UJANA SALAMA: CASH PLUS MODEL ON YOUTH WELL-BEING AND SAFE, HEALTHY TRANSITIONS

Study Design Overview and Baseline Findings • May 2018

A group of Cash Plus livelihood and health training course participants discuss an assignment in Ikama Village in the Rungwe District of Tanzania.

BACKGROUND

Adolescents in Tanzania face many barriers to safe transitions to adulthood, including health-related risks, barriers to schooling, and lack of livelihood opportunities. Poverty is a driver of poor educational opportunities and health-related risks, including early pregnancy, gender-based violence and sexually transmitted infections such as HIV. Social protection, including cash transfers, is a leading tool in the fight against poverty and has also shown potential in facilitating safe transitions to adulthood.

Motivated by the largest ever adolescent population in Tanzania entering their economically productive years, along with the idea that cash can be leveraged with complementary programming, the Tanzania Social Action Fund (TASAF) is implementing a pilot targeted towards youth. The Cash Plus pilot, also known as "Ujana Salama" meaning "Safe Youth" in Swahili, is operated within the Government of the Republic of Tanzania's Productive Social Safety Net (PSSN), with technical assistance from UNICEF Tanzania and the Tanzania Commission for AIDS (TACAIDS).

The pilot jointly addresses livelihoods skills and education on HIV, sexual and reproductive health (SRH) and gender equity, also facilitating linkages to youth friendly SRH services. Figure 1 describes the three main intervention components. This approach recognizes that youth need a combination of social, health and financial assets to safely transition to adulthood. The pilot design was informed by a consultative process whereby government, development partners, and researchers came together to identify salient needs and vulnerabilities among Tanzanian adolescents and best practices to support them. The pilot and accompanying evaluation focus on impacts of a unique, multi-sectoral, government-implemented intervention targeted to vulnerable adolescents in impoverished households.

EVALUATION

The evaluation team, led by UNICEF Office of Research – Innocenti and Economic Development Initiatives (EDI) in collaboration with TASAF, TACAIDS and UNICEF Tanzania, is conducting a longitudinal, mixed-method study to examine the impacts of this pilot on youth transition to adulthood. The study builds on learnings from the Transfer Project, a multi-organization consortium providing evidence on government-run cash transfers in Africa, with a focus on safe transitions to adulthood for youth. Outcomes examined include livelihoods; educational or occupational aspirations; schooling; attitudes, such as self-esteem and locus of control[1] and gender norms; mental health; exposure to violence; partnerships; SRH and care seeking; HIV knowledge, testing and treatment. Detailed information is provided in the project brief, while the

Figure 1: Intervention Components

INTERVENTION COMPONENTS

1. Adolescent livelihood & SRH training

Sessions focus on livelihood, economic empowerment, and life skills training, and SRH knowledge/HIV prevention

2. Mentoring & coaching

Adolescents are connected with community-based mentors who coach them about livelihood options and life concerns during and after training

3. Linkages to youth-friendly services

UNICEF Tanzania, in collaboration with the Government of Tanzania, will strengthen youth-friendly SRH/HIV services in government health facilities

remaining sections of this research brief summarize the study design and findings from the Cash Plus baseline report.

The evaluation is informed by the Conceptual Framework in Figure 2 and includes both quantitative and qualitative components. The quantitative evaluation utilizes a cluster randomized control (RCT) design with two study arms (treatment arm receiving PSSN + adolescent cash plus and control arm receiving PSSN only), which allows researchers to estimate the impact of the Cash Plus package on youth well-being among PSSN households. Randomization of villages to study arms was conducted in July 2017, after implementation of the baseline surveys (April – June 2017), and was stratified by district and village size (large vs. small villages). All eligible youths in each village were interviewed in an intent-to-treat design (65 villages per study arm). The study includes adolescents (both males and females) between the ages of 14 and 19 years. The baseline sample is 2,458 youth from 1,946 households (1,287 youth in Mufindi and 1,171 youth interviewed in Rungwe). Additionally, 91 health facility surveys and 130 community surveys were conducted to gather contextual information relevant to the intervention and study.

The qualitative component includes in-depth interviews among 40 youth. Three waves of data collection are planned:

(1) Baseline pre-intervention implementation (completed April – June 2017)
(2) Midline (on-going May-July 2018)
(3) Endline (expected May-July 2019)

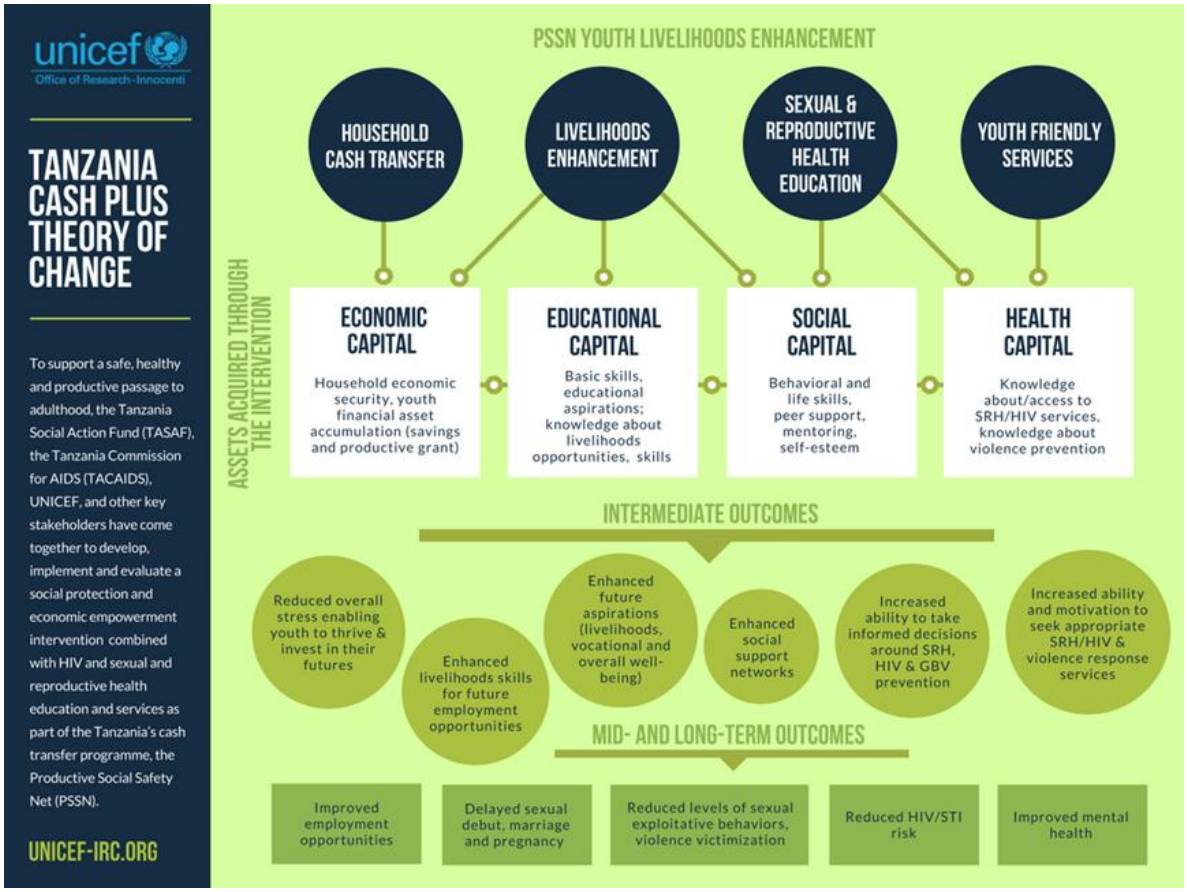
BASELINE KEY FINDINGS

Many youth are living in vulnerable circumstances, with one in three not living with a parent or guardian, and half of those being double orphans. About two in three households are female headed, with household heads approximately 60 years old on average. Adolescents live in labour-constrained households with fewer working-age adults when compared to similarly poor and rural households in Tanzania,[2] and adults in these households have low levels of education, on average. Household dwelling conditions are also poor. Cash Plus communities have little access to markets and limited livelihood activities. Youth live in households that mainly engage in agricultural activities, such as crop production and livestock rearing, while being faced with a number of shocks, including unusually high prices for food, livestock and crop failure, and other situations that can affect youth's ability to meet their basic needs. One in four households has some monetary savings, while the full sample receives the PSSN cash transfer[3].

About half of youth are attending school. Schooling rates drop rapidly with age, from about 80 per cent among 14-year-olds to about 15% among 19-year-olds. Distance to school may hamper school attendance, as adolescents walk 30-minutes to primary school and 80-minutes to secondary school, on average. Youth completed about seven years of education, corresponding to completion of primary education. There are significant gender differences in youth education; females are more likely to attend school and complete more years of education.

Most youth participate in some economic activities, with about three quarters engaged in agriculture or livestock herding for the household. About 16% work for pay outside the household, while a minority work in household non-agricultural businesses (5%) or in the TASAF public works programme (3%). Nearly all youth also engage in household chores, spending an average of 3 hours per day in these activities, such as taking care of

Figure 2: Conceptual Framework



children, cooking and cleaning, and collecting water and firewood. As with education, clear gender differences exist for youth participation in economic activities and household chores; while both females and males report participating in both, boys are more likely to engage (and spend more time) in economic activities. The gender pattern is reversed for household chores.

Youth living in poverty also face many challenges related to sexual and reproductive health. While only 17% of youth had sexually debuted at baseline, the overall knowledge of modern contraceptive methods is lower than national rates, putting them at a higher risk of unplanned pregnancy and acquisition of HIV and other STIs when they do become sexually active. However, almost all adolescents in the sample had heard of HIV and basic knowledge about HIV risk was generally high. Poverty can also be a direct driver of transactional sex and relationships, in order for youth to meet their basic needs. In our study, among adolescents who had sexually debuted, one in five had started a relationship for financial reasons, with a higher rate among females than males. Approximately 16% of adolescents ever having visited a health facility for services such as family planning and STI testing and treatment. The percentage is higher for youth who reported sexual debut. Females are more likely to use SRH services overall, with younger females more likely to seek services related to STIs, and older females more likely to visit for family planning.

Vulnerable youth are also at risk of violence, and risk is often affected by gender norms. Female youth, on average, show less equitable attitudes towards women's and men's roles, rights and responsibilities than male youth. Nearly half of respondents report experiencing some form of emotional or physical violence, with girls reporting higher rates of emotional violence than boys, and boys reporting higher rates of physical violence. Physical violence experience declines with age for

both genders. Experiences of sexual violence were collected among adolescents who had sexually debuted, with one out of five of these adolescents having had experienced forced sex during their lifetime.

We find baseline balance between study arms across all above dimensions, which are described in more detail in the baseline report. The same holds for other outcomes not described in this summary, such as mental health and fertility, among others. This confirms the internal validity of the study design.

CONCLUSIONS

This brief summarized key highlights from the Cash Plus baseline report. Findings indicate that despite benefiting from the PSSN social protection programme, adolescents living in households that receive PSSN cash transfers still face myriad challenges to safe and productive transitions to adulthood.

Youth live in extremely disadvantaged households, in settings with limited availability of schools. These factors may drive youth school dropout, which is shown to increase rapidly with age. At the same time, economic opportunities for youth are also very limited. Youth in the considered age range also face challenges related to sexual and reproductive health, such as unplanned pregnancy and HIV. Youth utilize sexual and reproductive health services at low rates, while overall knowledge of modern contraceptive methods is lower than for other Tanzanian youth in their age range.

This Cash Plus pilot is being implemented by government, through government structures, which maximizes the generalizability of findings and the capacity for scale-up. The relevance of the programme is also increased by the fact that the adolescent population in Tanzania is larger than ever. Moreover, our data show that almost all youth aspire to higher levels of education. The innovation in evaluating a range of health and wellbeing outcomes will contribute to understanding how "plus components" within national cash transfer programmes can contribute to safe transitions to adulthood for youth in Tanzania, Sub-Saharan Africa and globally.

Tanzania Cash Plus Evaluation Team

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1 Locus of control indicates the degree to which youth believe that they have control over the outcome of events in their lives, as opposed to external forces mainly governing their lives.

2 All comparisons made with nationally representative data from the 2015/2016 Tanzania Demographic and Health Survey

3 The Cash Plus baseline report includes descriptive statistics on amounts saved and received.