reproductive health services as perceived by adolescents themselves
- Mechanisms to enhance community and parental support are in place to ensure adolescents have the access to sexual and reproductive health services

3.5 Cross-cutting Issues

There are six key cross-cutting issues addressed in the strategy namely: Advocacy, Behaviour Change Communication, Adolescent Participation, Gender, Research, Monitoring and Evaluation, and Resources Mobilisation.

3.5.1 Advocacy

Advocacy aims at mobilising political will, commitment and resources for the implementation and sustainability of adolescent reproductive health programmes. Advocacy will be used to:

- Publicise the strategy;
- Provide information on adolescent health issues to all stakeholders;
- Build partnerships, alliances and coalitions among stakeholders;
- Build linkages among institutions that are implementing adolescent health programmes;
- Network with groups that have lobbying skills and experiences;
- Facilitate revision and implementation/enforcement of relevant policies and laws.

3.5.2 Behaviour Change Communication (BCC)

Behaviour Change Communication (BCC) is an interactive process with individual group of people or community through various communication channels for development and promotion of sustainable behaviour changes among the target group.

Various BCC strategies will be employed to enable adolescents to understand and cope with various physical, psychological and emotional changes and make informed decisions regarding their reproductive health. The BCC strategies will include but not limited to:

- Peer education;
- Peer and psychological counselling;
- Use of multi-media channels for dissemination of information;
- Social marketing of reproductive health products and services;
- Participatory Learning Approaches and Action (PLAs);
- Community engagement for sustainability of community-based interventions.

3.5.3 Adolescent Participation

Participation ensures that programmes and activities are appropriate and relevant to adolescents' needs, helps in building their self-esteem and empowering them. In the Convention on the Rights of the Child (CRC, 1990), participation of adolescents is observed as a moral and legal right. Thus, it is central in the design, implementation and evaluation of ARH programmes. For effective adolescent participation, implementation is guided by the following:

- Incorporate adolescent participation in ARH research agenda and the intervention settings at all implementation levels (national, district and community)
- Institutionalizing adolescent participation in all activities and programmes to avoid ad hoc implementation
- Voluntary participation that ensures adolescents empowerment in decision making for it to be meaningful

3.5.4 Gender

The strategy strives to mainstream gender in all programmes and activities by incorporating/strengthening gender equality and equity through the following:

- Incorporate gender issues in ARH research agenda
- Educate parents on positive gender socialization, highlighting the equal value of both boys and girls
- Incorporate gender equality issues in the training/reorientation programmes of services providers, programme implementers; youth centre operators, and other stakeholders
- Strengthen advocacy activities for promotion of girls' education and legislation enabling girls who become pregnant to return to school after childbirth.
- Strengthen advocacy activities targeting policy makers, community leaders including traditional leaders, circumcisers and parents to stop harmful traditional practices.
- Promote programmes that aim at increasing male involvement in ARH interventions

3.5.5 Research

The strategy utilizes different types of research including baseline studies, operations research and socio-cultural studies. For ARH Strategy to be successfully implemented, a research agenda will address the gaps in health issues in Tanzania. Listed below are some of the proposed research areas:

- Adolescent well being needs
- Adolescent relationships connectedness, parent and community
- Sexuality and sexual health problems and needs of adolescents.
- Adolescents' perception of safer sex practices including condom and barriers to condom use.
- Quality obstetric care for adolescent mothers.
- Adolescent pregnancies, unsafe abortion and baby dumping.
- Effective approaches for preventing HIV infection among adolescents.
- Prevailing environment for optimal realization by young people of their sexual and reproductive health.
- Quality and effectiveness of health education and services.
- Health and development needs of young people in various population groups and settings.
- Rural-urban migration of adolescents
- Socialization and communication processes and their influencing factors
- The health profile of adolescents
- Drug substance abuse and mental health
- Nutritional status
- Gender based violence.
- Impact of poverty on health of adolescents.

CHAPTER FOUR

EXPECTED OUTPUTS

This section highlights the expected outputs from implementation of different activities in line with the strategic through four strategic objectives as follows:-

4.1 Strategic Objective 1: Strengthened policy and legal environment to support provision of sexual reproductive health information, education, life skills and services for adolescents.

4.1.1 Output 1: Institutionalized international and Regional Conventions on Sexual Reproductive Health and Rights (SRHR) which are relevant to adolescents in the Government's Policy and Legal Framework.

(a) Target

- Adolescent SRH and rights integrated in all national policies, strategies and programmes.

(b) Indicator

- Proportion of national policies and laws incorporating adolescent SRH and rights.
- Proportion of district/village by-laws supportive of adolescent SRH in place.

(c) Activities

i. Review existing national policies and laws to conform to international and regional conventions on sexual and reproductive health and rights.
ii. Conduct Stakeholders analysis and map key partners in advocating for adolescent SRH at all levels.
iii. Facilitate formation of adolescent SRH and rights coalition at all levels
iv. Review/develop/adapt, print, disseminate and distribute adolescent SRH and rights advocacy messages and materials
v. Advocate for formulation of relevant national laws, district and village by-laws to promote adolescent SRH and rights.
vi. Advocate for resource mobilization and allocation for adolescent SRH interventions at all levels.

4.1.2 Output 2: Strengthened capacity of policy/decision makers, programme managers/ supervisors and service providers in implementing policies, laws and regulations that influence adolescent SRH and rights.

(a) Target

- At least two policy/decision makers, programme managers/supervisors at national, regional and district levels oriented on adolescent SRH and rights, laws and policies
- At least two service providers in a facility oriented.

(b) Indicator

- Proportion of policy/ decision makers, programme managers/supervisors implement existing policies and laws.

(c) Activities

i. Build capacity of national, regional, district core teams and interested CSOs on advocacy skills.

ii. Support development and implementation of Adolescent SRH and Rights advocacy plan at all levels.

4.2 Strategic Objective 2: Increased adolescents' access to, and utilization of integrated quality reproductive health services.

4.2.1 Output 1: Expanded integration of adolescent friendly services in health programmes (FP, NCH, RH cancers, Safe motherhood, PMTCT, EPI, NACP, etc) in public, private, FBOs and NGO service delivery points.

(a) Target

- All reproductive health essential interventions including STIs/HIV.

(b) Indicator

- Proportion of health programmes providing adolescent friendly services.

(c) Activities

i. Conduct rapid assessment of health programmes with integrated adolescent friendly services based on the national standards.

ii. Develop/adapt tools for integrated supportive supervision of adolescent friendly service provision at service delivery points.

iii. Develop/adapt/operationalize a system for outreach, effective referral and networking for adolescent SRH service.

iv. Equip health facilities in public, NGO, FBO and private with essential equipment, materials and supplies for adolescent friendly SRH services.

v. Use Social marketing initiatives to provide sexual reproductive Services and HIV/AIDS to adolescents.

4.2.2 Output 2: Adolescent friendly SRH in Public, private, FBOs and NGO service delivery points Scaled up.

(a) Target

- Increased number of health facilities providing adolescent friendly RHS from 30% to 80 % by 2015

(b) Indicator

- Proportion of service delivery points providing adolescent friendly SRH services.

(a) Activities

i. Disseminate and distribute the National Standards for Adolescent Friendly Reproductive Health Services to policy/decision makers, programme managers, supervisors and development partners at national, regional, district and community levels.

ii. Review/develop/ adapt, and print training materials to roll-out implementation of the national standards for adolescent friendly SRH Services.

iii. Assess the training needs among various service providers on provision of adolescent friendly SRH.

iv. Build capacity of human resource (TOTs, SPs, Refresher, study/ exchange visit, post training follow-up,) and health facilities in public, CSOs, private to implement the national standards for adolescent friendly SRH services.

4.2.3 Output 3: *Strengthened human resource development on adolescent friendly SRH service provision for in and pre-service training institutions.*

(a) Target

- Increased number of trained service providers on adolescent SRH by 50% by 2015.

(b) Indicator

- Proportion of training institutions with adolescent SRH integrated in the training curriculum.

(a) Activities

i. Assess existing national curricula for training various cadres on health to identify gaps on adolescent SRH

ii. Disseminate findings from the assessment to relevant stakeholders.

iii. Review/develop/print and distribute curricula for different levels of health cadres to integrate adolescent SRH;

iv. Support training institutions in the health sector to roll-out trainings on adolescent friendly SRH services.

4.3 Strategic Objective 3: Positive attitudes and behaviour change promoted among adolescents, parents and the community on adolescent friendly reproductive health services.

4.3.1 Output 1: Improved community practices for adolescent SRH information, education and services.

(a) Targets

- Parents, lay-counsellors, influential and community leaders supporting adolescent SRH services.
- Increased number of parents, lay-counsellors, influential community leaders supporting adolescent SRH by (%) by 2015.

(b) Indicator

- Proportion of adolescents, parents and communities adopting positive attitudes and behaviours on adolescent SRH at all levels.

(c) Activities

i. Conduct KABP and secondary data analysis to identify priority issues and concerns on adolescent's access to SRH information, education and services including gaps in most vulnerable adolescent groups.
ii. Disseminate KABP findings to stakeholders.
iii. Develop, print, disseminate and distribute national communication strategy for adolescent SRH program.
iv. Review/develop/ adapt/print and distribute IEC/BCC materials on adolescent SRH.
v. Develop, print and disseminate implementation guidelines for the formation of parent and community support groups.
vi. Conduct TOTs for parents and community support on adolescent SRH;
vii. Build coalition and network for parent and community support initiatives
viii. Conduct supportive supervision of parent and community support groups initiatives.
ix. Scale up formation of parent support groups to enhance their knowledge and skills in communicating adolescent SRH issues.
x. Conduct community sensitization activities and mobilize resources to create and maintain support of adolescent SRH at the community level.
xi. Scale up the provision of information and advice to young people delivered by (CORPS) e.g. lay-counsellors and peer educators.

4.3.2 Output 2: Demand for SRH services by adolescents expanded

(a) Target

- To reach all adolescents according to stages of development, SRH needs and problems, in different settings and circumstances.

(b) Indicator

- Proportion of adolescent reached with SRH information and services

(c) Activities

i. Roll out Social marketing initiatives on Adolescent SRH services e.g. Condoms for dual protection and family planning commodities;
ii. Roll out adolescent SRH communication interventions delivered by CORPS e.g. lay counsellors, peer educators, village health workers using national guidelines and standards.
iii. Design and conduct outreach services for adolescents to promote up take of SRH services e.g. Friendly SRH service, safe male circumcision.
iv. Orient teachers to provide SRH information and advice to adolescents in a friendly manner and appropriately refer them for health services.

4.3.4 *Output 3: Improved life skills education for adolescents in and out of school on SRH*

(a) Target

- All adolescents

(b) Indicator

- Proportion of in and out of school adolescents equipped with life skills education on SRH

(c) Activities

i. Review/ adapt/ harmonize, print, disseminate and distribute national life skills training materials for adolescent on SRH.
ii. Conduct TOTs for application of harmonized approaches for delivering life skills related to adolescent SRH.
iii. Harmonize/print/ distribute IEC/BCC materials on life skills related to ASRH in line with national documents.
iv. Support the implementation of life skills education using national training documents and IEC/BCC materials.

4.3.5 *Output 4: Improved skills of lay counsellors to provide Psychosocial support to adolescents.*

(a) Target

- At least 2 lay counsellors (male and female) per village.

(b) Indicator

- Proportion of lay counsellors with skills on psychosocial support to adolescents.

(c) Activities

i. Develop guidelines and standards for training lay counsellors.
ii. Develop training materials for lay counsellors
iii. Disseminate and distribute training materials for lay counsellors.
iv. Train TOTs (including refresher training)
v. Conduct counselling services and referral on adolescent SRH.

4.4 Strategic Objective 4: Strengthened capacity for more effective and efficient management, resource mobilisation and scaling up of adolescent friendly SRH programmes.

4.4.1 *Output 1: Improved coordination, management and partnership mechanisms of adolescent SRH programmes at all levels*

(a) Target

- National level and regions/districts with a joint plan to scale up adolescent friendly SRH services by 50% by 2015.

(b) Indicator

- Proportion of regions, districts with coordinated response mechanisms for adolescent SRH programme.

(c) Activities

i. Conduct an assessment of Institutional Capacity needs for planning and managing adolescent SRH services.
ii. Disseminate result on assessment of Institutional Capacity needs for planning and managing adolescent SRH programmes.
iii. Develop a comprehensive plan for building capacity on management of key adolescent SRH programme areas.
iv. Develop adolescent SRH training program and materials for stakeholders (public, NGOs, FBOs, private sectors) at all levels.
v. Conduct TOT for stakeholders in management of adolescent SRH programme.
vi. Develop monitoring and performance award plan for ARH programs.
vii. Build capacity for planning, implementation and resource mobilization for scaling up adolescent friendly SRH services.
viii. Conduct quarterly, bi-annual, annual joint planning, coordination and review meetings with adolescent SRH stakeholders at all levels (national, regional, districts, and community).

4.4.2 Output 2: Established sustained mechanism for resources mobilization to scale up adolescent SRH programme

(a) Target

- Resources mobilised/ leveraged in public, CSOs, private sector for the key component to increase coverage of adolescent SRH services.

(b) Indicator

- Proportion of resources mobilized and allocated for the key components of adolescent SRH programme.

(c) Activities

i. Develop mechanism to mobilise/ leverage resources for the key components of adolescents SRH programme at all levels.
ii. Implement financial plan on resource mobilization for adolescents reproductive health program at all levels.

4.4.3 Output 3: Strengthened advocacy to support adolescent SRH programmes

(a) Target

- At least 2 stakeholders from relevant sectors competent in advocating for adolescent RSH.

(b) Indicator

- Proportion of stakeholders with capacity to advocate and support adolescent SRH programme.

(c) Activities

i. Implement adolescent SRH advocacy strategy guidelines to enforce policies, solicit support of gate keepers and build linkages with other sectors.
ii. Train media practitioners on ARH to establish mechanisms for their involvement.
iii. Consolidate clearing house/resource centre for IEC/BCC materials on adolescent SRH and reports on best practices at all levels (national, regional, district, and community
iv. Disseminate best practices and lessons learnt in adolescent SRH programme.

4.4.4 Output 4: Strengthened formal and informal linkages between health institutions and non health institutions to address adolescent needs holistically.

(a) Target

- At least 2 institutions providing needed support for adolescents and youth at all levels (national, district and community).

(b) Indicator

- Proportion of formal and informal linkages on adolescent SRH.

(c) Activities

i. Update inventory of adolescent SRH implementing partners in the formal and informal sectors.
ii. Integrate adolescent SRH in organised youth groups in the formal and informal settings.
iii. Build formal and informal linkages between health services and non health programmes that address adolescents' needs.
iv. Secure community involvement and interest in adolescent SRH through sensitisation meetings and community events.

4.4.5 Output 5: Research, monitoring and evaluation framework for adolescent reproductive health developed and implemented.

(a) Target

- Comprehensive monitoring and evaluation system for adolescent SRH operational by mid 2015

(b) Indicator

- Monitoring and evaluation framework for adolescent SRH program in place and operational/ used 2% of health facilities with adolescent SRH data incorporated into HIMS.

(c) Activities

i. Orient programme managers and supervisors (in Public, Private CSOs,) on monitoring adolescent friendly SRH interventions;

ii. Develop ASRH component of Health Information Management System (HIMS) at all levels;
iii. Orient HSP on the use of updated HIMS adolescent SRH component;
iv. Develop/adopt, print, disseminate and distribute supervisory checklist for ASRH activities.
v. Support capacity building on adolescent SRH supervisory activities at all levels
vi. Conduct quarterly supportive supervision of adolescent SRH at all levels.
vii. Orient managers, supervisors and service providers on quality assurance/ improvement methods for adolescent SRH services.
viii. Conduct operational research and surveys on adolescent SRH.
ix. Conduct mid-term reviews of policies and laws that influence adolescent SRH and rights.
x. Document and disseminate best practices on ARH interventions.

CHAPTER FIVE

IMPLEMENTATION OF THE STRATEGY

In order to accomplish set objectives for Adolescent Reproductive Health Strategy 2010 – 2015, a comprehensive implementation matrix has been developed. For each strategic objective this framework provides anticipated output, target to be reached and indicator to measure the level of achievement. Activities in this frame work provide a general picture of what needs to be done. As such, implementers will come up with detailed activity plan for specific interventions. MoHSW through RCHS will be responsible to lead implementation of the plan and give adequate support and guidance to all actors interested in ASRH ascertain that set targets are met at all levels by 2015.

5.1 Level of Implementation

Having an effective, efficient and functioning structure is a pre-requisite for ensuring successful implementation of a system strategy. In conformity with the on-going central and local government reforms, the ASRH strategy will be implemented in collaboration with relevant stakeholders, which include related Ministries and agencies, development partners, the civil society, CBOs, FBOs, NGOs and private sector. The management and co-ordination of the strategy will be at national, regional, district and community levels.

5.1.1 National Level

The Ministry of Health and Social Welfare through Reproductive and Child Health Section will be the main co-ordinating body of the Adolescent Reproductive Health Strategy.

Roles and Responsibilities:

- Provision of technical support
- Establishment of advocacy mechanisms for the strategy
- Setting up a monitoring and evaluation mechanism
- Develop/reviewing policies, guidelines and standards
- Identification of relevant research areas
- Dissemination of policies, guidelines and findings
- Undertake Joint planning of activities with all key players and partners and drawing up plans of action
- Sharing lessons learned from all levels of implementation
- Receiving and analysing reports and giving feedback
- Co-ordinating activities of all partners
- Mobilization and leverage of resources
- Capacity building
- Design and develop IEC/BCC materials with stakeholders and disseminate them to the intended users
- Review and harmonise existing HIMS tools in collaboration with the District Councils

5.1.2 Regional Level

The Regional Health Management Team (RHMT) will be responsible for co-ordination of the implementation of Adolescent Reproductive Health Strategy and will provide linkage between the national level and councils.

Roles and Responsibilities:

- Translate/interpret and facilitate implementation of policies and guidelines for the Adolescent Reproductive Health activities as issued by the national level.
- Build necessary capacity for implementation of the strategy in all districts within the region
- Co-ordinate and supervise Adolescent Reproductive Health activities.
- Receive and analyse periodic reports from the Council Management Team (CMT), compile periodic regional implementation reports for submission to the national level and provide feedback to the CMT.
- Provide technical support for effective implementation of ARH programmes at council level.
- Support and promote operational research to address the effectiveness of Adolescent Reproductive Health activities in the region and share results with relevant authorities at all levels.
- Mobilize resources to support implementation of Adolescent Reproductive Health activities.

5.1.3 District Level

The Council Management Team will be responsible for co-ordination and implementation of the Adolescent Reproductive Health Strategy activities in the District. The team will be strengthened in both management and technical skills in order to cope with the added responsibilities. It will identify a focal person who will co-ordinate and facilitate partnership/ collaboration with stakeholders.

Roles and Responsibilities:

- Carry out needs assessment/research on Adolescent Reproductive Health issues specific to the district.
- Ensure implementation of the Adolescent Reproductive Health Strategy according to guidelines and standards for all players in the district
- Co-ordinate, supervise and harmonize all Adolescent Reproductive Health activities implemented by all actors in the district.
- Organize periodic meetings of all implementing partners
- Monitor and evaluate implementation of the Adolescent Reproductive Health Strategy at the district level.
- Compile periodic district reports and share with Regional Health Management Team.
- Provide technical support to all strategy implementers at all levels in the district.
- Mobilize and support Community Owned Resource Persons (CORPS) and Community Based Organizations (CBOs) to plan and implement Adolescent Reproductive Health Strategy.
- Enhance capacity for effective implementation of the Adolescent Reproductive Health Strategy.
- Ensure that Adolescent Reproductive Health Strategy activities are incorporated in the district plans.
- Share lessons learnt, best practices and research findings on ARH with stakeholders for effective collaboration, influencing policy change and improving performance.

5.1.4 Community Level

The Village Development Committee (VDC) or Urban Ward Development Committees (WDC) will be responsible for supervision and implementation of Adolescent Reproductive Health Strategy activities in their respective areas. The committee will be provided with management and technical skills in order to fulfil its obligations.

Roles and Responsibilities:

- Develop ARH work plans
- Mobilize and allocate resources
- Supervise interventions
- Promote parental and community support for adolescents and youths to access information, education friendly health services
- Implement strategy interventions
- Convene community meetings to deliberate on issues and concerns of young people
- Share lessons learned and best practices on ARH
- Monitor the implementation progress of the strategies
- Compile periodic ARH reports

5.2 Partnerships, Co-ordination and Collaboration

In addressing issues and concerns of adolescents, collaboration becomes important. It sets collective norms and expectations of stakeholders and partners, based on the philosophy which emphasizes integration on multi-sectoral and multi-disciplinary approach in addressing ASRH issues. An effective co-ordination mechanism amongst stakeholders thus, requires a forum for regular dialogue and sharing of information on the implementation of the strategy.

5.3 Implementation Framework

Expected Output	Activities	Timeframe (Year 2011 - 2015)					Process Indicators	Responsible
		11	12	13	14	15		
Strategic Objective 1: Strengthened policy and legal environment to support provision of sexual reproductive health information, education, life skills and services for adolescents.								
Output 1 Institutionalised international and Regional Conventions on Sexual Reproductive Health and Rights (SRHR) which are relevant to adolescents in the Government's Policy and Legal Framework. ***Target*** • Adolescent SRH and rights integrated in all national policies, strategies and programmes. ***Indicator*** • Proportion of national policies and laws incorporating adolescent SRH and rights. • Proportion of district/village by-laws supportive of adolescent SRH in place.	1.1.1 Review existing national policies and laws to conform to international/ regional conventions on sexual and reproductive health and rights.	X					Number of laws and policies reviewed.	MOHSW-RCHS, Ministry of Justice and Constitutional Affairs, development partners, media associations.
	1.1.2 Conduct Stakeholders analysis and map key partners in advocating for adolescent SRH at all levels.	X					Number of assessments carried out at national, regional and district Levels. Number of stakeholders mapped as key partners in advocating for ASRHR at all levels.	MOHSW-RCHS Development partners.
	1.1.3 Facilitate formation of adolescent SRH and rights coalition at all levels	X	x	x	x	x	Number of adolescent SRH coalitions at national, regional and district levels formed.	MOHSW-RCHS, development partners, CSOs, private sector, health professional associations, Ministry of Justice and Constitutional Affairs.
	1.1.4 Review/develop/ adapt, print, disseminate and distribute adolescent SRH and rights advocacy messages and materials.	X	X	X	X	X	Number and type of advocacy messages and materials developed. Number of meetings conducted to disseminate and distribute adolescent SRH and rights advocacy messages and Materials. Number of materials distributed No of people attended dissemination meetings.	MOHSW-RCHS
	1.1.5 Advocate for formulation of relevant national laws, district and village by-laws to promote adolescent SRH and rights.	X	X	X	X	X	Number and type of by -laws formulated.	MOHSW-RCHS, Development partners, CSOs, MoCGDC PMO-RALG.
	1.1.6 Advocate for resource mobilization and allocation for adolescent SRH interventions at all levels.	X	X	X	X	X	Amount of resources allocated for ASRH programme in MTEF,CCHP, CSOs.	MOHSW-RCHS MoFEA, CSOs, private sector.

Expected Output	Activities	Timeframe (Year 2011 - 2015)					Process Indicators	Responsible
		11	12	13	14	15		
Output 2 Strengthened capacity of policy/decision makers, programme managers/ supervisors and service providers in implementing policies, laws and regulations that influence adolescent SRH and rights. ***Indicator*** Proportion of policy/ decision makers, programme managers/supervisors implement existing policies and laws. Proportion of regions/ districts with advocacy plan for adolescent SRH and rights. Proportion of service providers oriented on adolescent SRH and rights, policies and laws. ***Target*** • At least two policy/ decision makers, programme managers/supervisors at national, regional and district levels oriented on adolescent SRH and rights, laws and policies • At least two service providers in a facility oriented.	1.2.1 Build capacity of national, regional, district core teams and interested CSOs on advocacy skills.	X	X	X	X	X	Number of core teams with advocacy skills developed.	MOHSW-RCHS MoFEA, CSOs, private sector.
	1.2.2 Support development and implementation of Adolescent SRH and Rights advocacy plan at all levels.	X	X	X	X	X	Number of advocacy plans on adolescent SRH developed and rolled out.	MOHSW-RCHS MoFEA, CSOs, private sector.

Expected Output	Activities	Timeframe (Year 2011 - 2015)					Process Indicators	Responsible
		11	12	13	14	15		
Strategic Objective 2: Increased adolescents' access to, and utilization of integrated quality reproductive health services.								
Output 1 Expanded integration of adolescent friendly services in health programmes (FP, NCH, RH cancers, Safe motherhood, PMTCT, EPI, NACP etc) in public, private, FBOs and NGO service delivery points **Indicator** Proportion of health programmes providing adolescent friendly services. **Target** All reproductive health essential interventions including STIs/HIV.	2.1.1 Conduct rapid assessment of health programmes with integrated adolescent friendly services based on the national standards.	X	X	X	X	X	Number of health programmes for in and out of school with integrated adolescent friendly services assessed.	MoHSW, PMO-RALG, NGOs, FBOs, private sector, development partners.
	2.1.2 Develop/adapt tools for integrated supportive supervision of adolescent friendly service provision at service delivery points.	X					Number and type of tools developed/ adapted.	MoHSW, PMO-RALG NGOs, FBOs, private sector.
	2.1.3 Develop/ adapt/ operationalise a system for outreach, effective referral and networking for adolescent SRH service.	X	X	X	X	X	Referral and networking system for adolescent SRH services developed.	MoHSW, PMO-RALG, NGOs, FBOs, private sector.
	2.1.4 Equip health facilities in public, NGO, FBO and private with essential equipment, materials and supplies for adolescent friendly SRH services.	X	X	X	X	X	Number of facilities in NGO, FBO and Private equipped with essential materials and supplies for adolescent friendly SRH services.	MoHSW, PMO-RALG, NGOs, FBOs, private sector.
	2.1.5 Use Social marketing initiatives to provide sexual reproductive Services and HIV/AIDS to adolescents.	X	X	X	X	X	Number and type of social marketing services provided to adolescents Number of adolescents utilising SRH and HIV services through social marketing.	MoHSW, PMO-RALG, NGOs, FBOs, private sector.

Expected Output	Activities	Timeframe (Year 2011 - 2015)					Process Indicators	Responsible
		11	12	13	14	15		
Output 2 Adolescent friendly SRH in Public, private, FBOs and NGO service delivery points Scaled up. **Indicator** Proportion of service delivery points providing adolescent friendly SRH services. **Target:** Increased number of health facilities providing adolescent friendly RHS from 30% to 80 % by 2015	2.1 Disseminate and distribute the National Standards for Adolescent Friendly Reproductive Health Services to policy/decision makers, programme managers, supervisors and development partners at national, regional, district and community levels.	X	X	X	X	X	Number of policy/ decision makers, program managers, supervisors and development partners at national, regional, district and community levels reached. Number of copies of the National Standards for Adolescent Friendly Reproductive Health Services distributed.	MOHSW (RCH Unit, NACP, Health Service Inspectorate Unit), PMORALG, (RHMT,CHMT), CSO, development partners.
	2.2 Review/develop/ adapt, and print training materials to roll-out implementation of the national standards for adolescent friendly SRH Services.	X	X				Number of national training materials reviewed/developed adapted with reference to the national standards for adolescent friendly RHS services. Number of service delivery points provided with the reviewed national training materials.	MoHSW, PMO-RALG, NGOs, FBOs, private sector.
	2.3 Assess the training needs among various service providers on provision of adolescent friendly SRH.	X	X				Number and type of training needs identified.	MoHSW, NGOs, FBOs, private sector.
	2.4 Build capacity of human resource (TOTs, SPs, Refresher, study/ exchange visit, post training follow-up,) and health facilities in public, CSOs, private to implement the national standards for adolescent friendly SRH services.	X	X	X	X	X	Number of trainers and service providers trained on adolescent friendly SRH services. Number of service providers refreshed in adolescent SRH. Number of exchange visits conducted. Number of post training follow up conducted. Number of service delivery points implementing the national standards. Number of trainers trained in basic and refresh trainings. Number of trainings conducted.	MoHSW, NGOs, FBOs, private sector.

Expected Output	Activities	Timeframe (Year 2011 - 2015)					Process Indicators	Responsible
		11	12	13	14	15		
Output 3 Strengthened human resource development on adolescent friendly SRH service provision for in and pre-service training institutions. **Indicator** Proportion of training institutions with adolescent SRH integrated in the training curriculum. **Target** Increased number of trained service providers on adolescent SRH by 50% by 2015.	3.1 Assess existing national curricula for training various cadres on health to identify gaps on adolescent SRH.	X	X				Number of national training curricula assessed for integration of adolescent SRH.	MOHSW
	3.2 Disseminate findings from the assessment to relevant stakeholders.	X	X				Number of dissemination sessions conducted. Number of stakeholders reached.	MoHSW
	3.3 Review/develop/print and distribute curricula for different levels of health cadres to integrate adolescent SRH.	X	X	X			Number of curricula on adolescent SRH for different cadres in place.	MoHSW.
	3.4 Orient principals of training institutions in health sector on adolescent friendly SRH.		X	X	X	X	Number of Principals from training institutions oriented.	MoHSW, NGOs, FBOs, private sector.
	3.5 Support training institutions in the health sector to roll-out trainings on adolescent friendly SRH services.		X	X	X	X	Number of institutions trainings adolescent SRH.	MoHSW, MOVT MOLY.

Expected Output	Activities	Timeframe (Year 2011 - 2015)					Process Indicators	Responsible
		11	12	13	14	15		
Strategic Objective 3: Positive attitudes and behaviour change promoted among adolescents, parents and the community on adolescent friendly reproductive health services.								
Output 1 Improved community practices for adolescent SRH information, education and services. **Indicator** Proportion of adolescents, parents and communities adopting positive attitudes and behaviours on adolescent SRH at all levels. **Target** Parents, lay counsellors, influential and community leaders supporting adolescent SRH services . Increased number of parents, lay counsellors, influential community leaders supporting adolescent SRH by (%) by 2015.	1.1 Conduct KABP and secondary data analysis to identify priority issues and concerns on adolescent's access to SRH information, education and services, including gaps in most vulnerable adolescent groups.	X	X				Number and type of adolescent SRH priority issues identified.	MoHSW (lead partner), MoEVT MCDGC,MLEYD, NGOs, CBOs.
	1.2 Disseminate KABP findings to stakeholders.		X				Number of dissemination sessions conducted. Number of stakeholders reached.	MOHSW, NGOs FBOs, Private sectors
	1.3 Develop, print, disseminate and distribute national communication strategy for adolescent SRH program.	X	X	X	X		National communication strategy on adolescent SRH developed, printed and distributed.	MoHSW And partners.
	1.4. Review/develop/ adapt/ print and distribute IEC/BCC materials on adolescent SRH.	X	X	X	X	X	Number and types of Materials reviewed, developed, adapted, printed and distribute.	MoHSW, NGOs And partners.
	1.5. Develop, print and disseminate implementation guidelines for the formation of parent and community support groups.	x	X	X	X	X	Number of guidelines printed disseminated.	(MOHSW), NGOs FBOs, Private sector, Local Govt
	1.6. Conduct TOTs for parents and community support on adolescent SRH.		X	X	X	X	Number of TOTs Trained.	MOHSW, NGOs, FBOs, Private sectors, Local Govt
	1.7. Build coalition and network for parent and community support initiatives.	X	X	X	X	X	Number and type of coalition and network formed	MOHSW, NGOs, FBOs, Private sectors, Local Govt.
	1.8. Conduct supportive supervision of parent and community support groups initiatives.	X	X	X	X	X	Number of supportive supervision visit conducted.	MOHSW, NGOs FBOs, private sector.
	1.9. Scale up formation of parent support groups to enhance their knowledge and skills in communicating adolescent SRH issues.		X	X	X	X	Number of parent support groups formed and scaled up.	MoHSW, NGOs FBO, Private sector.
	1.10. Conduct community sensitization activities and mobilize resources to create and maintain support of adolescent SRH at the community level.	X	X	X	X	X	Number of community sensitisation activities conducted. Number and type of target audience reached.	MoHSW, NGOs FBOs, private sector.
	1.11. Scale up the provision of information and advice to young people delivered by (CORPS) e.g. lay counsellors and peer educators.		X	X	X	X	Number of lay and peer educators functioning at community levels.	MoHSW, FBOs, NGOs Private sector.

Expected Output	Activities	Timeframe (Year 2011 - 2015)					Process Indicators	Responsible
		11	12	13	14	15		
Output 2 Demand for SRH services by adolescents expanded. **Target** To reach all adolescents according to stages of development, SRH needs and problems, in different settings and circumstances. **Indicator** Proportion of adolescent reached with SRH information and services	2.1. Roll out Social marketing initiatives on Adolescent SRH services e.g. Condoms for dual protection and family planning commodities.		X	X	X	X	2.1.1. Number of institutions involved in social marketing of specific products i.e. condoms and family planning commodities	MoHSW, NGOs, FBOs, Private sector.
	2.2. Roll out adolescent SRH communication interventions delivered by CORPS e.g. lay counsellors, peer educators, village health workers using national guidelines and standards.		X	X	X	X	Number and type of Adolescent SRH communication interventions conducted	(MOHSW-Deleted) NGOs, FBOs, Local Govt, private sector.
	2.3. Design and conduct outreach services for adolescents to promote up take of SRH services e.g. Friendly SRH service, safe male circumcision.	X	X	X	X	X	Number of outreach services designed and conducted. Number of adolescents reached by campaign messages and materials.	MOHSW, NGOs, FBOs Private sectors, Local Govt
	2.4. Orient teachers to provide SRH information and advice to adolescents in a friendly manner and appropriately refer them for health services.	X	X	X	X	X	Proportion of teachers oriented on adolescent friendly SRH.	MOHSW, MOET NGOs, FBOs Private sectors Local Govt
Output 3 Improved life skills education for adolescents in and out of school on SRH **Target** All adolescents **Indicator** Proportion of in and out of school adolescents equipped with life skills education on SRH	3.1 Review/ adapt/ harmonize, print, disseminate and distribute national life skills training materials for adolescent on SRH.	X	X	X			Number of training manuals reviewed/ harmonized/ printed, disseminated and distributed to stakeholders.	MOHSW-RCHS, Development partners, MoEVT, MLEYD, NGOs, Private sector.
	3.2 Conduct TOTs for application of harmonized approaches for delivering life skills related to adolescent SRH.	X	X	X	X		Number of TOTs Trained.	MOHSW, NGOs, FBOs, MoEVT, MLEYD, Private sectors, PMO-RALG
	3.3 Harmonize/print/ distribute IEC/BCC materials on life skills related to ASRH in line with national documents.	X	X	X	X	X	Number and types of IEC/ BCC materials harmonized, printed and distributed.	MOHSW, NGOs, FBOs, Private sectors, Local Govt.
	3.4 Support the implementation of life skills education using national training documents and IEC/ BCC materials.	x	x	X	X	X	Number and type of target audiences reached by different approaches.	MOHSW, MOEt, NGOs, FBOs, Private sectors Local Govt.

Expected Output	Activities	Timeframe (Year 2011 - 2015)					Process Indicators	Responsible
		11	12	13	14	15		
Output 4 Improved skills of lay counsellors to provide Psychosocial support to adolescents. **Indicator** Proportion of lay counsellors with skills on psychosocial support to adolescents. **Target** At least 2 lay counsellors (male and female) per village.	4.1 Develop guidelines and standards for training lay counsellors.	X	X				Number of guidelines and standards developed.	MOHSW
	4.2 Develop training materials for lay counsellors.		X				Number and types of materials developed.	MOHSW, NGOs, CBOs, FBOs.
	4.3 Disseminate and distribute training materials for lay counsellors.		X	X	X	X	Number and types of materials disseminated and distributed.	MOHSW, NGOs, CBOs, FBOs, PMO-RALG, private sector.
	4.4 Train TOTs (including refresher training)		X	X			Number of TOTs trained	MOHSW
	4.5 Conduct counselling services and referral on adolescent SRH.		X	X	X	X	Number of target audiences reached for counselling services. Number of target audiences referred for SRH services.	NGOs, CBOs, FBOs, PMO-RALG, private sector.
	4.6 Conduct monitoring, supervision and evaluation of lay counselling activities.	X	X	X	X	X	Number and types of monitoring, supervision and evaluation activities conducted.	MOHSW, NGOs, CBOs, FBOs, PMO-RALG, private sectors.

Expected Output	Activities	Timeframe (Year 2011 - 2015)					Process Indicators	Responsible
		11	12	13	14	15		
Strategic Objective 4: Strengthened capacity for more effective and efficient management, resource mobilisation and scaling up of adolescent friendly SRH programmes.								
Output 1 Improved coordination, management and partnership mechanisms of adolescent SRH programmes at all levels. **Indicator** Proportion of regions, districts with coordinated response mechanisms for adolescent SRH programme. **Target** National level and regions/ districts with a joint plan to scale up adolescent friendly SRH services by 50% by 2015.	1.1 Conduct an assessment of Institutional Capacity needs for planning and managing adolescent SRH services.	X	X				Number and types of ARH management Capacity needs identified.	MoHSW
	1.2. Disseminate result on assessment of Institutional Capacity needs for planning and managing adolescent SRH programmes.	X	X				Results on assessment of institutional capacity needs for planning disseminated. Number of sessions conducted to disseminate the results. Number of institutional representatives reached.	MoHSW/RCHS, PMO-RALG.
	1.3. Develop a comprehensive plan for building capacity on management of key adolescent SRH programme areas.	X	X				ARH Comprehensive plan for building capacity on management developed.	MoHSW PMO-RALG
	1.4. Develop adolescent SRH training program and materials for stakeholders (public, NGOs, FBOs, private sectors) at all levels.	X	X				Adolescent SRH training program and materials developed.	MoHSW PMO-RALG
	1.5. Conduct TOT for stakeholders in management of adolescent SRH programme.		X	X			Number of TOTs in ARH management trained.	MoHSW PMO-RALG
	1.6. Develop monitoring and performance award plan for ARH programs.	X					Monitoring and performance award plan for adolescent SRH program developed.	MoHSW/RCHS, CSOs, private sector, PMO-RALG
	1.7. Build capacity for planning, implementation and resource mobilization for scaling up adolescent friendly SRH services.		X	X	X		Capacity built for planning, implementation and resource mobilisation for scaling up adolescent friendly SRH services. Number and types of adolescent SRH interventions conducted. Amount of resources mobilised.	MoHSW, Civil Society organizations, Private sector, PMO-RALG.
	1.8. Conduct quarterly, bi-annual, annual joint planning, coordination and review meetings with adolescent SRH stakeholders at all levels (national, regional, districts, and community).		X	X	X	X	Number of coordination and review meetings conducted.	MoHSW, PMO-RALG
	1.9. Establish/consolidate ASRH technical working groups at National, regional and district levels.	X	X	X	X	X	Adolescent SRH technical working groups established at the national, regional and district levels.	MoHSW/RCHS, RHMTs, CHMTs

Expected Output	Activities	Timeframe (Year 2011 - 2015)					Process Indicators	Responsible
		11	12	13	14	15		
Output 2 Established sustained mechanism for resources mobilization to scale up adolescent SRH programme. **Indicator** Proportion of resources mobilized and allocated for the key components of adolescent SRH programme. **Target** Resources mobilised/ leveraged in public, CSOs, private sector for the key component to increase coverage of adolescent SRH services.	2.1 Develop mechanism to mobilise/ leverage resources for the key components of adolescents SRH programme at all levels.	X	X	X	X	X	Mechanism to mobilise/ leverage resources developed. Amount of funds mobilised. Number of adolescent SRH staff deployed.	MoHSW/RCHS Civil Society organizations, Private sector, PMO-RALG.
	2.2 Implement financial plan on resource mobilization for adolescents reproductive health program at all levels.	X	X	X	X	X	Number and type of adolescent SRH interventions implemented.	RCHS/MoHSW, PMO-RALG, CSOs, private sector.
Output3 Strengthened advocacy to support adolescent SRH programmes. **Indicator** Proportion of stakeholders with capacity to advocate and support adolescent SRH programme. **Target** At least 2 stakeholders from relevant sectors competent in advocating for adolescent RSH.	3.1 Implement adolescent SRH advocacy strategy guidelines to enforce policies, solicit support of gate keepers and build linkages with other sectors.	X	X	X	X	X	Number and type of advocacy strategies and guidelines to enforce polices implemented.	MoHSW/RCHS, CSOs, private sector, PMO-RALG, adolescents and youth, parents, teachers.
	3.2 Train media practitioners on adolescent SRH and establish mechanisms for their involvement.	X	X	X	X	X	Number of media practitioners trained.	RCHS/MoHSW, CSOs, private sector, PMO-RALG.
	3.3 Consolidate clearing house/ resource centre for IEC/BCC materials on adolescent SRH and reports on best practices at all levels (national, regional, district, and community.	X	X	X	X	X	Number of clearing houses /resource centres with adolescent SRH IEC/BCC activities Established.	RCHS/MoHSW, CSOs, private sector, PMO-RALG.
	3.4 Disseminate best practices and lessons learnt in adolescent SRH programme.	X	X	X	X	X	Number and type of adolescent SRH best practices and lessons learned disseminated.	RCHS/MoHSW, CSOs, private sector, PMO-RALG.

Expected Output	Activities	Timeframe (Year 2011 - 2015)					Process Indicators	Responsible
		11	12	13	14	15		
Output 4 Strengthened formal and informal linkages between health institutions and non health institutions to address adolescent needs holistically. **Indicator** Proportion of formal and informal linkages on adolescent SRH. **Target** At least 2 institutions providing needed support for adolescents and youth at all levels (national, district and community).	4.1 Update inventory of adolescent SRH implementing partners in the formal and informal sectors.	X	X	X	X	X	Number of adolescent SRH implementing partners updated.	MoHSW/RCHS CSOs, private sector, PMO-RALG, adolescents and youth, parents, teachers.
	4.2 Integrate adolescent SRH in organised youth groups in the formal and informal settings.	X	X	X	X	X	Number of organised youth groups that have integrated SRH interventions in their activities.	MoHSW/RCHS CSOs, private sector, PMO-RALG, adolescents and youth, parents, teachers.
	4.3 Build formal and informal linkages between health services and non health programmes that address adolescents' needs.	X	X	X	X	X	Number of linkages/ networks established.	MoHSW/RCHS CSOs, private sector, PMO-RALG, adolescents and youth, parents, teachers.
	4.4 Secure community involvement and interest in adolescent SRH through sensitisation meetings and community events.	X	X	X	X	X	Number of community meetings/ events conducted.	MoHSW/RCHS CSOs, private sector, PMO-RALG, adolescents and youth, parents, teachers.

Expected Output	Activities	Timeframe (Year 2011 - 2015)					Process Indicators	Responsible
		11	12	13	14	15		
Output 5 Research, monitoring and evaluation framework for adolescent reproductive health developed and implemented. **Indicator** Monitoring and evaluation framework for adolescent SRH program in place and operational/ used 2% of health facilities with adolescent SRH data incorporated into HIMS. **Target** Comprehensive monitoring and evaluation system for adolescent SRH operational by mid 2015	5.1. Orient programme managers and supervisors (in Public, Private CSOs,) on monitoring adolescent friendly SRH interventions.	X	X	X	X	X	Number of managers and supervisors oriented on monitoring adolescent SRH interventions.	MoHSW, RHMTs CHMTs, Development partners
	5.2.Develop ARH component of Health Information Management System (HIMS) at all levels.	X	X				Number and type of adolescent SRH data incorporated into HIMS.	MoHSW, RHMTs, CHMTs, development partners.
	5.3 Orient HSP on the use of updated HIMS adolescent SRH component.		X	X	X	X	Number of providers oriented on updated adolescent SRH HIMS.	MoHSW, RHMTs, CHMTs, Development partners
	5.4 Develop/adopt, print, disseminate and distribute supervisory checklist for ASRH activities.	X	X	X	X	X	Number of supervisory checklist developed, adopted, printed and distributed.	MoHSW, RHMT/CHMT, Development partners
	5.5 Support capacity building on adolescent SRH supervisory activities at all levels.	X	X	X	X	X	Number of people trained on adolescent SRH supervision. Number and type of supervisory capacity building activities provided.	MoHSW/RCHS
	5.6 Conduct quarterly supportive supervision of adolescent SRH at all levels.	X	X	X	X	X	Number of supportive supervision conducted	MoHSW/RCHS RHMT/CHMT
	5.7 Orient managers, supervisors and service providers on quality assurance/ improvement methods for adolescent SRH services.	X	X	X	X	X	Number of managers, supervisors and service providers oriented on quality assurance/ improvement.	MoHSW/RCHS RHMT/CHMT CSOs
	5.8 Conduct operational research and surveys on adolescent SRH.	X	X	X	X	X	Number and type of operational researches conducted and reports produced and disseminated.	MoHSW/RCHS M&E Unit and research institutions.
	5.9 Conduct mid-term reviews of policies and laws that influence adolescent SRH and rights.		X			X	Number of laws and policies reviewed.	MOHSW-RCHS, media associations, development partners, Ministry of Justice and constitutional affairs.
	5.10 Document and disseminate best practices on ARH interventions.	X	X	X	X	X	Number of best practices documented and disseminated.	MoHSW/RCHS (M&E Department), relevant CSOs.

CHAPTER SIX

MONITORING AND EVALUATION

Monitoring and evaluation (M&E) will be conducted to track progress and identify gaps to be address at different levels of implementation of the strategy. The process is expected to strengthen and implementation of various adolescent sexual and reproductive programmes by generation necessary information for decision-making and action in different area. Furthermore results from monitoring and evaluation will also be used to solicit support for adolescent SRH programmes, from stakeholders including community leaders and gatekeepers. Both monitoring and process evaluation will be conducted routinely by managers, supervisors and service providers and beneficiaries to track activities and measure performance. Outcome and impact evaluation will be conducted midway and at the end of the 5-year implementation period to measure results and impact. The Results Matrix below highlights important indicators for measure in line with the four strategic objectives and the expected outcomes from implementation of the strategy.

6.1 Results Matrix

Outputs	Indicators of results	Means of verification	Assumptions
Strategic Objective 1: Strengthened policy and legal environment to support provision of sexual reproductive health information, services and life skills for adolescents. **Expected outcome:** Supportive Policy environment and legal framework to effectively address health and development issues and rights of adolescents			
1. Institutionalized international and Regional Conventions on Sexual Reproductive Health and Rights (SRHR) which are relevant to adolescents in the Government's Policy and Legal Framework.	• Proportion of national policies and laws incorporating adolescent SRH and rights. • Proportion of district/village by-laws supportive of adolescent SRH in place.	• National Policy and Laws document availability for implementation • Policy, decision makers programme managers supervisors implementation report • Advocacy plan for adolescent SRH available for implementation. • Report of service provider oriented on adolescent SRH rights laws, and policies.	• Government compliance of the UN 2 and Regional conventions on Sexual reproductive health and rights. • Government commitment to support adolescent SRH programmes. • Basket fund available for adolescent SRH interventions. • Commitment by donors/ partners. • Relevant ministries and regulating bodies willing to review and harmonize existing policies and laws that influence adolescent SRH. • Willingness of district and village councils to re-enforce policies and laws that is supportive of adolescent SRH rights

Outputs	Indicators of results	Means of verification	Assumptions
2. Strengthened capacity of policy/decision makers, programme managers/supervisors and service providers in implementing policies, laws and regulations that influence adolescent SRH and rights.	• Proportion of policy/ decision makers, programme managers/supervisors implement existing policies and laws.	• ASRH Orientation implementation reports	• Willingness of policy decision makers, program to advocate for ASRH rights
Strategic Objective 2: Increased adolescent's access and utilization of innovative, integrated and high quality friendly reproductive health services. **Expected outcome:** Confident adolescents who have access to health services and programmes, and are utilizing them effectively			
1. Expanded integration of adolescent friendly services in health programmes (FP, NCH, RH cancers, Safe motherhood, PMTCT, EPI, NACP, etc) in public, private, FBOs and NGO service delivery points.	• Proportion of health programmes providing adolescent friendly services.	• Services Statistic • Supervision and monitoring reports • Resources for updating knowledge and skills of managers, supervisors and service providers on adolescent SRH available. • Human Resource for Health Strategic Plan	• Availability Service providers to be trained on adolescent friendly SRH services. • Collaborative and cooperation among CSO and private sector will continue to exist. • Parent and community willing and committed to support the provision of adolescent friendly SRH Services. • Availability of funds for Social Marketing of Adolescent friendly SRHG Services
2. Adolescent friendly SRH in Public, private, FBOs and NGO service delivery points Scaled up.	• Proportion of service delivery points providing adolescent friendly SRH services.	• Service statistic • Service availability mapping	
3. Strengthened human resource development on adolescent friendly SRH service provision for in and pre-service training institutions.	• Proportion of training institutions with adolescent SRH integrated in the training curriculum	• Training with adolescent friendly ASRH component available to implementation	

Outputs	Indicators of results	Means of verification	Assumptions
Strategic Objective 3: Positive attitudes and behaviour change promoted among adolescents, parents and the community to improve adolescent friendly reproductive health services. **Expected Outcome**: • Confident well-informed, healthy and well developed adolescents that are able to adopt positive behaviour to cope with demands and challenges of everyday life. • Supportive community members who are committed to the promotion of adolescent health and development			
1. Improved community practices for adolescent SRH information, education and services.	• Proportion of adolescents, parents and communities adopting positive attitudes and behaviours on adolescent SRH at all levels.	KABP report	• Gate keepers of adolescent to SRH rights willing to change. • Parent and community acceptance of adolescent access to SRH information, education and service guaranteed. • District and Community leaders willing to provide support for adolescent SRH information, education and services. • People willing to be trained as CORPs e.g. lay counsellors, peer educators. • Increase in coverage and of electronic media • Continuity of supplies/supplies for Social Marketing Services
2. Demand for SRH services by adolescents expanded.	• Proportion of adolescent reached with SRH information and services	Programme	
3. Improved life skills education for adolescents in and out of school on SRH	• Proportion of in and out of school adolescents equipped with life skills education on SRH	Project reports	
4. Improved skills of lay counsellors to provide Psychosocial support to adolescents.	• Proportion of lay counsellors with skills on psychosocial support to adolescents.		

Outputs	Indicators of results	Means of verification	Assumptions
Strategic Objective 4: Strengthened capacity of programme management to deliver effective and efficiency adolescent reproductive health services **Expected Outcome**: Sustainable cost effective results through skilfully managed adolescent health and development programme			
1. Improved coordination, management and partnership mechanisms of adolescent SRH programmes at all levels	• Proportion of regions, districts with coordinated response mechanisms for adolescent SRH programme.	• Programme statistic • Special reports • Facilities HMIS reports	• The government will continue to support ARH programme • Government, development partners will commit funds to support human resource development for ARH program • Village government will rate adolescent SRH as one of the priorities for support. • Owners of health service delivery points willing to offer and commit funds for adolescent friendly SRH services. • The government, development partners, business community and individuals will commit funds to support ARH programme.
2. Established sustained mechanism for resources mobilization to scale up adolescent SRH programme	• Proportion of resources mobilized and allocated for the key components of adolescent SRH programme.		
3. Strengthened advocacy to support adolescent SRH programmes	• Proportion of stakeholders with capacity to advocate and support adolescent SRH programme.		
4. Strengthened formal and informal linkages between health institutions and non health institutions to address adolescent needs holistically.	• Proportion of formal and informal linkages on adolescent SRH		
5. Research, monitoring and evaluation framework for adolescent reproductive health developed and implemented.	• Monitoring and evaluation framework for adolescent SRH program in place and operational/ used 2% of health facilities with adolescent SRH data incorporated into HIMS.		

CHAPTER SEVEN

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