

Module proposal



DC-Programme: Program to support the health sector in Tanzania
TC-Module: Strengthening the reproductive health and the empowerment of young women
Project number: 2024.2052.9

Submission of an offer for a follow-on TC module
at an estimated offer price of up to EUR 9,000,000

Parts of the German contribution are to be awarded to contractors.

Inhalt

Abkürzungsverzeichnis	iii
1 Kurzbeschreibung	Error! Bookmark not defined.
2 Einordnung des Moduls	Error! Bookmark not defined.
2.1 Einordnung des Moduls in das EZ-Programm	Error! Bookmark not defined.
2.2 Andere Entwicklungsmaßnahmen im konkreten Interventionsbereich des Moduls	Error! Bookmark not defined.
3 Problem- und Potentialanalyse (bezogen auf das Modul)	Error! Bookmark not defined.
4 Ziele, Wirkungshypothesen, Indikatoren und Partner des Moduls	7
4.1 Ziele, Zielgruppe, Wirkungshypothesen und Indikatoren	Error! Bookmark not defined.
4.2 Träger und Partnerstruktur	Error! Bookmark not defined.
5 Gestaltung des Moduls	Error! Bookmark not defined.
5.1 Methodischer Ansatz und Laufzeit	Error! Bookmark not defined.
5.2 Sicherstellung der nachhaltigen Wirksamkeit der Maßnahmen (Outcomes)	Error! Bookmark not defined.
5.3 Partnerleistungen, Kombifinanzierung	Error! Bookmark not defined.
5.4 Auftragswert und detaillierte Kostenschätzung	Error! Bookmark not defined.
6 Bewertung der Wirkungen und der Risiken des Moduls	Error! Bookmark not defined.
6.1 Bewertung der Wirkungen	Error! Bookmark not defined.
6.2 Bewertung der Risiken für die Wirksamkeit des Moduls	Error! Bookmark not defined.
6.3 Testat	Error! Bookmark not defined.
A Anlagen	
A1 Wirkungsmatrix	
A2 Wirkungslogik	
A3a Kostenschätzung und Mittelabfluss nach Haushaltsjahren	
A3b Kosten-Output-Zuordnung	
A4a Kennungen	
A4b Standardindikatoren	
A4c Maßnahmenbeschreibung	

Abkürzungsverzeichnis

CHWs	<i>Community Health Workers</i>
DICT	<i>Department for Information, Communication and Technology</i>
DRMCH	<i>Department for Reproductive, Maternal and Child Health</i>
FCDO	<i>Foreign, Commonwealth and Development Office</i>
FID	<i>Fond d'innovation pour le développement</i>
HPS	<i>Health Promotion Section</i>
HSSP	<i>Health Sector Strategic Plan</i>
PWD	<i>People with Disabilities</i>
MoCD	<i>Ministry for Community Development, Women, Gender and Special Groups</i>
MoE	<i>Ministry of Education, Science, Technology and Vocational Training</i>
MoH	<i>Ministry of Health</i>
PMO-RALG	<i>Prime Minister's Office – Regional Administration and Local Government</i>
QM	<i>Quality marker</i>
SGBV	<i>Sexual and gender-based violence</i>
SMART	<i>Standards-based, machine-readable, adaptable, requirements-based, tested</i>
SRHR	<i>Sexual and Reproductive Health and Rights</i>
STIs	<i>Sexually transmitted infections</i>
TDHS	<i>Tanzania Demographic and Health Survey</i>
TFPCIP	<i>Transitional Family Planning Costed Implementation Plan</i>
TMCHIP	<i>Tanzania Mother and Child Health Improvement Program (World Bank funded)</i>
UNFPA	<i>United Nations Population Fund</i>
WB	<i>Worldbank</i>

1 Short description

Module title	Strengthening the reproductive health and the empowerment of young women in Tanzania
Kernthema	Core topic 6: Health, social protection and population policy
Field of action (and, if applicable, initiative)	Population dynamics; sexual and reproductive health and rights
No core topic/initiative	☐ yes ☒ no
DC-Programme	Programme to support the health sector
DC- programme objective	All households are reached by evidence-based and efficient basic health and social services that meet objective quality criteria and, where possible, the population's expectations.
Core problem	Young women are structurally disadvantaged in their sexual and reproductive health and in exercising their rights, which simultaneously entails a significant threat to newborn health.
Module objective	The reproductive empowerment and health of young women and newborns are inclusively improved in selected regions in Tanzania.
Contribution to national implementation of the 2030 Agenda	National 5-year development plan (goal Human development, including gender equality); Health sector strategy 2030 (goals Reproductive, maternal, newborn, child and adolescent health; Improving quality of care; and gender equality)
Target group	Population of Tanga region, especially girls, young women, persons with disabilities (PwD), pregnant women, newborns; intermediaries: technical and managerial staff of health institutions, parents, teachers, members of civil society Political lead institution
Political partner	<i>Ministry of Health, MoH</i>
Methodological approach (incl. instruments)	Capacity development in the health sector: training, technical, organizational and process advisory services by 4 international, 10 national long-term advisors (LZFK), integrated experts (KZE), EUR 783,500 in financing, EUR 770,600 in goods/equipment.
Key outputs	(1) Improved quality of neonatal, sexual and reproductive health care, (2) strengthened competencies of young people to protect their sexual and reproductive health and rights, (3) improved framework conditions for young people's access to SRHR health services, (4) strengthened capacities of a disabled persons' organization to improve PwD access to SRHR services
Cooperations, joint donor approach	None
Commission value	Up to EUR 9.000.000
Duration	07/2026 to 06/2029 (3 years)
Funding region and country	Not applicable

2 Context of the module

2.1 The module in the context of the DC-Programme

The TC module is assigned to core theme 6 Health, social protection and population policy and focuses in particular on promoting sexual and reproductive health and associated rights (SRHR) under Field of Action 3. The module supports implementation of Germany's global commitments to strengthen gender equality and bodily self-determination of girls and women, as reflected inter alia in the BMZ initiative self-determined family planning and reproductive health for all and in Feminist Development Policy.

The TC module is part of the DC program designed in 2015 Program to support the health sector. The program aims to improve health care for pregnant women, mothers, newborns and children, to promote self-determined family planning and to reduce unplanned pregnancies. An adjustment of the program is expected after completion of BMZ's reform process and finalization of the country strategy. The current DC program objective corresponds to the national health sector target: All households are reached by evidence-based and efficient basic health and social services that meet objective quality criteria and, where possible, the population's expectations.

The TC module contributes directly to achieving the DC program objective and to implementing the associated program indicators in neonatal and child mortality, maternal mortality and contraceptive prevalence. This is done by improving the quality and efficiency of medical care for newborns and children (program indicators 1 and 2). In addition, the module contributes to optimizing health and counseling services in sexual and reproductive health and rights (SRHR) (program indicator 3). Another focus is strengthening education and participation of girls and young women, including women with disabilities. This strengthens their decision-making power regarding body, sexuality and family planning (program indicator 4). In parallel, civil society actors and local communities are engaged to reduce stigmatization, enabling actual uptake of SRHR and family planning services. Implementation is pursued in particular by increasing the youth-friendliness of services in the supported health facilities.

The TC module works with the TC module Strengthening the statutory health insurance system in Tanzania (PN 2024.2053.7) and the FC module Digital solutions to achieve Universal Health Coverage (PN 2017.6813.4). The TC module contributes to reducing financial barriers to using health services by expanding insurance coverage. The FC module upgrades the insurer's information technology and thus improves efficiency. The project complementarily improves the quality of reproductive health services in selected facilities and increases demand for and utilization of SRHR services. Synergies arise from joint gender-responsive information measures on statutory health insurance and SRHR topics, especially family planning and covered benefits. This collaboration enables cost sharing and thus increases efficiency at the outcome level.

The TC module is part of the regional Team Europe Initiative (TEI) Sexual and reproductive health and rights (SRHR) in Sub-Saharan Africa. It aims to improve coordination of Team Europe-funded SRHR initiatives to enhance the health and rights, particularly of girls and young women, in the target region.

DC-Programme Objective			
All households are reached by evidence-based and efficient basic health and social services that meet objective quality criteria and, where possible, the population's expectations.			
Indicators	Baseline	Current	Target
DC-Programme-Objective Indicator 1 Neonatal mortality has fallen from 26 deaths per 1,000 live births (2022)	26/1.000 (2010)	24/1.000 (2022)	16/1.000 (2022)
DC-Programme-Indicator 2 Under-five mortality has fallen from 81 deaths per 1,000 live births (2010) to 55 per 1,000 live births (2022).	81/1.000 (2010)	43/1.000 (2022)	55/1.000 (2022)
DC-Programme-Indicator 3 Maternal mortality has fallen from 432 per 100,000 live births (2012) to 292 per 100,000 (2022).	432/100.000 (2012)	104/100.000 (2022)	292/100.000 (2022)
DC-Programme-Indicator 4 Contraceptive prevalence increased from 36% (2010) to 60% (2022)	36 % (2010)	38 % (2022)	60 % (2022)

2.2 Other development measures in the module's specific intervention area

UNFPA's Tanzania Country Program strengthens systems, institutions and communities to provide quality sexual and reproductive health and rights services, including HIV prevention and measures against sexual and gender-based violence (SGBV). UNFPA empowers young people and vulnerable groups to exercise their reproductive rights and use relevant services. By working with women and men, gender roles are changed and gender equality strengthened. The program also promotes [self-determination/agency] and participation of adolescents in central and northwestern Tanzania. Measures create synergies by improving youth-friendly SRHR health services and strengthening young people—especially girls and young women—in their [self-determination/agency] and participation (outcome level). In addition, leveraging UNFPA's implementation experience enables the TC module to achieve outcomes faster and at lower cost (outcome level). The UK's FCDO supports family planning services in Tanga through Scaling Up Family Planning (SUFPP). Contraceptives are supplied via UNFPA, health personnel are deployed, and mobile family planning outreaches are organized. Inclusion of persons with disabilities is a focus. Synergies arise especially in promoting modern family planning methods and in measures to reduce teenage pregnancies (impact level). The World Bank provides USD 250 million in loans and USD 25 million in grants through the Global Financing Facility for Reproductive, Maternal, Neonatal, Child and Adolescent Health under the Tanzania Mother and Child Health Improvement Program (TMCHIP). Funds serve to expand health infrastructure, strengthen the health workforce—

including Community Health Workers (CHWs)—and improve health system management. The TC project and TMCHIP act complementarily to reduce maternal and neonatal mortality, promote modern family planning and reduce teenage pregnancies (impact level). Close coordination with TMCHIP also helps lower the TC project's investment needs. The French innovation fund (FID) supports Touch Health Foundation's WatotoCare project, which aims to improve identification as well as simultaneously reduce neonatal mortality outside formal health facilities. Touch Health plans a randomized controlled trial to generate evidence on effective intervention approaches. There is interest in expanding to Tanga to test applicability in a broader context. Overall, these initiatives contribute complementarily to reducing neonatal mortality (impact level). The TC module Access to justice for women and children (PN 2021.2286.3) strengthens SGBV survivors' access to legal support and judicial processing. It cooperates closely with law enforcement agencies, which rely on forensic data and medical evidence from health facilities for effective evidence preservation. The module promotes exchange of implementation experience and cross-sectoral collaboration with relevant partner institutions. Gender-transformative measures at community level help address structural gender inequalities and increase social acceptance of seeking support. This combined approach enables effective, resource-efficient and holistic services for SGBV survivors that integrate legal, health and psychosocial components (outcome level). The project also builds on implementation experience from the TC project Promoting the rights of young women and girls in Zambia (PN 2022.2056.4), which implements gender-transformative approaches and works with influential local actors such as religious and traditional authorities to improve young people's access to health services. This synergy saves costs in achieving outcomes through exchange and adoption of existing approaches (outcome level). USAID's withdrawal in early 2025, previously the largest donor in Tanzania's health sector, will significantly affect financing and hit maternal and child health particularly hard. While German DC cannot close this gap financially, the health program—including this TC module—helps cushion the political vacuum in cooperation with other partners. Several philanthropic foundations, including the Beginnings Fund with around USD 100 million, are preparing larger investments in maternal and child health. Details on scope and collaboration modalities are not yet clear.

No negative interactions are expected.

Donor	Programme	Expected synergies at result levels
UNFPA	<i>Tanzania Country Programme</i>	Improving youth-friendly SRHR services; efficiency gains by using implementation experience (outcome level)
FCDO	<i>Scaling Up Family Planning</i>	Spreading modern family planning and reducing teenage pregnancies (impact level)
WB	TMCHIP	Reducing maternal and neonatal mortality; spreading modern family planning; reducing teenage pregnancies (impact level)

FID	<i>Touch Health (WatotoCare)</i>	educing neonatal mortality (impact level) and improving the data situation (outcome level)
BMZ/GIZ	Access to justice (2021.2283.6)	Effective and cost-saving improvement of holistic services for SGBV survivors (outcome level)
BMZ/GIZ	SRHR Zambia (2022.2056.4)	Cost savings in achieving outcomes through adoption of existing gender-transformative approaches (outcome level)

3 Problem and potential analysis (module-related)

Initial situation in the intervention area: Gender equality has not yet been achieved in Tanzania despite progress in women's rights and political representation. Women remain disadvantaged, and the reproductive [self-determination/agency] of young women is limited. Social norms and cultural practices reinforce these constraints by cementing traditional roles and limiting women's decision-making. The TDHS shows that men still have more influence on household decisions than women—even on matters directly affecting women's health. While most households (53%) decide jointly, where one person decides alone, it is more often the man than the woman (26% vs. 21%). This indicates persistent gendered power asymmetries limiting women's reproductive agency.

Unmet need for family planning in Tanzania decreased only slightly between 2016 and 2022 and remains high at 21%. In parallel, the share of adolescent women aged 15–19 who have already given birth fell only from 122 to 114 per 1,000 (World Bank). Tanzania thus remains higher and declines more slowly than the Sub-Saharan average (from 106 to 94 per 1,000). Young people face high STI risk: an estimated 6% of young women and 7% of young men are infected annually, yet few test. Other reproductive health risks are critical: cervical cancer is the most common cancer among women in Tanzania and a leading cause of cancer deaths. Screening and early treatment are insufficiently available. SGBV is widespread: 39% of women of reproductive age who have ever lived in a partnership report at least one experience of physical and/or sexual intimate partner violence.

While official maternal mortality has fallen by nearly 80% from 556 per 100,000 live births (2015) to 104 in 2022, neonatal mortality shows little change: at 23 per 1,000 live births it is only slightly below the Sub-Saharan average of 27. This indicates persistent deficits in newborn care.

Research on access of young women with disabilities to health services in Tanzania shows combined physical, economic and social barriers. Discrimination by health personnel is significant, adding stigma. Census data indicate around 5.1 million people over seven live with a disability; women are slightly more affected (11.5%) than men (10.9%). Overall data on PwD are very limited; there is little empirical evidence on use of SRHR services. The poor data base is due to missing systematic instruments, insufficiently disaggregated data and low institutional prioritization of disability in the health system.

Health sector development is among the strategies to implement Tanzania Development Vision 2050. Under the goal High quality of life and well-being for all and the pillar Human

Capabilities and Social Development, Tanzania aims to expand access to quality health services focusing on women, children, PwD and older persons, including sexual and reproductive health education and services (Pillar 2, Attribute 2). Implementation follows the National Five-Year Development Plan (strategy Human development) and HSSP V; in SRHR especially One Plan III. NAIA guides cross-sector measures for adolescent health and wellbeing. Digital transformation in the health sector is shaped by a National Digital Health Strategy. Potentials to improve service quality include prioritizing reduction of teenage pregnancies under TFPCIP (2024–2026) and improving newborn care, both supported by strategies to expand primary care and roll out CHWs. Financing comes from the Tanzanian government, inter alia via WB funding (see 2.2). Introduction of universal health insurance seeks to generate additional domestic resources. In the national SGBV action plan, the government commits to gender-transformative approaches.

Potentials are foreseeably limited by the United States' withdrawal as a development partner in reproductive health and cuts among other partners. For PwD rights, Tanzania ratified the UN CRPD and passed a law in 2010; implementation is inadequate. Stakeholders often lack resources to support PwD initiatives locally. Progress in digital health information systems now opens opportunities to use digitization to improve concrete patient care.

Deriving the module objective: Limited access to sexuality education and to quality, youth-friendly and inclusive SRHR services—reinforced by cultural practices and economic constraints—results in more unintended pregnancies, higher STI risk and constrained reproductive agency among young women. For women with disabilities, multiple barriers exacerbate exclusion and limited service use. Lack of autonomy increases risks during childbirth and contributes to avoidable maternal and newborn deaths. Young women are structurally disadvantaged in SRHR and in exercising their rights, simultaneously endangering newborn health (**core problem**).

The TC module addresses needed improvements in SRHR services, focusing on youth-friendliness; gender-sensitive strengthening of young people's capacities—especially young women; improving community-level enabling conditions; and inclusion of PwD, who are particularly disadvantaged. The **module objective** is: The reproductive empowerment and health of young women and newborns are inclusively improved in selected regions in Tanzania.

Causes and assessment of changeability: Key causes lie in inadequate SRHR service quality, insufficient education, and social environment conditions around girls' and young women's rights. Poor service quality stems from shortages of qualified staff and poor facility equipment, including availability of basic medicines and medical products. Limited data—especially on neonatal deaths outside facilities and PwD access—hinders evidence-based planning. Education is impeded by constrained education systems and deep-rooted moral, religious and cultural norms that stigmatize and taboo reproductive development and sexual activity of girls and (unmarried) young women. Social change is long-term but can be fostered by activities promoting education and empowerment of youth, dialogue between youth and authorities, and reflection by authority figures on norms, values and trade-offs. For health personnel, mentoring and on-the-job training are relevant. Availability of medicines

and contraceptives can be influenced only marginally by the module—this is a risk at impact level (see 6.2).

Results achieved so far: The predecessor module (PN 2022.2029.1) laid important foundations for quality improvements in youth-friendly health services. TFPCIP was further developed with a youth focus. A new training plan for youth-friendly counseling in family planning was developed, explicitly emphasizing reflection and changes in health personnel's values and norms. More than 20,000 secondary students, through participation in school clubs on SRHR, gained improved knowledge and a strengthened awareness of their sexual and reproductive rights. This durably expanded their [capacity/agency], strengthened their [self-determination/empowerment], and increased the likelihood of informed SRHR decisions and more reflective engagement with discriminatory social norms.

Module measures significantly improved emergency obstetric care, reducing female case fatality by 38% over 27 months. Seven of eight supported facilities now meet 80% of essential standards for neonatal units. New registers for neonatal units were developed, enabling more precise analysis of access and care problems in facilities where applied. User influence on service design was strengthened; representation of vulnerable groups—including youth, girls and young women, and PwD—was anchored in the draft guidelines for Health Facility Governance Committees (HFGCs) on community participation and accountability.

4 Objectives, impact hypotheses, indicators and partners of the module

4.1 Objectives, target group, impact hypotheses and indicators

Module objective

The reproductive empowerment and health of young women and newborns are inclusively improved in selected regions in Tanzania.

Indikatoren

1. Neonatal mortality in neonatal units in 8 selected health facilities
Baseline: 63.9 deaths per 1,000 neonatal-unit admissions (2025)
Target: 57.5 deaths per 1,000 neonatal-unit admissions (2028)
2. Number of couple years of protection (CYP) in 19 selected health facilities achieved through modern contraceptive methods
Baseline: 87,507 CYP (2025)
Target: 96,258 CYP (2028)
3. Share of births among young women aged 10–19 years in 11 selected health facilities
Baseline: 12.2% of approx. 13,500 annual attended births among 10–19-year-olds (2025)
Target: 10.9% of approx. 13,500 annual attended births among 10–19-year-olds (2028)
4. Share of SRHR services used by young people aged 10–24 years in 11 selected health facilities
Baseline: 43.7% of approx. 39,000 annual SRHR services (2025)
Target: 48.0% of approx. 39,000 annual SRHR services (2028)
5. Share of young women with high reproductive autonomy in selected communities
Baseline: 20% of young women, including 10% among young women with disabilities

(2025)

Target: 25% of young women, including 15% among young women with disabilities

(2028)

The baseline and target values of module indicators 1–5 are preliminary. They will be reviewed in the first implementation year and adjusted in the first report.

National 2030 Agenda implementation is embedded in the Five-Year Development Plan 2021/22–2025/26. HSSP V reflects national sustainability goals for the health sector. Module indicators were derived from HSSP V indicators on neonatal mortality and family planning and adjusted to ensure data reliability and plausible attribution. For details see the graphical theory of change and the results matrix in the annex.

The target group is the population of Tanga region—2022 census: 2.6 million people, 51.2% women; assumed annual growth approx. 2.5%. Household Budget Survey 2018: approx. 21% of the population lives in poverty. Female-headed households are more often affected than male-headed. TDHS 2022: 16% of the Tanzanian population lives with disabling conditions, in Tanga even 23%. Direct effects benefit young women, pregnant women and newborns in selected communities in Tanga using public health services. Approximately 50,000 annual users of family planning services and 30,000 delivering women and their newborns in supported facilities benefit directly. 50,000 adolescents aged 13–19 will be reached with sexuality education in and out of schools. Women benefit particularly due to their disadvantage in SRHR. Gender-transformative effects are pursued especially through work with men. Intermediaries include technical and managerial staff in catchment areas of selected health facilities and administrations, teachers and parent representatives at selected secondary schools with elective afternoon clubs on sexual and reproductive health and gender, social services staff, and selected civil society members trained and supervised as multipliers at community level (e.g., religious authorities).

Impact hypotheses: Output 1 (quality of care) seeks to improve the quality of neonatal and SRHR services through digital clinical standards and improved care processes. The hypothesis is that needs-based, differentiated, high-quality care responsive to target group needs increases service utilization and thereby reduces neonatal mortality and morbidity and improves young women's health (module objective). WHO standards summarize evidence, aligning with prior module experiences improving women's, maternal and newborn health in Lindi and Mtwara (2015–2017), Mbeya (2019–2023) and Tanga (2019–2026) (see progress reports). Assumption: MoH and local governments provide sufficient resources (contraceptives, medicines, equipment, staff) for quality SRHR services, especially for adolescents.

Output 2 (SRHR competencies) aims to strengthen young people's gender-sensitive competencies in SRHR. The hypothesis is that by promoting SRHR knowledge and a positive self-identity, young people—especially girls and young women—strengthen self-confidence, self-efficacy and self-worth and are enabled to greater sexual and reproductive [self-determination/agency] (module objective). A meta-analysis supports this (Kim et al. 2023). Output 2 also contributes to Output 1 outcomes: family planning avoids unintended, high-risk and abortion-prone pregnancies, especially among adolescents (Stover and Ross, 2010). Assumption: adolescents of all genders are willing to reflect on their actions and gender norms.

Output 3 (enabling environment) seeks to improve community-level conditions for access of young people—especially girls and young women—to gender-responsive SRHR services. The hypothesis is that young women’s sexual and reproductive [self-determination/agency] increases (module objective) only if access is not hindered by negative social norms and stigma but such barriers are reduced. Various Sub-Saharan studies including Tanzania support this regarding stigma, while noting effects depend on initial stigma strength (Kim et al. 2022; Krug et al. 2023; Wagner et al. 2024). Assumption: community actors, including religious authorities, are willing to engage constructively on SRHR for young people, especially girls and young women.

Output 4 (inclusion) aims to strengthen institutional capacity of organizations for PwD to improve their access to SRHR services. The hypothesis is that stronger self-advocacy organizations are better able to anchor SRHR of PwD appropriately and sustainably in the health system and wider society and to improve their reproductive empowerment and health (module objective). Evidence for influence on societal framework conditions is found in evaluations of support to disability self-advocacy organizations (e.g., Disability Rights (Advocacy) Fund; Universalis, 2023). Effects on SRHR access are less systematically studied, but projects such as WISH2ACTION (MSI Choices, 2023) report positive results. Assumption: work at the sexuality/reproduction–disability interface is supported by state and societal authorities.

BMZ’s strategic requirements have been considered.

4.2 Political partner and implementation structure

The **political partner** is the Ministry of Health (MoH) of the United Republic of Tanzania.

Upon commissioning, the political lead (MoH) is entitled to demand services due to it directly from GIZ. GIZ and the political lead will regulate details in an implementation agreement. BMZ may exercise its rights from the contract, in particular under the General Agreement, without the political lead’s consent. MoH covers core tasks in health policy, strategy development, financing, medical care, quality assurance, as well as monitoring and evaluation of health data. It also supervises hospitals at regional and national levels. The Department of Policy and Planning (DPP) coordinates formal aspects of collaboration with the TC module.

DRMCH is the central technical counterpart and contributes significantly to developing and overseeing implementation of strategies and guidelines on SRHR and maternal, newborn and adolescent health. Other relevant units are Preventive Services with HPS (responsible for CHWs) and DICT. Capacity needs exist especially in three areas: (1) strategy and training on newborn care and adolescent SRHR in DRMCH; (2) use of digital technologies to support clinical work in regional hospitals in DICT; (3) stronger inclusion of PwD in CHW work in HPS. Tanga Regional Hospital, administratively under MoH, operates a neonatal intensive care unit. Despite previous TC support, organizational and staff capacity development needs persist.

Implementation partner is PMO-RALG and the regional and district health authorities under it. PMO-RALG is responsible for providing and maintaining the digital health information system up to district hospitals. There is a need to strengthen capacities to use digital technologies to support clinical work. District authorities ensure primary health care via community-

based services, dispensaries, health centers and district hospitals. Despite prior capacity development, significant needs remain to strengthen staff competencies in maternity and neonatal wards and in outpatient units offering SRHR services. Needs are particularly high for CHW training and for developing mentoring competencies among facility staff from health center level upwards. At facility level, organizational capacities often need strengthening. At district level, development needs are notable among biomedical engineers responsible for equipment maintenance. At regional level, health authorities coordinate and supervise, supporting districts and aligning with partners. Expanding supervision and mentoring competencies is essential for quality service delivery.

MoE and MoCD are involved in school and community work. There is substantial need to strengthen their capacities to regulate and technically support SRHR-related youth clubs both in schools (MoE) and out-of-school (MoCD). In general, vocational and adult education schools—organizationally under districts but technically under MoE/MoCD—need improved abilities to guide such youth clubs effectively. In addition to state structures, PwD self-advocacy organizations are further implementation partners.

5 Module design

5.1 Methodological approach and duration

Duration: 07/2026 to 06/2029 (3 years).

Strategy: The project aims to build key competencies to implement national policies on SRHR for young women, in particular NAIA and One Plan III. It builds on predecessor results and lessons and on gender analysis insights to strengthen gender-sensitive and gender-transformative approaches. The approach addresses individual capabilities, organizational performance, and underlying social and systemic framework conditions, including public service provision and user behavior of individuals and communities.

At the individual level, clinical and nursing staff in selected facilities will be trained in gender-responsive, youth-friendly and inclusive counseling on SRHR, especially family planning, emergency obstetric care and neonatal care. This includes promoting training and employment of CHWs. Adolescents of all genders will be educated in youth clubs with gender-transformative content on their SRHR and services. Dialogues on youth SRHR, especially for young women, will be held with local opinion leaders to increase openness to education and service uptake or reduce rejection. At organizational level, management processes in facilities will be strengthened, e.g., equipment maintenance. Local NGOs will be supported to implement approaches such as Community Dialogues, Men as Partners, or Girl-led Advocacy that foster reflection and change in traditional gender roles. A particular focus of organizational development is strengthening self-advocacy organizations for PwD. Broad communication measures support social changes initiated by these activities. Systemic conditions are addressed through implementation-oriented technical advice at national level, especially supporting new national training concepts (e.g., neonatal care), guidelines (e.g., school-based youth clubs), and digitization (e.g., converting narrative into digital SMART guidelines).

Hospitals and health centers are selected for fair demographic and geographic distribution and meeting minimum criteria for infrastructure, equipment and staff. Schools and communities are selected from facility catchment areas. Selection is done with partners at the start. Synergies and efficiency gains at local level with other initiatives are sought by selecting the same districts and communities (see 2.2). The do-no-harm approach tailors training and awareness campaigns on SRHR to different target groups: adolescents, parents, health professionals, teachers, and influential figures such as religious and local leaders.

Instruments: 4 international and 10 national long-term advisors, integrated experts, EUR 671,000 in financing and EUR 723,100 in goods and works.

One international advisor holds overall responsibility for personnel, financial and technical implementation and collaboration with MoH and PMO-RALG at planning/strategy level. A second international advisor provides technical guidance for Output 1 and management support. Additionally, part-time international advisors are assigned for cluster coordination and financial management. This is justified by strategic complexity, international knowledge transfer and compliance assurance. National advisors support MoH and other partners and implement activities in Tanga (3 in Output 1, 2 each in Outputs 2 and 3, and 1 in Output 4), plus one in results-oriented monitoring and one in communications across outputs. National advisors enable cost-effective steering. Medical and IT equipment will be procured to improve neonatal care, sexuality education and counseling for self-determined family planning. To support access to adequate neonatal care in growing population centers, necessary construction will be implemented where neither MoH nor other partners can finance within the module term. Complementary procurement of neonatal equipment is necessary. This will occur via a EUR 200,000 grant to MoH to ensure types maintainable by local staff. To anchor module activities at community level, CHW deployment in selected communities will be supported (EUR 40,000 grant to MoH). Using grants allows integrated and efficient delivery of training and equipment. Touch Health Foundation will receive a EUR 185,000 grant to expand WatotoCare in Tanga. Additional local grants will go to various CSOs to economically implement gender-transformative and inclusion-promoting measures at community level, better attuned to cultural context and more cost-effective via local institutions.

Output 1 (quality of care) aims to improve the quality of neonatal, sexual and reproductive health services, focusing on young women. Staff competencies will be strengthened via repeated, tailored mentoring visits providing hands-on guidance, coaching and feedback. Focus areas: (1) clinical competencies, decision-making, documentation and teamwork; (2) monitoring and data quality; (3) maintenance; (4) administration, management and logistics in everyday service delivery. All capacity measures are oriented to youth-friendly, gender-responsive and inclusive services, strengthening especially women in management and contributing to a more inclusive organizational culture. Competencies built in the predecessor module will be leveraged by increasingly shifting mentoring delivery to partner staff, with backstopping by project advisors. Activities will focus on a selection of predecessor facilities. In a growing population center with outdated hospital infrastructure, a neonatal unit will be constructed to support access to adequate care. Essential equipment will be provided for neonatal units newly built by the government and the project, and training on equipment maintenance and medicines management will be conducted. Through WatotoCare, an AI-supported risk assessment at neonatal discharge will be introduced in selected district

hospitals. To ensure better ANC, neonatal care and family planning at community level, CHWs will be trained, equipped and temporarily compensated. To strengthen accountability of health services to users, community health dialogues based on a Community Score Card will be conducted. The module advises MoH and PMO-RALG on country-specific adaptation of SMART guidelines (family planning, postnatal care) and development of SMART guidelines for neonatal care. It also supports development and integration of a module in existing electronic medical records to support forensic evidence collection in SGBV cases.

Output 2 (SRHR competencies) aims to strengthen young people's gender-sensitive competencies to protect their SRHR. The project strengthens competencies of teachers and leaders of youth clubs in and out of schools to deliver life skills (SRHR competencies, entrepreneurship, civic engagement) inclusively. Girls and young women are supported in communication, conflict and decision-making skills to better protect themselves against gender-specific risks. Boys and young men are engaged to develop a nuanced understanding of gender roles and dynamics, expanding space for young women's reproductive [self-determination/empowerment] and reducing SGBV (synergy with Output 3). Particularly competent and engaged youth will be trained as peer counsellors. With teachers and parent representatives, the project implements activities to reflect values and norms, reducing reservations about sexuality education, [self-determination/agency] and contraception for adolescents. To lower barriers among adolescents to visiting facilities, the project supports cooperation between youth clubs and health facilities. It also advises and promotes exchange formats between inclusive schools to enable mutual learning and further strengthen their inclusive approach. Persons with disabilities will be included in activities where access can be created; specific approaches will be further developed based on available data and local structures. Use of digital menstruation applications will be supported in youth clubs where mobile phones are common. CHWs will also accompany adolescents in their communities. The TC module brings implementation experience into policy dialogue on sexuality education with MoH and the Ministry of Education.

Output 3 (enabling environment) aims to strengthen community-level framework conditions for access of young people—especially girls and young women—to gender-responsive SRHR health services. In cooperation with CSOs, local opinion leaders such as religious authorities, community boards and traditional healers and midwives are sensitized to young people's rights to inclusive and gender-responsive SRHR services. Using gender-transformative approaches, local opinion leaders expand their knowledge on reproductive health, early pregnancy and gender-based violence, as well as on rights to protection and self-determination. They are encouraged to reconsider discriminatory gender roles and norms and to use their social influence for young people's rights to inclusive access to SRHR information and services. The project advises progressive opinion leaders on SRHR-positive communication. Supporting social and mass media campaigns (e.g., radio programs) will be deployed in selected communities to increase reach. Communities and responsible health offices are advised to strengthen community-based referral and support mechanisms (e.g., peer educator networks, CHWs). Experiences feed into national technical dialogue.

Output 4 (inclusion) strengthens the institutional capacities of self-advocacy organizations for PwD that promote access to SRHR services for PwD. This contributes to equality and fairness in SRHR (principle Leave no one behind, LNOB). Based on a needs analysis, an

umbrella organization will be advised on structures, processes and cooperation, and supported as needed in use and/or mobilization of resources. Staff competencies on SRHR will be expanded and deepened. Technical advice includes developing training formats for member organizations and SRHR information materials for one or more specific types of disability (e.g., Braille), supporting dialogue with state bodies on reviewing registers for PwD data to enable better monitoring while preventing/reducing discrimination. Collaboration with self-advocacy groups will also be used to ensure needs-appropriateness in Outputs 1–3.

Deployed instruments

Outputs	key activities	timeframe/milestones	numbers/scope
Output 1	- Regular on-the-job mentoring for clinical, management and maintenance staff for youth-friendly and inclusive service - Country-specific adaptation/development of SMART guidelines (family planning, postnatal care, neonatal care) - Construction and equipping of a guideline-compliant neonatal unit in a district hospital - Development of a module to support forensic evidence collection in SGBV cases and integration into government-used EMRs - Introduction of AI-supported risk assessment at neonatal discharge and strengthening follow-up (grant to Touch Health Foundation)	03/27: 600 health professionals took part in 90 mentoring visits 09/27: 2 SMART guidelines ready for user testing 12/26: priced bill of quantities available 03/28: integrated digital SGBV module piloted in application	International LTE: 43 months National LTE: 122 months STE: 11 months Goods: EUR 558,818 Financing: EUR 293,000
Output 2	- Training of organizers and moderators to deliver life skills in youth clubs in and out of schools - Advising youth clubs on cooperation with health facilities and on inclusion of PwD - Technical advice on exchange formats between inclusive schools	09/27: 50 youth clubs offer SRHR content within life skills 03/28: 44 teachers trained and exchanging Instruments: International	International LTE: 18 months National LTE: 99 months STE 12 months Goods: EUR 81,330 Financing: EUR 76,800
Output 3	- Sensitizing local opinion leaders on young people's rights to access gender-responsive SRHR services - Advising opinion leaders on SRHR-positive communication - Local grants to implement gender-transformative approaches - Social and mass media campaigns	03/27: 48 opinion leaders sensitized 03/28: 5 approaches implemented 09/27: 145,000 people reached	International STE: 16 months National STE: 63 months STE: 6 months Goods: EUR 36,220 Financing: EUR 226,200 Finanzierungen: 226.200 EUR
Output 4	- Needs analysis for capacity development of an umbrella organization of PwD organizations for advocacy on inclusive SRHR services	03/27: Capacity development work plan available	International STE: 9 months

Outputs	key activities	timeframe/milestones	numbers/scope
	- Organizational and technical advice to strengthen the umbrella organization - Technical advice for disability-specific SRHR information materials - Advice on collecting utilization data of SRHR services by PwD	03/27: Information materials available 03/27: Options paper submitted to MoH	National STE: 50 months STE: 4 months Goods: EUR 46,732 Financing: EUR 75,000

5.2 Ensuring the sustainable effectiveness of the measures (outcomes)

he project secures sustainability on three levels. Societal: through gender-transformative work with youth, it promotes norms of equality whose effects grow as the new generation takes positions of power and passes norms to their children. Health system: the multi-level implementation strategy contributes to sustainability. Anchoring the approaches in national strategies, guidelines, training formats and digital systems strengthens Tanzanian ownership to plan domestic budgets for future implementation of standards. Practically, the project focuses on cost reduction in implementing measures whose effects were shown previously; for example, mentoring relies more than before on professionals from the growing pool of SRHR and neonatal expertise despite ongoing shortages; to secure financial sustainability of community health dialogues, capacities are built at the lowest government level; to ensure effects in inclusion, organizational advisory to self-advocacy also covers resource mobilization.

5.3 Partner contributions, combined financing

	Specifics	Estimated value
Combined financing (donor)	-	-
Partner contribution	MoH: 64 months staff time, venues, catering PMO-RALG: 12 months staff time, venues, catering Kommunalverwaltungen: 964 months staff time	420.000 EUR

5.4 Commission value and detailed cost estimate

Up to EUR 9.000.000.

cluded are costs for participation in the “Health and Social Protection” technical network to secure the technical quality and knowledge management required for implementation. Also included are costs for project follow-up and interim/final evaluations as key instruments of success control and accountability of German TC.

Preparation of the project is part of the commission. Preparation costs will be charged to the project after commissioning. If not commissioned, costs will be rebooked to the Tanzania Studies and Experts Fund (PN 2021.2288.5).

Preparation and evaluation follow the BMZ–GIZ agreed procedures, implemented by GIZ on behalf of BMZ.

For a detailed cost overview, see Annexes 3a Cost estimate and disbursement by fiscal years and 3b Cost–output allocation.

6 Assessment of the module's impacts and risk

6.1 Assessment of impacts

General impacts: Achieving the module objective contributes to gender equality (SDG 5), to improving sexual and reproductive health and rights (SRHR) (SDG 3), especially for young women and PwD (quality criterion Human rights, gender equality and inclusion), and thus to reduced inequality (SDG 10). Improved access to information, contraceptives and health services around pregnancy and childbirth enables women and girls to make empowered life choices. Adolescents are enabled through school clubs and youth-friendly inclusive services to better protect themselves against early pregnancy, STIs and gender-based violence. The module strengthens the quality of SRHR services, including neonatal care, inter alia through digitization of clinical standards (quality criterion Digitization [digital by default]). The do-no-harm approach includes key actors in education and community in a target group—appropriate manner to create an enabling environment for change for youth, especially girls and young women (see 5.1). The module supports national sustainability goals under the 2030 Agenda embedded in the National Five-Year Plan (strategy Human development) and HSSP V (Reproductive, maternal, newborn, child and adolescent health; Improving quality of care). In particular, SDGs 5 Gender equality and 3 Good health for all and sub-goals 3.1 and 3.2 (reducing maternal and neonatal mortality) are supported. The module further contributes to improved access to SRHR care, including family planning, information and education (SDG 3.7, 5.6). This supports slower population growth and faster realization of the demographic dividend, contributing to sustainable development and reduction/long-term ending of poverty (SDG 1).

Economic impacts: By improving SRHR services and strengthening adolescents, the module contributes to household economic development. Better sexuality education and access to contraceptives reduce early pregnancies and increase chances that young women and men complete education and obtain income. Lacking economic prospects, reinforced by traditional roles, severely constrain empowered life planning. Societally, counselling of adolescents and women of reproductive age contributes to reducing high population growth. Preconditions for realizing a demographic dividend are positively influenced (quality criterion Reducing poverty and inequality). Participation of women and youth in facility management oversight increases need-responsiveness and transparency, improving efficiency of public spending (quality criterion Anti-corruption and integrity). Negative unintended effects were not identified.

Environmental impacts: The health sector contributes noticeably to environmental burdens and is responsible for roughly 4–5% of global GHG emissions, especially via energy use, materials and waste. Within the sector, obstetrics and family planning, supported by the module, are much less resource-intensive than fields like radiology. The project therefore does not work at care–environment interfaces such as waste management. No unintended

negative environmental effects were identified. Climate change affects maternal and child health (e.g., heat stress for pregnant women and newborns, increased vector-borne diseases following heavy rains/floods, malnutrition due to crop failures). These topics are already part of antenatal counselling, will grow in importance, but need no adaptation (quality criterion Environmental and climate impact assessment).

Social impacts: The project contributes to realizing the right to gender equality, legally recognized by and in Tanzania but not yet realized in practice (see 3). The TC module complements societal norm and stereotype change (gender transformation) to address structural inequalities in young women's and PwD's rights to [self-determination/agency] (quality criterion Human rights, gender equality, inclusion). Indirect effects on women's access to education and employment are expected. The highest attainable standard of health, medical care for everyone and social security are recognized rights (ICESCR Art. 12.1, 12.2(d), and 9). Inadequate care quality impairs realization of these rights. The project aims to improve the quality of SRHR services and newborn health and to enable women of reproductive age and newborns to access a more capable public health system. It contributes to health (SDG 3), gender equality (SDG 5), and indirectly to SDG 4 (education). The Leave No One Behind principle is addressed by striving for target group-oriented services and information for young women and men, considering intersections of gender, age and disability. Possible unintended negatives include a conservative gender backlash against gender-transformative approaches undermining equality progress, and increased domestic and gender-based violence if more self-confident women assert rights to sexual and health [self-determination/agency] (quality criterion Conflict sensitivity).

Conclusions for module design: The expected impacts underpin the module's conceptual frame. Identifying the core problem (see 3) explicitly linked gender equality with promoting sexuality education and quality, target group-appropriate health services. The health sector plays a key role and must be further strengthened. Module indicators contribute to improving health and rights and thus SDGs 3 and 5 (see Annex 1). Negative unintended effects are considered under social impacts. To avoid backlash, gender-transformative approaches will be implemented socio-culturally sensitively, as also requested by the Tanzanian government, without compromising principles of values-based cooperation. The module will take measures to prevent and secure evidence of SGBV, e.g., through addressing both genders in youth clubs. Sensitizing local opinion leaders will simultaneously create a more tolerant and supportive environment that offers youth better opportunities to exercise SRHR (see 5.1).

Markers and identifiers are summarized in Annex 4a; for the quality criterion Gender equality see the in-depth assessment (gender analysis) in the annex.

6.2 Assessment of risks to the module's effectiveness

Political risks: During the presidential and parliamentary elections in October 2025, violent unrest occurred for the first time since independence. Protests against election interference via court cases against the opposition, disappearances of activists, and unequal media access were met with state violence, internet shutdowns and curfews. Reports of severe and

widespread state violence and the contrast between the announced result—the ruling party's best since multiparty democracy—and the scale of protests shook public trust. This risks participation of target groups in module measures. The risk is mitigated by working with local NGOs rather than state entities for community-based, particularly gender-transformative, measures. A limited risk is that the government scapegoats other minorities—especially homosexual and transgender people—alongside foreigners from neighboring states and persecutes them more. This would affect sexuality education that actively questions and changes gender roles for adolescents, due to suspicions that promoting gender equality implies permissiveness in sexuality. Collaboration with the embassy and other donors is the only, albeit often only partially effective, risk management approach. A greater risk lies in the increasing number of interfaces among government partners. Besides MoH and PMO-RALG, MoE and MoCD are now increasingly relevant partners with their own demands. Strong inclusion of all partners in governance structures and in preparing and implementing activities is essential to balance interests.

Implementation risks: Complex approval procedures for implementation agreements and work/import/other permits pose a risk to timely implementation. This has increased under new processes led by the Planning Commission. The project will manage this by assigning a national liaison staff member in Dodoma and collaborating with the GIZ country structures and the embassy. Achieving targets on modern contraceptive use is at risk due to unreliable contraceptive availability. Reduced partner financing, insufficient compensating increases in Tanzanian budget funds, and acute failures of planned deliveries make this risk high to very high. Mitigation is only possible for local interruptions (e.g., supporting needs planning and redistribution). For national-level interruptions due to missing funds and/or long lead times, the project has no effective influence. Further risks relate to long-term effects and local acceptance of nationally agreed gender-transformative measures. The risk of insufficiently quantifiable short-term measurability by the set indicators can be mitigated by qualitative accompanying research with reporting. Acceptance can be secured via local actor analyses, socio-culturally sensitive implementation, and cooperation with locally rooted organizations. The latter entails a risk of working with organizations with limited financial administration capacities. To mitigate financial risks, commercial capacity checks will be conducted, local subsidies used instead of grants, and capacities built.

Risks for sustainability: Implementing parts of the project via CHWs requires short-term increases in their numbers, as they are not yet nationwide. This requires financing training, equipment and allowances. Allowances are ongoing costs to be borne by local governments after project end to secure long-term effects. This risk will be mitigated via dialogue with local governments. The risk of declining long-term impact due to rotation of trained staff has decreased after the regional administration issued staff rotation guidelines. The risk can be further reduced by working with regional and local administrations. Overall staff shortages, however, are not influenceable.

Impacts on environment and social (unintended): Relevant risks and mitigation are discussed in Section 6.1.

Corruption risk: There is a risk that health personnel condition access to services on illegal payments. The project mitigates this by scaling community dialogues (Community Score Card), where users can report such misconduct.

Overall risk: Overall, the risk to target achievement is assessed as high, mainly due to dependence on contraceptive availability and high likelihood of this risk. Influenceability is assessed as medium overall, with national availability of contraceptives not influenceable and timely administrative processes only slightly influenceable.

Risk	Rating	Influenceability *	(undertaken) risk-management-measure
Political risks	2	1	
- Low participation in community-based measures - Policy changes on sexuality education and contraception among youth - Turf disputes among government partners			- Cooperation with locally rooted NGOs - Cooperation with embassy and donors for joint positioning with the government - Inclusion of all partners in governance and in preparing and implementing activities
Implementation risks	3	2	
- Delays signing implementation agreement and issuing work/import/other permits - Availability of essential medicines, especially contraceptives - Time-delayed effects of gender-transformative approaches - Local resistance to nationally agreed gender-transformative approaches - Limited financial management capacities of recipients			- Cooperation with GIZ country office, embassy, and deployment of a liaison person in Dodoma for effective process follow-up - Support for better needs planning, budgeting, redistribution - Qualitative accompanying research and, if needed, sharpening of quantitative indicator - Local stakeholder analyses, implementation with locally rooted organizations, socio-culturally sensitive delivery - Use local subsidies (instead of grants) and direct support to recipients
Risks for sustainability	3	1	
- Taking over of costs for employed CHWs by local governments - Staff shortages and rotation			- Dialogue with local governments, strengthen domestic resource mobilization - Work with regional and local health administrations
Impacts on environment and social (unintended)	2	3	
- Gender backlash in communities implementing gender-transformative measures - Increased domestic and gender-based violence against women using self-determined family planning			- Involve experienced local organizations; use context-appropriate language - Embed SGBV content in sexuality education and community work; strengthen SGBV clinic(s)
Corruption risk (VI063)	2	3	
Restricting access to services without illegal payments			Strengthen community oversight by scaling the <i>Community Score Card</i>
Overall risk	3	2	

*) Rating: 1=low, 2=medium, 3=high, 4=very high

6.3 Certification

The TC measure presented and its implementation modalities, after examining alternatives, represent the optimal relation between the TC measure's purpose and the means to be employed. Country strategies and DC programs as well as BMZ's binding thematic steering documents were taken into account in planning.