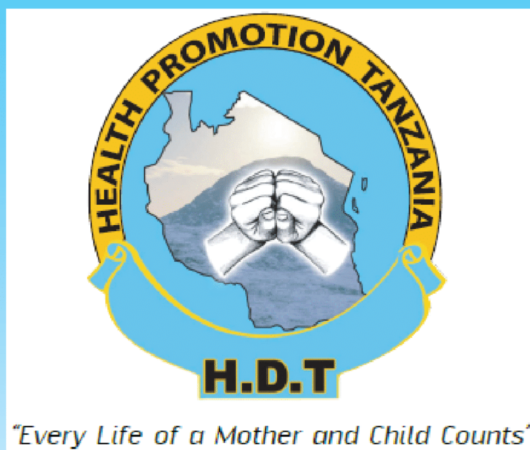
ACHIEVEMENT REPORT

July 2019 to June 2020



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Acronyms and Abbreviations

ANC	Antenatal Care
CHW	Community Health Worker
CHMTs	Council Health Management Team
CPR	Contraceptive Prevalence Ra te
CSC	Community Score Cards
CTC	Care and Treatment Clinic
DLI	Disbursement Linkage Indicator
DHIS	District Health Information System
FSW	Female Sex Workers
HDT	Health Promotion Tanzania
HIV	Human Immunodeficiency irus
HJFMR	Henry Jackson Research Medical Foundation
KP	Key Population
PAI	Population Action International
PEPFAR	The President's Emergency Plan For AIDS Relief
PORLAG	President's Office, Regional Administration and Local Government
PPFP	Post-Partum Family Planning
RHMT	Regional Health Management Team
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
TB UN HLM	Tuberculosis United Nations High Level Meeting

Letter from Executive Director

First and foremost, I would like to thank the Board of Directors and staff of Health Promotion Tanzania (HDT) who have collec- tively made this work possible. I would like in particular to thank our donors who have supported our work in the past year including Bill and Melinda Gates Foundation/ Johns Hopkins University, Population Action International (PAI), Result Educa- tion Fund, Comic Relief/ RESULTS UK, USAID|BORESHA Afya and PEPFAR|H-JFMRI. I would like to thank the Govern- ment of Tanzania in particular Ministry of Health Community.

Development, Gender, Children and Elderly and PORALG for their cordial support throughout the year. I salute a multitude of volunteers who have worked with us to achieve the results we will present in this report.

We at Health Promotion Tanzania dream that all Tanzanians are healthy and are responsiblefor their health, but this is yet to be the case. We have no better ways of restating the vision of fourth Health strategic plan "Reaching all households with quality health care", and it remains import- ant. Hindsight this ostentatious goal, financing the health sector to achieve it has remained far from expected. For example, government budget share has fallen from double digit (11.5%) in 2015/16 to single digit (7.8%) in year 2020. Correspondingly health sector allocation in year.

2019/2020 was only 38% of Health Sector Strategic Plan IV annual estimates. This reminds us of wisdom by William Hutchinson Murray who said, *"Until one is committed, there is hesitancy, the chance to draw back, always ineffectiveness….the moment one definitely commits himself, the providence moves, too."* There seem to be some hesitancy to provide reasonable funding for health. In our rightful positions, we will continue to advocate that this becomes a concern for everyone.

We look forward to applying human centered approaches and work around policies, capacities and resources to support Tanzania's ambitious journey towards universal health access. We similarly look forward to seeing allocation and disbursement efficiency of both donor and domestic funding on health that is needed to achieve the targets of the Health Sector Strategic Plan V (HSSP V).

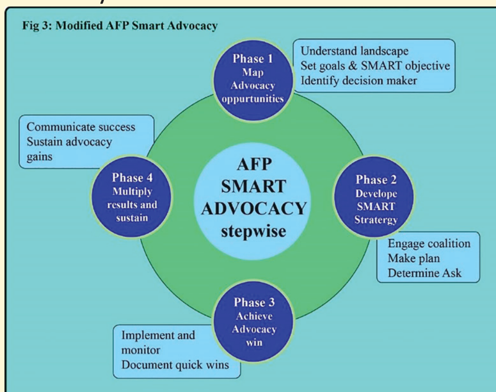
With kind regards.
Peter Bujari,
Executive Director

1.0. About Health Promotion Tanzania

Health Promotion Tanzania, commonly known as HDT is a local not-for-profit Non-Government Organization (NGO), legally registered in Tanzania bringing over 14 years of experience in managing Reproductive, Maternal, Newborn and Child Health through community-based interventions and strategically tailored advocacy. Over the 14 years, HDT has constantly envisaged to improve the lives of mothers, children, and adolescents through its operations using a resul-tbased human centered approach to plan and implement innovative, community and national level-based interventions that have proven to yield positive outcomes. Health Promotion's experience is informed by community led initiatives through our field-based offices, national level through our engagement in national policy, strategy and budget processes and internationally through our partnership in ACTION Global Health Advocacy Partnership (www.action.org). This blend of experience is not always easy to find among local organization peers.

Our implementation of Reproductive, Maternal, Newborn and Child Health programs is in support to the Government of Tanzania and thus aligns to with Tanzania Strategic Plan to Improve Reproductive, Maternal, Newborn, Child and Adolescent Health in Tanzania One Plan II (2016 - 2020) and SDGs which aims at ending maternal, newborn, child and adolescent deaths by 2035. Our programmatic experience in RMNCAH spans directly in two organiza- tional pillars areas namely Community Systems Strengthening and Policy advocacy. RMNACH therefore forms the pivot of organization mission and motto "Every life of mother and child counts". Our vision is healthy and responsible society and we envisage to achieve this through our mission "To use Result based-human centered approaches to design and implement innovative community and national level-based health related interventions that impact on maternal, newborn, child health and youth".

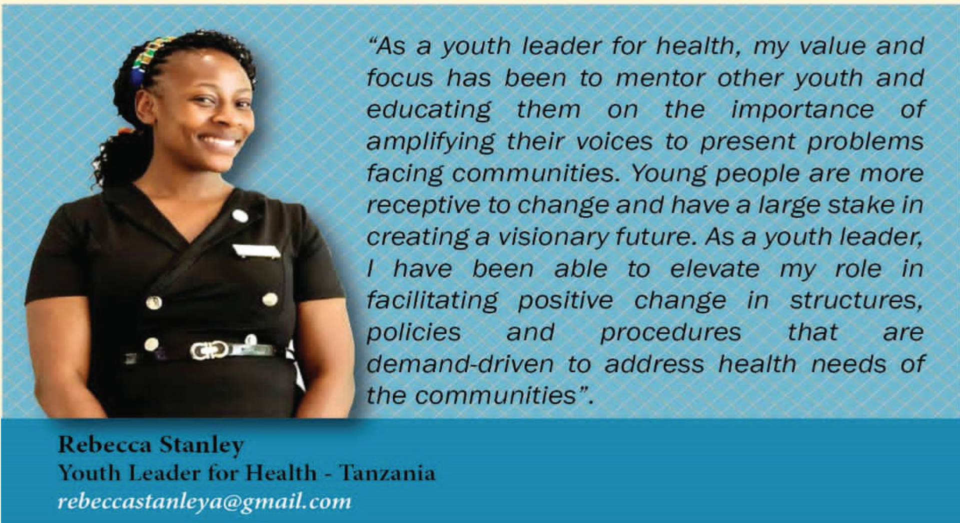
Health Promotion Tanzania has good track records in evidence-based advocacy at regional, national and subnational level, all these informed by evidence either directly from community system strengthening and or research and literature reviews. Our advocacy rubric is decision maker centered using Advance Family Planning Advocacy SMART (AFP SMART®) that targets Right Decisionmaker with Right Message at Right time. AFP SMART assumes that decision makers will act on compelling evidence that is presented in an accessible way by a credible messenger. Our approach is therefore tailoring evidence-based messages to decision makers and building the skills of champions to maintain a regular drumbeat of interaction and information to raise the profile and funding of TB.



2.0. The Value of Engaging youth advocates

Of interest and new in this report is engaging youth as leaders in health system advocacy. It has opened a whole new chapter to value and cherish every moment that we have mentored youth as leaders for Health, their enthusiasm in engaging a cross section of communities to national level and global scal e. With limited funding among youth, COVID -19 has become an opportunity in a way that youth leaders have be en able to engage at lower cost. We have all appreciated what late Nelson Mandela said *“...... It is what we make out of what we have, not what we are given, that separates one person from another.* ***Young people*** *must take it upon themselves to ensure that they receive the highest education possible so that they can represent us well in future as future leaders......”*

In successful advocacy history of HDT, it became critical to apply Nelson Mandela principle of leadership. We therefore carefully identified and trained ten youth leaders, provided them with opportunities and allowed them to move in health system advocacy. This program has chal- lenged other youth training programs to move from rhetoric to hands on mentoring- a seed that multiplies. Rebecca Stanley, a youth leader for health puts it in best way to recon with.



Working with and mentoring youth is like irrigating a growing seed-that grows overnight to triumph day to day challenges of access to better health. One lasting mile phrase that has moved us a long way was one given by youth leader Mr. Nelson Telekela in November 2019 “...Sit- oshindwa....” Translated as “I will not fail”. We could not have selected and trained a better group of youth leaders and we remain proud to be part of their journey, we continue to cherish every key moments of youth leaders for health work in Tanzania and we commit to continue being supportive in the best ways possible.

3.0. Policy Advocacy Achievement

3.1 Introduction

Health Promotion Tanzania is a local not for profit non-governmental organization that has over 12 years' experience in advocacy through the application of SMART approach. HDT has become a household name in the country, reputable in mobilizing other partners to attain outcomes in health through SMART advocacy - an evidence-based decision maker-centered approach that stresses on right timing, right message, and right target for advocacy interventions. With the SMART advocacy approach, HDT has been on the frontline to advocate for domestic financing for TB, HIV, improved quality of reproductive, maternal, newborn and child health as well as enhancing accountability through mobilizing CSOs.

Even though advocacy takes time to yield results and realize impact, the SMART advocacy approach takes note of quick wins that eventually build up to attaining positive health outcomes. In the period of July 2019 to June 2020, Health Promotion Tanzania has recorded a number of achievements as clearly elaborated below.

3.2 Scaled up provision of Post-Partum Family Planning uptake in the region of Tabora.

According to the Tanzania Demographic Health Survey of 2015/16, Tabora is one of the regions with the lowest CPR of 21% which is below the national average of 32%. With such trends, the National Family Planning Costed Implementation Plan II (NFP-CIP II) lays out strategic interventions that support and guide regions like Tabora to boost their contraceptive uptake. One among the identified strategic interventions for Tabora region is the scale up of Post-Partum Family Planning (PPFP). Text box 1 summarizes key.

Text box 1: CIP recommended Priorities

The CIP (II) recommends three key drivers of mCPR in Tabora as:

(1) Improve uptake of **Post-partum family planning** (defined as up to 12 months after birth)

(2) Address **social norms** that hinder individuals from using contraception to delay, space, or limit births

(3) **Reduce stock-outs** at facilities to offer clients a full range of contraceptive

Health Promotion Tanzania (HDT) with support from the Advance Family Planning supported the region of Tabora in the use of their own data to inform planning and prioritization of PPFP. While the region has made significant thrives towards improving RMNCAH services such as (a) increase of facility delivery, (b) ante-natal care clinic attendance and post-natal care; modern contraceptive prevalence rate remained lagging behind. Through a collaborative approach HDT supported RHMTs and CHMTs to analyze RMNCAH data, develop trends of performance, identify bottlenecks, and develop strategic interventions in line with the NFP-CIP II.

Additionally, Health Promotion Tanzania conducted a series of advocacy meetings with the RHMTs and CHMTs to advocate for scale up of Post-Partum Family Planning in at least 10 health facilities. The advocacy meetings went hand in hand with knowledge and capacity building on the importance of family planning and how family planning can improve lives and contribute to avert maternal mortalities. As a result, Tabora's Regional Medical Officer – Dr. Honoratha F. Rutatinisibwa issued a directive (Text box 2) to all Local Government Authorities (LGA) to increase family planning uptake to up to 40% by prioritizing PPFP. In the directive, the Regional Medical Officer advised LGAs to scale up number of community outreach and make efficient use of PPFP trained healthcare providers during the community outreach services.

Text box 2: TABORA PPFP DIRECTIVE

1. ALL RCH facilities to introduce and scale up PPFP services after delivery and 12 months post-delivery.
2. All districts with limited number of trained healthcare providers on PPFP service provision should utilize the currently trained healthcare providers in their monthly community outreach programs.
3. Increase Family Planning method mix and address PCIUD stock out by ordering from Tanzania Medical Stores Department.
4. All councils should increase enrollment of iCHF through community outreach and CHMTs regular monitoring.
5. Increase Family Planning coverage from the current 53% to 60% by December 2020.

As a result, in June 2020 District Health Information system (DHISII) indicate that family planning uptake increased from 53% to 60%, while PPFP uptake increased from 4.9% in December 2019 to 7.1% in June 2020. These remarkable achievements were largely contributed by the regional government efforts to scale up facilities providing PPFP from 3 in 2019 to 11 in 2020 and 81 healthcare providers were trained on the provision of PPFP.

3.3 Strengthened CSOs engagement in the GFF processes and mechanisms

Health Promotion Tanzania (HDT) being the secretariat for the CSO-GFF coordinating group, has been on the frontline to mobilize CSOs, build their capacity and spearhead advocacy initiatives by influencing the Government at the central and regional level to achieve and meet the end targets of the World Bank's funded program "Strengthening Primary Healthcare for Results". The engagement in the GFF processes kicked off in 2017 and steadily took pace in 2018 after the formation of the CSO- GFF coordinating group – a coalition of 20 CSOs from 8 regions whose aim is to enhance accountability for the Global Financing Facility program "Strengthening Primary Healthcare for Results"

Tanzania benefit $306 million from the GFF but disbursement of those resources depended

on the performance of the pre-determined indicators. Table 1 below summarize the disbursement status as if June 2020. CSOs have closely followed up grant performance for accountability purposes.

Table 1: GFF Financing and disbursement in Tanzania

Financier	Amount (USD Mil)	Disburse	%	Remaining USD Mil
IDA	200	172.18	86%	28.78
GFF TF	40	29.57	74%	10.43
USAID TF	46	3.98	8.7%	42.02
PoN TF	20	11.43	57%	8.57%
Totals	**306**	**217.16**	**70.9%**	**88.84%**

For that to be done, Health Promotion Tanzania (HDT) has been on the frontline to build the capacity of CSOs in the following dimensions. For CSOs to do accountability role, capacity building as shown in figure 1 below.

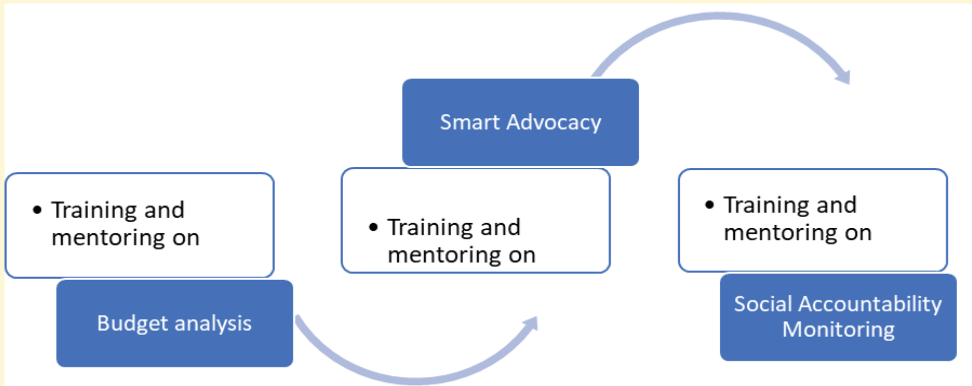


Figure 1: Capacity building to CSOs

While in the previous year's CSOs have been trained on budget analysis, budget tracking, accountability and advocacy there still remains to be a great capacity need to foster CSOs meaningful engagement. Health Promotion Tanzania being the secretariat for the CSOs GFF coordinating group took lead to conduct a 5-day extensive training on budget analysis, advocacy and accountability followed by 3-day refresher training; both trainings aimed at ensuring CSOs have the adequate knowledge and tools to generate evidence through budget analysis and tracking. Thus, CSOs were capacitated on the appropriate use of the Government's budget books, tracking the proportion of health budget out of the national budget, proportion of government financing against donor funding and the use of tools to determine trends of allocations, disbursements, and expenditure.

Understanding that decision makers (government and donors) are at the center of GFF processes, it became of necessary to train, coach, and mentor CSOs on influencing policies and actions through the use of SMART advocacy approach. An approach that calls for non- confrontational, yet evidence based driven focusing on the ***right decision makers***, with the ***right message*** and at ***right time***. Even though the training focused on regional CSOs from the regions of GFF implementation, the training was strategically conducted in Dodoma to provide an exclusive yet rare chance for CSOs to make use of the knowledge gained by advocating for GFF/RMNCAH as guided by evidence from the GFF Analysis

Report. The report showed that in five years of implementation, only 65.1% had been disbursed and 34.9% was to be spent within the one-year extension.

(CSOs training in Dodoma and Mwanza)

This requires advocacy to ensure increased disbursement, spending and reporting. While it is clear that the positive performance of GFF cannot be completely owned by CSOs advocacy and accountability initiatives, their role remains crucial in influencing Local Government Authorities (LGAs) in the 8 regions of GFF to meet the targets set in the Disbursement Linked Indicators. ***(See table 2***)

Table 2: GFF Disbursed Linked Indicators.

Priority Area	DLIs
Institutional Readiness	DLI1. Recipient completed all foundational activities
Institutional Performance	DLI 2. Recipient achieved all the Program annual results in institutional strengthening (national, regional, LGA)
Performance at facility level	DLI 3. PHC facilities have improved MNCH service delivery and quality as per verified results and received payments on that basis each quarter
Performance at LGA level	DLI 4. LGAs have improved annual MNCH service delivery and quality as measured by the LGA Scorecard
Performance at regional level	DLI 5 Regions have improved annual performance in supporting PHC services as measured by Regional Scorecard
Performance at national level	DLI 6. MOHCDGEC and PO-RALG have improved annual PHC service performance as measured by the National Scorecard
Capacity building	DLI 7. Completion of annual capacity building activities at all levels

As of June 2020, 5 out of 7 Disbursement Linked Indicators had been fully met while the remaining two were partially met ***(See figure 2)***. Likewise, as of January 2019 a total of 1,724 facilities in the 8 focal regions of GFF had fully operationalized RBF, a system that links monetary disbursements to performance on key health indicators as per DLIs.

Additionally, CSOs have continued to be supported in enhancing their knowledge and skills to actively engage in conversations and processes of GFF at regional and national level. OPTIONS Consultancy in collaboration with Health Promotion Tanzania (HDT) dissem-

inated a budget tracking tool that intends to support CSOs work in analyzing RMNCAH budget in line with their Comprehensive Council Health Plans (CCHPs).

Table 3: GFF Program Indicator performance

Table3: End of year five performance for selected indicators			
Indicator	**End target**	**Actual**	**%**
HF with 3 star	30	19	63%
4+ ANC visits	60	78.4	131%
HF deliveries	60	82.4	137%
12 - 59 months _VAS	65	81.7	126%
HF with 10 tracer med	55	96.3	175%
HF with CEmOC facilities	104	44	42%

3.4 Increased visibility of TB at national level

The World TB report estimates that in Tanzania about 39,000 people die of TB every year and that four in ten are HIV positive. That is, 3,250 Tanzanians die of TB monthly while 108 die of TB daily. Prevalence data from Tanzania HIV Indicator Survey (THIS 2016) shows that 6.3% among females and 3.4% among males are infected by HIV, this translated to about 1.4 million living with HIV and needing treatment and care. One in ten (9.9%) households in Tanzania had at least one HIV-positive household member. About a quarter (27.7%) of HIV-positive adults ever visited a tuberculosis (TB) clinic. About half (54.2%) of them were diagnosed with TB and almost all (98.7%) of those diagnosed with TB were treated.

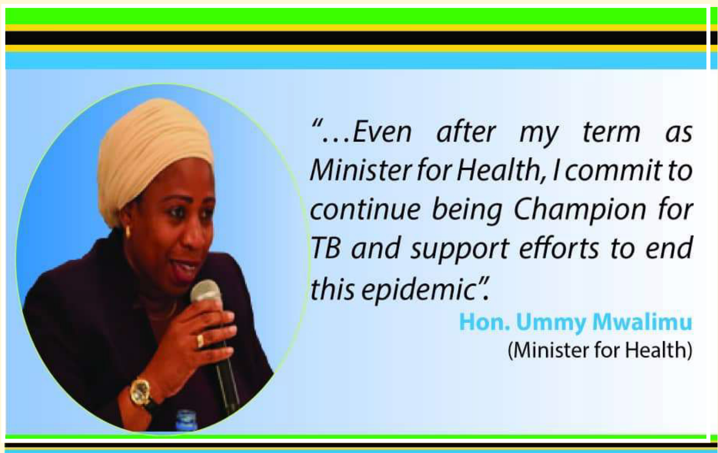
Text box 3: Tanzania HIV incidence

In 2017, Tanzania estimated 24 new HIV infections for every 10,000 persons in a year, and to approximately 72,000 new cases of HIV infection among adults aged 15 years and older in the country every year

To contribute to Tanzania efforts to end TB epidemic, Health Promotion Tanzania forms part of the ACTION Global Health Advocacy Partnership, - a partnership of 13 locally rooted organizations, committed to advocating to end diseases of poverty including Tuberculosis (TB). The chair of the ACTION Global Health Advocacy Partnership Dr. Joanne Carter also serves as the vice-chair of the Global STOP TB Partnership which aims at placing TB at the top agenda. In efforts to do so, together with other TB global advocates, the world witnessed the first ever TB United National High-Level Meeting that took place in September 2018 in New York. Led by head of states, countries signed on TB commitments to end TB by 2030 and ensuring sustainable financing pursuing science, research, innovation and developing multisectoral accountability framework.

Trickling down at country level, Tanzania committed to (a) diagnose and treat 561, 100 TB cases by 2022 (b) treat 3,961 TB_MDR cases by 2022 (c) Diagnosis and treatment of 72,600

TB cases among children and (d) offer to 373,769 cases TB preventive therapy. The achievement of the afore mentioned commitments demands a holistic approach that improves, strengthens, and interlinks components such as policies, financing, human resources for health, community engagement and multisectoral accountability.



(Ummy Mwalimu quote)

Tanzania request to Global Fund in 2018 and 2020 shows that total estimated funding gap for TB and HIV is 309.7 USD million for three years, being 219.6 million for HIV and 90.1 for TB. This is equivalent to about Tshs 710.1 billion for three years which makes Tshs 236 billion per year. With low funding, and the continuous threat TB poses on the lives of millions of Tanzania, Health Promotion Tanzania (HDT) began advocating for TB prioritization in structural polices and funding as illustrated below with a showcase of quick wins attained.

Below is a summary of achievements:

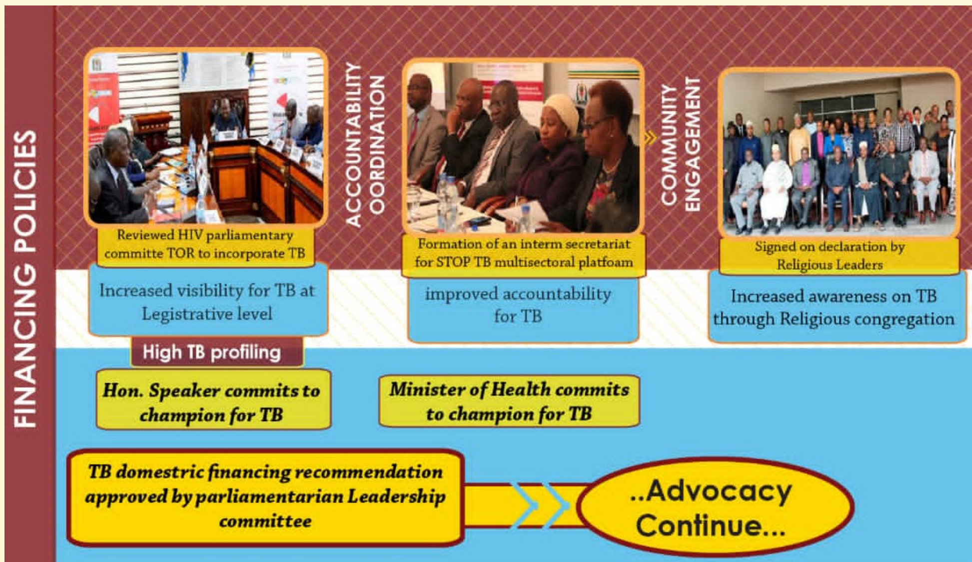


Figure 2: TB Advocacy processes and quick wins

3.4.1 HIV parliamentary committee scope expanded to include TB.

Even though HIV and TB are sister diseases, discussions around TB had no formal forum inthe Parliament of Tanzania which serves as the legislative machinery of the country. Health Promotion Tanzania (HDT) worked with other partners to advocate for the inclusion of TB in the parliamentary HIV committee, an advocacy initiative that was timely and crucial. Through engag- ing members of parliament that serve in the committee, HIV parliamentary com- mittee Terms of Reference (ToR) was reviewed and amended to incorporate TB. As such the committee began to serve as a dialogue forum for TB thus enhancing visibility for TB and attempt that continues to create a high profile for TB.

(HIV Parliamentary Committee)

3.4.2 Formation of an interim STOP TB secretariat.

As part of honoring the TB UNHLM commitments, it remains of importance to lay down accountability mechanism for TB through the formation of a multisectoral accountability framework. Working in collaboration with Tanzania National TB and Leprosy Program, Health Promotion Tanzania supported a high-level meeting that brought together stakeholders from the government, private sector, Civil Society Organizations (CSOs), Non-Governmental Organizations (NGOs) and Religious institutes as part of the establishment of

(STOP TB Meeting Group pic with Ummy Mwalimu)

Multisectoral Accountability Framework for TB in the country as advised by WHO. The meeting that was graced by Hon Ummy Mwalimu – Minister of Health marked the beginning of what would be a forum for accountability and TB coordination in the country. Addressing participants in the meeting, Hon Ummy Mwalimu committed to being a TB champion even beyond her term as the Minister for Health. Ever since the foundational meeting for the formation of the STOP TB partnership, several initiatives have been underway to formally launch the STOP TB partnership by end of 2020.

Table 4: TB score card information

INDICATOR	TB UNHLM	RESULTS	
		2018	2019
Diagnosis and treatment	74200	75845	82242
Childhood TB diagnosis and treatment targets	9600	10513	12242
MDR-TB diagnosis and treatment targets	170	449	518
Underfives Child contact TPT coverage	7500	4729	7738
Households contacts who received TPT	3449	3156	13542
PLHIV TPT Coverage	76161	75371	787365
Total TPT Coverage	76161	74692	795103

In line with exercising the duties of Multisectoral Accountability Framework (MAF), and as part of enhancing accountability; tracking progress of commitments over time and determining the resources and actions needed to reach the pre-set targets is important. Health Promotion Tanzania (HDT) in collaboration with National TB and Leprosy Program, developed a TB_UNHLM scorecard to determine the trends of performance across the key indi- cators. The scorecard took into consider- ation the TB_UNHLM commitments against actual results for the year 2018 and 2019. Using color codes (Green, Yellow and Red) to mark indicators as (Achieved, On track and under performance) respec- tively. All of the seven indicators are seen to be on track as informed by routine data as of 2019.

3.4.3 Signed on declaration by religious leaders

In the fight against TB, the role of community leaders cannot be neglected. Honoring his commitment as TB champion, Hon Speaker Job Ndungai through the support of Health Promotion Tanzania and other partners brought together religious leaders from across the country to bring them on board

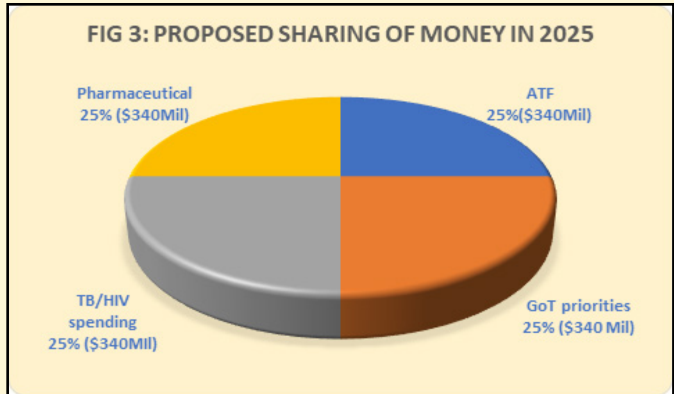
(Speaker with religious leaders)

in the fight against TB. It is from this meeting that was held in Mwanza where reli-

gious leaders declared their support by signing a declaration witnessed by Hon Speaker – Job Ndungai, former prime minister – Mizengo Pinda and the chairperson for the TH/HIV parliamentary committee – Dr. Oscar Mukasa. Religious leaders committed to being on the frontline to create awareness on TB prevention and treatment.

3.4.4 TB/HIV domestic financing proposal approved by parliamentary

As part HDT's health financing advocacy, we conducted evidence-based advocacy to 34 members of the HIV and TB parliamentary committee in Dodoma on the need of the government of Tanzania to increase domestic funding for TB. The committee was convinced beyond doubt that there was a need to strategize and initiate alternative financing mechanism. The committee requested HDT to develop and present a proposal for alternative domestic financing. To take that forward, the committee met with minster for finance who provided some guidance on step-by-step process to develop and submit such a proposal.



HDT hired an economist to undertake the analysis and make a proposal. To be technically, politically, economically, and public health perspective correct, we set up an advisory team to oversee and guide the process. The team composition ensured that important aspects of national interest are considered and well presented. The team proposed two modalities (i) collect and finance TB and HIV for interim five years of 2020-2025 and (ii) collect, invest in treasury bonds, and generate funds that will finance TB and HIV in long-term without any more collection 2025 and beyond.

The interim funding for TB and HIV estimated to collect and spend annually TZS 2,756,775,000 equivalent to $1.2million for TB and HIV. Considering that in 2018/19 AIDS Trust Fund released TZS 750 million, this mechanism would have increased domestic funding to three times.

Text box 4: DRM Advisory team

1. Prof. Prosper Ngowi- Consultant
2. Oscar Mukasa PhD- Politician
3. Peter Bujari – Disease expert
4. Hassan Mshinda PhD – Public Health
5. John Ulanga PhD- Business

The second proposal was to charge each mobile network subscriber TZS 10,000 a year, which trans-

lates to TZS 477,615,200,000 annually, which would have then been invested in treasury bonds[1] for five years. With capital and profit reinvested for five years, this will help collect up to 3,132,000,713,889 or USD 1,306 million in five years. The proposal was to divide the money in four parts, first part funds ATF, second quarter funds government priorities, third quarter funds HIV and TB response and 4th quarter funds pharmaceutical industries that would minimize pharmaceutical imports (See figure 3). By 2025, Tanzania would have been able to fund USD 340 million to HIV and TB response.

Using the estimation of 2018-2021, where there was annual gap of USD 101 million, and this mechanism would fund the entire gap and provide additional $240 million for HIV and TB. That is to say, if international donor continues to fund the HIV and TB response and this proposal accepted, by 2025, Tanzania will have no funding gap. Instead, it would have:

1. Additional fund USD 240 million for TB and HIV response
2. Strengthened pharmaceuticals industries that would have reduced HIV and TB related imports
3. Financing AIDS Trust Fund with USD 340 million that would be used on rolling basis
4. Financed government priorities by USD 340 million in that year
5. Continuous investment in treasurer bonds

These recommendations were then presented to the parliamentary leadership committee headed by the Hon. Speaker and recommended to be tables to finance committee of the ministry of finance. This proposal was however not approved by the committee for inclusion in financial bill. While this was a heart break, it offers another opportunity to re-strategize and continue with advocacy for TB domestic financing.

3.5 Ten youth leaders become expert in health system advocacy

With over 12 years' experience in advocacy, HDT is committed to creating a mass of advocates who are well capacitated to influence health policies at national and local level. Continuing with such initiatives and through the program funded by Comic Relief, Health Promotion Tanzania trained, mentored, and coached 10 youth leaders as health leaders advocate for health system strengthening to achieve greater health outcome for malaria and attaining Universal Health Coverage (UHC).

Over 200 applications were received for the role of youth leader for health, from what seemed to be a competitive process, 10 (4 female 6 male) youth leaders from health were fairly and keenly recruited with all bringing diverse yet crucial qualities that added value to the group. Understanding the diversity that propel the group, Health Promotion Tanzania (HDT) hosted a one-day seminar with the youth leaders – aiming at familiarizing with the organization and amongst themselves.

[1] A Treasury Bill is a short-term security, with less than a year to maturity. It is issued by the government to investors at a discount but without interest payments. Bills maturities period in Tanzania are of 35 days, 91 days, 182 days, and 364 days

Text box 5: Tanzania Youth Leaders for Health Achievements

(i) Developed and submitted malaria recommendations to the Government to be considered in the national Global Fund proposal writing.
(ii) 2 youth leaders participated in the national dialogues for global fund proposal writing.
(iii) Engaged in the social media campaign for malaria "The Beat Continues" during World Malaria Day and amplified their voices to influencing health systems strengthening for malaria.
(iv) Engaged in a series of webinar on International Youth Day
(v) Led and formed part of a 5-day social media campaign on debt relief for health.
(vi) Participated in the World Bank Advocacy week and RESULTS International Conference

In the one-day meeting, youth leaders were introduced to the objectives of the projects, expected results, and the role they are expected to play as young advocates, advocating for health systems strengthening for malaria and the attainment of universal health coverage.

Joining other 15 youth leaders from Ghana and Sierra Leone, youth leaders attended a 5-days practical training in Addis Ababa on advocacy and leadership. The training was strategically conducted in Addis Ababa aiming at providing youth leaders with the experience of engaging at the African Union, an objective that was met. Youth Leaders got a rare chance to visit the African Union Headquarters and met His Excellency Ambassador Kwesi Quartey – The Vice President of African Union and presented a communique. The training further aimed at preparing youth leaders for future engagement in influencing decision makers during pivotal moments such as CHOGM, Commonwealth health ministers meeting and World Malaria Day. Through the use of the SMART advocacy – an evidence-based approach that calls for influencing policies at the right time with the right messages and targeting the right decision makers and the day-to-day coaching. The skills and knowledge that Youth Leaders have gained over the course of time have not only been beneficial to them as a group of young advocates but also as individuals who aim to thrive and amplify their voices to highlight on social issues. See Youth Leaders testimonies in page 31-34

4.0. Achievement in Community Health System strengthening

Health Promotion Tanzania supports access to services in reproductive, maternal, newborn and child health, HIV and TB services at the household, community, and health facility levels. HDT intervention focusses on health promotion, accountability, behavioral change, service delivery and quality. HDT works closely with trained Community Health Workers (CHWs), health facilities, Council and Regional Health Management Teams (R/CHMTs) to improve the coverage and quality of RMNCAH services. We work with over 300 well- trained community health workers who supported with provision of RMNCAH education, household visits, escorting pregnant women to health facilities and data collection to inform progress over time. In this report of year 2019/2020, we present two commu-

nity-based health promotion-based programs: one for RMNCAH and another for HIV and TB services.

4.1 USAID/JHPIEGO Boresha Afya Project

Text box 6: People Centered Approaches

Our People centered health care services consciously adapts the perspective of individuals, families and communities and sees them as participants as well as beneficiaries to a trusted health system that responds to needs in holistic ways

Health Promotion Tanzania implemented USAID Boresha Afya Lake and Western zone, which was a five years project implemented in seven regions of Mara, Kagera, Kigoma, Shinyanga, Geita, Simiyu and Mwanza. The project goal was to improve health status of all Tanzanians with a focus on women, youth and children through reproductive health (RMNCH+N) outcomes. We report achievements of this project in two districts of Kagera region (Ngara and Biharamulo). To support the project goal, HDT implemented several activities in Biharamulo and Ngara such as Community Score Card, Gulio la Afya, gender dialogue groups, Gender & Respective, Maternal and Care (RMC)[2] meetings, and community outreaches whereby both focused on improving availability and access to quality, respectful and integrated RMNCAH services. HDT used a "People - Centered Approach" see text box 6 in which Community Health Workers (CHWs) in both Ngara and Biharamulo were centered to the program. CHW's brought education and awareness to households and facilitated accountability among communities, health facilities and government.

4.1.1 Achievement in Community Score Card

Text box 7: Community Score Card

Community Score card is an accountability initiative that provided a platform for stakeholders such as healthcare providers, health service recipients and representatives of Council Health Management Team to evaluate performance and quality services. Community Score card identifies (1) how services are experienced by uses, (2) Establishes mechanism between user and provider, (3) Ensure informed decision making, (4) Track progress of service provision, (5) Reports on Quality

To increase quality of health services and accountability, Health Promotion Tanzania used ***"community score-cards"*** see text box 7. On monthly basis, HDT supported two community scorecard meetings with 60 people each meeting, from different wards of the districts, to evaluate the quality of RMNCAH services such as Antenatal Care visits, Family Planning up-

[2] Respectful maternal care refers to care organized for and provided to all women in a manner that maintains their dignity, priva cy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labor and childbirth

take, facility delivery, exclusive breastfeeding, male involvement and post-natal care. These platforms underpinned the client charter issued by ministry of health in 2013[3]. During the

Text box 8: Challenges to access quality RMNCAH services in Ngara and Bihamulo

(1) Myth that when noticed pregnancy below 12 weeks may bewitch,
(2) Long distance from community to health facilities
(3) Inadequate trained RMCH service providers
(4) Poor infrastructure such as medical equipment WASH, delivery beds
(5) Lack of waiting rooms/houses before deliveries in health facilities

meetings challenges limiting access to quality services were identified, reasons, and plans to address them developed. A total of 72 events bringing a total of about 4,360 people Ngara and Biharamulo districts participated in community score card meetings. In these meetings a number of challenges hindering access to quality RMNCAH were identified.The text box 8 below summarizes the challenges in both Ngara and Biharamulo, respectively.

Community Score Card achievements were numerous, ranging from improvement in infrastructure to improvement in quality of health services in both Ngara and Biharamulo. Friendly languages among service providers to clients and patients were among CSC results in both Biharamulo and Ngara. Mr. Selestine Nziko (village chairman) from Kirusha in Ngara district was the firsthand witness as he said: *"Currently, when you go to health facilities, clients are well welcomed by health providers than it was before and this has led to increased number of patients and clients at our health facility".*

Community Score Card results

As a result of Community score card, Nyabusozi, Lusahunga and Nyakahura wards in Biharamulo district council, a resolution was made to develop pregnant women registers that will identify and follow up all pregnant women in the wards **"Uturo Model".**

Shortage of staffing was identified as a challenge, because of community score card, deployment of additional two health providers in Mkalinzi health center was done. Before CSC meeting, Mkalinzi dispensary had one service provide who could attend all clients all the time. The dispensary receives an average of 3 women giving birth on a daily basis. Community members raised this challenge during CSC meeting held in Mkalinzi village in August 2019 and later the council deployed two more health service providers to the area.

Addressing infrastructure challenges using community score card, led to construction of a dispensary in Kitwechembogo and Migango in Biharamulo district by members of the village supported by the Government. In Ngara district there was a construction of placenta pit in Mrutabo dispensary. Both these initiatives have led to increased access to health services.

[3] Ministry of health client charter emphasize on quality of service and standards, Relationship and responsibility and response time for clients.

CSC meeting in Nyakasenga village, November 2019

4.1.2 Gulio la Afya

To address the challenge of distance to health facilities and departmentalization of services, Health Promotion Tanzania worked with CHMTs to develop a model- Gulio la Afya – See text box 9 that will take health services closer to people. To that end, we worked with CHMTs to put together multiple health services such as HIV Testing and Counselling, Malaria testing, family planning and ANC, vaccination for missed opportunity were provided at the proposed marketplace. This activity brought together many people getting multiple services at the market instead of getting these services at health facilities.

Text box 9. Gulio la Afya

Gulio la afya refers to variety of health services offered at once at a marketplace. Services provided during Gulio la afya in these contexts included HIV Testing and Counselling, malaria testing, FP uptake provision and Antenatal Care

HIV testing services, during Gulio la Afya activity at Mabawe village in Ngara

Five Gulio la Afya events in Ngara and Biharamulo were conducted reaching over 2,000 community members. Over half 61% of clients attended were men. This intervention has proved to reach more men than women, a phenomenon that is not common for facility-based access to services.

4.1.3 Gender Dialogue groups

Health Promotion Tanzania used gender dialogue sessions to spark discussion among couples (men and women) to identify and discuss gender-based issues that restrict optimal use of gender sensitive RMNCAH. Gender dialogue groups were facilitated by community health workers in their respective villages, with 30 couples each (15men, 15women) and collaborated on discussing 10 sessions on gender norms, accessibility and utilization of RMNCAH services. The aim was to increase awareness on gender equality issues and to build good relationship among couples/relationships within the family level and equipping them with knowledge on male involvement and their responsibilities on improving gender equality and child health. Gender dialogue activity also aimed at ending gender-based violence in communities, encouraging women to have positive decisions on their health status/for their children and making decisions (together as partners) on family planning, family resources for the benefit of the whole family.

Through these gender dialogues, we supported healthcare providers to participate in the sessions and facilitate sessions on RMNCAH, entrepreneurship that mobilized communities to plan and enroll in improved community health fund. Another innovation was to mobilize households to plan for emergence transport for women and under-fives needing emergency health services. In Biharamulo district, 36 groups were formed bringing together 1070 (470 male, 600 female) in gender dialogue.

Text box 10. Gender dialogue

Gender dialogue as per Boresha Afya refers to health campaigns focusing more on bringing men and women together (f15, m15) to discuss gender equality that promotes access of RMNCAH services to reduce maternal and under five mortality

In Ngara district, 486 people (189 male, 279 female) joined gender dialogue and a total of 24 groups were formed. The groups were eligible to graduate if completed 8 or 10 sessions whereby among 36 groups formed in Biharamulo only 24 graduated from gender dialogue sessions while all 24 gender dialogue groups formed in Ngara succeeded to graduate. The smart chart below shows the reasons as to why gender dialogue groups were formulated, processes, results and sustainability plan even after the end of Boresha Afya project in both Biharamulo and Ngara districts.

Gender dialogue groups assumed different roles and we report some success in the box below:

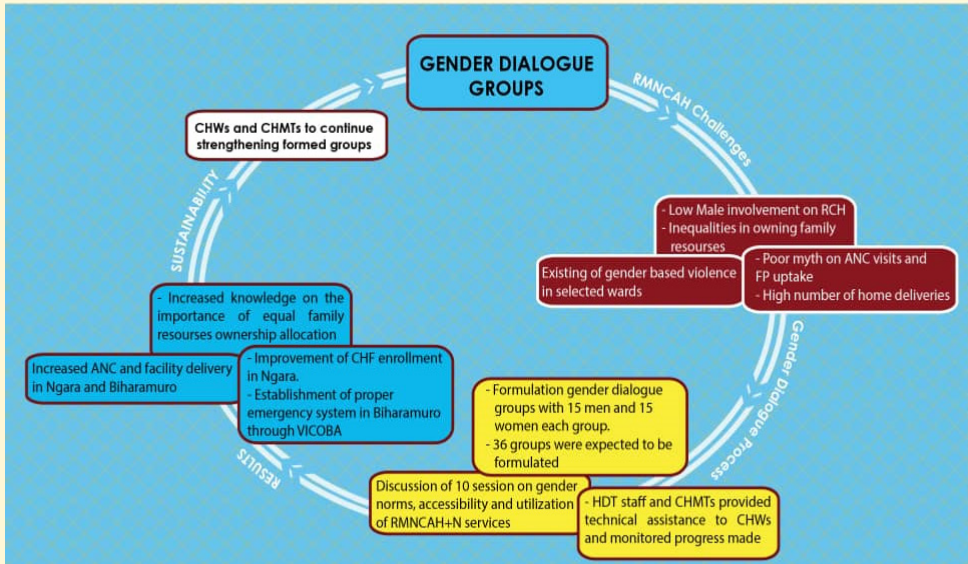


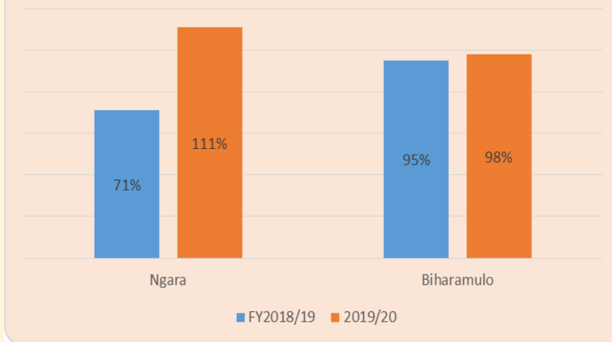
Figure 4: Gender dialogue formulation process and achievements

When HDT staff visited Upendo gender dialogue group in Kalenge ward during their last session in November 2019

4.2 Health performance indicators

4.2.1 Increased antenatal Care coverage

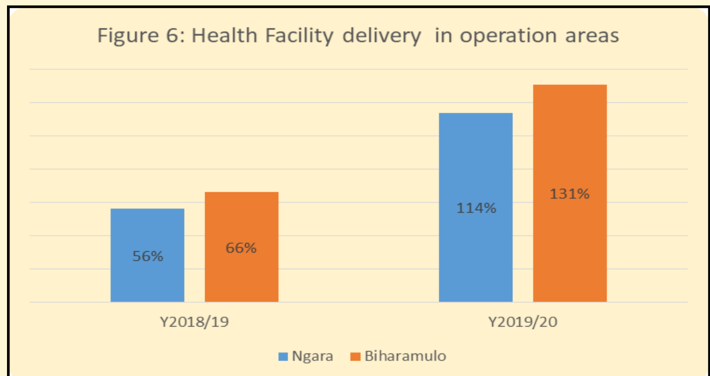
The USAID-Boresha Afya project contributed to increase of both ANC1 and ANC4 coverage in both Ngara and Biharamulo districts. In implementation wards/facilities from Ngara for instance, ANC4 coverage increased to 111% in a year of 2020 as compared to 71% in 2018. (See the graph). Biharamulo district data (DHISII) shows a slightly positive change of ANC4 from 95% in 2018/2019 to 98% in 2019/2020



4.2.2 Increased health facility delivery

In low and middle-income countries, pregnancy and delivery complications may deprive women and their newborns of life or the realization of their full potential. Provision of quality obstetric emergency and childbirth care at health facility can reduce maternal and newborn deaths, but underutilization of maternal and childbirth services remain a public health concern in Tanzania. This project therefore worked with Community Health Workers to mobilize communities and pregnant women to deliver at health facilities. An array of interventions such as household visits, gender dialogue sessions, community score cards and community outreaches contributed to increased health facility deliveries.

Jhpiego-District Health Information System (DHISII) data shows an improvement in facility delivery in both districts which contributed to increased institutional deliveries at district level. In Ngara district for instance, the data collected by CHWs shows a number institutional deliveries with a positive change in all health facilities of project interventional wards/facilities of Bukiriro, Kirusha, Murusagamba and Mabawe. In Biharamulo CHW data shows an increase from 63% to 98% in year 2019/2020. These district averages are above national average reported in a World Bank Strengthening Primary Healthcare for Results through Result Based Financing report with an average of 77% health facility delivery by June 2020.



Lilian Paul, who is among the Community Health Worker's in Biharamulo district who shares her sentiments of her household visit

Lilian (CHW) holding her working tools

"....As a mother of two, I am proud to be a Community Health Worker. Since 2018 not only I have managed to save lives of many women in my area but also, I have learnt so many new things that I even apply in my own family. I have succeeded to provide referrals to clients with dangerous signs, escorting women to our dispensary during delivery times. Nowadays, I am not just the normal Lilian I used to be, I have gained so much knowledge and skills. I call upon HDT, other CSOs and partners to continue with amazing work which HDT started....".

4.3 Achievements under Comprehensive Civilian HIV/AIDs Prevention and Home-Based Care

Comprehensive Community Based HIV Program was a project funded by PEPFAR though Henry Jackson Research and Medical Foundation (HJRMF) and implemented in Mbinga district council, town council and Nyansa District council from 2016 to 2019. Project focus is summarized in text box 11. This report covers data from July to September 2019. The project worked in-Stciglomsae rceodlulcatbioon-ration with District AIDS Coordinator and Council HIV coordinator. It focused on community-based HIV prevention and care targeting groups of Key Population (Female Sex Workers), Priority population (Adolescent girls and young women), People living with HIV (PLHIV), partners of FSW, and men. Program reportable indicators were HIV testing, Positive identified and positive enrolled to CTC, HIV prevention among KP, priority population, Gender based violence and gender norms. Other indicators were current on treatment, new clients on treatment, lost to follow up reinstated to CTC, Nutritional and economic support, and positive health dignity.

Text box 11. CCHP project focus

- Tailored outreach activities to key and vulnerable population on HIV testing, referrals, and community care
- Improving referral, linkage to Facility and tracing lost to follow up
- Reduction in Gender Based Violence and prevention

4.3.1 Achievement in HIV Testing Services

HTS program was to reach 13,274 clients for the quarter of July to September 2019, but only 11,146 clients were reached (84%). The project envisaged to identify 1,327 positives

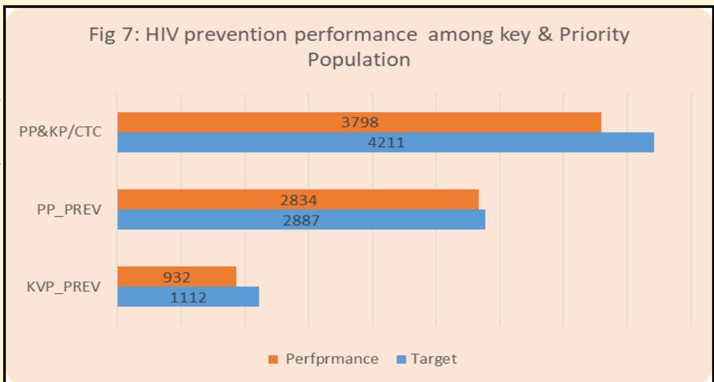
in the same quarter but identified 696 clients (53%). 659 clients were linked to CTC which is equivalent to 95%.

Table 5: HIV TESTING SERVICES DATA			
	July-Sept 2019 TARGET	performance	% performance
HTS_TST	13274	11146	84.0
Positive identification	1327	696	52.4
Linkage with CTC	696	659	94.7

These clients were successfully reached through mobile index and other testing modalities (focused testing) strategies adopted by the counselors. These methods include index testing, partner testing, Sibling testing, FSW and their client testing and door to door. This successful linkage of more than 90% was justified by 208 referral feedbacks returned to HDT office in Mbinga.

4.3.2 HIV prevention services

HIV prevention services among key population and priority population was implemented in two district councils of Mbinga TC and Mbinga DC, service provided included safer use condoms, gender-based violence (GBV) education, violence against children (VAC) and gender norms sessions. Others were risk reduction for HIV and other STIs, community-based screening of TB, HIV prevention intervention services including education were provided by trained community-based Peer Educators (PEs). The performance of the prevention services in quarter of July to September 2019 in some of the program indicators has been described here under (see figure 7).



The key population target to be reached with prevention service in the quarter of July to September 2019 were 1112 FSW, 620 MSM, 212 PWID, linking 35 clients with Prep services, and 2567 gender norms. Clients reached were 932 FSWs which is equivalent to 84% of the total quarterly target, 31 PWIDs which is equivalent to 15% of the quarterly target, 1MSM which is equivalent to 0.1%. 48 clients out of 35 targeted were linked to Prep services which equivalent to 137%. Gender norms education was provided to 3295 clients which is equivalent to 128%. Services provided to these clients include condoms, psychosocial education, STI screening through referral networks. Prevention education services were intensively rendered by trained peer educators in 25 identified hotspots in two district councils of Mbinga TC and DC.

4.3.3 Community Based HIV/AIDS services

HIV/AIDS intervention services were provided to PLHIV clients after being registered at Care and Treatment Center (CTC). Trained providers provided a number of services to clients enrolled in services. Community based HIV/AIDS service volunteers provide adherence education, PHDP package, nutrition, economic education, prevention education and enrollment of new clients in the program so that they can be retained into care and track lost clients. A summary some data for the quarter of July to September 2019 is presented in the table below:

Table 6: COMMUNITY BASED HIV/AIDS SERVICES			
	Quarterly target	Actual performance	% performance
CARE_COM (NEW)	4378	4215	96.3
CARE_COM (OLD)	10710	8846	82.6
TZ_NUT	362	10795	2982.0
TZ_ECON	223	9796	4392.8
LTFU	812	978	120.4
PHDP	2785	5933	213.0

As the table shows, CARE_COM (new clients) enrolled target for the quarter of July to September 2019 was 4,378 new and 10710 old (retention) clients. HDT managed to reach 4215 new clients and 8846 retention clients which is equivalent to 96% and 83% of the quarterly target, respectively. The target for clients to be provided with nutrition education services in July-September 2019 were 362 PLHIV clients. 10795 clients were identified and provided them with nutrition services which were beyond the targeted. Target of clients to be provided with economic strengthening services were 223 clients, 9796 clients were provided with economic strengthening trainings which was also beyond the target. The target of LTFU to be tracked for the quarter of July-September 2019 was 812 clients. 978 LTFU clients were reconnected back to CTC which is equivalent to 120% of the annual target. The Positive Health Dignity and Prevention (PHDP) services target was to reach 2,785 clients whereas 5933 PLHIV were provided with minimum packed of family planning, TB screening, nutrition, economic strengthening interventions which are equivalent to 120% of the annual target.

CHBC and CHMT discussion on effective way of tracing LTFU clients at Mbinga district hospital in July 2019

5.0 Global and Regional engagement

Health Promotion Tanzania engages globally through ACTION Global Health Partnership (www.action.org) which is a partnership of locally rooted organizations around the world that advocates for life-saving care for millions of people who are threatened by prevent- able diseases. ACTION operates on the premise that all countries can end diseases of poverty and improve health if they step up funding and create more effective policies.

OUR VISION

A world where all people have equitable access to health.

OUR MISSION

To influence policy and mobilize resources to fight diseases of poverty and achieve equitable access to health.

OUR CORE VALUES

Advocacy/action that is equity-focused, evidence-based, collaborative, accountable, and bold!

Supported by a Washington-Dc based secretariat, 14 independent ACTION partners work together to increase investments and build political support for global health. Because they disproportionately impact people living in poverty and have lacked the political prioriti- zation they deserve, our core campaigns focus on TB, the world's lead- ing infectious killer; vaccine-preventable diseases; child health; nutrition; and other ways to advance universal health coverage (UHC). Over the last seven years alone, ACTION partners have helped bring more than US$15 billion to the Global Fund, $5 billion for Gavi to support poor countries in immunizing half a billion children, and $3 billion for the long-neglected fight against undernutrition. ACTION believes that when local expertise is paired with global perspectives, we create a multiplier effect of individual and collective action. We work as equal partners to set and achieve advocacy goals that move the needle on policies and investments to secure health for all. Our work builds relationships and momentum over time that are resilient to change.

HDT Excutive Director Dr. Peter Bujari with Deputy chair of AU Ambassador Kwesi Quartey

Health Promotion Tanzania benefits from South – South cooperation through working with ACTION Africa composed of KANCO- Kenya, CITAM+ Zambia, WACI Health- Kenya and South Africa, Princes of Africa Foundation- South Africa. ACTION Africa team is to serve as a coordinating hub for ACTION partners based in Africa with a mandate to facilitate greater impact and presence on the continent. WACI Health a pan African organization serves as a leader and door opener for regional engagement. Advocacy and partnership to raise voices has been made with a range of African civil society and community advocates including GFAN Africa, AfNHi and the Civil Society Platform for Health in Africa (CiSPHA).

6.0. Lesson learnt

6.1. Engaging the right decision makers is the secret behind successful advocacy

As the concept of advocacy revolves around influencing those in authorities, to effect policies and actions that will benefit large section of population, it is important to identify key decision makers. While in some advocacies endeavor, we have recordedquick wins that resulted to positive outcomes, other advocacy initiatives did not yield any immediate output nor positive result because we engaged the wrong decision makers who are in no way placed to call for action. Thus, it is therefore to conduct a thorough and informed research on the existing structures of decision making and identifying key actor (s) who have either constitutional or rightfully placed to make decision or even inform part of the advocacy. We have leant that general messages and or reaching out to people with no power to make decision leads to making advocacy tedious and often with no tangible results. In most cases, decision makers are likely to respond to an agenda that is aligned to the things they care about. Understanding what decision makers care about and incorporating them in the advocacy agenda is likely to win their support. Additionally, it is important to build good relationship with decision makers and for Civil Society Organization to position themselves as critical friends to the Government and/or donors instead of shaming and blaming.

6.2. Social media can be an effective tool for advocacy especially in times of COVID-19

In a world that is catching pace to digitalization, the use of social media to undertake advocacy is increasingly becoming effective. While social media can reach a huge number of people and can be effective in awareness creation, it remains effective in reaching and targeting decision makers who have increasingly become more active on social media. One still need advocacy technique to use social media for advocacy. As presented in social media tips, the advocacy on .

Social Media Tips

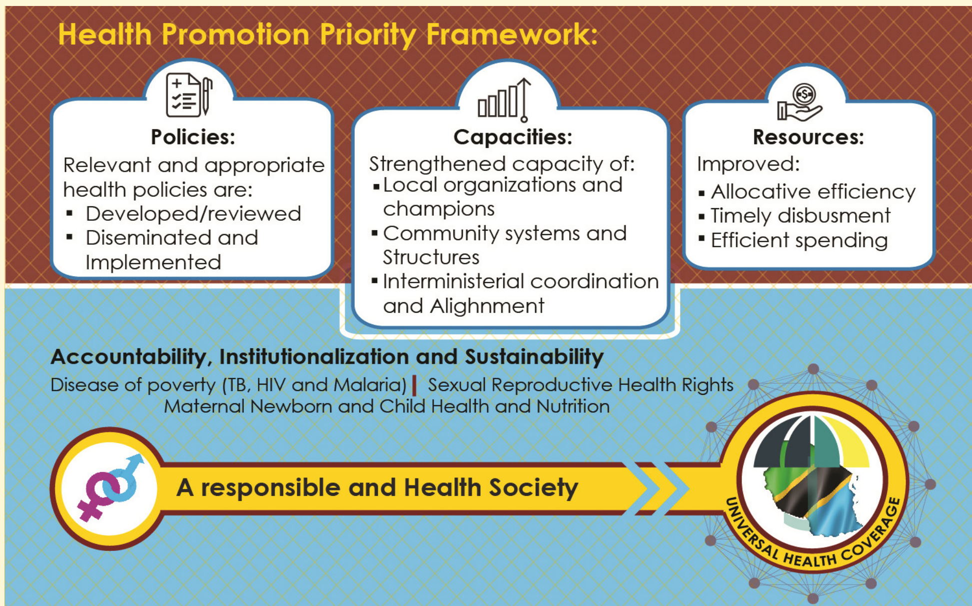
- Define your objective & make sure you know your facts
- Pick your platform (Twitter, Facebook, Instagram, LinkedIn)
- Include a call to action
- Be respectful but bold
- Keep it short
- Make it timely
- Use visuals
- Use the right hashtags & tag the right people – be strategic
- The point is to engage – not just to like and share

6.3 Bringing key players in health sector to identify challenges and provide solutions increase accountability in health sector

We implemented community score card that allowed stakeholders such as district medical officers or his/her designee from Council Health Management Teams, Community Development Officers, healthcare providers and the community members to sit together. In this session, they sat together to identify bottlenecks to accessing quality health services and collectively identify and prioritize solutions. In this meeting, it was clear that the community perception differs from leaders and so was for health care providers. It therefore provided opportunity to understand beneficiary perspective of quality. Health care providers were brought to do corrective measures and so was the CHMT. Community members also were required to take actions that would increase their positive response to both prevention and care. A work plan was then jointly developed and monitoring mechanism agreed upon. We leant that community score card is one of the best instrument to increase accountability and build resilient community systems.

7.0 Looking Ahead

The time of presentation of this annual report is also the time the government is developing its Health Sector Strategic Plan V and One plan 3. These are opportune moment to design high impact interventions and commit to move from rhetoric to actions. Health Promotion Tanzania is positioning to work with, and support government identify game changer and innovative approaches that can contribute to significant reduction in maternal mortality and morbidity. To achieve this, we have redefined our priority frame for 2021-2025 as shown below.



8. Cherishing Youth Leaders for Health

Being a youth leader for health has enabled me to critically examine gaps and challenges that need immediate action in community health systems strengthening as well as checking the means to push governing authorities and other stakeholders to implement the sustainable solutions to those challenges. My role as a youth leader has geared my passion to encourage my fellow youth to gain skills on the use of advocacy as a tool for change in different aspects of their interest as it brings conspicuous results when done smartly.

Isack Kaniki
Student – KCMC
isackkaniki@gmail.com

Being a lawyer by profession, I never would have imagined the extent to which advocacy can bring about change. As a youth leader for health, I have been fortunate to learn from the best mentors to understand the underlying problems in my community, identify solutions through evidence, engaging decision makers with the right messages and at the right time. In a period of less than a year, I have been presented with a rare yet crucial opportunity to advocate for health systems strengthening, eradication of malaria and debt relief for health – all of which has enhanced my knowledge and skills. I have been able to diffuse the knowledge I gained to other young people like myself who are committed to use their voices to bring change. I continue to influence decision makers at my community to eradicate malaria by placing the community at the center. I have seen the value in my voice, and I vow to continue using my change as a young person to impart change in my community.

Damas Mwambe
Lawyer
mwambedamas@gmail.com

My journey as youth leader for health has exposed to a diverse group of fellow youth leaders and mentors who have constantly shared their experiences, knowledge and skills. Having the opportunity to engage regionally at the African Union and Commonwealth has given me a rare opportunity to understand my role as a young person is critical and I can use my voice to advocate for issues that affect people in my community. Ever since, I have been better positioned to influence decision makers at my community to take the needed actions in the fight against malaria with a much greater focus of strengthening health care systems to not just address malaria, but killer diseases such as TB, HIV and non-communicable diseases that continue to kill millions of people. The future belongs to the youth, and now more than ever, I committed to use my voice to influence, inform and educate.

Salome Kavishe
Student - Muhimbili University for Health and Allied Sciences (MUHAS)
sallygk77@gmail.com

The youth leaders for health program has heloped me to incorporate and implement the skills and experiences I have gained to promoto healthy lifestyle and create health care awareness programs such as using insecticide-treated mosquito nets and engaging the community in the fight against malaria. On a personal level, being a youth leader has been significant in my career and shaping my focus. I am now pursing a master's degree in global health to learn new concepts, enhance my knowledge and transform it into practise. I am excited to continue advocating for health systems strengthening to ensure that quality health services and interventions reach to the most vulnerable people in the community. I strongly believe that investing in health and well-being of the people is key in eradicating poverty and achieving sustained health improvement and development.

Edna Mgunda
Student - Liverpool School of Tropical Medicine
eomgunda@gmail.com

Through the Youth Leaders for Health Program, I have been empowered with smart advocacy skills in health systems strengthening. I am now using the skills to develop a what is going to be a successful advocacy campaign for the organization I am working with. I am excited that I have been able to practise the skills in real work environment which I believe will yield greater impact in the future.

Dorina Mathayo
National Council of People Living with HIV
dorinamathayo2@gmail.com

"As a Youth Leader for Health I have ensured that health systems strengthening & a focus on diseases such as Malaria & Neglected Tropical Diseases in light of COVID19 continues to be a part of national and international discussions involving the youth and other stakeholders within the health sector".

Farhan Yusuf
SHOPS PLUS - Tanzania
farhan.yusuf88@gmail.com

"Going across the communities, training people, meeting local leaders and government officials has provided me with an immense opportunity. An opportunity that has brought impact to me and the community. I have been able to stand not only in words but in action to support better health for all. The power of young leaders for health in advocacy for health systems strengthening is truly incredible and should not be undermined as it yields indispensable results at every level".

Aloyce P. Urassa
Student - KCMC
louisurrassa@gmail.com

"I have raised the level of familiarity in health systems and advocacy through learning the best strategies and steps towards achieving advocacy outcomes. With that knowledge, I have played a role in assisting, educating, and supporting my community in make informed and appropriate decisions for their health including advocating to decision makers on the urgent need to strengthen healthcare systems".

Amiry Kaiza
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