Tanzania

Collaborative Advocacy Action Plan (CAAP)

Delivering on country commitments for women's, children's and adolescents' health and well-being

Hosted by the World Health Organization

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CAAP overview

The aim of the Collaborative Advocacy Action Plan (CAAP) initiative is to improve accountability for women, children and adolescents health (WCAH) through the collaborative efforts of partners. The process in Tanzania involves an initial partner-led and the Ministry of Health (MoH), scoping and assessment of national WCAH commitments. Based on this evidence, representatives of the National Reproductive Maternal Newborn Child and Adolescent Health (RMNCAH) Technical Working Group(TWG) of the Sector Wide Approach (SWAp) Technical Committee from the MOH, PORALG, Multilateral and Bilateral Agencies, Implementing Partners, Academia, Practicing clinician's and Nurse-Midwives came together to identify a set of advocacy actions to be undertaken collaboratively by WCAH stakeholders to improve the quality and implementation of existing WCAH commitments, while responding to the need for new commitments where critical gaps exist. Tanzania's commitments to SDG include:

- Strong political: Tanzania has a strong political will to implement the SDGs.
- Integrated planning: Tanzania is implementing the SDGs within the framework of its five-year development plans.
- Supportive legal frameworks: Tanzania has supportive legal frameworks to implement the SDGs.
- Capacity building: Tanzania is building capacity in resource mobilization, data management, and technological capability.
- Partnerships: Tanzania is working with partners to implement the SDGs.
- Regional and district strategic plans: The President's Office Regional Administration and Local Government (PORALG) has initiated regional and district strategic plans to supplement the Five-Year Development Plan II
- The country has domesticated the Global Strategy for Women's, Children's, and Adolescents' Health (2016-2030) into the RMNCAH Strategy from I to One Plan III (2021-2026) to ensure that no one is left behind in reaching the SDGs by 2030.

At the summit, where the SDGs were signed off by 193 countries including Tanzania, the then UN Secretary General, Ban Ki-moon, underlined the importance of implementation as a show of commitment to the goals, the need for partnership and solidarity in ensuring the success of the goals, and expressed the commitment of the United Nations in providing the necessary support to Member States.

"This is the future we want for humanity and for our planet. Tanzania stands ready and pledges its unwavering commitment to fully support the Sustainable Development Goals and its implementation. We will do everything in our power to play our part accordingly... For sure, no-one will be left behind" – Jakaya M. Kikwete."

H.E. Dr. Jakaya M. Kikwete, former President of the United Republic of Tanzania, reiterated his and Tanzania's commitment to the Sustainable Development Goals by joining the High Level Group to support the implementation of the SDGs, announced by H.E. Stefan Löfven, Prime Minister of Sweden.

The Clinton Health Access Initiative (CHAI), serving as the Partnership for Maternal, Newborn & Child Health (PMNCH) country coordinating partner, collaborated with the Ministry of Health (MoH) under the Division of Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) together with partners to develop a country-specific Collaborative Advocacy Action Plan (CAAP). The primary objective was to develop a CAAP based on:

- In-country analysis of commitment implementation
- Identification of gaps requiring commitment mobilization

The CAAP process in Tanzania was financially and technically supported by Partnership for Maternal Newborn and Child Health (PMNCH)

PMNCH for
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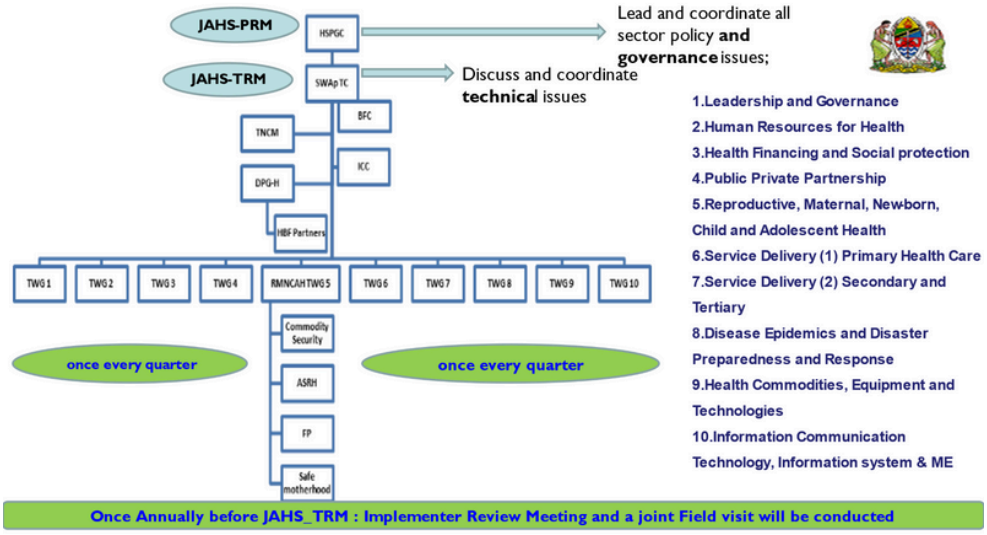
CLINTON HEALTH ACCESS INITIATIVE

Process and Activities

1. Partner Verification

The MoH provided an initial list of RMNCAH partners generated from the # 5 TWGs and related sub- committees' stakeholders. Individual partners were contacted to verify current contact information and ongoing RMNCAH activities. A comprehensive database of national RMNCAH partners was established and maintained to ensure effective communication and engagement.



2. Commitment Compilation

CHAI in collaboration with the MoH jointly compiled existing commitments related to Women, Child, and Adolescent Health (WCAH), including international commitments, regional commitments and National commitments(SEE ANNEX 4)

3. Stakeholder Engagement

Initially CHAI organized two consultative meetings to gather evidence for generating the needed action points for Advocacy. The first meeting was held Dodoma with the Division of RMNCAH's Section Heads and Senior RMNCAH officials. During this meeting, National RMNCAH Commitments and Implementation Progress were collected. The second meeting was held in Morogoro convened representatives of key RMNCAH stakeholders from MOH, PORALG, Academia, Development Partners and Practicing Clinicians and Nurse-Midwives. It was from this meeting the advocacy Goals and activities were agreed based on the evidence collected in the previous meeting. The following five advocacy goals were mutually agreed upon:

Advocacy Goal 1	The Ministry of health improves availability of competent midwifery workforce in high mortality geographical areas and facilities to at least 60% of the HRH establishment guideline by 2030
Advocacy Goal 2	The ministry of health improves the availability of neonatal care facilities, equipment, supplies and competent neonatal health care workers to contribute to the reduction of the neonatal mortality rate to at least less than 12 per 1000 live births by 2030
Advocacy Goal 3	The Ministry of health strengthens youth SRH education, access to adolescents and youth-friendly health services, and community engagement to reduce the teenage pregnancy rates to less than 12% by 2030.
Advocacy Goal 4	The Ministry of Finance increases health budget allocation to 15% and ensure ringfenced and Universal Health Insurance coverage of the maternal, neonatal, under 5 child health services by 2030
Advocacy Goal 5	The Ministry of health to improve quality of emergency obstetric care through strengthening service delivery systems and capacity building prioritizing high maternal mortality geographical areas and facilities to reduce country maternal mortality ratio to less than 70 per 100,000 live births by 2030

Background of WCAH in Tanzania

Tanzania is committed to improving the health of women, children, and adolescents to achieve the 2030

Tanzania has made stride in achieving the 2030 SDGs commitments. For example, 80% progress in reduction of Maternal Mortality from 556:1OO,000 live birth (2015/16) live birth during the launch of SDGs to 104:100,000 live birth (DHS,2022) and reduction by 55% from 432 to 198: 100,000 according to the Census (2012 to 2022). The achievement was made in line with the Government and partners' commitment and efforts to improving access to and utilization of quality RMNCAH+N services. Tanzania was committed to ending preventable maternal mortality and to reaching a global maternal mortality ratio of less than 232:100,000 by 2025 and reach SDG target of less than 140 deaths per 100,000 live births by 2030. Although improvements have been made, however, maternal death has remained

persistently high in urban Tanzania. For example, Tanzania Census 2012 recorded higher mortality (443) deaths per 100,000 live births than rural (336) mortality deaths per 100,000 live births. Dar es Salaam MMR was 499:100,000 while Rukwa recorded highest 860 and lowest 187:100,000 MMR in Simiyu. Another similar evidence was generated form MPDSR in 2018; 1,744 maternal deaths were mapped equal to MMR of 104: 100,000 live births; Dar es Salaam led with MMR of 221: 100,000 maternal death live births two folds above national average. Equally, RAMOS study revealed that within two years from January 2019 to December 2020; 848 maternal deaths were recorded in Dar es Salaam; translated to 239:100,000 MMR. Ilala shared both highest number of live deliveries (99,364) and 409 nearly half (48%) of maternal death which can be translated as 412:100,000.

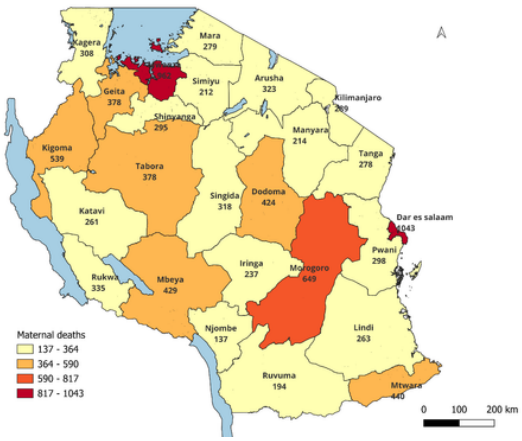


Figure 1: Regional maternal death counts reported in six years_ 2018 - 2023

Almost all women in Tanzania (98%) receive ANC from a skilled provider. The number and rate of women delivering at health facilities has also increased from just over half of all women (50.2%) in TDHS 2010 to two–thirds (63%) in the TDHS 2015/16 with observable continued increasing trend from 65% to 72% during 2015–2017, followed by an acceleration in 2018 to 81% coverage, and 81%. Highest institutional deliveries were recorded in the following regions: >99% DSM and Iringa, Njombe 99%, Ruvuma and Lindi 96%, Kilimamnaro Rukwa 95%, and Kigoma 94%. Highest home based were recorded in the following regions: Mnayara only 44%, Tanga 34%, Katavi 33%, Mara and Geita 28%, Simiyu and Tabora 27%, Kagera 23%, and Singida 22%.

However, newborn death has remained constantly high for the past decades 25 to only 24:1000 against national targets of reducing the neonatal mortality rate to less than 12 deaths per 1,000 live births and the under-5 mortality to less than 25 deaths per 1,000 live births by 2030. Contrary to long held assumption that mortality rates are higher among children in urban areas than among those in rural areas, urban areas recorded higher 49 against 41 deaths per 1,000 live births in rural areas. This is similar to findings from the 2010 TDHS and the 2015–16 TDHS-MIS.

Teenage pregnancy has remained high with observable burden shift from western and lake which has recorded significant decrease to South and Southern Highland zones. The age at which childbearing commences is an important determinant of the overall level of fertility, as well as the health of the mother and the child. Teenage pregnancy is a major health concern and has been associated with maternal and child morbidity and mortality. Additionally, childbearing during the teen years has adverse social and economic implications, particularly regarding educational attainment. Women who become mothers in their teens are more likely to drop out of school and affect potential Human Development Index and widen Gender Inequality gaps.

The high number of maternal and newborn deaths in some areas of the country reflects inequities and inequalities in access to quality health services and highlighting existing gap between rich and poor. Furthermore, Gender Inequality Index (GII) mirrors how health system is functioning and responding to women's health needs, aspiration and health outcomes and negatively affect Tanzania performance on Gender Inequality Index. During the Collaborative Advocacy Action Plan multi-stakeholder's workshop, it was apparent the issue of Quality of Care in line with the WHOs, especially on human resource competence, accountability and leadership remains the challenge for health system delivery of high quality of care.

It is clear that while great achievement on sharp decrease of maternal mortality however, the current pace of progress the urban will fall short of meeting the SDG-3. Clearly, different studies in Dar es Salaam and Mwanza reflects what is happening in other urban settings of the country and should be taken as a future picture of programming for the fast urbanizing Tanzania. For example, in Mwanza, Mwanza City accounted more than half of all maternal mortality. Recent MPDSR analysis showed majority of maternal and newborn death were city dwellers especially from among poor households. Tanzania is rapidly urbanizing. Taking the current demographic profiles and population growth rate pace, it is expected that Tanzania's population will be 50% urban by 2030 not far from now. Low status restricts women's and children opportunities and freedom, giving them less access to quality care.

Progress against WCAH Commitments in Tanzania

Maternal Health					
S/N	**Indicator/Domain**		**Target**	**Progress by 2022 / 2023**	**Global /Regional Commitment Body**
1.	Maternal Mortality Ratio	a.	Reduce global maternal mortality to less than 70 per 100,000 live births per year	The Maternal Mortality Rate (MMR) is reduced to 104 per 100,000 live births from 556 per 100,000 live births. (TDHS – MIS 2022). The improvement is also reported in the following ANC Visit: 65% women had recommended 4 or more Antenatal care (ANC) visit during pregnancy compared to 48% in 2025/26 Institutional deliveries: 81% of pregnant women deliver in health facilities (TDHS – MIS 2022) as compared to 65% (TDHS – MIS 2015/16) Skilled assistance during delivery: 85% of live births were attended by skilled health provider in 2022 TDHS – MIS compared to 66% in 2015/2016 TDHS – MIS. However, institutional delivery is lower in urban setting. For example, in Dar es Salaam M-MAMA: initiative offers affordable emergency transport services to connect mothers and newborns to vital life-saving healthcare facilities. It is Implemented in all councils Mama Samia Mentorship program: Cover all 26 regions of Tanzania.	Global Strategy for Women, Children and Adolescent Health 2016 – 2030) ICPD 25
		b.	Strengthening the availability of and access to EmONC facilities to provide quality services of emergency obstetric and newborn care from 28.5% to 80% for the Health Centres and from 50.2% to 100% for Hospitals by 2030	The government of Tanzania continue to build strategic CEmONC facilities aiming to reach each council hospitals and all referral hospitals. There are 525 CEmONC health centre facilities by March 2024 increase from 475 in the year 2023/2024 (MoH Budget speech 2024/2024)	ICPD 25
		c.	Ensuring the availability of and access to MNH commodities from 92% to 100% by 2030	The availability of MNH commodities has increased from 82.5% in 2021 to 88.2% in 2023 (eLMIS 2023)	ICPD 25
		d.	Reviewing and rolling out a competency-based curriculum for midwives by 2030.	Tanzania Nurse Midwifery Council (TNMC) has the mandate to review midwife's curriculum. Curriculum reviewed for mid-level training (Diploma level) done in 2022 which aim to equip hands-on knowledge to graduates. 2. The rolling out of the training to be implemented from 2024/2025 intakes	ICPD 25
		e..	Elimination Of Cervical Cancer as a public health problem 2020 – 2030: Vaccination: 90% of girls fully vaccinated with the HPV vaccine by the age of 15 Screening: 70% of women screened using a high-performance test by the age of 35 and again by the age of 45 Treatment: 90% of women with pre-cancer treated and 90% of women with invasive cancer managed	The progress is as follows: The Human Papilloma Virus (HPV) vaccination coverage reached 96% (IVD Afya campaign Data base 2024) The 76.3% of women screened using VIA in 2023. N.B: for Tanzania using Visual Inspection with Acetic Acid (VIA) (cervical cancer 2023 annual report & DHIS 2) Percentage of clients screened VIA+ and received treatment of cryotherapy in a same day is 72.1%, (cervical cancer 2023 annual report & DHIS 2). Percentage of all via positive clients treated (both cryotherapy and LEEP) is 75.6% (cervical cancer 2023 annual report & DHIS 2).	Global Strategy to Accelerate The Elimination of Cervical Cancer as a Public Health Problem and its Associated Goals and Targets for the period 2020–2030

Progress against WCAH Commitments in Tanzania

Neonatal Health					
S/N	**Indicator/Domain**		**Target**	**Progress by 2022 / 2023**	**Global /Regional Commitment Body**
1.	Neonatal mortality rate	a.	Reduce neonatal mortality to at least as low as 12 per 1,000 live births	There neonatal mortality rate is at 24 per 1000 live births and 18 stillbirths per 1,000 live births (TDHS – MIS 2022) from 25 per 1000 live births (TDHS – MIS 2015/16). • 70.2% of neonates were put on the breast within one hour after delivery • Exclusive breast feeding to children under six months increased from 59% in 2015-16 TDHS – MIS to 64% in 2022 TDHS - MIS The following activities efforts are in place to enhance the target achievement: • Neonatal care units (NCU) expand from 175 (2023) to 241 (June 2024). • 190 Hospitals and 100 Health Centres are providing NCU services (MoH Report on NCU assessment, 2023) Target by 2025 to have 300 NCU. • Facility capacity assessment and advocacy in establishing NCU – 36 NCU established on their available blocks in health facilities. • Capacity building: 1,500 HCWs from ten regions were capacitated on neonatal care in general. HCWs were from Zonal, Regional, District and Health Centre facilities. • Equipments: Neonatal care equipment purchased and distributed in 5 district hospitals of Kigoma (2) and Tabora (3). • Integration of neonatal interventions within RMNCAH interventions such as rehabilitations, comprehensive supportive supervision (Mama Samia Mentorship program) • National Neonatal Guideline review done • Community: Neonatal care is within the CHW training package. 160 CHWs trained in health education, referral and linkage. • The ministry expects to introduce the neonatal care registers (Neonatal HMIS Register) in 2024, which will collect information on neonatal care services and clients at the facility level	1.Global Strategy for Women, Children and Adolescent Health 2016 – 2030) 2. ICPD 25
Child Health					
S/N	**Indicator/Domain**		**Target**	**Progress by 2022 / 2023**	**Global /Regional Commitment Body**
1.	Under five mortality rate	a.	End preventable deaths children under 5 years of age, with all countries aiming to reduce under-5 mortality to at least as low as 25 per 1,000 live births.”	1. The child mortality rate reduced to 43 per 1000 live births in 2022 (TDHS – MIS) from 67 per 1000 live births in 2015-16 (TDHS-MIS). Other achievement include: • The prevalence of malnutrition among under-fives is reduced from 34 (2015-16 TDHS-MIS) to 30% (2022 TDHS – MIS) with the aim to reduce to below 20% by 2030. • The prevalence of wasting is reduced from 5 (2015-16 TDH-MIS) to 3.3% (2022 TDHS-MIS) • Obesity seems not to decrease it still stand at 4% (2015-16 and 2022 TDHS-MIS). • IMCI training to 4000 health care providers in 11 Regions. • Printing and distribution of child health booklets to 26 Regions.	Global Strategy for Women, Children and Adolescent Health 2016 – 2030) ICPD 25
		b.	Accelerating the integration of HIV and RH services to reduce burden of HIV to the population including reducing MTCT to <5% by 2030.	Mother to child transmission (MTCT) is reduced to 8.1 % (2022) from 16.2% (2015).	

			PMTCT		
	Pilar 1: Early testing and optimized comprehensive, high quality treatment and care for infants, children, and adolescents living with HIV to achieve universal coverage of ART and viral suppression	a.	Increase EID coverage for children aged 6-8 weeks from the current 82% to 95 %	The EID coverage among children aged 6-8 weeks is 80.3% by 2023	• Global Strategy for Women, Children and Adolescent Health 2016 – 2030) • ICPD 25 • GLOBAL ALLIANCE INITIATIVE TO END AIDS IN CHILDREN BY 2030
		b.	Increase 18-month confirmatory testing coverage for infants exposed to HIV from the current 43.8% to 95%	Coverage of 18-month confirmatory test for infants exposed to HIV is 47.7% by 2023	
		c.	Increase paediatric 0-14 coverage of 2nd and 3rd 95 (UNAIDS target) i.e., ART coverage from the current 60% to 95%, HVL coverage from 93% to 100%, HVL suppression from 87% to 95%	Pediatric ART coverage for children aged 0-14 years is 75%; HVL coverage in children aged 0-14 years is 90%, HVL suppression in children aged 0- 14 years is 95% by 2023	
	Pilar 2: Closing the treatment gap for pregnant and breastfeeding women living with HIV and optimizing continuity of treatment towards the goal of elimination of vertical transmission [ART for PBAW, and eMTCT]	d.	Maintain ART coverage among PBAW at 100%	The ART coverage among PBAW is maintained at 96.4% (DHIS2, 2024)	
		e.	Increase retention in care among PBAW from the current 92.5% to 95%	the retention in care for PBAW At 12 months is at 102.9%; and at 24 months is 70.1%	
		f.	Increase HVL coverage among PBAW from the current 79.2% to 95%	The HVL coverage among PBAW is 70%by 2023	
		g.	Increase HVL suppression PBAW from the current 58.4% to 95%	The HVL suppression among PBAW is at 96.8%	
	Pilar 3: Preventing new HIV infections among pregnant and breastfeeding adolescents and women [Prevention among PBAW]	a.	Increase HIV retesting coverage among PBAW from the current 31% to 95%	HIV retesting coverage among PBAW is at 50% (DHIS2 2023)	

	Pilar 4: Addressing rights, gender equality, and social/ structural barriers that hinder access [Enabling environment]	a.		Available enabling environment for addressing rights, gender, equality and social/structural barriers for the PMTCT programs such as National Multisectoral Strategic Framework for HIV 2021/22 – 2025/26 (NMSF V), USAID	GLOBAL ALLIANCE INITIATIVE TO END AIDS IN CHILDREN BY 2030
Adolescent Health					
S/N	**Indicator/Domain**		**Target**	**Progress by 2022 / 2023**	**Global /Regional Commitment Body**
1.	**Ensuring access for adolescents and youths to reproductive health information**	**a.**		• Youth Friendly reproductive health services centres increased from 901 (in 2023) to 1,111 centres (March 2024). • For 2023/2024 a total of 750 Health care providers from 9 regions were trained on implementation of youth friendly reproductive health services • For the year 2023/2024, 3 one-stop centres were established making a total of 29 centres.	• ICPD 25 • The UN convention on the elimination of all forms of Discrimination: CEDAW • CRC: Conventional on the right of the child • Maputo Plan of Action 2016-2030 • African Unity Charter on the Rights and Welfare of the Child: The African Charter on the Rights and Welfare of the Child (ACRWC/the Charter). • ECSA-Health Community: East Central and Southern Africa
2.	**Improve school health programs on age-appropriate reproductive health education**	**b.**	**Implementation of age-appropriate Comprehensive Reproductive Health Education and services to in- and out-of-school youths by 2030.**	• The school health program on age-appropriate reproductive health education and is provided in schools in collaboration with Ministry of educationby trained school health teachers who are trained. • Peer educator manual for adolescents who are in and out of school is developed and in use.	
3.	**Prevention of unintended and unwanted adolescent pregnancies**	**c.**	**Reduce teen pregnancies/adolescent birth rate from the current 123 per 1,000 women girls 15-19 years in 2022 to 61 per 1,000 women girls by 2030.**	The teen pregnancy is reduced to 112 per 1,000 women 15-19 (TDHS – MIS 2022) this stipulates the progress made in reducing teenage pregnancy from 27% (2015-16 TDHS – MIS) to 22% (2022 TDHS MIS)	
4.		**d.**	**Improve access and utilization of modern contraceptives among adolescents by building the capacity of more than 5000 health care providers on provision of adolescent-friendly gender responsive health services; and increasing the proportion of health facilities providing adolescent-friendly services from the current 69% (SARA Report 2020) to 80% by 2030.**	**3,025 health care providers capacitated to manage GBV/VAC cases through training and mentorship.**	**FP 2030**

Progress against WCAH Commitments in Tanzania

Family Planning					
S/N	**Indicator/Domain**		**Target**	**Progress by 2022 / 2023**	**Global /Regional Commitment Body**
2	Obj 2: By 2030, national gender-focused programs and organizations address gender and social norms impeding rights-based family planning services.	b.		• Development of National Framework for Delivery of Integrated Reproductive Health, HIV/AIDS and GBV in Higher and Tertiary Learning Institutions that will guide the provision of quality, friendly and integrated services in respective institutions. • Review of the national male engagement guidelines and framework. • Review of the GBV and VAC Job aids for HCPs to include PWD • Operationalization of Gender and respectful care guideline which among other it addresses gender and social norms. • Capacity building of Service Providers to manage GBV/VAC cases through training and mentorship of 3025 providers This is reported from IPs • Support establishment and functioning of 27 One Stop Centers for GBV including provision of EC to GBV survivors	ICPD 25 FP 2030 EWEC
3	By 2025, Tanzania's modern contraceptive prevalence rate (mCPR) for all women	c.	Modern contraceptive prevalence rate (mCPR) for all women increased from 27% (TDHS 2015/2016) to 42% (One Plan III)	The modern contraceptive prevalence rate (mCPR) for all women increased from 27% (2015-16TDHS – MIS) to 25.4% (TDHS – MIS 2022).	ICPD 25 FP 2030 EWEC
4	By 2030, Tanzania increases domestic resources to finance family planning commodities by at least 10% annually from the current annual allocation of 14 billion Tanzania shillings, and disburses fully	d.	Increase domestic FP commodity allocation by 10% annually from the current allocation of 14 billion by 2030	The Compact Agreement (CA) signed between UNFPA and Ministers of Health and Finance from Mainland Tanzania and Zanzibar in supporting the procurement of FP and life-serving commodities, the two governments disbursed the committed amount of US$26,714 as the 1% contribution to domestic funding of the allocated ceiling of US$2,671,400.	

Progress against WCAH Commitments in Tanzania

Cross Cutting					
S/N	**Indicator/Domain**		**Target**	**Progress by 2022 / 2023**	**Global /Regional Commitment Body**
1	**GBV**				
	Enhance mitigation of sexual and gender-based violence through establishment of more one stop centres and review of marriage act.	**a.**		For the year 2023/2024, 3 one-stop centres were established making a total of 29 centres (MoH 2024/2025 budget speech) 1. Increase collaboration with different stakeholders to mitigate sexual and gender-based violence and violence against adolescents and young people through preparation and review of policies, guidelines and laws and implementation, (National Anti-FGM Strategy (2021-2024)) 2. Promote gender equality by addressing harmful practices, such as child marriage and female genital mutilation, and by empowering women and girls to make their own decisions regarding their bodies and lives.	ICPD 2025. Global Strategy for Women, Children and Adolescent Health 2016 – 2030) FP 2030 Maputo Plan of Action 2016-2030
		b.		**Mariage Act: on going effort for amendment of the law.** **However: the government continue efforts on protecting girl child who is at school by:** • Enforcement of a law: if when a child/teenage at school is pregnant the responsible person is imprisoned for not less than 30 years. • The government is implementing universal basic education for all for primary and secondary education which also protect the girl child.	
2	**Universal Health Coverage**				
	Improve budget allocation and health insurance coverage to improve well-being of the people	**a.**	**Countries increase their health budget to at least 15% of the state's annual budget**	• The budget allocation for health is increased from 14.6% (2019/20) to 14.9% (2021/22) (VNR 2023) • Universal health insurance bill is passed in the parliament and commence for implementation 1st July 2024. The operationalization of UHC in Tanzania is highlighted by the passing and implementation of the Universal Health Insurance Bill, which marks a significant step towards achieving health coverage for all Tanzanians. • The current national health insurance coverage is at 8% of the total population covering 4,987,292 people (VNR 2023).	ICPD 25, Abuja Declaration (2001)

Tanzania Collaborative Advocacy Action Plan

Activity	Decision-Makers	Influencers	Coordinating partner	Contributing Organization(s)	Non-financial Resources	Timeline/ Milestones	Linked accountability mechanisms, as applicable
Advocacy Goal 1: The Ministry of health improves availability of competent midwifery workforce in high mortality geographical areas and facilities to at least 60% of the HRH establishment guideline by 2030	**MPDSR report of 2024 showed that 80% of maternal death was due to inadequate skills among health care providers There is critical shortage of providers for anaesthesia and neonatal care Average total gap of human resource for health is 66%**						
Activity #1 : Deployment of human resource for health basing on workload indicators of staffing need (WISN).	MOH -DHR and PORALG-Health	DRMNCAH	BMF	POPSMGG MOF POIP CHA I AMREF JMKF World Bank Global Fund	Coordination Cost, MoH	June 2025	Capacity building on WISN Annual WISN report Deployment report
Activity #2: Advocate for fast tracking of the operationalization of Higher Diploma training program in midwifery, neonatology, theatre management and anesthesia alongside recognition of scheme of work.	MOH- DHR	DRMNCAH TAMA TNMC MCT PAT A GOTA SATA	CHAI	Health training institutions	Coordination , MoH	December 2025	Technical meeting reports Curriculum for higher diploma developed

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Activity	Decision-Makers	Influencers	Coordinating partner	Contributing Organization(s)	Non-financial Resources	Timeline/ Milestones	Linked accountability mechanisms, as applicable
Activity #3: Design and accredit special training programs for neonatal care for clinicians and nurses	MOH-DHR	DRMNCAH DCS D NMS TNMC MCT PAT TAMA AGOT A SATA	UNFPA	NACTE PORALG POPSMGG WHO AMREF BMF JMKF		December 2025	Designed and accredited Curriculum in place
Activity #4: Offer scholarships for mid-level healthcare providers undergoing training on in demand cadres (anesthesia, theatre management, neonatology and midwifery) to encourage more healthcare providers to enroll	MOH - DHR	DRMNCAH DCS D NMS TNMC MCT PAT TAMA AGOT A SATA	UNFPA	PORALG WHO AMREF BMF JMKF WB		December 2026	Advocacy meeting report Scholarship programs in place
Activity #5: Scheme of service to recognize and reward all healthcare providers who have undergo additional training for specific skills(Neonatologists and Noenatal/Paediatric Nurses, Anaesthestits etc)	MOH - DAHRAM	DRMNCAH DCS D NMS TNMC MCT PAT TAMA AGOT A SATA	POPSMGG	PORALG WHO AMREF BMF JMKF WB		June 2026	Revised scheme of service operationalized

Tanzania Collaborative Advocacy Action Plan

Activity	Decision-Makers	Influencers	Coordinating partner	Contributing Organization(s)	Non-financial Resources	Timeline/ Milestones	Linked accountability mechanisms, as applicable
Activity #6: Review and develop a comprehensive multi-cadre implementation of retention guideline for hard-to-reach areas and service delivery points	MOH –DAHRAM	DRMNCAH DCS D NMS TNMC MCT PAT MAT TAMA A GOTA SATA	BMF	PORALG WHO AMREF JMK F WB		December 2025	Revised retention guideline operational
Activity #7: Involve cooperate and development partners to recruit midwifery workforce to a high mortality geographical area	MOH –Minister	DRMNCAH DNMS	AMREF	PORALG JMKF BMF TPSF V ODACOM Foundation Tanzania Editors Forum Development partners group-health APHTA	Coordination MoH	June 2026	Fund raising event conducted
Activity #8: High level advocacy meeting with stakeholders for recruitment of human resource for RMNCAH	MOH –Minister	DRMNCAH DNMS	BMF	PORALG JMKF AMREF TPSF VODACOM Foundation Tanzania Editors Forum Development partners group-health		December 2026	Advocacy meeting conducted

Tanzania Collaborative Advocacy Action Plan

Activity	Decision-Makers	Influencers	Coordinating partner	Contributing Organization(s)	Non-financial Resources	Timeline/ Milestones	Linked accountability mechanisms, as applicable
Activity #9: Ministry of health to review the leadership guideline to address rotation of nurses in relations to experiences and expertise	MOH –DRMNCAH	DAHRAM DCS DNMS TNMC MCT PAT MAT TAMA AGOTA SATA	BMF	PORALG WHO AMREF JMKF WB APHTA		December 2026	Reviewed leadership guideline in place
Activity #10: Strengthening skills in pre-service training for clinical and nursing/midwifery cadres at mid-level, and graduate	MOH - DAHRAM	DRMNCAH DCS DNMS TNMC MCT PAT TAMA AGOTA SATA	UNFPA	PORALG WHO AMREF BMF JMKF WB Health Training Institutions APHTA		December 2026	Pre-service training assessment reports
Activity #11: Senior practitioners in facilities at all levels to design and implement training/mentorship programs for healthcare workers to strengthen their clinical skills including the establishment of learning corners for providers to conduct regular facility based high frequency, low-dose simulation-based skills training on management of obstetric, surgical, anesthesia and neonatal complications and emergencies.	MoH - DRMNCAH	DCS DNMS TNMC MCT PAT TAMA AGOTA SATA	AGOTA TAMA	PORALG WHO AMREF BMF JMKF WB Health Training Institutions APHTA		December 2027	Mentorship plans developed Learning and simulation corners established

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Activity	Decision-Makers	Influencers	Coordinating partner	Contributing Organization(s)	Non-financial Resources	Timeline/ Milestones	Linked accountability mechanisms, as applicable
Advocacy Goal 2: The ministry of health improves the availability of neonatal care facilities, equipment, supplies and competent neonatal health care workers to contribute to the reduction of the neonatal mortality rate to at least less than 12 per 1000 live births by 2030	Rationale: • Persistent high neonatal mortality rate, which has remained stagnant for nearly two decades with absolute numbers on the increase • Neonatal period (one month) currently contributes to the 56% of the National Under-five mortality burden • The President of the URT, Hon. Samia Suluhu Hassan has urged the Ministry of Health and PORALG to ensure establishment of neonatal care units in all hospitals to accelerate country's gains towards SDG targets						
Activity #1 : Advocate for fast tracking of the operationalization of Higher Diploma training program neonatology alongside recognition of scheme of work.	MOH - DHR	DRMCH	UNFPA	PO-LARG PO-PSMGG MCT TNMC AGOT A TAMA SATA TANNA AMR EF BMF		December 2027	Number of courses established Number of Advocacy meeting
Activity #2 To design and implement training/mentorship programs for healthcare workers to strengthen their clinical skills including the establishment of learning corners for providers to conduct regular facility based high frequency, low-dose simulation-based skills training on management of neonatal complications and emergencies.	MOH - DHR	DRMCH	UNFPA	IPs		December 2027	Number of mentors identified and mentorship conducted.

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Activity	Decision-Makers	Influencers	Coordinating partner	Contributing Organization(s)	Non-financial Resources	Timeline/ Milestones	Linked accountability mechanisms, as applicable
Activity #3: Construction or refurbishment of neonatal care units in hospitals and Health centres as National Guidelines	MOH PO - RALG	DRMCH		NEST 360, HYDOM, GIZ		December 2028	Number of NICU constructed and refurbished
Activity #4: Advocate and follow-up with TMDA, MSD and facility in-charges to ensure in-country registration, reliable supply, ordering and use of cPAP machines, transfer coats, oxygen cylinder, caffeine citrate, surfactant and neonatal fluids	MOH PO - RALG	Permanent Secretary DRMCH	CHAI			December 2027	Number of commodities registered
Activity #5: Strengthening of mentorship, clinical attachment and on-job training	MOH PO - RALG	DRMCH	USAID AFYA YANGU	Other IPs		December 2027	Number of mentorship, clinical attachment and On Job trainings conducted

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Activity	Decision-Makers	Influencers	Coordinating partner	Contributing Organization(s)	Non-financial Resources	Timeline/ Milestones	Linked accountability mechanisms, as applicable
Activity #6: Implement Guidelines for timely and appropriate referral of newborns to higher level facilities for definitive care.	MOH PO - RALG	DRMCH	USAID AFYA YANGU	Other IPs		December 2028	Guidelines reviewed or developed and in use
Advocacy Goal 3: The Ministry of health strengthens youth SRH education, access to adolescents and youth-friendly health services, and community engagement to reduce the teenage pregnancy rates to less than 12% by 2030.	Rationale Slow reduction of teenage pregnancy from 27% (TDHS2015) to 22% (TDHS 2022) Low utilization of family planning (18%) among adolescent's target 2O%						
Activity #1: Ensure availability of adolescents and youth-friendly services and youth corners for the provision of reproductive health services among adolescents and youth.	MOH PO - RALG	DRMCH	GLOBAL FUND	Other IPS		December 2028	YFS and Youth Corners are established

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Activity	Decision-Makers	Influencers	Coordinating partner	Contributing Organization(s)	Non-financial Resources	Timeline/ Milestones	Linked accountability mechanisms, as applicable
Activity #2: Adopt and scale-up high impact innovative models to improve access to SRH information and services (Weekend Clinics, Human-Centred Design events)	MOH PO - RALG	DRMCH, PO-RALG - Health	DSW	Marie Stopes,			Number of SRH innovative models
Activity #3: Community engagement: conduct community awareness through outreach service, media, and village health days on the availability and utilization of youth-friendly services in HFs	MOH	DRMCH, PO-RALG – Health,	USAID	PO-RALG – Health, MoH-Health Promotion, DRMNCH, AMREF		December 2027	Number of community engagement events
Activity #4: SRH Education: training of teachers and peer educators on how to deliver comprehensive sexuality education to in-school and out-of-school adolescents.	MOH	DRMCH, PO-RALG – Health, PMO, MoE		PO-RALG- Health, MoE, Ministry of Culture, Arts&Sports		December 2027	Umber of teachers of teachers and peer educators trained

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Activity	Decision-Makers	Influencers	Coordinating partner	Contributing Organization(s)	Non-financial Resources	Timeline/ Milestones	Linked accountability mechanisms, as applicable
Activity #5: Youth economic empowerment: advocate for strengthening life skills subjects in primary schools to address adolescent health and well-being and soft skills for empowerment in collaboration with the Ministry of Education.	MOH	DRMCH, PO-RALG, Ministry of Community, Development, Gender, Women and Special Groups		Plan International, Pathfinder, DSW and DREAM, PACT		December 2028	Groups of youth economic empowerment formed, adolescent dropouts and number of adolescent enrolments in schools
Activity #6: Advocate with the Ministries for Education and Community Development to strength vocational education and training (VETA), Folk Development Colleges (FDC) and Post Primary Training Centers (PPTC) soft skills programs in partnership with private centers	MOH and MINISTRY OF EDUCATION	DRMCH, PO-RALG, Ministry of Community, Development, Gender, Women and Special Groups	NACTVET	Plan International, Pathfinder, DSW and DREAM, PACT		December 2028	Number of Adolescent enrolled in vocational training
Activity #7:Review and update NAIA_AHW and advocate for public budget across all relevant sectors and levels to support implementation	MOH	PMO, DRMCH, PO-RALG, Ministry of Community, Development, Gender, Women and Special Groups	UNFPA, GAC	IPs and Others		December 2025	Updated NAIA_AHW document

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Activity	Decision-Makers	Influencers	Coordinating partner	Contributing Organization(s)	Non-financial Resources	Timeline/ Milestones	Linked accountability mechanisms, as applicable
Advocacy Goal 4: The Ministry of Finance increases health budget allocation to 15% and ensure universal health insurance to cover maternal, neonatal, under 5 child health services by 2030	Inadequate funding in health sector below 15% as per Abuja declaration RMNCAH services are more affected by limited funding National Health Policy (2007) stipulates that maternal, neonatal and under-five children services are to provide free with the state covering the costs Tanzania enacted the landmark and historical National Universal Health Insurance act(2023)						
Activity #1: Advocate on operationalization of new Health insurance Act to ensure health insurance coverage of maternal, neonatal and child health services.	MoH - DPP	DRMNCAH DCS D NMS TNMC MCT PAT TAMA AGOT A SATA	UNFPA	PORALG WHO AMREF BMF JMKF WB Health Training Institutions APHTA		June 2025	Insurance packages covering maternal, neonatal and child health services in place
Activity #2: Track at MoF, MoH and councils to ensure sufficient and timely disbursement of health sector budget for RMNCAH services	MoF - DPP	DRMNCAH MoH-DPP PORALG - Health	CHAI	BMF JMKF DSW SIKIKA		Annually	Annual MoH budget analysis reports Annual CCHPs Analysis Reports

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Activity	Decision-Makers	Influencers	Coordinating partner	Contributing Organization(s)	Non-financial Resources	Timeline/ Milestones	Linked accountability mechanisms, as applicable
Activity #3: Operationalization of essential RMNCAH interventions guideline at CCHPs level	PORALG - Health	DRMNCAH	TMEPiD	BMF JMKF DSW SIKIKA MST		Annually	Guideline dissemination report
Activity #4: MoH, PORALG and councils to allocate adequate budget for maternal and neonatal referrals including availability of functional well-equipped ambulances and payment of m-mama community drivers.	MoF - DPP	DRMNCAH	CHAI	BMF JMKF DSW SIKIKA Pathfinder International		Annually	RMNCAH Budget reports M-mama reports
Activity #5: Allocation and timely disbursement of adequate budgets for procurement of essential and life-saving reproductive, maternal, neonatal and reproductive health care commodities.	MoF - DPP	DRMNCAH	UNFPA	BMF JMKF DSW SIKIKA Pathfinder International MST		Annually	Annual MoH budget allocation and expenditure analysis reports
Activity #6: Advocate to MoF and MoH honor and comply to Compact Agreement entered for family planning and other reproductive health commodities.	MoF - DPP	UNFPA	DRMNCAH	MST Engender Health AMREF USAID WHO		Annually	Annual SRAT tool Assessment Reports

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Activity	Decision-Makers	Influencers	Coordinating partner	Contributing Organization(s)	Non-financial Resources	Timeline/ Milestones	Linked accountability mechanisms, as applicable
Advocacy Goal 5: The Ministry of health to improve quality of emergency obstetric care through strengthening service delivery systems and capacity building prioritizing high maternal mortality geographical areas and facilities to reduce country maternal mortality ratio to less than 70 per 100,000 live births by 2030	Rationale: Maternal mortality has declined by 80% in Tanzania, thanks to massively improved access to CEmONC to majority of the populations Nonetheless, routine MPDSR data estimates more than 1500 hundred women dying annually, with the burden of mortality distributed unequally, more deaths happening in tertiary hospitals in urban settings, especially at night, on weekends and holidays Improving the current situation requires scaling-up of high impact interventions to improve both access and quality of EmONC services in high burden geographical areas and facilities while embarking on quality improvement initiatives such as clinical audits and MPDSR						
Activity #1: Secondary and tertiary facilities to build work friendly relationship with lower-level facilities and routinely offer mentorship to ensure standardize quality of services.	MOH	DRMCH	JHPIEGO	EH		December 2028	RMNCAH TWG
Activity #2: Referral protocols should be followed for all referred patients.	MOH	DRMCH	Pathfinder	Vodaphone Foundation		December 2027	M-mama steering committee
Activity #3: Supervise and mentor on implementation of quality assurance processes in facilities including MPDSR and clinical audit	MOH	DRMCH/DNMS	JHPIEGO	Professional associations (AGOTA, TAMA, SATA)		December 2028	RMNCAH TWG
Activity #4: Develop, disseminate and ensure use updated guidelines and SOP for PPH and anesthesia	MOH	Professional associations	JHPEIGO	Professional associations		June 2026	SMI TWG

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Activity	Decision-Makers	Influencers	Coordinating partner	Contributing Organization(s)	Non-financial Resources	Timeline/ Milestones	Linked accountability mechanisms, as applicable
Activity #5: Finalise, disseminate, supervise and mentor providers and use of recent versions of EmONC Job Aids and Learning Resources Packages that have included the EMOTIVE bundle.	MOH	DRMCH	JHPIGO	Professional associations		June 2026	SMI TWG
Activity #6: Revise management guidelines (National, Regional and Council) to capture anesthesia practitioners to strengthen supervision of anesthesia practice	MOH/PORALG(Health)	Professional associations (SATA)	SATA(Professional association)	JHPIEGO		June 2026	RMNCHAH TWG
Activity #7: Advocate to MoH, PORALG and professional associations to conduct regular targeted supervision, mentorship and clinical attachment on safe surgery and anesthesia including theatre management and management of anesthesia complications.	MOH	Professional associations	JHPEIGO	Professional associations		December 2027	
Activity #8: Advocate for availability and use of lifesaving commodities e.g. anaesthesia machine, balloon tamponade, Heat-stable carbetoxin, Tranexamic acid, anti-shocks garments and parenteral iron.	MSD/TMDA	DRMCH	R4D	JHPIEGO		December 2027	Quantification meetings

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Activity	Decision-Makers	Influencers	Coordinating partner	Contributing Organization(s)	Non-financial Resources	Timeline/ Milestones	Linked accountability mechanisms, as applicable
Activity #9: Advocate for collection, testing, distribution and use of safe blood and blood products (platelets, FFP)	NTBTS	DRMCH	JHPIEGO			June 2028	RMNCAH TWG
Activity #10: Advocate for constant availability of competent healthcare throughout the time (24/7) to ensure timely availability of services especially in the weekends, holidays and nights	MOH/PORLAG	DRHRD-MOH	JHPIEGO	BMF		December 2027	RMNCAH TWG
Activity #11: Advocate for establishment of accreditation mechanisms of new CEmONC health facilities (that includes an independent multidisciplinary technical team of experts) before commencement of services	MOH/PORALG	MOH-DRMCH PORALG-DHNSW	JHPIEGO	Professional associations		April 2028	RMNCAH TWG

ANNEX 1: WHAT IS A QUALITY COMMITMENT?

Commitments should be of the highest quality, including as many as possible of the following attributes:

Scope

- Government-led financial, policy and/or service delivery pledge to advance WCAH through MNCH, SRHR and/or AHWB. Commitments may be supported by Official Development Assistance (ODA);
- Commitments are made in support of national campaign targets as well as global or regional financing, policy, programmatic, or accountability processes and platforms generated by Member State-led institutions or initiatives in support of these processes;
- A specific focus on WCAH, and a subsequent link to the national social development plans, policies, and budgets.

Context and format

- Context-specific, highlighting concrete and measurable results that can be monitored through established institutionalized accountability mechanisms;
- SMART – Specific, Measurable, Achievable, Relevant, Time-bound;
- 'New' or 'Additional' commitments, where possible;

An example of a quality commitment is:

F*inancing commitment made by Secretariat of State for Planning and Regional Integration, Guinea Bissau towards ICPD25:*

Mobilize at least $1,000,000 through domestic and foreign funding mechanisms for implementation of the ICPD Programme of Action in Guinea-Bissau, especially ICPD interventions related to young people, by 2024.

ANNEX 2: MNCH, SRHR, AND AHWB SUB DOMAINS

MNCH	SRHR	AHWB
High-quality MNCH services for mothers, newborns and children, including stillbirths: essential antenatal, childbirth and postnatal packages of care, including emergency obstetric and newborn care, and the prevention of stillbirths. Maternal: • Preconception care • Antenatal care • Skilled birth attendants • Postnatal care • Emergency obstetric care Newborn • Small and vulnerable newborn care • Prevention of stillbirths Child: • Child health services including • Breastfeeding and child nutrition • Immunization services MNCH interventions embedded in UHC schemes, including financial protection and MNCH financing. • UHC Schemes • Country health expenditure per capita on MNCH financed from domestic sources and ODA for MNCH • Out-of-pocket expenditure for MNCH services (% of current health expenditure) Health systems strengthening including MNCH data and accountability, human resources for health – especially midwifery and nursing – and essential medicines and commodities • MNCH information systems and accountability mechanisms including birth registration and disaggregation of data (sex, age)	Access and choice to effective contraception methods (family planning). • Family planning needs satisfied • Strengthened autonomy and access to contraceptive services • Comprehensive sexual health education Access to safe and legal abortion services. • Legalized abortion and access to safe abortion services Prevention and treatment/referrals for Sexual and Gender-Based Violence. • Legal mechanisms for addressing GBV • Training and support for health workers on GBV • Violence against women and girls including intimate partner violence Prevention, detection and management of reproductive cancers, especially cervical cancer. • Cervical cancer screening programs • HPV vaccine programs Inclusion of essential packages of SRHR interventions within UHC and PHC schemes, including financial protection and SRHR financing. • Coverage of all essential SRH interventions • Country health expenditure per capita on SRHR financed from domestic sources and ODA for SRHR • Out-of-pocket expenditure for SRHR services (% of current health expenditure	Policy: National policy and programs for adolescent well-being (10-19 years) offering information and services in the public sector (e.g., health, education including CSE, nutrition, financial protection, and vocational training) • Health education for children and adolescents – including mental health • Provision of quality education and training opportunities to ensure their future employability • Nutrition programs and physical activity for children and adolescents • Pregnant adolescent support • Financial protection for adolescent health National standards for delivery of AHWB information and services to adolescents, including on user fee exemption • Health services for adolescents – user fee exemptions for health services (contraceptives, immunizations) Legal systems to protect the rights of adolescents (both female and male) with a specific focus on minimum age of consent (e.g. for marriage, sexual activity, and medical treatment without parental consent) • Legal provisions against child marriage • Interventions to eliminate female genital mutilation • protection from violence (including physical, sexual, gender-based and electronic violence) and injury.

• Training and support for health workers for service delivery • Essential medicines, vaccines, commodities, technologies and innovations • Health information systems • Health system financing • Leadership and governance Intersectoral approaches for MNCH across the life-course, including nutrition, WASH, environment, and gender equality • Nutrition schemes and food security across the life course: pregnancy nutrition, breastfeeding support, child nutrition, adolescent nutrition • Financing for WCAH • Education • Shelter • WASH facilities and services • Protection from pollutants and toxicants and excessive heat • Social protection • Child Protection • Women in the workforce and leadership positions		AHWB is embedded in national policies and plans with dedicated financing for AHWB programs • Country health expenditure per capita AHWB financed from domestic sources and ODA for AHWB • Out-of-pocket expenditure for AHWB services (% of current health expenditure)

ANNEX 3: LIST OF ORGANIZATIONS INVOLVED AND/OR CONSULTED IN THE DEVELOPMENT OF CAAP

Government

- Ministry of Health (MoH)
- National Reproductive Maternal Newborn Child and Adolescent Health (RMNCAH) Technical Working Group (TWG) of the Sector Wide Approach (SWAp)
- President's Office, Regional Administration and Local Government Tanzania (PO-RALG)

International Development Partners

- Aga Khan Foundation
- Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)
- Henry M. Jackson Foundation Medical Research International (HJFMRI)
- Jhpiego
- KfW Development Bank
- Pepal
- The Korea Foundation for International Healthcare (KOFIH)
- UN Women
- UN World Food Programme (WFP)
- United Nations Children's Fund (UNICEF)
- United Nations Population Fund (UNFPA)

Non-Governmental Organizations

- Amref Health Africa in Tanzania
- Call Africa Organization
- Centre for Counselling, Nutrition and Health Care (COUNSENUTH)
- Chama cha Uzazi na Malezi Bora Tanzania (UMATI)
- Clinton Health Access Initiative (CHAI)
- Deustsche Stiftung Weltbevolkerung (DSW)
- Doctor with Africa CUAMM
- Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)
- EngenderHealth
- EpiC Tanzania
- Hope Centre for Children, Girls and Women in Tanzania (HCCGWT)
- Kitovu cha Maendeleo Safi (KIMAS)
- Management and Development for Health (MDH)
- Marie Stopes
- National Council of People Living with HIV in Tanzania (NACOPHA)
- Pathfinder International
- Plan International

- Plan International
- Save the Children
- SOS Children Village Tanzania
- Tanzania Health Promotion Support (THPS)
- Tanzania Home Economics Association (TAHEA)
- Thamini Uhai
- The Partnership for Nutrition in Tanzania (PANITA)
- World Vision Tanzania
- Youth Education through Sports-Tanzania (YES-TZ)

Private Sector

- Deloitte
- PharmAccess

Faith-based Organizations

- Anglican Church Tunduru Dioces
- Christian Social Services Commision (CSSC)
- Dodoma Christian Medical Centre Trust
- Evangelical Lutheran Church in Tanzania (KKKT)
- Haydom Lutheran Hospitals

ANNEX 4: TANZANIA COMMITMENT ON WCAH

1	Sustainable Development Goals (SDGs) related to reproductive, maternal, newborn, child, and adolescent health (RMNCAH).	The Millennium Development Goals (MDGs) have officially expired this year and a new era in development with a new set of Sustainable Development Goals (SDGs) was launched in New York from 25 – 27 September at the 'United Nations summit for the adoption of the post-2015 development agenda' ***"This is the future we want for humanity and for our planet." – Jakaya M. Kikwete*** H.E. Dr. Jakaya M. Kikwete, President of the United Republic of Tanzania, reiterated his and Tanzania's commitment to the Sustainable Development Goals by joining the High-Level Group. ***"Tanzania stands ready and pledges its unwavering commitment to fully support the Sustainable Development Goals and its implementation. We will do everything in our power to play our part accordingly… For sure, no-one will be left behind" – Jakaya M. Kikwete*** Tanzania's commitments include: • Strong political will: Tanzania has a strong political will to implement the SDGs. Integrated planning: Tanzania is implementing the SDGs within the framework of its five-year development plans. • Supportive legal frameworks: Tanzania has supportive legal frameworks to implement the SDGs. • Capacity building: Tanzania is building capacity in resource mobilization, data management, and technological capability. • Partnerships: Tanzania is working with partners to implement the SDGs. • Regional and district strategic plans: The President's Office Regional Administration and Local Government (PORALG) has initiated regional and district strategic plans to supplement the Five-Year Development Plan II.
2	The country is guided by the Global Strategy for Women's, Children's, and Adolescents' Health (2016-2030) and One Plan III to ensure that no one is left behind in reaching the SDGs by 2030.	**One Plan III**
3	These commitments include initiatives like Family Planning 2030 (FP 2030),	• Increase access and utilization of modern contraceptives among adolescents from 13 % (TDHS 2015) to 20% (HSSP V) by 2025. • By 2030, national gender-focused programs and organizations address gender and social norms impeding rights-based family planning services. • By 2025, Tanzania's modern contraceptive prevalence rate (mCPR) for all women increased from 27% (TDHS 2015/2016) to 42% (One Plan III). • By 2030, the Government of Tanzania increases domestic resources to finance family planning commodities by at least 10% annually from the current annual allocation of 14 billion Tanzania shillings, and disburses fully.

4	The International Conference on Population Nairobi Summit (ICPD 25), Commitments	**Accelerating to ICPD Promise:** 1. Accelerating implementation and funding of the ICPD Programme of Action: I. Sustained political will among leaders at all levels to accelerate the implementation of the Tanzania Development Vision 2025. ii. An increase by 10% of the proportion of youths in the decision-making bodies by 2030. 2. Enhancing efforts towards achieving the goal of zero preventable maternal deaths, and maternal morbidities, , through integrating a comprehensive approach of the essential sexual and reproductive health packages: i. Strengthening the availability of and access to EmONC facilities to provide quality services of emergency obstetric and newborn care from 28.5% to 80% for the Health Centres and from 50.2% to 100% for Hospitals by 2030. ii. Ensuring the availability of and access to MNH commodities from 92% to 100% by 2030. iii. Reviewing and rolling out a competency-based curriculum for midwives by 2030. iv. Accelerating the integration of HIV and RH services to reduce burden of HIV to the population including reducing MTCT to <5% by 2030. 3.Enhancing efforts towards achieving the goal of zero unmet needs for family planning information and services, and universal availability of quality, affordable and safe modern contraceptives: i. Increasing mCPR form 32%-54% by 2030. 4.Ensuring access for adolescents and youths to reproductive health information: i. Implementation of age-appropriate Comprehensive Reproductive Health Education and services to in- and out-of-school youths by 2030 5.Enhance mitigation of sexual and gender-based violence through establishment of more one stop centres and review of marriage act. 6. Improve budget allocation and health insurance coverage to improve well-being of the people. 7. Harnessing demographic dividend by investing in adolescent and youth in health, education, life skills and employment. **Budgetary and financial** I. Increase national budget allocation for health to meet the Abuja declaration target of 15% from the current base of 8.9% by 2030. ii. Increase health insurance enrollment to cover more population with one of the existing health insurance Value: Generally will improve health outcome with good coverage, access and equity with no one left behind. **Change or creation of legislation** **To Review the Marriage Act and key legal and institutional frameworks by 2025 in order to address gender inequality.** **Policy and guidance** *1. Sustained political will among leaders at all levels to accelerate the implementation of the Tanzania Development Vision 2025.* *2. Increase by 10% of the proportion of youths in the decision-making bodies such as the Parliament, as well as Region* ***Programmatic action*** *1. Improve availability of youth friendly services.* *2. Improve school health programs on age appropriate reproductive health education.* *3. Increase CPR from 32% to 54%, EmONC services by 2030.* *4. Industry sector contribute by 40% of GDP by 2025.*
5	The UN convention on the elimination of all forms of Discrimination (CEDAW);	The United Republic of Tanzania has committed to addressing gender and racial imbalances by 2025. Tanzania's commitment includes: Ensuring that economic activities are not identifiable by gender or race Addressing social relations and processes that breed inequality in all aspects of society
6	Conventional on the right of the child (CRC);	

7	**Maputo Plan of Action 2016-2030; African Unity Charter on the Rights and Welfare of the Child;**	**Tanzania ratified the Maputo Protocol on 3 March 2007 with no reservations.33 There is no specific law in Tanzania that clarifies the procedure for ratification of international instruments**
8	**The African Charter on the Rights and Welfare of the Child (ACRWC/the Charter);**	Tanzania ratified the African Charter on the Rights and Welfare of the Child (ACRWC) in March 2003. Tanzania has submitted reports to the African Committee of Experts on the implementation of the charter, which outline the measures taken to ensure the charter's provisions are met. These reports are based on guidelines from the African Committee of Experts and the UN Convention on the Rights of the Child
9	**East Central and Southern Africa-Health Community (ECSA, Every Woman Every Child (EWEC) Global Strategy for Women's Children's and Adolescents' Health (2016-2030), Global Strategy to Accelerate**	Framework translated into One Plan III: Survival; ending all maternal Child and Adolescents preventable death Thrive Transformation
10	**The Elimination of Cervical Cancer as a Public Health Problem and its Associated Goals and Targets for the period 2020–2030; and**	
11	**Global Alliance Initiative to End AIDS in Children by 2030.**	Tanzania is committed to the Global Alliance to end AIDS in children by 2030, and has made several commitments to the cause: **Signing the Dar es Salaam Declaration** Tanzania signed the Dar es Salaam Declaration **for Action to End AIDS in Children on February 1, 2023**. The declaration includes commitments to: • End stigma, discrimination, and gender inequities • Work with communities to prevent gender-based violence • Have dedicated budgets for ending AIDS in children • Partner with people with HIV and communities • Share progress and learning for joint accountability **Setting goals** Tanzania has a goal to eradicate AIDS in children to less than four percent by 2025. **Increasing access to treatment** Tanzania is committed to ensuring that all children with HIV have access to life-saving treatment. **Finding and caring for children living with HIV** Tanzania is committed to finding and caring for infants and children living with HIV. **Increasing financial investment** Tanzania is committed to increasing financial investment from local resources. **Increasing community involvement** Tanzania is committed to increasing the involvement of communities to improve access to new technologies The Global Alliance to end AIDS in children was launched in July 2022 at the AIDS conference in Montreal, Canada. The alliance is a collaboration between UNAIDS, UNICEF, WHO, PEPFAR, and The Global Fund.

12	**The national development and health policies, such as Tanzania Vision 2025 and HSSP V 2021-2025, also reflect these commitments.**	The Tanzania Development Vision 2020-2025 emphasizes the need to improve the quality of reproductive health services and aims for a three-quarters reduction in maternal and infant mortality. The third the Five-Year Development Plan (2021-2025) focuses on improving quality of life and human well-being by strengthening health systems. Furthermore, the Health Sector Strategic Plan V (HSSP V, 2021-2026) outlines strategies and interventions for both facility and community settings to increase the availability, access, and utilization of quality Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) services.

This CAAP plan was developed in November 2024 and reflects priorities and activities identified at that time with present partners. It is a living document and will be updated regularly. The implementation of the CAAP is at the discretion of partners and we invite you to join efforts to achieve the collectively identified advocacy goals by collaborating on the listed and additional activities.

For further exchanges on CAAP implementation, MSP membership and PMNCH country partners, please go to Tanznaia Country Digital Advocacy Hub. Share your interest in joining the CAAP initiative with pmnch@who.int

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