Building Sustainable Research Capacities for Health and its Social Determinants
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Mapping Research for Social Determinants of Health and Health Inequity: a focus on Knowledge Production and National Research Systems and Networks

Tanzania Country Mapping Report
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Social Determinants of Health Network (SDH-Net)
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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
AMC	Adult Male Circumcision
AMREF	African Medical Research Foundation
ASDP	Agricultural Sector Development Programme
COSTECH	Commission for Science and Technology
DHS	Demographic and Health Survey
DP	Development Partner
ECD	Early Childhood Development
EPI	Expanded Programme of Immunisation
ESDP	Education Sector Development Programme
ESRF	Economic and Social Research Foundation
ETP	Education and Training Policy
FGM	Female Genital Mutilation
GBS	General Budget Support
GDP	Gross Domestic Product
GHI	Global Health Initiative
HBS	Household Budget Survey
HSR	Health Sector Reform
HSSP	Health Sector Strategic Plan
HIV	Human Immuno Deficiency
IHI	Ifakara Health Institute
ITN	Insecticide Treated Nets
HMIS	Health Management Information System
MAAM	Mpango wa Maendeleo ya Afya ya Msingi (Swahili for PHSDP)
MAFS	Ministry of Agriculture and Food Security
MCDGC	Ministry of Community Development and Gender and Children
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MoEC	Ministry of Education and Culture
MoEVT	Ministry of Education and Vocational Training
MoFEA	Ministry of Finance and Economic Affairs
MoHSW	Ministry of Health and Social Welfare
MoWI	Ministry of Water and Irrigation
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini (Swahili for NSGRP)
MUHAS	Muhimbili College of Health and Allied Sciences
NACP	National AIDS Control Programme
NCD	Non Communicable Diseases
NGO	Non Governmental Organisation
NIMR	National Institute of Medical Research
NMCP	National Malaria Control Programme
NMSF	National Multisectoral Strategic Framework
NSGRP	National Strategy for Growth and Poverty Reduction
PEDP	Primary Education Development Programme

PHDR	Poverty and Human Development Programme
PHSP	Primary Health Sector Development Programme
PLHAs	People Living with HIV/AIDS
PMO	Prime Minister's Office
PMO-RALG	Prime Ministers Office, Regional and Local Government
PMTCT	Prevention of Mother to Child Transmission of HIV
PPP	Public Private Partnership
RAWG	Research and Analysis Working Group
REPOA	Research on Poverty Alleviation
SDC	Swiss Development Corporation
SDH	Social Determinants of Health
SDH-Net	Social Determinants of Health Network
SEDP	Secondary Education Development Programme
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
TFNC	Tanzania Food and Nutrition Centre
TGNP	Tanzania Gender Network Programme
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
URT	United Republic of Tanzania
WB	World Bank
WHO	World Health Organisation

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Executive Summary

The SDH-Net is a four-year (2011-2015) collaborative project that aims to strengthen and link research capacities for health and its social determinants in African and Latin American low and middle income countries in close collaboration with European partners. The focus is on strengthening capacities to produce research of high quality, as well as on reinforcing the research to policy continuum towards addressing existing health inequities.

This mapping report presents an overview of the 'Social Determinants of Health' (SDH) landscape in Tanzania –its conceptualization and role in addressing health inequities; SDH-related policies, research trends, priorities and capacity needs; national systems in place for coordination and quality assurance of research; mechanisms to promote flow of information between researchers, advocates and policy makers; and the way forward towards strengthening systems towards a national SDH and health inequity research and related policy agenda.

The report is based on a desk review of available SDH-related research information from 2005 onwards, complemented by in-depth interviews with 34 individuals from a cross section of institutions – 10 national research, policy or advocacy institutions; one national coordinating institution; six government ministries and centres; and four development organisations. The mapping process was carried out over five months, from February to June 2012, following standard guidelines based on a conceptual framework for building sustainable SDH research capacity.

The conceptualization of SDH varies considerably but there is some consensus that it is linked to existing "inequities and inequalities". According to the interviewees, a number of steps need to be taken towards addressing these inequities, including mobilization of "own" resources to address national priorities; strong governance structures and better coordination and collaboration between health and other "SDH" stakeholders to make effective use of available resources; and expanding citizen engagement with policies and budget process towards ensuring allocation of resources according to need.

Nationally, there is no "SDH specific" research and/or policy portfolio. SDH research is scattered, and embedded within disease-, health systems- and poverty-specific research thematic areas. Available research suggests that Tanzania's social and economic development is challenged by sharp inequalities – urban/rural and among different socio-economic groups – compounded by demographic and societal change, unequal access to essential basic services and employment opportunities, and challenged by the gendered division of labour and structural and social norms, as well as unequal power relations.

A number of organisations in Tanzania are working on issues pertaining to health and its inequities, some with a focus on research, others working actively towards dissemination and advocating for change, and a few on programme implementation. Most of the research undertaken employs a range of analytical and research skills - quantitative, qualitative, mixed methods, reviews, policy and budget analysis, animation methodology, investigative journalism - ranging from the conventional to participatory approaches aiming for inclusiveness. Many research disciplines are involved - epidemiologists, social scientists, medical anthropologists, statisticians, economists, political scientists, demographers, public health specialists, geographers, public policy analysts, urban-regional planners, gender activists, advocacy and communication specialists. Interdisciplinary research towards lending

a critical multidimensional "SDH" view to existing inequities is just beginning to gain momentum.

The SDH agenda in Tanzania is still in its infancy and there is considerable scope for further research on SDH and health inequity. Specific research capacity needs as noted by some of the interviewed researchers include: strengthening analytical skills at all levels; synthesising research findings from an 'SDH & inequity' perspective; structural equation modeling to tease out complex relations; analysis of measures of economic status responsive to changes in time (not just as determinants, but also as outcomes of health interventions); use of explanatory models to better understand interrelations between general aspects – social, economic and political factors and how they effect health of groups and individuals; and use of inter-disciplinary and participatory approaches to better understand what works where and why - the context. Considerable research capacity building takes place in the process of undertaking collaborative research that is usually linked to ongoing mentoring. A number of research institutions also offer periodic trainings.

There are no policies, programmes or legislation specific to SDH, but the concern for inequalities and inequities is central to Tanzania's Vision 2025 and to the National Strategy for Growth and Reduction of Poverty (NSGRP/ MKUKUTA, 2011-2015). Vision 2025 sets the country's long-term development agenda towards achieving a high quality of livelihood for all Tanzanians by 2025. MKUKUTA, the national framework to achieve Vision 2025 and the Millennium Development Goals, recognizes the multidimensional nature of poverty, and adopts an outcome based approach which requires all sectors to contribute to the poverty reduction agenda. The goals of MKUKUTA are incorporated in sector specific strategic plans and budgets. Progress towards outcomes and targets is reviewed and reported annually by the MKUKUTA Monitoring System, through reports that draw data from national surveys, routine administrative data systems, public expenditure reviews and independent research undertaken by research institutions in Tanzania. Findings and recommendations from these reports aim at influencing both National and Sector Strategic Plans and Budgets. 'Monitoring' reports are publicly available and discussed at open meetings, including at the annual 'poverty policy week' and sector specific technical working groups and performance review meetings, facilitating a discourse between representatives from the Government, Civil Society and the Development Partners.

Institutions generally differ in their dissemination approach, ranging from the conventional to the activist – reaching out to national, sectoral and district policy makers to the beneficiaries at the grassroots. Some of the most common strategies used by researchers to disseminate their research outputs include through participation in various national technical and dissemination forums, seminars, policy briefs, peer reviewed publication and conference presentations. Institutions also provide periodic updates to their respective funders and the most relevant sector.

The Tanzania Commission for Science and Technology (COSTECH) that is under the Ministry of Communication, Science and Technology, is the principal advisory organ to the Government and is responsible for coordinating all research and development in the Country. In practice, coordination of research is reported to be difficult. There is some consensus and concern amongst those interviewed that despite evidence available on the existing inequities in health and the possible social aspects, there has been limited effort in guiding the implementation of research from an SDH perspective towards addressing broader national priority needs. This, according to the respondents, is for a number of reasons, including: limited national allocation to research and development, though this is on the increase; weak infrastructures and

research activities that don't always address national research priorities i.e. an externally driven research agenda with limited national ownership; a lack of appreciation of the usefulness of research; weak networks at all levels resulting in adequate use of available research findings; poor access to national research and other relevant data; and limited skills to understand the need for, as well as the ability to synthesize available research findings from an SDH perspective. The recently adopted national research and development policy and strategy is expected to improve the use of research evidence in the policy process and practices. However, available evidence from some 'best practice' examples suggests that the 'research to policy' continuum is a complex one. A number of factors are critical in shaping the extent to which research is used – credible evidence, informed citizens and public debate, mobilization of resources, strategic alliances, coalitions and framing research evidence in ways that are attractive to policy makers are effective modes of influence; and political priorities.

There are various mechanisms and processes in place, nationally and institutionally, that can potentially serve to monitor the performance of research products and systems, and the implementation of sectoral and national strategic plans, including the overall status and well being of Tanzanians. The ethics review bodies are a good means for assessing the soundness, feasibility and ethics of the proposed research and methodology, prior to its implementation. Some institutions are more vigilant in their requirements than others and not all research carried out in the country is ethically cleared**. Nationally**, the MKUKUTA Monitoring Master Plan provides a framework for deeper and broader monitoring of the range of issues covered by MKUKUTA in growth, well-being and governance. A key concern expressed by several respondents is the focus on 'averages', on meeting the MDG targets, and the absence of indicators that identify the extent of inequality in the country. There is a need to develop and adopt clear measurable indicators of progress on reducing inequalities; as well as incorporating more of the 'qualitative' indicators to better understand 'quality' aspects as well as perceptions of the beneficiaries.

Suggestions from a cross-section of interviewees towards strengthening systems towards a national SDH and health inequity agenda, include establishing an SDH consortium that would work towards: identifying and working with some potentially influential 'champions' for getting SDH into the Constitution; mainstreaming SDH in policy and strategy framework documents, including the MKUKUTA; a representation in ministerial advisory and policy formulation boards; promoting public debate on SDH and health inequities and building on existing platforms for effective dissemination of SDH related information, as well as informing and empowering communities to demand for their basic human rights; packaging of research findings that consider the needs of different policy audiences; putting in place a central depositories of research information coordinated by a public institution to enable greatest access; pulling together a critical mass of 'SDH' researchers with appropriate skills base; strengthening communication networks towards ensuring complementarity and promoting collaborative interdisciplinary research partnerships within and across research institutions (and with advocacy groups and policy makers at all levels), ensuring complementarity between ongoing research within and between institutions; and in the translation of research findings into policy.

1. Introduction

Health inequities, the differences in the quality of health and health care across different populations, are a global phenomena. They exist within and between countries, and the causes extend beyond the health sector. Health inequities may be a result of biological variations and certain lifestyle choices, but also due to the broader socio-economic inequities and their determinants. Linking expertise and exchanging experiences across institutions, sectors and countries for a better understanding of what does and does not work, and within which context, is essential towards strengthening research capacities and health systems and to develop contextually relevant approaches to pressing health challenges facing individuals, families, communities and nations at large.

The SDH-Net is a four-year (2011-2015) collaborative project[i] that aims to strengthen and link research capacities for health and its social determinants in African and Latin American low and middle-income countries in close collaboration with European partners. The focus is on strengthening capacities to produce research of high quality, as well as on reinforcing the research to policy continuum towards addressing existing health inequities. Based on a conceptual framework for building sustainable SDH research capacity, guidelines for mapping research for SDH and health inequity was designed to capture aspects of SDH knowledge production and relevant national research processes and systems [SDH-Net 2012a, 2012b].

This mapping report presents an overview of the SDH landscape in Tanzania –its conceptualization and the role of SDH in addressing health inequities; trends in recent research and priorities and capacity needs of some of the national research /advocacy/policy groups working in the broader area of SDH and health inequities; existing national systems, processes and mechanisms in place to coordinate, guide and monitor research and policies and /or programmes, as well as facilitate an exchange of information between research and advocacy bodies and with policy makers (at all levels) towards strengthening the research to policy continuum; and the way forward towards promoting a national SDH research and policy agenda.

This mapping report is not comprehensive or exhaustive. It does not reflect all SDH related activities in the country. It is based on a desk review of some national policies, strategies and programmes and published SDH-related research outputs from 2005 onwards, complemented by in-depth interviews with 34 individuals from a cross section of institutions – ten national research, policy or advocacy institutions; one national coordinating institution; six government ministries and centres; and four development organisations. The mapping exercise was carried out over a five-month period, from February to June 2012.

Annex A summarises the mapping process. **Annex B** lists the stakeholders interviewed.

2. Conceptualisation of the Social Determinants of Health (SDH) and health inequities: stakeholder perceptions.

SDH is noted to be a very vague and an all-encompassing term including anything and everything that might impact on health. The conceptualization of SDH varies considerably, but there is some consensus that it is linked to "inequities" (**See Box A**).

Box A. Conceptualisation of SDH and health inequity

"For rich countries at least, the landmark Black Report in the UK clearly stands out; it argues that inequality has a strong and independent effect on the health of individuals and entire nations. I don't know how this would apply in a poor and not-so-unequal country like Tanzania. Here I can think more in terms of things like these: mothers in Pemba who allegedly refuse being immunized against tetanus because they think it will make them infertile..; community members in Lupalilo, Makete, who said it was fine, and normal, for a woman to plough the field until the very final stages of their pregnancy because that's their job and anyway it was their responsibility if they got pregnant in the first place; family and larger societal pressures that force a girl to marry young rather than complete school, despite the known risks to her health from early pregnancy; economic forces and social pressures that force new mothers to go back to the field just weeks after delivery, thereby compromising their ability to care for their health and breast feed their newborns / infants; traditions that impose FGM (female genital mutilation) upon unsuspecting girls and adolescents, endangering their health; beliefs, such as witchcraft, that put the life of albinos at risk; and if we count economic forces as being part of SDH, then another example would be the poor fishermen who engage in dynamite fishing, are maimed and end up as beggars in a Dar es Salaam street corner."

"As an urban/regional planner as well as GIS expert, I am dearly concerned with determinants of health. Most especially now, when public health mostly in the Least Developed Countries faces a Double Burden of Diseases (from communicable and non communicable diseases as well as emerging diseases); due to unguided urbanization that leads to rapid changes in physical environments."

"In line with our transformative feminist perspective on health, I consider SDH to be rooted in the dominant structures of power in society, including economic, political, cultural and ideological…. understanding that health includes not only the absence of illness, but also a sense of well-being, security, dignity, happiness and self-fulfillment, different groups of people have different levels of access to the basic resources necessary for health, well being, and sustainable livelihoods. These include access to dignified and secure employment and livelihoods with a livable income, and the means to acquire employment and livelihoods – be they land, water, markets, information, credit; and the prerequisites for employment such as formal education and employment such as a formal education and employment experience."

"Girls and women also experience, on a daily basis, a variety and a barrage of emotional and sexual abuse, discrimination and oppression which eats away at their self-esteem and deprives them of security and safety, as well as physical health……on the other hand, however, SDH also include the way in which marginalized girls/ women, and their communities, respond to the existing structures of power at all levels …women have organized themselves in HISA groups which not only provide a safe space for savings and loans, but also provide mutual support mechanisms in times of illness and death. Community groups along with national/ local NGOs increasingly participate in performance tracking to demand accountability from health delivering institutions…however, there is not yet a high level of community consciousness about basic human and citizenship rights, let alone health rights, nor the development yet of a strong popular movement for health as a basic human right…"

See Annex C for a summary of additional opinions regarding SDH and health inequities.

Some of the main causes of inequities within the country, according to the respondents, include:

- Poverty and insufficient resources.
- Poor planning, weak governance structures and political priorities and resource allocation practices that result in underfunding of some essential priorities, geographical areas and some of the most vulnerable sections of the population.
- A top-down approach, with minimal engagement of the intended beneficiaries in the planning process, in identifying and prioritizing their needs.
- Perpetual sense of dependency coupled with lack of political will to mobilise 'own' resources coupled with increasing reliance on external support to implement strategies, plans and programmes that are not in line with local and national priorities (and for health there is increasing reliance on global health initiatives, and thus improving the health system has been a balancing act: disease specific programmes versus those targeting the health system as a whole).
- Poor awareness/consciousness among the population about basic human and citizenship rights and obligations, including health rights.

Box B. According to some policy makers…..

The country does not consider vulnerability in the distribution of its resources. Overemphasizing on population size as the main determinant of resource allocation increases inequality in health status because at the end of the day some people will be favored more than others.

… we have our own health priority areas and we do have our felt needs which we believe that if addressed will help improve the welfare of many people, but we are dependent on donors who come with their own priorities, different from ours…. therefore, we end up implementing what donors want and not what we want (despite this practice being totally against the basic agreements of the more than 20 years old Paris Declaration for coordination, integration and harmonization).

…. the main constraints in addressing SDH and health inequity are several but the main ones include negative forces that come with the heavy reliance on external funds, lack of engagement and participation of key stakeholders in decision making due to their ignorance as regards their rights and obligations and conflicting ideologies between politicians and planners (and pending on which technocrats are involved, politics usually overrides planning).

To address existing inequalities and inequities, respondents recommended the following:

- Political will and mobilization of "*own resources to address our priority health needs*".
- Put in place strategies to ensure more robust transparency and allocation of adequate resources according to need, especially to the remote rural underserved areas; for example, improving rural infrastructure to facilitate transportation of farmers' crops and improve health systems (infrastructure).

- Building the capacity and capabilities of those who plan and budget and improve their understanding of SDH and resultant health inequities, with priority given in resource allocation first to the basic health needs of the majority.
- Expanding citizen engagement with policies and budget process at all levels (not only with health, but also for example, water, education, agriculture and food security, communication and transport, industry and trade, energy and all other sectors which have an impact on health).
- Encouraging coordination and collaboration between health and other 'SDH' stakeholders (education, nutrition, social welfare, environment, water and sanitation, infrastructure, gender, community development, agriculture, labour, finance and economic affairs, etc.) towards promoting access to essential basic services (education, employment, health care, information, food, water, etc.).
- Strengthening and enforcing existing social accountability mechanisms at various levels and ensuring 'real voice' (not token remarks to silence debate) to sector people, and well-informed citizens who are capacitated to demand their rights; enforcing stronger links between communities and their constituencies, and between local and the central government.
- Addressing constraints to quality health care such as shortages of skilled and semi-skilled health workers including midwives nurses, as well as laboratory technicians and doctors – with appropriate training, remuneration and support structures, including retention schemes (e.g. housing & other incentives); close supportive supervision; ensuring availability of medicines and equipment, especially to the primary care facilities, and ensuring that resources reach its intended destination; and strengthening two way referral structures.
- Attention to attainment of sexual and reproductive rights – relevant education, legal reform (raising marriage age for girls to 18 years, same as boys) and taking steps to reduce the factors which lead so many girls and women to seek abortion services (i.e. access to knowledge, contraceptives and power to say no to unwanted sex and serious government action against all forms of sexual abuse, in and out of marriage).
- Promoting innovative health promotion strategies and encouraging healthy eating and living practices.

3. Knowledge Production: General Trends in Recent Research around SDH and Health Inequity.

The National Institute of Research (NIMR) comes out with a National Health Research Priority document that provides some guidance on health research priorities. Evidence on the burden of disease that is based on cumulative findings from various researches that have been done in the country is one of the criterions for health research priority settings. Research priorities are also guided by the individual research institution's mission statement and key priority areas as stipulated in the institutional strategic plan document. Bigger collaborative research projects are largely shaped by available funding opportunities. Fellowships supporting doctoral and postdoctoral research allows researchers some flexibility in following up on their individual interests.

Nationally, there is no "SDH specific" research and/or policy portfolio. A brief review of recent

research carried out nationally suggests that SDH research is scattered and embedded within disease- and poverty-specific research thematic areas: health systems and biomedical research (HIV/AIDS; maternal, child and neonatal health (MNCH); malaria; TB; environmental health; non-communicable diseases (NCDs); universal access to health care; governance and accountability; and vulnerability and social protection (see **Annex D** for a summary of the main health research priorities in Tanzania and SDH related information and **ANNEX E** for a list of some of the SDH-related published research in the key priority thematic areas - an overview of research trends since 2005 reflecting the diversity).

"*…as urbanization rapidly transforms Tanzania's physical, social and economic landscape, attention must be paid to the conditions in which new generations of Tanzanian children will be raised….The challenges posed by urban growth continue to receive scant attention from policy makers, due partly to widespread belief in an 'urban advantage' …..the misconception according to which urban dwellers must invariably be better off than rural people stems partly from the tendency to equate availability of services with access to them…the unplanned settlements where up to 80 per cent of urban residents live, most of whom cannot afford to pay fees and other costs for services…"* UNICEF 2012.

In the last few years, there has been some increase in the quantity and improvement in the quality of studies on the existing associations between the health of populations and the inequalities in life conditions. Available research findings suggests that Tanzania's social and economic development is challenged by sharp inequalities – between and within urban centres and rural areas, and also among different socio-economic groups. Economic disparity is compounded by unequal access to essential basic services and employment opportunities, and challenged by the gendered division of labour and structural and social norms, as well as unequal power relations.. Thus, while Tanzania has made significant progress towards achieving global and national targets in key areas of well-being, particularly in health and education, these achievements risk being undermined by persistent poverty (Masanja et al 2008, RAWG 2005, 2007, 2009, 2012; Smithson 2006, 2009, 2011; UNICEF 2009, 2012). There is a growing commitment to the expansion of health insurance to achieve a universal health system, whereby all those needing care can access affordable services. However, even though health insurance coverage is on the increase, studies indicate that wealthier groups are more likely to benefit (Kuwawranuwa & Borghi 2012; SHIELD 2010). Infant and under-five mortality rates have improved substantially in Tanzania over the last decade. However, neonatal mortality which is intrinsically linked with maternal mortality has not shown the same rate of decline. Maternal mortality also remains exceptionally high. Malnutrition of children is a serious problem in Tanzania, a manifestation of not only poverty and food insecurity but also of the nutrition status of the pregnant mother. Educated mothers are more likely to use health care services including family planning, taking their children for immunization and so forth. Progress in the water sector has been slow and improving coverage, especially in rural areas, and addressing geographic disparities remain top priorities (TAWASANET 2008). Most households have access to basic latrines, but these are often unsanitary and vectors for disease. Most schools fail to meet basic sanitation needs, and children with disabilities and adolescent girls following menarche are particularly affected. Lack of clean water in a majority of healthcare facilities severely compromises the quality of care offered, with poor infection control practices endangering both staff and patients. Despite major successes, the primary and secondary education programmes face ongoing challenges – securing adequate resources, financial and human, achieving greater geographic and gender equity, improving the quality of educational inputs and outputs; and meeting the needs of vulnerable children

(Leach 2007, Mkombozo 2005, 2006, 2010). There are also a number of critical governance and accountability issues in delivery of health care and education, including ensuring the appropriate exemption from health care and school charges (RAWG 2008). The need for decent shelter is noted in both rural and urban areas, but more pronounced in urban areas because of rapid urbanization and the growth of unplanned settlements that is largely due to rural-urban migration (UNICEF 2012). Other challenges facing settlement planning and management include poor infrastructure and poor social services. Thus contrary to expectations, findings from the most recent Demographic and Health Survey (2010) shows that the infant mortality rate in urban areas is slightly higher than in rural areas (63 and 60 deaths per 1,000 live births, respectively). Youths face a number of threats to their health, including HIV infections and sexually transmitted infections which can leave young women infertile and stigmatized by their families and communities (Mashoto et al 2010; Mhina & Hiza 2011; UNESCO 2008). Teenage mothers are at a much higher risk of dying of pregnancy-related causes. Young people face an uphill battle to gain the skills and experience they need to compete in the job market or make a living through self-employment. Majority end up working in the informal sector with limited opportunities to earn sufficient income to break out of the poverty cycle. Unemployment is an acute problem in youths who lack quality education and skill based training, in particular in the rural areas. Increased rates of depression, anxiety and substance abuse make those without a steady income far more susceptible to developing disease and chronic health problems. Poor mental health outcomes are associated with unstable employment (e.g. non-fixed term temporary contracts, being employed with no contract, and part-time work). Thus, whether one lives in poverty depends not only on income, but also on access to essential public goods and services. Some three fourths of Tanzania's population live in rural areas, though urbanisation has increased over the last three years. Poverty is increasingly urban: about one in six Dar es Salaam residents (and one of four in other Mainland cities) live below the poverty line. Between one in eight and one in fourteen households in Dar es Salaam are destitute (i.e. living below subsistence level). Overall, a little over a third of Tanzanians live below the basic needs poverty line.

Research from Tanzania also suggests that of the social determinants that affect health status and outcomes, poverty is the key (Gwatkin et al 2007; Khan et al 2006; Mahmood et al 2005; RAWG 2012). In Tamasha's study of specific educational needs of HIV positive learners for example, poverty is cited as a limiting condition at almost every level of the HIV positive child or youth learners' experience and is a key influence in the attitude and actions of many parents. Poverty is linked to school dropout and hunger, the latter posing a real problem for children on treatment. As noted by one young orphan (UNESCO 2008, p19):

"*We are tempted to enter love affairs to get money to pay for our school requirements. When a girl is propositioned and life is tough, she cannot refuse. Those who want to have sex with us are not boys or our own age, but adults*."

Or another, " *I don't have the school sweater and sports clothes and my mother can't afford to buy them for me because they are very expensive. This means I fail the subject of sports because every time I go to sports, the teacher cuts my marks and at the end of the day I fail. And they don't want to see any student wearing a sweater that is not the school uniform and if it is the cold season or I have a chest infection, I get problems*."

Stigma and discrimination was described as "*more killing*" than the disease itself, and the levels of denial evident in the system "*could be said to promote the spread of HIV*", seriously affecting the national response to HIV/AIDS in every way. Reflecting the level of isolation encountered by HIV-positive learners in rural areas, one young girl in rural Tanzania told

researchers: "*I am in pre-Form One. No one at school knows. It would be better if they do know but I am afraid of stigma.*"

SDHs matter even more for poorer people. Among the characteristics of poor people and poor households, relevant for disease focused SDH research in Tanzania are:

- Lack of access to quality public services, especially health, education, safe water and sanitation, and housing (shelter)
- Poor people suffer poorer health than those who are better off. They need more health care, but often get less. The poor are defined as 'hard to reach': care is more expensive and difficult to deliver.
- Poor people are more likely to have an inadequate diet than the better off.
- Many poor areas and individuals have limited social capital, and limited access to social networks essential to obtain resources and overcome periodic domestic crises.

When discussing SDH and health inequities in the Tanzanian context, one must therefore at least include the following:

- ***Socio-demographic factors*** (e.g. urbanization, migration, erosion of the extended kin/family system, social networks/ social cohesion, gender, etc.)
- ***Structural determinants*** (poverty, disparities, informality and self-employment); and with agro-pastoralism at the heart of the economy, land and animal ownership are the key determinants of wealth and poverty, followed by labour availability within the household
- ***Access to public services*** - quality health care, health financing strategies, education (especially mothers education, as it impinges on health-seeking behavior), housing (shelter), water and sanitation
- ***Access to information***, governance and accountability
- ***Coping strategies*** in the face of a shock or chronic poverty
- ***Migration and rapid urbanization*** – living in overcrowding and high density slums
- ***Rapid urbanization and changing lifestyles*** – diet, insufficient exercise, alcohol abuse, excessive smoking, emotional/mental stress
- ***Social and cultural norms and unequal power relations***[1] - for example, the effect of women's farm labor and limited self-determination in decisions affecting their healthcare and that of their children; harmful practices such as Female Genital Mutilation (FGM) and compared to women and girls born in Dar es Salaam, those born in Dodoma are more likely to perform; traditional beliefs and superstitions resulting in delayed health care seeking practices, or prohibiting women from eating some particular nutritious foods during pregnancy
- ***Food security*** – infrastructure and access to markets, inflation, drought, climate change and geographical location

The SDH agenda in Tanzania is still in its infancy and there is considerable scope for further

[1] Tanzania has more than 125 ethnic groups (tribes) each with their own social norms and cultural practices

research on SDH and health inequity. Effecting change in any one of the SDH factors mentioned (reducing poverty and informality, managing demographic and societal change, challenging the gendered division of labour in the agricultural economy, structural, social norms) is a long, long process. There are however, some relative quick wins - "actions" or "research priorities" – that fall under the purview of 'health policy' and though not focused on SDH, some progress in tackling health inequities can be obtained by focusing first, on these less daunting challenges. The fact that the economic, political and social conditions exert an important influence on health and disease, such interrelations should be subjected to scientific research.

Thus, moving beyond the narrow definition of health as combatting diseases only, **Annex F** provides a list of "SDH-health inequity" research/policy priorities coming from a cross-section of stakeholders interviewed – researchers, advocacy, policy, activists, development partners - with equity as a central issue.

4. National Systems: Research and Advocacy on SDH and health inequity: capacity needs and gaps.

"..we need to revisit the Alma Ata definition which would help us focus on the mental and social aspects of health in particular and which are not even considered; and also place an emphasis on todays young people, our future generation, who may appear physically reasonably healthy, but are not in other ways…" Researcher.

A number of organisations in Tanzania are working on issues pertaining to health and its inequities, some with a focus on research, others working actively towards dissemination and advocating for change, and a few on programme implementation (COHRED 2009). Some of these institutions are looking into disease and system research priorities, whereas others are examining the socio-economic and governance aspects of health and its implications. So for example, in the last five years or so, research undertaken by the NIMR, the Muhimbili College of Health and Allied Sciences (MUCHAS) and the Ifakara Health Institute (IHI) has been largely concentrated on issues related to strengthening health systems and addressing the determinants of malaria, HIV/AIDS and reproductive health, and more recently on health promotion, environmental health and urbanization. There has been some analysis of equity implications of specific health policies and practices in place - for example, an assessment of the extent to which exemption policies protect the poor and vulnerable and facilitate their access to quality health care; who pays and who benefits from the current health insurance system; and the role of health facility governing committees in ensuring that facilities address community priority needs. Related research undertaken by the Economic and Social Research Foundation (ESRF) and Research on Poverty Alleviation (REPOA) very much revolve around addressing the socio-economic, vulnerability and governance aspects of health. REPOA has also done considerable poverty analysis looking into specific disparities across the country and has also researched on aspects of maternal health and children's vulnerability. TAMASHA is a 'young' research and advocacy organization that gives a 'voice' to young people – recent participatory research undertaken by young men and women reflects their perspectives of HIV/AIDS and how it impacts on their lives; and of services (e.g. health and education) and governance issues affecting their well-being. TWAWEZA and SIKIKA on the other hand have been largely working on governance related issues within the health system; on health worker motivation and availability of essential medicines to citizens and books and teachers in schools; and on building capacities of citizens to demand for their rights and needs and

ensuring an informed community (i.e. health communication on aspects of water, citizen agency, education). SIKIKA also conducts analysis on social accountability in the districts they operate from to promote equity in the district health sectors, including planning and resource allocation, expenditure management, performance management, public integrity, and oversight, for affordable and accessible health care. The Tanzania Gender Network Programme (TGNP), an activist organization committed to the goal of contributing to a transformative feminist and empowered society, has since 1993 worked for the practical promotion of gender and women's advancement though activism, lobbying and policy advocacy, analysis and research, generation and packaging and dissemination of information, and training and capacity building. TGNPs main emphasis is to work directly with grassroots women / feminist/ activist groups and networks and coalitions at local level and facilitate enhancement of the capacities of these groups to carryout critical reflection and organized actions within their communities and develop linkages with others at regional, national and international levels.

Most of the research undertaken nationally employs a range of analytical and research skills - quantitative, qualitative, mixed methods, reviews, policy and budget analysis, animation methodology, investigative journalism - ranging from the conventional to participatory approaches aiming for inclusiveness. Many research disciplines are involved in SDH related research - epidemiologists, social scientists, medical anthropologists, statisticians, economists, political scientists, demographers, public health specialists, geographers, public policy analysts, urban-regional planners, gender activists, advocacy and communication specialists, etc. However, interdisciplinary research, pulling together various disciplines and approaches and lending a critical multidimensional view to poverty and existing inequities is just beginning to gain momentum.

Following are specific research capacity needs as noted by some of the interviewed researchers and/activists:

- qualitative social science research skills
- strengthening analytical skills at all levels, enabling researcher analysts and community animators to link micro and macro issues
- promoting public discourse about the SDH concept
- synthesising available research findings from an "SDH and inequity" perspective that would guide their next "research/ policy/ communications" agenda
- mainstreaming ethics in research
- structural equation modeling "to tease out complex relations"
- measurement and analysis of measures of economic status that are more responsive to changes in time, like spending power; not just as determinants, but also as outcomes of health intervention (e.g. WASH projects, intervention projects for chronic diseases (because chronic diseases usually cause huge income losses /increased expenses)
- use of explanatory models that analyse the relation between the way a given society is organised throughout time and the health conditions of its people; determining interrelations between general aspects such as social, economic and political factors and the way through which these factors affect the health of groups and individuals (will for a better understanding of correlations/ dynamics between general wealth indexes of a given society, such as the GDP, and the health indexes.

- use of available secondary data to understand the determinants better and design of potential interventions to address inequities

Over the last few years, policy makers, development partners and practitioners[2], activists, as well as academics working in applied research are recognising the importance of contextualizing research towards a better understanding of what works, how, where, why and why not. There is a clear recognition that in the process of scaling up, even the most successful pilots need to be adapted to the specific context and needs of the communities they serve. Thus, within IHI for example, there is an increasing appreciation that the value of research can be enhanced through a more systematic combination of quantitative and qualitative methods – through interdisciplinary and participatory approaches aiming to involve concerned stakeholders at various stages of the research process. To better understand people's perceptions to existing strategies and interventions, their needs and constraints, REPOA has over the last few years undertaken and/ or commissioned a number of participatory national research initiatives – the Afrobarometer survey, Views of the People and the Views of Children – an insight into people's / children's perceptions of social and economic policies and strategies in place and how it affects their well-being.

Exploration of the social determinants of health raises a number of methodological issues, chiefly related to measurement, that are not experienced in the more quantitatively oriented discipline of epidemiology. It is, for example, likely to take much longer for the impact of social determinants, be they changes in behaviour, in wealth status, or in effective access to quality social services (health care, education, water and sanitation), to show up in SDH evaluation studies. Also, the methods, definitions and scale of operation used in SDH research are distinct from those used in epidemiology. Community-based research for example, is essential in SDH research to contextualize the research and provide insights into determinants of malaria for example, at the local level, in the setting in which interventions actually have an impact on health - what do people do when infected with "malaria" and why? What are their health care seeking behavior patterns? Processes are difficult to measure objectively, but the dynamics of change can be analysed rigorously. Thus, information on topics such as malaria, diarrhea, water use and treatment-seeking behaviour can be used for designing appropriate health promotion messages.

In the context of local conditions, many terms used in discussions of the social determinants of some of the most common morbidities in the country (HIV/AIDs, malaria, TB, diarrhoea, etc.) take on specific significance. Survey questions may need to be re-evaluated to recognize local variations –to include a full range of work-related activities, by women and men, and related vulnerabilities, as these affect such things as the time available to visit health centres for treatment, and exposure to infection during farming; as well as try to gain insights into social capital and social networks used to access resources.

Overall, considerable research capacity building takes place in the process of undertaking collaborative research that is usually linked to ongoing mentoring from a team of senior researchers (national and international), often with opportunities for young and seasoned researchers to attend short trainings, methodological meetings and conferences. A number of research institutions also offer periodic trainings. REPOA for example, has a training portfolio that includes short courses on research methodology, data analysis, report writing and

[2] See Annex I for a brief summary of activities of some select development partners supporting research and policy related initiatives in Tanzania.

dissemination. These courses are open to researchers across the country. REPOA also provides funds and provides mentorship to young scientist to design and implement their own research projects. With financial support from the UNDP, and together with the ESRF and the Hague (in the Netherlands), REPOA offers a one year course on poverty analysis, a very popular and sought after course attended by mid- to senior-level professionals from the government, research and advocacy institutions. Ifakara Health Institute also provides funds to support its young researchers to undertake a Masters or a PhD programme. An in-house system of mentorship is also available to support young scientists in implementing their research studies, and analyzing secondary data. In collaboration with the Ministry of Health and Social Welfare (MoHSW), IHI is implementing the Sentinel Panel Districts (SPD) which is responsible for capacity building of the health facility personnel at the district level toward strengthening existing facility level health management information system (HMIS), as well as establishing the cause of illness and death at the household level through a system of verbal autopsies. Available information from the SPDs is supposed to be fed into a central database which can be accessed by different stakeholders towards programme development and for future policy implications. The Tanzania Gender Network Programme (TGNP) undertakes capacity building and training through its sister organization, Gender Training Institute. SIKIKA engages with councillors and district authorities to increase their capacity to hold their superiors to account in terms of, for example, ensuring effective budget and resource allocation for the health sector.

Most of the respondents were of the opinion that nationally and collectively, there is no shortage of individual research skills (though some institutions are faced with a basic human resource gap – not having enough staff who are employed specifically to carry out analysis and research). The issue is one of coordinating and maximizing the use of available research skills, and instilling some critical 'out of the box' thinking towards defining the research question.

Annex G provides a brief summary of a select few research / advocacy institutions, including ongoing SDH related research and dissemination strategies, as well as future research capacity needs.

5. National Systems Guiding Research and Policy on SDH and Health Inequity

5.1 National Policies, Strategies and Programmes addressing SDH and Health Inequity.

"*Having accepted that the determinants (of health and health inequalities) lie in many different sectors, there is obviously a need to look at policies in all sectors, assessing their likely impact on health, and especially on the health of the most vulnerable groups in society and to coordinate policies accordingly*". Margaret Whitehead 1990

National future plans and priorities are reflected in specific national documents, especially Vision 2025 and the National Strategy for Growth and Reduction of Poverty (NSGRP/ MKUKUTA, 2011-2015) which is the national framework to achieve Vision 2025 and the

Millenium Development Goals (MDGs) (URT 1999, URT 2010). MKUKUTA recognizes the multidimensional nature of poverty, and adopts an outcome-based approach which requires all sectors to contribute to the poverty reduction agenda. While there are no policies, programmes or legislation specific to SDH, the concern for inequalities and for inequities is central to Tanzania's Vision 2025 and to the MKUKUTA. These national priorities are further translated and reflected in sector specific strategic plans and policies, and the several reforms and programmes that Tanzania has adopted over the years.

Vision 2025, adopted in 1999, sets the country's long-term development agenda. In this Vision, Tanzania aims to achieve a high quality of livelihood for all Tanzanians by 2025; peace, stability and unity, good governance; a well-educated and learning society; and a competitive economy capable of producing sustainable growth and shared benefits. A high quality of livelihood for all Tanzanians is expected to be attained through realization of national goals encompassing food self sufficiency, universal access of essential services (including education, health care, water), gender equality and the empowerment of women, the elimination of abject poverty, and the reduction of infant and maternal mortality rates by three-quarters.[3]

Under Vision 2025, the health sector has been prioritized through cluster two of the NSGRP as a key factor in economic development, with the ultimate goal of improved quality of life and social well-being for all Tanzanians. The other two broad clusters in this five year national strategy that aims at addressing poverty in a comprehensive outcome-based approach are: Growth and Reduction of Income Poverty and Governance and Accountability. Reduction of vulnerability and effective access to quality of services are central to cluster II. Attention is particularly set on the promotion of clean and healthy environment and sustainable use of natural resources, and reducing disparities between rich and poor, persons with disabilities, across age groups, and between urban and rural citizens in access and use of social services. The goals of NSGRP/ MKUKUTA are incorporated in government plans and budgets. Implementation is reported annually in a MKUKUTA Annual Implementation Report (MAIR). Progress towards outcomes and targets is reviewed and reported annually by the MKUKUTA Monitoring System, either through an analytic volume, the Poverty and Human Development Report (PHDR), or through a Status Report. These reports are publicly available and are discussed at open meetings (URT 2006).

The National Health Policy also aspires for the achievement of improved health status through provision of equitable, quality and affordable basic health services, which are gender sensitive and sustainable. The Health Strategic Plan of 2007-2010 aims at enabling the Ministry of Health and Social Welfare (MoHSW) to critically examine and identify priority areas for strategic allocation of limited available resources (where maximum impact may be realised in line with MKUKUTA and other national policy frameworks). There are several Reforms and Programmes that aim towards delivery of fair, equitable and quality health services to the community, as well as empowering communities and involving them in health services provision - the Public Service Reform Programme, the Health Sector Reform Programme, the Local Government Reform Programme, the Primary Health Service Development Programme (PHSDP), commonly referred to by its Kiswahili acronym of *MMAM (Mpango wa Maendeleo ya Afya ya Msingi*), etc.

The MoHSW oversees the implementation of all health aspects within the country. Different departments within the Ministry are responsible for overseeing implementation of specific health issues – for example, Malaria, HIV/AIDS, TB, reproductive health and immunization aspects. Thus there is the 'One Plan' to accelerate reduction of maternal, newborn and child

[3] President's Office, Planning Commission. 1999.

deaths, the National Multisectoral Strategic Framework on HIV and AIDS (2008 -2012), the National Scale up Plan for the Prevention of Mother-to-Child Transmission of HIV and Paediatric HIV Care and Treatment (2009 – 2013), the Malaria Medium Term Strategic Plan 2008-2013 (URT, NMCP 2009), the National Nutrition Food Strategy and the National Food Security Strategy, and so on. (see **Annex H** for a summary of national some reforms, programmes, plans and strategies).

The MoHSW also works with other Ministries and sectors on different health aspects: with the Ministry of Agriculture through the TFNC (Tanzania Food and Nutrition Centre) towards addressing issues pertaining to food insecurity and malnutrition in mothers and children; Ministry of Community Development, Gender and Children (MCDGC); Prime Ministers Office, Regional and Local Government (PMORALG), education, youth, water and sanitation sectors; etc. etc. A number of CSOs, advocacy groups and research institutions work together with, and thereby lend technical support to, the various Ministries on specific issues.

Policies are important to promoting wellbeing. Altogether, there is no shortage of 'good' policies, strategies and programmes at national, sectoral and local government level. They are important to promoting wellbeing. But their importance in affecting actual wellbeing varies – only draw political attention, get translated into programmes, attract resources and are implemented. Further, whether the majority of the population benefits from the many good policies and programmes in place will depend ultimately on how these benefits and resources are allocated and distributed. As noted earlier, sustained economic growth (of around seven percent over the last few years) has not benefit the majority of the population. Poverty is pervasive. Disparities persist across the country. For example, according to some of the interviewees, health sector reform policies focusing on management issues and cost-effectiveness, do not leave much room for equity considerations. Even among the uniformly poor populations the very poor may not be reached.

5.2. Coordination and Governance Mechanisms

"*Coordination of all research carried out within Tanzania is not, in my opinion, possible nor desirable – let 100 flowers bloom. At the same time, it would be useful to strengthen mechanisms of sharing information and documenting all the different kinds of research which are carried out*." Policy Analyst

The Tanzania Commission for Science and Technology (COSTECH, Act No. 7 of 1986) that is under the Ministry of Communication, Science and Technology is the principal advisory organ to the Government and the coordinator of all research and development in the Country. In principle, COSTECH should therefore involve all important stakeholders in its activities. COSTECH is reported to have twelve research and development (R&D) committees in place with members coming from the industry, academia and the private sector. COSTECH does not undertake research but facilitates and provides a forum for cutting edge discussions. Researchers are reportedly encouraged to collaborate with COSTECH for effective dissemination of their research results.

In practice however, there is no single body that really coordinates research and policy related activities nationally to guide, avoid duplication and make effective use of available

resources.[4] As noted earlier in Section 4.1, NIMR for example, does provide some guidance on health research priorities towards addressing the existing burden of disease in the country. Additionally, research institutions and non-governmental organisations (NGOs) have their own institutional priorities in line with institutional objectives, and also to a large extent responding to available funding opportunities. Most of the respondents interviewed were against the idea of setting up yet another 'body' or 'committee' to coordinate or guide an SDH national research agenda – it is not a realistic or even a preferred option. In fact, "*is it realistic to expect coordination of research at national level*", when researchers/ advocates are often not even aware of what's taking place within their own institution (small or large ones).

"*NIMRI can not have a research agenda and expect others to implement; there should be a re-formation on how research agendas are being created*." Senior Researcher

There is however, some consensus and concern amongst those interviewed that despite evidence available on the existing inequities in health and the possible social aspects, there has never been substantial efforts to guide the implementation of research that reflect the integration of social determinants of health and health inequity. Most of the known recent and ongoing research on SDH and health inequity does not adequately accommodate the broader national health needs. For example, as noted by one respondent, even though mental health conditions are thought to be on the increase, in fact, noted to be "*quite alarming with inadequate infrastructure and resources to accommodate the number of patients*", there is an absence of data on the magnitude and the dimension of the problem. Aside from existing stigma within the community, researching on mental health is not a funding priority. As noted earlier, much of SDH related health research has largely centered around malaria and HIV/AIDS and reproductive health and confined to income poverty, risk behaviors, attitudes, perceptions and social demographic characteristics (age, marital status, education and sex), overlooking emerging health priority needs and their social determinants, such as for example, urbanization and environmental factors and the growing burden of non-infectious diseases, NCDs, as well as other social aspects which may be affecting individual's health outcomes including eating habits, taboo, housing status, employment status, nutrition and infrastructures. This, according to many of the respondents, is for a number of reasons, including:

- Limited national allocation to research and development (R&D) resulting in weak infrastructures and research activities that don't always address national health priorities i.e. an externally driven research agenda with the research question already defined and with limited national ownership.
- An absence of political will and governance systems to appreciate the need to embark and invest on emerging national priorities.
- Weak research networks and knowledge to policy link - mechanisms for coordinating and ensuring two way flow of information are weak though slowly gaining ground.
- Poor access to national research and other relevant data. According to one policy analyst, "*it is very difficult to access all official national level data, such as financial data at local government level, or human resource data by districts*"; generally, there is an "*absence of disaggregated data (by districts, target populations, gender, etc.) to understand existing disparities*", and is hard to understand why after all these year,

[4] See COHRED (2009): Figure 1,Tanzania Health Research Architecture, p17 for a glimpse of the pizza like mess – the difficulties in coordinating ongoing research, programmatic and policy related activities.

"*the routine health system is still not working*."

- Professional background and interest of concerned researchers as well as a preference of national academics to address issues that are publishable rather than those of national importance (though publications are also linked to a researcher's integrity, recognition in the world of research and promotion)
- An absence of scholarly/theoretical debates on Tanzania's development path and poor commitment to research (short-term relatively well-paid consultancies are common) resulting in poor quality of research outputs.
- Poor conceptualization and an understanding of SDH, poor national representation in the "SDH" international forums/bodies and limited skills to understand the need for, as well as the ability to synthesise available research findings from an SDH perspective. Even within some of the bigger research institutions, it was noted that research on SDH and health inequity per se is scarce due to Inability to link health and the social determinants, inability to create a demarcation between social determinants of health and other medical causes of health, as well as lack of interest and available resources. Researchers generally noted a bias towards "*traditional/ conventional*" ways of doing research, and '*not looking outside the box*' to allow for a broader inclusion and consideration, beyond individual level characteristics towards incorporation of structural determinants of health.

"*I am working in a government research institute… since last financial year we have received less than 40 % of funds required for research… the only hope is from donors … and of course to address their research needs and not ours!*" Researcher, TAKNET October, 2011.

Overall, external funding reportedly dominates government and non governmental organizations' (NGOs) activities. Nationally, long and short term policies or strategies and programs are often prepared in ad hoc and clouded with political pressures. Conformity to donor requirements completely distorts the *'already defragmented*' policy making process. Most respondents expressed their concern that research priorities are often set by collaborating partners and funding agencies and "*unpopular*" priority areas remain underfunded. Researchers are of the opinion that Government needs to step up its investment in the Research and Development (R&D), not only to ensure that national research priorities are met, but also to have the advantage of expert training and the technical competence to undertake research of an international standard.

"*..budget allocation to R&D as a proportion of GDP Tanzania is expected to reach 1% by 2015..South Korea's R&D expenditure as a proportion of GDP is 3.5…. implies that if the allocation of research is bigger, the government really expects researchers to feed them with well evidence based research to policy process and practice….*" Researcher, TAKNET, 01/11/2011.

As pointed out by one researcher, Tanzania needs to learn from countries such as South Korea and China that give a high level of recognition to research, researchers and their outputs. On average, countries prioritizing their R&D sector will be more productive in the future. According to COSTECH, the Government of Tanzania is recognizing the role of innovation and technology as a prerequisite to development, and though still small, support to the research sector is on the increase – from Tshs 1bn to Tshs 19bn last year (2011). It however, remains to be seen if Tanzania has the capacity to absorb available resources towards quality outputs: "*we need to focus on Human Resource development and infrastructure …and Tanzania needs*

a minimum of Tshs 30bn just to build research infrastructure. ..It is not cheap!"

The budget for research has been set but it's important for politician to uptake seriously recommendations from local experts. It is also necessary for the government to invest in long term research projects in all fields of development. According to one policy analyst, it's equally important to rebuild the process, "*to re-examine the basic assumption of the question, which is that policy formulation is carried out by the government and 'development partners', and the responsibility of researchers is to orient their research towards the priorities of 'the state*". According to another respondent, structures which are created within government institutions as think tanks might not be very effective, but strengthening already created research institutions to work independently is the most effective decision.

The institutionalization of evidence-based decision-making processes has reportedly resulted in an insufficient link of research institutions to private or public implementing agencies or to civil society organizations and has resulted in a general suspicion on the part of policy makers and researchers (*elaborated further in section 5.3 on national systems*). The prominence of donor- or external- driven research also raises a number of issues related to dissemination.

- First, policymakers often disregard research outputs that are not focused on national areas of priority.
- Second, researchers involved in donor-initiated research as consultants are not obliged to become involved in dissemination activities (often only authorized to share their report with the sponsor which can be either the government or the funding agency); they usually pass research findings only to the donor agency and then move on to the next consultancy.
- Third, research conducted by international agencies that are based outside of Tanzania is at times time bound (restricted to fieldwork), with little or no time for the researchers to consult national policymakers to refine research proposals that embrace local research needs or to discuss the policy or program implications of the research findings with ministries or health providers.

Researchers felt that the drawback of this situation was an inability for research organizations to identify research priorities, understand the cultural and contextual issues surrounding the research, and develop policy recommendations that reflect ''on the ground'' realities. Further, such research outputs were also quite likely to be presented at international conferences or published in international journals, and hence are not easily accessible to policymakers and government ministries within the country.

Of concern to many policy makers, activists and researchers alike, is the absence of a central depository for health research outputs, an inventory of research carried out nationally often resulting in unnecessary duplication of research on the same issues. As noted by one respondent, '*sometimes you find out about Tanzanian research while at a conference abroad. … in fact, there is more available abroad than in Tanzania*.'

5.3. Mechanisms are in place to promote networks and facilitate a two-way flow of information between governing bodies and research and advocacy institutions/ groups and decision makers (policy making bodies).

"*There is also a lot of confusion as regards the term "policy makers". Often researchers and other actors in the development arena define and recognize on National policy makers as* ***the***

policy makers, totally oblivious to the reality that there are local policy makers at district level who in fact wield the power to make or break, regardless of what national policy dictates! Papers have been published, presentations have been made, interesting discussions have been held and decisions taken, based on local research data and findings (that even the locals themselves are unaware of). Charity begins at home and not otherwise. What use is it for a conference or a reputable journal published in New York to address the rise in malnutrition rates in a district in Tanzania when the local leaders and local policy makers there are unaware of the situation? Who will address the challenge in the district - the conference, the journal, or some unseen force? Unless and until researchers learn to provide timely feedback at local level, learn to engage with the target audiences in planning for and implementing "doable" interventions to address the findings, however small, conferences will continue to be held, papers will continue to be published in reputable journals, but to zero results for the poor Tanzanians and others in the same category across the globe…." Senior Policy Analyst

At national level, there are a number of formal mechanisms in place that to some extent does facilitate a discourse, an exchange, between various stakeholders; a potential venue for sharing and discussing some major research/ policy outcomes. National performance is for example, discussed annually during the annual 'poverty policy week' that is attended by representatives from the Government, Civil Society and the Development Partners; as well as in national MKUKUTA cluster groupings – a review and discussion of milestones achieved, pending constraints and future priorities. Sectoral performance is also reviewed annually during the technical and sector performance review meetings – for example during the annual health or education or water sector review meetings. The focus of these annual assessment forums is largely on the overall implementation and performance of national and sectoral plans, if they are on track to achieving the MKUKUTA and sector targets and milestones, and the MDGs. Additionally, there are a number of sector-specific technical working groups addressing specific MKUKUTA priorities (health finance working group, social protection working group, HIV/AIDS working group, maternal and neonatal health technical working group, governance working group, etc.), and these also present a venue for presenting specific research findings and informing relevant stakeholders .

Within research, policy and/ or advocacy organisations, except for one interviewed researcher who noted that "*we do not conduct forums with policy makers…… we just share inside*", most institutions were reported to have some mechanisms in place for disseminating their research findings. Some of the most common strategies used by researchers to disseminate their research outputs include through participation in various national technical and dissemination forums, seminars, policy briefs, peer reviewed publication and conference presentations. Institutions also provide periodic updates to their respective funders and the most relevant sector.

To influence and feed into policy level decisions, research institutions can (and some do) also present some of their nationally relevant research outputs to the Research and Analysis Working Group (RAWG)[5] where research findings are critically reviewed by a cross-section of members from the government, civil society, research institutions and development partners. Some of the most relevant findings of this poverty analysis feeds into the making of the Tanzania Poverty and Human Development Report (PHDR) that usually comes out every other year and as noted earlier in Section 4.1, contributes to the Government Monitoring and Reporting Processes. The PHDR presents a consolidated view of the progress of in implementation of the three clusters of MKUKUTA, including an overview on the status of well-being, highlighting emerging challenges and future priorities. The PHDR assesses major

[5] A part of Tanzania's MKUKUTA poverty monitoring system.

changes over time by using indicators from a combination of commissioned studies by the RAWG, analysis of data from national surveys and routine administrative data systems, and independent research undertaken by a range of institutions in Tanzania. It also draws from public expenditure reviews. Findings and recommendations from the PHDR aim at influencing both National and Sector Strategic Plans and Budgets.

Differences in the dissemination process, however, may exist between research that is commissioned (by a donor or a government agency) and noncommissioned. With commissioned research there is possibly a direct channel of communication between the researcher and the end user, which facilitates the dissemination of the final research outputs (which is usually via donor-funded workshops). The commissioning agency typically is involved in the research process and has a vested interest in the research outputs and it is therefore more likely to be utilized in policy development. For noncommissioned research the channels of dissemination to policymakers are likely to be less clear and more varied, but usually limited to academic channels (e.g., papers in peer-reviewed journals or presentations at conferences). The direct dissemination of noncommissioned research to policymakers most commonly involved either distributing a research report to a range of policymakers or inviting key policymakers and other stakeholders to a dissemination workshop.

> *"when it comes to turning research into policy and practice, I am a big believer in getting out of the academics' comfort zone. That means less research reports and policy briefs, and using a more public approach, heavy on dissemination through the media (including social media) and trying to build a small network of influential political allies.– more through the informal political scene than through formal channels of dialogue and/or research. … a blog / facebook page / twitter account can have a lot of influence (though that depends a lot on who you are targeting)."* Researcher/ Activist

Institutions generally tend to differ in their approach, ranging from the conventional with a focus at reaching out to the national policy makers to the activist that is focused on bring change from below. Dissemination processes will depend upon the target recipient of information; for example, grassroots activists may benefit best from information shared through social media, popular theatre and radio/TV, and public fora. (**see Annex E**).

Researchers from the Ifakara Health Institute (IHI) for example, normally meet with relevant key stakeholders at the national and district levels (and perhaps relatively less so with concerned communities/ beneficiaries) to discuss research findings and its relevance for policy implication. Notes a senior policy analyst: "*a good example is the vast amount of data generated over the last 10 years through the Health and Demographic Surveillance Sites (HDSS) - what difference has all this data made to the concerned districts in terms of their better understanding of their health challenges, as well as the process of prioritization and planning to address these challenges*?" Also, through its Resource Center, IHI normally publishes policy briefs (Spotlight) that reflect various findings from research activities and these documents are normally distributed and shared among donors and decision makers at different levels. For example, recent spotlight publications have focused on health insurance coverage in Tanzania highlighting the fact that though insurance is on the increase among the Tanzanian population, the wealthier groups are more likely to benefit; on implementation processes and challenges to roll out (or scale-up) of the Integrated Management of Childhood Illnesses (IMCI) that has been relatively well integrated within the health system in Tanzania; and more recently highlighting the findings of a systematic monitoring and evaluation to track the equity and effectiveness of the Tanzania National Voucher Scheme that was introduced in 2005 to provide subsidized Insecticide Treated Nets (ITNs) to pregnant women, and later

infants. In the last couple of years, IHI has also supported the MoHSW to coordinate a number of national dissemination forums that have been useful avenues from getting a cross-section of stakeholders together to discuss research findings and current concerns and potential solution in malaria, quality of health care and health financing strategies. These forums do influence and shape policies in the longer run. IHI is also a member of the INDEPTH network for health research on longitudinal studies promoting the involvement of different research network systems. Generally, while IHI has done very well in the field of international development policy, influencing national policy has proven to be a challenge. More recently, an increasing premium has been put on research and knowledge communication and ensuring that research findings are communicated internationally and nationally, both to political leaders and the public at large.

Research on Poverty Alleviation (REPOA) disseminates its findings via a variety of channels in an attempt to reach out to a wide range of stakeholders working with 'poverty alleviation' and shape the national policy agenda, including through: annual and periodic research dissemination workshops involving stakeholders (CSOs, government institutions, multi-lateral and bilateral partners and Ministries; monthly open seminars; REPOA special research papers and policy briefs; participation in development of poverty monitoring master plan; secretariat to the RAWG and coordinating the PHDR. Through its various dissemination channels, but specifically through the RAWG and other 'informal' mechanisms, as well as by lending strategic technical support, REPOA has been quite successful in strengthening its collaboration with the Government and other sectors, and in shaping and/or influencing national policies, national poverty monitoring master plan, strategies and programmes.

Twaweza argues that "*sustainable change is driven by the actions of motivated citizens"* and "*public pressure and public debate are more effective drivers of change than expert or policy driven technocratic reforms".* With access to relevant information and ideas, as well as practical tools to translate these as into action, *"ordinary citizens can become the drivers of their own development and act as co-creators of democracy".* Civic agency, therefore, is both a goal in itself and effective means by which to improve service delivery and public resource management. Through publications, media, press conferences, stakeholder meetings, focused stakeholder materials, cell phones, primary and secondary school teachers and religious institutions, TWAWEZA tries to shape and inform public policy, as well as build the capabilities of citizens to know and demand for their rights.

Sikika works somewhat along the same lines as Twaweza, trying to influence stakeholders at national and community level, through: quarterly newsletter to communicate and disseminate findings and lessons learned from all its activities (an oversight role of existing mismanagement and misuse of public health funds); advocacy and engagement with Parliamentarians - to increase their capacity in holding the government accountable by sharing their analysis and evidence for improvement of policy and governance in the health and HIV/AIDS sectors (i.e. assist them in tracking the implementation of their past years recommendations to the health sector and health sector responses to the respective Committees); public policy dialogues –policy forums and press conferences with journalists and relevant stakeholders; and weekly radio sessions to stimulate awareness, knowledge and active participation amongst citizens on issues of social accountability in the health and HIV/AIDS sectors.

TGNP has adopted innovative strategies to influence and/ or change structures, policies and budgets at all levels. These include basic analysis and research, including participatory action research [PAR] using animation; activism and advocacy; organizing and networking; and

communications and information sharing. All their strategies focus on a specific campaign at any one moment, and on the strengthening of the 'transformative feminist movement' at all levels. These campaigns and most strategies have consistently included a specific focus on health or on health related issues, because of the way that grassroots women prioritise health as one of their primary needs and demands – access to quality health care has emerged as a major issue in every one of TGNPs research activities, and has guided the focus of their work in budget and policy analysis.

More recently, a number of NGOs (Haki Elimu, SIKIKA, TWAWEZA, Policy Forum, TGNP) are increasingly working closely together with the media on disseminating information to the public and decision makers on issues related to governance and prevailing inequities.

Despite all the research being carried out nationally, with some important advances in the knowledge of SDH and health inequities, and despite the range of dissemination mechanisms in place, there appears to be limited progress in the use of available knowledge towards developing or strengthening existing policies for addressing inequities. Some policy makers report that the link between researchers and policy makers remains a weak one and research is of limited value in influencing policies. What are some of the reported barriers?

Both researchers and policy makers reported that much research was conducted without collaboration and this posed a significant barrier to dissemination and utilization of research results. Policymakers reported that when they were involved in the research process, had commissioned the research, or the research was in direct response to a policy need, it was more likely to be utilized for policy development. Often, researchers may recommend the "*most effective but not the cheapest solution, and we cannot implement it*". The involvement of policymakers in the research process can result in more effective consideration of policy issues, political limitations, and practical realities in implementing the research findings. There is reportedly a "*huge disconnect between researchers and implementers*", in particular " *at local level where most of the data is generated*." Social/economic research in particular, is "*not demand driven in the sense that it is not initiated by policy makers or implementers to inform themselves on specific problems*". In such instances, "*even if you send research reports to the ministries or invite them to presentations the reports are likely to end up gathering dust on shelves*" (TAKNET, October 25, 2011).

Policy makers noted that there is no concrete advice coming from the research community on how research findings can effectively get translated into action and change at community level, or insights into the next priorities. Researchers' often lack skills and/or time in disseminating research outside academic circles of appropriate; they fail to appropriately ''package'' research findings that consider the needs of different policy audiences. Research institutions address a wide range of research topics and methods, from clinical trials, qualitative research with service users, service provider assessments, policy analysis, longitudinal demographic research, and systematic reviews, etc. and the different kinds of evidence they produce have varied implications and uses for policy and practice. Policy makers can be more receptive to some kinds of research evidence than others, and this should be heeded when planning communications strategies. Choosing appropriate techniques for sharing and communicating research is essential – get it out to the policy maker and into the media in innovative ways, seizing windows of opportunity and capitalizing on networks and personal links is critical. Research results can inform and be used by a wide variety of decision makers, such as politicians, public officials, program implementers, nongovernmental organizations (NGOs), international organizations, or service delivery bodies. Policy decisions also can vary from government ministries developing national

population policies at one end of the spectrum to informing program delivery strategies at local service points at the other end. Due to the variation in scope and level of decision makers, research results need to be communicated differently to each policy audience and according to the type of policy, decision, or program being influenced.

Many of the interviewed researchers described the desire to contribute to positive change as being a central aspect of their work, but many also struggle with competing demands on their time, especially when they are assessed solely on their research publication performance. Researchers also note that a fundamental barrier to the uptake of research by decision makers is the lack of appreciation of the important contribution that research can make to policy and program development. The equity analysis of the 2004/05 DHS data undertaken by Smithson (2006) for example, was an obvious piece of work that could have informed the national agenda towards addressing inequities, but "*it really did not get taken up by leaders in terms of what it started to tell us about the SDHs*… ". There has to be some motivation for the better off to bring about change, and what can that be? Or for example, how can we "*get the agricultural sector (who will want to maximize productivity and profits) to work together with the nutritionists who are interested in addressing maternal and child malnutrition* ", as well as disparities in access to foods across the countries? Often, research is perceived as an unnecessary expenditure for policy development in resource-poor countries. Also, policy makers appear to be interested in '*outputs for today*', in '*quick wins*'. Promoting an ideological change that values research evidence in policy development is a long-term process. It can be influenced, however, through closer collaboration among researchers and policy and program personnel.

Available evidence from some 'best practice' examples suggests that a number of factors are critical in shaping the extent to which research is used – credible evidence, an influential leader/champion that values critics and outside the box thinkers, policy networks and partnerships, advocacy and sharing of knowledge and experiences, informed citizens and public debate, and mobilization of resources (Mamdani et al 2008, Mubyazi 2005, Mwakyusa 2007, Orenge et al 2001, Tulloch et al 2011, (**see Box C**).

Box C. Effective dissemination of research – Some best practice examples

A study in three Sub-Saharan African countries suggested a combination of factors help explain uptake of research on Cotrimoxazole Prophylaxis (CPT) to policy: i) context and processes; ii) how evidence is understood and conceptualised; and iii) actors and links in policy, research and communications. Therefore research programmes and funders can identify what key actors link research and policy and work with them, ensuring findings reach them; identify potential problems that might hinder uptake (e.g. how an idea is conceptualised –policy relevance); and look at the process by which policy change happens and identify strategic windows of opportunity to link in findings to achieve change (Carden 2009).

The introduction and scaling-up of Adult Male Circumcision (AMC) services in Tanzania exemplifies the necessity of coordinated action from multiple stakeholders (Mwita et al.). HIV/AIDS remains the most important public health problem in Tanzania. Promoting effective interventions that prevent new infections and control of the epidemic is a policy priority. After evidence that emerged from trials conducted in South Africa, Kenya and Uganda showed that AMC provided partial protection against HIV infection, the Tanzanian government was keen to introduce AMC on a large scale from 2007. Strong political will to create a forum to develop AMC policy was in existence. Momentum was given to the process from policy actors at all levels. The president of the United Republic of Tanzania was enthusiastic for AMC to be introduced as an additional strategy against HIV infection. Two AMC relevant policies have been in place for several years, The National HIV/AIDS Policy of 2002 and the Traditional and Alternative Medicine Act of 2002. Rather than formulating a new policy it was agreed to adapt them to accommodate AMC as an intervention against HIV infection. Actors with a range of expertise contributed, including those from the donor community, NGOs, policy makers, researchers, advocacy groups and AMC practitioners in the policy process all of whom were crucial in the scale up efforts The lobby and advocacy group led the advocacy and mobilisation campaigns, the donor community funded the situation analysis study through the government of Tanzania and funded the development of a costed action plan and AMC demonstrations sites. To ensure decisions are evidence based, national researchers (NIMR) conducted a situation analysis of male circumcision in Tanzania. AMC scale-up is under-way and there is an enabling environment regulated by policy. New policy was not developed but existing policies were adapted to include provision of safe male circumcision procedures for the prevention of HIV infection. Several challenges remain such as the integration of traditional and clinical based circumcisions and how limitations within the public health system will affect the national AMC programme. The Tanzanian experience of planning and rolling out male circumcision services illustrates the potential of an inclusive, interconnected and on-going relationship required between policymakers, donors, advocacy groups, researchers and AMC practitioners within a national health programme (Wambura et al 2011).

The Ifakara Health Institute participated in several studies to assess the determinants of access to malaria prevention strategies and income was noted to be a barrier to access a treated mosquito net. This finding was shared with stakeholders at the Ministry and a discount voucher policy for treated mosquito net was institutionalized in the government to create access to malaria prevention services for the vulnerable groups including pregnant women and under five children (Sedekia 2012).

Evidence highlights the importance of on-going and continuous links between a range of actors to use evidence to develop policies which are sensitive to context: political, cultural and practical, and to maximize research impact on policy uptake and implementation. Research is not only valuable in itself but as a driver of wider social change. Research based on co-production of knowledge with different sets of stakeholders has the potential to contribute to better policy and public debate. Initiatives that resonate with and respond to broad public concern are more likely to gain traction, exercise accountability and be sustainable. Research also has the potential to make funders better informed as to how to allocate research funds, though the process is complicated because impact is difficult to track. Context plays a crucial role in shaping how research evidence is used; this varies between district, national and international levels and leads us to question whether these experiences can be replicated in other settings and if so, how and what we can learn from these case studies.

6. System performance: mechanisms in place to monitor the ethics and research and/or policy performance.

There are various mechanisms and processes in place, nationally and institutionally, that can potentially serve to monitor the performance of research products and systems, and the implementation of sectoral and national strategic plans, including the overall status and well being of Tanzanians. These include the ethical, technical, sectoral and national performance review processes; as well as periodic progress reports, seminars and dissemination workshops.

6.1. Ethical Review Committees

The ethics review bodies are a good means for assessing the soundness, feasibility and ethics of the proposed research and methodology, prior to its implementation. There are two national level ethics review bodies: the National Research Ethics Committee that is coordinated by the Research Ethics Department within NIMR, and COSTECH. There are another seven individual national research institutions.

Research protocols may be reviewed at the institutional level by the Institutional Ethics Review Committee. For institutions that do not have such committees in place, research protocols may be presented directly to and reviewed by the relevant national ethics committees. All research protocols involving foreign researchers (or internationally sponsored research, invasive procedures such as vaccine/ drug related research, human subjects (including research with and of communities)) have to be submitted to the National Research Ethics Committee for a second phase of the review process –all health related research to NIMR, and all non-health related research to COSTECH.

Even though ethics review bodies and 'National Guidelines on Research Ethics' in Tanzania are in place, not all research carried out within the country is ethically cleared. For example, not all national institutions undertaking or promoting research enforce an ethical review process (i.e. do not always require proposed research to be ethically cleared before implementation), unless of course it is a requirement by their collaborating partner, or their funder. Having said this, some institutions do have stringent ethical requirements in place, and often research protocols may require clearance by national bodies as well as those of their collaborating partners. According to NIMR, the presence of the National Research Ethics Committee and the review process in general has to some extent helped ensure that aside from protecting

research participants from any potential harm, the proposed research addresses national priorities, builds national research capabilities and is conducted in accordance with the national and international accepted standards. Also, even though there are no specific committees in place, nationally or institutionally, for reviewing research specifically on SDH and health inequity, existing Committees can ensure representation of reviewers who are best qualified to comment and provide technical inputs to specific subject areas.

An ethics review process costs – in terms of time and money. A full approval process (through institutional and national bodies) can take from a minimum of two to three months and beyond, pending on the complexity of the research, the soundness of proposed methodologies and availability of relevant reviewers. For example, research originating at IHI (alone or with one of its collaborators) is first presented to the Scientific Committee within IHI that usually provides useful feedback on the overall methodology and proposed analytical plan, including the level of priority that should be given to the proposed area of research, institutionally and nationally. This Committee usually tries to meet once a month or every other month. Once relevant comments are incorporated, a revised protocol is then shared with the Institutional Ethics Review Committee members that usually meets as required – phase two of the review process that may call for another revision of the research protocol before it is submitted to the NIMR National Review Committee (if need be) that is supposed to meet once a month, though this may not always be possible. The National body may well have questions and comments for further clarification that will need to be addressed before it once again reviews and approves the proposed research. Finally, as noted earlier, some external collaborators may have their own stringent ethical review requirements which can incur additional costs (also their requirements might not always be in sync with national ethical process and at times resulting in a conflict of interest).

To hasten the ethics approval process and make it more cost-efficient (or affordable), interviewed researchers reported a dire need to establish ethics committees at the respective academic institutions that can review the entire process (i.e. without having to go through 'national' bodies). Such committees' have to be approved and endorsed by the National Committee: the NIMR Act No. 23 of 1979 (an amendment of NIMR ACT of 1977) stipulates the criteria, conditions and fulfillments of establishing ethics committees. On the other hand, according to one senior researcher, "*the real research ethics story is the way in which 'ethics' have been abandoned as research has become commercialised, personalised, privatised*…"

6.2. Institutional Mechanisms

Research and advocacy institutions generally have a range of processes in place that provide a forum for periodic technical support as well as mentoring of ongoing research, ranging from monitoring institution specific indicators (generally linked to their five year strategic plans) and periodic progress reports to national dissemination forums. For example, REPOA has several mechanisms for monitoring ongoing research within the institution - the annual strategic plan that defines the institutional research priorities over a period of time (usually five years), periodic progress reports to the funders, periodic reviews by and feedback from REPOA's technical committee of senior researchers and policy makers from a several institutions, dissemination of research findings or methodological issues through 'open' and 'closed' seminars, as well as the annual research workshop that solicits feedback from a cross section of researchers, advocates, activists and policy makers from across the country.

The choice of indicators to inform institutions of their annual 'outputs' are usually related to number of research outputs (e.g. number of completed research projects in a specified time

period, number of reports submitted, number of conference presentations, number of publications in peer reviewed journals, number of dissemination forums, etc.) in specific thematic areas of interest. While these 'numbers' are a useful insight into the range and magnitude of ongoing activities, they are not necessarily a good indication of the quality of research being implemented, except perhaps for the published papers being accepted in well-known peer reviewed journals.

6.3. National Mechanisms

Nationally, the MKUKUTA Monitoring Master Plan provides a framework for deeper and broader monitoring of the range of issues covered by MKUKUTA (URT 2006). The monitoring system provides an analysis of changes in relation to goals and operational targets of MKUKUTA and these then inform decisions about national planning, budgeting, and public expenditure management. A total of 80 national level outcome oriented indicators provide the basic skeleton of evidence of changes in growth, well-being and governance during MKUKUTA implementation. They track changes and help to assess whether Tanzania is achieving the goals set in its MKUKUTA Strategy. Indicators are complemented by analytical research (the PHDR) which provides evidence about the causes and consequences of change. Availability of data and the potential to determine trends were two key factors in determining the categories and levels of disaggregation of each indicator. The national-level MKUKUTA indicator set is complemented by larger sector specific indicator sets (and as far as possible national indicators are drawn from sector indicator sets). Sectoral indicators assist in monitoring implementation of sector plans and priorities. And specific departments and Commissions within sectors have their own list of monitoring indicators linked to their current priorities. So for example, TACAIDS whose support to research and implementation of interventions revolves around issues related to HIV/AIDS, monitoring indicators include the number of MARPS reached with counseling or supporting groups, number of condoms distributed, number of people who have used VCT services, number of people (men/women/children/) on treatment, etc. Again, while these indicators provide some insight into access to essential services and numbers served, they do not say much about the quality of service provision.

The health M&E system consists of routine systems (Health Management Information System {HMIS}, demographic and disease surveillance) and the MoHSW is in charge of this; and non-routine systems (household surveys, research) that is done by other government or research entities. Tanzania can provide information of reasonable quality on health status of population, on diseases, and on health service provision. There are however, weaknesses in the collection of HMIS routine data which is not always complete or reliable, and often delayed. Vital registration does not have good coverage (and this information is required for planning health services). Other reporting systems in the context of MKUKUTA operate parallel to the HMIS. Operational research is under-funded. Data are not always analysed, organised or presented in a user-friendly way. Interpretation is limited.

A key concern expressed by several respondents is the focus on 'averages', on meeting the MDG targets, and the absence of indicators that identify the extent of inequality in the country. Most respondents noted the dire need to develop and adopt clear measurable indicators of progress on reducing inequalities; as well as incorporating more of the 'qualitative' indicators to better understand 'quality' aspects as well as perceptions of the beneficiaries.

The existing national monitoring system is under review. The revised MKUKUTA II Monitoring Master Plan is expected to document a set of monitoring indicators for all clusters, including the tool for data collection, timing, responsibilities and the institutional arrangements for data collection, analysis, and dissemination.

7. Strengthening systems towards a national SDH and health inequity agenda

"*Limited involvement of advocacy groups in dissemination forums has not been very effective ….. need to make sure that various relevant communication channels are used to disseminate findings and target policy makers at different ….. "* Development Partner

"..we already know the underlying reasons behind health inequities… can research make a difference?... addressing 'inequities' is challenging the 'status quo', the power base… we can only shift the scene when planners, policymakers, civil society, etc. actively recognize that social determinants shape equity/ barriers to services and opportunities, and that these are the drivers of poor health and the absence of well-being. It is to a large extent a political will issue, and the translation of political will into formal expectations of planners and service providers." Policy Analyst

"*…good number of researchers have cocooned themselves in the research activities with little attention to 'forward and backward linkages' of the process and results of the research. Efforts in the later would already make the research responding to a particular development problem/challenge*" (Researcher, TAKNET, October 25, 2011).

Tanzania has recently adopted a research and development policy (2010). The national research and development strategy is expected to improve the use of research evidence in the policy process and practices. The discourse on promoting change through research is picking up. For example, in October 2011, TAKNET facilitated an intensive discussion on what strategies and interventions need to be employed to improve the use of research evidence in the policy process and practices. But like any other commodity, researchers need to '*market and promote*' their findings.

Research and advocacy institutions and development partners as well, are giving growing attention to how research evidence is communicated to influence policy. The research to policy interface is influenced by policy context, characteristics of researchers, disciplinary perspectives, multiplicity of actors, and nature of the research evidence. Strategic alliances, coalitions and framing research evidence in ways that are attractive to policy makers are effective modes of influence. Practice is not necessarily influenced as a result of policy change. There are complex interactions between policy actors. Policy issues in sexual and reproductive health for example, can be controversial and neglected, influenced by political factors and shaped by context such as religion, ethnicity, gender and sexuality. Research evidence is complex.

According to a policy analyst, the work that researchers do is inherently transformatory and not easily moved into a framework of direct channels of influence. Some research influences only become visible over time and can have a variety of uses and impacts. It might contribute to a body of evidence, change attitudes and discourses, bring new issues onto policy agenda, influence policies or guidelines, or are taken up in the work of practitioners. The research

process itself may have impacts, for example through building partner's capacity or changing attitudes to controversial health issues both locally and internationally. The need to build networks is important, not only to influence policy but also for research and communication, it is, however, time consuming.

Also, it needs to be recognized that regardless of the evidence however, policy change requires substantial resources – human and financial - without which even the most glaring evidence can go unheeded. Thus, aside from evidence, a number of other factors were reported to shape research, policy and advocacy agenda's at institutional levels. And some of these same issues determine the extent to which national priorities are funded, including:

- conditionalities/ priorities attached to external support (for research and for implementing the national plans) that the country is increasingly reliant on
- many competing priorities fighting for scare available resources, an absence of 'key' stakeholders in decision making, conflicting ideologies between politicians and planners and pending on which technocrats are involved, politics usually overrides planning (generally, those who prepare budgets and make decisions on funding allocations are not always aware of issues at the community level.)
- electoral promises made by the ruling party
- sectoral guidance and lack of conformity in sectoral plans

Generally, researchers, advocates, development partners and policymakers acknowledged that research dissemination and policy formulation often is superseded by overriding influences such as the political environment, political ideologies and political priorities (particularly the influence of donors and constrained by government resources). It was recognized that research that advocates change may disrupt long-standing power relationships and organizational cultures that take a great deal of effort to implement, and as such may be ignored by policymakers. Thus even well-developed research findings may not be acted upon if the political climate is not conducive to change. In fact, researchers are quite reluctant to disseminate research findings that might be contrary to the prevailing political climate.

The research to policy is not an easy straightforward process. Policy makers and funders have their own interests and agenda's.

Following are some suggestions from a cross-section of interviewees towards promoting greater awareness and collaboration amongst decision makers across health and other sectors, and fostering better linkages between researchers, activists, the civil society, development partners and the relevant national policy making bodies – towards furthering a coherent SDH research and policy agenda, institutionally and nationally:

- Use the present Constitutional Review to get SDH on the agenda..". *Brazil and South Africa have managed to make big strides by ensuring a strong human rights focus in their Constitutions, and then following through on the commitments made to ensure the progressive realization of the right to health and other human rights. THINK BIG, build a coalition and don't fall prey to ….'churning out' policy briefs*."

- Identify, working with and through some potentially influential 'champions' of SDH and mainstreaming SDH in policy and in strategy framework documents; an acknowledgement of SDHs in the National Strategic Framework (MKUKUTA)
- Establish an organ, a 'SDH' body that which will champion the mainstreaming of SDHs in health research priority and agenda…."*There are many possible arrangements, but if you want to push this (SDH) agenda some sort of consortium of organizations interested in the subject would probably be a good idea…".*
- A representation of the 'SDH' body in ministerial advisory boards to identify priority research areas and to define appropriate research agendas to allow research activities to respond to programmatic needs.
- An increased awareness and public debate on SDH and health inequities amongst all stakeholders - trying out innovative approaches to enable participants to increase their knowledge of integrated approaches to issues surrounding health and well-being; and in raising awareness of the importance of addressing determinants of health and informing and monitoring public policy to address determinants of health - for example, researchers need to closely engage with all civil society actors who have a role to play in mitigating problems of poverty (such as NGOS, media, trade unions, schools and religious networks, etc.); identify people with 'spectacles' to iron the SDHs from the existing literatures and synthesize the knowledge for action and transformation; and generate an interest and willingness to engage in researching and addressing health inequities and their social determinants. Formal, 'institutional' avenues would be to get SDH into the agenda of the Annual Poverty Policy Dialogue or the REPOA Annual Conference. Less formal would involve, for example, organizing special sessions with relevant parliamentary committees or major Conference on SDH every couple of years, hold regular media seminars or Policy Forum breakfasts, a portal/gateway on SDH within a larger Observatory of Human Rights hosted by a coalition of CSOs sponsored by COSTECH under the lead of REPOA, TWAWEZA or similar; or perhaps build on existing platforms for dissemination, such as the Regional Capacity for Evidence-based Health Policy in East Africa (REACH) or the Tanzania Knowledge Network (TAKNET) (a platform for professionals and experts to meet , share and exchange experiences www.taknet.or.tz) or the Commonwealth Regional Health Community Secretariat (CRHCS) [6] that is an effective clearinghouse of research information.
- Packaging' of research findings that consider the needs of different policy audiences and to widen the target audiences for research dissemination – for example, policy briefs tailored to specific audiences; media seminars; popularisation of research through advertisements/videos/comic books etc. (even linked to a broad based adult education programme), monthly seminar series on health and development issues, which is open to the public and endeavours to attract practitioners as well as researchers, analysts, and activists, etc.
- A central depositories of research information – a self driven coordination of research within specific broad areas of analysis and research, including health – it should be coordinated by a public institution to enable greatest access and be publicized widely amongst policymakers and health and advocacy practitioners. Making information more accessible institutionally as well as to other stakeholders within the country (will also

[6] An objective of CRHCS is to collect relevant health research information from a variety of sources, repackage it, and disseminate it to its member states in East, Central and Southern Africa.

facilitate horizontal and vertical linkages between policy makers, research institutions, advocacy groups and the media).

- A roaster of researchers and topics of specialization to facilitate easier identification by policymakers and ensuring a critical mass of researchers with appropriate skills base, and out of the box thinking; instill critical thinking along the course of research, from conceptualization to interpretation of findings – Why do some people access care and others not? Why are some people better off and others not? Why are some treatments more effective in certain contexts than others? Why is the government more willing to support and subsidise the better off and not the poor? Why despite sustained growth in the last ten years, are inequities on the increase?
- National priority and support towards building national research capabilities (including strengthening research infrastructures)
- Strengthening communication networks and getting researchers/policy makers/ advocates/ communication specialists within and between institution(s) "*talking to and working with each other*" - bringing together different disciplines that can contribute to research on SDH and health inequity, and promoting collaborative interdisciplinary research partnerships within and across research institutions (and with advocacy groups and policy makers at all levels), ensuring complementarity between ongoing research within and between institutions; and in the translation of research findings into policy. Collaboration between researchers and policy makers, (a relationship of trust between researchers and the policy community) was encouraged at various stages in the research process by the respondents and policy makers – during designing research questions, and particularly in shaping policy recommendations to be sure that they are realistic and relevant to the resource constraints of the concerned ministries. Ensuring that policymakers gain a sense of ownership of the research is seen as crucial to the uptake of findings, illustrating the importance of giving careful consideration to appropriate. The key challenge for researchers is how to involve and promote effective participation of all stakeholders (advocates, decision makers, funders) at all stages of the research – i.e. make research a truly participatory process – without compromising on the research process and ensuring the objectivity and credibility of the findings.
- Researchers need to be proactive to include a dissemination phase in research proposals that include a dissemination plan, target audiences, dissemination activities, research ''products'', the range of communication media to be used, and a budget.
- Donors can enable and encourage dissemination activities and communication between researchers and policymakers or practitioners by encouraging researchers to incorporate dissemination strategies into a research proposal, so that funding for project-based dissemination is available and the researchers remain involved in in-country dissemination activities; and by giving priority to research proposals that have planned collaborative activities with key stakeholders at various stages in the research process, in particular, joint development of the proposal or identification of the research problem.
- Researchers' lack of skills in disseminating research outside academic circles needs to be addressed through the provision of training in communication strategies for differing audiences, developing a variety of research outputs, and shaping messages for policy audiences. Such training also would foster a greater awareness of how policymakers use research information and the constraints within which most. Training modules also could be included in the teaching curriculum at universities to foster an appreciation of the importance of research dissemination and utilization. An alternative to training researchers in dissemination is to have communications experts within their own research institutions or utilize ''communication mediators'' or ''knowledge brokers'' who work at

the interface between research organizations and target audiences (they may be advocates, communications experts, etc.).

8. References (in addition to references in Annex E).

COHRED. 2009. Tanzania. An assessment of the health research system. A country report of the AHA series. Geneva: COHRED. (Report written by Gabriela Montorzi, Sylvia de Haan and Carel IJsselmuiden from COHRED; and Leonard Mboera from NIMR.}

Ministry of Agriculture and Food Security (URT, MAFS). 2004. National Food Security Policy (Draft).

Ministry of Community Development and Gender and Children (MCDGC). 1996. 'Child Development Policy'.

MCDGC. 2001. 'A national plan of action for prevention and eradication of violence against women and children 2001-2015: Stop gender-based violence.'

Ministry of Education and Culture (MoEC). 1995. 'Education Training Policy'

MoEC. 2001. Education Sector Development Programme: Primary Education Development Plan (2002-2006). Basic Education Development Committee, Dar es Salaam.

Ministry of Education and Vocational Training (MoEVT). 2007. 'Education Sector Development Programme (ESDP): Education performance report 2006/07.'

Ministry of Health and Social Welfare (MoHSW) 2007. Primary Health Sector Development Programme, 2007-2017. Dar es Salaam: MoHSW.

MoHSW. 2007. National MVC Plan of Action.

MoHSW. 2008. National Road Map Strategic Plan to Accelerate Reduction of Maternal and Newborn Deaths in Tanzania (2006-2010). Dar es Salaam: MoHSW.

MoHSW. 2008. National Costed Plan of Action for Most Vulnerable Children, 2007-2010. Dar es Salaam: MoHSW.

MoHSW. 2009. National Nutritional Strategy (July 2009 – June 2015). Final draft. March 2009.
Ministry of Planning, Economy and Empowerment (MPEE). 2007. National Multisectoral Social Protection Framework. Second draft.

Ministry of Water and Irrigation (MOWI). 2007. Water Sector Development Programme 2006-2025. Dar es Salaam: MOWI.

Prime Minister's Office (PMO). 2001. 'National Policy on HIV/AIDS. Dar es Salaam: PMO.
PMO. 2007. National Multisectoral Strategic Framework on HIV and AIDS (2008-2012). Dar es Salaam: PMO.

SDH-Net 2012a. Conceptual framework "Building sustainable research capacity for health and its social determinants". SDH-Net Consortium.

SDH-Net 2012b. Guidelines for mapping research for SDH and Health Inequity. A focus on knowledge production and national research systems and mechanisms.

URT. 1999. *Tanzania Development Vision 2025.* President's Office, Planning Commission, Dar es Salaam.)

[1] URT. Ministry of Planning, Economy and Empowerment. December 2006. MKUKUTA Monitoring Master Plan and Indicator Information.

URT, MoFEA. 2010. National Strategy for Growth and Reduction of Poverty II. NSGRP II. Dar es Salaam, Tanzania: MKUKUTA Secretariat.

END NOTES

[i] SDH-Net is a collaboration between Universidad Nacional de Columbia (UNAL, Columbia), Instituto Nacional de Salud Publica (INSP, Mexico), Fundacao Oswaldo Cruz (FIOCRUZ, Brazil), WITS (South Africa), Ifakara Health Institute (IHI, Tanzania), University of Nairobi (UON, Kenya), London School of Hygiene and Tropical Medicine (LSHTM, UK), University of Geneva (UNIGE, Switzerland) and the Council on Health Research for Development (COHRED, Switzerland). SDH-Net is coordinated by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) and IESE Business School (Spain). The Project was launched in October 2011 and is financed by the European Commission under the 7th Framework Research Programme.

ANNEXES – TANZANIA: Social Determinant of Health (SDH) MAPPING PROCESS

ANNEX A. Mapping Process.

Based on a conceptual framework for building sustainable SDH research capacity that was developed by the SDH Network, guidelines for mapping research for SDH and health inequity was designed to capture aspects of SDH knowledge production and relevant national research processes and systems.

In the absence of a specific "SDH research portfolio" or "SDH centre/policy/department", as well as a lack of consensus amongst national researchers and policymakers on conceptualization of SDH within the Tanzanian context, we decided on the following approach:

- Kick start using the key health research priorities as defined by the National Institute of Medical Research (based on the burden of disease, national policy commitment, relevance and urgency)
- Review recent literature /strategies relevant to the specific research priorities to better understand the underlying reasons behind existing health inequities, the affected population, type and range of SDH-related research carried out (since 2005), the relevant sectors and actors (government, research institutions/ research groups and non-governmental organisations (NGOs)) involved in undertaking, communicating and advocating the implications of the specific research findings.

Criteria for shortlisting of key stakeholders:

- Representation from governing /coordinating bodies for research, relevant ministries, research institutions/groups and NGOs involved in advocacy
- Limited to Dar es Salaam based institutions (for practical reasons – cost and time)
- Research institutions/advocacy groups – those working on health, social policy, advocacy, gender (social and economic angle); a couple of small groups that might benefit from capacity building.
- Institutions/groups are accessible and representatives are available for an interview or a focus group discussion
- Absolute flexibility
- Objective is to get a bit of in-depth information on conceptualization and understanding of research on SDH and health inequity, ongoing SDH related research/ advocacy and future priorities and capacity needs/gaps.

ANNEX B. List of Stakeholders Interviewed

National Level Coordinating Systems
Centre for Science and Technology (COSTECH, 1 person)

National – Government Ministries/ Centres
Ministry of Agriculture, Department of Food and Nutrition (1 person)
Ministries of Community Development, Gender and Children (MCDGC) (2 persons)
Ministry of Health and Social Welfare (MoHSW), Department of Non Communicable Diseases (Mental Health) (1 person)
Ministry of Finance and Economic Affairs (MoFEA), Department of Planning and Budgeting (2 persons)
Tanzania Commission for AIDS (TACAIDS, 1 person)
Tanzania Food and Nutrition Centre (TFNC, 1 person)

National Research and/or Policy/advocacy Institutions:
African Medical and Research Foundation, Tanzania (AMREF) (1 person)
DARAJA (1 person)
Ifakara Health Institute (IHI, 7 persons)
Muhimbili University of Health and Allied Sciences (MUHAS), Department of Behavioural Sciences (2 persons)
National Medical Research Institute (NIMR), Department of Research Ethics (2 persons)
Research on Poverty Alleviation (REPOA) (2 person)
SIKIKA, Department of Health Governance and Finance (1 person)
TAMASHA (1 person)
Tanzania Gender Network Programme (TGNP, 1 person)
TWAWEZA (1 person)

Development Partners
Swiss Development Corporation (2 persons)
Irish Aid (2 persons)
UNICEF (1 person)
World Health Organisation (WHO, 1 person)

ANNEX C. Conceptualisation of SDH - Some Insights.

"Social inequalities, including deprivation, poor education and unemployment, that predict the shorter life-spans of the worst-off in society"

"These are drivers of epidemic [HIV/AIDS] and they differ locally and across regions and groups. They are behaviors that make people prone to disease which include, lack of condom use, lack of decision making power among women in marriage, mothers not going to the health facility for delivery, un willingness of men to check for their health status."

"First, one aspect of "health" that often slips through the gaps is sanitation and hygiene. Folks in the health sector tend to think more about health care services than about preventative health and/or more about …. preventative issues (i.e. malaria, HIV/AIDS, TB, etc.) than sanitation, while folks in the water sector are happier dealing with pipes and pumps than with public education and community mobilisation."

"It is something to do with the social demographics and social economic status of individuals that have an influence to their health status. It is also about the wealth indexes and level of possessions. Because the more people possess assets the more they become resilience in acquiring diseases."

"Social determinants of health and health inequity is all about the people's behavior practices, knowledge and health seeking behavior that puts them at risk of acquiring diseases. "

"Underlying" factors that contribute to health – for example, the "Babu" incident in Tanzania was largely linked to people's beliefs, attracted people from diverse backgrounds in search of solutions/ "magic cures" for their well-being (including "a need for children", a social need); therefore SDHs may also include 'faith related behaviours', and depending on one's perspective, SDHs may also be viewed as the basis of health inequity, or the "intervening issues to health inequity."

"How do you define SDH? Underlying determinants of ill-health? Structural determinants? It is very difficult to unpack SDH, very context specific, very broad, it is everything…rights based approach of addressing poverty….it is the MKUKUTA [National Strategic Plan]....cluster based outcome approach towards well being…health in a social context"

"SDHs are the direct and non direct factors related to health outcome, the enabling and pre-disposing factor, individual and structural/ system factors; moving beyond the health sector to all social aspects that may in one way or another contribute to one's well being, including issues related to empowerment, housing conditions, lifestyles, economic and social status, having clean water, food, education, as well as infrastructures for transporting food, accessing health care. Factors that are associated with either negative or positive outcome of health."

"In general, SDH should be defined as involving the non-biological or medical factors that impinge upon the health of an individual or a social group,

however defined by reference to a commonly held attribute (race, ethnicity, sex, sexual orientation, etc.). By 'health' I mean mental, physical as well as emotional well-being. I also include in the definition questions relating broadly to someone's quality of life (to the extent that it is determined by its health status) and life expectancy….I am deliberately omitting 'environmental' among the factors to be considered, along with other non-biological or medical ones, when one thinks about the strictly 'social' determinants of health.…The main reason for omitting a reference to 'environmental' relates to the 'physical environment' (as we are dealing here with SDH), but one must consider the importance of the 'broader environment', which includes culture, mores, social attitudes, etc. Thus understood, the 'environment' does clearly exert an impact on people's health and well- being. For instance, drought-induced hunger and disease would not count as part of SDH, but the coping strategies people adopt, which are partly determined by social structure and organization, traditions, beliefs, etc. do have a major influence on their capacity to withstand an environmental shock and recover from it without long-lasting, negative consequences to their health."

"Discrimination on the basis of gender -- as when couples abort female fetuses or neglect their baby girls when faced with a need to ration scarce food in a household -- can clearly have life-or-death consequences on people's lives. Here there is a collective -- unborn, newborn or infant females -- whose health is put at risk for reasons which have nothing to do with biology, medicine or the physical environment."

"From the point of view of health workers in the public health system, they have been deprived of adequate remuneration, job-security, and fringe benefits including hardship allowances, housing allowances and the like – which are especially crucial for women, given their vulnerability to gender based violence. Health workers have also been deprived of access to the means to provide quality health care, including adequate and quality equipment, drugs and medicines and other necessary facilities."

"They are social behaviours that includes taboos and perceptions; it is linked to accessibility and utilization of food; gender issues are involved; as well as transport issues"

"Goes beyond a biomedical understanding of diseases as it affects individuals to consider the social and behavioural setting within which the infection is transmitted and has its impact… it encompasses every aspect of disease transmission and control: diagnosis, treatment and care, preventive activities such as health education, vector control, and the provision of safe water and sanitation."

"Stakeholder concerns for priority health conditions including the integration of SDH policies and actions into general health programmes; equitable access to public services; intersectoral action; and promoting equitable access to health care….it is essential to focus on disease most common among poor, marginal populations – schistosomiasis, nutritional deficiencies that are a major barrier to social development."

"Availability of basic services to people (water, schools-education, housing-shelter, health care, food and nutrition, adequate income (livelihoods), and an awareness of causes of illness."

ANNEX D. Key Health Research Priorities in Tanzania and SDH Related Information

Key Health Research Priorities [as set by NIMR]	**Malaria-HIV/AIDS [TB]**	**Non-Communicable Diseases** **[Diabetes, Cancer, Mental disorder, Hypertension]**	**Environmental Health – Water Born Diseases** **(e.g. diarrhoea, schistosomiasis, worms)**	**Maternal, Neonatal and Child Health [MNCH]**	**Health Systems (quality of care, public private partnership [PPP], financing options -universal access to care, drug supply, human resources for health [HRH], governance & accountability)**	**Vulnerability/ Social Protection**
Most Important SDHs ***(Root causes of inequities in health)***	***Common*** • Social & cultural practices • Socio- economic status ***Malaria*** • Poor access to prompt malaria care, diagnosis and treatment; health education/ relevant information • Attitude towards malaria prevention strategies (use of insecticide treated bed-nets) • Living environment (presence of mosquito breeding spots)–water, sanitation, poor drainage	• Rapid urbanisation • C21st – changing lifestyles, unhealthy diet (obesity - nutritional transition), smoking, excessive alcohol, insufficient physical activity • Gender - Male migration due to climatic changes, linked	• Lack of basic services (clean drinking water, sanitation, poor drainage systems, shelter, access to health care, education) • Drought/ Floods • Urban poverty -overcrowding and high density, living in slums, unhealthy living conditions and	• Access to quality MCH services (family planning, EMOC, ANC, immunization, etc.) • Child spacing • Women's workload • Low Birth Weight • Rearing and Weaning practices of under two's	• Facilities in poor remote rural areas • Regressive financing strategies • Disparity in deployment of HRH • Poor infrastructure	• Weak governance and accountability mechanisms • Breakdown of traditional support structures and networks • Social isolation/ social exclusion • Absence of state support and safety nets • Regressive

	systems, poor garbage collection • Education status ***HIV/AIDS*** • Stigma and discrimination • Abuse at home and school • Sexual and physical violence against children • Engagement in unprotected sex • Concurrent sexual partners • Male circumcision • Female Genital Mutilation • Social isolation • Access to confidential and affordable quality reproductive and sexual health services (including testing and treatment) • Rapid Urbanization • Livelihoods – employment, seasonal migration (temporary work), widows and inheritance rights –land and property (property grabbing after death of a husband)	to women as sole caretakers of children (increasing stress, hypertension among women) • Age • Environment: Pollution] • Low awareness of potential risk factors	hazardous locations • Informal economy - insecure tenure, irregular or informal settlements • Poverty and social exclusion			financing mechanisms • Growth is not pro-poor • Growth of sectors that have poor linkages to the rural economy (the agriculture sector) where the majority of the population live

	• Lack of psychosocial support and resilience					
Some of the most vulnerable populations	**Malaria** • pregnant women & under five children • living in poor urban slums **HIV/AIDS** • Children and young people, girls in particular • Sex workers, bar maids, truck drivers, intravenous drug users, health workers (working under poor infection control practices), • Seasonal migrant workers (e.g. miners, tea plantation workers) • Older home-based carers (for PLWHAs) without any support • Widows without assets and failing to secure their inheritance rights.	• Urban population, especially in the affluent and educated • Elderly (health seeking behaviour studies for febrile illnesses focuses on under fives; adults as care takers/ heads of households; little is know on diabetic health care seeking behaviour)	• The poorest living in poor remote rural areas and the urban slums without access to health services, safe water, sanitation, and education (basic amenities) • Schistosomiasis - engaging in certain occupations (fishing, agricultural activities associated with irrigation); women during pregnancy and exposure during domestic activities; school-age children are of particular	• Poor Pregnant women, neonates, children under two years of age	• Poor people living in poor and remote districts, especially pregnant women, under-fives, the elderly, people with chronic conditions	Poorest and the most vulnerable living in poor rural and urban areas, especially the MVCs (orphans, street children, child workers), elderly as heading households and looking after children)

			concern, not only because of the high rates of reinfection, but mainly because of the association between schistosomiasis and stunting, vitamin A deficiency and developmental and cognitive problems.			

ANNEX E: General Recent Research Trends in SDH and Health Inequity (since 2005): published and ongoing research, some examples reflecting the diversity

Malaria	Bernard J, George Mtove, Renata Mandike, Frank Mtei, Caroline Maxwell and Hugh Reyburn. 2009. Equity and coverage of insecticide-treated bed nets in an area of intense transmission of *Plasmodium falciparum* in Tanzania. *Malaria Journal* 8:65 . Bruno P Mmbando et al. 2011. Spatial variation and socio-economic determinants of Plasmodium falciparum infection in north eastern Tanzania. *Malaria Journal*, 10:145 Kahigwa E. undated. Social-cultural factors that influence the implementation of malaria prevention diagnosis and treatment interventions in Tanzania. www.ihi.or.tz Manuel W, Hetzel et al. 2008. Malaria risk and access to prevention and treatment in the paddies of the Kilombero valley, Tanzania. Malaria Journal 2008. Masanja H. Information and beliefs about malaria and bed net usage in Rufiji DSS: www.ihi.or.tz Mulligan JA, Joshua Yukich and Kara Hanson. 2008. Research on Costs and effects of the Tanzanian national voucher scheme for insecticide-treated nets. *Malaria Journal* 7:32. Rashid A Khatib et al, Market, Voucher, subsidies and free nets combine to achieve high bed net coverage in rural Tanzania. (IHI) Smithson P. 2009. Down but not out: the impact of malaria control in Tanzania. Spotlight, 2. Dar es Salaam: IHI.
HIV/AIDS	Bastien S. 2008. Out-of-School and "At Risk?" Socio-Demographic Characteristics, AIDS Knowledge and Risk Perception among Young People in Northern Tanzania. *International Journal of Educational Development,* v28 n4, pp393-404. Fox A. 2010. Social determinants of sero-status in Sub-Saharan Africa. An inverse Relationship between Poverty and HIV. Public Health Reports, Supplement 4, Volume 125, 16-25. Kessy F, Mayumana I and Msongwe Y. 2010. Widowhood and vulnerability to HIV and AIDS-related shocks: exploring resilience avenues. REPOA Research Report 10/5. Mtenga S and Nathan R. (date?) Reaching the poor with Voluntary Counselling and Testing for HIV/AIDS and Treatment of

	Opportunistic infections. Mamdani M, Rajani R & Leach V. 2008. How best to enable support for children with HIV/AIDS: A policy case study in Tanzania. IDS Bulletin, 39(5): 52-61. TACAIDS, ZAC, NBS, OCGS, and Macro International, *Tanzania HIV and AIDS and Malaria Indicators Survey (THMIS) 2007/08*, TACAIDS, ZAC, NBS, OCGS and Macro International, Dar es Salaam, Tanzania, 2008. UNESCO with EducSector AIDS Response Trust ,RAISON Namibia and TAMASHA Tanzania. December 2008. Supporting the Educational Needs of HIV-positive learners: lessons from Namibia and Tanzania. Report written by Peter Badcock-Walters, Director of ESART. (participatory research, funded by UNESCO's Section on HIV and AIDS (http://unesco.org/aids)
Reproductive, Neonatal and Child Health	Alderman H, Hoogejveen J & Rossi M. 2006. Pre-school nutrition and subsequent schooling attainment: Longitudinal evidence from Tanzania. World Bank. Amury Z & Korriba A. 2010. Coping strategies used by street children in the event of illness". REPOA Research Report 10/1. Care International (Tanzania) and Women's Dignity Project. 2008. "We have no choice": Facility-based childbirth – the perceptions and experiences of Tanzanian women, health workers and traditional birth attendants. Elisaria E. December 2009. Malnutrition in Tanzania: Declining but not on track. IHI Spotlight. Issue 3. FAO, *Urban Food Insecurity and Malnutrition in Tanzania*, Revised Report prepared by Bureau for Agricultural Consultancy and Advisory Services (BACAS) of Sokoine University of Agriculture, March, 2009. Masanja H, de Savigny D, Smithson P, Schellenbert J, John T, Mbuya C et al. 2008. Child survival gains in Tanzania: analysis of data from demographic and health surveys. Lancet, 371, 1276-1283. Mascarenhas O & Sigalla H. 2010. Poverty ad the Rights of Children at Household Level: Findings from Same and Kisarawe Districts, Tanzania". REPOA Research Report 10/3. Radboud University Nijmegen, CIDIN/NICE/NICHE & Muhimbili University for Health and Allied Sciences. Forthcoming. Impact of

	Reproductive Health Services on Socio-Economic Development in Sub-Saharan Africa: Connecting Evidence at Macro, Meso and Micro-Level. A Reproductive Health and Development Research Programme. Draft Discussion Document on Policy Implications. (Research Programme initiated in 2008). Sommer M. 2009. Where the education system and women's bodies collide: the social and health impact of girls' experiences of menstruation and schooling in Tanzania. Journal of Adolescence. Van de Poel E, Hosseinpoor AR, Speybroeck N, Van Ourti T & Vega J. 2008. Socioeconomic inequality in malnutrition in developing countries. Bulletin of World Health Organisation 86(4): 282-291. Victora CG. October 2006. 'Are health interventions implemented where they are most needed? District uptake of the Integrated Management of Childhood Illness strategy in Brazil, Peru and the United Republic of Tanzania', Bulletin of the World Health Organization 84 (10)
NCD	Health care seeking behaviour in the context of epidemiological transition in Tanzania: a case of malaria and diabetes. (IHI - PhD)
Environmental ***Health***	Castro et al (2010) in World Bank, *Mayor's Task Force: Urban Poverty & Climate Change in Dar es Salaam, Tanzania: A Case Study,* Final Report, World Bank, Washington D.C., May 31, 2011. Climate Works Foundation et al (2009) in World Bank, *Mayor's Task Force: Urban Poverty & Climate Change in Dar es Salaam, Tanzania: A Case Study,* Final Report, World Bank, Washington D.C., May 31, 2011. Health Focus (2006) in World Bank, *Mayor's Task Force: Urban Poverty & Climate Change in Dar es Salaam, Tanzania: A Case Study,* Final Report, World Bank, Washington D.C., May 31, 2011. Moore S et al. Undated. Health promotion for impoverished rural and refugee populations in Tanzania focusing on malaria control, sanitation and water supply. (LSHTM, Concern Worldwide, IHI, Durham University collaboration). www.ihi.or.tz Ndalahwa Faustin Madulu et al., "Population, Health, and Environment Integration and Cross-Sectoral Collaboration in East Africa: Tanzania Country-Level Assessment" (2007), available from popref@prb.org Sheuya SA. 2008. Improving the Health and Lives of People living in Slums. Ann. N.Y.Acad.Sci. 1136: 298-306. (contact:

	sheuya@yahoo.com, Ardhi University, Dar es Salaam, Tanzania). Stansfeld S & Candy B. 2006. Psychosocial work environment and mental health – a meta-analytic review. *Scandinavian Journal of Work and Environmental Health*, 32:443-462. TAWASANET. 2008. Water: more for some….or some for more? Watkiss et al (2011) in World Bank, *Mayor's Task Force: Urban Poverty & Climate Change in Dar es Salaam, Tanzania: A Case Study,* Final Report, World Bank, Washington D.C., may 31, 2011.
Health System ***Research***	Equity and Efficiency in Service Delivery: Human Resources. Background Analytical Note for the Annual Review of the General Budget Support 2008. Kida, Tausi, *The Systemic Interaction of Health Care Market and Urban Poverty in Tanzania*, Ph.D. Dissertation, International Institute of S of Erasmus University Rotterdam, The Hague, The Netherlands, 2009. Kuwawenaruwa A & Borghi J. June 2012. Health insurance cover is increasing among the Tanzanian population but wealthier groups are more likely to benefit. Ifakara Health Institute Spotlight, Issue 11. Prosper H, Macha J and Borghi J. March 2010. Despite challenges, IMCI scale-up is possible. IHI Spotlight, Issue 4. SHIELD Information Sheet. 2010. Who pays for Health Care in Tanzania? IHI Spotlight. SHIELD Information Sheet 2010. Who benefits from Health Care in Tanzania? IHI Spotlight. SIKIKA. 2011. Medicines and medical supplies availability report. Using absorbent gauze availability survey as an entry as an entry point. A case of 71 districts and 30 health facilities across Mainland Tanzania. 10th-20th May, 2011. Dar es Salaam: SIKIKA (www.sikika.or.tz) Performance based incentives implemented in East Africa (research project IHI, synthesis of available literature and secondary analysis of available data)

Governance And Accountability	Croke K. August 2011. Politics, Child Mortality, and Health Systems Development in Tanzania and Uganda. 1995-2009. Draft Version. Johns Hopkins University, School of Advanced International Studies, kevinjcroke@gmail.com) Fjeldstad O-H, Katera L & Ngalewa E. April 2008. Citizens demand tougher action on corruption in Tanzania. REPOA Brief No. 11. Fjeldstaf O-H, Katera L & Ngalewa E. November 2008. Disparities exist in citizen's perceptions of service delivery by local government authorities in Tanzania. REPOA Brief No. 13. HakiElimu. December 2006. Is Government Managing Money Well. Findings from Recent Audit Reports. Report written by Ruth Carlitz. www.hakielimy.org Hoogeveen J & Ruhinduka R. 2009. Poverty reduction in Tanzania since 2001: Good intentions, few results. Paper commissioned by the Research and Analysis Working Group, Tanzania. (unpublished) Katera L & Semboja J. 2008. Budget allocation and tracking expenditure in Tanzania: the case of health and education sectors. In: Pressend, M & Ruiters, M. (eds). *Dilemmas of poverty and development – a proposed policy framework for the Southern African Developn Community.* Midland. The Institute of Global Dialogue. Tidemand P & Msami J (forthcoming). Local government reforms and their impact on local governance and service delivery: Empirical evidence of trends in Tanzania Mainland 2000-2008. Twaweza. October 2008. Twaweza fostering an ecosystem of change throughout East Africa through imagination, citizen agency and public accountability! www.twaweza.or.tz.
Vulnerability, Social Protection &	Aikaeli J. 2010. Determinants of rural income in Tanzania: an Empirical Approach. REPOA Research Report 10/4. Amury Z & Aneth K, *Coping strategies used by street children in the event of illness*, Research Report 10/1, 2005, REPOA, Dar es Salaam. Gwatkin DR, Rutstein S, Johnson K, Suliman E, Wagstaff A & Amouzou Agbessi. April 2007. Socio-economic differences in health, nutrition and population. HNP, The World Bank.

Poverty Analysis	Khan et al. March 2006. Geographic aspects of poverty and health in Tanzania. Does living in a poor area matter? Health Policy and Planning 21(2): 110-112. Kijakazi O Mashoto, Anne N Astrom, Marit S Skeie and Joyce R Masalu. 2010. Social demographic disparity in oral health among the poor: a cross sectional study of early adolescents in Kilwa District, Tanzania BMC. Open access. Leach V. 2007. Children and vulnerability in Tanzania. A brief synthesis. REPOA Special Paper 07.25. Dar es Salaam: REPOA. Lindeboom W, Leach V, Mamdani M & Kilama B. 2006. Vulnerable children in Tanzania and where they are. An unpublished report, REPOA. Maarifa ni Ufungo. 2008. Cost sharing in education in Kilimanjaro III: How the gaps are widening. Kilimanjaro: Maarifa ni Ufungo. Mahmud MK, Hotchkiss DR, Berruti ASA, Hutchinson PL. 2005. Geographic aspects of poverty and health in Tanzania: does living in a poor area matter? . Oxford University Press. Mbelle. A.V.Y. 2007. Macro Economic Policies and Poverty Reduction initiatives in Tanzania: What Needs to be done? ESRF Publication. McAlpine, Kate, Robert Henley, Mario Mueller and Stefan Vetter, 'A Survey of Street Children in Northern Tanzania: How Abuse or Support Factors May Influence Migration to the Street, *Community Mental Health Journal*, Volume 46, Number 1, 26-32, 2010, DOI: 10.1007/s10597-009-9196-5. Mboghoina T & Osberg L. 2010. Social Protection of the Elderly in Tanzania: current status and future possibilities. REPOA Special Paper 10/5. Mhina, Edward Hiza, *Youth Policies and Violence Prevention in the Great Lakes Region: A Study on Tanzania—Towards Youth Inclusive Policies and Prevention of Violence in Tanzania*, A study conducted for United Nations Educational, Scientific and Cultural Organisation, UNESCO, Dar es Salaam, 2011. Ministry of Labour, Employment and Youth Development in collaboration with HelpAge International, Dar es Salaam, Tanzania. May 2010. Achieving income security in old age for all Tanzanians: a study into the feasibility of universal social pension.

Ministry of Foreign Affairs of Denmark, DANIDA. 2008. Gender equality in health. www.um.dk

Minot N, Simler K, Benson T, Kilama B, Luvanda E and Makbel A. January 2006. Poverty and malnutrition in Tanzania: New approaches for examining trends and spatial patterns. International Food Policy Research Institute: Washington, DC. or www.repoa.or.tz)

Mashoto et al. 2010. Social demographic disparity in oral health among the poor: a cross sectional study of early adolescents in Kilwa District, Tanzania.

Mkombozi, *Census report 2005: A comparative analysis of Tanzania's most vulnerable children*, Mkombozi, Moshi and Arusha, 2005.

Mkombozi, *Census report 2006: The rhetoric and reality of Tanzania's street children,* Mkombozi, Moshi and Arusha, 2006.

Mkombozi, *Census Report 2010: Empowering children, engaging families, and engaging communities*, Mkombozi, Moshi and Arusha, 2010.

Mkombozi, *'Perceptions' Survey: Survey of Community members' perceptions of children who are living/working in the street*, Mkombozi, Moshi and Arusha, 2010.

Mwanakombo Mkanga, *Impact of Development-Induced Displacement on Households Livelihoods: Experience of people from Kurasini Dar es Salaam – Tanzania*, MSc Thesis, 2010.

National Bureau of Statistics (NBS), *Key Findings; Child Work and Child Labour in Tanzania: The Integrated Labour Force Survey (2006)*, NBS, Dar es Salaam.

NBS and UNICEF (2011), *Children with disabilities in Tanzania: Prevalence and experiences, Report based on the Tanzanian Disability Survey of 2008,' Final Report*, NBS and UNICEF, Dar es Salaam, June 2011.

RAWG, MKUKUTA Monitoring System & Ministry of Finance and Economic Affairs. 2012. Poverty and Human Development Report 2011.

RAWG. 2009. Poverty and Human Development Report 2009. Dar es Salaam: Mkuki na Nyota Publishers

RAWG. 2008. Views of the People 2007: Tanzanians give their opinions on growth and poverty reduction, their quality of life and social well-being, and governance and accountability. Dar es Salaam: REPOA.

RAWG. 2008. Tanzanian children's perceptions of education and their role in society: Views of the Children 2007. Dar es Salaam: REPOA.

RAWG. 2006. Status Report 2006: Progress towards the goals for growth, social well-being and governance in Tanzania. Dar es Salaam: REPOA.

RAWG. 2007. Poverty and Human Development Report 2007. Dar es Salaam: Mkuki na Nyota Publishers

RAWG. 2005. Poverty and Human Development Report 2005. Dar es Salaam: Mkuki na Nyota Publishers

Save the Children, UK, Singida District Council (Tanzania), Sustainable Environment Management Action. 2006. Poverty and Vulnerability in Singida Rural District. Household Economy Analysis. Report written by Claire Chastre

Smithson P. 2006. Fair's fair. Health inequities and equity in Tanzania. Dar es Salaam: Women's Dignity Project and Ifakara Centre for Health Research and Development.

Smithson P. October 2011. Tanzania Demographic and Health Survey 2010. What has changed? Ifakara Health Institute, Spotlight, Issue 9.

Tanzania Gender Network Programme (TGNP). 2009. Will the 2009/10 budget work for marginalised women? Gender, Democracy and Development Digest. Issue No 1.

Tanzania Gender Network Programme (TGNP). 2009. "Who cares for us?" Time Use Study of Unpaid Care Work in Tanzania. Dar es Salaam: TGNP

TAWASANET. 2008. Water: more for some….or some for more?

	UNICEF, Tanzania. 2009. Childhood Poverty in Tanzania: Deprivations and Disparities in Child Well-Being. A Joint Report by REPOA, NBS and UNICEF. UNICEF, Tanzania. 2012. Cities and Children. The Challenge of Urbanisation in Tanzania. Dar es Salaam, Tanzania. URT, RAWG. Poverty and Human Development Report (2003, 2005, 2007, 2009, 2012). Dar es Salaam: Mkuki na Nyota Publishers. URT. 2011. *Stopping Violence Against Children. The Tanzania Violence against Children Study and the National Response*, UNICEF, Ministry of Community Development, Gender and Children, Dar es Salaam.
Knowledge ***to Policy***	Carden F. 2009. Knowledge to Policy. Making the Most of Development Research. IDRC, Ottawa. www.sagepublications.com Hennink M & Stephenson R. 2005. Using Research to inform Health Policy: Barriers and Strategies in Developing Countries. Journal of Health Communication, 10:163–180, 2005 (Univ of South Hampton). IDRC, Research Matters. Some major projects supported Matters. Mubyazi GM & Gonzalez-Block MA. October 2005. Research influence on antimalarial drug policy change in Tanzania: case study of replacing chloroquine with sulfadoxine-pyrimethamine as the first-line drug. Malaria Journal 2005 , 4:51. http://www.malariajournal.com/content/4/1/51 Mwakyusa DH. May 2007. From Research to Policy: the Role of Health Research institution in social development in Africa. Tanzania Health Research Bulletin Vol 9, No. 2: 140. (Opening address by the Minister for Health and Social Welfare during the 22nd Annual Joint Scientific Conference of the National Institute for Medical Research, Arusha, Tanzania, 7h March, 2007) Oronge RN, Undie CC,Zulu EM, Crichton J. June 2011. Engaging media in communicating research on sexual and reproductive health and rights I sub-Saharan Africa: experiences and lessons learned. Health Research Policy and Systems 2011, 9(Suppl 1):S7 (http://www.biomedcentral.com/1478-4505/9/S1/S7). [IDS, Population Council, African Institute for Development Policy, University of Bristol; case study approach – personal experiences, literature review, science journalists] Policy Forum. 2009. Reducing Poverty. Have the lives of Tanzanians improved? Media Briefs. www.policyforum.or.tz Sedekia Y. March 2012. Using monitoring and evaluation to improve ITN strategy equity and effectiveness. Ifakara Health Institute Spotlight, Issue 10.

Tanzania Academy of Sciences (TAS). 2009. Engaging and Influencing Government and Decision Makers. Report of a workshop held at the Holiday Inn Hotel, Dar es Salaam, 16-17th October 2009 as part of the Royal Society Pfizer African Academies Programme.

Tulloch O, Mayaud P, Adu-Sarkodie Y, Kofi Opoku B, Oye Lithur N, Sickle E et al. May 2009. Using research to influence sexual and reproductive health practice and implementation in Sub-Saharan Africa: a case-study analysis (From Strengthening the research to policy and practice interface: Exploring strategies used by research organisations working on Sexual and Reproductive Health and HIV and AIDS Liverpool, UK. 18-19 May, 200}. Health Research Policy and Systems 2011, 9(Suppl 1):S10 http://www.biomedcentral.com/1478-4505/9/S1/S10

Mamdani M, Rajani R, Leach V. 2008. 'How best to enable support for children with HIV/AIDS. A policy case study in Tanzania'. IDS Bulletin, 39 (5): 52-61.

TWAWEZA, *Malnutrition: Can Tanzania afford to ignore 43,000 dead children and TShs 700 billion in lost income every year: A Policy Note*, No 35, Uwazi InfoShop at Twaweza, Sikika, and Policy Forum, Dar es Salaam, 2011.

Wambura M, Mwanga J, Mosha J, Mshana G, Mosha F, Changalucha J. National Institute for Medical Research, Mwanza, Tanzania. 2011. Case-study Four (CS4). Scaling up adult male circumcision for HIV prevention. The Tanzanian experience. In: Tulloch O, Mayaud P, Adu-Sarkodie Y, Opoku BK, Lithur NO, Sickle E, Delany-Moretlwe S, Wambura M, Cahgalucha J and Theobald S. 2011. Using research to influence sexual and reproductive health practice and implementation in Sub Saharan Africa: a case-study analysis. Health Res Policy Syst. 9 (Suppl 1): S10.

Whitworth J & Pang T. 2007. Using Research to Inform Health Policy: A Perspective From the World Health Organization's Advisory Committee on Health Research. Harvard Health Policy Review. Vol. 8, No. 1 :107-113.

ANNEX F. Some " SDH-health inequity" research/policy priorities according to the interviewed stakeholders

- The effect of corruption and poor accountability, the lack of faith in leaders, the despair… on the mental health of all Tanzanians
- The effect of poor quality of education in primary and secondary education, '*of sitting doing nothing all day*' on the mental and social health of the 'students' advocate.
- Correcting for disparities in literacy levels, especially among women; in ease of access, utilization and quality of health and education services; and in access to clean and safe water.
- Addressing the costs of health services (open and hidden) and facilitating access to health care (e.g. ensuring proper implementation of user fee waiver/exemption schemes; removing fees for critical, life-saving interventions; granting free health cards to extremely poor households deemed eligible to existing social safety nets under the TASAF/PSSN or MVC programs; providing regular and predictable cash transfers to chronically poor and vulnerable groups), etc.
- A better understanding of health seeking and caring practices, especially for long-term chronic conditions.
- Impact of forced sex and sexual harassment at an early age on health and well being of adolescents.
- Addressing harmful practices based on traditional beliefs, superstition, stigma and discrimination - challenges faced by the education system in addressing the specific learning needs of the increasing number of children and young people with HIV/AIDS who are faced with stigma, discrimination and poverty; and stigmatisation and neglect of people with disabilities.
- Problems faced by older, school-age children that are rooted in social determinants such as poverty, malnutrition, and poor hygiene that are linked to lack of safe water and sanitation; the nutrition vulnerability of school-age children; and effects of childhood stunting on learning outcomes.
- Researching 'gender' that is socially determined and refers to the social roles, responsibilities and activities of males and females (hence the need to disaggregate data according to gender):
    - Gendered treatment-seeking behavior taking into account the status of women, issues of safety and security, their lack of social power, the decision-making dynamics at the household level, etc.
    - Gendered difference in workloads which leads to poor maternal health and nutritional status - again especially among rural women - and then the caring and feeding practices for babies and infants
    - How to best to reach out to and address the immediate health and nutrition needs of pregnant and lactating women that affect their own health and that of their unborn children, to those most in need? How best to provide integrated care – combine a range of programmes that involve women and young children such as reproductive and sexual health, PMTCT, nutritional supplements, vaccination, etc.? to what extent can it be combined with other programmes that involve women and their young children, such as nutritional supplements and vaccination?
    - Analyse and research issues pertaining to economic justice and the mobilization/ allocation of resources, from the point of view of marginalized women.
- Revisit the broader agenda in nutrition that "*has fallen through the cracks – neither is it in agriculture, nor in health*."
- Effective implementation of policies that could improve lives, a focus on Early Childhood Development (ECD) – "….*policy does not take seriously enough*

the need to improve the care of babies and young children and the burden inevitably falls on mothers. There's not nearly enough provision for early childhood care and development and we really need to understand the reasons why several attempts at informally organised neighbourhood schemes have not fared well."

- The impact of globalization on infectious diseases – on changes in disease distribution, transmission rate, disease management (Globalisation as a long term process of increasing global connectivity and change…often associated with increasing poverty)
- Forced population movements (also a consequence of globalization), the extreme vulnerability of refugees ('displaced people')to disease, especially due to malnutrition and absence of safe water and sanitation.
- A focus on urban health – the effect of increasing urbanisation, cramped living conditions, poor infrastructure and lack of sanitation and water on one's health and well being (also an aspect of urbanization with the push/pull pressures of rural poverty and urban opportunities).
- An assessment of how water resources development affects the status of infectious diseases, schistosomiasis for example – ecological (movement of vector snails) and social disruptions, (movement of people) ? Is intersectoral collaboration sufficient? What about the role and responsibilities of international agencies, funders and other partners in protecting the health of people affected by such projects?
- The consequences of declining space afforded to pastoralists and the collapse of the pastoralist economy (because of inability to access watered areas during dry season) on their wellbeing.

Annex G. A Snapshot of Research /Policy/Advocacy Organisations Interviewed

African Medical and Research Foundation (AMREF), Tanzania (www.amref.org)	
General	Priority is addressing the health needs of women and children, including: maternal, neonatal and child health; nutrition; HIV/AIDS; TB; Malaria; Sexual and Reproductive Health; Safe Motherhood; FISTULA; water, hygiene and sanitation (and NCD is coming up) for interventions and research.
Staff	A total workforce of 206 with mixed skills ranging from public health specialists, epidemiologists, social scientists, engineers, M&E specialist, program analysts.
Key collaborators/ partners	MoHSW, MoEVT, MCDGC, Ministry of Water, USAID, TACAIDS, NACP, IHI, NIMR, MUHAS, KUHAS-Bugando, Ardhi University, UDSM, LSHTM, KI,-Sweden.
Key Financiers	CIDA, SIDA, Netherland, Global Fund, DFID, EU, CDC, USAID, Private Institutional Donors (Spain, Germany, USA and Italy) -GEITA GM, BARCKLAYS BANK.
Capacity Building Strategies	Conducts short courses depending on need and requirements of their researchers. Receives periodic technical support from KI – Sweden, AMREF HQ in Nairobi and other local research institutes (NIMR, MUHAS etc.).
Dissemination Strategies	AMREF has reportedly been doing very well in influencing policy at local and national level through various best practices and interventions including research findings, as well as through representation in several national technical working groups. However more evidence based advocacy is needed to influence both national and international policies. Attention is now focused towards conducting well designed implementation research and proper documentation of best practices for dissemination at national, regional and international level through stakeholders meetings, conferences and publications in peer reviewed journals.
SDH Research	Operational research focused on our health priority areas depending on the gaps or challenges encountered during implementation of our programs but also in generating new knowledge (revolving around HIV/AIDS, MNCH, SRH, Water, Hygiene & Sanitation). AMREF is processing to establish local institutional research ethical review board.
Capacity Gaps	Need to strengthen capacity on undertaking health system research and in this respect would like increased collaboration for focused mentorship and technical support, in particular in data management and analysis. Additional needs include epidemiologists, social scientists for qualitative research and economist for assessing the cost effectiveness of on-going interventions.

Ifakara Health Institute (IHI) www.ihi.or.tz	
General:	An independent, Tanzanian non-profit trust since 1996, IHI has grown rapidly from a "research field station" of the Swiss Tropical Institute that was established in 1957 in Ifakara, to seven sites across the country. IHI employs over 1,000 staff and has an annual turnover of more than USD 25m. IHI conducts district based research that contributes to the translation of research into relevant policies. Key research areas include: (i) Vector research: malaria-related studies remain the largest part of IHI's work; and the environmental research group undertakes fundamental research to describe and model mosquito ecology, malaria transmission and the potential impact and interaction of new control interventions. (ii) Health and demographic surveillance (HDSS) in Ifakara (1996-), Rufiji (1997-) and Kigoma (2009-) track vital events and cause-specific mortality in a combined population of 330,000. Population demographic surveillance is presently being extended to a nationally-representative sample of >1,000,000 across 23 districts, using Sample Vital Registration with Verbal Autopsy (SAVVY). A second surveillance arm in the same 23 districts generates facility-based data from around a third of all health facilities in Tanzania. The two surveillance arms combined provide a rich platform for monitoring health and demographic trends, understanding determinants of mortality, describing patterns of disease and service-delivery, monitoring progress towards the MDGs, and undertaking national-scale evaluation of programme implementation and impact. (iii) Clinical trials – in Ifakara, Rufiji and Bagamoyo, IHI has developed clinical surveillance platforms covering the district hospitals and satellite clinics. (iv) HIV, TB, Maternal & Neonatal, Health Systems. HIV studies are focused on treatment and adherence, as well as a new cohort study (MZIMA, see below). Research on maternal and neonatal health includes an assessment of maternal and neonatal mortality in two districts in Tanzania, health beliefs surrounding pregnancy and childbirth, as well as a range of health system-based, replicable interventions, to increase skilled birth attendance and improve the accessibility and quality of obstetric emergency care. (v) Emerging interests – in "neglected tropical diseases" (NTDs), non-communicable disease risk factors, social determinants of health, impact assessments and policy analysis. (vi) Training – development of human capacity (see below under capacity building strategies)
Staff	Urban/ regional planner, GIS experts, epidemiologists, geographer, qualitative social scientist, demographer, public health researcher, health economist, communication specialist

Key collaborators	National: NIMR, MoHSW, CCBRT, TFNC, AMREF (Tanzania) International: WHO, LSHTM, Swiss TPH, LSTM, Columbia University (Mailman School of Public Health), Harvard University, Glasgow University, University of California, Help Age International, ICAP
Key Financiers	IHI receives funding from both development agencies and the Tanzanian government. Most of its budget comes from competitive grants. In 2008-2009, the institute's grant income was USD 16.4 million, compared with USD 3 million for core support. Grant income is expected to increase to USD 18m in 2009-2010, and to USD25m by 2012-2013. Core funding: SDC, Irish Aid, Norwegian Government, DFID Project funding: Bill and Melinda Gates, Wellcome Trust, NIH (via Univ of California), EDTCP, CDC, Global Fund, Comic Relief, DFID, Concern Tanzania, EU (via LSTM), BBSRC (via Glasgow Univ), NERC (via Aberystwyth), USAID, BMGF, US-CDC, Swiss TPH, LSTM-Mshinda Fellowship
Capacity Building Strategies	Core support to young researchers for MSc/MPH and PhDs with more than a dozen PhD's enrolled annually Through a new alliance with Tanzanian universities, IHI has committed to developing and co-delivering a Master's programme in Public Health research and expanding the PhD and postdoctoral level training. The Master's programme is being developed under the overall umbrella of Nelson Mandela (NM-AIST, Arusha) and with technical support from LSHTM, Columbia Univ (Mailman School of Public Health), Swiss TPH and James P Grant School of Public Health in BRAC (designed such that some modules can be offered as stand alone modules to interested health professionals), and several national universities; process of developing the Masters is funded by NICHE (Royal Tropical Institute KIT, University of Groningen), but the funds for offering the course are yet to be identified (partners in training…NM-AIST, Arusha, Swiss TPH, London School of Hygiene and Tropical A number of IHI senior scientists are affiliated with national and international centres of excellence, thereby contributing to teaching Short courses offered to meet emerging needs of young researchers over the course of the year with built in mentorship scheme and periodic technical support from Columbia and Princeton University e.g. analysis of DSS data; short one day trainings coordinated by the Data Analysis Cluster .

Dissemination Strategies	While IHI has done very well in the field of international development policy, influencing national policy has proven to be a challenge. More recently, an increasing premium has been put on research and knowledge communication and ensuring that research findings are communicated internationally and nationally, both to political leaders and the public at large : • 50+ peer-reviewed journal articles that are authored/co-authored by IHI scientists every year • Subject specific knowledge forums coordinated by IHI bringing researchers, policy-makers, donors and practitioners together to review national progress and international knowledge & best practice on malaria control, monitoring and evaluation, health financing, human resources, quality of care and other topics. • Policy and research communication briefs – the Spotlight. • Conference presentations (international, regional and national) • IHI's website, coupled with a digital repository and data archive, are expected to maximize the reach and utility of IHI's work for both policy audiences and the broader research community. • Membership and participation in national technical working groups – health finance, MNCH, Research and Analysis Working Group (RAWG), NCD, HIV/AIDS.
SDH Research	The **INDEPTH Effectiveness and Safety Studies of Anti-malarial Drugs in Africa (INESS)** is a project of the INDEPTH Network (www.indepth-network.org), an exciting new platform that aims to enable African researchers to carry out large Phase IV trials. INESS aims to: provide objective country-specific effectiveness and safety data to inform global and national policy and practice and to speed up access to evidence on treatment effectiveness and safety. INESS also aims to enhance African capacity to monitor local health systems in order to track the costs, effectiveness of coverage, and impact of newly registered antimalarial treatments. Overall, INESS aims to reduce the time gap between the licensing of a new drug and its introduction into health systems for use. Since its inception INESS has placed much emphasis on fostering collaborations with a range of influential organizations and institutions in the North and South and at national, regional, international and global level. These collaborations have contributed immensely to the progress of work and resulted in extensive expertise being developed in specialised areas. They have generated multiple viewpoints, created legitimacy and promoted a sense of shared responsibility while stimulating broad awareness and momentum for change. **The SHIELD (Strategies for Health Insurance for Equity in Less Developed Countries) Project** aims to critically evaluate existing inequities in health systems and to examine the extent to which insurance (mechanisms to provide financial protection) can address these inequities in Ghana, South Africa and Tanzania. SHIELD is a multi-partner project (IHI, LSHTM, Royal Tropical Institute (KIT Development Policy & Practice), Karolinska Institute, Health Economics Unit….), funded by the European Commission and by the

	IDRC (http://web.uct.ac.za/depths/heu/SHIELD/about/about.htm) **An evaluation of the Pay for Performance Pilot in Pwani Region, Tanzania (P4P, 2011-2013)**: an assessment of P4P pilot on motivating health workers and improving quality of maternal and child health care, is a collaborative project between IHI, LSHTM, and CMI. Funded by Government of Norway. **BIMA WAZAZI (2011-2014)-** Impact, process and economic evaluation of free insurance cards for poor pregnant women. Uses economics and social science methods. Funded by Population Council (through Gates funding). Partners: IHI, LSHTM, Pop council. **BIMA PAMOJA (2011-2012)** - Assessment of effect of community health fund takeover by the National Health Insurance Fund (NHIF) on universal coverage, using a case study approach. Largely qualitative, with some analysis of financial data. An Alliance for Health Policy & Systems Research. **UNITAS (Universal Coverage in Tanzania and South Africa (2011-2016))** . Monitoring and evaluating universal coverage reforms in Tanzania and South Africa. Includes policy analysis, implementation science methods and impact evaluation techniques. Funded by EC under FP7. Partners: IHI, LSHTM, UCT (South Africa), Africa Centre (South Africa), Wits (South Africa), Institute of Tropical Medicine, Belgium. **RESYST (Research into Resilient and Responsive Health Systems, (2011-2016))** - The RESYST Consortium aims to generate new knowledge about how health system interventions can be developed and implemented in ways that build synergies among them and contribute to developing health systems that are resilient to external and internal shocks, and responsive to the needs of its users. By end of the programme in December 2016, RESYST seeks to have used innovative research methods to answer the following questions: • How can progressive financing systems be developed in different contexts particularly through increased domestic public funding, and strengthened pooling and purchasing arrangements that promote equity and financial protection?** • What is the relative importance of different incentives influencing health professionals' behaviour and job location choices?** • What is the extent and impact of health worker training by private institutions? • How can health system accountability be strengthened to support improved responsiveness? • What specific leadership and other strategies can support effective implementation of health system policies?

	Funded by DFID, Key Partners: IHI, LSHTM, UCT, Wits, KEMRI, International Health Policy Programme, Thailand, AMREF. **The Ifakara MZIMA cohort (2012-2017), a** 5 year prospective cohort is lodged in the Ifakara Urban HDSS. In addition to the routinely collected data by the HDSS team, this open adult health community cohort will do repeat sere-surveys approximately every 2 years to collect information on HIV, NCDs, their determinants and related health seeking behaviour. Data from individual participants will be linked throughout the repeat sere-surveys, thus creating a longitudinal database of their risk and disease experience. Specifically: to describe the HIV prevalence and incidence trends in adults and older people in relation to biological, demographic, behavioural, social and contextual determinants ; to analyse what the determinants are of community members' access to and health seeking behaviour for HIV prevention programmes, Volunteer Counselling Testing (VCT) services and Anti Retroviral Treatment (ART) services; to describe the prevalence and incidence trends of common NCDs in adults and older people, in relation to biological demographic, behavioural, social and contextual determinants; and to analyse community members' access to and health seeking behaviour for NCDs. MZIMA study is looking at the economic status, education status, degree of social networking and women's power status in relation to: the prevalence and incidence of HIV and NCDs, the individual risk behaviours for these disease, and the health seeking behaviour and access to programs of the participants (in DSS sites). Additional studies will be lodged in this platform. Project Sponsors: Global Fund for AIDS, TB, Malaria, round 9 (cohort implementation and HIV measurement) + NICHE (NCD measurement and training of PhD student) + IHI Core (home support of PhD student). **Health Seeking Behaviour in the Context of Epidemiological Transition in Tanzania (Sept 2011-Sept 2015, PhD):** A case study of malaria and diabetes in Kilombero District, Morogoro Region - seeks to explore the socio-cultural aspects shaping adult people's health seeking behaviour for diabetes and malaria. Secondary data will involve review of the existing literature on health seeking behaviour in Tanzania while primary data will be collected through Focus Group Discussions (FGDs), In-depth Interviews (IDIs) and questionnaire. Partners IHI and University of Groningen Netherlands. Funders: IHI Core providing home support to PhD student and NICHE project supporting research and training cost for the PhD student **EMPOWER (**July 2008 – June 2012) is focused on scaling-up for sustainable health impact using maternal health as an entry point. It consists of four components: guidance for scaling-up decentralized training for health systems innovation: upgrading health systems tools to operate in the scaled-up environment; accelerating the scale-up for new maternal, neonatal and child health interventions; and promote utilization of maternal, neonatal and child interventions and strengthen accountability. The project uses a before and after design: baseline assessment of Maternal, Newborn and Child Health (MNCH) services established at the beginning of the project will be compared with similar assessment done at the end of the project. Project Funders: Comic Relief (UK). **Improving maternal and newborn health using the HIV/AIDS program platform in Tanzania (MNH+) (August 2011 – August 2016) –** aims to test the hypothesis that strengthening MNH+ will increase the quality and utilization of essential MNH and HIV services

	among women in a low-resource setting - Pwani Region, Tanzania. This cluster-randomized implementation research study has two distinct components: health system strengthening quality improvement activities and research on health care utilization and quality. The research component will involve two population-based surveys of 4000 women with a recent delivery at baseline and again at 4 years to measure impact on maternal and newborn health service utilization. Facility data on service quality and extent of program implementation will be collected throughout the project from all project facilities. Data collection activities will include questionnaires, provider vignettes, focus group discussions, chart abstraction, and review of facility records. Collaboration between Columbia University, Ifakara Health Institute, and Tanzania Health Promotion Services (THPS). The Tanzania Ministry of Health and the regional and district health authorities in Pwani Region are key partners. Project Funders: United States National Institutes of Health. **Evaluation of service delivery interventions to mothers (their perspective) and children**; community interventions for maternal and neonatal care; a systematic review of risk factors specifically affecting teenage mothers **Health Promotion for impoverished rural and refugee populations in Tanzania focusing on malaria control, sanitation and water supply (**April 2008 - May 2013). Focus on how simple interventions including behaviour change can reduce disease burden using clinical trial and social science skills, linked to PhD. A combination of both qualitative and quantitative methodologies was used, including: understanding the perceptions and behaviour of the local people, assessing interventions, and devising a community based educational programme on improved health prevention and care; a household randomized study measured mosquito densities in houses with and without repellent plants and an on-going trial is evaluating the impact of hand-washing and water treatment on diarrhoeal disease. The focus of the research into behavioural factors involved in the transmission of malaria and diarrhoeal disease has been conducted through focus group discussion, in-depth interviews and participant observation. Funded by Concern World Wide Tanzania. Malaria research includes: • Perceptions of transmission of malaria, outdoor living and acceptability of mosquito traps- new and better spatial repellents? (participatory methodology, FGDs…Masters' research) • Spatial determinants of malaria (PhD research)- using GIS and Bayesian geospatial statistics to explore spatial determinants relevant to predict malaria and LF hotspots in Dar es Salaam. The hotspots maps will be predicted from a combination of hazard and resilience variables. The final maps will be shared with urban planners to assess if they can be useful in implementing targeted urban planning interventions for malaria and LF. Part of ongoing PhD (March 2011-Feb 2015)

Capacity Gaps	There is a huge potential in researching on SDH in specific areas (but it is very important to first focus the research question), e.g. if linked to maternal mortality or infant mortality, especially in the SPD where one can link facility based data to verbal autopsies and household vulnerabilities. Some capacity gap areas that need to be addressed: • Require more senior social science researchers…strengthen social science research skills, and ' demedicalise IHI and move beyond'. • Structural equation modelling because with SDH research "we will often end up needing to tease out complex relations" • Measuring economic status …use of a cumulative measure (asset score) • Experience in measurement and analysis of other measures of economic status that are more responsive to changes in time, like spending power; not just as determinants, but also as outcomes of health intervention (e.g. WASH projects, intervention projects for chronic diseases (because chronic diseases usually cause huge income losses /increased expenses) • How to use available secondary data to understand the determinants better and design of potential interventions to address inequities – e.g. How to randomise control trials with poverty (MIT-Twaweza)- amplify the Ifakara product; get together a multidisciplinary group of social scientists, developmental scientists, economists, etc. to design interventions. • Generally, revisit IHIs approach to research – there is an absence of critical thinking and analysis, of pulling together various determinants, of contextualising; need to build capacities towards defining the research question that is context specific. • Be cautious and consider the changing dynamics when researching on SDH – the changing demography, migration, urbanization, smaller families, etc.
National Institute of Medical Research NIMR	
General:	NIMR is supposed to coordinate the ethical review process. NIMR also implements research and key priorities include: • Health Systems Research (HR, health financing, quality of care, public-private partnerships) • HIV/AIDS, Malaria, and Tuberculosis and other communicable diseases • Neglected Tropical Diseases • Reproductive, Neonatal and Child Health • Climate variability, environmental health and eco-health • Non-communicable Diseases • Socio-cultural determinants Ref: Tanzanian Health Research Priority Document (NIMR, 2006)).
Staff	Not Available (NA)

Key collaborators	KCMC, IHI, TFNC, CDC, MoHSW, TFDA, Bugando Hospital, Sokoine University, University of Dodoma, MoEVT, COSTECH
Key Financiers	Welcome Trust, Global Funds, DANIDA, PEPFAR, IFAD, UNFPA (NIMR is largely reliant on external funds and most are largely interested in clinical aspects of infectious diseases.)
Capacity Building Strategies	NA
Dissemination Strategies	• Since 1982, the National Institute for Medical Research (NIMR) has been organizing an Annual Joint Scientific Conference (AJSC) which provides a forum for researchers, practitioners, trainers, decision and policy makers, media and representatives of special groups to share research results and experiences in issues related to health and health research. • Annual journal of Health Research which includes a selection of health research carried out by different research institution within Tanzania • A special unit in the making which will be mainly responsible for the reinforcement of policy translation from the available evidence. • Peer reviewed publications
SDH Research	STRIVE (2011/12 – 2017/18): - **this programme aims to provide evidence on the best ways of understanding and tackling the key structural drivers of HIV risk and vulnerability, in order to improve and sustain impact of proven HIV prevention strategies.** The programme will focus on: • gender roles and inequalities that are culturally and institutionally reinforced and structure men's and women's sexual behaviour, economic opportunities, power and vulnerability to violence, and undermine their efforts to avoid HIV; • stigmatisation, discrimination and criminalisation that acts as a barrier to people seeking HIV testing or access to services, and which hinder the efforts of MSM, sex workers and other marginalised or disempowered groups to avoid HIV; • poor livelihood opportunities and the associated population movements, which help shape patterns of sexual mixing, deplete hope, self-efficacy and trust, and can encourage risky behaviour and hinder HIV prevention and treatment efforts; and, • unrestricted alcohol availability and drinking norms that may directly influence HIV risk and exacerbate sexual risk-taking and gender-based violence. Aside from the importance of structural factors and new insights into how they influence HIV, this programme also hopes to

	produce methodological & conceptual advances in understanding and approaches to evaluating complex social interventions and new techniques to incorporate structural factors into HIV modelling. The research will take place in two or more contrasting sites within India, South Africa, and Tanzania (NIMR, Mwanza). Programme is funded by DFID.
Capacity Gaps	Strengthen skills to undertake social behaviour studies
Research on Poverty Alleviation (REPOA) www.repoa.or.tz	
General:	REPOA is an independent, non-profit organization concerned with poverty and related policy issues in Tanzania. REPOA undertakes and facilitates research, provides training, enables monitoring, and promotes capacity building, dialogue and knowledge sharing. REPOA's research agenda is concerned with poverty and its alleviation (socio-economic development), with the objective to: develop the research capacity in Tanzania; enhance stakeholders' knowledge of poverty issues and empower them to act; contribute to policy dialogue; support the monitoring of the implementation of poverty related policy; and strengthen national and international poverty research networks, and forge linkages between research(ers) and users. Key research priority areas: growth and poverty reduction, social protection and governance. Present collaborators include ESRF, Help Age and TASAF (national), as well as a number of international collaborators, including CMI (Norway), The Hague and Open University (UK).
Staff	NA
Financiers	Dutch, Basket funding (WHO??), DFID, SIDA
Capacity Building Strategies	• Capacity strengthening for poverty analysis, including research on health inequities – periodic seminars and short courses on data analysis, report writing, research methodology and dissemination. • Provide funds for young scientist to design their own research project and provide mentorship to assist in the implementation of the research project. • A part-time one year Post-graduate diploma course in poverty analysis delivered through distance learning coupled with short-term intensive training workshops. It places specific emphasis on developing capabilities for research and applied policy analysis on poverty issues. The course is jointly delivered and managed by the three institutions – the Economic and Social Research Foundation (ESRF), REPOA and the International Institute of Social Studies (ISS) of Erasmus University Rotterdam in The Hague. ISS is the Postgraduate Diploma awarding institution. The PGD programme is being supported by United Nations Development Programme (UNDP) through United Nations Development Assistance Plan (UNDAP).
Dissemination Strategies	• Annual research workshops and periodic research dissemination workshops involving stakeholders (CSOs, government institutions, NBS, UNDP, DPs, Ministries (Finance, Agriculture, MCDGC, Ministry of Work, Industry, Ministry of Trade and Energy, and PMORALG). • Monthly open seminars

	• REPOA special research papers and policy briefs • Strengthen collaboration with the Government • Participate in development of poverty monitoring master plan • Research and Analysis Working Group (part of poverty monitoring system, and a secretariat to the Group)- • Poverty and Human Development Reports (an output of the RAWG)
SDH Research	**Study on Ethics, Payments and Maternal Survival in Tanzania (ongoing) -** The objective of the study is to explore the extent to which charging practices in maternal care are seen by users, staff and management as unethical in themselves, and the extent to which charging is both a cause and a consequence of other unethical practices. Partners: REPOA, ESRF, Open University (UK). Funders: Wellcome Trust. **Study on Industrial Productivity, Health Sector Performance and Policy Synergies for Inclusive Growth**: A study in Tanzania and Kenya (started in June 2012).The overall objective of this research project is to investigate the scope for improved productivity, process and product innovation, and hence increased output and employment in the industrial sector supplying the health system, and the potential benefits in terms of more inclusive health care. Partners: REPOA, ESRF, Open University (UK). Funders: DFID?
Capacity Gaps	NA
Muhimbili College of Health and Allied Sciences (MUCHAS), Department of Behavioural Sciences	
General:	NA
Staff	NA
Key collaborators	NA
Key Financiers	EU, NUFFIC, SIDA SAREC, CDC
Capacity Building Strategies	NA
Dissemination Strategies	Seminars and workshops, publications and peer reviewed journals. national and international conferences
SDH Research	Linked to ongoing research on HIV/AIDS (approx.. 60% of ongoing research at the Institute of Public Health), Reproductive Health, Malaria and TB.
Capacity Gaps	• Linking interdisciplinary approaches

	• Longitudinal approaches / analysis that would incorporate SDH issues • Synthesis of research findings and policy implications • Dissemination skills
SIKIKA (www.sikika.or.tz)	
General:	Sikika seeks to enable citizens to understand and participate in decision making processes regarding their health; to strengthen the demand side and to build a local constituency for change. Sikika works with health service providers and users, district authorities and policy-makers in districts in Dar es Salaam and Dodoma. SIKIKA's activities are clustered under four departments: health governance and transparency; medicines and medical supplies; human resources for health and HIV/AIDS; and equity in resource allocation to local government (as per the WHO recommended criteria (considering population size, under five mortality, distance, distribution of medicine, mileage). In brief, SIKIKA engages in monitoring and evaluating the Ministry's budget and expenditure, as well as the quarterly implementation of CCHPs to assess if the budgets and plans are implemented appropriately (for the benefit of the majority). SIKIKA engages with councillors and district authorities to increase their capacity to hold their superiors to account in terms of, for example, ensuring effective budget and resource allocation for the health sector. SIKIKA also conducts analysis on social accountability in the districts they operate from to promote equity in the district health sectors, including planning and resource allocation, expenditure management, performance management, public integrity, and oversight, for affordable and accessible health care. SIKIKA is also monitoring the availability and distribution of human resources, drugs and equipments under ethical legal analysis. The aim is to capture all public funds and resources available for the health sector in the coming year and assess efficiency in allocations; i.e. if allocations reflect policy priorities and experiences in the delivery of health services and if past experiences have improved budget planning and allocations.
Staff	**NA**
Partners (pending on priorities and need)	Policy Forum, Tanzania Aids Forum, HIV & AIDS PER Working Group, Local Governance Working Group, Budget Working Group, Health Equity Group, FemAct, White Ribbon Alliance, Tanzania Gender Network Programme(TGNP), CARE, MoHSW, Legal & Human Rights, IBP-International Budget Partnership, Pathfinder, Pharmaceuticals
Financiers	HIVOS, Irish Aid, SDC, IBP, CIDA
Capacity Building Strategies	Engagement with Councillors and Districts Authorities
Dissemination Strategies	• Sikika Newsletter four times per year to communicate and disseminate findings and lessons learned from all its activities (an oversight role of existing mismanagement and misuse of public health funds) • Central Government Policy and Advocacy and Engagement with Parliamentarians - to increase their capacity in holding the government accountable by sharing their analysis and evidence for improvement of policy and governance in the health and

	HIV/AIDS sectors (i.e. assist them in tracking the implementation of their past years recommendations to the health sector and health sector responses to the respective Committees) • Public policy dialogues – press conference with journalists and relevant stakeholders • Weekly radio sessions to stimulate awareness, knowledge and active participation amongst citizens on issues of social accountability in the health and HIV/AIDS sectors. • Translation of the health policy into Swahili (laypersons language for ease of understanding and knowing their rights)
SDH Research	Use of youth action volunteer groups to collect governance related information from various stakeholders engaged in health
Capacity Gaps	Statistical skills, monitoring information, appropriate use of information, public discourse about the SDH concept
TWAWEZA www.twaweza.org	
General	Twaweza means "we can make it happen" in Swahili. It is a 10 year East African based initiative (2009 - 2018) that "seeks to enable people in Kenya, Tanzania and Uganda to improve their quality of life through a bold, citizen-centred approach to development and public accountability." Twaweza therefore aims to "promote broad public engagement by creating spaces for ordinary people to improve their situation and compel governments to be more responsive." To enable millions of ordinary citizens, in particular the most vulnerable (those who live on less than USD 2/day or are otherwise marginalized) to: • exercise agency – i.e. access information, express views and take initiative to improve their situation and hold government to account • access basic services (primary and secondary education, primary health care, clean water) that are of better quality, and exercise greater control over resources that have a bearing on these services
Staff	NA
Financiers	CIDA, SNV (Netherlands), HIVOS (Dutch).
Key partners	Media (Star TV, Mlimani TV, Daladala programmes); Tanzania Teachers Union, Sumaria Group (Industries), Solar Aid, UWEZO Group, Daraja (Njombe, focused on addressing inequities related to access to clean water and sanitation)
Capacity Building Strategies	NA
Dissemination	Twaweza argues that "public pressure and public debate are more effective drivers of change than expert or policy driven

Strategies	technocratic reforms." With access to relevant information and ideas, as well as practical tools to translate these ideas into action, *"ordinary citizens can become the drivers of their own development and act as co-creators of democracy.* Civic agency, therefore, is both a goal in itself and effective means by which to improve service delivery and public resource management: "*sustainable change is driven by the actions of motivated citizens*." Through publications, media, press conferences, stakeholder meetings and focused stakeholder materials, TWAWEZA tries to shape and inform policy. Also by building the capabilities of citizens to know and demand for their rights (see below).
SDH Research /Policy priorities	Does not implement research but commissions organization to undertake quick surveys on specific aspects in relation to organizational priorities which regarding health are focused on: governance within health system; availability of medicines to citizens, build capacities of citizens to demand for their rights and needs, ensuring an informed community (i.e. health communication on aspects of water, citizen agency, education) through: mass media, printed materials, cell phones, primary and secondary school teachers, religious institutions, and fast moving consumer items.
Capacity Gaps	Specific to SDH, research planning, implementation and analysis; building strong partnerships and strengthening research on citizens.
Tanzania Gender Programme (TGNP) www.tgnp.org	
General	Working Towards A Transformative Feminist and empowered Society where there is social gender equality, equity, social and economic justice TGNP is an activist NGO committed to the goal of contributing to the building of a vibrant transformative feminist movement that challenges patriarchy and neo-liberalism at all levels, and advocates for gender equality/equity, women's empowerment, social justice and social transformation in Tanzania and beyond. Since 1993 TGNP has worked for the practical promotion of gender and women's advancement though activism, lobbying and policy advocacy, analysis and research, generation and packaging and dissemination of information and training and capacity building. In its programme TGNP works to mainstream gender and pro-poor perspectives at all levels of Tanzanian Society. TGNP goal is being operationalized through adoption of three main clusters: Activism Lobbying and Coalition Building, Knowledge Generation and Communication and Feminist Leadership Institute. These Clusters are highly interlinked and support each other

	through a variety of strategies that contribute to the campaign and the transformative feminist movement building agenda. TGNP is currently implementing the five year strategic plan 2008 – 2012 which focuses on facilitating the building of a transformative feminist movement which is grounded locally and capable of engaging, challenging and claiming changes in policies, institutional frameworks and processes at all levels. The main emphasis is to work directly with grassroots women / feminist/ activist groups and networks and coalitions at local level and facilitate enhancement of the capacities of these groups to carryout critical reflection and organized actions within their communities and develop linkages with others at regional, national and international levels.
Staff	17 academic qualified staff (5 BSc, 10 MSC and 2PhD)
Financiers	TGNP is largely depends on donor funding from a variety of sources, including international NGOs as well as bilateral and multilateral development agencies. Many donors provide basket funding i.e. they support the overall plan of the organisation, including Irish Aid [through 2010]; SIDA, Wellspring, DANIDA, FOKUS. Others provide project funding, which is still defined by projects already included in the Annual Plan; namely UUSC, UNFPA, Action Aid and UNIFEM. In 2011 the organisation received additional funding to support the Gender Festival from Foundation for Civil Society and HIVOS.
Key partners	TGNP collaborates with partner activist organisations and networks in civil society, including member organisations of the Feminist Activist Coalition, FemAct, the Health Equity Group, Policy Forum and the network associated with the Mwalimu Nyerere Chair for PanAfrican Studies (UDSM). TGNP also collaborates with grassroots activist organisations whose leaders/ members participate in the weekly Gender and Development Seminar Series (GDSS) and in the biannual Gender Festival, and in intermediary gender networks. Through Participatory Action Research and Intensive Movement Building Cycles, the organisation is strengthening its links with grassroots activists in the five zones of Tanzania. TGNP has developed links with key research institutions including REPOA and ESRF, and will endeavour to strengthen these and make them more systematic. TGNP also collaborates with Members of Parliament through facilitation of specific seminars with Parliamentary Committees (mainly Finance and Economics, Social Services, and the Women's Parliamentary Caucus) on budget and campaign issues. The organisation has developed good working relationships with the Ministry of Community Development Gender and Children, Ministry of Finance, and in the past with the Ministry of Water. TGNP also has close links with regional networks including the African Feminist Forum (AFF), CODESRIA, EASSI, and broader networks such as Women for Water and AWID.

	In addition, TGNP has developed a variety of collaborative ties with its key funders, who are listed below.
Capacity Building Strategies	Capacity building and training through sister organisation, Gender Training Institute.
Dissemination Strategies	TGNP has adopted different strategies to influence and/or change structures, policies and budgets at all levels. These include basic analysis and research, including participatory action research; activism and advocacy; organising and networking; communications and information sharing; and capacity building and training. All of their strategies focus on a specific campaign at any one moment, and on the strengthening of the transformative feminist movement at all levels. These campaigns and most strategies have consistently included a specific focus on health or on health related issues, because of the way that grassroots women prioritise health as one of their primary needs and demands. For example, TGNPs campaign on *HIV, Gender and Resources: Return Resources to the People* [2002-2009] led to the demand for universal access to free primary health care without user fees, and to the demand for universal access to free ARVs. As a part of that campaign, policy analysis was carried out about the mainstream approach to HIV&AIDS, and a series of critical reports were prepared. Research was carried out about home based care of PLWHAs in the mid 2000s and again in 2007/08 with UNRISD [see below]. Budget analysis was carried out of the health sector and of TACAIDS, separately and with sister organisations in FemAct, and especially the Policy Forum HIV&AIDS Working Group. The results of the policy and budget analysis were communicated to the wide public through traditional media, and increasingly through social media, as well as through a variety of campaign publications [posters, popular booklets]. A march and demonstration was organised to 'launch' the campaign in 2003, which received high level media attention. Since then, TGNP has also been represented in the TACAIDS Fiscal and Audit Committee; in addition to being active in the PER process. The Gender Budget Initiative campaign highlighted the right of all citizens to engage with policy and budget formulation processes at all levels; this activity continues as part of ongoing campaigns. At present TGNP is promoting the campaign on *Economic Justice: Making Resources Benefit Marginalised Women is a Constitutional Issue*, arising from the results of participatory research in 2008 on the priorities and strategies of grassroots women organising in Dar es Salaam, Mbeya and Kisarawe. TGNPs work in analysis and research is grounded, as much as possible, in local level organising and participatory work, so as to enhance the capacity of grassroots activists to do their own analysis, research, and to present their views on their own behalf in public fora and through the media. This, we believe, is an essential part of transformative feminist movement building and campaign

	work. At the same time, a variety of publications are generated as a result of analysis and research work, in English and Kiswahili, for different targeted groups, including grassroots communities themselves, as well as government [local, central], civil society organisations and networks, private enterprises as relevant [e.g. private health institutions] and donors. The results also guide TGNPs ongoing media engagement, including the production of press releases and their participation in talk shows [TV, radio]; and inform the production of our weekly TV programme on Star TV, *Siafu* which largely consists of grassroots girls and women.
SDH Research /Policy priorities	The major research projects that TGNP carries out are participatory action research [PAR] using animation; participatory research; Intensive Movement Building Cycles which use animation methodology; investigative journalism; policy and budget reviews and analysis; secondary gender statistical analysis of official survey data; and desk research of key contextual and policy issues For example, TGNP produced *Enhancing Gender Equity: Country Gender Profile Of Tanzania* in 2007, based on secondary gender statistical analysis of major official surveys available at that time. This report has been in high demand from civil society, government and donor institutions, including students, teachers and other researchers. Participatory research was carried out with grassroots and national women/gender organizations/groups in 2008 to find out what are the major issues they focus on; what strategies they use; and what implications the findings have for the building of a transformative feminist movement. The main findings were that a high level of organizing is taking place at grassroots level; that the number one priority is to enhance women's economic independence, regardless of the particular focus of a group; that capacity needs to be built in linking micro and macro issues, and strengthening networking and movement building which links grassroots to national and regional levels and vice versa. The findings were published in our *Gender Platform Newsletter* in 2009; a popular report will be published shortly. Participatory action research was carried out in Kisarawe District in 2010 as a follow up to the 2008 research, as part of the economic justice campaign: making resources work for marginalized women. Village activists identified priority issues, analysed basic causes and planned future action strategies. Feedback was provided to local government authorities and other civil society organizations at ward and district level. Major issues identified included land grabbing, lack of access to markets, lack of resources and poor performance in service delivery for education, health and water, lack of transport and communications for many villages, and lack of adequate grassroots participation in planning/budgeting processes. The findings were used to guide investigative

	journalism activities later in 2008, which led to immediate and practical action by the district authorities to improve health and water facilities. The popular report has been published in Kiswahili, entitled *Mapambano ya Wanawake Kisarawe dhidi ya Mfumo Dume na Utandawazi* (2011). Collaborative research was carried out with UNRISD funding on the care economy in 2007 and 2008 in Tanzania and South Africa, along with other countries in Asia and Latin America. In Tanzania TGNP focused on provision of care for people living with HIV and AIDS. The popular report, *The Care Economy in Tanzania* was published in 2012. Annual reviews are carried out by staff and grassroots partners of the national budget, and of selected district budgets, in the light of the ongoing campaign. The results of budget reviews are shared immediately by means of press conferences, press releases, on the web and on social media; articles are written in the *Ulingo wa Jinsia* newsletter in Kiswahili [last two years only in Kiswahili] and a 'Budget Digest' is published each year. Two context reports were produced in 2011 on the constitution making process and on land, employment and livelihoods, respectively; the results were used to guide the organisation's ongoing engagement with the constitution making process and both supported the economic justice campaign. The major objectives of all of these research activities is to support the building of a transformative feminist movement, starting at the grassroots level, and in that context, to advocate for major campaigns. The current campaign is on Economic Justice: Making Resources Work for Marginalised Women is a Constitutional Issue. The main research priorities - to analyse and research issues pertaining to economic justice and the mobilisation/allocation of resources, from the point of view of marginalised women, in support of the economic justice campaign. Access to quality health and especially reproductive and maternal health rights remains a part of our campaign. A variety of analytical and research skills are being used, including policy and budget analysis at local and national level; and participatory action research as well as participatory research methodology. A multidisciplinary approach has been adopted which is informed by transformative feminist theory and methodology, and animation philosophy/methodology, drawing on economics, sociology, anthropology and adult education.
Capacity Gaps	There is a basic human resource gap, not having enough staff who are employed specifically to carry out analysis and research [at present only two full time programme staff in analysis and research; much of the work is carried out by colleagues in other

	units/departments and by non-staff members, for example, of the Budget Analysis Task Team, along with contracted resource persons including animator/researchers from grassroots and national level]. There is a need to strengthen analytical skills at all levels, enabling researcher analysts and community animators to link micro and macro issues; to strengthen its capacity in basic survey research methodology and secondary gender statistical analysis, as well as popular feminist story making; and to strengthen report writing skills in Kiswahili and English, along with statistical analysis of the data generated by our research, along with budget reviews.

ANNEX H. Government Policies, Plans, Strategies (National, Health, Social Protection) (www.tanzania.go.tz)

Tanzania Development Vision 2025 (URT. 1999. *Tanzania Development Vision 2025.* President's Office, Planning Commission, Dar es Salaam.)	The overall National plans stipulated under Vision 2025 are to achieve the following: • High quality livelihood • Free from abject poverty by 2025 • With respect to growth, a strong, diversified, resilient and competitive economy • A growth rate of the economy of eight per cent per annum or more is targeted A high quality of livelihood for all Tanzanians is expected to be attained through strategies which will ensure the realization of the following health service goals: • access to high-quality PHC for all • access to high-quality reproductive health services for all individuals of appropriate ages • reduction in infant and maternal mortality rates by three quarters from current levels • universal access to clean and safe water • life expectancy comparable to the level attained by typical middle-income countries • food self-sufficiency and food security • gender equality and empowerment of women in all health parameters; and encourage the participation of community in the delivery of health services.
National Strategy for Growth and Poverty Reduction (NSGRP/MKUKUTA), 2005-2010; 2011-2015. (URT. 2005, 201O. *National Strategy for Growth and Reduction of Poverty*, Vice President's Office, June; United Republic of Tanzania (URT). 1998. *The*	Under the National Vision 2025, the health sector has been given higher status through cluster two of the NSGRP as a key factor in economic development, with the ultimate goal being improved quality of life and social well-being. The other two broad clusters in this five year national strategy that aims at addressing poverty in a comprehensive outcome-based approach. are: Growth and Reduction of Income Poverty and Governance and Accountability. The poverty reduction targets by 2010 (basic needs poverty) are from 25.8 per cent (2000/01) to 12.9 per cent in urban areas and 38.6 per cent (2000/01) to 24 per cent in rural areas. Reduction of vulnerability and enhancement on access to quality of services are the important aspects of cluster II. Attention is particularly set on the promotion of clean and healthy environment and sustainable use of natural resources, and reducing disparities between rich and poor, persons with disabilities, across

National Poverty Eradication Strategy, Vice President's Office, Dar es Salaam.	age groups, between urban and rural citizens in access and use of social services.
Public Service Reforms	Programme aims at strengthening the public service, specifically addressing the : weak capacity of the public services and poor delivery of public services. Each sector is executing sectoral reforms to meet the goals of the Public Service Reforms. This includes the provision of adequate staff in government health facilities.
Local Government Reform Policy Paper	LGR emphasises devolution of power and the establishment of a holistic local government system in order to achieve a democratic and autonomous institution. Within this context, primary health services are also managed and administered by LG authorities.
Health Sector Strategic Plan II, 2007-2010; Health Sector Strategic Plan III, July 2009 – June 2015.	The HSSP continues the implementation of the Health Sector Reform Programme. The second Strategic Plan of 2007-2010 (HSSP II) aimed at enabling the MoHSW to critically examine and identify areas which are core to MoHSW as stipulated by its mandate and strategically allocate the limited available resources to priority areas where most impact is realised in line with MKUKUTA and other national policy frameworks. The third Strategic Plan (HSSP III) builds on the second and is focused on "Partnership for delivering the MDGs" – contributes to Tanzania's efforts to reduce child and maternal mortality and to control important infectious diseases, as well as, in its efforts to improve the environment and access to clean water. Accordingly, the Health Sector will embark on two major programmes – the Primary Health Sector Development Programme (MMAM) and the Human Resources for Health Strategic Plan - both towards improving accessibility and quality of health services and contribute to achieving the MDGs. The HSSP III is to guide the preparation of the five-year Regional Strategic Plans, Hospital and Council Health Strategic Plans, as well as the formulation of specific plans and programmes, including annual plans, at all levels.
The National Health Policy 2007 (MoHSW 2006. Tanzanian National	The National Health Policy aims at facilitating the provision of equitable, quality and affordable basic health services, which are gender sensitive and sustainable, delivered for the achievement of improved health status. The policy also aims at empowering communities and involving them in

Health Policy) **The Primary Health Service Development Programme (PHSDP): 2007-2017 (MoHSW 2007).**	health services provision. The PHSDP seeks to address some of the dominant constraints facing the health system (e.g. infrastructure, shortages of health workers, equipment, drugs, poor referral structures, etc) towards delivery of health services to ensure fair, equitable and quality services to the community.
National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania (the 'One Plan') (MoHSW 2008).	The objectives of the 'One Plan' include reducing maternal mortality from 578 per 100,000 live births to 193 by 2015; and neonatal mortality from 32 (per 1,000 live births) to 19 by 2015; and under five mortality from 112 per 1,000 live births to 54 by 2015. The Plan has been incorporated in the new HSSP. The policy focus is clear – maternal and newborn care is getting the attention it deserves. The challenge now is a systematic implementation of the Plan – ensure facilities are well-equipped and function, staffed by trained health workers, equipped to provide basic and comprehensive emergency obstetric care, and be able to provide rapid referrals for women with obstetric complications.
National Policy on HIV/AIDS 2001 **The Second National Multisectoral Strategic Framework (NMSF) on HIV and AIDS (2008 -2012). (PMO 2007)**	The Policy that upholds rights for people living with HIV (PLHSs), including non-discrimination, equal protection, and equality before the low; the highest attainable standard of physical and mental health; equal access to education; and social security. Key national bodies include the National AIDS Control Programme (NACP) within the MoHSW, set up in 1987, and the Tanzania Commission on HIV and AIDS (TACAIDS) established in 2001 to provide strategic leadership and to coordinate the national response. The NMSF operationalizes the national HIV/AIDS policy. The NMSF enumerates four goals to reach by 2012: create a political, social, economic and cultural environment for the national response to HIV based on a human rights and gender-sensitive approach with transparency and accountability at all levels, broad public participation, and empowerment of PLHIV, women and youth; reduce HIV transmission in the country; reduce morbidity and mortality due t HIV/ AIDS; and improve the quality of life of PLHIV and those affected by HIV and AIDS, including orphans and other vulnerable children. The NMSF stresses the need to increase HIV prevention efforts, in particular in the younger generation (10-24 years of age).
National Scale up Plan for the Prevention of Mother-to-Child	The National Scale up Plan was established in 2008 to: increase facility coverage through integration of PMTCT services into routine reproductive and child health services in hospitals, health centres and

Transmission of HIV and Paediatric HIV Care and Treatment (2009 – 2013) (URT, MoHSW 2009)	dispensaries; routinely refer HIV+ mothers to care and treatment centres; prove ARV prophylaxis to 75% of all HIV-positive pregnant women who are not eligible for ART; and to follow up babies of infected mothers, including providing access to paediatric AIDS care.
National Care and Treatment Plan (2003-2008).	The Plan is to scale-up access to primary health facilities and make ART accessible to all in need by 2012. The Plan also includes building the capacity of health facilities and community members to provide home-based care services to PHLAs across the country.
National Malaria Medium Term Strategic Plan (NMMP) 2008-2013 (URT, NMCP 2009).	The NMMP advocates four main strategies to fight malaria mortality and morbidity: improved malaria case management; selective vector control, in particular expansion of use of ITNs; IPT for pregnant women; and prevention and control of malaria epidemics.
National Social Protection Framework (SPF) – Draft (MPEE 2007).	The SPF is consistent with MKUKUTA's objective to address vulnerability, the SPF envisages a comprehensive set of mechanisms to reduce the risk of all vulnerable members of Tanzanian society – both poor and non-poor. The national focus of social protection has shifted beyond responses to single-case crisis to address the structural, multi-causal vulnerabilities that can and do lead to persistent poverty and generalised insecurity.
Tanzania Social Action Fund (TASAF)	TASAF was established by the Government in 2000. TASAF Phase I is a multisectoral programme that provides financing for small-scale public investments that meet the needs of poor and vulnerable groups. TASAF phase II is also piloting a community-based conditional cash transfer programme that is intended to provide cash transfers to poor and vulnerable families conditional upon increased family access to education and health services.
Some of the key national plans, policies, systems and strategies relevant to a comprehensive social protection framework	National Costed Plan of Action for Most Vulnerable Children – towards supporting children vulnerable to poor outcomes (MoHSW 2007, MoHSW 2008). Social Security Policy 2003 that aims to extend social security to the majority of Tanzanians (MPEE 2007) National Policy for People with Disabilities 2004 aims to promote social and economic opportunities, equity, and services for people with disabilities (MPEE 2007) National Employment Policy 2007, National Employment Creation Programme and Youth Employment Action Plan aim to promote full employment (MPEE 2007) Agricultural Sector Policy is complemented by the Rural Development Policy (2001), the Sector Development Strategy (2001) and national interventions such as Kilimo Kwanza, Participatory

	Agriculture Development Project (PADEP) and the Agriculture Sector Development Programme (ASDP) (MPEE 2007) The Strategic Grain Reserve (SGR) through which the Government purchases grains for distribution at times of shortage, which are then sold to beneficiaries at a subsidised price. (MPEE 2007)
National laws and policies- Nutrition	Food and Nutrition Policy for Tanzania (MoHSW 2009) National Food Security Policy (URT, MAFS 2004) National Nutrition Strategy (NNS) 2009-2015 (MoHSW 2009) TFNC is charged with the responsibility for nutrition research and for advocating, advising, monitoring, evaluating, harmonising and facilitating nutrition activities.
Other relevant SDH-related policies, reforms, strategies, programmes.	Water Sector Reforms; Water Sector Development Programme (MOWI 2007) Child Development Policy (MCDGC 1996) National Plan of Action for Prevention and Eradication of Violence against Children and Women 2001-2015) (MCDGC 2001), Education and Training Policy, 1995; Pre-Primary Schooling and Early Childcare and Development (ECD) Programme; Primary Education Development Programme (PEDP); Secondary Education Development Programme (SEDP); Complementary Basic Education (COBET). (MoEVT 2007, MPEE 2007)

ANNEX I. Development Partners – SDH Financiers and/or Advocates

Ireland Aid (IA)	To date, IA does not have a specific focus on SDH/ health inequities; emphasis is on "poverty alleviation" and approach is to fund sectors and actors on "aspects of poverty" that would address equity e.g. education, nutrition, health and agriculture, with governance cutting across each of these sectors IA supports the government (General Budget Support), Health sector (Basket Fund), and CSO's (an indirect means of addressing inequities, as well as get independent alternative information). For FY 2011-2012, IA's total support to the Tanzanian Health Sector was close to Euros 30,500,000: Euros 9,000,000 towards GBS, Euros 6,300,000 to the Health Basket and approx.. Euros 3,000,000 towards Health and Nutrition Programme (project based support), includes funding to CSOs (CCBRT, IHI, Sikika, TWAWEZA, Wildaf, UNICEF, HKI, STC and Consenuth) IA is core funding to IHI is largely towards "policy analysis" - pulling together existing data and research information; to learn what we know, what we don't know and what we need to know.
Swiss Development Corporation (SDC)	SDC does not have specific budget for research at the level of Tanzania. Main contribution to health research in Tanzania is a core contribution for the implementation of the IHI's 2008-2013 Strategic Plan, with respective deliverables which IHI must produce annually as per the joint Memorandum of Understanding (signed by DFID, Irish Aid and Norway) and this includes a documents and events which are closely related with important policy issues (like the thematic days on M&E, or on health financing which were included in the Technical Review Meeting of the SWAp the last two years, or the Spotlights, or the malaria meetings...). There is nothing specified regarding content of research, but SDC can use their position as Founding member and Trustee to propose some topics we find relevant, including SDH research. As part of the Health Promotion and Systems Strengthening in the Dodoma region, there is an operational research component jointly managed by IHI and STPH focused on health promotion, equity, community empowerment and SDH. SDC does not support any other research institution. SDC HQ is developing a proposal for a joint research fund with the Swiss National Scientific Research Council which will be launched in 2013. This will entail a health research component and SDH might be part of the research topics eligible for funding. However, the definition of this fund is still underway. Regarding advocacy, SDC is working closely with the newly established Health Promotion working group of the SWAp. In the on-going definition of the new GoT Health Promotion Strategic Plan, SDC strives to bring in the Ottawa definition of Health promotion which entails SDH and equity (beyond environmental health). SDC is also advocating for the Rio declaration. At a global level, SDC will participate in the World Health Assembly and advocate for a concrete follow up on the Rio declaration at

	multilateral level and also at SDC level (through participation to the Health Network meeting, summer 2012). SDC also supports SIKIKA in their advocacy work (core contribution also). SDC supports some policy process (like the negotiation of the agreement between the Government and newly regional referral designated FBO hospitals).
UNICEF	UNICEF does not have a specific focus on the social determinants, though it does have a strong social policy unit that has come out with recent publications on Child Poverty and Disparities in Tanzania as well as the Challenge of Urbanisation in Tanzania; and the Nutrition unit is currently engaged in an analysis of the determinants of disparities in nutritional outcomes. The Health unit is also working closely together with the MoHSW 'Health Promotion' Unit around BCC strategies.
WHO	**Following are WHO's key health priorities as stipulated in the country cooperation Strategy:** • Health Systems - Human Resources for Health, Health Financing, Health Information Systems, Scaling up of Health Services Delivery, and Community based health services and health promotion • Support to national priority programmes - Reduction of maternal, newborn, and child mortality; Combating Communicable and Non-Communicable Diseases; and Epidemic Preparedness and Response • Supporting actions on social determinants of health - Addressing the risk factors for Non Communicable Diseases; and Contribution to Government and other partners' efforts. • Promotion of Food Safety and Reduction of Malnutrition - Integrate gender equality and rights into the health programmes, Support Tanzania to ensure environmental sustainability for better health • Supporting partnership for health development - Leadership role in technical matters related to health, Health coordination among UN and other Health Development Partners, Foster partnership to deliver the MDGs, Public Private Partnership (PPP) strengthening, Advocate for conduction of Health Impact Assessments and strengthening inter-sectoral collaboration for health WHO assign different institutions to do research on various health aspects but to date, none on research on SDH and health inequity (because of funding constraints and lack of interest) though the department is about to launch an equity activity in Zanzibar (waiting for approval and funds).