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SUMMARY REPORT

Gender and equity analysis for nutrition, health, sexual and reproductive health and rights services for adolescents in Simiyu Region, Tanzania





Background and rationale

12%

of adolescents aged 15–19 experience stunting*

18%

of adolescents aged 15–19 experience thinness*

23%

of adolescents aged 15–19 are affected by anaemia*

54%

of health facilities provide HIV counselling and testing for adolescents*

36%

of women aged 15–49 report receiving antenatal care**

11%

of women aged 15–49 report using contraceptives**

62%

of ever-married women aged 15–49 have experienced physical violence from their partners**



Adolescents (10–19 years old) constitute 23% of Tanzania's total population and face significant health and nutrition challenges.¹ These challenges are increasingly recognized in the country, and the National Accelerated Investment Agenda for Adolescent Health & Wellbeing (NAIA-AHW) represents an effort to respond to these emerging priorities.² According to the 2022 Tanzania Demographic and Health Survey (TDHS), 12% of adolescents aged 15–19 years experience stunting, 18% experience thinness and 23.1% are affected by anaemia.³ The 2023 Service Availability and Readiness Assessment revealed that while sexual and reproductive health (SRH) service availability had increased to 70%, access and comprehensiveness remained limited, with no facility having dedicated adolescent health guidelines for nutrition and limited availability of trained staff.⁴ Only 16% of staff in dispensaries, 32% in health centres and 48% in hospitals reported receiving training in adolescent health and nutrition. Furthermore, only 54% of facilities provided HIV counselling and testing for adolescents. These gaps likely contribute to adverse health and social outcomes among adolescents.

The Simiyu Region in Tanzania has poor performance indicators for population nutrition and health. According to the 2022 TDHS, the region records stunting prevalence of 33% among children under five (compared to 30% nationally), the wasting rate is 5% among children under five (compared to 3% nationally), and only 11% of women aged 15–49 years report using contraceptives (compared to a national rate of 38%).³ Furthermore, antenatal visit coverage is 36% among women aged 15–49 years (versus 65% nationally), and 62% of ever-married women aged 15–49 years have experienced violence from their partners (in contrast to 50% nationally).

* According to a 2022 nation-wide survey

** According to a 2022 survey of the Simiyu Region



Against this context, Nutrition International and its partners are implementing the Realizing Gender Equality, Attitudinal Change & Transformative Systems in Nutrition (REACTS-IN) project in Tanzania's Simiyu Region. This seven-year, multi-country program aims to address the key determinants of nutrition, gender inequalities and SRH for women, adolescent girls and children under five years of age who are living in vulnerable situations through integrated, multisectoral and evidence-based interventions.

The REACTS-IN project brings together expertise from Nutrition International, HarvestPlus and World Vision Tanzania to advance the rights and dignity of women and girls by increasing access to gender-equitable nutrition. At the country level, Nutrition International works in partnership with World Vision Tanzania, the Ministry of Health, the President's Office Regional Administration and Local Governments (PORALG), and the offices of Regional and District Medical Officers for Simiyu Region. At the grassroots level, the partnership involves the District Councils of Maswa and Meatu Districts, and community leaders from both districts.

Based on the contextual landscape, a need was identified for a comprehensive gender and equity analysis to understand the underlying issues that influence access to nutrition, health, and sexual and reproductive health and rights (SRHR) services for adolescents, particularly girls, in Meatu and Maswa districts. The findings would guide the development of strategies promoting gender equity under the REACTS-IN project.

The data collection team employed a mixed-methods approach involving key informant interviews (KIIs) with healthcare providers, education officials, community and religious leaders, government representatives, civil society organizations and implementing partners, alongside focus group discussions (FGDs) with adolescents (ages 10–19, both in school and out of school) and adult community members. Primary data was supplemented by structured observations at four health facilities and eight schools to assess service readiness and adolescent-friendly features, while secondary data was gathered through desk review of national policies, district plans and relevant project documentation on gender equity, adolescent health and nutrition.

Key findings

Gender norms, roles and decision-making power

The Simiyu Region operates as a deeply patriarchal society where men dominate decision making across all spheres, including health and nutrition, education, marriage and household resource allocation. Traditional gender roles position women and girls primarily as caregivers and domestic workers (performing unpaid work), while men are viewed as socio-economic providers. Early marriage is normalized as a cultural practice, often determined by bride price arrangement, leaving girls with minimal say over their futures. Girls also experience early sexual debut and childbirth due to these early marriages.



In our communities, economic hardship in some households is one of the major causes of early marriage. Poverty pushes parents to marry off their daughters early in exchange for dowry, seeing it as a way to address poverty.

— FGD participant, female adolescent (10–14), primary school, Maswa

Sex-based division of labour is strictly enforced, with women and girls responsible for all household chores while also contributing to farming activities. Despite their substantial contributions, women and girls have limited ownership of land and productive assets or the income generated from these assets, with wealth distribution following patrilineal patterns. Adolescent girls face significant restrictions on mobility, participation in public spaces and self-expression, while boys are encouraged to take leadership roles and make independent choices. These gender norms negatively impact health-seeking behaviours and access to health and nutrition information, as well as increasing the risk that girls experience gender-based violence. The cumulative effect is reduced self-confidence, limited service-seeking behaviour and long-term disempowerment of adolescent girls.

Despite substantial contributions to household labour and caregiving, women and adolescent girls have limited decision-making power over resources, with men controlling household finances and decisions about health and nutrition services, food purchases, dietary intake, and education investments. Food distribution practices within households are gender-biased, with boys and male household heads receiving larger or higher-quality portions while girls typically serve others and eat last.



We were born and brought up seeing how our mothers exercise respect for menfolk. They teach us to be like them, and we follow even if it is sometimes difficult.

— FGD participant, female adolescent (15–19), secondary school, Meatu



Existing institutions, groups and platforms to address gender norms and promote nutrition, health and SRHR

A diverse and extensive landscape of institutions and platforms exists to address gender equity, SRHR and nutrition in the study areas. At the community level, community health workers (CHWs) serve as crucial bridges between communities and health systems, primarily providing services and education to pregnant women and children under five, with adolescents largely not included as a routine target group. School-based platforms include student clubs that promote gender equality and SRHR awareness through interactive activities such as debates and peer education sessions, providing adolescents with information on gender equality, reproductive health and nutrition. Sports clubs and teams are also utilized as vehicles to communicate messages about SRHR and nutritional health. The *Shule Salama* (Safe School) campaign under PORALG, in collaboration with the Ministry of Education, works to ensure safety and security of school settings, addressing both gender-based violence (GBV) and violence against children (VAC). Teachers and Parents Unions (UWAWA) serve as platforms for discussions and decisions on reproductive health and nutrition services offered to adolescents in schools.

Traditional security structures are used to provide community security, particularly at night, to protect people and children from different forms of violence and abuse. These include community-organized safety arrangements and referrals to formal GBV response mechanisms. At the district level, existing government

structures such as police gender desks, social welfare officers and MTAKUWWAⁱ committees play a role in the prevention of and response to gender-based violence. In addition, multiple community-based organizations (CBOs) and civil society organizations (CSOs) contribute to gender equality, SRHR and nutrition initiatives through community awareness, peer education and service linkage activities.

However, despite this extensive infrastructure, critical system-level challenges undermine service delivery and sustainability. Many community-based services — including youth-friendly corners, peer education programs and mobile outreach clinics — are overwhelmingly project-driven and donor-dependent, facing high risk of collapse when funding ends. While donor-supported projects continue to play an important role, there may be an opportunity for the government to develop a costed sustainability plan to support the continued integration of adolescent health and nutrition programming within existing systems. In spite of these challenges, stakeholders at district and regional levels expressed strong willingness to strengthen systems if provided with technical support, budgetary resources and policy clarity. Existing systems such as ward health committees, village councils, school management teams, health facility governing committees and district development committees offer potential entry points for institutionalizing adolescent-responsive planning and ensuring sustainability beyond project lifecycles.

ⁱ This is a Swahili acronym referring to the action plan for the elimination of gender-based violence against women and children. As part of the plan, local committees have been established to educate communities and support those affected by violence.



Let me tell you something that you always miss. As a community leader, I have received many program implementers with the same topic — sexual and reproductive health for adolescents. You must know that parents are skeptical of your programs. When looking at the core content that the programs are bringing to us, most of it is sexuality. Parents are not happy with that, keeping in mind that some of the children you are involved with are as young as 10 years old.

— KII, village executive officer, Meatu



Perceptions of social influencers on gender, awareness and stigma

Understanding of gender as a concept is limited across all population segments, with many equating gender equality solely with women’s empowerment. Cultural and religious beliefs strongly shape attitudes toward SRHR, with open discussions considered taboo, particularly between parents and children. Many parents and community leaders view discussions around family planning, contraceptives and menstruation as inappropriate or “corrupting” for adolescents. Adolescents are perceived as children and denied participation in issues that concern them because parents fear they will adopt undesirable behaviours.

Stigma surrounding adolescent health service use is particularly strong for adolescents seeking contraception, HIV testing or counselling, with young people often facing suspicion, ridicule or reprimand from community members or health workers. Some community members believe that iron supplements or improved diets could lead to “early maturity” or increased sexual activity among girls, further discouraging uptake. Reproductive health and nutrition services are considered “women’s business,” hindering male engagement efforts. Conflict of interest was observed among community gatekeepers and service providers whose personal cultural and religious beliefs inhibited their professional conduct.

These beliefs and perceptions affect adolescents, especially girls, who expressed fears about sexual abuse, forced marriages, lack of participation in decisions affecting them and limited future opportunities.



I have worked in this region and with many partners, many government leaders. I think we are yet to thoroughly understand the concept of gender, and this might be hampering our efforts to address gender imbalances. I would like people to have enough knowledge of gender equality in its full package by giving them different examples so that it can help them to reduce abuse of children and women, and in the end of the day, to have safe families in their communities.

— KII, regional-level government official, Simiyu



Sometimes I think, even if I finish school, what will I do next? There are no jobs. No one listens to us.

— FGD, adolescent girl, Maswa



We want to help, but there is no training, no updated materials and no space for privacy. Sometimes we don't even know how to talk to adolescents.

— KII, health worker, Meatu



Access to adolescent-friendly services

The availability and accessibility of adolescent-friendly services remain severely limited. While all schools and health facilities in the study offered some SRHR and nutrition services to adolescents, overall quality and comprehensiveness were poor.

Health facilities showed more pronounced availability of SRHR services than nutrition services, while schools demonstrated better integration of nutrition interventions. Adolescents, particularly girls, expressed discomfort and fear of judgment when seeking services at health facilities, with some reporting discrimination by service providers who questioned their age. Out-of-school adolescents had little to no access to services or information. Nutrition services for adolescents are not well-integrated into existing systems, primarily focusing on children under five and pregnant women. Limited outreach services, low male involvement, lack of adolescent-specific materials and absence of adolescent input in service design all contributed to poor utilization.



You feel embarrassed going to the clinic because people will think you are already doing bad things. Even if you are just sick, they judge you.

— FGD, adolescent girl, Meatu

Adolescents living in vulnerable contexts — including those who are orphaned, living with disabilities or from lower socio-economic backgrounds — face multiple intersecting barriers including discrimination, lack of transport and low confidence in seeking services. While social protection measures exist in policy, they are largely non-functional in practice. GBV and VAC are significant concerns, with girls particularly exposed to sexual abuse during activities such as travelling to and from school or while grazing animals. Access to SRHR and nutrition services appeared generally equitable across ethnicity and religion, though poverty affected service uptake due to the indirect costs associated with accessing these services.

System-level gaps and opportunities

A critical gap identified was the disconnect between policy development and resource allocation. While the NAIA-AHW was developed as a costed strategy with resource mobilization plans, increased health sector funding has not translated into additional resources for SRHR and nutrition programming for adolescents. Government stakeholders noted that despite a small increment in the overall health sector budget, this has not resulted in proportional increases for adolescent-specific services. Furthermore, the expansion of service delivery points through newly constructed health facilities has increased resource needs without corresponding budget allocation, stretching already limited resources even thinner.

Capacity gaps at the service provider level emerged as a major barrier to quality service delivery. Many service providers, including health workers, teachers and community leaders, lack training in adolescent-responsive approaches, gender sensitivity and rights-based delivery. Observational data revealed that only 12.5% of teachers and none of the health workers in sampled facilities had received any training on SRHR, nutrition or health. At the facility and school level, services targeting adolescents often operate without adequate guidelines, supervision or dedicated funding. None of the health facilities had a designated focal person for provision of SRHR and nutrition services, while only 37.5% of schools had such a person. Additionally, only 25% of health facilities had adolescent-specific guidelines for the provision of SRHR services, and none of the schools had any type of guidelines for SRHR service provision in the school context.

Coordination between key sectors such as health, education, community development and social welfare emerged as a persistent challenge, particularly at the district level, where partners work with limited integration. While the Regional Health Management Team (RHMT) provides relatively better coordination at the regional level, coordination becomes more challenging at the district level. Driven by project focus, timeframes and donor-driven expected results, partners often operate in silos. This fragmentation results in duplicated efforts, missed opportunities for collaboration and a lack of integrated support for adolescents across service points, spanning the key sectors.

Government representatives identified potential coordinating platforms that remain underutilized for adolescent health and nutrition programming. The District Management Team (DMT) was suggested as an appropriate platform to communicate and strategize interventions and action plans for SRHR, nutrition and health. Similarly, district council sessions were identified as forums where adolescent health and nutrition could be elevated as permanent agenda items to ensure sustained attention and resource allocation.

Conclusion



The gender and equity analysis has revealed deep-rooted structural, social and institutional barriers that limit adolescents, particularly girls, in the Simiyu Region from accessing quality, equitable nutrition, health and SRHR services. The findings demonstrate that while efforts are underway to improve adolescent well-being, a lot remains to be done to ensure that interventions are not only available but also accessible, acceptable and responsive to the unique realities that adolescents face.

The assessment highlights the critical role of gender norms, stigma, service readiness and household dynamics in shaping adolescents' health trajectories. Factors across individual, household, community and system levels interact to perpetuate gender inequalities and limit access to essential services for adolescents, especially girls. The study underscores the need for intentional, context-driven strategies that promote gender equity, adolescent empowerment and community ownership. Girls and women were the most-affected groups compared with other sub-populations in the studied communities.



Despite the challenges, the assessment identified promising opportunities that include community readiness for change, existing entry points at the school and facility level, and a strong base of willing stakeholders. Most importantly, the central government's commitment and readiness to strengthen adolescent health and nutrition services provides a solid foundation on which sustainable, gender-transformative programs can be built.

Recommendations

The following are selected key recommendations from the gender and equity analysis, specifically directed towards central and local government stakeholders to strengthen adolescent nutrition, health and SRHR services, and corresponding outcomes in Simiyu Region.

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- 1 Address gender norms and strengthen adolescent decision-making power**
 - Integrate gender-transformative curricula in schools and community forums, promoting positive masculinity, equality and respectful relationships from an early age.
 - Support school-based and community leadership programs for adolescent girls to build confidence, negotiation skills and decision-making power.
 - 2 Expand access to adolescent-friendly health and nutrition services**
 - Establish/scale up adolescent-friendly corners in health facilities and schools, ensuring privacy, trained staff/peer educators, flexible hours and access to both SRHR and nutrition services.
 - Develop outreach services targeting out-of-school adolescents in vulnerable contexts and those in remote areas, using mobile clinics, CHWs, peer educators and adolescent health and nutrition campaigns during school holidays.
 - Establish anonymous feedback mechanisms for adolescent services, such as suggestion boxes or digital platforms, to improve service accountability and responsiveness and ensure privacy.
 - 3 Enhance community awareness and reduce stigma**
 - Introduce parent–adolescent dialogue toolkits to share accurate, evidence-based adolescent health and nutrition information, and help households discuss sensitive topics like puberty, menstrual and sexual health, and nutrition — including use of iron supplements for girls — in a culturally respectful way.
 - Create safe spaces (physical or digital) where adolescents can access information, share experiences and seek guidance anonymously or with peer support.
 - 4 Strengthen education and information access**
 - Integrate comprehensive sexuality education (CSE) into school curricula, ensuring it is age-appropriate, medically accurate, gender-sensitive and responsive to the realities of adolescents' lives.
 - Train both male and female teachers in delivering CSE and nutrition education, with emphasis on building trust, confidentiality and non-judgmental facilitation skills. Having both male and female trained teachers enables delivery of CSE in single-sex settings, which can increase acceptability.
 - Develop extra-curricular health and nutrition clubs in schools that provide adolescents with a safe platform to learn, ask questions and engage in peer-led awareness activities.
 - 5 Promote equity in households and community structures**
 - Facilitate inclusive community platforms where women, adolescent girls and vulnerable groups can voice their needs and participate in local decision-making processes.
 - Collaborate with local leaders through structures at the regional, district and community levels by providing evidence-based information and technical guidance to challenge harmful cultural practices that limit adolescent rights and opportunities.
 - 6 Strengthen system-level coordination and sustainability**
 - Institutionalize adolescent health and nutrition services within existing government systems.
 - Foster intersectoral collaboration across health, education, social welfare and community development sectors
 - Develop district-level referral and coordination mechanisms that link schools, health facilities, community organizations and social services.
 - Strengthen data systems and generate evidence by improving collection, disaggregation and analysis of adolescent-specific indicators in health and nutrition programs, including those related to equity and inclusion.
 - Scale up and strengthen youth-friendly services in all councils in the region.
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References

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- 3 United Republic of Tanzania. (2022). *Tanzania demographic and health survey and malaria indicator survey (TDHS-MIS) 2022*. National Bureau of Statistics (NBS) and ICF.
- 4 Ministry of Health. (2023). *Service availability and readiness assessment (SARA) 2023*. United Republic of Tanzania.

