9/1/2017

Tanzania and the Sustainable Development Goals:

Has Tanzania prepared to roll-out and domesticate the health SDGs?

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2. Background

The Sustainable Development Goals – hereby SDGs – are an extension to the previous global Millennium Development Goals (2000-2015). The SDGs constitute a post-2015 development agenda with a vision for equity, sustainability, peace and security, and the elimination of poverty. The SDGs come with a number of similarities and differences. Seventeen goals are defined which are universal, applying to high, middle and low-income countries (see Table X in the Appendix). The SDGs are interconnected and encourage a multi-sectorial perspective for improving the lives of future generations; partnerships are thus central to achieving the SDGs. An official list of indicators has been created to monitor progress in implementing the SDGs, with United Nations Development Programme (UNDP) the key international body guiding implementation (see Table X in the Appendix). Furthermore, a number of international forums, and meetings, have been established to domesticate and raise awareness on the SDGs, for example: Data4SDGs: http://www.data4sdgs.org/.

However, this report focuses on Tanzania. When discussing the SDGs in the context of Africa a number of factors need to be taken into account. Agenda 2063: The Africa We Want, created in 2013, defines the continents development declaration. Agenda 2063 defines 20 goals, 256 targets and 231 indicators, specifically contextualised for Africa and its vision for an integrated, prosperous and peaceful continent. With this, there is convergence between the SDGs and Agenda 2063. Visions of social development; inclusive economic prosperity; peaceful societies and institutions; and sustainable environments, are reflected in both (Cassaza, 2015). Divergences emerge with the exclusion of sustainable consumption, production and management of ecosystems in Agenda 2063, and its inclusion of specific cultural targets and security agendas (ibid.). Tanzania has ratified both the SDGs 2030 and longer term, Agenda 2063; alongside regional development plans, such as the South African Development Community (SADC) Regional Indicative Strategic Development Plan (2005-2020). The concern is how effectively has the nation 'domesticated' the agenda(s); and what are the future plans to integrate the SDGs, as well as Agenda 2063, into national plans, policies and practice? Kida (2017) identifies three key needs for Tanzania to effectively implement the SDGs by 2030: (i) effective participation of local government authorities (LGAs) and stakeholders to define how SDGs should be adapted in Tanzania; (ii) increased, and innovative, financing to support the agenda, and (iii) adequate resources for developing a statistical system to monitor and evaluate progress. This report builds on such discussions.

The African Centre for Global Health and Social Transformation (ACHEST) was formed as a Think-Tank with the objective of creating ownership over the solutions identified, and implemented, in Africa. In 2015, ACHEST formed a key member which aimed to understand, and motivate, the role Health Policy Think Tanks (HP-TT) play in LMICs to ensure the achievement of SDGs. This scoping study was set up by ACHEST and the Think Tank Initiative, to form a regional consultation on the status of Think Tanks support to achieving the SDGs. The focus is on support provided within the 'first 1,000 days' of implementation following the SDG finalisation, and beyond. Much discussion is taking place on the role of Think Tanks, research organisations, and academic institutions, in implementing Agenda 2063 in Africa and the SDGs (i.e. 3rd Africa Think Tank Summit, 2016).

Following this regional consultation, ACHEST arranged consultants in seven African countries to conduct scoping studies to understand national-level institutional arrangements for implementing, and monitoring, the SDGs. This scoping study focuses on the case of Tanzania. Scoping studies will also be conducted in Uganda, Kenya, Ethiopia, Zambia, Zimbabwe and Rwanda. The findings from each of the scoping studies will provide information for guiding the Think Health Initiative and potential programs aimed at SDGs. The study objectives for the scoping studies are explained further in *Section 4: Study Objectives*. The study objectives are integrated within a broader vision.

This report introduces the case of Tanzania and the domestication of the SDGs. The following section provides an overview of the national context, in relation to the SDG's. Following that the study objectives and methodology used are explained. Findings of the literature review are presented. Key informant interviews were held to clarify some of this information and fill necessary information gaps. Finally, the discussion and conclusion raise key points and ways forward as Tanzania prepares to domesticate the SDGs.

3. National context about SDGs

Tanzania has made significant changes over the past century: poverty rates have been reduced; economic growth has been documented; and progress made in terms of building an educated, and skilled labour force, through various programs. However, in 2017 Tanzania was rated third 'unhappiest' country (out of 155) in the world (Moller et al, 2017). The report suggested there to be a 'happiness' deficit as a result of poor governance, dissatisfaction with democracy, poverty, lack of investment in infrastructure, and a neglect for the needs of Africa's 'future generation' – the youth bulge (ibid). Such findings need to be heavily criticised and taken lightly; however, they form part of the discussion on the changing economic, social, and political development Tanzania is undergoing. Table 1 shows some of key indicators and contextual features for Tanzania.

Tanzania's population continues to grow – and is urbanising. Access to public services has improved as shown in increased basic education enrolment, longer life expectancies, and access to safe WASH facilities. However, public debt remains high, and estimations suggest risks to fiscal stability need to be carefully acted on. No districts currently have disaster risk reduction strategies or climate change strategies in place; and trade to GDP is calculated below 50%. Innovations and governance changes are being implemented to increase domestic resource mobilisation and secure the means to achieve Tanzania's Vision 2025. The key policies in place, and linked to mainstreaming the SDG agenda, are discussed in *Section 6.*1. However, the current context identifies the need for a realistic approach on how to plan, budget, and ultimately achieve, such goals.

Table 1: Summary key indicators for Tanzania, in relation to sustainable development challenges and implications in Mainland Tanzania.

Sustainable Development Challenge	**Data**	**Comments**
Economic Sustainability		
Poverty	28.2%	
Unemployment	10.3%	There is also a highly informal economy
Inequality (national)	0.34	
Economic growth	7%	Control inflation, strengthen productive capacity and markets, resilience to external shocks, etc
Trade to GDP	48.6%	
Public debt	39%	Percent of GDP
Social Sustainability		
Population growth (p.a)	2.7	Expected to reach 100mn by 2040
Burden of Disease (BoD)		13 essential services identified by using BoD approach
Health expenditure	7%	Per capita, % of GDP
Health insurance		<10% (2015/16)
Primary school enrolment	93.3	Enrolment has increased as a result of fee-free basic education and the national (basic) education PforR
Secondary school enrolment	41.7	"
Social security coverage	34.7	20% are receiving financial transfers (private and social protection prog.)
Gender inequality	41%	Proportion of women holding senior positions in decision-making (Government)
Environmental Sustainability		
Water access	71%	Of the population have access to safe water
Sanitation access	88.3%	Of the population are able to access sanitation.
Air pollution	--	
Climate change	0%	Districts don't have climate change/ disaster risk reduction strategies
Land: degradation and deforestation	--	
Natural resource		Oil, minerals (tanzanite, gold, and diamonds), are some.
Electricity production	1501	Electrical power generation in MW
Internet	22%	Population using internet
Urbanisation	29.1%	Half population expected to live in urban areas by 2050
Governance context, and challenges, for achieving sustainable development		

- 27 administrative regions, 133 districts, 162 LGAs (2017). With the decentralisation by devolution (D-by-D) policy these have key administrative and implementation roles/responsibilities for public service delivery, monitoring, and implementation.
- Policy mainstreaming of SDGs and Agenda 2063:
    1. Tanzania Development Vision 2025: integrated in all policies and plans
    2. Long-Term Plan (2011-2026): is to be implemented through Five Year Development Plans. The most current Five Year Development Plan (FYDP (2016-2021)) aims for industrial growth and human development.
    3. National Strategies for Growth and Reduction of Poverty (NSGRP I (2005/6 – 2009/10), II (2010/11-2014/15)): shorter-term plans that are integrated into the FYDP and using the same planning framework; and thus key for SDG planning.
    4. Sector Strategic Plans are created for each sector: i.e. Health Sector Strategic Plan (HSSP);
    5. Tanzania's policy and planning process requires the integration of community voices through the opportunities and obstacles to development (O&OD) planning and active LGA planning.

Reference: HBS, 2012; UNDP, 2014; URT, 2016

4. Study Objectives

The overall concern is 'how prepared is Tanzania to roll-out and domesticate the health SDGs?' The concern is focusing on the modes, methods, and tools, for domesticating the health SDGs in the seven respective country case studies. For this scoping study three key objectives emerge:

1. Establish to what extent have the SDG been introduced, adopted in national health, and health-related, sector plans?
2. Determine to what extent have the interdisciplinary nature of SDGs been inclusive and cross-cutting?
3. Articulate to what extent are the common national and sectoral reporting frameworks been adopted?

This requires scoping to understand the context of SDGs nationally, and within specific sectors. The contextual concern is on **preparedness**, **integration**, and **integration across sectors**. Preparedness may be defined as: a) institutional bodies, arrangements and structures; b) resource allocation and budgeting; c) planning processes; d) the inclusivity of multiple partners; and e) the definition of a national roadmap to implement SDGs. The focus on integration is identifying the extent of integration across plans, budgets and policies; and the methods of doing so.

5. Methodology

The methodology used in this report incorporated two key steps: 1) desk (literature) review; and 2) consultations for verifications. In stage one, two consultants worked on reviewing key literature sources on SDGs, national policy discussions and the dialogue around the post-2015 agenda and domestication of SDGs. This stage was conducted over the period of one month. Key words were selected to focus the literature search and filter key documents for review. However, the search focused on discussions beyond 'health' to understand the extent to which domestication was cross-cutting, and/or inter-sectoral. Within this report a focus is placed on two cases of SDG domestication: nutrition and urbanisation through healthy cities, to show progress made, methods used and key challenges, of domesticating the SDG goal (health and related).

Following this, a short series of key informant consultations were conducted with crucial stakeholders driving the domestication. Consultations were conducted with Dr. Blandina Kilama, of REPOA and Dr. Anna Nswilla, of President's Office-Regional Administration and Local Government; with written feedback from Dr. Tausi Kida and Dr. Danford Sanga, of Economic and Social Research Fund; Dr. Eveline Geubbels of Ifakara Health Institute; Dr. Oberlin Kisanga, of Ministry of Health, Community Development, Gender, Elderly and Children. The stakeholders were identified due to their knowledge, and experience, of the political discussions on *how* to domesticate SDGs; whether domesticating the SDGs was *relevant*; the monitoring systems *in place* and data quality; and the interlinks made to, and with, the health sector. We thank the key informants consulted for their viewpoints shared. This report is aiming to provide a foundation for further discussion on the SDG movement.

6. Findings: Domesticating the SDGs in Tanzania

6.1. Step One: Vision and the Post-2015 SDG Agenda in Tanzania

The MDGs were embedded in Tanzania's national Poverty Monitoring System (Mashindano, 2014). This enabled progress towards achievements to be monitored. Table 2 provides a summary of the progress made towards MDGs. The Table indicates where implementation challenges have been faced: meeting poverty reduction targets, ensuring improved access to water and sanitation and reducing maternal health risks.

Table 2: MDG achievement progress for Mainland Tanzania.

MDG	Indicator	Target 2015	End Achievement
1	Population below $1 PPP, national income poverty line	19.5	
	Population below $1 PPP, national food poverty line	10.8	
	Under 5 underweight (%)	14.4	
	Under 5 stunted	23.3	
2	Net enrolment ratio in primary education	100	
	Gross enrolment ratio in primary education	100	
3	Ratio of girls-boys in primary	100	
	Ratio of girls-boys in secondary	100	
	Ratio of females-males in tertiary	100	
	Proportion of women MP members	100 (50%)	
4	Under 5 mortality rate	64	
	Infant mortality rate	38	
	Proportion of children vaccinated against measles	90	
5	Maternal mortality rate	133	
	Proportion of births attended by skilled health personnel	90	
6	HIV prevalence, 15-24yrs	<6	
	HIV prevalence, 15-49yrs	<5.5	
7	Population using improved drinking water source (rural)	74	
	Population using improved drinking water source (urban)	84	
	Access to improved sanitation (rural/urban)		
8			

Reference: URT, 2014. N.B. National evaluations have only been conducted in 2008 and 2010.
Key: red = not achievable; orange = probable achievement; green = achievable.

With such evidence, Tanzania has led post-MDG discussions and consultations as the post-2015 agenda was to be defined. The key questions were: a) what has been achieved, and b) what do people and national stakeholders, including the Government, the private sector, the research community and the civil society, identify as priorities for moving forward? National consultations were organised between 2012-2013 to review the MDG achievements and identify an agenda for moving forward (Government of United Republic of Tanzania ((URT), 2015a; UNDP, 2015; URT, 2013a). Firstly, consultations were held in seven zones of the country, covering all regions, and inviting civil society organisations (CSOs), LGAs and vulnerable groups, such as women, the elderly, children and youth to share their views on the MDGs and key issues to be prioritised. Further, citizens' suggestions for the post-2015 agenda were invited through social media campaigns; newspapers, TV and radio. Secondly, technical consultations were held with stakeholders from the private, public, and academic, sectors. Finally, national-level consultations were held to validate findings of the MDG progress made. The national consultations on the post-2015 agenda were to ensure the future global framework was to receive inputs from the voices of vulnerable groups; additionally, the consultations were to inform Tanzania's long, and mid-term, development plans and strategies (UNDP, 2015; URT, 2013a). A key lesson learned from the MDG was the inadequacy in localising and domesticating Tanzania's MDGs. The consultations identified 10 goals to be prioritised for Tanzania, to be aligned with the global agenda that was forming (see Table 2 in the Appendix). Such consultations: the identification of priorities and areas requiring further investment or strengthening – such as engagement with the private sector – marked Tanzania's transition towards a post-2015 agenda.

Within the development of the post-2015 agenda and national consultations coordinated, it is important to note Tanzania's Development Vision (TDV), that had been recognised within a number of key principles. A clear alignment is found with TDV 2025. TDV 2025 is based on achieving three objectives: "high quality livelihood for its people; attain good governance through the rule of law; and develop a strong and competitive economy" (URT, 1995:11). The TDV identifies Tanzania's objective to becoming a middle-income country; and ensuring all citizens are able to live a 'high-quality' life defined by food security, universal education and health care, equality, an absence of poverty and reduced burden of disease. The TDV strategises' the need for soft skills – a change in mind-set and investment in education, as well as systemic change – with the pre-requisites of governance strengthening and economic resilience identified. The TDV progress was to be monitored every five years, through the Five Year Development Plans (FYDP) (URT, 2011; 2016). This has been particularly key in localising the post-2015 agenda, and subsequent SDGs, as the SDGs are integrated into the development plans and planning framework. Furthermore, address key aspects of the Health Sector Strategic Plan (HSSP) IV whereby intra-sectoral collaboration, universal health coverage and the development of a minimum benefit package are prioritised (URT, 2017).

6.2. Step Two: Global SDGs

In 2015, the global SDGs (17), and indicators (169) were defined (see Appendix Table 1). The 17 goals are shown in Table 3 and compared to the Africa continent Agenda 2063. The global goals were defined through the involvement of stakeholders from all countries, including Tanzania. Aspirations for human development; economic development; environmental sustainability, and good governance can all be identified. However, with the dissemination of such goals new questions were raised in Tanzania: a) are the goals relevant; b) how can they be integrated into national planning and implementation systems; c) how prepared are we: to finance, implement and monitor these goals, and d) what needs to be done? The direction is described below.

In order to achieve the health SDG (3), the following actions were identified by the UN: 1) an increase in health sector spending in national budget by 3%; 2) increase enrolment in health training institutions by 5,000 and number of graduates; 3) improve recruitment, deployment and retention of health workforce, particularly maternal and child health; 4) continue to implement steps for ensuring universal health care – improving access, pre-payment schemes, referral systems, and free services (UN Partnership for SDGs, 2017). When talking about the 'health and health-related' SDGs reference is made to Goal 2, 3, 6, 9, 11, 12, 14, and 16 (see UNDAP, 2016).

Table 3: Sustainable Development Goals and Agenda 2063 tables.

	Sustainable Development Goals	**Aspiration**	**Agenda 2063**	**Aspiration**
1	End Poverty	HD	High standard of living, quality of life and wellbeing for all citizens	HD, ED
2	Zero Hunger	HD, ED	Well-educated citizens and skills	HD
3	Good Health and Wellbeing	HD	Healthy and well-nourished citizens	HD, ED
4	Quality Education	HD	Transformed economies	ED
5	Gender Equality	HD	Modern agriculture for increased productivity and production	ED
6	Clean Water and Sanitation	ES	Blue/ocean economy for accelerated economic growth	ES
7	Affordable and Clean Energy	ES	Environmentally sustainable and climate resilient economies/ communities	ES
8	Decent Work and Economic Growth	HD	A United Africa (Federal/ Confederate)	GG
9	Industry, Innovation and Infrastructure	ED	Continental financial and monetary institutions established/ functional	GG, ED
10	Reduced Inequalities	HD, ED	World class infrastructure across Africa	ED
11	Sustainable Cities and Communities	HD, ES, ED	Democratic values, practices, principles of human rights, justice and rule of law	GG
12	Responsible Consumption and	HD	Capable institutions and	GG

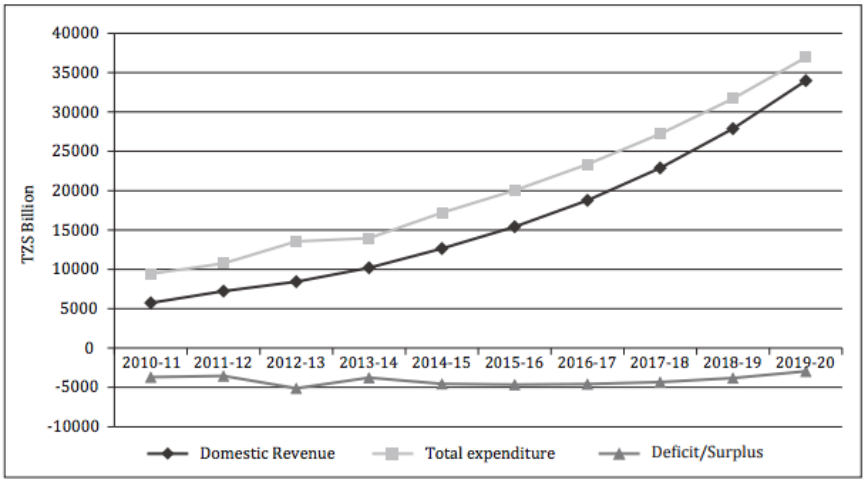
	Production		transformative leadership	
13	Climate Action	ES	Peace, security and stability is preserved	GG
14	Life below Water	ES	Stable and peaceful Africa	GG
15	Life on Land	HD, ES	A fully functional and operational APSA	GG
16	Peace, Justice and Strong Institutions	GG	African cultural renaissance	HD
17	Partnerships for the Goals	GG	Full gender equality in all life-spheres	HD
18			Engaged and empowered youth/children	HD
19			Africa being a major partner in global affairs and peaceful co-existence	GG
20			Africa takes responsibility for financing her development goals	ED

Key: HD = Human Development and Culture (yellow); ES = Environmental Sustainability (green); GG = Good Governance, Rights and Political Unity (pink); ED = Economic Development and Industrialisation (blue).
Reference: UNDP, 2015; AU, 2015.

6.2. Step Three: Moving SDGs towards implementation

This section describes the domestication of SDGs through from policy recognition and discussion, to planning and coordination. At a national level, SDG integration relies heavily on the FYDP II: its implementation, objectives and direction. The current FYDP II (2016-2021) focuses on industrialisation and human development, identifying interventions to achieve such priorities (URT, 2016a). The cost of implementing FYDP II, is 107trillion Tsh (59tr Tsh to be contributed from the public sector and 48tr Tsh from the private sector[1]). Thus the Government is allocating a maximum of 40% of the budget to support development activities. In addition, a financing strategy is identified to mobilise projected resources. Domestic resources will be mobilised through increasing tax revenue ratio to GDP from 13% (2014-15) to 15.9% (2020); this will be achieved through improving the efficiency of tax collections – reducing leakages, strengthening institutional capacities, and expanding the tax base. Furthermore, non-tax revenue collection – from rents, property tax, investment funds, enterprises, and natural resources; domestic revenue production and partnerships with non-government entities, will be enhanced. Funds are to be mobilised and pubic finance systems strengthened (URT, 2016). Such strategies need to be implemented for the SDGs to be realised. Figure 1-2 shows both the financial resource gap in Tanzania and thus required growth trajectory in a context of increasing debt and uncertain business environment; it also shows the breakdown of costing per sector in the 5YDP. By 2020 the aim is to achieve a real GDP growth rate of 10% (URT, 2016a). As Figure 2 shows the health sub-sector was calculated to have the highest cost.

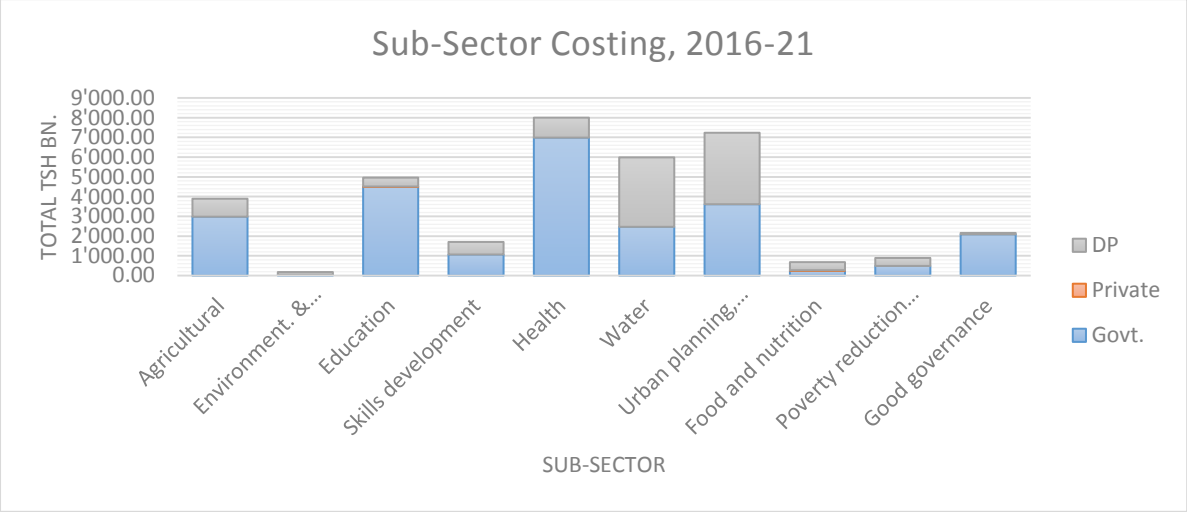
Figure 1: Financial resource gap in Tanzania: 2010/11 to 2019/20.



Reference: URT, 2016a. See Mashindano and Baregu, 2016:12.

[1] Approximately: US $48mn 0 (US $26mn for public sector and US $21mn), as per September 2017 exchange rate.

Figure 2: Costing for specific sub-sectors in the 5YDP, Tsh Bn. total over the five-year period 2016-2021.



Reference: URT, 2016a.

The FYDP II identifies implementation strategies to be incorporated across Ministry of Finance and Planning (MoFP), Sectors, Regional Secretariat (RS) and LGA, private sector, academia, research, and financial institutions, with challenges for implementation identified (URT, 2016a). Challenges for implementation identify the risks posed by corruption, inadequate resource mobilisation, policy-planning incoherence and lack of prioritisation, inadequate decentralisation and LGAs not being able to fully implement and/or monitor the plan. Proposed solutions and reforms to tackle these challenges are shown in Table 4. Annual Development Plans and Budgets are to be made. Implementation is to be led, and monitored by, a FYDP II Delivery Unit (in MoFP); the unit will follow the coordinating approach used by Big-Results-Now[2]. The FYDP II identifies alignment to the SDGs, particularly in Goals 1, 2, 3, 4, 5 (social development); 6, 7, 9 (utility supplies and industrialisation); and goal 17 (strengthening implementation and partnerships). The FYDP II states SDG implementation will be operationalised through the Local Economic Development Approach[3]. The MoFP will be responsible for mobilising government funds and innovative financing; coordinating, and establishing, stakeholders; and providing guidelines to MDAs/LGAs. MoFP thus is key for planning and financing SDGs. See Figure 3 for the 'in policy' management and coordination structure for SDG implementation in Tanzania. The coordination structure described is planned, and tentative, further evaluation is required to see how it being implemented.

Table 4: Reforms to resolve implementation challenges for FYDP II.

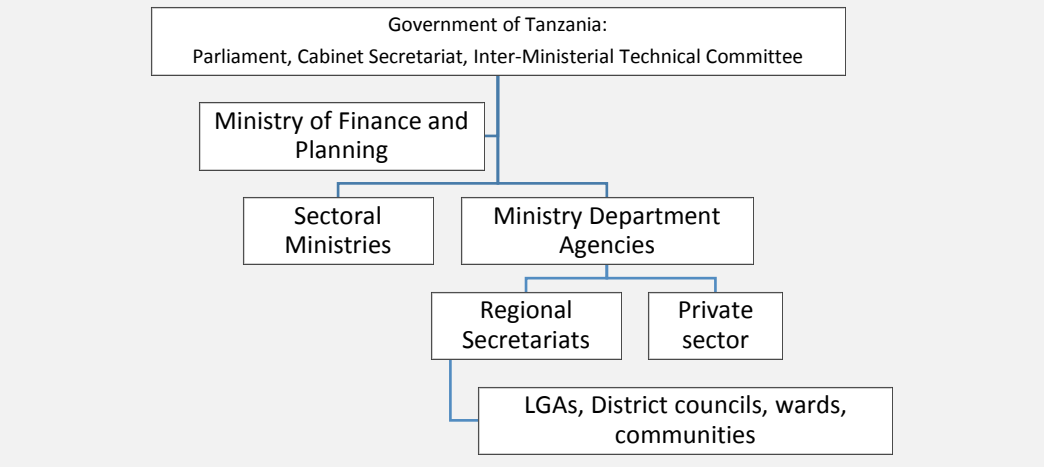
Reform	**Actions**
Eradicate Corruption; promote strong leadership and governance	Zero tolerance to corruption; improve decision-making and leadership to implement, ensure a pro-business environment, support investment and the specific flagship projects (governance). Government reforms such as increased transparency, rule of law, democracy and participation
Implementation Culture	FYDP II Delivery Unit, based in MoFP. Policy and Planning depts., in each MDA responsible to link
Land administration reforms	Formalisation of ownership and land accessibility to promote industrialisation; increasing non-tax property/land revenue collection; reviewing and updating the Village Land Act No.4 and Land Act No.5
Formalisation of economy	National identification system introduced; links to land use plans; business registration database

[2] The Big-Results-Now (BRN) is a national programme in Tanzania's public sectors. The focus in the health sector is on human resources for health and mother and neonatal child health (URT, 2017a). The programme aims for improved performance.
[3] The Government was to come up with a plan for implementing the SDGs through the Local Economic Development Approach, however, the status of this was not certain (ESRF KI, 2017).

Strengthen Local Economic Development	Build LGA capacities in procurement/tendering to favour small/emerging business; marketing opportunities; local partnerships, business clusters; building communities capacity to solve problems

Reference: URT, 2016a.

Figure 3: Coordination and management of SDG implementation in Tanzania.



Reference: Mashindano and Baregu, 2016.

Additionally, in terms of coordination, the UN supports the implementation of SDGs for Tanzania through the UNDAP II (United Nations Development Assistance Plan II). A Mainstreaming, Acceleration and Policy Support (MAPS) implementation strategy has been formed to: 1) assist Tanzania in incorporating the SDGs into national plans, budgets and policies i.e. NSGRP (MKUKUTA) and translating this to LGA level priorities; 2) introduce a MDG Acceleration Framework, such as Tanzania Social Action Fund (TASAF) and Tanzania Productive Social Safety Net (PSSN) for MDG 1 *(see Section 7.1)*; and 3) providing policy assistance for the SDG implementation to run alongside Tanzania's five year plans. Through the MAPS implementation strategy synthesis was emphasised to the FYDP II. The UN Interagency Expert Group on SDG Indicators is responsible for creating a global indicator framework, that can be universally used by countries to track progress and achievements. The defined indicators for SDG 3 on health are shown in Appendix Table 1-2. Interlinked indicators from other goals are also key to monitor, for example particularly SDG 1,2,4,5, and 10, due to emphasise on equality, financial security and access to safe environments and services related to health. No evidence was found on whether the indicators (see Table 7) are being used nationally, or have been adapted from the IAEG-SDG recommendations.

However, planning in Tanzania remains decentralised. National plans – such as FYDP II, are reflected in council and district plans by the Local Government Authorities, regional bodies, and communities, where priorities can be shared. The principles, and Tanzania's development vision, are required to be reflected in all plans, budgets, and reports, produced. Key limitations however emerge: 1) how *much* the community level is empowered, capacitated, and involved, in the process; 2) how much are LGAs empowered and adequately financed to incorporate such elements; and 3) are LGAs able to create evidence-based plans (data availability and of quality) and are they able to realise these?

Taking this development in mind, Table 5 provides a summary of the key stakeholders within the SDG implementable: the roles and responsibilities are explored in more depth in forthcoming sections.

Table 5: Summary of the key stakeholders for post-2015 agenda in Tanzania

Sector	**Stakeholder (state/ non-state)**	**Role of Stakeholder**
Government	**Ministry of Finance and Planning (MoFP)** President's Office Planning Commission Relevant sectoral ministries: i.e. MoHCDGEC, MoICAS, MoNRT, MoLHHS, MoAFC, MoT, MoJCA, MoFAIC, PO-RALG, MoEST,	Planning with Sector Plans Coordination Financing Implementation Awareness raising Open Data Initiatives, Data

	Poverty Eradication Department	Awareness raising among Govt. and LGAs
	National Bureau of Statistics (NBS)	Coordinator of official statistics Awareness raising
	Tanzania Open Data Taskforce	Communication Strategy for Open Data Initiative
	Local Government Authorities, Regions, Districts	
Partnerships	Interim Joint Steering Committee (Govt., CSOs, Private, Development Partners (DPs), Research Institutions; Technical Working Groups)	
	Thematic (Sector) Working Groups: i.e. Poverty Monitoring Group, Nutrition, Gender Macro Working Group, Open Data Taskforce, Health	
DPs/ Bilateral aid organisations	United Nations (UNDP; UN-Women; IAEG-SDG Indicators); FAO; Global Partnership for Sustainable Development Data; World Bank; MCC-PEPFAR; PARIS21	Different roles, including implementation, policy design, Open Data Initiatives
CSO/ NGOs	CIVICUS African Philanthropic Foundation SIKIKA, Haki Elimu, Twaweza**,** Tanzania Gender Network Programme, Data Vision	Data sharing opportunities; and commissioned gender data. Conducted CSO mapping; data CSOs collecting data
Think-Tanks	REPOA dLab ESRF Ifakara Health Institute	Key partners in discussing domestication of indicators. CSO Census completed; and consultations for post-2015.
Research/ Academia	Higher Education Institutes	Invited to post-2015 consultations.
Private	Private sector	Invited to post-2015 consultations.

Reference: Authors own.
Abbreviations: Ministry of Finance and Planning (MoFP); Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC), Ministry of Information, Communication, Arts and Sport (MoICAS), Ministry of Natural Resources (MoNRT), Ministry of Lands, Housing and Human Settlement (MoLHHS), Ministry of Agriculture, Food Security and Co-operatives (MoAFC), Ministry of Transport (MoT), (MoJCA), Ministry of Foreign Affairs and East African Cooperation (MoFAIC), President's Office – Regional Administration and Local Government (PO-RALG), Ministry of Education Science and Technology (MoEST).

6.4. Step Four: Data and the Role of Think Tanks in Tanzania's SDGs

Think Tanks, and Research Institutes, have played a key role in SDG domestication, particularly through data. Three key roles are found: data evaluation and assessments; data creation or production; and capacity building for monitoring progress. Some of the Think Tanks specialise in the health sector.

6.4.1. SDG Data Roadmap: Assessment

A key pathway for Tanzania domesticating the SDGs has been through data, evaluating and establishing effective data systems to monitor progress towards the SDGs. In 2014, REPOA led discussions on testing post-2015 datasets. The objectives were to evaluate the SDG goals in Tanzania's context and the resources available to monitor progress made (Kilama et al, 2016; post-2015 dataset, 2014). The Post-2015 goals were praised, particularly the emphasis on science, technology, innovation as well as research and development; however, challenges were identified in the timing by which the targets would be achieved. Additionally, external shocks, such as climate change and economic resilience, were identified as risks. Targets aiming for 'total elimination', for example of hunger, were criticised as impractical considering the financial and human resources available. Tanzania has a different baseline and a limited set of resources to implement the targets.

With discussions on the post-2015 agenda, criticisms have been raised on the data: availability and consistency. Data indicators on governance, accountability and environment are not available, or scarce (Kilama et al, 2016; see NBS, 2017). This presents a challenge as it is recognised over half of the SDGs, and Agenda 2063, require environmental statistics to compile the indicator (NBS, 2017). Datasets are not always

comparable, with methodologies not being standardised (for example poverty data from Household Budget Survey (HBS) Vs. National Panel Survey by National Bureau of Statistics (NBS)). The lack of comparativeness also comes with the infrequent nature of data collection. Finally, data is not disaggregated: whether down to districts, through locations, or based on gender. This limitation is crucial, with Tanzania operating through a system of decentralisation-by-devolution (D-by-D) whereby district levels are critical for sustainable implementation. Some of these data gaps, and necessary requirements, are being filled through the work of CSOs – for example Twaweza's citizen's surveys; and health-specific data such as the Health Demographic Surveillance Sites hosted by IHI. Such data is based on a foundational idea of the SDGs: reaching the most vulnerable and getting the perspective, or experiences, of such population groups, to effectively achieve (equitable) development for all. Such datasets are discussed further in *Section 6.5*. However, although these larger-scale datasets capture and focus on citizens, they are not always nationally representative or reflect the regional divergences and similarities. Additionally, what emerges is the lack of presence of larger-scale health datasets such as IHI's HDSS and SAVVY – which have the potential to measure a number of the indicators in Table 7 – raising a question of why they are not included in the discussions?

A number of national initiative are being pushed to support a data revolution and access to information, of which the SDG push for improved data complements well (Kilama et al, 2016). However, effort still needs to be made on how to build capacity of 'data producers' and ensure statistics are of quality, disaggregated for use-value, and consistent. Taking into account limited resources, what factors are used to prioritise resource allocation in the goals? However, the report (ibid.) highlighted which data sources could be used, and strengthened, for SDG domestication in Tanzania (see Table 6: n.b. these need to validated by further KI with key personnel working on Open Data and in NBS. Table 3 (Appendix) shows data available and to be collected for monitoring progress on the SDGs; and the data quality. Key 'relevant' datasets to include are the follow: Household Budget Survey (HBS), Basic Education Statistics (BEST), Population and Housing Census (PHC), Integrated Labour Force Survey (ILFS), Employment and Earnings Survey (EES), Tanzania Demographic Health Survey (TDHS), FinScope Tanzania Survey, and National Panel Survey (ibid.).

Table 6: Post-2015 indicators for Tanzania.

SDG goal	**Post-2015 dataset and indicators**
End Poverty	Household Income Poverty and Inequality: Household Budget Survey; food sufficiency; meals per day; income/consumption, MPI
Quality education for all	Basic Education Statistics in Tanzania; TVET/Skills
Jobs, sustainable livelihoods and inclusive growth for all	Productive employment; employment conditions; CCT eligibility; access to financial services and basic infrastructure; child labour
Ensure energy and develop infrastructure	Energy: sources, consumption, production, clean and renewable; ICT; transport
Establish a sustainable, health and resilient environment for all	Publish environment, social and economic accounts; regulations and plans; environmental assessments; ecosystem biodiversity
Establish open, accountable, inclusive and effective institutions, role of law and a peaceful/ inclusive society	Social groups, freedom to discuss and join political part; outstanding court cases, number of attorneys; and newborns registered at birth
Establish a Global Partnership	Non-performing loans in banking systems; banking standards; banking transparency; imports-exports
Ensure access to quality health care	Data on influences for universal health care

Reference: Kilama and Mushi, 2016.

In 2015, Tanzania conducted its first workshop on the localisation of SDGs. In August 2016, the first SDG Data Roadmap Workshop was conducted – defining the data roadmap for monitoring progress, aligning national and global SDG goals, and localising the SDGs into the 5YDP. The workshop was jointly initiated by NBS, Global Partnership for Sustainable Development Data (GPSDD), the World Bank, and MCC[4]-Pepfar. The key concern was how to domesticate the SDGs and establish a baseline of data available and its gaps. An Interim Joint Steering Committee – composed of government members, CSO, the private sector, development partners and

[4] Millennium Challenge Corporation.

research institutions, was formed following the workshop to assist NBS in implementing recommendations raised[5]. Exact members are not stated.

6.4.2. SDG Data Roadmap: Training and Capacity-Building

Several of the recommendations emphasised in the 2015 Data Roadmap Workshop emphasised the need for internal capacity building and strengthening institutional capacities. Data working groups and committees were required; but also data capacities needed to be build, data in Tanzania required appropriate visualisation, and the data needed to be made available and transparent. Think Tanks have played a key role in this.

dLab (Tanzania Data Lab) is a Think Tank, and collaborative space, working with data from multiple-sectors for improved decision-making and policy. Focus areas include health; economic growth; transparency and accountability, and gender equality. In order to assist the Government in synthesising the SDG indicators with FYDP II, dLab collaborated with NBS and PARIS21 to conduct a data gap assessment training (December 2016) (NBS, 2017). ADAPT (Advanced Data Planning Tool) was used to assess the key data gaps, and strategise a national development strategy by identifying the required indicators; methodological changes needed; and technical and financial resources required to produce the necessary data. Members from NBS, Planning Commission, MoFP (Zanzibar and Tanzania) attended. The results were to build current data infrastructure (i.e. Tanzania Open Data Portal; the Open Government Partnership; and proposed National Reporting Platform). The results were also to feed into the Tanzania Statistical Master Plan (2009-2014): coordinating data infrastructures, strengthening the National Statistics System through creating standards, and providing the right environment for data production and dissemination (URT, 2010a). However, training on SDG monitoring was also provided by UNCTAD (UN Conference on Trade and Development) in July 2017 (UNCTAD, 2017). It remains unclear whether the training invited the same participants, or incorporated the same training on how to coordinate national monitoring and align the national data systems with the global SDGs, as those trained by UNCTAD.

Secondly, dLab is a key stakeholder working to build the health (indicator) data visualisation dashboard for SDG: working together with NBS (dLab, 2017). The prototype health dashboard has not been made public.

Economic and Social Research Fund (ESRF) has also played a key role – zonal workshops on post-2015 agenda but also ESRF coordinated four workshops on implementation challenges for SDG. Through the workshops, jointly organised by MoFP and Poverty Eradication Division, the following frameworks were discussed (1) research; (2) localisation to integrate SDGs agenda into LGA plans; (3) communication and dissemination; and (4) M&E, of the SDGs (Kida and Mushi, 2016). Awareness raising workshops to LGAs were also organised. This is also seen in the dissemination of updates on SDG workshops and meetings through blogs, You Tube videos, and more, thus inviting a wider (connected) audience to connect with the discussions.

6.4.3. SDG Data Roadmap: Data Production and Creation

In addition to the assessment of datasets. CSOs, research institutes, and Think Tanks are involved in collecting data – being 'data producers', some of which collaborate with the NBS. The key data producers identified included: NBS, Bank of Tanzania (BoT), and non-Governmental data producers: REPOA (Afrobarometer[6]); Ifakara Health Institute (Demographic Health Surveillance System[7]); Haki-Elimu (Right to Education Index[8]; Open Budget Survey[9]), and Twaweza (Uwezo Assessment[10]). A further key dataset is the Open Data Portal, collecting data on water, health and education sectors. The datasets all provide information on different elements of governance, health and education outcomes. However, the difficulty in the smaller data sets is how to link them to the national agenda and ensure their continuation over the duration of the post-data agenda. To facilitate synthesis of available data, standards are required and strategies are needed to ensure

[5] Eight recommendations were made, with the responsible stakeholder identified: 1) conduct a mapping of Tanzania's data ecosystem and statistical capacity (NBS/UNDP); 2) further strengthening the link between FYDP II and SDGs (MoFP and NBS); 3) awareness raising among Permanent Secretaries (MoFP); 4) establish SDG data working groups (MoFP); 5) form a high-level SDG data committee (Chief Secretary); 6) develop SDG and FYDP II data visualisation dashboard; 7) invest in data capacity at MDA and LGA level; 8) improve Open Government Partnerships and Open Data Initiatives by awareness raising (NBS, 2017).

[6] http://www.repoa.or.tz/highlights/more/7th_round_of_afrobarometer_2017_survey

[7] http://ihi.or.tz/ihi-data-system-and-platforms/

[8] http://www.right-to-education.org/resource/right-education-index-pilot-report

[9] http://www.internationalbudget.org/wp-content/uploads/OBS2015-CS-Tanzania-English.pdf

[10] http://www.uwezo.net/publications/reports/

comparability across the data collected. The Government's 'National Statistical System' requires strengthening (see URT, 2010). The Tanzania Health Data Collaboration was recently launched – to address priority issues that need collaborative action to align and support ONE monitoring framework for Measurement and Accountability in the Health Sector[11]. However, there is also a need for quality assurance and consistency among non-government data producers. Furthermore, there is a need to explore how to enhance the use of available citizen-generated data and developing means to gather citizens' perspectives.

Additionally, the potential limits to data production need to be understood. Two key policies require consideration, in this respect. Firstly, Tanzania is promoting an Open Data Policy as part of the Open Government Partnership, making data transparent, available and accessible through online platforms (see URT, 2016a). Such a partnership, and initiative, is being led by the Government to make data accessible to all. However, there are notable gaps in the Government being able to remain consistent and ensure key data is transparent, and available, to all. Secondly, the Statistics Act of 2015 (URT, 2015b). Under the Statistics Act of 2015, NBS remains the key body for assuring data quality and management of the statistics system. Any statistical information to be published will have to be authorised and approved by NBS, the official coordinator of National Statistics Systems.

6.5. Establishing Monitoring and Evaluation of Health SDGs

On this role of data and SDG integration, a M&E system for monitoring SDG achievement and implementation progress has been emphasised for Tanzania. The system would allow for monitoring the 169 SDG targets. This would be built on the data assessment findings, as conducted by CSOs and Think Tanks – detailed in *Section 6.4.*. The system will use the current national and sector M&E systems: "programme or project-based per reporting MDAs and LGAs" (Mashindano and Baregu, 2016:10). Thus M&E for the health SDGs will involve the following data sets and systems: see Appendix Table 3. The MoFP is required to coordinate the stakeholders and produce SDG Performance Reports on status and to inform the Economic Committee of the Cabinet.

Within this health data system – capacity building and the inclusion of different data collected is required. The initiatives described in *Section 6.4.* are part of this, aiming to follow the objectives of the Statistical Master Plan, improving the data infrastructure. However, data collection in Tanzania remains heavily donor reliant, of which funds are becoming unreliable (Kilama and Mushi, 2016); and also largely centrally-led. Citizen-led data collection is limited and under-utilised. Resources such as 'Sauti za Wananchi' ('Citizens Voices') collected by Twaweza present a useful citizen response data collection service which should be included in monitoring the SDGs (see Twaweza, 2017ab). Table 7 provides a summary table of the SDG monitoring indicators: baseline (current status, based on the data source year i.e. 2012-2016) and 2030 target, from the available data sources. A column for 'alternative data sources' is indicated to show where health Think Tank data can be used for improved accuracy. Targets for 2030 are not available; therefore, quoting available targets up to 2025/6 (after end of FYDP).

Table 7: Summary table of SDG monitoring indicators for health SDG 3.

SDG	Indicator	Baseline	Target	Data source	Alternative Data source?
3.1.	3.1.1. MMR (per 100,000)	556	220	TDHS, 2015	
	3.1.2. Birth attended by skilled professional (%)	98	90	TDHS, 2015	
3.2.	3.2.1. U5MR (per 1,000)	67	40	TDHS, 2015	
	3.2.2. NMR (per 1,000)	25	16	TDHS, 2010, 2015	
3.3.	3.3.1. New HIV infections	7.5		TDHS, 2015	
	3.3.2. TB (mortality rate)	1,202*		TZ Open Data (OD), 2013**	SAVVY (IHI)
	3.3.3. Malaria (prevalence)	14%***		TDHS, 2015	
	3.3.4. Hepatitis B (mortality rate)	34			SAVVY (IHI)
	3.3.5. NTDs incidence (mortality rate)	282****		TZ OD, 2013	
3.4.	3.4.1. Mortality from CD (mortality rate)	2,493		TZ OD, 2013	

[11] https://www.healthdatacollaborative.org/where-we-work/tanzania/

	3.4.2. Mortality from cancer (total)	19,900		WHO, 2014	
	3.4.3. Mortality from diabetes (mortality rate)	535		TZ OD, 2013	
	3.4.4. Mortality from respiratory disease and infections (mortality rate)	488		TZ OD, 2013	
	3.4.5. Mortality from suicide	--			SAVVY (IHI)
3.5.	3.5.1. Coverage of treatment interventions	--			
	3.5.2. Harmful use of alcohol	--			
3.6.	3.6.1. Mortality due to road traffic injuries	31.5		SAVVY, 2014	
3.7.	3.7.1. Women of reproductive age with access family planning methods	38% (married women only)		TDHS, 2015	
	3.7.2. Adolescent birth rate per 1,000	81		PHC, 2012	
3.8.	3.8.1. Coverage of UHC (access to essential services)	NEHCIP TZ, 2013^			
	3.8.2. People covered by health insurance	<10%	--	Borghi; URT, 2016a	
3.9.	3.9.1. Mortality from air pollution, unsafe water, unsafe sanitation and hygiene	308			
	3.9.2. Mortality from unintentional poisoning	207		TZ OD, 2013	
3.a.	Strengthen implementation of WHO Framework Convention on Tobacco Control	Ratified			
3.b.	Support R&D of vaccines and medicines for CD/NCD	Organisational leads			
3.c.	Increase health financing and recruitment, development, training and retention, of health workforce	Health Financing Strategy (TBC)			
3.d.	Strengthen capacity for early warning, risk reduction and management of national/global health risks	Mapping of flood risk (only Dar es Salaam)			

*The National TB Prevalence survey of 2013 reported 145 prevalence per 100,000.
**Reports on deaths for above (and below) five years. The figure used is reported deaths above 5 years.
***Based on Rapid Malaria Tests on children aged 6-59 months.
**** Reporting on diarrhoeal diseases, ear and eye infections but the cause of this mortality is not stated. It could be linked to NTD which would increase the mortalities caused by NTDs. The number reported includes: intestinal worms, leprosy, schistosomiasis, skin infections and skin diseases, snake and insect bites.
^the National Essential Health Care Interventions Programme has defined 13 essential interventions for Tanzania, however, monitoring of this implementation (and thus coverage) is done through LGA reports. Such data is not circulated or open access. The NECHIP is predicted to cost $4-64 USD across different levels of the health system.

Looking at Table 7, a number of challenges, gaps, and indicators requiring strengthening, can be found. Taking into account criticisms already raised on consistency and availability of data (Kilama et al, 2016), further limitations are prevalent. Firstly, the data (and indicators) require weighting to reduce the risk of over-estimation. For example, 98% are reported above to have a skilled birth attendant during delivery, however the national average for delivering in a health facility is 63%, being as low as 40% in some regions (i.e. Simiyu) (URT, 2016d). Secondly, key indicators show a rise: for example, MMR for 2015. This raises a question of whether the increase reflects improved data collection or worsening health service conditions. Thirdly, reflection is needed on the sample provided. Although a majority of the datasets used are 'nationally representative' sample populations are sometimes selected to answer certain questions. Questions to determine the contraceptive prevalence rate, and demand for such services, is directed to married women. Fourthly, not all aspects may be covered: for example, the poisoning recorded does not ask, or state, if it was 'intentional'. Additionally, applying this to the results for health insurance coverage the reported number is based on the percentage of population who are covered under health insurance (private or public); however, a better indicator of health financing security (or insecurity) may be the Out-of-pocket expenditure spent on health. Finally, the Table shows a need to connect open, and available, data to data collected at the local government level. This is particularly crucial in analysing progress made in terms of universal access to essential health, and more. The recent Twaweza 'Voices of Citizens' is a useful resource. The mobile survey conducted in May 2017 revealed 29% of citizens experienced absent doctors; 28% experienced problems with

the cost of services; 70% experienced a lack of medicine and other supplies, as well as increased satisfaction with cleanliness of facilities (Twaweza, 2017ab). However, the results raise a number of questions on policy implementation. Despite having a right to free treatment in reality 28-37% of children under 5, pregnant women and the elderly are forced to pay (ibid). The citizens' perspective is key for ensuring accountable monitoring.

It is important to note – targets have not been defined for each of the indicators. Targets shown were extracted from the 5YDP. Additionally, the targets stated are for 2025/6, prior to the end of the global SDGs. Finally, the global health indicators defined which will test and evaluate progress made remain highly disease specific and pose a risk of continued vertical approaches in creating a healthy society.

7. Sector Case Studies and Health

The following section presents case studies within health, and related sectors, to showcase the strategies and data for domesticating the SDGs. Health takes a central position within the TDV 2025; FYDP II; and the post-2015 SDG domestication. Wellbeing, and universal access to health, is an underlying theme. Prior to discussing how the post-2015 SDGs are being domesticated we need to recognise which policies and plans Tanzania had that supported similar targets. Overtime, national strategies have been formed, defining the methods to achieve such goals – from the National Strategy for Growth and Poverty Reduction (NSGPR/MKUKUTA I 2005-2010 and NSGPR/MKUKUTA II 2010-2015 (URT, 2005; 2010)); Primary Health Services Development Plan (PHSDP/MMAM 2007-2017 (URT, 2007)); the National Health Policy (URT, 1990; 2007); sector-specific plans (i.e. the Health Sector Strategic Plans I-IV); and the recent shift towards Direct Facility Financing (DFF) (URT, 2017). Tanzania's Health Sector Strategic Plan (HSSP) IV takes forward the MDG agenda, with more attention paid to maternal health (MDG5); sustaining gains made in child health indicators (MDG4), & primary and secondary prevention gains in the high burden communicable diseases (malaria, TB, HIV): & a focus on prevention and management of non-communicable diseases (NCDs).

The policies, designed at the Ministry level, operate through the decentralised health system: implemented through PO-RALG and LGAs. A number of aspects in Tanzania's health sector require recognition. Firstly, with the call for universal access to health care, and quality health care, challenges are being faced in implementing Tanzania's essential health benefits package (Todd et al, 2017; URT, 2013c). Challenges are both financial and on moving the policy to practice through a decentralised system, and upon consideration of insufficient human resources, finances and infrastructure requirements. Tanzania is developing a Single National Health Insurance (SNHI) in a movement towards sustaining domestic resource mobilisation for universal access to essential services. Secondly, political restructuring suggests a move towards social accountability within the health sector. Table 8 provides a summary of key national policies, strategies and plans, that aim to tackle the challenges within achieving, and ensuring, universal health and wellbeing.

Table 8: Key health programmes and plans (pre-SDGs) defining implementation strategies to the move towards achieving 'Good Health and Wellbeing' (SDG 3).

Geography/ Access	**Availability**	**Affordability**	**Quality**	**Equity**
• Arusha Declaration • MMAM (2007-17) • Planning through DHSM	• MMAM (2007-17) • HRH (1996-2001; 1998-2013) • HSSP (I-IV): technology; infrastructure, equipment; drugs; commodities • Diseases specific programmes: i.e. NEHSIP, *(NCD/CD)* • *Maternal and Reprod health, FP, HIV*	• Sector-Wide Approach and Health Basket Fund • Health Financing Strategy (2017): Single National Health Insurance • CHF Act (2001) • Insurers: Tiba Kwa Kadi, National Health Insurance Fund, Private	• MMAM (2007-17) • Client Service Charter (2017) • Tanzania National eHealth Strategy (2012-2018) • Planning through CCHP; DHA; DHEM • HSSP (I-IV) • CSO citizen generated user response (Uwezo)	• NEHCIP-TZ to identify the BoD and essential services (for all citizens). Children U-5, elderly, women of reproductive age are exempt. • HSSP (I-IV) • The social determinants

	• Planning through the CCHP			of health is recognised.

Abbreviations: CCHP (Comprehensive Council Health Plans); CHF (Community Health Fund); DHA (District Health Accounting); DHEM (District Health Expenditure Mapping); DHSM (District Health Service Mapping); HRH (Human Resources for Health); HSSP (Health Sector Strategic Plan); MMAM; NEHCIP-TZ; NEHSHIP;
References: URT, 2013c; URT, 2007ab; URT, 2015b.

Within the health sector, monitoring of morbidity, mortality, access, and service quality, is can be obtained from using different datasets – project based and national. A number of challenges arise with such datasets: from accuracy, reliability and quality; and also a lack of funding (donor and Government) to support the development of M&E systems and data systems for health. Therefore, how has Tanzania prepared for, or begun, domesticating the health SDGs within the health sector and beyond? The following sections describe actions, interventions, and data strengthening for health.

Tanzania is going through key investments to improve data systems. In the health sector, Nswilla (2017) a KI explained the Government is focusing on improving data collection for decision-making, strengthening the data collected and used in reporting. Firstly, the Direct Health Facility Funding (DHFF) (URT, 2017b) aims to improve data collection and use, by incentivising data quality improvements through 'performance-based disbursements'. Indicators monitored for SDGs thus need to take into account strengthened local data; and funding provided to facilities for strengthened data feed back into national data systems. The empowering of local data collectors, and HMIS data systems, is key. On paper, there is an allowance for feedback into the monitoring of SDG progress and health professionals to measure performance and target achievements. A Memorandum of Understanding has been made for strengthening data. The MoU incorporates the HSSP IV (URT, 2016), National Health Policy (URT, 2007) and Health Basket Funding.

Secondly, the call for improved data is seen in the development of Electronic Population Register (e-PRS), by NBS. e-PRS is a working tool for improving coordination of data and routine collection of data at different levels (Chuwa, 2017). The e-PRS will work across sectors: including health, education, civil registration, social services, governance and more. The innovative tool will allow routine data collection through mobile phones.

Finally, it is important to note the link being solidified between NBS and the health sector. NBS was chosen to be the coordinating body due to the multi-sectoral alignment of the SDGs – the NBS enables an inter-sectoral approach to the data systems built and also coordination across the sector datasets. However, as one of the KI's consulted confirmed, although NBS will be the coordinating body they cannot work in isolation to the data within the health sector. Such supportive work is seen in data collaborations for HIV, Malaria, Verbal Autopsy, Tobacco Surveys, The Household Budget Surveys, and evaluations for the One Plan. and DHS, NBS use health data). Such data's monitor health policies, performance and programs – including the HSSP, Tanzania Vision 2025, and Global SDGs. The latest Health Sector Strategic Plan (HSSP) IV identifies over 100 indicators to monitor SDG implementation. The September issue of Open Government Partnership (2017), reported NBS would be receiving 500 tablets; which would significantly reduce the cost of data collection for the scheduled Household Revenue and Expenditure 2017/18 survey.

Good health and wellbeing can only be achieved through a social determinants of health (SDH) approach. This thinking is promoted in Tanzania's NEHCIP (2013c); HSSP IV (2015b) and the post-2015 SDG UNDAP II (2016). There is an understanding that solutions do not simply involve service provision and a 'vertical' approach to curing disease, but rather requires investment in building safe, secure and healthy communities. Such a conceptualisation, has improved wellbeing at the heart. This is further enabled through Tanzania's Sector-Wide Approach (SWAp). Five Development Partner Groups have been formed in Tanzania; and the following two case studies on nutrition and sustainable cities, explore how the health SDGs are integrated into related sectors.

7.1. Case Study 1: Health and nutrition – a multi-sectoral approach for domestication

Nutrition outcomes vary regionally: with chronic (child) malnutrition, as measured by stunting, +40% in Dodoma, Ruvuma, Rukwa, Kigoma, Katavi and Geita; and +50% in Iringa, Njombe and Kagera (see AAH, 2017). However, anomalies occur, as despite having one of the highest rates of chronic malnutrition, Iringa (51.3%), has the lowest Global Acute Malnutrition (AAH, 2017). Such shows how results' for 'wasting' and 'stunting'

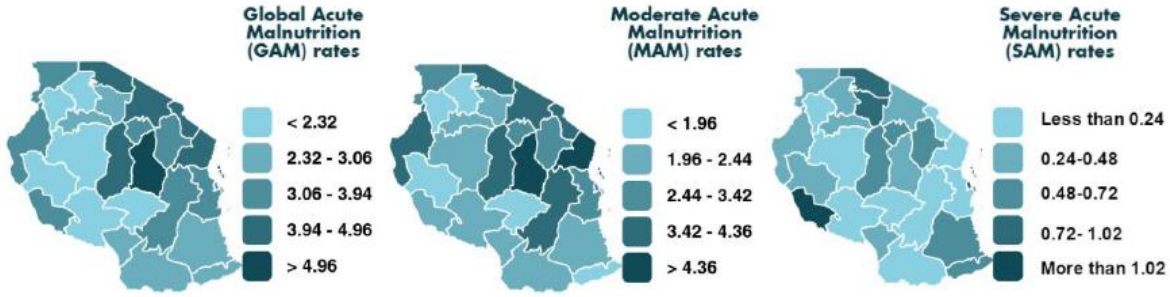
show different progress and risks (see Figure 4). Table 9 shows the baseline for nutrition indicators, linked to health.

Table 9: Summary of key health and nutrition indicators, SDG 2 and 3.

SDG	Indicator	Baseline	Target
2.1.	Prevalence of undernourishment	28% women*	
	Prevalence of moderate/severe food insecurity	77% urban 55% rural**	
2.2.	Prevalence of stunting (WHO standards)	32% urban 45% rural	15%
	Prevalence of malnutrition (WHO standards) – Stunting? Underweight used:	11% urban 17% rural	
2.3.	Volume production per labour unit by classes (farming, pastoral, forestry enterprise size)	--	
	Average income of small-scale food producers	--	
2.4.	Proportion of agricultural area under productive/ sustainable agriculture	Over 2006-16 annual ave contribution to GDP growth=13.7%	
2.5.	No. plant and animal genetic resources for food and agriculture in medium or long-term conservation	--	
	Proportion of local breeds classified as at risk or unknown risk of extinction	--	
2.a.	Agricultural orientation index for government expenditures	--	
	Total official flows to agricultural sectors	685.65bn Tsh (2016-2021)	
2.b.	Producer Support estimate	--	
	Agricultural export subsidies	--	
2.c.	Indicator of food price anomalies	--	

Reference: IADG-SDG, 2015; TDHS, 2016; URT, 2016a)
*Figure reported for women aged 15-49.
**Defined as three meals per day.
Targets identified are from the 5YDP: URT,2016a.

Figure 4: Nutrition indicators across Tanzania regions, 2014.



Reference: Action Against Hunger, 2017:3.

A National Multisectoral Nutrition Action Plan (NMNAP) (2016-2021) (URT, 2016c) has been formed to enable multi-sectoral action; financial and political commitment; and evidence-based decision making on issues around nutrition. One of the first of Tanzania's kind. The NMNAP identifies that by 2021 Tanzania aims to reduce child undernutrition; maintain global acute malnutrition prevalence below 5%. Such is due to the recognition of fatalities, and lost opportunities, caused as a result of under nourishment: undernutrition results in mortality and lost economic and educational advances (see AAH, 2017). A number of integrated nutrition interventions are being planned which link across sectors to create an enabling environment for improved nutrition and achieving outcomes in improving the quality of health and wellbeing. A total of $10,119 (ten thousand) mn USD is estimated to be required over the five years for implementing nutrition-specific, and sensitive, interventions and creating an enabling environment for ensuring food security (URT, 2016c). Figure 5 showcases the financial resources budgeted across interventions over the five years. The budget figures (Tsh Billion) were extracted from the 5YDP, related sectoral plans (i.e. HSSP and TASAF), and

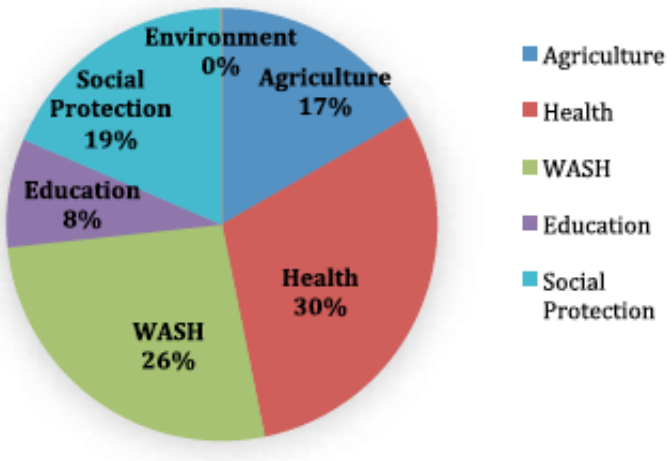
nutrition interventions identified by the Task Team (ibid.). Each of the interventions budgeted for aim to achieve defined outcomes. The Figure shows the disproportionate budget allocated for 'Intervention 5' (Nutrition-sensitive interventions scaled up to reach all communities), which includes outputs of communities having access to nutritious food throughout the year; regular use of quality maternal health (family planning, HIV, malaria treatments); access WASH; girls complete primary and secondary education; vulnerable households benefit from conditional-cash transfers and nutrition education; and there is resilience to drought and climate change to avoid food shortages. The outputs impact across multiple sectors, including health. The health sector is to provide 30% of the budget for nutrition-sensitive interventions; potentially thus having a greater 'say' in the direction taken for improving nutrition (ibid: Figure 6).

Figure 5: Budget allocation for the seven nutrition interventions (2016-2021).

	2016/17 Tsh Bn.	2017/18 Tsh Bn.	2018/19 Tsh Bn.	2019/2020 Tsh Bn.	2020/21 Tsh Bn.	Total Tsh Bn.	Total USD mn.
Intervention 1	34,9	49,9	60,9	36,1	14	195,8	89
Intervention 2	21,9	23,4	24,3	25,3	24,9	119,8	54,46
Intervention 3	4	12,6	24,6	30,7	24,9	96,7	43,94
Intervention 4	1,8	18,9	22,1	18,4	10,6	71,8	32,65
Intervention 5	4,128.40	4,287.00	4,950.90	5,058.20	3,247.20	21,671.70	9850,78
Intervention 6	6,3	8,8	7,4	8	7,4	37,8	17,8
Intervention 7	8,5	16,3	20,4	16,3	6,6	68	30.91
						21739.7	119.91

URT, 2016c: pp 112-115. Figures shown in Tsh Billion. Total over the five years is 22,261.6bn Tsh, equivalent to $10,119.54mn USD.
Key: Intervention 1 = an increased proportion of adolescents, pregnant women, and mothers/ caregivers of children under two practice optimal maternal/infant and young child nutrition behaviours; Intervention 2: children, adolescents and women of childbearing age consume adequate micronutrients; Intervention 3: increased coverage of management of severe/moderate acute malnutrition by 2021; Intervention 4: communities in Tanzania are physically active and eat healthy; Intervention 5: Line sectors, private sector and CSOs scale-up nutrition-sensitive interventions to reach all communities to improve nutrition; Intervention 6: efficient and effective nutrition governance; and Intervention 7: quality nutrition-related information is available and used for evidence-based policy.

Figure 6: Budget distribution across sectors for nutrition-sensitive interventions.



URT, 2016c: pp 117.

If intervention 5 is excluded the key result area budgeted is for 'maternal, infant, young child and adolescent nutrition'. A 73.7% funding gap has been identified for the NMNAP (ibid.). With this funding gap, strategic prioritisation will be placed on (a) coverage of maternal/infant/child/adolescent nutrition; (b) scaling up the management acute malnutrition for children under 5; (c) preventing anaemia for women of reproductive age (15-49); and (d) developing functional human resources and institutional capacity (totalling $97mn USD over five years). Such strategic prioritisation has been defined to invest in early years and develop human capital. Additionally, a resource mobilisation strategy will be made through the to-be formed 'thematic working groups' for resource mobilisation. The planning around the NMNAP is interesting. Not only is the NMNAP multi-sectoral – both in planning, budgeting and prioritisation, involving DPs, Government and implementers; but also pushes for a broader understanding of malnutrition. The NMNAP changes the environments, and vulnerabilities, which cause lack of secure access and availability of nutrients for a healthy lifestyle.

Links have been made to the Education sector, as seen in the Education Sector Development Plan aims for equitable access, and quality, education to ensure a healthy population. The third component of the strategy focuses on the school environment, aiming to ensure safe, inclusive and child-friendly schools. Strategy five within this component involves working together with the MoHCDGEC to 'strengthen health and nutrition' within schools (URT, 2016c). A number of nutrition, and school feeding, programmes have been established nationally supported by the World Food Programme (WFP): 1) Food for Education (School Feeding), 2) Mother and Child Health and Nutrition: Maisha Bora, and 3) Home grown school feeding Pilot. The programmes are focused in the districts of Longido, Simanjiro, Bungi and Bunda. The programme aims to increase enrolment, survival rates, and transition rates. The WFP also has catered programmes to improve access to, and use of, nutritious food in high risk regions: Dodoma and Singida.

National programmes have been set up across primary and secondary schools which introduce a sexuality and sexual, and reproductive, health into the education curriculum (SDG 3.7.); and empower adolescent girls and young women through education. The programmes are funded by UNESCO. A result of such programmes, and the collaborations made with MoHCDGEC, is to ensure the availability of health and nutrition services in schools across Tanzania.

Within the discussion on health, education and nutrition, it is key to note the role played by social protection; particularly the Productive Social Safety Net embedded in Tanzania's Social Action Fund. TASAF provides conditional transfers to identified vulnerable households across Tanzania in order to ensure their resilience to shocks and access to basic services and needs (SDG 3.8.). Conditions for cash include attending school, nutritional monitoring or health care visits (TASAF III). The opportunity of using social protection mechanisms to improve nutrition, and change nutritious behaviours, is recognised elsewhere, see FAO (2015). A recent report on out of school children in Tanzania recommended that stronger links were required with TASAF to ensure continued education: for example, linking the TASAF funds received to school attendance and school performance (Hasan, 2016). TASAF currently provides vulnerable parents monthly funds to support payment for associated school costs.

The NMNAP was launched in Dodoma in early September 2017, attended by the Prime Minister, the Ministers of Health and Finance, as well as key Nutrition stakeholders. This high level political commitment is backed by specific budget, performance and staffing commitments (Godfrey 2017; URT Sept 2017c). Overall there is noted to be good progress against indicators, with almost half (48%) of the NMNAP targets met, in part as a result of successful integration of services (such as collaboration with large scale stunting projects and collaboration with the private sector). Also, there have been some improvements in multisectoral coordination in a few regions (such as the collaboration between large stunting reduction projects, TASAF and the National Sanitation Campaign) (URT Sept 2017c).

However, malnutrition is a complex problem and there remain multiple challenges that need to be tackled. One, funding is noted to be insufficient; at present about 43% of spending is from international partners. LGA spending in nutrition remains heavily dependent on DPs contribution. Two, existing capacities need to be strengthened at central and local government level to be able to manage and monitor implementation of complex programmes. Three, coordination with nutrition sensitive sectors remains weak at all levels. Four, the Nutrition Information System is not harmonized and needs to be integrated with the DHIS2; this will lend to improved quality and ownership of data at all levels. And five, the Strategy is focused on nutrition specific actions with only 3 of the 29 indicators linked to food systems (two on fortification, one on dietary diversity) and this requires building partnerships with business to boost the consumption of healthy and affordable diets - a start has been made in fortifying staples, and launching the Tanzania SUN Business Network. The Strategy calls for 10% of the investment from business, a pioneering effort – but there are few roadmaps globally to draw on (Godfrey 2017, URT Sept 2017c, URT Sept 2017d). Altogether, deliberate efforts will need to be made to harmonise and align plans and budgets and build synergies across sectors, at national and local government level.

The nutrition case study shows how inter-sectoral planning and budgeting is being used to achieve the SDGs – although not under a 'SDG' umbrella. However, despite the inter-sectoral efforts shown in NMNAP a number of questions emerge: how does the NMNAP align with all sectoral plans and budgets; and what are the

challenges of implementing such inter-sectoral alliances, at both the policy and practice levels? Finally, who is leading nutrition data collection and monitoring systems?

7.2. Case Study 2: Sustainable Cities, Communities and Health – opportunities for localising the domestication of health SDGs

The second case study focuses on planning, budgeting and interventions for creating sustainable cities. Again such requires multi-sectoral efforts; unlike the Nutrition case presented in *Section 7.2.* this has not been institutionalised. The case study focuses on (a) what urban SDGs aim for; (b) how health SDGs are relevant for the urban context; and (c) what localised data sources can be used to domesticate a localised approach for the health and urban SDGs.

Increased data is becoming available on 'wellbeing' in cities however, routine data which is to scale and thus enabling evidence-based analysis is limited. Table 10 shows baseline indicators for SDG 6, 11 and 3 as defined by the global agenda. Targets and data sources are included where defined and available. A majority of baselines and targets can be seen to be missing.

Table 10: Summary of key sustainable cities and health indicators, SDG 6, 11 and 3.

SDG	Indicator	Baseline	Target
6.1.	Proportion using safely managed drinking water (%)	71	95 urban 90 rural
6.2.	Proportion using safely managed sanitation services	88.3%*	85 rural
6.3.	Proportion of wastewater safely treated	--	
	Proportion of water bodies with good water quality	--	
6.4.	Water-use efficiency		
	Level of water stress (freshwater withdrawal) (No.)	59^	250
6.5.	Integrated water resources management implementation	--	
	Proportion of transboundary basin area with operational arrangement for water cooperation	--	
6.6.	Change in extent of water-related ecosystem	--	
6.a.	Amount of water and sanitation related ODA	3,517.59	
6.b.	Proportion of local administrative units with established and operational policies and procedures for participation of local communities in WASH	--	
11.1.	Proportion of urban population in slums (%)	66**	40
11.2.	Proportion of population with convenient access to public transport	--	
11.3.	Ratio of land consumption rate to population growth	--	
	Proportion of cities with direct participation of CSO in urban planning/management	--	
11.4.	Total expenditure (pub-priv) per capita on preservation/protection/conservation	--	
11.5.	No. of deaths/affected by disasters	3,547	2,837
	Direct disaster economic loss in relation to global GDP	--	
11.6.	Proportion of urban solid waste collected and adequate discharge	--	
	Annual mean levels of fine particulate matter in cities	--	
11.7.	Average share of built-up area of cities that is open space for public use for all	--	
	Proportion of persons victim of physical or sexual harassment	--	
11.a.	Proportion of population living in cities that implement urban/regional development plans (with population projections and resource needs)	--	45***
11.b.	Proportion of local governments that adopt and implement local disaster risk reduction strategies	--	
	Number of countries with national/ local disaster risk reduction strategies	--	

11.c.	Proportion of financial support to LEDCs that is allocated to construction/retro-fitting of sustainable, resilient and resource-efficient building	--	

*Using a toilet, but does not state if the sanitation services are 'safely managed'.
^Number of water sources demarcated and gazetted for protection and conservation.
**Land covered by 'informal settlements.
***Number of towns with up-to-date general planning schemes (Master Plans).
Reference: URT, 2016a.

Although the rate of urbanisation in Tanzania varies depending on the data used, estimates from NBS suggest in 2012, 29-31% of the population lived in urban areas (NBS, 2011); with numbers set to rise. The rate, and speed, of urbanisation varies regionally, with urbanisation 'hot spots' such as Dar es Salaam, Mbeya, Ruvuma, Rukwa/ Katavi, Kagera and Geita identified in the data (Wenban-Smith, 2014). Such figures draw concern and opportunity. SDG 11 emphasises the need for 'sustainable' city growth and spaces. Within the 5YDP statements are made on how Tanzania will ensure healthy, and sustainable urban spaces – setting targets to reduce informal settlements, formalise/regularise property within slums/informal settlements, and developing soft (and hard) infrastructure to ensure more efficient cities (URT, 2016a). An aim, for example, is to move towards sustainable and renewable energy sources by 2020 5YDP: reducing charcoal consumption in urban areas from 90% to 60% by 2020/21. Additionally, a total of 183.66bn Tsh is being invested in natural resource management, environment and climate change over the 5YDP period. A majority of which is Development Partner funding, followed by Government funding (ibid). Targets have been set to reduce the proportion of the population living below the food poverty line in urban areas from 8.7 (2015/16) to 3.1 (2025/26) (ibid). Urban centres, and planning, are also identified as crucial areas for Tanzania's path to industrialisation (ibid.). However, as they stand, such spaces are not ensuring healthy populations and some health indicators are worse off in urban areas. Research shows potential health disadvantages, with higher maternal mortality and non-communicable diseases in urban spaces (see Institute of Health Equity and Ifakara Health Institute, 2016; Todd and Levira, 2016).

The turn towards sustainable cities relies on collaborations between the Ministry of Environment; Ministry of Lands, Housing and Human settlements; MoWI; and the MoHCDGEC. A number of land policy changes and updates are required. In terms of improving sanitation, Tanzania has initiated a four-year National Sanitation Campaign that begun in 2012 (Phase One). The campaign was designed to meet the MDG targets and links to SDG 3.9., and thus far has increased coverage of improved sanitation from 19.9% (2013) to 62% (2016) (see Tawasanet, 2014). Such positive changes are particularly eminent in Simiyu, Katavi, Rukwa, Mwanza and Dodoma, whereby sanitation was extremely poor.

Although urban data is available in Tanzania (see Table 10, above) there is limited data to showcase intra-urban features and lifestyles; and also evaluate the different progress' and achievements' made across regional cities and towns. Links between HMIS and routine collected urban data is needed. For example, the sample data collected from Ifakara Health Institute's SAVVY and Demographic Surveillance Sites (DSS) sites will allow health SDG indicators to be monitored at a finer scale. The Ifakara DSS dataset disaggregates morbidity, mortality, access and availability to health services, between the rural and urban boundaries. Analysis conducted in the 2012 Ifakara DSS shows the following results: the top ten causes of mortality are changing in urban, rural and national contexts. In 2012, the top causes of mortality among young adults were as follows 1) HIV; 2) injuries and accidents (including road accidents); 3) AFI including malaria; 4) tuberculosis; 5) maternal causes; 6) nutritional and anaemias; 7) ill-defined and un-determined causes; and 8) diseases of the circulatory system (Todd et al, 2016). Further analysis can be done through disaggregating gender.

Finally, links between open-access data, such as Dar Ramani Huria, need to be explored for improved planning. Dar Ramani Huria is a "community-based mapping project" in Dar es Salaam, supported by the UKs Department for International Development Urban Resilience Program (Dar Ramani Huria, 2017). The project was developed to reduce community vulnerability to flooding, and ensure resilient planning could be applied by providing Local Government Authorities (particularly Ward Officers), with mapped evidence of high flood risk areas. The data is open-source available on Open Street Map, with community members and trained volunteers the actors digitizing streets, homes and community spaces. The project is part of Tanzania's Open Data Initiative (Open Government Partnership). Digitized maps, which are available, and displayed, within communities has the potential of strengthening the planning of urban services, housing and land.

8. Discussion

8.1. SDGs have been domesticated: but are they new?

Through the evidence and literature reviewed three concluding findings can be made. Firstly, the global SDGs have been domesticated and integrated in planning in Tanzania. This is seen in the post-2015 agenda shift, whereby in developing the post-2015 agenda a series of stakeholder consultations were held, inviting citizens, CSOs, policy-makers and academics to share recommendations and ways forward. Such recommendations were intertwined with the global SDGs and found in the TDV 2025; FYDP; and sectoral plans. It is important to note the basis, or foundation, of the SDGs, can be categorised in three areas: (i) social development; (ii) economic growth; and (iii) good governance. Such principles have been found within Tanzania's development vision, and mission, for a much longer duration of time. As a KI confirmed the SDGs are aligned to Tanzania's HSSP and vision, thus ensuring their domestication.

Secondly, several assessments have been conducted on the SDG as a specific set of goals to identify what financial, soft, and hard infrastructure, are required. Fiscal gaps have been identified; as well as a need for trainings for health professionals, human resources, and shift in planning. As Kida (2017) concludes there are three key challenges in implementing the SDGs: encouraging LGA participation in planning; ensuring innovative financing to reduce the fiscal gap; and strengthening a statistical system for monitoring and evaluation. Data, and the role of Think Tanks in this, has been identified as a key area to strengthen. Finally, domestication has been followed through a move towards implementation through national planning. Tanzania's FYDP II stated that 40% of the Government's budget would be assigned and innovative financing pushed. Health remains the highest sector as per costing.

With these findings, a question of terminology can be raised. The 'SDGs' as a term are becoming more common, particularly in policy and plans – such as the recently approved NMNAP (URT, 2016c). Additionally, some indicators may be new. However, the idea behind the SDGs raise question over whether they are being incorporated under more sectoral, and contextually appropriate, terminology. The agenda, and principle, is the same but not always the terminology.

8.2. National integration: but missing decentralisation?

As explained in *Section 7.1.* integration in national systems is evident. Additionally, with key national stakeholders – such as NBS and MoFP – leading the discussion and way forward, more and more effort seems to be placed on strengthening **national** data systems for monitoring domestication of the SDGs. NBS does state the collaborations it will continue with the health sector, and emphasis on training health professionals to measure performances and targets achieved (Chuwa, 2017). However, how far have we reached in this and what future steps are needed? This is crucial considering Tanzania's recent self-removal from the Open Government Partnership (Open Government Partnership, 2017).

As Kida (2017) advocates local participation in planning is paramount; and Kilama (2017, KI) identified that data remains key for accountability, however, we need to focus more attention on LGA administrative data. Data needs to be relevant to, and valued by, the data collectors. Data needs to have value attached, in that it can be used for planning and advocacy over what a specific community needs. With such large regional, and district, differences across Tanzania, administrative data systems are crucial in enabling and empowering local communities, by ensuring they can plan, forecast, and demand based on evidence of need. Local data sources need to be strengthened to ensure consistency and accuracy; but that will only be ensured through bottom-up initiatives. Data collectors need to be empowered to collect data with value to their own districts, regions, and local communities, not simply 'nationally representative'.

This is particularly crucial in health, and tracking the health SDGs. Data systems operating, and collected, at the administrative levels include the HMIS as well as project-specific datasets, such as SAVVY, DHSS, or AMMP. Within the health sector, routine data is collected but it needs to be complete and applied. What is key to remember is: routine data, and data of relevant scale, are available, however, improvements are required in being able to link these datasets to national discussions and monitoring systems. A divergence seems to have emerged. Sample datasets and routine datasets are not being utilised as per maximum potential.

In addition, citizen-generated data is needed to capture indicators such as 'governance' whereby the Government-body may have conflicts of interest. A path is required for transparency and openness. Such perceptions need to be captured and triangulated at a larger scale, the district level.

8.3. SDG Indicators in Tanzania

The recommended SDG monitoring is cumbersome: 17 goals, 169 targets and 231 indicators proposed. There remains a lack of clarity over what indicators, baselines and targets, Tanzania will use to monitor its progress within the SDG implementation and evaluation (KI Blandina and ESRF, 2017). Such information seems to be embedded with the key stakeholders: NBS and MoFP, and thus operating at a national level. Representatives from ESRF (2017) were aware of two processes: 1) the development of the SDG roadmap initiative by NBS and the World Bank; and 2) preparing the poverty monitoring master plan, coordinated by the Poverty Eradication Division and integrating poverty monitoring indicators. Further clarification is needed on these issues, including:

- What indicators have been adopted; and not adopted, yet relevant to the health sector (nationally)?
- What additional indicators have been suggested for adoption, to contextualise SDGs in Tanzania's health sector?
- Are Local, community-based, and routine data sources and results included as the 'evidence' base for monitoring SDG progress and implementation?
- Through the indicators adopted, and thus targeting for interventions, is there a risk that implementation becomes too targeted, neglecting some areas? Is the assurance of universality being lost through 'indicator' based targeting? Where is this particularly prevalent?
- Finally, how active is the Poverty Eradication Division and monitoring indicators?

Indicators are assigned across sectors, however, as seen in the case of nutrition some remain cross-cutting. With budgeting being applied, and sectoral financial contributions identified, each indicator should be able to track public expenditure and contributions from the different sectoral ministries and agencies.

8.4. SDG domestication: but where are the health think tanks?

Upon reflection the presence of Think-Tanks can be seen. However, these Think-Tanks are key for policy-level discussions, particularly poverty-reduction, economic and social development, and data. Think-Tanks which specialise in health research in Tanzania such as Ifakara Health Institute, Sikika, and academic institutes (Kilimanjaro Christian Medical College, Bugando Medical College; Aga Khan Medical Centre; and Muhimbili) seem to be missing or lacking a voice in the evolving dialogue. On the one hand the question is why? Is this due to the fact that the 'SDG' dialogue has concentrated on broader links to the FYDP and terminology changes within specific health sector plans, budgets and policy? On another hand, what can such Think-Tanks or academics institute add to strengthen the domestication, tracking and monitoring of SDGs? With access to large evidence bases, area specific evaluation can be set up for health SDGs. Advocacy strategies are needed to showcase the richness, and value-added, of such sample datasets. For example, there is a challenge in how to show the value of DSS data, and using this in monitoring SDGs simultaneously in one population not simply identifying the 'burden of disease'.

8.5. Limitations: Targeting with the risk of neglecting?

Two key challenges that emerge with SDG domestication require emphasise. Firstly, is on the empowerment of LGAs and communities to utilise their own evidence for improved targeting, and contextualised targeting. As shown in the Tables for indicators to monitor the SDGs a number of national datasets are used. However, a valuable set of evidence is available at the local levels: which is routinely collected and shows the reality of citizen-life on the ground. This data requires better utilisation, integration, and investment, to ensure bottom-up targets are set and priorities are relevant to the regional contexts. With this, however, missing indicators remain, such as data on good governance and environmental wellbeing. Secondly, the indicators and data available present a risk of targeting through neglecting. For example, the two case studies presented are examples of where increased multi-sectorial efforts are being placed, due to donor, Government, and other stakeholder recognition of not only the vulnerabilities within this sub-sector but also popularised sub-sectors to invest in. Increasing the 'urban' agenda and 'nutrition' action is becoming hot topics amongst development partner groups. This presents a risk. It becomes likely that such areas will receive investment: financial, human and data strengthening, whilst others remain neglected and side-lined. This is a particular issue as Tanzania

emphasises a turn towards universalism in public health: universal health care, equality in vaccines, and a single national health insurance policy (URT, 2015b), all fall under this idea. However, will targeting to achieve certain indicators change that? Can foundations of equality and universality be lost through the definition of a targeting system.

9. Conclusions and Policy recommendations

In conclusion, we would like to raise the following points. Firstly, in the case of Tanzania, SDGs are integrated through national policy and plans. Domestication has been phased. The process has taken a number of steps starting in 2013 with the post-2015 development agenda, however, a gap seems to be emerging in including local evidence and participation in planning/budgeting. A question needs to be asked on firstly, how a focus is needed on strengthening existing routine data collection systems while moving away from survey-based data collection. Additionally, what are the challenges in collecting citizen-data and why are more efforts not being placed on strengthening alternative datasets to 'big data' in Tanzania? There needs to be a focus on looking into the means of how these routine systems can incorporate, or be complemented by citizens' perceptions, – through community monitoring systems and planned surveys such as Afrobarometer. Such are key gaps considering Tanzania's system of decentralisation by devolution. Addressing these are key for moving from monitoring to discussing impact evaluations and assessing whether the objective of 'development for all' is achieved.

Secondly, a dialogue is occurring on what is needed for building and sustaining a national data system: what indicators will be used and data sources relied on? Additionally, how interlinked is Tanzania's baseline to the global indicator list? With regards to the health SDGs there continues to remain a great reliance on disease-based evidence datasets, collected at a national scale. Datasets across sectors need to be linked. Finally, Think-Tanks seem to have been heavily engaged in developing the agenda and the first-steps for domestication through data assessment and capacity building, however, 'health' Think-Tanks in particular seem to be missing from the discussion.

Discussions on domestication of health SDGs seems to have largely focused around the issues of policy and national data. However, when looking at the foundation of Tanzania's HSSP's and budgeting SDG thinking and implementation plans can be seen, but under different terminology. The SDGs in many ways, have already been domesticated and are part of Tanzania's Development Vision and strategic health objectives. Nonetheless, movement towards monitoring the specific SDG indicators and tracking progress requires coordinated efforts across sectors for improved implementation. The Goals require multi-sectorial action, this makes it difficult to limit M&E and implementation to sector-specific strategies. There needs to be further reflection on what 'domestication' means and who needs to be involved in a strategy to domesticate. SDGs need to be localised; understood throughout the decentralised governance system; and mainstreamed in LGA data collection, budgets, and planning.

Two case studies are presented which show the strategies used to domesticate SDGs, and how health SDGs fit into this. Case study one showed the value of using a multi-sectoral approach to address health, nutrition and SDGs simultaneously; however, much remains to be seen as to how the multisectoral policy approach will work in implementation and expenditure spending. The second case study showed how a strengthened system for domestication could be used in Tanzania. Scoping is needed to look at localised and routine data systems, to identify how they can fit into the monitoring of SDGs and the value-added to knowledge. Comparability of SDG indicators across countries is key, and we can see significant investments in building Tanzania's national data systems to do so. However, the policy and practice discussion needs to turn towards comparability and analysis at a finer scale and using data from lower-levels and the decentralised system for evidence-based planning. The key principles of the SDGs are equity and encouraging inclusive participation, which in a large part is missed through the nationally representative datasets. Systematising M&E for SDGs has a risk of missing how practice is implemented and the bottom-up participation in planning, budgeting and allocation. Systematising national datasets risks domestication remaining a national agenda with citizens not understanding the value of using data for improved policy and practice. Domestication of the SDGs has been implemented in Tanzania, however, more work is required to ensure the systems put in place are contextualised and are durable in that evidence-systems are built. Think-Tanks are key in this, and in Tanzania's case health Think-Tanks need to be advocating for better use of finer data sample sets.

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11. Appendix

Table 1: Sustainable Development Goals and the Approved Indicators List.

	Sustainable Development Goals	**Summary of Indicators**
1	End Poverty	Population living below International, and National, Poverty Line Population covered by social protection schemes Population accessing basic services Population with tenure (recognised) rights to land Mortality, morbidity, after disaster Economic loss from disasters, in relation to GDP Countries with national/local disaster risk reduction strategies Govt. resources allocated for poverty-reduction; essential services; vulnerable groups
2	Zero Hunger	Prevalence of undernourishment; stunting; malnutrition Prevalence of food insecurity Volume of production per labour unit Average income of small-scale food producers Proportion of agricultural area under productive/sustainable agriculture Plant and animal genetic resources for FAO secured Proportion of breeds classified per extinction risk Govt. expenditure agriculture orientation; and total official flows to agriculture sector Food prices; export subsidies; producer support estimates
3	Good Health and Wellbeing	MMR; skilled health person at birth; U5MR; NMR HIV new infections; TB incidence; Hep. B incidence NTD interventions required Mortality rate due to different diseases, accidents, substance abuse, pollution, WASH Family planning; adolescent birth rate Coverage of essential health services and medicines Coverage of health insurance Total official development assistance Health worker density and distribution

		Capacity and emergency preparedness
4	Quality Education	Proportion children/young people in primary; completing primary; lower secondary, and 3Rs Children U5 developmentally on track Participation in organised learning, formal/non-formal education Population with ICT skills Equality of education and 3R skills Mainstreamed national curricula designed, teacher education and student assessment Utilities in schools Official development assistance flows Teachers across levels of education
5	Gender Equality	Legal frameworks Gender-based violence Child marriages; FGM; Unpaid domestic, and care, work Women parliamentary seats; managerial positions; SRHR; land ownership; mobile phones Public allocation system supports gender equality
6	Clean Water and Sanitation	Proportion using safe WASH services Waste water safely treated Quality of water bodies Change in water-use efficiency; level of water stress; water resource management and trans-boundary arrangement Official development assistance Proportion of local admin. units with policies/plans
7	Affordable and Clean Energy	Access to electricity Reliance on clean fuels and technology Renewable energy share Energy intensity Investment in energy efficiency
8	Decent Work and Economic Growth	Annual growth rate of real GDP per capita; employed person Proportion of informal employment; unemloyed Material footprint Domestic material consumption Average hourly earnings (female/male) Youth not in education/ employment/ training Child labour Occupational injuries National compliance in labour rights Tourism direct GDP; jobs in tourism Commercial banks; accounts at a bank Aid for Trade commitments Govt. spending on social protection and employment programmes
9	Industry, Innovation and Infrastructure	Rural population distance to all-season road Passenger and freight volumes Manufacturing value added Manufacturing employment Small scale industries CO2 emissions R&D expenditure Official development assistance

		Medium and high-tech industry value-added Mobile network coverage
10	Reduced Inequalities	Household expenditure and income Discrimination Labour share of GDP Voting rights Migration policies Tariffs applied to imports (LEDCs/MEDCs) Official development assistance Remittance costs
11	Sustainable Cities and Communities	Urban population living in slums Access to public transport Ratio of land consumption; open space Participatory planning structures; regional and city planning Expenditure on preservation, protection, etc Mortality and morbidity, and economic loss, from disasters; and presence of DRR strategies Urban solid waste; pollution management Official development assistance
12	Responsible Consumption and Production	Sustainable consumption/production action plans Material footprint Domestic material consumption Global food loss index Hazardous waste, recycling rate Sustainability reports produced and plans Official development assistance Fossil-fuel subsidies per unit
13	Climate Action	DRR strategies; plans; policies; and implement Mortality and morbidity, and economic loss, from disasters
14	Life below Water	Coastal eutrophication and floating plastic debris Exclusive economic zones using ecosystem-based approach Marine acidity Fish stocks; sustainable fisheries Protected marine areas Plans and implementation Frameworks; research budgets; policies
15	Life on Land	Forest/ terrestrial and freshwater biodiversity as proportion of land area Sustainable forest management Land degradation Coverage of protected areas Mountain Green Cover Index; Red List Index Policies adopted/ legislations/ target progress Proportion of traded wildlife (poaching etc) Official development assistance
16	Peace, Justice and Strong Institutions	Victims of homicide; conflict-related deaths; violence (sexual, physical) Feeling safe Proportion experience physical punishment Human trafficking Corruption Satisfaction with services, and decision-making Civil registration

		Human rights institutions
17	Partnerships for the Goals	Total Govt. revenue as proportion of GDP Proportion of budget funded by domestic tax Official development assistance FDI; Remittances; Investment; Internet

For full list see: Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators. Reference: Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators, 2015.

Table 2: Full health target and indicator list (SDG: 3), global list.

Ensure healthy lives and promote wellbeing for all at all ages.		
3.1.	Reduce global MMR to less than 70:100,000 live births	MMR; Birth attended by skilled professional
3.2.	Reduce deaths of newborn (at least 12:1,000) and children under5 (25:1,000)	U5MR NMR
3.3	End AIDS, TB, Malaria, NTDs, and combat hepatitis, water-borne diseases and NCD	No. of new HIV infections, population TB; malaria, Hep.B; NTDs incidence;
3.4	Reduce premature mortality from NCD through prevention and treatment, and promote mental health	Mortality from CD, cancer, diabetes, respiratory disease Suicide mortality rate
3.5.	Strengthen prevention and treatment of substance abuse	Coverage of treatment interventions Harmful use of alcohol
3.6.	Halve deaths and injuries from road accidents	Death rate due to road traffic injuries
3.7.	Universal access to SRH services	Women of reproductive age access family planning methods Adolescent birth rate per 1,000
3.8.	Achieve universal health coverage	Coverage of UHC (access to essential services) Number of people covered by health insurance per 1,000
3.9.	Reduce deaths/illnesses from hazardous chemicals, air, water, soil and contamination	Mortality from air pollution, unsafe water, unsafe sanitation and hygiene Mortality from unintentional poisoning
3.a.	Strengthen implementation of WHO Framework Convention on Tobacco Control	
3.b.	Support R&D of vaccines and medicines for CD/NCD	
3.c.	Increase health financing and recruitment, development, training and retention, of health workforce	
3.d.	Strengthen capacity for early warning, risk reduction and management of national/global health risks	

Reference: Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators, 2015.

Table 2: Post-2015 National Consultation: Goals identified (2012-2013).

	Post-2015 Goals
1	End poverty, hunger and inequality
2	Achieve decent and productive employment
3	Ensure quality service delivery (health, education, water and sanitation)
4	Eliminate gender inequality (i.e. equal access to education/employment/assets, GBV, FGM)
5	Combat diseases (i.e. malaria, HIV/AIDs, TB, NCDs)
6	Reduce child and maternal mortality
7	Promote sustainable development (i.e. environmental management and impact assessments, natural resource management, population growth, sustainable energy use, and adapt to climate change effects)
8	Improve governance (i.e. rule of law/enforcement, anti-corruption, freedom of expression,

	participation and inclusivity, and social protection)
9	Enhancing effective development cooperation
10	Promoting peace and security

Reference: UNDP, 2015.
The goals were synthesised from consultations at the local/zonal level; with higher learning institutes, research institutions, private sector, government officials and youth groups. Consultations were in Mainland Tanzania and Zanzibar.

Table 3: Health sector, and related sector, datasets and links to SDG indicators.

Dataset	Scale	Objective	Links to SDG indicators
Health			
Health Management Information System (District)	National, health facility level	Routine collection from health facilities. Provides information on morbidity, mortality, services delivered, commodities accessible, and financial management. Captures the disease burden. The data is linked with district planning.	3.7., 3.8.,
Sample Vital-events Registration with Verbal Autopsy (SAVVY)	Districts		3.1., 3.2., 3.3., 3.4., 3.5., 3.6., 3.9.,
Adult Mortality and Morbidity Project (AMMP)	Districts	Captures the disease burden. The data is linked with district planning.	3.1., 3.3., 3.4., 3.5., 3.6., 3.9.,
Service Availability and Readiness (SARA)	27 districts	Shows which services are available (where); and their 'readiness' in terms of equipment, standard procedures, diagnostic capabilities, medicine etc.	3.7., 3.8.,
Service Delivery Indicators		Service quality indicators collected by World Bank	3.1., 3.7., 3.8.,
Tanzania Demographic Health Survey	National, household	Collects data on fertility, family planning, maternal and child health.	3.1., 3.2., 3.3., 3.4., 3.5., 3.6., 3.9.,
Programmes: THMIS	National	Collects data on HIV/AIDs and Malaria	3.3
Related Sectors			
Population and Housing Census	National, household		Goal 1, 10
Household Budget Survey	National, household	Information on consumption and expenditure for poverty mapping	Goal 1, 2, 5, 10,
Basic Education Statistics in Tanzania	National, regional	Data on pre-primary, primary, secondary, adult vocational education/ training, higher education, teacher education, school inspection and finances	Goal 4, 5
National Panel Survey	National, panel	Information on agricultural production, income-generating activities, consumption and other socio-eco	Goal 1, 10

Reference: author own. SDG indicator based on the global proposed indicator list for SDGs, see Appendix Table 1.