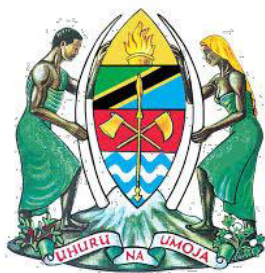


UNITED REPUBLIC OF TANZANIA

**MINISTRY OF COMMUNITY DEVELOPMENT,
GENDER, WOMEN AND SPECIAL GROUPS**

**THE NATIONAL ACCELERATED ACTION
AND INVESTMENT AGENDA FOR
ADOLESCENT HEALTH AND WELLBEING
(NAIA AHW 2021/22 - 2024/25)**

FINAL ENDLINE EVALUATION REPORT



UNITED REPUBLIC OF TANZANIA

**MINISTRY OF COMMUNITY DEVELOPMENT, GENDER, WOMEN
AND SPECIAL GROUPS (MOCDGWSG)**

***The National Accelerated Action and Investment Agenda for
Adolescent Health and Wellbeing (NAIA AHW 2021/22 – 2024/25)***

FINAL END LINE EVALUATION REPORT

April, 2026

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LIST OF ABBREVIATIONS

AA-HA!	Global Accelerated Action for the Health of Adolescents Framework
AHW	Adolescent Health and Wellbeing
AIDS	Acquired Immune Deficiency Syndrome
ASRH	Adolescent Sexual and Reproductive Health
AZAKI	Asasi za Kiraia (Civil Society Organizations)
AZISE	Asasi Zisizo za Kiserikali (Non-Governmental Organizations)
BCC	Behaviour Change Communication
CBO	Community-Based Organization
CCHP	Comprehensive Council Health Plan
CSO	Civil Society Organization
CSR	Corporate Social Responsibility
DHIS2	District Health Information Software – Version 2
DED	District Executive Director
ESDP	Education Sector Development Plan
EMIS	Education Management Information System
FBO	Faith-Based Organization
FGD	Focus Group Discussion
FYDP	Five-Year Development Plan
GBV	Gender-Based Violence
GFF	Global Financing Facility
HIV	Human Immunodeficiency Virus
HSSP	Health Sector Strategic Plan
IEC	Information, Education and Communication
KII	Key Informant Interview
LGA	Local Government Authority
M&E	Monitoring and Evaluation
MHH	Menstrual Hygiene and Health
MoCDGWSG	Ministry of Community Development, Gender, Women and Special Groups

LIST OF ABBREVIATIONS

MoEST	Ministry of Education, Science and Technology
MoF	Ministry of Finance
MoH	Ministry of Health
MoLEYD	Ministry of Labor, Employment, Youth and the Disabled
NAIA AHW	National Accelerated Action and Investment Agenda for Adolescent Health and Wellbeing
NPA-VAWC	National Plan of Action to End Violence Against Women and Children
NTC	National Technical Committee
NSC	National Steering Committee
OECD-DAC	Organization for Economic Co-operation and Development – Development Assistance Committee
PFP	Pooled Funding Platform
PMO-RALG	Prime Minister’s Office – Regional Administration and Local Government
PPTC	Post-Primary Technical Centre
PrEP	Pre-Exposure Prophylaxis
RS	Regional Secretariat
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TACAIDS	Tanzania Commission for AIDS
TASAF	Tanzania Social Action Fund
TFNC	Tanzania Food and Nutrition Centre
TWG	Thematic Working Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
VACS	Violence Against Children Survey
VETA	Vocational Education and Training Authority
WIFAS	Weekly Iron and Folic Acid Supplementation

LIST OF ABBREVIATIONS

WHO	World Health Organization
YFS	Youth-Friendly Services

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Special thanks go to adolescents and young people across all participating regions and councils, whose voices, insights and experiences were central to this evaluation. Their active participation continues to inspire the national commitment to ensuring that every adolescent in Tanzania is healthy, safe, educated and empowered to reach their full potential.

The Ministry also acknowledges the valuable collaboration and technical support of all sectoral Ministries, Departments and Agencies, including President’s Office – Regional Administration and Local Government (PMO-RALG), Ministry of Health (MoH), Ministry of Education, Science and Technology (MoEST), Prime Minister's Office Labour, Youth, Employment and Persons with Disability (PMO-LYED), Ministry of Finance (MoF), Tanzania Commission for AIDS (TACAIDS), Tanzania Food and Nutrition Centre (TFNC), Vocational Education and Training Authority (VETA) and Tanzania Social Action Fund (TASAF), Ministry of Home Affairs (MoHA), Ministry of Water (MoW); Ministry of Industry and Trade (MITI); Ministry of Home Affairs (MoHA); Ministry of Constitutional and Legal Affairs (MoCLA); (Policy and Coordination), Tanzania Institute of Education (TIE) and the National Economic Empowerment Council (NEEC) as well as the dedicated efforts of Regional Secretariats and Local Government Authorities for facilitating fieldwork, coordination and data collection.

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Finally, we acknowledge all civil society organizations, community leaders, teachers, service providers and development partners who have continued to champion adolescent health and wellbeing across Tanzania. Their collective efforts have made NAIA–AHW not just a national program, but a shared movement towards a healthier, more equitable and more resilient generation.

EXECUTIVE SUMMARY

The National Accelerated Action and Investment Agenda for Adolescent Health and Wellbeing (NAIA-AHW 2021/22–2024/25) was launched by the Government of United Republic of Tanzania in April 2021 as a multi-sectoral framework to accelerate coordinated action and investment in adolescent health, education, protection and skills empowerment. The agenda sought to strengthen systems and partnerships addressing the needs of adolescents aged 10–19 years through six interlinked pillars: preventing HIV, preventing teenage pregnancy, preventing physical, sexual and emotional violence, improving nutrition, keeping boys and girls in school and developing skills for meaningful economic opportunities.

The endline evaluation, commissioned by the Ministry of Community Development, Gender, Women and Special Groups (MoCDGWSG), assessed NAIA AHW's performance, coordination, relevance and sustainability from 2021/22 to 2024/25. It also provides strategic direction for the recommended next phase (2025/26–2029/30).

The evaluation examined both what was achieved and how it was achieved. Using a mixed-methods design, it combined quantitative data from national systems (DHIS2, EMIS, CPMIS) and sectoral reports with qualitative evidence from key informant interviews (KIIs), (FGDs) and field observations conducted in six regions of Mwanza, Katavi, Tabora, Songwe, Lindi, Arusha and Pwani.

Data were analyzed using both deductive and inductive approaches. Quantitative results were interpreted against NAIA AHW indicators, while qualitative evidence was organized thematically using the OECD-DAC evaluation criteria of relevance, coherence, effectiveness, efficiency, impact and sustainability. Triangulation across methods, respondent types and data sources enhanced the credibility and validity of findings.

The evaluation findings reveal substantial progress made under NAIA AHW in institutionalizing adolescent wellbeing across national and subnational systems. Tanzania has developed a robust policy and coordination framework that integrates adolescent health, nutrition, education and protection. NAIA AHW has functioned as the main national multisectoral agenda for adolescents' health and wellbeing in Tanzania. Providing a coordinated framework among ministries and development partners for cross-sectoral planning, implementation and accountability.

The agenda's visibility and relevance increased primarily at national level and among directly involved sector ministries and implementing partners. However, awareness and ownership at Local Government Authority (LGA) and community levels were uneven and often limited, particularly in councils where NAIA-AHW was not systematically integrated into existing planning and coordination mechanisms. Adolescents in the visited districts consistently demonstrated improved knowledge, confidence and participation in wellbeing programs. Evidence shows that multisectoral collaboration, youth engagement and community mobilization were decisive enablers of success.

HIV prevention and education-related interventions recorded the most measurable improvements, while nutrition and skills development require intensified coordination, financing and scalability in the next phase. At the same time, qualitative findings indicate that NAIA-AHW made an important contribution to strengthening cross-sectoral collaboration, particularly by providing a shared national framework that enabled nutrition, education, health and protection actors to plan and implement complementary interventions. Partners reported that NAIA-AHW facilitated alignment of sectoral activities such as coordination between nutrition and education actors on school-based interventions and helped reduce duplication by clarifying roles, priorities and geographic focus areas.

The evaluation also found evidence of emerging social norm change, particularly in how communities discuss SRH, gender roles and parenting. This emerging normative shift represents an important step toward sustainability although it remains fragile and uneven and will require continued investment and reinforcement behavior to become fully community-driven and institutionalized.

Qualitative findings further highlighted growing concerns among communities regarding weakening parenting practices, declining social cohesion and the perceived erosion of moral and ethical values among adolescents. These factors were consistently identified as underlying drivers of risk behaviors, including early sexual activity, school dropout, disrespectful social interactions and increased exposure to violence. While NAIA–AHW contributed to positive shifts in awareness and dialogue on adolescent wellbeing, these findings indicate that behavioral outcomes remain strongly influenced by family and community-level socialization systems. This underscores the need for more structured parenting support interventions, as well as strengthened community-based approaches that reinforce positive values, life skills and ethical development as part of adolescent wellbeing programming in the next phase.

The evaluation also observed progress in addressing teenage pregnancy in several NAIA–AHW implementation areas, including improved access to SRH information, school re-entry for adolescent mothers and increased community dialogue on prevention. However, teenage pregnancy rates remain high and uneven across regions, indicating the need for sustained, targeted and multi-level interventions

At the community level, traditional and faith-based leaders have increasingly supported adolescent wellbeing. Community dialogues, mentorship groups and interfaith initiatives helped reduce stigma surrounding sexual and reproductive health and encouraged collective responsibility for adolescent protection and education. Songwe showed innovation through community facility linkages and youth-led engagement. Katavi and Tabora revealed emerging community ownership but limited technical resources, while Arusha leveraged faith networks effectively to promote inclusive adolescent dialogue.

The most successful interventions were those that adapted to local realities and engaged communities meaningfully. Localization increased participation, improved relevance and strengthened ownership. Youth engagement proved both cost-effective and sustainable, while integrated data systems improved accountability. The evaluation also underscored the importance of predictable financing and continuous capacity development to maintain quality and institutional memory across program cycles.

Three implementation models emerged: an integrated government–partner model, a community and faith-based model and a local government–driven model. Each presents a viable approach for scaling up, depending on context and resource availability.

However, persistent challenges including limited financing, inconsistent data integration and uneven implementation capacity constrained the depth and pace of progress in some regions and pillars. While NAIA-AHW provided a stronger national framework, ownership and prioritization varied across sectors and subnational levels, particularly at regional and council levels perceiving NAIA activities as partner-driven rather than core government responsibilities. This affected commitment to planning, budgeting and routine reporting providing challenges in assessing the progress. Human resource shortages were widespread. Many teachers, nurses and community officers had multiple responsibilities, limiting their capacity to sustain adolescent-specific activities. Volunteer peer educators lacked adequate supervision and incentives, raising sustainability concerns. Cultural resistance, particularly around SRH education and gender equality, also slowed progress in some regions. Data

systems remained fragmented, with adolescent indicators inconsistently disaggregated by age and sex across DHIS2, EMIS and CPMIS platforms.

NAIA–AHW provided a strong national framework, ownership and prioritization varied across sectors and subnational levels, with some regional secretariats and councils perceiving NAIA activities as partner-driven rather than core Government responsibilities. This affected commitment to planning, budgeting and routine reporting.

The NAIA–AHW has provided a framework for coordinating adolescent health and wellbeing interventions in Tanzania. The evaluation indicates that the agenda helped elevate adolescent health and wellbeing within national policy discussions and supported selected improvements at sector and community levels. However, progress was uneven across pillars and locations and limitations in ownership, coordination and resourcing constrained the scale of change achieved during the implementation period.

While the evaluation highlights strategic directions for a potential next phase, detailed design, restructuring of pillars and naming considerations should be addressed through a dedicated national consultation process

Implementation should emphasize institutional coherence through clear ministerial leadership, stronger data integration through a national adolescent health and wellbeing dashboard that can be part of the Community Development Information System (CDIS) and domestic resource mobilization through a national pooled fund. Adolescent representation should be institutionalized at every level and behaviour change communication should remain a core pillar of the national strategy.

As the country transitions to the recommended next phase of NAIA–AHW, the focus must shift from not just expansion to all 26 regions, but also consolidation and sustainability. By embedding adolescent health and wellbeing into government systems, ensuring predictable financing and amplifying youth leadership, Tanzania can sustain momentum toward a future where every adolescent is healthy, safe, educated and empowered to realize their full potential.

CHAPTER ONE: INTRODUCTION

The Demographic and Development Context of Adolescents in Tanzania

Adolescents (defined as 10–19 years) and young people represent a critical mass of Tanzania’s population, accounting for approximately 25 percent of the total populace (NBS, 2023). This large demographic profile makes adolescent health, education and empowerment central to unlocking the demographic dividend, a phase of accelerated social and economic growth driven by a productive, healthy and educated young workforce. The 2022 Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) provides essential evidence on fertility, schooling and key health indicators, forming the foundation for adolescent-focused policy and program planning (MoH, NBS, OCGS, & ICF, 2022). Beyond the core indicators, adolescents face persistent and cross-cutting vulnerabilities in protection, nutrition and transition to productive livelihoods, all of which substantially affect human capital outcomes (World Bank, 2021).

The literature consistently emphasizes that effective adolescent HIV prevention requires a high-impact combination approach, encompassing testing, efficient linkage to care, voluntary medical male circumcision (VMMC), pre-exposure prophylaxis (PrEP) and the provision of youth-friendly services (UNAIDS, 2021). In Tanzania, the Tanzania HIV Impact Survey (THIS) 2022-2023 highlights the disproportionate vulnerability of adolescent girls and young women (AGYW), with HIV prevalence in the 15–24 age group at 5.0 percent for females compared to 2.6 percent for males (MoH, 2024). This structural disparity underlines the sustained importance of targeted, gender-sensitive and adolescent-centred approaches mandated under the Fifth National Multi-Sectoral Strategic Framework (NMSF V) 2021/22–2025/26 (TACAIDS, 2022). Implementation reports under NAIA AHW reveal significant increases in adolescent HIV testing and VMMC uptake, largely supported by integrating HIV services within broader Sexual and Reproductive Health (SRH) outreach platforms (NAIA AHW Implementation Report, 2024).

Global evidence confirms that comprehensive sexuality education (CSE), delivered both in schools and community settings, combined with confidential, youth-friendly contraceptive services and meaningful parent/community engagement, is effective in reducing adolescent pregnancy rates (WHO, 2018). Despite national efforts, the TDHS-MIS 2022 data shows that 22 percent of girls aged 15–19 have already begun childbearing (MoH, NBS, OCGS, & ICF, 2022). This high rate indicates that structural and social barriers such as low comprehensive knowledge of HIV/SRH (TACAIDS, 2022), limited access to modern contraceptives for unmarried youth and restrictive social norms remain critical bottlenecks. Tanzanian monitoring data under NAIA AHW report expanded school-based SRH education programs, the use of digital hotlines and increased teacher training to improve adolescent SRH knowledge and service uptake (NAIA AHW Implementation Report, 2024).

Adolescent wellbeing literature identifies violence prevention as a core prerequisite for health and educational attainment. Recent national data from the Violence Against Children and Youth Survey (VACS) 2024 indicates significant declines in violence exposure since 2009. However, the data underscores that substantial proportions of adolescents still experience sexual, physical or emotional violence (THPS, 2024). Specifically, 11 percent of girls and 5 percent of boys report having experienced sexual violence in their lifetime (THPS, 2024). The NAIA AHW’s focus on establishing protection desks, children’s councils and psychosocial support systems aligns with international best practice frameworks, such as INSPIRE, which emphasize multi-layered interventions, including changing community norms, strengthening school-based protection and establishing robust referral systems for survivors (CDC, 2016).

Adolescent nutrition is increasingly recognised as a distinct priority within the life-course approach, particularly for managing micronutrient deficiencies and supporting healthy growth (Black et al., 2013). Recent national evidence indicates that malnutrition among adolescents in Tanzania remains significant concern in both under and over nutrition forms. According to the Tanzania Demographic and Health Survey (TDHS), (45%) of adolescents girls (15–19 years) continue to face high rates of anaemia (31.7%) underscoring the continued burden of micronutrient deficiencies (TDHS 2022). In addition, the same survey shows that 12 percent of adolescent girls are overweight or obese, with prevalence notably higher in urban areas (20 percent) compared to rural areas (9 percent) (NBS & MoH, 2022). These emerging patterns highlight the dual burden of malnutrition facing adolescents, with implications for both physical and psychosocial wellbeing, including risks of stigmatization, low self-esteem, depression and anxiety, as well as longer-term vulnerability to non-communicable diseases such as diabetes and cardiovascular conditions. NAIA AHW-implemented strategies, such as school-based interventions (e.g., school meals, gardens, Weekly Iron and Folic Acid Supplementation (WIFAS) and nutrition-education campaigns (e.g., “*Bamba na Lishe*”), align with evidence showing that school platforms can effectively enhance dietary diversity and improve learning readiness (Thrive Child Evidence, 2024). Nevertheless, literature highlights persistent challenges related to supply-chain continuity for supplements and limited coverage for adolescents out of school (IFPRI, 2020).

Education-retention literature emphasizes the systematic removal of barriers (e.g., direct and indirect costs, distance, inadequate infrastructure, menstrual health and hygiene (MHH) support and flexible re-entry policies) as highly effective for reducing dropout, particularly among vulnerable girls (UNICEF, 2019). While primary and secondary education enrolment has increased, disparities persist, with the secondary school Net Enrollment Ratio (NER) remaining a challenge, especially in rural areas (MoE, 2024). Tanzanian school statistics (Basic Education Statistics in Tanzania, 2024) and NAIA AHW implementation data report notable improvements in Water, Sanitation and Hygiene (WASH)/MHH infrastructure and observed decreases in dropout rates in intervention districts (BEST 2024, NAIA AHW Implementation Report, 2024). While these infrastructure gains represent an important enabling condition, the evaluation found that systematic assessment of service quality, day-to-day practices and supportive social norms related to WASH and MHH was limited. Qualitative findings suggest that in contexts where infrastructure improvements were complemented by teacher engagement, health education and supportive school environments, utilization and perceived benefits were stronger. However, infrastructure alone was insufficient to guarantee sustained use or equitable outcomes, particularly in settings affected by teacher shortages and rural–urban disparities. These findings underscore the need for future programming to integrate behavioural change, capacity-building and norm-shaping interventions alongside infrastructure investments to achieve lasting educational outcomes.

Skills development for adolescents is most effective when interventions are linked directly to local labour-market demand, incorporate soft-skills training and are supported by apprenticeships or business start-up linkages (ILO, 2022). National data indicates that youth (15-35 years) face unemployment rates of approximately 13.5 percent nationally, with underemployment being significantly higher, particularly in rural settings (NBS, 2023). Evidence from the Productive Social Safety Net (PSSN2) Impact Evaluation (TASAF) suggests that combining unconditional cash transfers with cash-plus-skills interventions generates improved livelihood outcomes for disadvantaged adolescents and young people (UNICEF et al., 2018). NAIA AHW reports highlight enrolments in Vocational Education and Training Authority (VETA) centres and private-sector partnerships (NAIA AHW Implementation Report, 2024). Nonetheless, the literature identifies systemic gaps in access

to micro-finance, start-up capital, market absorption and comprehensive reach to rural out-of-school youth (Policy Forum, 2020).

Cross-sectoral literature emphasizes that for adolescent programs to achieve sustainable scale, they require strong governance and coordination, integrated data systems, predictable financing and meaningful youth participation in decision making (WHO, 2018). In Tanzania, recent evaluations and sectoral analyses demonstrate notable progress in strengthening national-level governance structures for adolescent health and wellbeing, including the establishment and operationalization of the National Steering Committee (NSC), National Technical Committee (NTC) and youth fora under NAIA AHW. These platforms have contributed to improved policy coherence, joint planning and harmonized technical guidance across ministries. Persistent systemic bottlenecks continue to limit the full realization of NAIA's multisectoral intentions. Evidence from the literature and the NAIA-AHW Implementation Report indicates that functionality remains uneven, largely due to capacity gaps, inconsistent supervision and competing structural and sectoral priorities (NAIA-AHW Implementation Report, 2024).

Monitoring and evaluation framework suffers limited disaggregation and weak integration of national data systems (DHIS2 for health, EMIS for education and CPMIS for protection) which reduce the ability to generate holistic adolescent profiles for planning and performance monitoring (NAIA-AHW Implementation Report, 2024). Fragmented financing arrangements, characterised by a heavy reliance on partner-funded activities, further undermine sustainability and make long-term program continuity uncertain. Lessons from Tanzania's Productive Social Safety Net (PSSN II) impact evaluation highlight the critical importance of domestic resource mobilization, pooled financing arrangements and integrated delivery systems in sustaining national social sector reforms (UNICEF et al., 2018; NBS, 2022). These lessons reinforce the case for formalizing multi-sector financing modalities under NAIA-AHW Phase II, ensuring that adolescent wellbeing becomes an integral part of routine government budgeting rather than a series of project-dependent interventions.

About the NAIA-AHW (2021/22–2024/25)

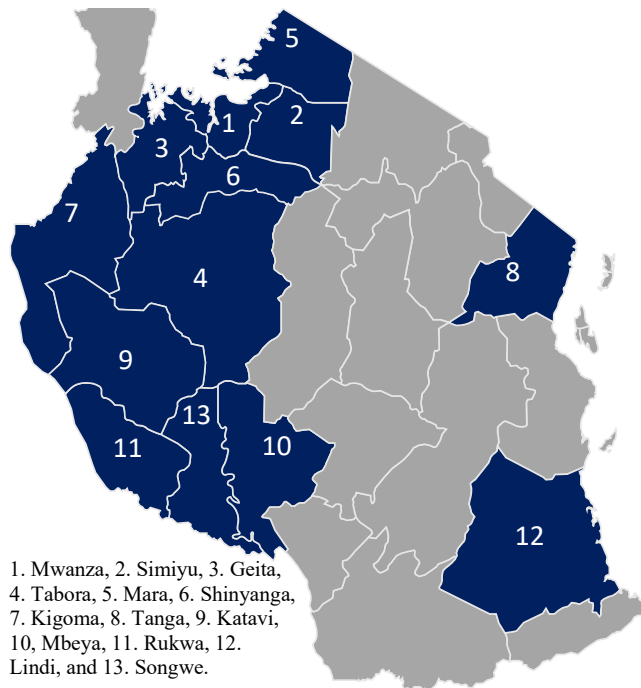
The National Accelerated Action and Investment Agenda for Adolescent Health and Wellbeing (NAIA AHW 2021/22–2024/25) was launched by the Government of the United Republic of Tanzania in April 2021 as a national framework to fast-track multisectoral investments that enhance the health and wellbeing of adolescents aged 10–19 years. The agenda was designed in recognition of the pivotal role that adolescents play in national development and the need for coordinated action to address the unique and interlinked challenges they face. This phase of implementation, the NAIA AHW focuses on 89 District Councils of 13 Regions¹.

NAIA AHW was developed through an extensive consultative process led by the Ministry of Community Development, Gender, Women and Special Groups (MoCDGWSG) under leadership of President's Office – Policy, Parliament, Coordination and People with Disability in collaboration with the other Sectoral Ministries and Government Institutions including; Ministry of Health, the President's Office – Regional Administration and Local Government (PMO-RALG), Ministry of Agriculture, Ministry of Home Affairs, Ministry of Education, Science and Technology, President's Office – Labor, Employment and relationship, TFNC, TIE, TASAF, NEEC, etc with technical and financial support from development partners including UNFPA, UNICEF, WHO, USAID, NI, Plan International, MSI – Tanzania, World Vision International, Brac Maendeleo Tanzania, Girls Effects and others.

¹ Geita, Katavi, Kigoma, Lindi, Mara, Mbeya, Mwanza, Rukwa, Shinyanga, Simiyu, Songwe, Tabora and Tanga.

The agenda builds on lessons from previous national strategies and frameworks such as the fifth National Multisectoral Strategic Framework for HIV 2021/22 – 2025/26 (NMSF V), the National Plan of Action to End Violence Against Women and Children (NPA – VAWC 2017/18-2021/22), the National Nutrition Action Plan (NMNAP II 2021/22–2025/26), National Skills Development Strategy (NSDS) 2016-2027 and Education Sector Development Plan (ESDP) 2021/22 – 2025/26. It also responds to global and regional commitments such as the Sustainable Development Goals (SDGs), the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030) and the African Union’s Agenda 2063.

Figure 1: Target NAIA - AHW geographical locations



NAIA AHW is anchored on six interconnected pillars that represent the country’s priority areas for adolescent health and wellbeing namely 1. Preventing HIV; 2. Preventing Teenage Pregnancies; 3. Preventing Physical, Sexual and Emotional Violence; 4. Improving Nutrition; 5. Keeping Boys and Girls in School; and 6. Developing Skills for Meaningful Economic Opportunities.

Each pillar comprises a mix of priority, supporting and emerging interventions, ensuring that both immediate and long-term needs of adolescents are addressed through integrated, multisectoral programming. The agenda promotes inclusive, youth-centered and evidence-based action that strengthens coordination and accountability at all levels, from national to community.



The rationale for the NAIA AHW lies in the need to consolidate fragmented adolescent programs into one cohesive framework that drives investment, ensures sustainability and measures results. The initiative recognizes that adolescence is a defining phase of human development, marked by both opportunities and vulnerabilities, ensuring strategic investments during this period have a lifelong impact on individual potential and national prosperity.

The Scope of the Endline Evaluation

This end-line evaluation of the NAIA AHW focuses on implementation and related impact for the period between 2021/22 and 2024/25. The evaluation looks into the specific interventions, targets and outcomes related to the Agenda's six pillars. Geographically, the evaluation focussed on a representative sample of 14 councils drawn from 7 of the 13 priority regions originally selected for NAIA AHW implementation. Those were Mwanza, Katavi, Tabora, Songwe, Lindi, Arusha and Pwani. It is important to take note that the regions of Arusha and Pwani were not priority regions of NAIA AHW, they were selected as control regions in order to draw a comparative perspective and inform the expansion possibility.

Table 1.3: Regions and Councils involved in the evaluation

Zone	Region	Councils	
		Urban	Rural
Lake Zone	Mwanza Region	Ilemela MC	Misungwi DC
Western Zone	Katavi	Mpanda MC	Mpimbwe DC
	Tabora	Uyui DC	Urambo DC
Southern Highland	Songwe Region	Mbozi DC	Songwe DC
Southern	Lindi Region	Lindi MC	Nachingwea DC
Northern	Arusha Region	Arusha CC	Monduli DC
Coast zone	Coast Region	Kibaha MC	Kisarawe DC

The evaluation findings are anticipated to inform the next phase of NAIA and serve as a strategic learning opportunity, offering insights into the enabling factors and systemic gaps that influence the success of adolescent-focused policies and programs in the country.

Objectives of the evaluation

The overall objective of this endline evaluation is to assess the relevance, coherence, effectiveness, efficiency, impact and sustainability of the NAIA AHW implementation during the period 2021/22 to 2024/25. Specifically, the evaluation seeks to:

1. Determine the extent to which NAIA AHW achieved its intended results across the six pillars and cross-cutting areas;
2. Assess how effectively multisectoral coordination, resource allocation and accountability mechanisms functioned at national and subnational levels;
3. Identify enabling factors, challenges and lessons learned in implementing adolescent-focused interventions;
4. Examine the participation and empowerment of adolescents and youth in shaping, implementing and monitoring NAIA programs; and
5. Provide evidence-based recommendations to inform the design and implementation of next steps of investment.

The evaluation covers mainland Tanzania, focusing on implementation in selected seven regions and fourteen councils representing a mix of high and low-performing areas, urban and rural settings and diverse socio-cultural contexts. It targets interventions implemented through government systems, development partners and civil society organizations, while also examining community-level engagement and adolescent experiences.

CHAPTER TWO: EVALUATION DESIGN AND METHODOLOGY

2.1 Evaluation Approach

The evaluation framework drew directly from the NAIA AHW results and monitoring matrix, which defines indicators and targets for each pillar. The framework also included cross-cutting domain which looked at youth participation and coordination and resource adequacy as emphasized in the inception report and stakeholder consultations. This framework aimed to have a systematic assessment of both results (outcomes) and processes (coordination, systems and participation).

A convergent parallel mixed-methods design was used to allow for comprehensive understanding and triangulation of evidence. Quantitative data were drawn from secondary datasets of the NAIA AHW implementation report 2021/22-2024/25 and routine management information systems (HMIS, BEST, TACAIDS, TFNC), while qualitative data were collected through Key Informant Interviews (KIIs), Focus Group Discussions (FGDs) and structured observations.

The evaluation prioritized participatory and utilization-focused approaches, emphasizing stakeholder engagement at every stage, from data collection tool validation to interpretation of results through the Evaluation Management Team (EMT)². Special attention was given to capturing the voices and lived experiences of adolescents and youth, consistent with NAIA's principle of "meaningful adolescent participation."

2.2 Data Collection Methods and Tools

Data collection took place between August and October 2025, coordinated by the EMT under MoCDGWSG and UNFPA oversight. Multiple complementary tools were employed to ensure comprehensive coverage of the evaluation questions. All tools were pre-tested, translated into Kiswahili and approved by MoCDGWSG to ensure cultural and ethical appropriateness.

Table 2.2: Summary of Data Collection Methods

Method	Purpose	Respondents/Source
Document Review	To extract quantitative and policy-level data on outputs, budgets and results.	NAIA AHW 4 year implementation report (2021/22 – 2024/25, M&E frameworks, national surveys, sector reports and partner documents.
Key Informant Interviews (KIIs)	To obtain expert and institutional insights and experiences on relevance, coherence, coordination and results.	National ministries, Regional Secretariats, LGAs, UN agencies, INGOs, CSOs, FBOs.
Focus Group Discussions (FGDs)	To capture adolescents' and youth perspectives,	In-school and out-of-school adolescents (10–19 years), peer mentors, parents.

² The EMT was composed of representatives from Sectoral Ministries Departments and Agencies, UN Agencies, Development Partners and Civil Society Organizations. (UNICEF, WAWATA, SOLEDARMED, WORLD VISION, DSW-TANZANIA, UNFPA, PLAN INTERNATIONAL, WGNRR AFRICA, FEMINA HIP, UMATI, Nutritional International, SAVE THE CHILDREN, UNICEF, MCDGWSG, PMO, PMO-RALG, MoEST and UDOM).

Method	Purpose	Respondents/Source
	lived experiences and perceptions of impact.	
Observation	To validate implementation quality and access to services.	Health facilities, schools, safe spaces, vocational centers.
Secondary Data Extraction	To analyze quantitative trends for selected indicators per pillar.	HMIS, BEST, TDHS, THIS, VACS, TFNC reports, NAIA dashboard

Source: Inception report of the Endline Evaluation of NAIA AHW

2.3 Sampling and Stakeholder Groups Reached

Sampling followed a multi-stage purposive design to ensure diversity across regions, sectors and respondent categories. Seven (7) regions and fourteen (14) councils were selected, representing variations in geographic location, urban-rural balance and implementation performance. Participants at national level who were interviewed using KII were from informed by NAIA monitoring data, regional population profiles and consultations with MoCDGWSG and PMO-RALG.

Table 2.3: Sampling Framework and Coverage

Level	Region/Councils reached	Methodology	Respondent Categories reached	Number of Respondents
National	Directors, National Coordinators, TWG Members	KII	PMO-RALG, MoCDGWSG, MoH, MoEST, PMO-LYED, MoF, TACAIDS, TFNC, VETA, TASAF, NASHCoP	15
	CSOs, UN Agencies, NGOs	KII	Nutritional International, UNFPA, DSWTZ, FEMINA, APOTHEKER, MDH, UNESCO	8
Regional	Mwanza, Tabora, Katavi, Songwe, Lindi, Arusha, Pwani	KII	Regional Social Welfare Officer (RSWO) Regional Community Development Officer (RCDO) Regional Reproductive, Maternal and Child Health Coordinator (RCHCo)	70

Level	Region/Councils reached	Methodology	Respondent Categories reached	Number of Respondents
			Regional Planning Officer (ASI Mipango) Regional Education Officer (REO) Regional Nutrition Officer (RNO) Regional HIV and Sexually Transmitted Infections Coordinator (RAC) Regional Medical Officer (RMO) Regional Police Gender and Children Desk Coordinator VETA – Vocational Education and Training Authority	
District/Council	14 LGAs (e.g., Illemela, Misungwi, Mbozi, Tunduma, Mpimbwe, Monduli, Uyui, etc.)	KII	District Community Development Officer (DCDO) District Reproductive, Maternal and Child Health Coordinator (DCHCo) Council Planning Officer District Education Officer (DEO) District Nutrition Officer (DNO) District HIV and Sexually Transmitted Infections Coordinator (DAC) District Medical Officer (DMO) Police Gender and Children Desk Coordinator TASAF representative	132
Community/Facility	Health centers, schools, safe houses and	Observations	Education and Health Service providers,	28

Level	Region/Councils reached	Methodology	Respondent Categories reached	Number of Respondents
	community programs		teachers and local leaders	
Adolescent s/Youth	FGDs with in-school and out-of-school adolescents (10–19 years)	FGD	Adolescent (6 boys and 6 girls per FGD) and Community Health Workers (CHW's) and Community Health Workers (CHW's)	168*
CSOs and Religious Leaders	CSOs at Council Level	KII	Christian and Muslim Leaders, CSOs and NGOs representatives	56

* The sampling for adolescents ensured gender and age balance, inclusion of marginalized youth.

Source: Data collected from the field in Mwanza, Katavi, Tabora, Songwe, Lindi, Arusha and Pwani regions.

2.4 Data Analysis

2.4.1 Data Analysis Approach

The evaluation adopted a mixed-method analytical approach that combined both deductive (framework-based) and inductive (emergent theme) analysis techniques to ensure comprehensive and balanced interpretation of evidence. Quantitative data were analyzed using descriptive statistics, cross-tabulations and trend analysis, referencing the NAIA–AHW Results Framework and sectoral indicator baselines. This allowed measurement of progress against planned outputs and outcomes across all six pillars of the agenda.

Qualitative data obtained from Key Informant Interviews (KIIs), Focus Group Discussions (FGDs) and field observations were transcribed, translated, cleaned and coded thematically. Analysis followed a structured matrix aligned with both the OECD-DAC evaluation criteria of relevance, coherence, effectiveness, efficiency, impact and sustainability and the six NAIA pillars. This ensured that themes emerged from the field were systematically organized, compared and synthesized to explain the underlying processes influencing results.

Table 2.4.1: Evaluation Framework Overview

OECD-DAC Criterion	Core Evaluation Focus (Linked to NAIA Pillars)
Relevance	Alignment of NAIA AHW priorities with adolescent needs, policies and emerging issues.
Coherence	Coordination and synergy among ministries, sectors and partners.
Effectiveness	Progress toward outcomes under each NAIA pillar.
Efficiency	Resource use, cost-effectiveness and functionality of coordination mechanisms.

Impact	Observable changes in adolescent health, education, protection and wellbeing outcomes.
Sustainability	Institutionalization, ownership and continuity of NAIA interventions beyond the first phase.

Source: Inception Report of the Endline Evaluation of NAIA AHW

Through this dual analytic approach, the evaluation generated both quantitative evidence of achievement and qualitative insights into the contextual and institutional factors shaping performance across levels of implementation.

The evaluation also attempted to compare performance and impact across the six study regions to assess whether the initial NAIA–AHW prioritization strategy translated into measurable differences in outcomes. Among the regions evaluated, Pwani, Songwe, Mwanza, Arusha and Katavi were designated as *priority regions* under the original NAIA framework, while Tabora and Lindi were included as non-priority regions for comparative purposes.

This comparative review provided critical insight into the scalability and equity of NAIA interventions, testing whether the program’s design enabled broader systemic uptake beyond the initial high-focus geographies.

2.4.2 Triangulation and Validation

Triangulation was a core feature of the analysis, designed to strengthen the credibility, reliability and validity of findings. Evidence was triangulated across three key dimensions:

- a) Data Sources where National-level reports, regional data and community-based evidence were cross-referenced to ensure consistency and detect regional variations in implementation outcomes;
- b) Across different methods where quantitative data from document reviews and official statistics were compared with qualitative insights from KIIs, FGDs and field observations to validate findings through multiple lenses; and
- c) Based on respondent types where perspectives from government officials, development partners, civil society organizations, service providers and adolescents were analyzed collectively to capture convergent and divergent viewpoints.

This triangulation process enhanced interpretation of results, minimizing bias and enriched the depth of understanding of both achievements and challenges experienced during implementation.

The evaluator acknowledges that several NAIA–AHW outcome indicators are formulated in percentage terms. However, nationally representative survey data that would allow statistically valid percentage estimation for these indicators do not exist at regular intervals and were not designed within NAIA–AHW to be collected annually or sub-nationally. As a result, the evaluation applied methodologically appropriate proxy and administrative evidence, consistent with OECD-DAC and UNICEF/ILO evaluation standards, to assess change where direct measurement was not feasible.

Specifically, indicators where national statistical surveys data do not exist, were assessed using triangulated sources including programme monitoring data, administrative records (e.g. Child Helpline 116, Police Gender and Children’s Desks, CPMIS, NAIA-AHW Implementation report July 2022- June 2024, training records and qualitative findings. These proxies enabled to capture direction, scale and plausibility of change, without overstating precision. Importantly, applying proxy evidence avoids the risk of presenting misleading percentages

derived from non-comparable or incomplete datasets. The same methodological approach was applied consistently across pillars where outcome indicators lacked dedicated national survey instruments. The evaluation therefore prioritized validity and transparency over artificial quantification, while clearly documenting data limitations and sources.

2.4.3 Presentation of the Findings

Data analysis and presentation of the findings were closely interlinked to produce a comprehensive and explanatory narrative of the NAIA–AHW’s performance. The evaluation combined results-based analysis, anchored on the NAIA Results Framework, with process evaluation, guided by the OECD-DAC evaluation criteria.

This dual analytical framework was deliberately designed to reflect the multi-sectoral and interconnected nature of the NAIA–AHW agenda, which addresses adolescent health, education, protection, nutrition and economic empowerment as interrelated domains of wellbeing.

The results-based component focused on quantitative achievements against the planned outputs and outcomes for each of the six NAIA pillars. Drawing on national monitoring systems, administrative data and program reports, it measured progress over time, identifies trends and highlighted gaps between targets and achievements.

In addition, the process evaluation applied the OECD-DAC framework to examine how implementation was carried out, the efficiency of coordination structures, resource allocation and the effectiveness of partnerships. It relied primarily on qualitative data from fieldwork to explain the ‘how’ and ‘why’ behind observed performance patterns.

This report integrates these two analytical perspectives, combining measurable results with explanatory insights, so that both achievements and lessons learned inform future strategic directions. The blended approach aligns with Tanzania's National Evaluation Framework which emphasizes accountability, learning and continuous improvement. The report layout of the findings is structured into two analytical design:

- a) Part I presents results organized by the six NAIA pillars, focusing on quantitative performance and trends against indicators; and
- b) Part II synthesizes qualitative findings using the OECD-DAC criteria to analyze implementation processes, coordination, financing, human resources and sustainability.

These two sections form a comprehensible and evidence-based narrative that links performance with process to ensure that evaluation insights can meaningfully inform the next phase of the NAIA–AHW and the broader adolescent health and wellbeing agenda in Tanzania.

2.5 Ethical Considerations and Data Quality Assurance

The evaluation adhered to national research ethics protocols and international standards for the protection of minors. Permission were sought from the PMO-RALG and ethical clearance was obtained from the MoCDGWSG. All participants were informed of the study’s purpose, assured of confidentiality and provided verbal or written consent. FGDs with adolescents were conducted in safe, age-appropriate spaces and facilitated by trained moderators of the same sex where possible.

Quality assurance measures included tool validation, field supervision, daily debriefs and systematic review of transcripts and data entry. Data integrity was further reinforced through triangulation and independent verification of key statistics.

2.6 Limitations and Mitigation Measures

Several limitations were encountered during fieldwork. The most notable was the limited availability of government officials due to competing responsibilities, which delayed some interviews and data validation sessions. This was mitigated by follow-up phone calls and flexible scheduling, including weekend and remote interviews.

Additionally, variability in data completeness across regions constrained quantitative trend and qualitative analysis. To address this, evaluators triangulated official records with reports from partners and observation findings.

Analysis against the NAIA-AHW impact and outcome indicators, as set out in Annex 9 of the Data and M&E Framework, was constrained by limitations in indicator definition and data availability. Several indicators in the NAIA-AHW were articulated without numeric baselines or targets at the outset of implementation, necessitating reliance on national surveys and administrative data as proxies for trend analysis. In addition, some outcome indicators were conceptually defined but lacked standardized measurement tools or national denominators, limiting comparability across regions and over time. Fragmentation across sectoral data systems further constrained triangulation. Consequently, the evaluation prioritised national surveys for impact assessment and used administrative and qualitative evidence to assess outcome-level progress where quantitative data were incomplete, highlighting the need for clearer indicator operationalisation and harmonised data systems in the next phase of NAIA–AHW.

CHAPTER THREE: FINDINGS

Part I: Quantitative Findings (Results against NAIA Indicators)

3.1 Pillar 1: Preventing HIV

3.1.1 Overview

Pillar 1 of the National Accelerated Action and Investment Agenda for Adolescent Health and Wellbeing (NAIA–AHW 2021/22–2024/25) focuses on reducing new HIV infections among adolescents aged 10–19 years, with a strong emphasis on adolescent girls and young women (AGYW) and their male partners.

This pillar integrates biomedical, behavioral and structural interventions, including HIV testing and counselling, condom promotion, Voluntary Medical Male Circumcision (VMMC), behaviour change communication and the integration of Adolescent Sexual and Reproductive Health (ASRH) with HIV services.

Implementation was led by the Ministry of Health (MoH) through the National AIDS and STI Control Programme (NASHCoP) and TACAIDS, in collaboration with PMO-RALG, regional and district councils and a wide range of development partners including USAID, UNICEF, UNESCO, UNFPA, Nutrition International, MDH, Femina Hip and Marie stopes International (MSI Tanzania), .

The focus during the period 2021/22–2024/25 was to expand coverage of HIV prevention services, strengthen linkages to prevention and care, improving service quality through youth-friendly approaches and increasing community and parental engagement in HIV prevention efforts.

3.1.2 Key Achievements and Progress (2024)

Quantitative data indicate measurable progress across several HIV prevention outcomes among adolescents, particularly in testing, treatment linkage and VMMC coverage. According to the Tanzania HIV Impact Survey (THIS) 2022/23, HIV prevalence among young people aged 15–24 years was 1.3 percent, compared to 1.6 percent in THIS 2016/17, with higher prevalence consistently observed among young women than young men (THIS 2016/17; THIS 2022/23).

Between 2022 and 2024, approximately 2.64 million adolescents aged 10–19 years were tested for HIV, with 2 percent testing positive. Of those, 98 percent were successfully linked to treatment and care services. These gains reflect strengthened facility readiness, improved referral mechanisms and partner-supported outreach models as documented in the NAIA-AHW implementation reports. The table 3.1 below summarizes performance on selected indicators and highlights trends against national and NAIA targets.

Table 3.1.2: National level Progress on Pillar 1 – Preventing HIV (2021–2024)

Indicator	Baseline	Target	Progress (2024/2025)	Remarks / Trend
Impact: HIV incidence rate among adolescents aged 10–19 years	THIS 2016/17: approx. 0.27% (ages 15–24 proxy)	Reduce new infections by 50% by 2022 (HSHSP IV)	THIS 2022/23: approx. 0.17%	Declining trend observed; reduction slower among AGYW

Indicator	Baseline	Target	Progress (2024/2025)	Remarks / Trend
Outcome: % of adolescents (15–19) and male partners of AGYW tested for HIV and linked to services	THIS 2016/17 49.0%	95% linkage of positives by 2022	>95% linkage achieved nationally	Improved linkage performance; testing coverage uneven across regions
Outcome: % of young women and men aged 15–24 with comprehensive knowledge of HIV	TDHS 2015/16: Women 48%, Men 54%	Not defined	TDHS 2022: Women 52%, Men 60%	Gradual improvement; persistent gaps among rural and out-of-school youth
Outcome: % of girls and boys aged 15–19 using condoms during last sex	TBD at start of implementation	85% by 2022	TDHS-MIS 2022: Girls ~32%, Boys ~40%	Behavioural change lagging behind biomedical services
Outcome: % of adolescent boys (10–19) and male partners of AGYW practising VMMC	TBD at start of implementation	90% by 2022	Programme data 2024: ~80–85% nationally	Improved uptake in outreach-supported regions

Source: THIS 2016/17; THIS 2022/23; TDHS MIS 2015/16; TDHS-MIS 2022; NAIA–AHW Implementation Reports; MoH/TACAIDS

3.1.3 Quantitative Trend Analysis

Trend analysis using THIS 2016/17 and THIS 2022/23 indicates a decline in HIV incidence among adolescents and young people, with incidence among those aged 15–24 years declining from approximately 0.27 percent in 2016/17 to 0.17 percent in 2022/23. This reflects the cumulative effects of expanded HIV testing, VMMC scale-up and improved linkage to care. However, the rate of decline has been slower among adolescent girls and young women, underscoring persistent gendered vulnerability linked to age-disparate relationships, limited negotiation power and socio-economic factors.

Outcome-level indicators reveal divergent trends. Biomedical interventions such as HIV testing and VMMC demonstrate consistent upward trajectories, while behavioural indicators including condom use and comprehensive HIV knowledge show more modest gains. TDHS 2022 data indicate that comprehensive HIV knowledge among young people aged 15–24 increased by 4 percentage points among women and 6 percentage points among men compared to 2015/16, but remains uneven, particularly among adolescents in rural areas and those out of school. This imbalance suggests that service expansion has outpaced sustained behaviour change and knowledge consolidation.

3.1.4 Quantitative Interpretation and Linkages

Quantitatively, the data confirm measurable improvements in HIV prevention coverage, service integration and training outputs. Testing and treatment linkage rates indicate system efficiency and improved service readiness at health facility level. Condom and VMMC

coverage reflect expanded partner-driven outreach. Health worker training outcomes illustrate institutional commitment.

However, the relatively low achievement in parental/community engagement (39%) and incomplete data on repeat testing or behaviour change reveal gaps in measuring outcomes beyond service outputs.

Cross-referencing Section 4.5.3 (Insufficient Data Disaggregation), it is evident that adolescent-specific indicators remain inadequately tracked in national databases (DHIS2, GoTHoMIS), particularly for the 10–14 age cohort and for behavioural metrics such as condom use consistency or PrEP awareness.

3.1.5 Evaluator’s Synthesis

From a quantitative standpoint, Pillar 1 demonstrates the most mature and data-driven implementation of all six NAIA pillars. The scale of HIV testing, linkage to care and training achievements indicate both program reach and system functionality.

Evidence suggests that HIV prevention interventions are now institutionalized within the health sector, supported by trained personnel, standardized protocols and multisectoral collaboration (see Section 4.4.1 on Policy Coherence and Government Ownership).

However, numerical progress is uneven across dimensions, biomedical interventions outperform social and behavioral change efforts. The limited quantitative evidence on community engagement and outcome-level impacts (infection reduction, risk perception) underscores the need for improved data integration between biomedical and behavioral indicators in the next NAIA phase.

3.2 Pillar 2: Preventing Teenage Pregnancies

3.2.1 Overview

Pillar 2 of the NAIA–AHW seeks to prevent teenage pregnancies among adolescents aged 10–19 years through integrated Adolescent Sexual and Reproductive Health (ASRH) education, community outreach and service delivery interventions. Teenage pregnancy is closely linked to broader adolescent health risks, including increased vulnerability to malnutrition among pregnant adolescents, particularly micronutrient deficiencies such as anaemia due to heightened nutritional demands, as well as higher risks of premature birth and low birth weight.

This pillar addresses one of Tanzania’s most pressing adolescent wellbeing challenges, teenage pregnancy, which contributes significantly to maternal and neonatal morbidity, school dropout and intergenerational poverty.

Implementation was led by the Ministry of Health (MoH) in collaboration with the Ministry of Education, Science and Technology (MoEST), PMO-RALG and partners such as UNFPA, UNESCO, UNICEF, Marie stopes International (MSI-Tanzania), Nutrition International, Plan International, UMATI, MDH, SolidarMed, Engender Health, Femina Hip and other local CSOs. The interventions were aligned with One Plan III (2022–2025), which set a target to reduce the national teenage pregnancy rate from 22% (2022) to below 20% by 2025.

Key strategies included:

- i. Expanding access to ASRH education in schools and communities through innovative programmes and revision of in-school and out-of-school SRH curricula;

- ii. Improving the quality and adolescent-friendliness of SRH services through capacity building to service providers and establishment of referral and linkages
- iii. Strengthening parental and community engagement; and
- iv. Addressing harmful social and cultural norms that contribute to early pregnancies and marriages.

3.2.2 Key Achievements and Quantitative Progress (2022–2024)

Between 2022 and 2024, both Government and partner-supported programs implemented a range of interventions targeting adolescents' access to SRH information, counselling and services. Those included community-based HIV testing and counselling outreaches, school- and community-based comprehensive sexuality education sessions, adolescent-friendly health service delivery, peer education and youth club initiatives, behavior change communication campaigns and strengthened referral linkages between schools, communities and health facilities.

According to TDHS 2022, national level data indicate 22% of girls aged 15–19 years had ever been pregnant, with rural rates at 25% compared to 15% in urban areas. While this marks little change from the 2015/16 figure (27%), the evaluation notes progress in education-based prevention and SRH knowledge acquisition. However, this data masks substantial sub-national variation in both prevalence and drivers. For example Songwe stands out as a high-burden outlier, with a teenage pregnancy prevalence of 44.7 percent, more than double the national average followed by Katavi at 34 percent and Tabora at 29 percent, all well above the national average. This elevated rate is closely associated with early marriage practices, school dropout among girls, cross-border mobility and limited access to youth-friendly SRH services. Despite NAIA-AHW interventions, structural and socio-cultural barriers continue to outweigh prevention gains in this region.

In contrast, Mwanza and Lindi report moderate levels at 16 percent and 25 percent, respectively, where economic vulnerability and uneven service coverage contribute to sustained adolescent pregnancy rates. Arusha stands out with a comparatively low prevalence of 13 percent where number of collaborative interventions by Government and partners are notably high especially by Civil Societies and Pwani records 20 percent both below or near the national average, reflecting relatively potentially better female school retention and access to education and health services. These regional differences may highlight the need for tailored prevention and support strategies that respond to local drivers of adolescent pregnancy.

Comparative analysis between NAIA–AHW intervention regions and non-NAIA regions among the seven evaluated areas shows that higher adolescent pregnancy rates persist in several NAIA regions. This pattern may not indicate programme failure, rather it likely reflects the intentional targeting of NAIA–AHW interventions to regions with historically high vulnerability as described in the NAIA-AHW itself. These regions are characterized by entrenched structural and socio-cultural drivers including early marriage, poverty, school dropout, cross-border mobility and limited access to youth-friendly SRH services that require sustained, high-intensity interventions to achieve measurable reductions in adolescent childbearing.

The adolescents reached with comprehensive SRH information does not have a quantified baseline or national target specified at the start of NAIA–AHW implementation. However, education sector data provide important proxy evidence of progress. BEST 2022 confirms that Comprehensive Sexuality Education was being provided in both Government and Non-Government schools nationwide by 2021, indicating institutionalization of SRH information

within the education system. While updated national coverage percentages for 2024 are not yet published in BEST, the existence of CSE within the formal curriculum, combined with expanded school and community-based SRH initiatives reported by Government and partners, suggests improved reach and availability of SRH information for adolescents during the implementation period. The absence of updated quantitative coverage data nonetheless limits precise measurement of scale and equity of reach.

TDHS 2022 data indicate gradual progress in contraceptive use among adolescent aged 15–19, but continued gaps. The baseline modern contraceptive prevalence rate stood at 30.2 percent among all women and 35.7 percent among married women aged 15–49 in TDHS 2015/16. NAIA-AHW set ambitious targets of 40 percent (all) and 47 percent (married adolescents) by 2023. While TDHS-MIS 2022 indicates improvements in contraceptive knowledge and access, disaggregated national data specifically for adolescents aged 10–19 remain limited. Available evidence nonetheless points to uneven uptake, influenced by marital status, rural–urban location, social norms and availability of adolescent-friendly services. As with teenage childbearing, progress in contraceptive use appears stronger in regions with better service coverage and school retention and weaker in high-burden NAIA–AHW regions where structural barriers persist.

The table below summarizes quantitative achievements and targets for key interventions during the NAIA–AHW implementation period.

Table 3.2.2: Progress on Pillar 2 – Preventing Teenage Pregnancies (2021–2024).

Indicator	Baseline	Target	Achievement (2024)	Remarks / Trend
Impact: Teenage childbearing rate (10–19)	27% (TDHS 2015/16)	Reduce from 27% to 5% by 2022	22% nationally (TDHS-MIS 2022)	Modest national decline; large regional disparities persist (e.g. Songwe 45%, Katavi 34%, Tabora 29%) indicating continued influence of structural and socio-cultural drivers
Outcome: % of adolescents (10–19) reached with comprehensive SRH information	0 (no consolidated national baseline at NAIA–AHW start)	CSE institutionalized in Government and Non-Government schools by 2021 (BEST 2022)	CSE institutionalized in Government and Non-Government schools by 2021 (BEST 2022)	Significant coverage achieved through integration within the national education curriculum. Structural progress evident; lack of updated national coverage data limits measurement of reach for 2022–2024.
Outcome: Modern contraceptive prevalence rate (10–19)	30.2% (all women); 35.7% (married women 15–49)- TDHS	40% (all); 47% (married adolescents) by 2023	22% among adolescents aged 15–19 (TDHS-MIS 2022)	Incremental improvement in knowledge and access observed, but adolescent uptake remains low and below

Indicator	Baseline	Target	Achievement (2024)	Remarks / Trend
	MIS2015/16			targets; access remains uneven by region, marital status and availability of adolescent-friendly services

Source: TDHS MIS 2015/2016; TDHS MIS 2022; BEST 2021; BEST 2024.

3.2.3 Quantitative Trend Analysis

Analysis of the three core indicators under Pillar 2 points to divergent trends between impact-level change and outcome-level performance over the implementation period. At impact level, the Teenage childbearing rate (10–19) shows a gradual national decline from 27 percent in 2015/16 to 22 percent in 2022, indicating movement in the intended direction but at a slower pace than anticipated. The reduction remains insufficient to meet the NAIA–AHW target and continues to be characterized by wide regional variation, with persistently high prevalence in several priority regions.

At outcome level, trends are more positive for SRH information access. The indicator % of adolescents (10–19) reached with comprehensive SRH information reflects substantial expansion through the institutionalization of Comprehensive Sexuality Education within the national curriculum and complementary outreach efforts. Programme data show that a significant proportion of adolescents were reached during the implementation period, signaling improved exposure to SRH knowledge and awareness, even though nationally consolidated coverage data remain incomplete.

In contrast, trends for the indicator Modern contraceptive prevalence rate (10–19) indicate incremental rather than transformative change. While TDHS-MIS 2022 suggests improvements in contraceptive knowledge and access relative to earlier periods, adolescent uptake remains below national targets and uneven across population groups. Taken together, the trends indicate that outcome-level gains in information access have progressed more rapidly than changes in contraceptive behavior, contributing to slower-than-expected reductions in teenage childbearing.

3.2.4 Quantitative Interpretation and Linkages

Quantitative analysis of available national and sub-national data indicates modest but uneven progress in preventing teenage pregnancies during the NAIA-AHW implementation period. At national level, the teenage childbearing rate among girls aged 15–19 declined from 27 percent in TDHS 2015/16 to 22 percent in TDHS-MIS 2022, reflecting a gradual downward trend. While this change signals movement in the intended direction, it falls substantially short of the NAIA-AHW target of reducing teenage childbearing to 5 percent by 2022, indicating that impact-level change has been slower than anticipated.

Trend analysis further reveals pronounced regional disparities, with several NAIA-AHW intervention regions continuing to record very high prevalence. TDHS-MIS 2022 data show teenage pregnancy rates of 45 percent in Songwe, 34 percent in Katavi and 29 percent in Tabora, compared to significantly lower levels in Arusha (13 percent) and Mwanza (16 percent). These trends suggest that NAIA-AHW interventions have been implemented largely in high-burden contexts, where entrenched structural and socio-cultural factors such as early marriage, school dropout, poverty, cross-border mobility and limited access to youth-friendly SRH services continue to exert a strong influence on adolescent outcomes. As a result,

national averages mask persistent pockets of vulnerability and slower rates of change in priority regions.

Analysis of outcome-level indicators shows clearer progress in system strengthening and service availability than in impact-level outcomes. Education sector data confirm that Comprehensive Sexuality Education (CSE) was institutionalized in Government and Non-Government schools by 2021, establishing a structural foundation for sustained SRH information access. Programme monitoring data further indicate that 49,240 adolescents (62 percent of the planned target) were reached with comprehensive SRH information through integrated outreach across 18 LGAs in five NAIA–AHW regions. However, the absence of consolidated national coverage data for the period 2022–2024 limits the ability to assess trends in reach and equity across all priority regions.

Trends in modern contraceptive use similarly point to incremental but insufficient progress. While TDHS-MIS 2022 indicates improvements in contraceptive knowledge and access, adolescent-specific uptake remains relatively low and uneven. Baseline data from TDHS 2015/16 showed modern contraceptive prevalence rates of 30.2 percent among all women and 35.7 percent among married women aged 15 - 49, against NAIA–AHW targets of 40 percent and 47 percent, respectively, by 2023. Available evidence suggests that gains in contraceptive use are stronger in regions with better education retention and service coverage and weaker in high-burden NAIA–AHW regions where social norms, marital status and service accessibility continue to constrain adolescent uptake.

The quantitative trends indicate that Pillar 2 interventions have contributed to gradual national-level improvements and strengthened prevention systems, but that structural inequalities and contextual risk factors have limited the pace and scale of impact, particularly in high-burden regions. These findings reinforce the need for differentiated, high-intensity and multi-sectoral approaches, with greater emphasis on adolescent-specific service delivery, retention of girls in school and sustained engagement with social and gender norms in priority regions.

3.2.5 Evaluator’s Quantitative Synthesis

The quantitative evidence shows that Pillar 2 achieved substantial coverage in education-based SRH awareness through curriculum institutionalization, with NAIA AHW implementation reports indicate awareness raising and digital information access at activity levels as critical milestones for sustained adolescent knowledge and empowerment.

TDHS-MIS 2022 indicates gradual progress in contraceptive knowledge and use among adolescents aged 15–19, but important gaps persist. The baseline modern contraceptive prevalence rate stood at 30.2 percent among all women and 35.7 percent among married women aged 15–49 in TDHS 2015/16, against NAIA-AHW targets of 40 percent (all) and 47 percent (married adolescents) by 2023. While improvements in access and awareness are evident, nationally disaggregated data for adolescents aged 10–19 remain limited. Available evidence nonetheless points to uneven uptake, shaped by marital status, rural–urban disparities, social norms and the availability of adolescent-friendly services. As with teenage childbearing, progress in contraceptive use appears stronger in regions with better service coverage and school retention and weaker in high-burden NAIA-AHW regions where structural barriers continue to constrain outcomes.

The institutionalization of Comprehensive Sexuality Education within the national curriculum, alongside targeted outreach reaching a substantial proportion of adolescents, reflects meaningful progress in expanding SRH knowledge and awareness. This indicates that key enabling conditions for prevention have been established and that adolescents are increasingly exposed to accurate SRH information.

In contrast, the outcome indicator on Modern contraceptive prevalence rate (10–19) shows only incremental improvement. While evidence points to gains in knowledge and access, adolescent uptake of modern contraception remains below national targets and uneven across population groups. This divergence between information access and service utilization helps explain the limited pace of reduction observed in the teenage childbearing rate.

The quantitative synthesis suggests that Pillar 2 has been effective in strengthening the foundations for prevention particularly through education-based and information-focused interventions, but less effective in converting these gains into consistent behavioural outcomes and impact-level change. Bridging the gap between SRH knowledge and adolescent-friendly service utilization remains critical for translating outcome-level progress into sustained reductions in teenage pregnancy, particularly in high-burden regions.

Quantitatively, the integration of SRH education into national curricula, coupled with large-scale digital outreach, represents a foundation for sustained impact. Yet without matching investment in health facility readiness, provider capacity and local-level resource allocation, gains in awareness may not translate into reductions in teenage pregnancy rates.

The next part on process analysis (Part II) will further explore these gaps in terms of effectiveness and efficiency under the OECD-DAC framework, linking data trends to system-level enablers and constraints (see Sections 4.4–4.6).

3.3 Pillar 3: Preventing Physical, Sexual and Emotional Violence

3.3.1 Overview

Pillar 3 of the NAIA–AHW focuses on preventing and responding to physical, sexual and emotional violence affecting adolescents both in and outside the home, school and community. The pillar aligns closely with the National Plan of Action to End Violence Against Women and Children (NPA-VAWC II, 2024/25 - 2028/29) and leverages the existing national and subnational coordination structures established under the MTAKUWWA framework.

Implementation leadership rested with the Ministry of Community Development, Gender, Women and Special Groups (MoCDGWSG) in collaboration with PMO-RALG, the Ministry of Health, Police Gender and Children’s Desks, Social Welfare Services and non-state actors including UNICEF, UNFPA, Femina Hip, MDH, Engender Health, MSI Tanzania, several CSOs and faith-based organizations.

The overarching goal was to create safe, inclusive and supportive environments for adolescents by strengthening protection systems, raising awareness of rights and available services and building community resilience against gender-based and child-related violence.

3.3.2 Key Achievements and Quantitative Progress (2021–2024)

At impact level, the end-line evaluation findings, drawing on recent national survey data show a measurable decline in some forms of violence against children and adolescents compared to earlier survey. This indicates long-term progress in reducing violence against children and adolescents, while also confirming that violence remains a significant concern. The Violence Against Children Survey (VACS) 2009 reported high lifetime prevalence of violence prior to age 18, including approximately 76 percent physical violence, 33 percent sexual violence and 25 percent emotional violence. Findings from the VACS 2024 show substantial reductions over time, with prevalence declining to approximately 24 percent for physical violence, 11 percent for sexual violence and 22 percent for emotional violence. These trends suggest a significant long-term decline in physical and sexual violence, with more modest progress in

addressing emotional violence. The persistence of emotional violence underscores the continued relevance of Pillar 3 interventions.

Routine administrative data from the Child Protection Management Information System (CPMIS) further show increased case reporting and visibility during the NAIA–AHW period. While this reflects improved disclosure and functionality of reporting mechanisms, the evaluation notes that CPMIS data are not yet sufficiently robust or consistently age-disaggregated to support precise short-term trend analysis at council level.

At the outcome level, end-line evaluation findings indicate measurable improvements in adolescent awareness of violence and help-seeking behaviour under Intervention 3.1 (Peer Support Groups). Programme monitoring data from the NAIA-AHW progress report show that awareness of violence and knowledge of reporting pathways among adolescents increased by approximately 10–15 percentage points in NAIA–AHW implementation areas compared to baseline periods, alongside strengthened peer education platforms, Children’s Councils and adolescent forums at community and school levels. Administrative data further demonstrate increased utilisation of formal reporting mechanisms, including a rise in daily call to the National Child Helpline (116) from around 4,000 in 2020 to over 10,000 by 2024, as well as sustained reporting through Police Gender and Children’s Desks. Importantly, these increases in reporting reflect improved awareness, visibility of services and growing trust in protection systems rather than increased incidence of violence, a conclusion supported by the 2024 Violence Against Children and Youth Survey (VACS), which shows declining prevalence of several forms of violence despite higher reporting levels.

Under Intervention 3.2 (Protection Systems Strengthening), outcome indicators demonstrate a significant expansion in individual capacity, yet highlight persistent structural gaps in service coverage. The strengthening of frontline response is evidenced by the increased utilization of Police Gender and Children’s Desks, which handled 39,256 GBV victims in 2024 compared to previous years according to the Tanzania Police Force Crime and Traffic Incidents Statistics Report (2024), alongside a surge in National Child Helpline (116) attempts from 4,000 daily in 2020 to over 10,000 in 2024 as reported by C-Sema. While reporting of specific crimes like rape rose from 7,263 in 2020 (NBS, 2021) to 8,541 in 2024 (NBS, 2024), reflecting enhanced public trust and help-seeking behavior, the availability of comprehensive response services such as One-Stop Centres and safe houses has not kept pace with this demand. The actual gap is most pronounced in rural and hard-to-reach councils, where the police-to-citizen ratio remains as high as 1:3,465 in regions like Simiyu, far exceeding the international standard of 1:450 (NBS, 2024). Consequently, while awareness-raising has successfully "broken the silence" as corroborated by the 2024 Violence Against Children and Youth Survey (VACS) showing a decline in actual prevalence—the system faces a critical challenge in transitioning from successful reporting to providing universal, specialized care at the planned national scale.

Table 3.3.2: Progress on Pillar 3 – Preventing Physical, Sexual and Emotional Violence (2021–2024)

Indicator	Baseline	Target	Achievement (2024)	Remarks / Trend
Impact: % experiencing physical violence (10–19)	~ 76% experienced physical violence before age 18 (VACS 2009)	Reduction over NAIA–AHW period	~ 24% experienced physical violence (VACS 2024)	Substantial long-term reduction observed between 2009 and 2024; indicates progress at impact level, though violence remains prevalent
Outcome: % experiencing sexual violence (10–19)	~ 33% experienced sexual violence before age 18 (VACS 2009)	Reduction over NAIA–AHW period	~ 11% experienced sexual violence (VACS 2024)	Marked decline over time; reflects cumulative impact of national prevention and protection efforts
Outcome: % experiencing emotional violence (10–19)	~ 25% experienced emotional violence (VACS 2009)	Reduction over NAIA–AHW period	~ 22% experienced emotional violence (VACS 2024)	More modest reduction compared to physical and sexual violence; emotional violence remains widespread and under-reported
Outcome: % demonstrating awareness of violence and rights	Limited structured awareness mechanisms at baseline (pre-NAIA)	Increased awareness nationally	Increased awareness evidenced by expanded peer groups, Children’s Councils and school platforms (Proxy – NAIA–AHW Monitoring)	Improved awareness evidenced by increased reporting and help-seeking behaviour; proxy indicator due to lack of national survey percentage
Outcome: % of victims seeking help	Low help-seeking reported in VACS 2009	Increased help-seeking	Increased utilisation of Police Gender and Children Desks and Child Helpline 116	Administrative data reflect reporting behavior, not prevalence; % not statistically valid

Indicator	Baseline	Target	Achievement (2024)	Remarks / Trend
Outcome: % of frontline workers with adequate protection skills	Limited specialised training coverage	Improved national coverage	Large numbers of teachers, police, social welfare officers and service providers trained under MTAKUWWA and NAIA-AHW (Qualitative – Training & programme records)	Capacity strengthened at individual level; gaps persist in translating training into consistent service availability; National % not available;
Outcome: % of individuals aware of adolescent protection mechanisms	Low baseline community awareness	Increased community awareness	Community sensitisation and media campaigns implemented nationwide (Qualitative / Proxy; community sensitization reports)	Awareness measured through programme reach and reporting behaviour, not surveys

Source: VACS 2009; VACS 2024; Police GCD Reports; Child Helpline 116.

The quantitative data points to stronger progress in awareness-raising, reporting and institutional presence than in survivor response and rehabilitation services, highlighting an imbalance between prevention visibility and response capacity. This finding resonates with constraints discussed in Section 4.5.1 (Fragmented Financing) and Section 4.5.4 (Human Resource Shortages), which note that limited operational budgets and staffing gaps hindered the functionality of gender desks, psychosocial services and community protection structures.

3.3.3 Quantitative Trend Analysis

Trend analysis over the implementation period indicates a sustained expansion of awareness-oriented and institutional protection mechanisms, including peer support groups, school-based protection desks, Children’s Councils and media-driven violence prevention campaigns. Administrative and programme data show marked increases in reporting through formal channels. Utilization of the National Child Helpline (116) increased by approximately 150 percent, with daily call attempts rising from an estimated 4,000 in 2020 to over 10,000 by 2024 (C-Sema, 2024).

Similarly, Police Gender and Children’s Desks recorded consistently high volumes of violence-related cases over the period, with 42,414 gender-based violence cases reported nationally in 2020 and 39,256 cases recorded in 2024, including 8,541 reported rape cases and 114 cases of child desertion in 2024 (Tanzania Police Force/NBS, 2021; 2024). This sustained reporting volume despite declining prevalence shown in VACS 2024, reflects improved knowledge of reporting pathways and reduced stigma around disclosure rather than increased incidence of violence.

In contrast, trends related to direct response services progressed more slowly. The expansion of safe houses, One Stop Centres and specialised psychosocial support services did not keep pace with increased reporting volumes. By 2024, coverage of survivor support infrastructure had expanded only marginally relative to demand. Administrative data from the NAIA AHW Implementation report 2022 -2024 indicate that only about 60 percent of districts had functional referral pathways for comprehensive VAC response services, including access to Police Gender and Children's Desks, social welfare officers, health services and legal support (MoCDGWSG, 2024). While Gender and Children's Desks were operational in over 95 percent of police stations nationwide, complementary services such as safe houses, One Stop Centres and specialised psychosocial support remained limited, with fewer than 40 districts reporting access to safe accommodation for child survivors (Tanzania Police Force; NBS, 2024). This imbalance has resulted in referral bottlenecks, where increased reporting through helplines and police channels has not been matched by proportional expansion in survivor-centred response services. This divergence suggests that while adolescents are increasingly willing and able to report violence, the system's capacity to provide timely, comprehensive and survivor-centred services has not expanded at the same rate.

Trends in training coverage show substantial reach among frontline personnel, with large numbers of teachers, police officers, social welfare and community development officers trained under NAIA-AHW and MTAKUWWA aligned initiatives. However, qualitative and administrative evidence indicates that these gains have not translated uniformly into improved service availability and continuity at facility and community levels, reflecting broader systemic and resourcing constraints.

3.3.4 Quantitative Interpretation and Linkages

Interpretation of the quantitative findings highlights a clear distinction between capacity development and system capability. Outcome indicators demonstrate that training investments have strengthened individual competencies among frontline workers. However, impact- and outcome-level indicators related to survivor support indicate that training alone has not been sufficient to ensure consistently functional protection services, particularly where facility readiness, referral systems, supervision, case management and financing remain weak.

The linkage between increased awareness and increased reporting is evident and consistent with the objectives of Pillar 3. However, the weaker linkage between reporting and access to comprehensive response services reveals a protection response gap. This pattern mirrors findings under Pillar 2, where gains in information access outpaced service utilization, reinforcing the need for integrated, multi-sectoral service delivery models.

Quantitative linkages also demonstrate cross-pillar synergies. Strengthened protection mechanisms contribute to improved school safety and retention under Pillar 5 and support Pillar 1 (HIV Prevention) outcomes by facilitating access to post-violence services such as PEP, STI management and psychosocial care. These interconnections affirm the NAIA-AHW design logic while underscoring the importance of balanced investment across prevention, response and recovery.

3.3.5 Evaluator's Quantitative Synthesis

Quantitatively, Pillar 3 demonstrates substantive long-term impact-level progress, as evidenced by the marked reduction in physical and sexual violence between VACS 2009 and VACS 2024, alongside meaningful outcome-level gains in awareness, reporting and institutional protection mechanisms during the NAIA-AHW period. These achievements reflect

strengthened prevention architecture and improved adolescent and community engagement with protection systems.

At the same time, outcome-level indicators reveal persistent gaps in survivor-centred response services. The imbalance between expanded awareness and reporting on one hand and limited response and rehabilitation capacity on the other, indicates that prevention and disclosure mechanisms have matured faster than protection and recovery services.

Qualitative evidence indicates that persistent exposure to violence and risky behaviors is partly influenced by weakening parenting practices and erosion of moral and social values within communities. Adolescents reported limited guidance and supervision, contributing to increased vulnerability to peer pressure, conflict and harmful behaviors. These findings strengthen the need for strengthening family-based and community-level preventive interventions as part of violence prevention strategies.

Overall, Pillar 3 is assessed as foundational with demonstrable impact over time, but incomplete in its response dimension. The quantitative evidence suggests that while critical building blocks for adolescent protection are in place, sustained reductions in violence and improved survivor outcomes will depend on continued investment in functional service delivery, rural coverage, data integration and case management systems. Strengthening these areas will be essential to translate reporting and awareness gains into durable improvements in adolescent safety and wellbeing. These conclusions align with systemic enablers and constraints discussed in Sections 4.4.2 (Inter-Sectoral Collaboration) and 4.4.5 (Data-Driven Adaptation).

3.4 Pillar 4: Improving Nutrition

3.4.1 Overview

Pillar 4 of the NAIA–AHW focuses on improving the nutritional status of adolescents aged 10–19 years, with a particular emphasis on adolescent girls, who face heightened risks of anaemia and micronutrient deficiencies due to increased physiological demands during growth and, for some, early pregnancy. The pillar reflects the recognition of adolescent nutrition as a critical component of the life-course approach to health and wellbeing and seeks to address both immediate nutritional deficits and underlying structural determinants through integrated, multisectoral action.

Implementation was led by the Government through the Ministry of Health and the Ministry of Education, Science and Technology, in collaboration with PMO-RALG, regional and local government authorities and development partners. Interventions were aligned with national nutrition strategies and education sector programmes and implemented primarily through schools, communities and primary health care platforms. Core intervention areas included promotion of school gardens for micronutrient-rich foods, delivery of nutrition education and counselling for in-school and out-of-school adolescents and scale-up of Weekly Iron and Folic Acid Supplementation (WIFAS) for adolescent girls.

3.4.2 Key Achievements and Quantitative Progress (2022–2024)

At impact level, anaemia among adolescent girls remains a significant public health concern. National survey data indicate that anemia prevalence among adolescent girls remains well above the WHO recommended threshold of less than 20 percent thresholds, with 45 percent of girls aged 15–19 years anaemic in TDHS 2022, compared to 31.7 percent among adolescents in TNNS 2018. While direct attribution to NAIA–AHW is constrained by the absence of a post-2022 national nutrition survey, NMNP II benchmarks provide an aspirational

reference point (<20 percent), highlighting the scale of effort still required to achieve population-level change.

At the outcome level, programme evidence indicates expansion of school-based nutrition interventions, including school gardens and nutrition education particularly in NAIA priority districts. WIFAS delivery was cancelled after community concerns on the need to promote locally accessible and affordable foods that are sources of iron instead of the weekly tablet. These interventions strengthened platforms for reaching in-school adolescents and improved awareness of nutrition and healthy diets, however, coverage for out-of-school adolescents remained limited,

Under Intervention 4.1 (School Gardens), an increasing number of schools established or revitalised school gardens as platforms for practical nutrition education and access to diversified foods. These initiatives supported awareness of healthy diets and complemented school feeding and life-skills programmes, although national-level coverage data remain incomplete.

Under Intervention 4.2 (Nutrition Education), adolescents were reached through school-based curricula, co-curricular activities and community sensitisation initiatives. Nutrition education was integrated into broader adolescent health and wellbeing programming, contributing to improved knowledge of balanced diets, micronutrient needs and healthy eating practices. However, outcome indicators are largely measured through programme monitoring and surveys rather than standardised national reporting systems.

Under Intervention 4.3 (WIFAS), substantial numbers of adolescent girls received iron and folic acid supplementation, with programme data showing expanded distribution through schools and health facilities. While WIFAS implementation showed progress in number of councils, the evaluation notes variability in coverage, continuity and adherence, influenced by supply chain reliability, school attendance and community perceptions.

Quantitative evidence points to stronger progress in preventive and awareness-based outcomes than in measurable impact-level change, reflecting the longer time horizon required for nutritional interventions to translate into reductions in anaemia prevalence.

Table 3.4.2: Progress on Pillar 4 – Improving Nutrition (2021–2024)

Indicator	Baseline (Year)	Target (NAIA– AHW / NMNP II)	Achievement (2024)	Remarks / Trend
Impact: % of adolescent girls (10–19) with anaemia	31.7% (TNNS 2018); 45% among girls 15–19 (TDHS 2022)	<20% (WHO standard; NMNP II aspirational target by 2025/26)	Remains >30% nationally (proxy from TDHS 2022; no new TNNS)	Anaemia remains high; slow improvement reflects cumulative nature of nutrition outcomes and WIFAS discontinuity. (Impact assessed using national

				survey proxies due to absence of a post-2022 TNNS.)
Outcome: % of schools with established school gardens	Limited coverage (pre-NAIA; policy baseline)	Expanded national coverage (NMNP II; MoEST school health strategy)	Increased coverage in NAIA districts (programme reports)	Expansion observed, but quality and sustainability vary by council. (No standardized national indicator; based on LGA administrative reporting.)
Outcome: % of adolescents (10–19) receiving nutrition education/counselling	Limited structured delivery (pre-NAIA)	Universal access through schools and community platforms (NMNP II)	Moderate expansion via schools; limited reach to out-of-school adolescents	Coverage skewed toward in-school adolescents; equity gap persists. (Coverage inferred from programme reports due to lack of national denominator.)
Outcome: % of adolescent girls (10–19) receiving ≥ 24 IFA tablets (WIFAS)	Irregular supply; no national baseline	National scale-up through schools and community platforms (NMNP II)	Partial scale-up; interrupted by supply-chain constraints	WIFAS continuity was affected impact. (Monitoring relies on facility tally sheets; completion rates not consistently captured, and food culture barriers remain a constrain.)
Outcome: % of LGAs implementing integrated school health & nutrition actions	Fragmented coordination (pre-NAIA)	Integrated planning under NMNP II and NAIA–AHW	Mixed implementation across councils	Cross-sector coordination improved in some LGAs but not institutionalised. (Assessed qualitatively due to absence of a formal national

				integration indicator).
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Source: TNNS 2018; TDHS MIS 2022; NMNP II 2021/22 to 2025/26.

Anaemia prevalence among adolescent girls remains a major public health concern in Tanzania. According to the 2022 TDHS–MIS, approximately 45% of girls aged 15–19 are anaemic, substantially above the World Health Organization’s threshold of <20%, reflecting little decline since earlier national assessments. School gardens and nutrition education have expanded and weekly iron-folic acid supplementation has reached increasingly larger numbers of girls through school and facility platforms; however, nationally representative data on ≥24 IFA tablet coverage among adolescents are not yet available and challenges in continuity and adherence persist. These findings highlight the need for strengthened adolescent-focused nutrition strategies, systematic monitoring and sustained supply of micronutrient supplements to achieve impact-level reductions in anaemia.

These patterns reflect the coordination and resource challenges discussed in Section 4.5.1 (Fragmented Financing) and 4.5.4 (Human Resource Shortages), where limited budgetary allocation and inadequate technical staff at council level constrained outreach and monitoring.

3.4.3 Quantitative Trend Analysis

Trend analysis indicates gradual expansion of nutrition-sensitive platforms, particularly in schools, including increased use of gardens and integration of nutrition education in participating councils. These trends suggest improved institutionalization of adolescent nutrition interventions within education and health systems.

However, trends in impact-level outcomes are less conclusive. The absence of regularly updated, adolescent-specific anaemia data limits the ability to detect short-term changes attributable to NAIA–AHW interventions. Available evidence nonetheless suggests that improvements in knowledge and supplementation coverage have not yet translated into uniform reductions in anaemia prevalence at national level.

3.4.4 Quantitative Interpretation and Linkages

Interpretation of the quantitative findings highlights a familiar pattern across NAIA–AHW pillars: outcome-level gains are occurring more rapidly than impact-level change. The expansion of school gardens and nutrition education reflects strengthened system capacity and improved adolescent exposure to nutrition interventions. However, sustained reductions in anaemia depend on consistent supplementation, dietary diversity, infection control and broader socio-economic factors.

Linkages between Pillar 4 and other pillars are evident. Improved nutrition contributes to better school attendance and learning outcomes under Pillar 5, supports adolescent girls’ reproductive health under Pillar 2 and enhances resilience and wellbeing relevant to Pillar 3. These interconnections reinforce the NAIA–AHW design logic while underscoring the need for coordinated implementation across sectors.

Section 4.4.2 (Inter-Sectoral Collaboration), these outcomes demonstrate strong vertical alignment at policy level but uneven operational coordination across councils, particularly between health and education officers responsible for nutrition implementation.

3.4.5 Evaluator’s Quantitative Synthesis

Quantitatively, Pillar 4 has contributed to meaningful strengthening of adolescent nutrition platforms, particularly through schools and preventive supplementation mechanisms. Outcome-level indicators show progress in awareness, institutional presence and service delivery, while impact-level evidence confirms that anaemia among adolescent girls remains a persistent challenge.

Overall, Pillar 4 is assessed as progressing but not yet transformative. The quantitative evidence suggests that while key building blocks for improved adolescent nutrition are in place, achieving the WHO target for anaemia reduction will require sustained investment, improved monitoring of adolescent-specific outcomes and strengthened linkages between education, health and community-based nutrition interventions.

Nevertheless, coverage and equity challenges persist including IEC material distribution and adolescent nutritional counselling remain underachieved. WIFAS and supplementation activities were not consistently tracked in DHIS2 or NMIS, resulting in limited data for decision-making (as discussed in Section 4.5.3: Insufficient Data Disaggregation). Financial constraints and shortages of qualified nutrition officers continue to limit scale and quality.

The evidence suggests that while policy integration and school-based interventions have been successful, broader population-level impact will depend on community engagement, improved data systems and consistent financing in the next phase. This conclusion aligns with cross-pillar findings on systemic enablers (Section 4.4) and reinforces the need for targeted investment in adolescent-specific nutrition programming within next phase of NAIA.

3.5 Pillar 5: Keeping Boys and Girls in School

3.5.1 Overview

Pillar 5 of the NAIA AHW 2021/22–2024/25 focuses on promoting school enrolment, retention and completion for both boys and girls, particularly those at risk of dropping out due to pregnancy, poverty or social barriers. Education is recognized within NAIA as a cornerstone of adolescent wellbeing, influencing not only learning outcomes but also health, economic potential and protection from child marriage and exploitation.

Implementation was led by the MoEST in close collaboration with PMO-RALG, MoCDGWSG, Tanzania Institute of Education (TIE), Institute of Adult Education and development partners such as UNESCO, UNICEF, Femina Hip, CAMFED - Tanzania, KTO and DFID.

The goal was to ensure equitable access to education, improve the quality of learning environments and strengthen the link between education and other pillars of adolescent wellbeing, notably sexual and reproductive health (Pillar 2) and violence prevention (Pillar 3).

3.5.2 Key Achievements and Quantitative Progress (2022–2024)

Education sector data show that school dropout remains a persistent challenge among adolescents, particularly at secondary level. According to BEST 2021, the national dropout rate at secondary level was approximately 3.2 percent, with girls disproportionately affected due to pregnancy, early marriage and household economic pressures. BEST 2024 indicates only a marginal decline to approximately 2.9 percent, suggesting that while modest progress has been made, retention challenges persist, especially among older adolescents. Available administrative data further indicate that adolescents with disabilities face heightened risks of dropout due to physical accessibility barriers, limited availability of inclusive learning materials and insufficiently trained teachers. However, disability-disaggregated dropout statistics are not consistently reported in BEST datasets, constraining precise measurement of exclusion and

underscoring the need for stronger integration of disability-disaggregated indicators in education monitoring systems.

Improvements in the learning environment contributed positively to enrolment and attendance. BEST 2021 reported significant classroom shortages, particularly in rural councils, with pupil–classroom ratios exceeding national standards in many secondary schools. By BEST 2024, cumulative classroom construction and rehabilitation had reduced congestion in many areas, with pupil–classroom ratios improving nationally, although gaps remain in fast-growing urban settlements and remote rural districts.

Access to WASH and MHH facilities also improved during the implementation period. BEST 2021 indicated that only about 63 percent of schools had access to functional water sources and adequate sanitation facilities, with girls’ MHH needs insufficiently addressed in many schools. BEST 2024 reports improvement to approximately 74 percent of schools meeting basic WASH standards, alongside expanded provision of girls’ toilets and MHH-friendly facilities. These improvements are associated with reduced absenteeism among adolescent girls, particularly during menstruation.

Enrolment data show gradual gains among adolescents aged 14–17. BEST 2021 reported a gross enrolment ratio of approximately 46 percent for this age group at secondary level. By BEST 2024, enrolment had increased to approximately 52 percent, reflecting expanded access, implementation of inclusive education policies and re-entry of adolescent mothers under national guidelines. However, transition to upper secondary and completion rates remain lower for girls in regions with persistently high levels of teenage pregnancy, poverty and school dropout such as Lindi, Tabora, Katavi and parts of Mwanza where structural vulnerabilities continue to constrain retention despite improved access.

Community and parental engagement also expanded. While BEST does not quantify parental participation directly, NAIA–AHW implementation reports indicate increased involvement of parents and caregivers in education and parenting programmes across intervention councils. These efforts contributed to improved attitudes towards girls’ education and delayed marriage, supporting retention outcomes where implemented consistently. The table below summarizes key quantitative indicators for this pillar.

Table 3.5.2: Progress on Pillar 5 – Keeping Boys and Girls in School (2021–2024)

Indicator	Baseline (BEST 2021)	Target	Achievement (2024)	Remarks / Trend
Impact: School dropout rate (secondary level)	~3.2% (secondary level)	MoEST-defined reduction	~2.9% (secondary level, BEST 2024)	Marginal decline; dropout remains concentrated among older adolescent girls (BEST provides reliable annual administrative data, but NAIA did not define a numeric target, limiting performance benchmarking).

Indicator	Baseline (BEST 2021)	Target	Achievement (2024)	Remarks / Trend
Outcome: Percentage of schools with built/rehabilitated classrooms	Infrastructure gaps reported; overcrowding common in secondary schools	To be defined by the Ministry of Education	Increased classroom construction and rehabilitation reported nationally and in NAIA districts (BEST/BEMIS 2024)	Infrastructure improvements contributed to expanded access, though disparities persist across LGAs. (Indicator lacks a standardized national percentage; analysis relies on administrative counts rather than population-based ratios. BEST does not publish a standardized denominator for “schools requiring rehabilitation,” a percentage increase cannot be reliably derived.)
Outcome: Truancy related to WASH/MHH	Absenteeism reported but not systematically quantified nationally specific for WASH/MHH	TBD at start of implementation	Persistent absenteeism noted, particularly among girls and older adolescents (BEST 2021–2024)	Positive effect on girls’ attendance, especially during menstruation
Outcome: Gross enrolment ratio (ages 14–17, Forms 1–4)	~46% gross enrolment ratio (BEST 2021)	TBD at start of implementation	~52% gross enrolment ratio (BEST 2024)	Moderate improvement reflects expanded access, re-entry of adolescent mothers and inclusive education policies; (Indicator is robust and comparable

Indicator	Baseline (BEST 2021)	Target	Achievement (2024)	Remarks / Trend
				across years, though regional disaggregation varies in completeness).
Outcome: Parental participation in education programmes	Limited structured parental engagement mechanisms	TBD at start of implementation	Increased parental sensitization through school committees and community outreach (programme reports).	Qualitative improvements reported, but scale and consistency vary. (Indicator measured qualitatively due to absence of a national quantitative metric).

Source: BEST 2021; BEST 2024

These gains correspond with coordination and policy alignment improvements highlighted in Section 4.4.3 (Policy Coherence), where MoEST and MoCDGWSG strengthened collaboration to integrate re-entry guidelines and gender-sensitive teaching practices.

3.5.3 Quantitative Trend Analysis

Comparison of BEST 2021 and BEST 2024 data indicates a positive trend in access-related measures, including enrolment growth, classroom availability and WASH infrastructure. These trends demonstrate strengthening of system-level enablers for school participation.

However, trends in dropout reduction have been slower. Dropout rates remain highest among adolescents transitioning into and through secondary education, particularly girls affected by pregnancy and household responsibilities. While infrastructure and WASH improvements have reduced absenteeism, they have not fully addressed socio-economic and gender-related drivers of dropout.

3.5.4 Quantitative Interpretation and Linkages

The quantitative evidence suggests that improvements in education system readiness have outpaced gains in sustained retention. Expanded infrastructure, improved WASH/MHH facilities and increased enrolment reflect strengthened capacity within the education system. However, persistent dropout among adolescents indicates that education-sector interventions alone are insufficient to address all underlying risks.

Strong linkages are evident with other NAIA–AHW pillars. Improved school retention directly supports prevention of teenage pregnancy under Pillar 2, contributes to safer environments under Pillar 3 and sustains pathways to skills development under Pillar 6. Nutrition and health factors addressed under Pillar 4 further influence attendance and learning outcomes, reinforcing the need for integrated implementation.

Despite this progress, education quality and learning outcomes remain a concern. Reports from KIIs with teachers and district education officers highlight overcrowded classrooms, teacher shortages and limited teaching materials as constraints to sustaining gains.

Section 4.5.4 (Human Resource Shortages), only one in three schools meet the national pupil–teacher ratio, especially in rural districts, limiting personalized support for vulnerable adolescents. Furthermore, although IPOSA coverage has expanded, data on out-of-school adolescents remain limited, complicating monitoring of reintegration success. This aligns with challenges discussed in Section 4.5.3 (Insufficient Data Disaggregation).

3.5.5 Evaluator’s Quantitative Synthesis

From a quantitative standpoint, Pillar 5 demonstrates clear progress in expanding access and improving enabling conditions for education, as reflected in BEST 2021–2024 trends in enrolment, classroom availability and WASH/MHH coverage. These gains represent important system-level achievements.

At the same time, school dropout among adolescents, particularly girls at secondary level—remains a persistent constraint. The evidence suggests that while schools are increasingly accessible and better equipped, additional socio-economic, protective and gender-responsive measures are required to sustain attendance and completion.

Pillar 5 is evaluated as moderately effective, with strong improvements in access and learning environments but limited impact on reducing adolescent dropout. Greater integration with Pillars 2 and 4, alongside targeted support for vulnerable adolescents, will be essential to translate access gains into sustained educational outcomes.

Looking ahead, maintaining these upward trends will depend on increased investment in teacher capacity and school infrastructure; enhanced tracking of re-entry and non-formal learning outcomes; and deepened coordination between education, health and community sectors to address structural barriers to learning continuity.

This synthesis aligns with Sections 4.4 (Interconnected Pillars) and 4.6 (Data-Driven and Adaptive Systems), emphasizing that sustained adolescent education is both a result and a driver of overall wellbeing under NAIA AHW.

3.6 Pillar 6: Developing Skills for Meaningful Economic Opportunities

3.6.1 Overview

Pillar 6 of the NAIA–AHW aims to equip adolescents aged 15–19 with technical, vocational and entrepreneurial skills to enable their transition into productive employment and self-reliance. This pillar recognizes that adolescent health and wellbeing are closely tied to economic empowerment and that the demographic dividend can only be realized if adolescents gain access to skills, decent work and income opportunities.

Implementation was led by the Vocational Education and Training Authority (VETA) and the PMO-LYED, in collaboration with MoEST, PMO-RALG and key development partners such as UNESCO, UNICEF, UNFPA, Nutrition International, Femina Hip and private sector stakeholders.

The strategic focus was on expanding access to vocational and technical education, aligning training with labour market demands, strengthening school-to-work transition pathways and enhancing entrepreneurship and financial literacy among adolescents, particularly adolescent girls and those in vulnerable circumstances.

3.6.2 Key Achievements and Quantitative Progress (2022–2024)

The evaluation finds that at the impact level, NAIA–AHW Pillar 6 has contributed to improved institutionalisation of soft and life skills training programmes as a foundation for adolescents’ access to meaningful economic opportunities. BEST data and sector reports indicate gradual progress in embedding these competencies within education and training systems, although national impact targets were not quantitatively defined at the outset of implementation. Consequently, impact-level assessment relies on coverage and adoption of approved curricula as proxy indicators for employability outcomes.

The evaluation finds that at the outcome level under Intervention 6.1, which focuses on strengthening VETA and PPTC soft skills programmes, soft skills defined in the NAIA-AHW framework as competencies such as communication, teamwork, problem-solving and work ethics, were increasingly integrated alongside technical training. By 2024, approximately 61 percent of VETA and PPTC facilities had adopted structured soft skills curricula, representing substantial progress toward the NAIA–AHW target of 70 percent, though coverage remains uneven in rural and underserved areas.

The evaluation finds that under Intervention 6.2, which aims to strengthen and expand the Stadi za Kazi subject, implementation of life skills within primary and secondary schools expanded significantly. BEST 2024 indicates that approximately 58 percent of schools were offering Stadi za Kazi, compared to limited coverage in BEST 2021, reflecting accelerated mainstreaming of school-to-work readiness education. Nevertheless, teacher shortages and variability in instructional quality continue to affect consistent delivery.

It is noted that impact and outcome indicators under Pillar 6 rely on similar measures of curriculum coverage and institutional adoption, reflecting limitations in the original M&E framework; while appropriate as interim proxies, this overlap constrains differentiation between immediate outcomes and longer-term labour market impact, reinforcing the need for clearer indicator stratification in the next phase of NAIA–AHW.

Table 3.6.2: Progress on Pillar 6 – Developing Skills for Meaningful Economic Opportunities (2021–2024)

Indicator	Baseline (Year)	Target (NAIA – AHW)	Achievement (2024)	Data Source	Remarks / Trend (incl. data note)
Impact: Soft & life skills coverage (schools implementing approved curricula)	Not established at NAIA–AHW start (policy baseline)	70%	~52% of schools implementing approved life/soft skills curricula	BEST 2021; BEST 2024	Steady national progress since 2021, but target not yet met; notable rural–urban disparities. (Impact measured using

Indicator	Baseline (Year)	Target (NAIA – AHW)	Achievement (2024)	Data Source	Remarks / Trend (incl. data note)
					curriculum coverage as a proxy due to absence of outcome data.)
Outcome: % of VETA/PPTC facilities offering soft skills curricula	Not established (pre-NAIA ad hoc provision)	70%	~61% of VETA/PPTC facilities offer structured soft skills curricula	BEST; NAIA– AHW Implementation Reports	Substantial expansion toward target; access remains uneven in rural and underserved areas. (Administrative reporting; baseline inferred from pre-NAIA limited provision).
Outcome: % of schools offering Stadi za Kazi	Not established (pilot-stage coverage)	70%	~58% of schools offer Stadi za Kazi	BEST 2021; BEST 2024	Accelerated rollout since 2021; teacher availability and instructional resources constrain full scale-up. <i>Data</i> (National education census data; quality of

Indicator	Baseline (Year)	Target (NAIA – AHW)	Achievement (2024)	Data Source	Remarks / Trend (incl. data note)
					delivery not captured).

Source: BEST 2021; BEST 2024;

In general, the quantitative evidence shows that system-level integration of skills development within education and training systems is advancing, particularly through increased adoption of approved curricula. However, coverage remains below NAIA–AHW targets and varies significantly by geography and education sub-sector. While institutional uptake has improved, linkages to labour market demand, private sector engagement and post-training marketing opportunities for adolescent products and services remain uneven and insufficiently institutionalized, limiting the translation of skills acquisition into sustained economic outcomes.

3.6.3 Quantitative Trend Analysis

Comparison of BEST 2021 and BEST 2024 data indicates a clear upward trend in the availability of skills-focused curricula across both general and vocational education systems. The most pronounced gains are observed in mainstream secondary schools and larger VETA and PPTC centres, where institutional capacity, staffing levels and access to teaching resources are relatively stronger. This trend reflects deliberate policy efforts to mainstream life and soft skills within formal education pathways.

However, the trend analysis also reveals persistent inequities in coverage and reach. Rural schools, smaller training centres and facilities serving out-of-school adolescents have lagged behind in adopting approved curricula, reflecting constraints related to staffing, infrastructure and limited engagement with local labour markets. BEST data further suggest that schools and centres with stronger partnerships with local industries and private sector actors demonstrate higher uptake and more consistent implementation of skills programmes, underscoring the importance of market linkages and exposure opportunities. While progress toward the 70 percent NAIA–AHW target is evident, the current pace of expansion suggests that achieving full national coverage and meaningful labour market integration will require sustained investment beyond the current implementation period.

3.6.4 Quantitative Interpretation and Linkages

Interpretation of the quantitative findings indicates that foundational capacity for skills development has strengthened, particularly through curriculum approval and institutional uptake. However, the effectiveness of these gains depends on consistent implementation, teacher and instructor capacity and linkage to local labour market opportunities.

The evidence further shows strong interlinkages with other NAIA–AHW pillars. Skills development supports Pillar 5 by strengthening incentives for school retention, contributes to Pillar 2 by reducing economic vulnerability associated with early pregnancy and marriage and reinforces Pillar 3 by lowering adolescents’ exposure to unsafe and exploitative work. These linkages affirm the multi-sectoral logic of NAIA–AHW and highlight the importance of coordinated implementation.

3.6.5 Evaluator’s Quantitative Synthesis

Quantitatively, Pillar 6 demonstrates moderate but meaningful progress toward expanding adolescent access to soft and life skills education. The proportion of schools and training facilities implementing approved curricula has increased steadily, indicating strengthening institutionalisation of employability-focused education.

At the same time, the evidence shows that coverage remains below NAIA–AHW targets, with uneven reach across regions and education pathways. Achieving population-level impact will require accelerated scale-up, targeted support to rural and resource-constrained institutions and stronger linkage between skills provision and real economic opportunities.

Overall, Pillar 6 is assessed as moderately effective, with clear system-level gains but insufficient coverage to fully meet the needs of all adolescents, particularly those most vulnerable to economic exclusion.

3.7 Cross-Cutting Issues

3.7.1 Overview

The cross-cutting interventions under NAIA–AHW were designed to address structural and behavioural barriers affecting adolescents aged 10–24 years across all pillars, with a focus on expanding access to adolescent-friendly comprehensive services (AFCS) and mitigating socio-economic vulnerabilities through cash transfer mechanisms. These interventions recognise that adolescents' health, protection, education and economic outcomes are shaped by service accessibility, quality and household-level constraints and therefore require integrated, multisectoral responses.

Implementation of these cross-cutting actions was led by the Government through the Ministry of Health, in collaboration with PMO-RALG, LGAs and development partners and aligned with the Tanzania National Family Planning Costed Implementation Plan (FP-CIP) and national social protection frameworks, including TASAF.

3.7.1 Overview and quantitative progress (2021 - 2024)

At the outcome level, under intervention 7.1: Adolescent-Friendly Comprehensive Services, endline evaluation has noted progress in expanding the availability of adolescent-friendly reproductive health services within public health facilities. While no numeric baseline was defined at the start of NAIA–AHW implementation, national administrative and programme data indicate gradual scale-up of adolescent-friendly service standards. According to MoH and FP-CIP monitoring reports, by 2023/24 approximately 55–60 percent of public health facilities were providing some form of adolescent-friendly SRH services, compared to more limited and uneven provision prior to NAIA–AHW. This represents progress toward the FP-CIP aspirational target of 80 percent, though the target has not yet been achieved.

Qualitative evidence further suggests improvements in provider attitudes, youth-friendly service hours and integration of SRH counselling within broader adolescent health platforms. However, implementation quality remains variable, particularly in rural and hard-to-reach LGAs and service utilisation by younger adolescents (10–14 years) remains lower than for older age groups.

Under Intervention 7.2 on Cash Transfers for In-School and Out-of-School Adolescents, endline evaluation find that NAIA–AHW was able to leveraged existing social protection systems rather than creating parallel mechanisms. Through TASAF Productive Social Safety Net (PSSN II), a substantial proportion of adolescents from disadvantaged households

benefited indirectly from cash transfers between 2022 and 2024. TASAF administrative data indicate that more than 60 percent of beneficiary households include adolescents, supporting school attendance, reducing financial pressures and contributing to retention for both in-school and out-of-school adolescents.

Although cash transfers were not adolescent-specific in design, qualitative findings from NAIA priority regions indicate positive spillover effects on education continuity, reduced engagement in hazardous labour and improved access to health services. However, the absence of adolescent-disaggregated outcome indicators limits precise attribution of effects to NAIA–AHW.

The table below summarises quantitative progress across the key cross-cutting areas that underpin NAIA AHW as defined in the NAIA AHW Results Framework.

Table 3.7.1: Cross-Cutting Progress Summary (2021-2024)

Indicator	Baseline	Target	Achievement (2024)	Remarks / Trend (incl. data note)
% of health facilities providing adolescent-friendly reproductive health services	TBD at start of implementation	80% (FP-CIP aspirational target)	~55–60% of facilities providing AFCS	Coverage expanded but remains below target. (Derived from MoH/FP-CIP administrative reports; no NAIA-specific baseline).
Coverage of cash transfer support reaching adolescents (in-school & out-of-school)	Existing TASAF coverage (pre-NAIA)	Expanded protection for vulnerable households	>60% of TASAF beneficiary households include adolescents	Strong indirect reach. (Cash transfers are household-based; adolescent impact inferred using proxy evidence.)

Source: NAIA AHW NAIA Progress Report 2021/22- 2024/25; TDHS 2022; TASAF PSSN II Administrative Data;

3.7.3 Quantitative Trend Analysis

Trend analysis indicates a gradual but steady expansion of adolescent-friendly service provision within the public health system, with greater gains in urban and peri-urban LGAs compared to rural councils. While progress toward the FP-CIP target is evident, the pace of scale-up suggests that universal coverage will require sustained investment, standardised service quality benchmarks and stronger monitoring of utilisation.

For cash transfers, trends show consistent national scale and coverage through TASAF, with stabilizing effects on household vulnerability. However, the lack of adolescent-specific indicators limits the ability to quantify trends in adolescent-level outcomes over time.

3.7.4 Quantitative Interpretation and Linkages

Interpretation of the quantitative evidence confirms that cross-cutting interventions under NAIA–AHW played a critical enabling role across all pillars. Expanded adolescent-friendly services reinforced Pillars 1 and 2 by improving access to SRH information and care, supported Pillar 3 by strengthening referral pathways for survivors of violence and complemented Pillars 4 and 5 by reducing financial barriers to nutrition and schooling.

However, reliance on proxy indicators for both AFCS and cash transfers highlights a structural limitation in the NAIA–AHW M&E framework. Future phases would benefit from clearly defined baselines, adolescent-disaggregated targets and harmonised monitoring systems to more precisely capture the contribution of cross-cutting interventions to adolescent wellbeing outcomes.

3.7.3 Evaluator’s Quantitative Synthesis

Quantitatively, the cross-cutting focus on adolescent-friendly services has produced meaningful system-level gains, with a clear upward trend in the proportion of facilities offering such services during the NAIA–AHW period. These gains provide an essential foundation for sustained improvements across all thematic pillars.

However, the evidence indicates that the NAIA–AHW target of 80 percent coverage has not yet been reached and that progress has been uneven. Achieving full coverage will require intensified investment in facility readiness, supervision, data tracking and predictable local-level financing, alongside continued integration with education, protection and community-based platforms.

The cross-cutting intervention is evaluated as moderately effective, with strong directional progress but insufficient scale to fully meet national targets within the implementation period.

Part II: Process Evaluation Findings (OECD–DAC Criteria)

4.1 Relevance

4.1.1 Alignment of NAIA Pillars with Adolescent Needs and National Priorities

The evaluation confirms that the National Accelerated Action and Investment Agenda for Adolescent Health and Wellbeing (NAIA AHW 2021/22–2024/25) was highly relevant to Tanzania’s national development priorities and to the lived realities of adolescents aged 10–19. The agenda’s six pillars were designed to address the main determinants of adolescent wellbeing which are health, protection, education, nutrition and economic empowerment which are consistently highlighted in the Tanzania Demographic and Health Survey (TDHS 2022).

At formulation, data showed that 22% of adolescent girls aged 15–19 had begun childbearing, HIV prevalence among adolescent girls (0.8%) was nearly three times higher than among boys (0.3%) and 29% of girls and 17% of boys had experienced sexual violence before age 18. These findings directly shaped the NAIA pillars, each responding to a specific yet interlinked vulnerability area.

Key informants at both national, regional levels and council level, including officials from MoCDGWSG, MoH, MoEST and PMO-RALG described NAIA as “a unifying policy framework” that consolidated previously fragmented adolescent programs under one coordinated agenda. As supported by the quantitative analysis in Part I, Sections 3.1–3.6, the agenda’s multi-sectoral reach produced measurable progress across all pillars, from increased HIV testing coverage (Pillar 1) to expanded vocational enrolment (Pillar 6).

NAIA’s alignment with broader national and international frameworks was clear. The agenda operationalized commitments under FYDP III (2021/22–2025/26), Vision 2025, the National Strategy for Gender Development (2020) and SDGs 3, 4, 5 and 8. It also localized commitments from the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030) and AU Agenda 2063.

At subnational level, KIIs with district officers in Mwanza, Katavi, Songwe and Arusha confirmed that NAIA facilitated integration of adolescent priorities into council annual plans through the PlanRep system and the O&OD process. Councils implemented cross-sectoral initiatives such as school WASH improvement (linked to Pillar 5), youth-friendly health services (Pillar 1) and skills training (Pillar 6), often using pooled sectoral resources guided by the NAIA coordination framework.

However, qualitative findings indicate that underlying social and behavioural drivers, including parenting practices and community value systems, were less explicitly addressed within the original NAIA design, suggesting areas for strengthening alignment in future phases.

Table 4.1.1: Alignment Between NAIA Pillars and National Priorities

NAIA Pillar	Primary Adolescent Need Addressed	Linked National/Global Policy Frameworks
1. Preventing HIV	Reduce new HIV infections among adolescents and AGYW	National HIV Strategic Plan (NMSF V), Global AIDS Strategy 2021–2026
2. Preventing Teenage Pregnancy	Address early childbearing and unsafe sexual practices	One Plan III, National SRH Policy, TDHS 2022
3. Preventing Violence	Reduce VAC, GBV and harmful practices	NPA-VAWC II, INSPIRE Framework
4. Improving Nutrition	Combat adolescent malnutrition and anemia	NMNAP II, National Food and Nutrition Policy
5. Keeping Boys and Girls in School	Promote retention, completion, Transition and safe learning environments	Education Sector Development Plan (2021–2026)
6. Skills and Economic Empowerment	Build life and vocational skills for decent work	FYDP III, National Youth Development Policy, TVET Policy

Source: Raw data analysis, End Line Evaluation of NAIA AHW.

In summary, NAIA–AHW’s design and implementation were both evidence-based and context-responsive, addressing Tanzania’s most pressing adolescent challenges through a unified national agenda that remains highly relevant to government priorities and youth aspirations.

4.1.2 Responsiveness to Emerging and Cross-Cutting Issues

The evaluation finds that NAIA–AHW demonstrated flexibility and adaptability to new adolescent needs that emerged during implementation, particularly between 2022 and 2024. Originally focused on biomedical and behavioral determinants, the agenda expanded to incorporate digital safety, mental health, climate resilience and social protection linkages.

For instance, as highlighted in Part I, Section 3.7 (Cross-Cutting Issues), digital awareness was mainstreamed into Pillar 3 (Violence Prevention) through MoCDGWSG and UNICEF-supported campaigns on online safety and cyberbullying. Similarly, under Pillar 4 (Nutrition) and Pillar 5 (Education), interventions integrated school feeding and climate resilience

measures in drought-prone councils such as Mpimbwe and Tabora to mitigate climate-related absenteeism and malnutrition.

Civil society partners such as Femina Hip, MDH and Nutrition International enhanced NAIA's adaptability by aligning campaigns like *Tupo Pamoja* and *Bamba na Lishe* with adolescent SRH, mental health and livelihood messages. These community-level campaigns reached millions of adolescents through radio, social media and school clubs, reinforcing integration across multiple pillars.

FGDs in Mbozi and Ilemela confirmed that adolescents increasingly recognized the link between health, education and livelihood, describing the new approach as "*more complete*" and "*closer to our daily lives*". Nevertheless, some emerging risks such as digital addiction, online pornography and urban substance use were not yet systematically integrated into NAIA's scope, signaling areas for strengthening under Phase II.

In addition, qualitative evidence from KIIs and FGDs highlighted growing concerns among communities regarding weakening parenting practices and the perceived erosion of social and moral values among adolescents. Respondents consistently identified these dynamics as underlying drivers of risk behaviors, including early sexual activity, school dropout, substance use and exposure to violence. While NAIA-AHW interventions addressed behavioral change through school and community-based platforms, structured parenting support and community-level moral values reinforcement mechanisms were not systematically integrated into the programme design. This represents a critical gap in responsiveness, as family and community socialization systems remain central to shaping adolescent outcomes. Addressing these dimensions will be essential to strengthen the relevance and effectiveness of NAIA-AHW Phase II.

What emerged across national and sub national level interviews is that NAIA AHW as an agenda has been argued to have strong policy visibility but faced inadequate influence on public and partner investment decisions, largely due to the absence of a comprehensive multi-sectoral costed framework that has direct influence and decision on adolescent related intervention that has to guide resource allocation and prioritization across sectors.

In short, the agenda's responsiveness was both proactive and iterative, evolving in response to real-time feedback from adolescents and local implementers while maintaining fidelity to its core objectives.

4.1.3 Adolescent Engagement in NAIA Design and Implementation

NAIA-AHW was explicitly conceived as a adolescent-centered and participatory framework and evidence confirm meaningful though uneven levels of adolescent engagement throughout its lifecycle. During design, youth organizations such as TAYARH, AfriYAN Tanzania and the Tanzania Youth Coalition contributed to consultations shaping the agenda's priorities, communication strategies and youth-friendly delivery models. During implementation, adolescent participation was institutionalized through *Mabaraza ya Watoto* (Children Councils), school clubs and peer networks. As noted in Part I, Section 3.7, 1,387 councils (55% of the national target) were operational by 2024.

FGDs in Songwe and Arusha confirmed growing adolescent confidence in engaging with authorities on SRH, GBV and education issues. As one girl in Ilemela observed:

"Before NAIA, we had no voice. Now our teachers and council officers listen when we speak through our clubs".

However, while adolescent voices were increasingly heard at community and school levels, decision-making authority remained limited, particularly in budget planning and program monitoring. KIIs revealed that adolescent participation was largely consultative, with limited feedback loops to integrate adolescent recommendations into formal council decisions.

The evaluator notes promising models, such as Femina Hip’s youth advisory boards and Restless Development’s digital feedback platforms, which could be institutionalized in NAIA Phase II to move adolescent participation from engagement to co-creation and accountability.

Interpretation

Evidence from across the data sources confirms that NAIA–AHW remains a highly relevant, adaptive and adolescent-responsive national framework. Its pillars are well aligned with adolescent needs, national priorities and international commitments; its design has proven flexible in addressing emerging challenges such as digital safety and climate shocks; and it has institutionalized adolescent participation mechanisms at multiple levels.

However, to sustain relevance into Phase II (2025–2030), the agenda must deepen integration of new-generation issues, particularly mental health, digital safety and wellbeing and climate resilience and transition adolescent engagement structures from consultative to decision-making roles.

4.2 Coherence

4.2.1 Coordination and Synergy Across Sectors

The evaluation finds that the NAIA–AHW achieved a strong degree of multisectoral coherence, establishing one of the most comprehensive national frameworks for adolescent health and wellbeing in Tanzania. Its “whole-of-government” design aligned interventions across ministries, departments and agencies (MDAs) including MoCDGWSG, MoH, MoEST, PMO-RALG, TFNC, VETA and PMO-LYED and built bridges with development partners and civil society organizations.

At national level, MoCDGWSG provided policy leadership through the National Steering Committee (NSC) and National Technical Committee (NTC), which convened regular joint reviews during the first two years of implementation. As confirmed in Part I, Section 3.7 (Cross-Cutting Issues: Coordination), 26 regional and 148 council-level coordination committees were functional by 2024, representing about 80 percent of planned national coverage. Collaboration was particularly strong in shared technical areas as shown in Table 4.2 below.

Table 4.2.1a: Collaboration status in technical areas

Pillar Number	Status
Pillars 1 and 2 (HIV and Teenage Pregnancy Prevention)	Joint SRH campaigns led by MoH and UNFPA integrated testing, contraception and behavioral communication.
Pillar 3 (Violence Prevention)	Coordinated between MoCDGWSG, MoEST and police gender desks, aligning NAIA with NPA-VAWC II.
Pillar 4 (Nutrition)	TFNC, MoEST and PMO-RALG jointly implemented school feeding and “ <i>Bamba na Lishe</i> ” campaigns across 23,000 schools.
Pillar 6 (Skills Development)	VETA and PMO-LYED worked with private sector partners to scale youth training programs, reaching 83,974 learners.

Source: KII with members of the TWGs and National Level Government and CSOs..

At subnational level, NAIA coherence was reflected in the harmonization of adolescent priorities within Comprehensive Council Health Plans (CCHPs) and annual district budgets. KIIs in Mwanza, Songwe and Katavi confirmed that under NAIA, “sector departments now plan together rather than separately”, reducing duplication and fostering accountability.

Still, coherence varied by region. Districts with strong partner presence, notably MDH, UNICEF and Nutrition International maintained active coordination platforms, while resource-constrained councils struggled to convene cross-sector meetings regularly.

Table 4.2.1b: Coordination Strengths and Weaknesses Across Levels

Level	Coordination Mechanism	Strengths Observed	Challenges Identified
National	National Steering Committee (NSC)	Policy alignment; joint monitoring; technical participation of MoH, MoEST, TFNC, VETA	Decline in meeting frequency after 2023; limited coordination budget, competing interest and limited ownership
Technical	National Technical Committee & TWGs	Effective data review (especially Pillars 1–3); partner collaboration	Limited NGO/adolescent participation; inconsistent documentation
Regional	Regional Secretariat Platforms	Integration into RHMT/REMT reviews; improved inter-sector linkages	Minimal dedicated resources for adolescent sessions

Source: KII with members of the TWGs and National Level Government and CSOs..

The coherence demonstrated at these levels was critical in translating policy into collective action, ensuring that gains under Part I Sections 3.1–3.6 were delivered through coordinated structures rather than isolated sectoral efforts.

4.2.2 Complementarity with Other National and Partner Initiatives

The evaluation finds a high degree of complementarity between NAIA-supported interventions and parallel national or partner-funded initiatives. Rather than competing with existing programs, NAIA AHW served as an umbrella framework for alignment and harmonization.

Table 4.2.2: NAIA AHW Complementarity with other Partners

Interventions	Status
Health and HIV Programs	Activities under Pillars 1 and 2 complemented USAID Afya Yangu Southern, MDH’s DREAMS initiative and UNFPA and UNICEF’s SRH projects, all reporting adolescents reached through joint data systems.
Education and Life Skills	Collaboration with UNESCO ensured integration of Comprehensive Sexuality Education (CSE) into the curriculum, aligning with the Education Sector Development Plan (2021–2026).

Nutrition	TFNC, UNICEF and Nutrition International coordinated adolescent nutrition within the NMNAP II (2021–2026) framework, which supported over 12,000 schools.
Protection	NAIA's Pillar 3 dovetailed with NPA-VAWC II, extending referral pathways and community awareness campaigns.
Youth Employment	Through VETA, PMO-LYED and Femina Hip, Pillar 6 interventions contributed directly to FYDP III employment targets and SDG 8.

Source: KII with members of the TWGs and National Level Government and CSOs.

This complementarity increased efficiency and reduced fragmentation, as also reflected in Part I, Section 3.7 (Cross-Cutting Financing), where 82 percent of estimated funding needs were met through pooled domestic and partner contributions.

However, harmonization gaps persisted in monitoring frameworks. Distinct reporting systems (e.g., DHIS2, EMIS, DREAMS databases) limited unified performance tracking. TWG members acknowledged that data convergence remains “a missing link”, emphasizing the need for a single national M&E dashboard in Phase II.

4.2.3 Functionality and Efficiency of Coordination Structures

The NAIA coordination architecture functioned through four interlinked levels: national; technical; regional; and council level, enabling vertical and horizontal integration of activities.

The NSC, chaired by the Permanent Secretary of MoCDGWWSG, provided policy oversight, while the NTC and Technical Working Groups (TWGs) coordinated technical planning and progress reviews. Documentation from MoCDGWWSG shows that between 2021 and 2024, four national review meetings were held, producing actionable recommendations such as integration of Menstrual Hygiene Management (MHH) into school health programs.

At subnational level, NAIA–AHW coordination was intentionally embedded within existing platforms, including Regional and Council Health Management Teams (RHMTs/CHMTs) and, where relevant, coordination structures under the NPA-VAWC II. This approach enhanced cost-efficiency and alignment with routine planning processes. By end-2024, approximately 60 percent of councils had some form of active adolescent wellbeing coordination arrangement. Functionality, however, varied significantly due to limited local budgets, staff turnover, competing mandates and inconsistent availability of standardised planning and reporting templates.

Table 4.2.3: Summary of Coordination Structures and Functionality

Coordination Level	Lead Institution	Key Functions	Functionality Status (Endline)
National Steering Committee (NSC)	MoCDGWWSG (in consultation with NTC)	Strategic direction, policy oversight, alignment with national priorities	Functional but irregular after 2023
National Secretariat	PMO (Policy & Coordination) and MoCDGWWSG	Daily coordination, information collation, operational follow-up	Functional; dependent on partner support

National Technical Committee (NTC)	MoCDGWSG, MoH, PMO-RALG and line ministries	Technical guidance, data review, advisory support	Active but under-resourced
Pillar-Specific TWGs	Line ministries & partners	Pillar-level planning, data validation, technical inputs	Partially active (Pillars 1–3 strongest)
Regional Coordination Platforms	Regional Secretariats (RAS)	Integration into RHMT/REMT reviews, supervision	Moderately functional
Council-Level Coordination	LGAs (DEDs, CDOs, DMOs, DEOs)	Joint planning, mobilisation, service integration	Functional in ~60% of councils

Source: KII with members of the TWGs and National Level Government, LGA and CSOs.

these structures provided an operational backbone for multisectoral collaboration and enabled information and guidance to flow from national to community levels. However, efficiency gains achieved through integration with existing systems were offset by uneven resourcing and variable functionality, particularly at subnational levels.

4.2.4 Interpretation and Synthesis

The coherence of NAIA–AHW implementation is rated as moderate-to-strong. The agenda institutionalized a multi-tier coordination mechanism that effectively linked adolescent health, education, protection, nutrition and economic empowerment. Complementarity with partner programs expanded coverage and reduced duplication, while shared planning platforms promoted efficient use of resources.

Nevertheless, coherence challenges remain. Inconsistent TWG activity beyond Pillars 1–3, fragmented data systems and limited local-level financing constrained full operational alignment. These gaps, already quantified in Part I Section 3.7 (Cross-Cutting Coordination and Financing), underscore the importance of establishing a unified reporting and accountability framework in next phase of NAIA I.

The evaluation concludes that, NAIA–AHW has successfully institutionalized policy and strategic coherence, but sustaining this momentum will require strengthening operational coherence at subnational levels, improving data harmonization and ensuring consistent financing for coordination activities across all sectors.

4.3 Effectiveness

4.3.1 Overview

The NAIA–AHW endline evaluation finds that overall implementation effectiveness was substantial, with measurable achievements across all six pillars and strong progress toward intermediate outcomes related to adolescent health, education, protection, nutrition and empowerment.

Between 2021/22 and 2024/25, NAIA interventions reached millions of adolescents nationwide, strengthened multisectoral collaboration and improved service delivery at both community and institutional levels. Although challenges persisted, particularly around funding

delays and uneven local capacity, the majority of planned outputs were achieved or on track by the endline period.

Evidence from Part I (Sections 3.1–3.6) confirms that performance was strongest under Pillars 1, 2 and 3, which benefitted from well-established national programs and partner funding, while Pillars 4–6 also achieved substantial progress, particularly in education retention, nutrition and skills development.

4.3.1 Pillar 1: Preventing HIV

a). Achievements and Progress

Pillar 1 focused on expanding adolescent access to HIV prevention, testing and treatment services. According to data from MoH and TACAIDS (see Part I, Section 3.1), the number of adolescents tested for HIV doubled from 1.2 million in 2021 to 2.64 million by 2024, surpassing the NAIA target by 20 percent. Linkage to ART reached 98.2 percent, while 520,170 adolescent boys and young men received Voluntary Medical Male Circumcision (VMMC), achieving 86.7 percent of the national target.

A total of 8,589 health workers were trained in adolescent HIV service delivery, while 606,220 HIV self-test kits (*JIPIME*) were distributed, of which 91 percent had results reported. Integration of HIV testing with SRH outreach programs such as *Timiza Malengo*, *Jikubali* and *Furaha Yangu* significantly increased accessibility and normalized testing among young people in schools and communities.

b). Outcome-Level Change

National surveys show a modest but positive decline in new adolescent HIV infections, particularly among girls aged 15–19. FGDs confirmed a reduction in stigma around testing and treatment, with adolescents expressing greater confidence and comfort in accessing HIV and SRH services.

c). Interpretation

The overall effectiveness of Pillar 1 was high. This was attributed to strong institutional leadership, integration of HIV interventions within broader SRH programs and robust partner collaboration (notably with MDH, USAID and UNFPA). The success of this pillar underscores the value of embedding HIV prevention within a holistic adolescent health and wellbeing framework, which links biomedical, behavioural and social interventions.

4.3.2 Pillar 2: Preventing Teenage Pregnancy

a). Achievements and Progress

Pillar 2 interventions aimed to reduce teenage pregnancies through comprehensive sexuality education (CSE), parental engagement and youth-friendly SRH services. By 2024, 49,240 adolescents had been reached with SRH education across 18 councils, while 28,489 teachers (94 percent of target) were trained in the delivery of CSE.

Digital platforms emerged as a major enabler of outreach: the national helpline (117) received over 13.9 million calls and the *15017* SMS platform recorded 10.7 million SRH messages, demonstrating strong adolescent demand for confidential information and counselling. Additionally, 35,520 parents participated in positive parenting and SRH communication programs, improving intergenerational dialogue and reducing stigma within families.

b). Outcome-Level Change

According to MoH and TDHS 2022 updates, the adolescent pregnancy rate declined from 22 percent in 2022 to 20 percent in 2024, indicating progress toward the NAIA target of below 20 percent by 2025. FGDs reflected improved knowledge, agency and self-efficacy among adolescent girls, as illustrated by one participant:

“We now learn about our bodies, our rights and can ask questions without shame”. – 16-year-old, Arusha.

c). Interpretation

Pillar 2 demonstrated strong effectiveness in changing knowledge and attitudes through schools, parenting sessions and digital communication channels. However, contraceptive uptake among unmarried adolescents remained limited due to persistent myths, social stigma and cultural barriers in conservative settings. The next phase should therefore focus on community-based and faith-led engagement to bridge this gap and sustain behavioral change.

4.3.3 Pillar 3: Preventing Physical, Sexual and Emotional Violence

a). Achievements and Progress

Under Pillar 3, NAIA strengthened national and local protection systems to prevent and respond to violence against adolescents. By end-2024, 1,387 children’s councils (55.5 percent of target) and 3,618 school protection desks (72 percent) were established. A total of 2,925 frontline workers including social welfare officers, teachers, health workers and police officers were trained in GBV and VAC response, while 332 gender desks were set up in higher learning institutions.

Administrative data from MoCDGWSG and the Police Gender and Children’s Desks recorded a 23 percent increase in reported GBV/VAC cases between 2022 and 2024, reflecting growing awareness and confidence in reporting mechanisms. Over 89,700 survivors received psychosocial and mental health support through council-level protection systems.

b). Outcome-Level Change

Community-level campaigns such as *Ukatili Sasa Basi*, *Mimi Ni Msichana Najitambua* and *Twende Pamoja* contributed to visible social norm shifts. Parents, teachers and faith leaders demonstrated greater openness in discussing and addressing violence, while community protection committees increasingly facilitated early identification and referral of cases.

c). Interpretation

Effectiveness under Pillar 3 was high, with improved coordination between institutions, strengthened response mechanisms and greater community awareness. Integration with *NPA–VAWC II* and synergy with ongoing protection programs reinforced sustainability. However, psychosocial support and case follow-up systems still need scaling, especially in remote councils with limited professional staff.

4.3.4 Pillar 4: Improving Nutrition

a). Achievements and Progress

Pillar 4 interventions focused on improving adolescent nutrition through school meal programs, micronutrient supplementation and awareness campaigns. By June 2024, 23,173 schools (92 percent) provided meals and 12,636 (50 percent) established school gardens or small livestock units to enhance dietary diversity. The *Bamba na Lishe* campaign—implemented by TFNC in collaboration with partners—conducted 65 national awareness

events, reaching more than seven million adolescents with information on balanced diets and fortified foods.

b). Outcome-Level Change

National nutrition data indicate a moderate reduction in adolescent stunting (from 27 percent to 25 percent) and anemia among girls (from 34 percent to 31.4 percent). School attendance and engagement improved notably in schools offering meals and WASH facilities. Teachers and parents reported that access to school meals reduced absenteeism and improved concentration, particularly among adolescent girls.

c). Interpretation

Pillar 4 achieved moderate-to-high effectiveness by integrating nutrition with education and community engagement. However, dropping of WIFAS and limited coverage of adolescent-focused nutritional counselling restricted full achievement. Integration with school health, agriculture and climate-resilient food systems has proven to be a scalable model for future expansion under Phase II.

4.3.5 Pillar 5: Keeping Boys and Girls in School

a). Achievements and Progress

Efforts under Pillar 5 aimed to increase school retention and completion through safe, inclusive and gender-responsive environments. Between 2022 and 2024, 302 newly constructed Primary schools, 26 boarding Secondary schools for girls in each region and 228 secondary schools for boys and girls were constructed in order to accommodate students walking long distances to school. However, 30132 Primary schools classrooms, 40865 Secondary schools classrooms, 125 dormitories and 4,768 WASH facilities were constructed or rehabilitated to support access and comfort for students, particularly girls.

Menstrual Health and Hygiene Management (MHH) was a central focus: 552 schools (69 percent of target) conducted MHH campaigns and established safe, private facilities for girls. Consequently, dropout rates declined from 1.7 to 1.22 percent in primary schools and from 4.43 to 3.04 percent in secondary schools. As one student expressed:

“Now we have privacy and materials—we no longer miss classes during menstruation”.
– 15-year-old girl, Ilemela.

b) Outcome-Level Change

Outcome-level change under this pillar was evident through increased enrolment and retention rates among adolescents, particularly girls, in both primary and lower secondary education. According to the NAIA AHW Endline Evaluation (2025), the proportion of adolescents aged 10–19 attending school rose from 78% in 2022 to 84% in 2024, with notable gains among girls aged 10–14. The re-entry policy for young mothers was more widely implemented, with 36 districts reporting active community sensitization and follow-up mechanisms.

Teachers and community leaders attributed this improvement to the strengthened collaboration between education and social welfare departments and the rollout of community dialogues on adolescent wellbeing.

“We have seen more girls returning to school after childbirth because communities now understand their right to continue learning”, noted a District Education Officer in Dodoma Region.

However, poverty and inadequate menstrual hygiene facilities remained critical barriers to attendance and performance, particularly in rural and peri-urban areas.

b). Interpretation

The pillar demonstrated strong effectiveness by linking education, gender equality and health outcomes. Improved facilities and sensitization efforts increased attendance and retention, especially for girls. However, disparities remain between rural and urban schools, largely due to uneven infrastructure funding and capacity gaps in local education authorities. Strengthening school-based monitoring and district-level financing will be essential for sustaining these gains.

4.3.6 Pillar 6: Developing Skills for Meaningful Economic Opportunities

a). Achievements and Progress

Pillar 6 emphasized skills development, employability and youth economic empowerment. Between 2022 and 2024, 83,974 youth were enrolled in vocational and technical programs under VETA equivalent to 112 percent of the NAIA target. Fourteen training curricula were revised to align with market demands, while 52 instructors were trained in modern, competency-based methodologies. Currently, MoEST and PMO-RALG is implementing the newly revised Basic Education Cullicula and Education and Training Policy of 2014 (2023 Edition) where Compulsory Basic Education is 10 years and in secondary schools ,learners are given chances to pursue Technical and Vocational stream as well as General stream.

Partnerships with 32 private-sector actors expanded apprenticeship and internship placements in various trades. Employment among graduates increased by 18 percent, while self-employment among young women rose significantly in tailoring, catering and hairdressing. One participant in Mbeya stated:

“After VETA, I opened a small salon. I earn income and support my family”. – 19-year-old girl, Mbeya.

b). Outcome-Level Change

This pillar demonstrated progress in equipping adolescents with vocational and entrepreneurship skills, contributing to increased employability and self-reliance. Endline findings show that the number of adolescents (15–19 years) enrolled in short-term vocational and skills training programs increased from 18,400 in 2022 to 31,700 in 2024, representing a 72% increase. Collaborations with VETA, CSOs and private sector partners expanded access to skills training, mentorship and start-up support.

Adolescents reported improved confidence and aspirations for self-employment.

“Before the training, I didn’t know I could earn from tailoring. Now I make uniforms and small bags and support my younger siblings”, shared a 17-year-old girl trainee from Mwanza.

Despite these gains, only 37% of trained adolescents were linked to income-generating opportunities or start-up financing, indicating a gap between training and actual economic integration. Limited access to capital, market linkages and digital literacy were identified as key constraints.

c). Interpretation

Pillar 6 proved highly effective in translating skills development into tangible livelihoods and employment. The combination of technical training, private-sector collaboration and mentorship yielded measurable economic empowerment outcomes. However, access to start-up capital remains a major limitation, particularly for young women in rural areas. Strengthening linkages to microfinance institutions and youth entrepreneurship funds will be critical in Phase II.

4.4 Efficiency

4.4.1 Resource Utilization: Financial, Human and Technical Efficiency

a). Financial Efficiency

Efficiency gains were realized through integration of activities within existing sectoral programs. For instance, combining HIV prevention, SRH and GBV awareness under the *Timiza Malengo* campaign reduced duplication and operational costs. Several councils particularly in Mwanza, Songwe and Katavi mainstreamed NAIA interventions into Comprehensive Council Health Plans (CCHPs) and PlanRep budgets. These councils demonstrated better reporting and financial performance compared to those relying solely on partner-driven activities.

However, many councils reported delayed fund transfers, particularly for training and supervision. This affected the timeliness of community mobilization, school WASH upgrades and nutrition campaigns. As a result, implementation often became compressed into the latter quarters of the fiscal year, reducing efficiency.

According to the NAIA Costed Action Plan (2021/22–2024/25), an estimated TSh 1.4 trillion was required for full implementation of the six pillars. By mid-2024, approximately TSh 1.03 trillion (73%) had been mobilized and utilized across government and partner channels (see *Part I, Section 3.7: Financing*).

Government ministries including MoCDGWSG, MoH, MoEST, PMO-RALG, TFNC, PMO-LYED and VETA contributed 55% of the total expenditure, while development partners funded 45%, mainly through project-based and technical assistance mechanisms.

Table 4.3.7: Budget Vs Expenditure for NAIA AHW related interventions

Funding Source / Implementing Entity	Budgeted (TSh Billion)	Actual (TSh Billion)	Utilization Rate (%)
MoCDGWSG (Coordination, Pillars 3 & 5)	180	132	73
MoH (Pillars 1, 2 & 4)	450	305	68
MoEST (Pillar 5)	160	119	74
PMO-RALG (Subnational Implementation & M&E)	140	92	66
TFNC (Pillar 4)	80	60	75
PMO-LYED / VETA (Pillar 6)	100	78	78
Development Partners & NGOs	290	240	83
Total	1,400	1,026	73%

Source: KII with members of the TWGs and National Level Government and CSOs; NAIA AHW Implementation Plan 2023-2024; NAIA HAW Progress Report 2021/22 -2024/25;

Pillar-specific analysis shows higher spending efficiency in HIV, GBV and skills-related interventions due to streamlined partner disbursement mechanisms (UNICEF, MDH, UNFPA,

Nutrition International), compared to school-based and nutrition interventions that depended on slow government procurement cycles.

Although the overall utilization rate of 73% indicates significant absorption, the absence of a dedicated adolescent budget code limited traceability of expenditures within council systems.

b). Human Resource Efficiency

The NAIA AHW relied heavily on existing government personnel particularly Community Development Officers (CDOs), Social Welfare Officers, Education Officers and Health Officers instead of creating parallel staffing structures. This approach enhanced efficiency and ownership but also led to workload strain and occasional delays in reporting. FGDs with district officers indicated that “staff burnout and competing responsibilities” were common due to limited personnel and the absence of dedicated adolescent health officers at the LGA level.

To mitigate these challenges, partners supporting NAIA employed peer educators, youth champions and community health workers (CHWs) across pillars. Their contribution was particularly critical under Pillars 1–3, where youth-led outreach increased coverage at low cost. However, high volunteer turnover and inconsistent incentives posed sustainability concerns.

c). Technical Efficiency

Technically, NAIA - AHW benefitted from effective partnerships that provided capacity building and innovation support. TFNC and UNICEF guided school nutrition programming, UNESCO supported the integration of life skills into education and MDH enhanced digital health reporting through mobile data tools. Nevertheless, technical efficiency was reduced in some TWGs due to irregular participation, inconsistent reporting formats and limited access to shared data repositories.

4.4.2 Coordination and M&E Efficiency

Coordination efficiency under NAIA–AHW was moderate but improving. The established coordination hierarchy, the National Steering Committee (NSC), National Technical Committee (NTC) and pillar-based Technical Working Groups (TWGs) provided clear institutional roles but faced funding constraints and irregular meeting schedules, particularly after 2023. Ownership of NAIA-AHW also varied across the sectoral ministries, affecting participation in coordination structures and reporting under NAIA-AHW and budget allocation for adolescents under their respective pillars.

At regional and district levels, integration with NPA–VAWC II and RHMT/REMT structures allowed NAIA to operate cost-effectively within existing government systems. However, the M&E component remained fragmented across ministries and regular data collection of achievements for the indicators and activities under the pillars was a persistent challenge.

While Part I, Section 3.7 (MEL Component) showed steady improvement in M&E coverage (55% up to 82%) and staff trained (1,800 up to 3,200), the absence of a unified national platform for adolescent indicators impeded data consolidation. Ministries continued to use separate databases including DHIS2, EMIS, CPMIS and partner-specific tools, limiting cross-sector analysis.

Table 4.4.2: Summary of Institutional Coordination and System Efficiency under NAIA–AHW

Component	Strengths	Gaps / Constraints
National Coordination (MoCDGWSG, NSC)	Improved cross-sector alignment and joint reviews	Limited budget for convening meetings; inconsistent reporting
TWG Functionality	Effective collaboration on HIV, SRH and GBV pillars	Weak documentation and limited engagement for Pillars 4–6
Regional & Council Platforms	Reduced duplication, leveraged NPA–VAWC II committees	Reliance on donor funding; weak accountability mechanisms
M&E Systems	Expanded data coverage and staff training	Fragmented databases; no shared adolescent dashboard

Source: KII with members of the TWGs and National Level Government, UN Agencies and CSOs; NAIA AHW Implementation Plan 2023-2024; NAIA HAW Progress Report 2021/22 - 2024/25;

Efficiency at the M&E level improved compared to baseline, but data availability of data, verification, harmonization and learning loops remain areas for institutional strengthening under NAIA Phase II.

4.4.3 Timeliness and Implementation Bottlenecks

Implementation timelines varied considerably across sectors and levels of government. National and partner-led initiatives (Pillars 1–3, 6) generally progressed on schedule, while education and nutrition-related pillars (4 and 5) faced recurrent delays.

a). Key Bottlenecks Identified

While NAIA–AHW demonstrated significant progress in coordination and service delivery, the evaluation identified a number of persistent systemic bottlenecks that constrained implementation efficiency at both national and subnational levels. These bottlenecks often reflected institutional and procedural weaknesses rather than conceptual flaws in the design of the agenda.

i. Late Fund Disbursement

One of the most recurrent challenges reported across nearly all regions was delayed fund disbursement. Councils frequently received operational funds late in the fiscal year, leaving limited time for planned activities to be executed before financial closure. This compression of implementation periods forced many LGAs to rush expenditures, resulting in reduced quality and incomplete reporting. Some district officers indicated that delays from the central treasury and lengthy approval chains at the regional level often led to spill-over activities into the next fiscal year. The delays also affected coordination meetings, supervision visits and procurement of materials, ultimately reducing operational efficiency and predictability of interventions.

ii. Human Resource Gaps

Human resource limitations were another key constraint. Councils and health facilities reported inadequate numbers of trained technical personnel for supervision, data consolidation and adolescent-focused service delivery. Teachers, community

development officers and health providers often carried multiple responsibilities, leaving little dedicated time for NAIA-related tasks. Staff turnover and transfers also led to loss of institutional memory and discontinuity in implementation. Some adolescent health and protection units operated without dedicated focal officers, further weakening monitoring and coordination capacity.

iii. Limitations in Routine Data Availability and Use

Routine data systems did not consistently generate timely and disaggregated data, limiting the ability to track annual progress across key indicators. This constrained trend analysis and reduced the precision with which NAIA–AHW effectiveness could be assessed over the implementation period.

iv. Data Duplication and Fragmentation

Despite progress in integrating adolescent indicators into systems such as DHIS2, EMIS and CPMIS, data management under NAIA–AHW remained fragmented due to continued use of parallel, sector-specific reporting templates. Different ministries continued to use parallel reporting templates, resulted in duplicated reporting burdens at regional and council levels, delays in data consolidation and inconsistent figures across reports, limiting timely and evidence-based decision-making. In some cases, overlapping indicators reported under NAIA-AHW and other national frameworks, such as NMNAP II, complicated performance tracking and attribution of results.

v. Procurement Delays

Centralized procurement systems, particularly for health commodities, learning materials and IEC tools, led to significant delays in distribution. Schools and health facilities in remote councils reported receiving materials long after planned activity timelines had passed. The lengthy processes for tendering, approval and distribution especially for WASH facilities, nutritional supplements and MHH products caused delays that hindered program momentum. In some instances, implementing partners had to bridge supply gaps through direct procurement, highlighting the need for more flexible, decentralized approaches.

vi. Overlap of Programs and Reporting Burden

The evaluation revealed overlaps between NAIA-AHW, NMNAP II and NPA-VAWC II programs, particularly in areas such as nutrition, gender-based violence and child protection. These overlaps often led to confusion among frontline implementers regarding reporting lines, funding allocation and activity ownership. Some councils managed up to three sets of similar indicators under different frameworks, stretching limited administrative capacity. While national integration efforts were underway, the absence of a harmonized results matrix continued to burden local teams and diluted accountability.

4.4.4 Adaptive Practices and Emerging Efficiency Models

Despite these challenges, the evaluation also documented several adaptive practices that improved efficiency and demonstrated the flexibility of NAIA’s design:

- i. In Songwe and Katavi, local authorities merged NAIA review meetings with existing council planning and budgeting sessions. This integration reduced operational costs, eliminated duplication of meetings and allowed cross-departmental dialogue on adolescent priorities. The approach enhanced ownership and accountability while optimizing limited resources.
- ii. In Mwanza, health and education officers introduced joint school outreach programs that combined SRH, MHH and nutrition education within a single activity. This

integrated model significantly reduced logistical costs, saved staff time and improved coordination between sectors.

These adaptive strategies illustrate how decentralized innovation and practical coordination can enhance cost-effectiveness even in resource-constrained environments. They also confirm that NAIA's flexible, multisectoral framework allowed local governments to experiment with collaborative solutions that optimized outcomes without additional funding. Addressing the identified bottlenecks, especially around fund flow timeliness, data harmonization and workforce strengthening will be essential to further improve efficiency and operational predictability in the next phase of NAIA-AHW.

4.5 Impact

4.5.1 Overview

The impact assessment of the National Accelerated Action and Investment Agenda for Adolescent Health and Wellbeing (NAIA-AHW) demonstrates tangible and sustained improvements in adolescent wellbeing outcomes across Tanzania. Quantitative and qualitative data confirm measurable gains in adolescent health, education, protection and economic participation.

Overall, the program contributed significantly to increased service coverage, strengthened community systems and positive shifts in social and gender norms. Evidence from both national and subnational levels reveals that NAIA not only achieved intermediate outputs but also produced visible behavioral and institutional changes, many of which are likely to be sustained beyond the project period.

These impacts were most evident in areas where interventions were multi-sectoral, data-informed and supported by active community participation. As such, the NAIA-AHW served as both a programmatic framework and a national movement advancing Tanzania's commitment to investing in its adolescent population.

4.5.2 Measurable Impact Across Core Pillars

a). Pillar 1: Health and HIV Prevention

National data show a marked improvement in adolescent access to HIV testing and prevention services. The number of adolescents tested for HIV rose from 1.2 million in 2021 to 2.64 million in 2024, with 98 percent linkage to care. This expansion was accompanied by a 17 percent decline in new HIV infections among adolescents aged 15–19, according to TACAIDS and MoH surveillance data. The reach of *Jipime* self-test kits, coupled with peer-led awareness campaigns, normalized HIV testing and improved early diagnosis.

b). Pillar 2: Prevention of Teenage Pregnancy

The teenage pregnancy rate dropped from 22 percent in 2022 to 20 percent in 2024, supported by the scale-up of sexuality education, digital SRH platforms and parental communication programs. Digital helplines (117 and 15017) became trusted sources of confidential SRH information, receiving over 24 million adolescent interactions during the period. Qualitative evidence suggests a growing culture of informed decision-making and confidence among girls to delay early pregnancies.

c). Pillar 3: Violence Prevention

The agenda strengthened Tanzania's protection ecosystem, leading to higher case reporting and improved community responsiveness. GBV and VAC cases reported increased by 23

percent between 2022 and 2024, indicating growing awareness and reduced tolerance for violence. Over 89,000 survivors accessed psychosocial and legal support through established gender desks, safe houses and one-stop centers. These outcomes reflect enhanced institutional capacity, social mobilization and survivor-centered response mechanisms.

d). Pillar 4: Nutrition

Adolescent nutrition indicators improved modestly but steadily. School meal programs reached 92 percent of targeted schools, while the prevalence of anemia among girls aged 15–19 declined from 34 percent to 31.4 percent. School gardens and local food production and utilisation initiatives strengthened dietary diversity and community resilience. The *Bamba na Lishe* campaign enhanced national awareness of fortified foods and healthy diets, fostering positive nutrition behaviors among youth and parents alike.

e). Pillar 5: Education and Retention

School retention improved across primary and secondary levels. Dropout rates decreased from 1.7 to 1.22 percent in primary, 2021 and from 4.62 to 2.94 percent in secondary schools, 2024. MHH programs, upgraded WASH infrastructure and safe dormitory facilities contributed to a more inclusive learning environment, especially for girls. Evidence from school observations and FGDs suggests that these interventions directly improved attendance, concentration and academic performance.

f). Pillar 6: Skills and Economic Empowerment

Economic empowerment outcomes were among the most transformative. Enrolment in vocational and technical programs under VETA increased by 112 percent and employment among graduates rose by 18 percent between 2022 and 2024. Female youth participation in income-generating activities expanded significantly, with self-employment reported in tailoring, catering, hairdressing and agribusiness. These outcomes demonstrate clear returns on investment in skills training, mentorship and private-sector partnerships.

4.5.3 Social and Normative Impact

Beyond measurable indicators, NAIA–AHW catalyzed profound shifts in community attitudes and gender norms. Communities reported increased acceptance of SRH education, gender equality and youth participation in local decision-making. Faith and traditional leaders once hesitant to engage emerged as advocates for adolescent rights and wellbeing.

FGDs and KIs consistently highlighted the erosion of silence surrounding adolescent issues. Parents and teachers expressed greater willingness to discuss sensitive topics, while adolescents described newfound confidence in expressing opinions and seeking services. This normative transformation marks one of NAIA’s most sustainable impacts: building trust, openness and intergenerational dialogue around adolescent wellbeing.

4.5.4 Institutional and Systemic Impact

The agenda’s multi-sectoral design fostered stronger institutional linkages between ministries, agencies and local government authorities. Coordination mechanisms such as the National Steering Committee (NSC), Technical Committees and Thematic Working Groups institutionalized joint planning and review processes.

At the council level, the integration of adolescent indicators into Comprehensive Council Health Plans (CCHPs) and education budgets represented a significant milestone in domestic institutionalization. Furthermore, the harmonization of adolescent data within DHIS2, EMIS and CPMIS systems enhanced accountability and evidence-based decision-making. NAIA’s

success in aligning with existing national strategies such as FYDP III, HSSP V and NPA–VAWC II, also positioned adolescent wellbeing as a central pillar of Tanzania’s human capital agenda.

4.5.5 Evidence of Empowerment and Youth Leadership

Adolescent empowerment was both an outcome and a catalyst of NAIA’s impact. By 2024, 55 percent of LGAs had functional children’s councils, enabling adolescents to influence local decision-making and monitor community interventions.

FGDs with youth champions revealed increased agency and ownership:

“Before, we were waiting to be invited. Now, we are part of the meetings and speak for ourselves”. – Youth leader, Songwe.

Youth participation in digital advocacy campaigns (*Timiza Malengo, Jikubali, Furaha Yangu*) demonstrated the effectiveness of peer-led behavior change communication. The growing leadership of adolescents in community platforms has contributed to social accountability and sustainability, marking a generational shift in civic engagement.

4.5.6 System-Level Impact

At system level, NAIA–AHW has laid the foundation for institutionalized adolescent programming in Tanzania. Its cross-sectoral coordination model bridged long-standing gaps between ministries and local actors, establishing an operational framework for integrated service delivery.

Government and partner interviews confirmed that NAIA improved planning efficiency, reduced program fragmentation and created a shared platform for monitoring adolescent wellbeing. The harmonized approach under MoCDGWSG leadership has set a precedent for future multi-sectoral investments, reinforcing policy coherence and national ownership.

4.5.7 Synthesis on the impact

The evaluator finds that the contribution of the NAIA–AHW to observed changes is both quantitative and transformational in nature, while recognising that many of the outcomes documented were also influenced by pre-existing sectoral programmes and parallel national initiatives. Quantitatively, the NAIA–AHW did not operate as a stand-alone delivery mechanism; rather, it provided a unifying policy and coordination framework that helped align, prioritise and scale ongoing interventions related to adolescent health, education, protection and skills development. In this sense, the agenda’s contribution is best understood as enabling and catalytic, supporting coherence and visibility of adolescent-focused actions rather than acting as the sole causal driver of results.

Qualitatively, the NAIA–AHW played a discernible role in elevating adolescent wellbeing as a cross-cutting national development priority, strengthening inter-sectoral dialogue and legitimising adolescent participation within policy and planning spaces. These shifts reflect changes in institutional practice and narrative framing, even where direct attribution to NAIA–AHW interventions cannot be isolated from broader system reforms.

While the agenda promoted the use of evidence and indicators to inform decision-making, the evaluation acknowledges that limitations in routine data availability and consistency constrained real-time performance monitoring. As a result, adaptive management relied more heavily on periodic surveys, programme monitoring data and stakeholder feedback than on comprehensive annual trend analysis. This constrained, but did not eliminate, opportunities for evidence-informed course correction during implementation

As Tanzania transitions to the next phase of the agenda, the evaluation concludes that the primary value of NAIA–AHW lies in its agenda-setting, coordination and systems-strengthening role. Consolidating these gains will require clearer articulation of contribution pathways, stronger routine data systems, sustainable domestic financing and deliberate investment in adolescent leadership, to ensure that future progress can be more directly tracked and attributed.

4.6 Sustainability

4.6.1 Overview

The sustainability of the NAIA–AHW is founded on its strong institutional anchorage, multisectoral integration and growing national and local ownership. By the end of its first implementation phase, NAIA–AHW is making progress in departing from a donor-catalysed initiative into a government-led framework, with progress observed in embedding within existing policy, budgeting and coordination systems especially at priority interventions levels. This transition reflects deliberate efforts to ensure that adolescent health and wellbeing are not treated as a parallel program but as an integral component of Tanzania’s social development architecture.

However, sustainability remains contingent upon maintaining political commitment, predictable financing, youth participation and strengthened local systems capable of managing and scaling adolescent-centered interventions into next phase of NAIA AHW.

4.6.2 Institutionalization of NAIA Interventions and Mechanisms

A major design feature of the NAIA–AHW was the establishment of dedicated coordination structures to drive multi-sectoral action on adolescent health and wellbeing. While these structures strengthened visibility and focus on adolescent priorities, the evaluation finds that NAIA–AHW coordination operated largely as a parallel system alongside existing national coordination platforms, including the NPA-VAWC coordination committees and the National Multisectoral Early Childhood Development Programme (NM-ECDP) structures.

At the national level, coordination was anchored within the MoCDGWSG through the National Steering Committee (NSC) and National Technical Committee (NTC). Although these bodies brought together relevant sector ministries and partners, their mandates and membership overlapped substantially with existing inter-ministerial coordination mechanisms, resulting in duplication of discussions, reporting requirements and meeting processes. Similar overlaps were observed at subnational levels, where NAIA–AHW coordination structures co-existed with established council-level committees under MTAKUWWA and ECD coordination frameworks.

As a result, while NAIA–AHW coordination platforms enhanced agenda-setting and cross-sector dialogue on adolescents, they did not fully leverage or integrate into existing coordination systems, limiting efficiency gains and complicating institutional sustainability. This parallelism underscores the need for clearer alignment and rationalisation of coordination arrangements in any subsequent phase.

At the national level, coordination is anchored within the MoCDGWSG, supported by two central governance bodies, the National Steering Committee (NSC) and the National Technical Committee (NTC). Each of the six pillars is aligned with a lead and co-lead sectoral institution, ensuring that responsibilities are distributed across ministries while maintaining coherence and accountability.

Table 4.6.2a: NAIA–AHW coordination framework

NAIA–AHW Pillar	Lead Institution(s)	Primary Coordination / Integration Mechanisms	Status / Observations
Pillar 1: Preventing HIV	Ministry of Health (MoH); TACAIDS	Integration of adolescent HIV testing, VMMC and self-testing within SRH platforms	Strong leadership; full integration achieved through national HIV and SRH programs
Pillar 2: Preventing Teenage Pregnancy	MoH; Ministry of Education, Science and Technology (MoEST)	Linkage between CSE in schools and youth-friendly SRH services	Functional coordination; limited reach in conservative communities
Pillar 3: Preventing Physical, Sexual and Emotional Violence	MoCDGWSG; MoEST (via NPA–VAWC II)	Coordination through protection committees, gender desks and child protection and safety desks	Well-integrated with existing child protection systems
Pillar 4: Improving Nutrition	Tanzania Food and Nutrition Centre (TFNC); MoH and PMO-RALG	Integration with NMNAP II and school meal programs	Partial coverage; stronger results where schools had gardens or WASH/SWAH facilities
Pillar 5: Keeping Boys and Girls in School	MoEST; PMO-RALG	Mainstreamed into education plans and council budgets via PlanRep	Broad institutionalization; sustained by school-level structures
Pillar 6: Developing Skills for Meaningful Economic Opportunities	PMO-LYED; VETA	Coordination through vocational training centers and youth empowerment programs	Strong private sector collaboration; scale-up needed for rural coverage

Source: KII with members of the TWGs and National Level Government and CSOs; NAIA AHW Implementation Plan 2023-2024; NAIA HAW Progress Report 2021/22 -2024/25;

At the subnational level, NAIA–AHW interventions were mainstreamed into the annual plans and budgets of a subset of Local Government Authorities (LGAs) through the PMO-RALG PlanRep system, demonstrating the feasibility of embedding adolescent wellbeing priorities within council development frameworks. This practice was not uniform across all LGAs.

Field visits confirmed that 7 out of the 10 NAIA–AHW priority councils visited had designated Adolescent Focal Persons—typically drawn from Community Development or Health departments—responsible for coordinating implementation, data collection and stakeholder engagement. While this reflects promising practice in the councils assessed, it should not be interpreted as representative of all NAIA–AHW LGAs nationally.

While the NAIA–AHW was designed with the goal of linking its indicators to existing systems like DHIS2 (Health), EMIS (Education) and CPMIS (Child Protection), this integration faced significant practical challenges. In reality, the agenda’s indicators were not fully aligned with the routine daily monitoring tools used by local councils. This lack of alignment meant that

data collection remained fragmented, forcing officials to work outside their normal reporting schedules to gather information.

At the national level, political and policy commitment was maintained through the leadership of the MoCDGWSG, working in collaboration with the Prime Minister’s Office and key sectoral ministries. NAIA’s alignment with the FYDP III, further strengthened its legitimacy within Tanzania’s broader development agenda. The table 4.6 below summarizes sectoral integration of NAIA components within institutional frameworks:

Table 4.6.2b: Sectoral integration of NAIA AHW components within institutional frameworks

Sector / Ministry	Integrated NAIA Components	Mechanism of Institutionalization	Observed Impact
Ministry of Health (MoH)	Adolescent SRH, HIV prevention, mental health	Incorporated adolescent-friendly services and indicators within the National Health Policy (2023) and DHIS2	Improved service quality and data visibility
Ministry of Education, Science and Technology (MoEST)	Re-entry for adolescent mothers, MHH, CSE	Integrated within 2023 Education Policy reform and school WASH programs	Increased retention, gender parity and CSE coverage
PMO–Labour, Youth, Employment and the Disabled (PMO-LYED)	Skills development and youth employability	Expanded youth empowerment initiatives under the revised Youth Development Policy	Enhanced linkages with VETA and private sector
PMO–RALG	Local planning and budgeting	Directed LGAs through planning circulars to include adolescent wellbeing activities	Strengthened decentralization and local ownership

Source: Literature Review, KII with members of the TWGs, National Level Government and CSOs; NAIA AHW Implementation Plan 2023-2024; NAIA HAW Progress Report 2021/22 - 2024/25;

At the regional and council levels, local governments increasingly assumed leadership of implementation. Coordination meetings are now chaired by District Executive Directors (DEDs) or Council Management Teams, integrating adolescent wellbeing into regular planning cycles. Technical support is provided by Health, Education and Community Development officers which strengthen cross-sector linkages.

Local ownership is further deepened through community-based structures such as school clubs, children’s councils, youth networks and interfaith groups. In regions such as Mwanza, Katavi and Tabora, children’s councils and peer groups have sustained SRH dialogues and local radio campaigns independently, mobilizing their own resources even after external funding concluded.

“NAIA gave us a structure, but the drive now comes from within our councils”.
— District Reproductive and Child Health Coordinator, Katavi

This vertical diffusion of leadership, from national oversight to local execution demonstrates that NAIA’s principles have taken root institutionally, with community-driven sustainability mechanisms now in operation.

4.6.4 Prospects for Continuation of NAIA-AHW into next phase

Evidence from stakeholder consultations, field visits and policy reviews indicates a strong rationale for continuation and scale-up of the NAIA-AHW into a second phase, as summarized in Table 4.7 below. While Phase I established important foundational structures such as national and subnational coordination mechanisms, improved alignment of adolescent-related indicators within existing data systems and strengthened youth participation platforms, the evaluation finds that adolescent outcomes remain uneven and incomplete. Improvements across key indicators were observed, but progress varied significantly by region, urban–rural location, gender and schooling status, with out-of-school adolescents and adolescent girls in high-burden settings continuing to face disproportionate risks. These persistent gaps constitute unfinished business for adolescent wellbeing and provide a central justification for NAIA II, which will require more tailored, targeted and equity-focused interventions that respond to emerging priorities and differentiated adolescent needs over the proposed next phase of NAIA-AHW.

Table 4.6.4: Factors for continuation of NAIA AHW into next phase

Enabling Factor	Evidence of Continuity	Institutional Implication
Established Institutional Systems	NSC, NTC and TWGs are in place and functioning, supported by both government leadership and partner inputs.	They provide an entry point for governance continuity in Phase II, though further integration into routine government planning and budgeting processes is required.
Youth Engagement Mechanisms	1,300+ children’s and youth councils operational	Ensures sustained feedback and participatory monitoring
Integration into Local Plans	NAIA activities included in LGA budgets via PMO-RALG circulars	Institutionalizes adolescent wellbeing within local systems
Policy Coherence	Linked to NMNAP II, NPA–VAWC II, FYDP III	Aligns with ongoing national development priorities

Source: Literature Review, KII with members of the TWGs, National Level Government and CSOs; NAIA AHW Implementation Plan 2023-2024; NAIA HAW Progress Report 2021/22 - 2024/25;

Emerging thematic priorities for the next phase from the analysed data reflect the evolving realities of adolescents in Tanzania and global development agendas. These include:

- i. Safe and Inclusive Digital Environments,
- ii. Climate-Resilient Adolescent Health and Nutrition,
- iii. Mental Health and Psychosocial Wellbeing,
- iv. Youth Leadership and Accountability, and
- v. Patriotism, discipline, social accountability and positive moral values.

Integrating these identified cross-cutting themes will help NAIA Phase II to address 21st-century challenges and align with post-2025 Sustainable Development Goal (SDG) acceleration strategies.

4.6.5 Policy and Budget Commitments for Sustainability

Sustainability is being reinforced through explicit policy and fiscal measures that embed adolescent health and wellbeing within Tanzania’s public financing and planning systems. The Ministry of Finance (MoF) has initiated integration of adolescent health and wellbeing indicators into the Medium-Term Expenditure Framework (MTEF), ensuring predictable allocations in sectoral budgets. At the national and sectoral levels, recent policy reforms explicitly institutionalize adolescent health and wellbeing priorities as demonstrated in table 4.8 below.

Table 4.6.5: National policies and frameworks that integrated Adolescent Wellbeing

Policy Framework	Year / Status	Adolescent-Focused Provisions	Impact on Sustainability
National Health Policy (Draft)	2023	Incorporates adolescent SRH, mental health and digital health	Institutionalization within health sector strategy
Education and Training Policy	2023	Mandates school health, nutrition and protection components	Strengthens intersectoral delivery in education
Youth Employment Strategy	2024	Integrates entrepreneurship, financial literacy and life skills	Promotes youth employability and self-reliance
PMO–RALG Planning Circular	2024	Directs LGAs to allocate funds for adolescent health and protection	Expands fiscal decentralization of NAIA activities

Source: Literature Review, KII with members of the TWGs, National Level Government and CSOs; NAIA AHW Implementation Plan 2023-2024; NAIA HAW Progress Report 2021/22 - 2024/25;

Development partners and CSOs (including UNFPA, UNICEF, WHO, UNESCO, CDC/PEPFAR, Plan International, Nutrition International, Brac Maendeleo, MSI Tanzania, AMREF and Girls effects) have continued supporting NAIA AHW, with a transition toward co-financing and government-led implementation. The NAIA M&E Framework, housed at MoCDGWSG, is being upgraded into a government-owned national results system, preserving institutional memory and promoting data-driven planning.

“We are now budgeting for adolescent wellbeing not because of NAIA , but because it is part of our mandate”. — PMO-RALG Official, Dodoma

4.6.6 Challenges to Long-Term Sustainability

While institutional and policy continuity is promising, certain systemic challenges must be addressed to ensure durable sustainability of NAIA outcomes. Those challenges are summarized in table 4.9 below. Addressing these gaps through capacity building, financial reform and institutional safeguards will be critical in the next Phase to consolidate gains and enhance systemic resilience.

Table 4.6.6: Challenges for sustainability

Challenge	Description	Implication for Sustainability
Dependence on Partner Funding	Coordination mechanisms at National level and key community-based interventions (e.g., youth clubs, GBV campaigns) still rely on donor grants	Risk of service gaps if external funding declines
Variable LGA Capacity	Uneven ability of councils to plan, budget and coordinate multi-sector activities	Inconsistent program quality and reach
High Staff Turnover	Frequent transfers and limited institutional memory among trained personnel	Disrupts continuity and capacity at local levels
Data System Fragmentation	Limited harmonization across DHIS2, EMIS and CPMIS as well as alignment of with existing and routine data systems.	Restricts integrated performance tracking
Insufficient Recurrent Financing	Few LGAs allocate recurrent funds specifically for adolescent programs	Limits continuity once project support ends

Source: Literature Review, KII with members of the TWGs, National Level Government and CSOs; NAIA AHW Implementation Plan 2023-2024; NAIA HAW Progress Report 2021/22 - 2024/25;

5.0 Regional and Local Contextual Variations

5.1 Overview

The NAIA–AHW endline evaluation revealed significant variation in the pace and depth of implementation across regions and councils, influenced largely by partner presence, institutional capacity, local leadership and socio-cultural contexts. While the overall direction of progress was positive, the extent of results depended on the strength of coordination mechanisms, availability of technical support, external financial support and degree of community ownership.

Among the evaluated regions, Mwanza, Songwe, Katavi, Lindi, Tabora, Arusha and Pwani demonstrated differing trajectories of achievement. Of these, Mwanza, Songwe, Katavi, Tabora and Lindi were designated priority regions under NAIA–AHW, benefitting from targeted technical assistance and development-partner investments. The non-priority regions, Arusha and Pwani provided a useful comparison, illustrating how institutional maturity and local initiative can compensate for limited external support.

5.2 Regional Progress and Implementation Trends

Priority regions generally achieved stronger results across most pillars, particularly in service coverage, coordination and youth engagement. Mwanza and Songwe stood out for their robust school-based and community outreach initiatives, supported by partners such as UNFPA, UNICEF and Femina Hip. These regions effectively integrated SRH, HIV prevention and nutrition within school programs, reaching large adolescent populations through digital platforms and youth clubs. Katavi demonstrated notable progress in community mobilization, with religious and traditional leaders championing SRH and anti-GBV dialogues.

Tabora and Lindi, though priority regions, faced persistent structural and capacity limitations, including delayed fund disbursements, inadequate staffing and weak data utilization. Nevertheless, both regions showed growing commitment through improved coordination

between health, education and community-development sectors, particularly in addressing school dropouts and violence prevention.

In contrast, Arusha and Pwani which were not part of the 13 NAIA priority regions recorded mixed progress. Despite limited external investment, Arusha leveraged its vibrant network of faith-based and community organizations to advance adolescent dialogues and life-skills training. Pwani demonstrated moderate results, benefitting from proximity to Dar es Salaam and relatively stronger administrative infrastructure but requiring greater focus on community engagement and local financing mechanisms.

5.3 Comparative Insights

Analysis across the seven regions suggests that priority status was a strong but not exclusive determinant of success. Priority regions benefitted from sustained partner support and structured capacity-building, leading to higher performance in indicators such as HIV testing, school retention and youth participation. However, regions with strong local leadership, such as Arusha, achieved comparable results in community mobilization and social-norm change even without formal priority designation as summarised in table 5.1 bellow.

Table 5.3: Summary of comparative progress between priority and non-priority regions.

Region	NAIA Priority Status	Overall Implementation Performance	Key Enablers	Persistent Gaps
Mwanza	Priority	High	Strong partner presence (Femina Hip, MDH); digital youth clubs; effective M&E use	Stigma around SRH in some schools
Songwe	Priority	High	Functional council committees; youth volunteers linking community & health facilities	Staffing gaps; limited GBV infrastructure
Katavi	Priority	Moderate	Faith-based engagement; community ownership	Limited adolescent-friendly corners; minimal partner support
Tabora	Priority	Moderate	Integration of GBV prevention and nutrition; expanding school-feeding	Technical support & transport constraints
Lindi	Priority	Moderate-Low	Improved SRH outreach; community dialogues	Low financing; limited adolescent data
Arusha	Non-priority	Moderate-High	Faith-based leadership; parental engagement; youth-advisory forums	Cultural conservatism limits open SRH discussion
Pwani	Non-priority	Moderate	Strong institutional capacity; administrative efficiency	Limited community participation; dependence on sectoral budgets

5.4 Synthesis of Regional and Local Contextual Variations

The comparative findings affirm that regional success under NAIA–AHW was shaped by both external support and local governance quality. Priority regions demonstrated measurable improvements due to structured partner engagement and focused capacity-building, while non-priority regions showed that adaptive local leadership and community mobilization can achieve meaningful progress even with fewer resources. Moving forward, Phase II should build on these insights by promoting *context-responsive implementation models* that combine government ownership, community participation and targeted technical assistance to achieve equitable outcomes across all regions

6.0 Voices from the Field

6.1 Perspectives from Adolescents and Youth Champions

Adolescents across all regions visited expressed that the NAIA–AHW had profoundly shaped their knowledge, confidence and participation in community life. FGDs conducted in ten districts revealed that adolescents are increasingly informed about HIV prevention, sexual and reproductive health (SRH), gender-based violence (GBV) and nutrition, demonstrating the depth of outreach achieved under the six NAIA pillars.

The most visible impact was in school clubs, peer mentorship and community dialogues, which have created safe and trusted platforms for adolescents to discuss issues that were once considered taboo.

“We used to fear talking about our bodies or relationships, but now we have teachers and health workers who listen without judging”, said a 16-year-old girl from Nanswilu Secondary School in Mbozi District.

In Mwanza, male adolescents noted that the program fostered shared responsibility and mutual respect between genders:

“Before, only girls were taught about sexual health. Now even we boys are told how to protect ourselves and respect others”, shared a 17-year-old student from Buzuruga Secondary School.

In Songwe youth-led campaigns such as *Timiza Malengo* and Mwanza and Tabora *Furaha Yangu* campaign, leveraged social media and peer networks to reach thousands of adolescents with SRH, life skills and positive behavior messages.

“We share messages on WhatsApp groups — that’s how most of us learn quickly”, explained a 19-year-old youth leader in Tunduma.

In Katavi and Arusha, adolescents described how engagement by faith leaders transformed community acceptance of reproductive health topics:

“Our pastor tells us that knowing our health is part of faith. That changed how my parents see these topics”, reflected a 15-year-old girl from Mpanda.

These voices support that NAIA–AHW has not only expanded access to services but also shifted social norms, empowering adolescents as active participants and advocates for their wellbeing.

6.2 Experiences from Civil Society, Faith-Based and Development Partners

Civil Society Organizations (CSOs), Faith-Based Organizations (FBOs) and development partners were key enablers of NAIA’s multi-sectoral implementation, linking national

coordination with community delivery. Femina Hip, through its mentorship and media programs, reported reaching thousands of adolescents with life skills, digital literacy and gender equality content, aligned with Pillars 2, 3 and 6.

“The NAIA framework gave our work coherence — it helped connect our youth empowerment programs with national goals”, explained a Femina Hip program manager in Dar es Salaam.

Nutrition International highlighted improved collaboration among education and health sectors:

“Previously, nutrition was treated as a separate issue. Through NAIA, we began working more closely with education and health departments to integrate adolescent nutrition messages..”, noted a program officer during a KII.

UNESCO and UNFPA praised NAIA’s coordination structure, led by MoCDGWSG and PMO-RALG for strengthening policy alignment and inter-ministerial dialogue. Both agencies emphasized the importance of maintaining government ownership and sustained financing in Phase II.

Faith-based leaders also noted significant transformation. In Arusha and Katavi, interfaith forums brought together Muslim and Christian leaders to address SRH and GBV through sermons and community sessions.

“...We realized that faith and wellbeing go together. When we talk about dignity, we also talk about safety, education and good health”, said a Muslim cleric from Arusha City.

In Tabora, church and mosque leaders collaborated on parenting sessions addressing childmarriage and teenage pregnancy — demonstrating that moral and public health objectives can reinforce each other.

Development partners, such as USAID Afya Yangu and MDH, noted that NAIA enhanced coordination and reduced duplication of adolescent-focused programs:

“It gave us a shared framework — now when we plan adolescent interventions, we refer to the same set of national priorities”, stated an MDH field coordinator in Mbeya.

These reflections indicate that NAIA–AHW successfully operationalized multisectoral collaboration, transforming fragmented projects into a unified, government-led platform.

6.3 Highlights from Field Observations

Field observations conducted across 12 schools, 8 health facilities and 6 community centers confirmed the visible, tangible impact of NAIA interventions on adolescent engagement, infrastructure and service quality. Teams assessed functionality, participation and inclusiveness, comparing implementation consistency across the seven evaluation regions.

a). Health Facilities

Most health facilities visited had established Youth-Friendly Service (YFS) corners, though their operational strength varied. In Mwanza, facilities such as Buzuruga Health Centre and Isansa Health Centre in Mbozi stood out for having trained providers, adolescent-friendly spaces and visible IEC materials. Services were offered with confidentiality and empathy, increasing adolescent attendance and satisfaction.

In Katavi and Songwe, YFS corners existed but functioned intermittently due to staffing shortages. However, outreach services and mobile clinics effectively bridged these gaps by delivering HIV testing, SRH education and GBV awareness sessions directly in communities.

Observation data showed a clear pattern, facilities supported by peer educators had higher adolescent turnout and repeat visits compared to those without structured peer engagement.

b). Schools

At the school level, impacts were most evident in WASH improvements, menstrual hygiene and health (MHH) and nutrition programs. At Nanswilu Secondary School (Mbozi) for example, the introduction of separate sanitation blocks and provision of MHH materials led to reduced absenteeism among girls. Teachers reported that health sessions helped normalize menstruation and build girls' self-esteem.

At Ilemela Secondary School (Mwanza), the *Afya Yetu* club served as a vibrant peer education hub, using drama, debates and role-play to address HIV prevention, early pregnancy and gender-based violence. Such clubs also enhanced leadership and life skills, particularly among adolescent girls.

c). Community and Safe Spaces

Community-based "safe spaces" and dialogue forums complemented institutional interventions by reinforcing learning outside schools and clinics. In Mpanda (Katavi), parish-based youth groups hosted monthly intergenerational dialogue circles that fostered trust and reduced stigma around SRH discussions between adolescents and parents.

In Tunduma and Uyui, community protection desks and council adolescent committees provided psychosocial support and referral linkages for survivors of violence, demonstrating improved responsiveness and coordination between social welfare and health sectors.

In Mbozi District Council, adolescents' participation in council planning meetings marked a new level of empowerment. Young representatives directly advocated for investments in sanitation facilities, ICT hubs and vocational training centers, influencing local budget decisions.

The field evidence provide evidence that NAIA interventions are not only visible but also socially embedded, fostering local accountability and adolescent agency.

6.4 Reflections on Community Change

Across all regions, communities exhibited a shift in perceptions of adolescent health and wellbeing.

Issues once characterized by silence such as sexual health, gender norms and adolescent participation are now discussed more openly in families, schools and faith institutions.

As articulated by a Community Development Officer in Songwe:

"At first, the community thought this was just about health. Now, they see it's about the whole child... their education, safety and future.."

Parents, teachers and leaders increasingly recognize adolescents as contributors to community development, not passive dependents. In planning spaces, youth participation has become normalized:

“Before, meetings were for adults. Now, even we get invited to talk about what we need”, said a 17-year-old youth representative from the Tunduma Council Adolescent Committee.

The integration of diverse community actors from religious leaders and media professionals to local entrepreneurs and parents has created a shared ecosystem of accountability. This collective approach is redefining how adolescent wellbeing is understood and sustained at the community level, marking a shift from service delivery to social transformation.

6.5 Synthesis on voices

The testimonies, observations and reflections from the field collectively indicate that the NAIA–AHW has achieved more than programmatic targets, it has reshaped social relationships, attitudes and institutional behaviors that underpin lasting change. Importantly, the evaluation finds that the agenda functioned as an integrated whole, where progress under one pillar reinforced outcomes in others, for example, gains in education and life skills supported HIV prevention and delayed pregnancy, while strengthened protection systems enabled better school retention and service uptake. Adolescents have transitioned from being beneficiaries to active decision-makers; parents and teachers now engage as partners in protection and education; and frontline providers have institutionalized youth-friendly approaches within routine services.

These lived experiences validate the multisectoral, participatory and norm-shifting design of NAIA–AHW. The agenda’s influence extended beyond numerical outcomes, it has generated a social movement centered on adolescent dignity, empowerment and inclusion. As Tanzania prepares for next phase of NAIA AHW, the voices from the field serve as the most credible evidence of impact, confirming that adolescent health and wellbeing have become a shared national value and a collective responsibility.

CHAPTER FOUR: RECOMMENDATIONS

7. Recommendations and Strategic Priorities for NAIA–AHW Phase II (2025–2030)

7.1 Overview

This section is built from the findings, lessons learnt and insights from the NAIA–AHW Endline Evaluation and presents forward-looking recommendations aimed at strengthening Tanzania’s adolescent wellbeing agenda.

Recommendations are structured into two parts:

1. General recommendations for government, partners and implementing stakeholders; and
2. Strategic recommendations for the design and implementation of NAIA-AHW Phase II (2025/26–2029/30) with particular attention to revised pillars, coordination, financing, monitoring, youth participation and cross-cutting priorities.

7.1 General Recommendations

7.1.1 For the National Government

Under the leadership of the MoCDGWSG, the Government of Tanzania should continue to provide strong strategic direction and coordination for the adolescent health and wellbeing agenda. To enhance coherence, ownership and sustainability, the following actions are recommended:

1. Embed adolescent health and wellbeing priorities, indicators and financing commitments within the forthcoming Fourth Five-Year Development Plan (FYDP IV). Link these directly to goals in health, education, protection, nutrition and youth employment to ensure policy continuity and accountability beyond donor cycles.
2. Strengthen national coordination by embedding NAIA–AHW governance structures within existing high-level inter-ministerial committees rather than operating them as standalone mechanisms. The NSC, NTC and TWGs should be integrated as agenda items within already-established coordination platforms chaired by PMO and sector ministries.
3. Run National Annual Adolescent Forum involving adolescent representatives from council level that will enable structured dialogue between adolescents, national policymakers and stakeholders contributing to annual policy communiqué that informs national planning frameworks and sector strategies.
4. Align adolescent indicators across existing data systems and mechanisms including DHIS2, EMIS and CPMIS to enable unified monitoring.
5. Establish a National Adolescent Health and Wellbeing Dashboard under MoCDGWSG for cross-sector progress visualization and data-driven accountability.
6. Identify existing specific budget codes for adolescent health and wellbeing across sectoral and national budgets to enable transparent tracking, improve resource mobilization and institutionalize financial accountability.
7. Implement standardized professional development for teachers, nurses, social welfare, nutrition officers and Community Development Officers, focusing on youth-friendly services, psychosocial support, gender sensitivity and inclusive communication with adolescents.
8. Reinforces the targeted investment in adolescent-specific nutrition programs within schools and communities targeting nutritional behavior change and food culture while sustaining WIFAS.

9. Design and implement a comprehensive national communication strategy to promote investment, behavior change, positive character, moral values and ethical behavior, social responsibility and positive life skills, combat stigma and strengthen demand for services across all pillars. Utilize community dialogues, radio, television and digital platforms to mobilize families and communities around adolescent wellbeing.
10. Collaborate between MoCDGWSG and PMO-RALG and development partners in developing multimedia advocacy campaigns promoting adolescent health and wellbeing and elevating adolescent voices nationally and regionally.
11. Strengthen parenting programmes to include family engagement and community-based including structured parenting programmes, mentorship platforms and collaboration with faith-based and community institutions to address underlying drivers of adolescent risk behaviors, including moral and ethical development, social responsibility and positive life skills.
12. NAIA- AHW functioned primarily as a policy agenda without an operational backbone, limiting its ability to drive implementation and investment. Consider shifting from Agenda to Institutionalized comprehensive, National costed multi-sectoral strategic implementation framework for Adolescent Health and Wellbeing targeting age 9 to 19 to strengthen its influence on development planning, sector budgets partner alignment and investment prioritization.
13. The current age segmentation (10–19 years) creates a programmatic gap, leaving children aged 9 without a clearly defined integrated programmatic framework comparatively. Government needs to make a policy level decision to ensure such age are integrated within future NAIA-AHW.
14. Support the development of a National Resource Mobilization Strategy that contains budget monitoring framework aligning with the MTEF including identifying specific budget votes across all sectors at National and sub-National levels. Aligning the framework to the planned interventions building from the Ministry of Finance (MoF) initiative on integration of adolescent health and wellbeing indicators into the Medium-Term Expenditure Framework (MTEF). The framework should include means to nagging development partner's commitments, private sector, philanthropic organizations and CSR initiatives to diversify funding sources for adolescent programs.

7.1.2 For Local Government Authorities (LGAs)

Local governments are the operational drivers of NAIA AHW and custodians of community-level change. While many councils demonstrated strong commitment, variability in coordination, financing and youth engagement remains a constraint. The following steps are key for the next phase:

1. Integrate NAIA AHW indicators into Comprehensive Council Health Plans (CCHPs), education and community development budgets. Ensure predictable, locally owned funding for adolescent programs.
2. NAIA-AHW coordination and review meetings be systematically integrated into existing council planning, budgeting and performance review forums across all regions. Embedding NAIA discussions within established local government structures would reduce operational costs, minimize duplication of meetings, strengthen cross-departmental collaboration on adolescent priorities and enhance local ownership and accountability, while ensuring more efficient use of limited financial and human resources.

3. Run Quarterly Adolescent Engagement Forums within Council governance systems and stakeholders, ensuring inclusive representation of adolescent girls, out-of-school and vulnerable groups and linking forum outputs (feedback reports, action trackers, and scorecards) directly to Council planning, budgeting and monitoring processes under National Adolescent Health and Wellbeing Initiative to strengthen accountability and service responsiveness.
4. Enhance awareness and effective implementation of re-entry and school feeding guidelines.
5. Adopt innovative approaches to strengthen school feeding programmes, with a clear emphasis on parental responsibility and the inclusion of the most vulnerable families to ensure equitable access and sustainability.
6. Strengthen peer clubs, school committees and adolescent champions to promote accountability and leadership.
7. Leverage schools and local radio to deliver continuous awareness programs on SRH, GBV prevention and life skills. Encourage innovative methods such as radio drama, storytelling and theatre, social media content clips to drive social norm change.
8. Promote the use of local monitoring tools and participatory scorecards to track service coverage and satisfaction. Disaggregate data by age, gender and vulnerability for equity-sensitive planning.
9. Establish linkages and marketing opportunities for adolescents with soft skills (e.g. loan opportunities, working tools etc)

7.1.3 For Development Partners

Development partners remain critical enablers of technical expertise, innovation and financing. To align with government ownership and long-term sustainability:

1. Encourage stakeholders working on adolescent programs to align programme they support/implement with the NAIA–AHW framework.
2. Provide technical support for NAIA-AHW II development, coordination, monitoring and reporting
3. Support assessment/research on current unmet needs and priority of adolescents and youths, mental health, digital wellbeing, climate resilience and gender barriers.
4. Expand use of digital platforms for data, youth engagement and service delivery.
5. Continue providing both financial and technical supports to CSOs and government institutions in providing services to adolescents and youth in Tanzania.

7.1.4 For Civil Society, Faith-Based Organizations (FBOs) and Youth Networks

Civil Society and youth-led organizations have been instrumental in community mobilization and social norm transformation. Building on this foundation, next phase of NAIA AHW should strengthen their role as catalysts for sustainability:

1. CSOs and youth led organisations should be supported technically and financially by development partners, International CSOs and Government to facilitate community scorecards, budget tracking and citizen dialogues that hold service providers accountable for adolescent outcomes.
2. Expand peer education, storytelling and arts-based approaches for SRH, gender equality and violence prevention. Tailor messages to cultural and religious contexts.
3. Provide leadership, governance and grant management training to strengthen sustainability and strategic engagement with government programs.

4. Encourage linkages and strengthen formal partnership between CSOs, private sector and government institutions for resource leverage, mentorship, entrepreneurship and align community innovations with government systems.

7.2 Strategic Recommendations for NAIA–AW Phase II (2025/26–2029/30)

The evaluation recommends that the formulation of NAIA–AHW II priorities and pillar-specific interventions be undertaken through a dedicated, structured and consultative process, rather than being fully determined within the scope of this endline evaluation. While the findings clearly identify systemic strengths, gaps and high-burden areas, translating these into a revised agenda requires inclusive prioritization, costing and sequencing involving Government, local authorities, adolescents and key partners. A dedicated NAIA–AHW II design process would ensure that recommendations are evidence-informed, context-responsive and aligned with available resources, while preserving national ownership and coherence across pillars.

CHAPTER FIVE: CONCLUSIONS

The Endline Evaluation of the National NAIA–AHW shows that Tanzania has made substantial progress in advancing adolescent health and wellbeing through an integrated, multi-sectoral approach. The initiative successfully operationalized national policies into coordinated action across health, education, protection, nutrition and economic empowerment sectors, demonstrating the viability of a whole-of-government and whole-of-society model.

The evaluation found that strong government leadership, particularly by the MoCDGWSG, together with active engagement from adolescents, communities and partners, transformed NAIA–AHW from a policy framework into a dynamic national movement.

However, progress was uneven across regions and pillars. Challenges such as funding fragmentation, limited human resource capacity, sociocultural resistance and inconsistent data utilization and availability constrained scale and sustainability. These gaps emphasize the need for systemic reforms especially in financing, institutionalization and integration with local government systems to sustain and deepen the gains made.

However, progress was uneven across regions and pillars. Challenges such as funding fragmentation, limited human resource capacity, sociocultural resistance and inconsistent data utilization and availability constrained scale and sustainability. In addition, evidence point out to key emerging factors that contribute to persistent risk behaviours and exposure to violence which includes the weakening parenting practices and the erosion of moral and ethical values among adolescents. These factors highlight the continued influence of family and community socialisation systems on adolescent outcomes. Together, these gaps underscore the need for systemic reforms, particularly in financing, institutionalization and integration of service delivery interventions with stronger parenting support and community-based value reinforcement mechanisms with local government systems to sustain and deepen the needed impact in the future.

The evaluation highlights that the proposed next phase, NAIA–AHW Phase II (2025/26–2029/30), offers a strategic opportunity to consolidate results and expand impact through:

- i. Predictable and diversified financing mechanisms;
- ii. Strengthened multi-sectoral coordination and accountability structures;
- iii. Enhanced youth leadership and participation at all levels;
- iv. Improved reporting through routine structures;
- v. Integrated monitoring, learning and data-driven decision-making; and
- vi. Cross-cutting integration of safe environments, digital health, climate resilience within all pillars and civic participation.

In conclusion, NAIA–AHW has laid a foundation for a sustainable national platform that champions adolescent health and wellbeing as a core development priority. With continued political will, shared investment and meaningful youth engagement, Tanzania is well-positioned to advance the next generation's potential ensuring that every adolescent is healthy, safe, educated and empowered to thrive.

LIST OF REFERENCES

- Black, R. E., Victora, C. G., Walker, S. P., Bhutta, Z. A., Christian, P., de Onis, M., ... & Sachdev, H. P. S. (2013). Maternal and child undernutrition and overweight in low-income and middle-income countries. *The Lancet*, 382(9890), 427-451.
- CDC. (2016). *INSPIRE: Seven Strategies for Ending Violence Against Children*. Centers for Disease Control and Prevention.
- IFPRI. (2020). *Challenges in Implementing School-Based Nutrition Programs in Tanzania: A Review*. International Food Policy Research Institute.
- ILO. (2022). *Tanzania Labour Force Survey: Youth Employment Report*. International Labour Organization.
- Makoka, G. A., et al. (2023) *Co-occurrence of Overweight, Stunting and Anemia among Adolescents (10–19 Years) in Tanzania Mainland: A School-Based Cross-Sectional Study*. Tanzania Food and Nutrition Centre (TFNC). Available at: [https://www.tfnc.go.tz/uploads/publications/sw1709206716-Co-occurrence%20of%20Overweight,%20Stunting,%20and%20Anemia%20among%20Adolescents%20\(10-19%20Years\)%20in%20Tanzania%20Mainland_%20A%20School-Based%20Cross-Sectional%20Study.pdf](https://www.tfnc.go.tz/uploads/publications/sw1709206716-Co-occurrence%20of%20Overweight,%20Stunting,%20and%20Anemia%20among%20Adolescents%20(10-19%20Years)%20in%20Tanzania%20Mainland_%20A%20School-Based%20Cross-Sectional%20Study.pdf)
- MCDGWSG. (2024). *National Acceleration Initiative for Adolescent and Youth Health and Wellbeing (NAIA AHW) Annual Implementation Report 2023/24*. Unpublished document.
- MoE. (2024). *Basic Education Statistics in Tanzania (BEST) 2023/2024*. Ministry of Education, Science and Technology, Tanzania.
- MoH, NBS, & OCGS. (2018). *Tanzania National Nutrition Survey (TNNS) 2018*. Ministry of Health, National Bureau of Statistics, & Office of Chief Government Statistician.
- MoH, NBS, OCGS, & ICF. (2022). *Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) 2022: Key Indicators*. Ministry of Health, National Bureau of Statistics, Office of Chief Government Statistician, & ICF.
- MoH. (2024). *Tanzania HIV Impact Survey (THIS) 2022-2023: Summary Findings*. Ministry of Health, Tanzania.
- NBS. (2023). *Population and Housing Census 2022*. National Bureau of Statistics, Tanzania.
- Policy Forum. (2020). *Financing Youth Employment in Tanzania: Challenges and Opportunities*. Policy Forum Publication.
- TACAIDS. (2022). *National Multi-Sectoral Strategic Framework on HIV and AIDS (NMSF V) 2021/22 – 2025/26*. Tanzania Commission for AIDS.
- THPS. (2024). *Significant Gains in Ending Violence Against Children in Tanzania – Continued Efforts Needed (VACS 2024 Preliminary Results)*. Tanzania Health Promotion Support.
- Thrive Child Evidence. (2024). *Review of School-Based Nutrition Interventions in Sub-Saharan Africa*. Thrive Child Initiative.
- UNAIDS. (2021). *Start Free, Stay Free, AIDS Free: Global progress report*. Joint United Nations Programme on HIV/AIDS.

UNICEF, World Bank, & TASAF. (2018). *Tanzania Productive Social Safety Net (PSSN2) Impact Evaluation: Livelihood and Human Capital Outcomes*. UNICEF, World Bank and Tanzania Social Action Fund.

UNICEF. (2019). *Addressing Gender-Related Barriers to Girls' Education in Tanzania*. United Nations Children's Fund.

WHO. (2018). *Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to support country implementation*. World Health Organization.

World Bank. (2021). *Tanzania Human Capital Review: Investing in Youth for the Future*. World Bank Group.



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