Building a Consortium to Address Climate Change, Inequality, and Other Complex Challenges Influencing Human Health (CHOICE)

CHOICE Tanzania Annual Report for 2023

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SUMMARY OF THE STATE OF THE SDGs IN TANZANIA

Mental Health

In Tanzania, mental health remains a significant concern, with indicators revealing both progress and persisting challenges. While the country's suicide mortality rate has slightly decreased, factors such as stigma and poor mental health literacy contribute to underreporting and a potentially higher prevalence of mental illness than documented. The shortage of mental health professionals, particularly psychiatrists, remains a critical issue, despite the existence of community-based support services and peer-to-peer initiatives. Task shifting presents a short-term solution, yet gaps in healthcare delivery persist, exacerbated by government deprioritization of mental health evidenced by budgetary neglect and inadequate training for healthcare workers. Traditional healers play a substantial role in mental healthcare provision, though collaboration with biomedical care providers faces hurdles. Nevertheless, there's recognition of the need for collaboration to bridge treatment gaps and ensure comprehensive care for those in need.

Gender Equality

Gender equity in Tanzania is a multifaceted issue deeply intertwined with cultural norms, economic disparities, and systemic challenges. Despite efforts to combat gender-based violence (GBV), such as intimate partner violence and Female Genital Mutilation (FGM), prevalent cultural norms and limited access to services continue to impede progress. While initiatives like police gender and children's desks aim to improve reporting mechanisms, gaps in data collection and utilization hinder policy effectiveness. Economic empowerment remains elusive for many Tanzanian women, particularly in rural areas, where access to resources and opportunities is limited by discriminatory practices and traditional gender roles. Educational and professional barriers, exacerbated by early marriages and childbirth, further perpetuate inequalities, reflected in the underrepresentation of Women in the STEM field and income disparities between genders. Additionally, the intersection of gender inequity and climate change exacerbates challenges, disproportionately affecting women's economic prospects in agriculture. Bridging these gaps requires comprehensive strategies addressing cultural norms, improving access to services, enhancing economic opportunities, and mitigating climate-related vulnerabilities to ensure a more equitable future for Tanzanian women.

Climate Change

Climate change poses significant challenges to Tanzania, with rising temperatures, extreme weather events, and environmental degradation threatening both livelihoods and public health. The country ranks among the most vulnerable to climate risks globally, experiencing a surge in natural disasters attributed to climate change. Such disasters not only claim lives, but also strain government resources for response and recovery. The health impacts of climate change are also evident, with infectious diseases like malaria spreading to new areas due to climate-induced changes in temperature and precipitation patterns. The agricultural sector, vital to the economy and livelihoods, faces declining productivity and increased reliance on harmful synthetic chemicals, further endangering both food security and environmental health. Despite these challenges, opportunities exist to leverage Indigenous knowledge for climate adaptation, yet awareness and understanding of climate change remain low among the public. Infrastructure and technological constraints hinder efforts to implement sustainable practices and resilient infrastructure, highlighting the urgent need for investment in climate-smart solutions and public education to mitigate the impacts of climate change in Tanzania.

BACKGROUND

The 2030 Agenda for Sustainable Development

With a plan to achieve a shared vision of peace and prosperity for both people and the planet, all 193 United Nations (UN) Member States came together in a global partnership to implement the 2030 Agenda for Sustainable Development (Agenda 2030) [1,2]. Within Agenda 2030 lies 169 targets that span across 17 Sustainable Development Goals (SDGs). The SDGs, which serve as a global call to action, emphasize that eliminating poverty and other forms of deprivation requires strategies that preserve the environment, facilitate economic growth, improve health and education, and target inequality and climate change [1].

Prior to the SDGs were the 8 Millennium Development Goals (MDGs), which ran from 1987 to 2015 and focused on key development areas such as poverty eradication, gender equality, health advancement, and environmental sustainability [3]. The SDGs and their targets came into effect on January 1st, 2016, with the intent to address the root causes that perpetuate the cycle of poverty and lead to inferior quality of life [1]. Compared to the MDGs, the SDGs are more comprehensive. Of significant importance is the message embedded within Agenda 2030, which conveys that the present generation can be the first to successfully end poverty but is also the last ones that can intervene before climate change takes an irreversible course [4].

The Millennium Development Goals in Tanzania

Tanzania is a sub-Saharan nation with a population of over 65 million [5]. In December 2014, Tanzania's Ministry of Finance released a country report focusing on entering 2015 with better MDG scores [6]. Reflecting on Tanzania's MDG performance, the country made satisfactory progress in a few areas. For example, from its 1990 levels, child mortality within Tanzania dropped by more than two-thirds [7]. By 2016, Tanzania had over a 70% decline in child mortality [7]. As translated to an Infant mortality per 1,000 live births of 43 and an under-five mortality per 1,000 live births of 67 in 2015-16, the nation met the MDG targets in this category [8]. This success was made possible by deploying healthcare workers to provide primary healthcare in rural areas, doubling public spending on health, and greater decentralization within the government that provided districts with the financial resources and opportunities needed to solve problems locally [7].

Regarding maternal mortality, Tanzania's maternal mortality ratio (MMR) per 100,000 live births decreased to 398 in 2015 from its 1990 MMR of 997 [8]. While this translates to 60.1% drop, it failed to meet the MDG MMR target of 133 [3]. Demand for family planning satisfied by modern methods among married women ages 15-49 years increased from 17% in 1992 to 53% in 2016 [9]. Accordingly, the aspiration of achieving universal access to reproductive health by 2015 under MDG 5 - Improve Maternal Health fell short. Indeed, Ngilangwa et al highlight the need for implementing unique approaches to convey sexual and reproductive health and rights information for different demographic groups, given that access to such information among young people decreases when disaggregated by age [10]. On the other hand, MDG 6 sought to halt and reverse the spread of HIV/AIDs, malaria, and other major diseases by 2015. The number of new cases of malaria in a year per 1,000 population at risk in 2015 was 140.5, much lower than the 2000 number of 350.3 [11]. The prevalence of HIV among ages 15-49 in 1990 was 4.9% and only slightly increased to 5.1% in 2015 but still met the MDG target of 5.5% [12].

The Global Status of the Sustainable Development Goals

At the midpoint mark to Agenda 2030, a comprehensive assessment aimed at evaluating SDG progress took place. At that time, results relieved that only 15% of targets were on track to be achieved by 2030 [4]. At present, with less than seven years left to meet Agenda 2030, global advancement on half the SDG targets is still weak. For example, The Special Edition of the 2023 SDG Progress Report conveyed that 30% of SDG targets have either stalled in their progress or, alarmingly, regressed below the 2015 baseline measurement [4].

With systematic linkages with 11 of the 17 SDGs, poverty alleviation is central to achieving agenda 2030 [1]. Therefore, efforts to improve global SDG performance must focus on the many factors that contribute to the development of poverty. For instance, SDG 1 - No Poverty is listed as its own goal on the SDG framework. However, like SDG 3 - Good Health and Well-Being, poverty is vastly interconnected with the other SDGs [13]. Poor health is known to trigger the development of poverty [14]. For example, poor health at birth decreases future productivity

[14]. Moreover, experiencing health inequalities can perpetuate existing mental health issues and constrain employment opportunities, thus setting the cycle of poverty in motion [14]. Premature morbidity or mortality of a family's bread winner can bring financial instability to their household if another source of income is insufficient or unavailable. This can then decrease the ability to support the attainment of higher education of younger family members, thus increasing the likelihood of intergenerational poverty [14]. To add, African countries, compared to their counterparts in other continents, also significantly lag in health outcomes [15]. Therefore, focusing on the health and health-related sustainable development goals (HHSDGs) will not only support poverty alleviation strategies but will also address many of the cross-cutting issues (i.e., economic instability, climate vulnerability, inequality) that fuel the positive feedback loops of health and poverty and which threaten sustainable development [16].

Existing Sustainable Development Initiatives in Tanzania

The Tanzania Development Vision 2025 (Vision 2025) was launched in 1999 to guide development planning and accelerate national efforts towards improving the nation's socioeconomic situation [17]. Tanzania's Long-Term Perspective Plan (LTPP) was formulated to achieve Vision 2025. This 15-year plan is broken down into three Five-Year National Development Plans (FYDP), each of which is focused on a specific thematic area. During the preparation of FYDP III, Agenda 2030 was among the documents consulted to ensure national efforts align with the SDGs [17].

Tanzania's National SDGs Coordination and Monitoring Framework (National SDGs Framework) tracks the status of SDG implementation, monitoring, and reporting to guide sustainable development initiatives in the context of FYDP III [17]. As part of the formal inter-governmental follow-up and review process on Agenda 2030, Tanzania has submitted two voluntary national reviews (VNR). Development of the most recent VNR in Mainland Tanzania, published in July of 2023, was overseen by the Ministry of Finance and Planning, and conducted by a National Task Force that ensured the participation of SDG stakeholders from the private sector and civil society [17].

The Tanzania Sustainable Development Platform (TSDP), co-convened by the United Nations Association of Tanzania and the Africa Philanthropic Foundation, is part of the National SDGs Framework and coordinates the collaboration and coordination of Civil Society Organizations (CSOs) working on the SDGs in Tanzania [18]. For instance, during the 2023 VNR, the TSDP consulted over two thousand CSOs to gather their data and inputs [17]. A notable accomplishment of the TSDP is their role in facilitating the official formation of the Parliamentary Group for Sustainable Development (PSGD) [18]. As the first-ever organized platform for sustainable development, the PSGD is a group for members of parliament to ensure political commitment in the domestication and implementation of the SDGs in Tanzania [18].

Presently, TSDP is executing the "Enhancing Visibility and Network Character of the Existing Organizational Effort in Implementing the UN SDGs" project, aimed at mapping all the CSOs working on one or more of the UN SDGs in Tanzania through The Global Forum for National SDG Advisory Bodies' online platform [19]. The objective of this project is to increase the visibility of existing sustainable development efforts so that partnership development and knowledge sharing is better coordinated for stronger actions and results [19].

RATIONALE

Building a Consortium to address Climate Change, Inequity, and other Complex Challenges influencing Health: The CHOICE Project

A paper published in the Global Health Division of the British Medical Journal exploring how HHSDG implementation can occur, emphasized ways HHSDG progress can be achieved. Of great importance was the emphasis to move beyond 'business as usual' and consider addressing existing weaknesses in HHSDG progress [7]. A lack of reliable, disaggregated data and poor coordination between HHSDG stakeholders and different levels of government is a key HHSDG implementation challenge within lower- and middle-income countries (LMICs). The authors went on to say that approaching SDG 3 – Good Health and Wellbeing requires a holistic approach that considers the many social, political, and commercial determinants of health, rather than simply focusing on individual targets, diseases, or programs. Given that health is an outcome of and a precondition for the economic, social, and environmental

spheres of sustainable development, HHSDG progress will largely benefit from cross-cutting approaches that include actors beyond the constraints of the health sector [27]. With this in mind, The Institute for Global Health and Development (IGHD) at Aga Khan University in Karachi, Pakistan and the Centre for Global Child Health at the Hospital for Sick Children in Toronto, Canada developed The CHOICE Project.

In response to inconsistent and delayed progress towards the HHSDGs within LMICs, the aim of The CHOICE Project is to implement multisectoral solutions towards sustainable development barriers by way of creating in-country Think Tanks. Given that LMICs face unique, and often disproportionate, challenges in the areas of mental health, gender inequity, and climate change, the CHOICE project has a special focus on them. Accordingly, the Think Tanks established under the CHOICE project will facilitate collaborative processes between academia, governments, CSOs, and multilateral organizations, while serving within an advocacy capacity to drive in-country mental health, gender inequity, and climate change progress. Given their vast point of view, Think Tanks are also uniquely positioned to ensure that HHSDG strategies related to these three areas tackle inequalities, consider the lived experiences of vulnerable and marginalized populations, and are grounded in local realities.

CHOICE PROJECT OBJECTIVES

Conceptual Objective: To improve health and wellbeing, and address inequality through ensuring the implementation of HHSDGs using the power of Think Tanks and regional consortia.

Empirical Objectives:

1. To create or activate in-country Think Tanks to facilitate work towards to achieving the HHSDGs.
    a) Develop local solutions to contextual barriers through focused research, analysis, and advocacy.
    b) Support inclusive and transparent governance processes for the oversight and monitoring of the HHSDGs.
    c) Advocate for progress towards the HHSDGs with government and civic society stakeholders.
    d) Monitor and evaluate action to achieve the HHSDGs and accelerate strategies to address climate change and mitigate its consequences.

2. Create regional and overall group consortia for accelerated learning, monitoring, and advocacy for accelerated implementation of HHSDG targets and reduction of inequities.

Choice Tanzania Think Tank Objectives

The CHOICE Tanzania Think Tank aims to generate an organized and evidence-based approach to sustainable development by considering the multi-dimensional factors that impact HHSDG progress. At the heart of the CHOICE Tanzania Think Tank is the opportunity to share learnings at the local, national, and global levels and facilitate a stronger dialogue between stakeholders, decision-makers, and wider society to ensure that this knowledge is easily accessible to all [27]. Accordingly, the action plans, outputs, and recommendations created by this membership will be evidence-based, ethical, relevant to the Tanzanian context, and reflective of the findings described in this report.

REPORT OBJECTIVES

For HHSDG solutions to be effective, the recruitment of members of the CHOICE Tanzania Think Tank must reflect the on-ground needs and realities of communities most vulnerable. This requires a comprehensive understanding of the major factors impacting health in Tanzania. Therefore, this report is a compilation of the results of a national situation analysis on the state of the HHSDGs in Tanzania. By serving as baseline on the state of the HHSDGs in Tanzania, it will be a tool used by the CHOICE Tanzania Think Tank to spearhead sustainable development initiatives that move the nation closer to the mental health, gender equity, and climate change targets listed within Agenda 2030. Following this analysis, CHOICE Tanzania Think Tank members will come together and achieve consensus on the project's methodological approach based on the findings from the situational analysis. A list of key measures and evidence-based actions needed to best achieve the HHSDGs will be generated.

REPORT METHODOLOGY

A baseline landscape analysis was conducted to understand the status of the HHSDGs, as well as the state of mental health, gender equity, and climate change within Tanzania. During this preliminary search, the peer-reviewed papers included were those published between 2016 and 2024, written in English, and whose full version was available

online. This portion of the search was done using four electronic databases: PubMed, Embase, Cochrane, and Google Scholar.

A combination of the following terms was used to narrow down search results and select the articles: (1) sustainable development goals, (2) health and health-related sustainable development goals, (3) Tanzania, (4) sub-Saharan Africa, (4) East Africa, (5) mental health, (6) mental illness, (7) mental health stigma, (8) mental health awareness, (9) mental health services, (10) gender, (11) gender equity, (12) gender norms, (13) cultural norms, (14) gender-based violence, (15) gender practices, (16) cultural practices, (17) climate, (18) climate change, (19) climate adaptation, (20) climate mitigation, (21) extreme-weather events, (22) changing weather patterns, (23) environmental health. The articles evaluated were included based on their relevance to the primary research questions:

1. How much progress has Tanzania made towards achieving the UN HHSDGs?
2. What is the state of mental health, gender equity, and climate change in Tanzania?

Due to the limited availability of peer-reviewed literature on the thematic areas of mental health, gender equity, and climate change published after 2015, most of the data gathered was supplied by grey literature publications. The databases these papers were extracted from include WHO's Global Health Observatory, WHO's Global Publications Database, WHO Africa Region's Publications Database, the 2023 Sustainable Development Report SDG Index, UNSTATS Global SDG Indicators Database, UN High-Level Political Forum on Sustainable Development's Documents and Reports, World Bank SDG Data for Tanzania, Work Bank Projects Database, and UN Women's Global Database on Violence Against Women.

The data published by the Government of Tanzania that was included was found from the following sources: Tanzania's National Bureau of Statistics (NBS) Publications, Tanzania NBS' Statistics for Development Database, United Republic of Tanzania (URT) Ministry of Health (MoH), UTR Ministry of Community Development, Gender, Women, and Special Groups (MoCDGWSG), URT Ministry of Finance and Planning, and URT Vice President's Office Environment Division.

Policies that cover health, mental health, climate change, environment, and gender in Mainland Tanzania were collected for the HHSDG scoping review of policies (Appendix 1). National plans, strategies, and other government documents related to national, regional, and local policy implementation were also assessed. The policy triangle approach, which considers the actors who formulate and implement policy, the context within which a policy is created, and the process of formulating a policy in addition to the policy's content was used to perform an analysis of HHSDG policies in Tanzania [20]. Elements and principles from the Centre for Disease Control and Prevention's approach to policy analysis in public health were referenced to help guide the careful review and evaluation of the policy documents [21].

Government publications and web searches also were used to identify HHSDG stakeholders active in the areas of climate change, mental health, and/or gender equity. Stakeholders included healthcare professionals, academics, parliamentarians, CSOs, and development partners. Key informant interviews were conducted with these stakeholders to determine their eligibility and fit for a membership position within the CHOICE Tanzania Think Tank.

RESULTS

Regional Sustainable Development Performance

Tanzania is a member of both the East African Development Community (EADC) and the Southern Africa (SADC) Development Community [22, 23]. (Appendix 2). Of the seven EADC countries, Tanzania ranks third on SDG progress, falling behind Kenya's SDG rank of 123 and SDG index score of 60.9% and Rwanda's rank of 126 and score of 60.2% [24]. Tanzania sits 32 spots ahead of South Sudan on the SDG ranking list. Sitting at spot 166, South Sudan is the poorest performing country, not only in the EADC, but also compared to all the other SDG countries [24]. Among the SADC, Tanzania is the 5th highest performing nation and is ahead of 10 member states [24]. Of all the EADC and

SADC members, Tanzania is among the few that have completed the most recent VNR, thereby demonstrating the government's commitment to monitoring and evaluating its sustainable development [17, 24].

National Performance on the Health and Health-Related Sustainable Development Goals

Considering the progress that the nation made towards the MDGs, it is unfortunate to report that Tanzania has poor SDG performance [25]. Achieving only 56.83% of the SDGs, Tanzania sits at the 134th spot on the list that ranks 166 UN countries on their SDG performance [24, 25]. Regionally, Tanzania has a 53% average [25]. 2023 data published by the UN indicates that the nation is experiencing major challenges on SDGs 1 to 4, 6, 7, 9 to 11, and 14 to 17 [25] (Figure 1). Indicators monitored by additional UN and WHO databases also provide insight into the nation's health performance [26, 27]. Accordingly, all these sources of information were used to compile Tanzania's HHSDGs indicators to evaluate progress over time (Figures 2-5).

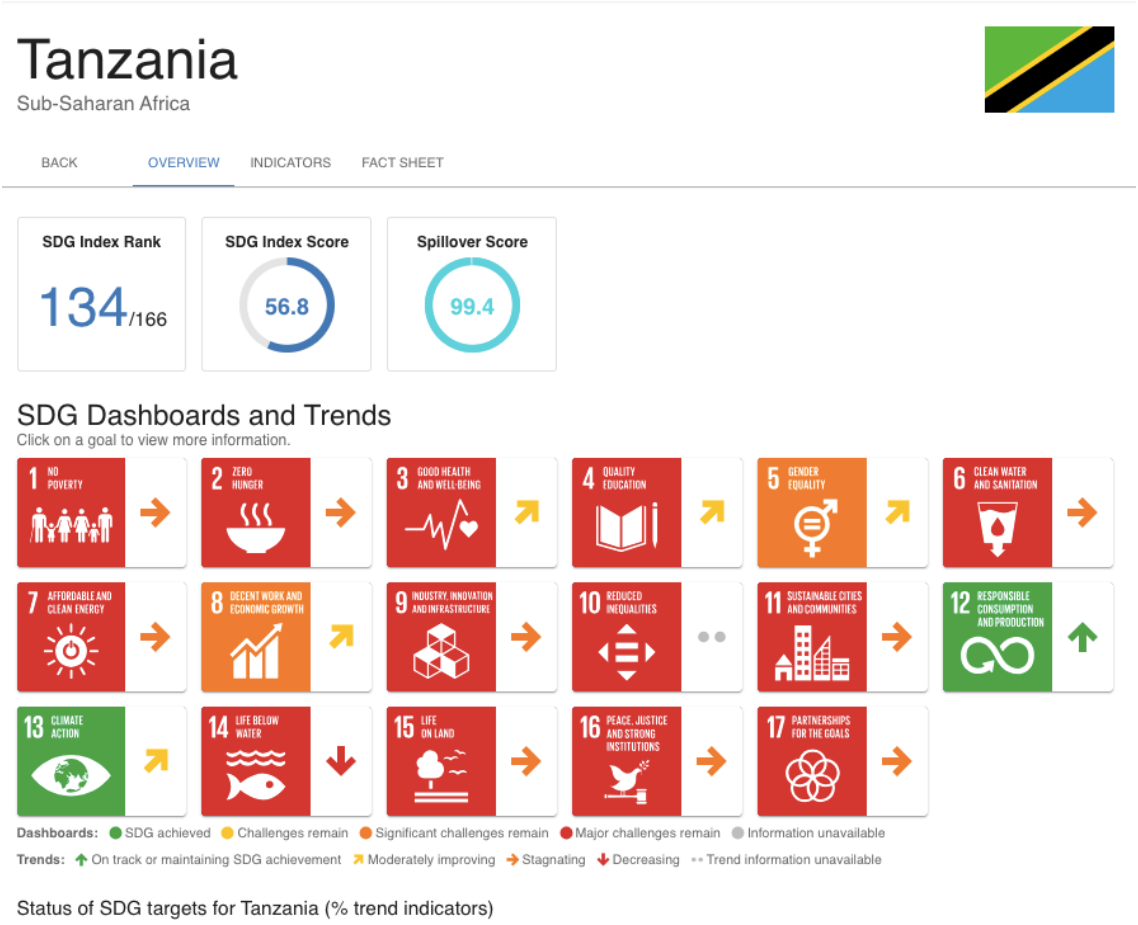


Figure 1: Tanzania SDG Dashboards and Trends for 2023

In 2018, Tanzania was among the 5 countries that accounted for half of the poor in the Africa [15]. In 2020, however, Tanzania achieved the lower-middle-income country status [17]. While this promotion is a significant accomplishment, in 2023 35.49% of Tanzania's population was estimated to be living under the poverty threshold of US$2.15/day, while 60.04% of the population was estimated to be living under the poverty threshold of US$3.65/ day [25-27]. Given that Tanzania's unemployment rate, defined as an estimate of the share of the labor force that is without work but is available and actively seeking employment, was 2.87% in 2023, labor rights in Tanzania aren't on track to reach the point where they are fundamentally guaranteed, indicating that the challenges of employment discrimination, forced labor, and child labor exist [17, 25-27]. For instance, under SDG 16 – Peace, Justice, and Strong Institutions, the most recent country data regarding violence against children indicates that 22.8% of female children

aged 5-17 years and 26.9% of male children aged 5-17 years were engaged in child labor in 2021 [17, 25-27]. Catastrophic healthcare expenditure for severe health conditions can also tip families into poverty [14]. In 2018, 0.98% of Tanzania's total population was pushed below the $3.65 USD/day poverty line due to household health expenditures and 3.73% of the households with child and adolescent dependents spent more than 10% of their total household budget on healthcare [17, 25-27]. Evidently, more work needs to be done to improve progress on SDG 1 – No Poverty.

It is very well known that education is one of the most effective ways to break the cycle of poverty [28]. Compared to lower-middle income, upper-middle-income and high-income countries, out-of-school rates are systematically higher in low-income countries [29]. In fact, evidence shows that lack of education is a dimension of poverty [28, 29, 30]. For example, findings evaluating growth and poverty reduction between 1965–2010 in developing countries found that increasing the amount of education that adults 15 years and older attain by 2 years would result in around 60 million being lifted out of poverty [29]. According to UNICEF, a lack of quality education increases the likelihood that a child will experience poor health outcomes [30]. For instance, it has been shown that a mother's education can reduce the factors that cause a child to die from pneumonia [28]. As well, maternal education is also contributed to better decision-making regarding fuel and cooking stove choice [28, 30]. On that note, regarding SDG 7 - Affordable and Clean Energy, almost 40% of Tanzania's population had access to electricity in 2020 [25-27]. However, only 4.5% of the population had clean cooking fuels and technologies as their primary sources [25-27]. Therefore, investing in SDG 4 - Quality Education is crucial for any nation wishing to improve their HHSDG performance. In 2020, only 56.32% of Tanzanian children aged 4 to 6 were enrolled in pre-primary education, while 83.92% of official school aged children were enrolled in primary education [26]. That same year's lower secondary school completion rate of 33.17% indicates that efforts must be made to support students to remain in school [26].

Malnutrition is one of the main factors that adversely impacts academic performance. In other words, for a student to achieve academic success, access to nutritious food is crucial [31]. Unfortunately, 30.60% of children ages 5 years and lower experienced stunted growth, while the prevalence of wasting within this age bracket was 3.30% [25-27]. On that note, 34% of Tanzania's population was facing undernourishment in 2002 [17, 25-27]. While this number has decreased to 22.6% in 2020, meaning that 77.4% of the population had food intake sufficient to meet dietary energy requirements for a minimum of one year, this rate has been stagnant in the past few years, indicating that major challenges remain in achieving SDG 2 - Zero Hunger [25-27]. In 2020, 60.72% of the population had access to, at minimum, basic drinking water services but only 31.76% of the population was using, at least basic, sanitation services [25-27].

HHSDG	Indicator	Data	
SDG 1 – No Poverty	% population living under $2.15 US/day	37.91% (2015)	35.49% (2023)
	% of population living under $3.65 US/day	62.73% (2015)	60.04% (2023)
	% of households with children and adolescent dependents spending greater than 10% of total budget on healthcare	4.67% (2011)	3.73% (2018)
	% of population pushed below the $3.65 USD/day poverty line due to household health expenditures	1.25 (2011)	0.98% (2018)
	% of population covered by one or more social protection benefits	4% (2019)	14% (2021)
	% of urban population living in slums	47.27% (2016)	40.88% (2020)
SDG 2 – Zero Hunger	% of population facing undernourishment	22.5% (2015)	22.6% (2021)
	Number of severely food insecure people (thousands of people)	10,814.3 (2015)	16,712.5 (2021)
	Prevalence of under nourishment among children under 5 years	34.4% (2019)	31.8% (2022)
	Prevalence of malnutrition among children under 5 years	3.5% (2019)	3.3% (2022)

	Prevalence of stunting among children under 5 years	35.4% (2015)	30.60% (2022)
	Prevalence of wasting among children under 5 years	4.5% (2015)	3.30% (2022)
SDG 3 – Good Health and Well-Being	Medical doctors per 10,000 population	0.59 (2014)	0.5 (2018)
	Nurses and midwives per 10,000 population	4.2 (2014)	5.5 (2018)
	Healthy Life Expectancy (in years)	45.4 (2000)	58.5 (2019)
	Maternal mortality rate per 100,000 live births	329.5 (2015)	238.3 (2020)
	% of births attended by skilled health personnel	92.7% (2019)	85% (2022)
	Under-five mortality rate per 1,000 live births	58.02 (2015)	47.12 (2021)
	Neonatal mortality rate per 1,000 live births	22.58 (2015)	20.01 (2021)
	New HIV Infections per 1,000 uninfected Population	2.01 (2015)	0.96 (2021)
	Tuberculosis incidence per 100,000 population	306 (2015)	208 (2021)
	Malaria incidence per 1,000 population	113.6 (2019)	71.8 (2022)
SDG 4 – Quality Education	% of children aged 4-6 enrolled in pre-primary education	42.86% (2015)	56.32% (2020)
	% of official school aged children enrolled in primary education	80.90% (2015)	83.92% (2020)
	Lower secondary school completion	30.80% (2016)	33.17% (2020)
	Literacy rate among population aged 15 to 24	85.76% (2015)	88.1% (2021)
SDG 6 – Clean Water and Sanitation	% of population using, at least, basic drinking water services	52.96% (2015)	60.72% (2020)
	% of population using, at least, basic sanitation services	25.74% (2015)	31.76% (2020)
	% of rural population using safely managed drinking water services	70.1% (2019)	74.3% (2021)
	% of urban population using safely managed drinking water services	84.0% (2019)	86.5% (2021)
SDG 7 – Affordable and Clean Energy	% of population with access to electricity	26.17% (2015)	39.9% (2020)
	% of energy derived from renewable or green energy	0.67% (2017)	0.67% (2018)
	% percentage of the population primarily using clean cooking fuels and technologies for cooking	2.9% (2015)	4.5% (2020)
SDG 8 – Decent Work and	National unemployment rate (female)	12.3% (2019)	12.2% (2021)
	National unemployment rate (male)	8.2% (2019)	5.7% (2021)
	Unemployment rate (% of total workforce ages 15+)	2.14% (2015)	2.87% (2023)
	Proportion of female youth aged 15 to 24 not engaged in education, employment, or training	19% (2014)	18.7% (2021)
	Proportion of male youth aged 15 to 24 not engaged in education, employment, or training	10.6% (2014)	8.9% (2021)
	Victims of modern slavery per 1,000 population	-	6.24% (2018)
SDG 9 – Industry, Innovation, and Infrastructure	Articles per 1,000 population published in academic journals	0.03 (2015)	0.04 (2021)
	% of population using the internet	10% (2015)	31.63% (2021)
SDG 10 – Reduced Inequalities	Proportion of paid employees whose monthly incomes are less than two-thirds of the national median monthly income (female)	43.2% (2019)	40.2% (2022)
	Proportion of paid employees whose monthly incomes are less than two-thirds of the national median monthly income (male)	27.6% (2019)	33.9% (2022)

	Unemployment rate among women with disabilities	6.4% (2019)	6.0% (2021)
	Unemployment rate among men with disabilities	1.1% (2019)	7.2% (2021)
SDG 16 – Peace, Justice, and Strong Institutions	Proportion of children aged 5-17 years engaged in child labour (female)	28.4% (2019)	22.8% (2021)
	Proportion of children aged 5-17 years engaged in child labour (male)	29.3% (2019)	26.9% (2021)
	Homicides per 100,000 population	7.13% (2015)	3.71% (2020)
	Access to and affordability of justice (worst 0-1 best)	0.41 (2015)	0.47 (2021)
	Government spending on health and education as a % of GDP	5.46% (2015)	4.91% (2021)

Figure 2: HHSDGs Indicators for Tanzania

Specific National Progress on Health, Mental Health, Gender Equity, and Climate Change

Health

Health is one of the key issues impacting Tanzania's citizens. In 2000, the World Health Organization (WHO) investigated the performance of the health systems in 191 of its member states. At that time, the Tanzania Healthcare System was given a ranking of 156 [32]. 23 years later, the nation still faces many health challenges. For instance, Tanzania's healthy life expectancy (HALE) at birth, defined as the average number of years that a person can expect to live in "full health" from birth, showed a 13-year improvement from 45.4 years to 58.5 years between 2000 to 2019 but still fell below the 2019 global HALE of 63.7 [33].

Major health challenges in the nation include HIV/AIDS, malaria, high rates of maternal and child mortality, as well as lower respiratory tract infections like pneumonia [33]. In 2020, for instance, Tanzania's MMR per 100,000 live births was 238.3 [17, 25-27]. A year later the nation's under-five mortality rate per 1,000 live births was 47.12, while its neonatal mortality rate, defined as the number of newborn infants per 1,000 live births who die before reaching 28 days of age, was 20.01 [17, 25-27].

Regarding infectious disease, in 2021 the number of people newly infected with HIV per 1,000 uninfected population was 0.96, the tuberculosis incidence per 100,000 population per year was 208, and the estimated malaria incidence per 1,000 population at risk was also 71.8 [17, 25-27]. That same year, the probability of dying between age 30 and 70 from cardiovascular disease, cancer, diabetes, or chronic respiratory disease was 17.41% for both sexes [25-27]. Overall, the total number of people requiring interventions against neglected tropical diseases in 2021 sat at 32,876,354 [25-27].

Mental Health

SDG Target 3.4 aims to reduce premature non-communicable disease mortality by one-third, while also promoting mental health and well-being [1]. Indicator 3.4.2 assesses a nation's mental health status by considering suicide mortality rate per 100,000 population. While Tanzania's suicide mortality rate for both sexes dropped from 8.32 in 2016 to 8.15 in 2019, this figure alone is insufficient in depicting the mental health landscape in Tanzania [34]. For instance, in 2020 the disability-adjusted life years per 100 000 population for mental health, defined by the WHO as the sum of the years of life lost due to premature mortality (YLLs) and the years of life lived with a disability (YLDs) due to prevalent cases of a condition in a population, was just under 1,722 years [34]. As well, the number of inpatient and outpatient cases of psychosis that were treated in 2020 was 55,246 [34]. Accordingly, such information gives slightly more insight into what types of mental health challenges Tanzanians are facing.

A situational analysis estimated that around 7 million Tanzanians were living with a mental illness in 2016-17 [35]. Given that stigma and poor mental health literacy are factors that prevent individuals from disclosing their challenges, it is likely that this number is much higher, thus painting an even graver picture [36]. For instance, myths, such as attributing mental health issues to witchcraft lead many to question the use of even visiting a hospital, given that healthcare professionals are not trained to deal with the supernatural [37]. This is exemplified by data taken from the 2020 WHO Mental Health Atlas, which indicated that in 2020 only 971.43 visits per 100,000 population

were made by mental health service users at outpatient facilities, while the number of inpatient admissions per 100,000 population in 2017 was 12.25 [34].
Alarmingly, the number of mental health professionals per 100,000 of the population in 2020 was 1.31 [34]. When looking further into this figure, the number of psychiatrists per 100,000 population was 0.07 in 2020 [34]. While this is an increase from 2015's number of 0.056, this is still insufficient to meet the country's mental health needs [34, 36]. Fortunately, community-based support services, such as sober houses and support networks like Alcoholics Anonymous and Narcotics Anonymous exist and fill in the country's mental health service gap to some extent [38, 39]. Peer-to-peer support initiatives offer a unique model where individuals in treatment accompany each other, fostering medication adherence and mutual encouragement [38, 39]. In sober houses, newly admitted individuals benefit from mentorship provided by those further along in their recovery journey [38]. Nevertheless, individuals undergoing in-patient mental health treatment frequently endure feelings of isolation, while caregivers often experience burnout when supporting their loved ones [40].

While task shifting, whereby existing personnel are trained in mental health service provision, offers a way forward to address these health sector shortcomings within the short term, there are many other gaps in mental healthcare. For instance, a study investigating mental health care and delivery Temeke Hospital in Dar Es Salaam found that majority of mental health care providers at the hospital had no prior training in mental health [41]. Given that families complained about the offensive and inappropriate language used by these workers during patient interactions, lack of formal mental health training for healthcare workers impacted the quality of patient care. This is alarming because appropriate education is essential to provide ethical and compassionate medical care, especially for mental health where cases are sensitive. A de-prioritization of mental health, as reflected by no budget allocated to on-the-job training for staff and a government policy shortening the duration of nursing programs and leading to the exclusion of mental health education contributed to this [41]. Secondly, it was identified that the hospital's lack of psychiatric wards, which compromised patient privacy and the ability to provide services, was due to the government's low priority of mental health [41]. Privacy issues, compounded by fear of stigmatization and pervasive cultural beliefs about mental illness, can prevent patients from returning for treatment if they feel that conversations surrounding their confidential health concerns can be overheard by others in the clinic [35-37]. The authors also noted that the few nurses who had training in mental health were allocated to other hospital departments. When asked why this was the case, a response they received mentioned the views that relocating hardworking nurses back to the mental health section would be a misuse of resources [41].

Estimates from the WHO say that around 80% of those residing on the African continent rely on traditional healers for their primary healthcare needs [35]. Of this, approximately 40-60% seek out care for mental health conditions [35]. Traditional healers are found across the nation, with an estimated density of 1 healer per 350 population [42]. Research conducted by Heuschen et al found that a great obstacle towards collaboration between these sectors is a lack of recognition of traditional healers by the government and the lack of respect towards them from biomedical care providers [35]. However, a qualitative pilot study in Zanzibar found favorable views toward such collaboration and support for the idea of bi-directional referrals between the two sectors [43]. Given that traditional healing practitioners are often the first point of contact with mental health patients, collaborative mental health care between them and the biomedical sector is one way to fill the treatment gap and provide continuity of care for those who need help [43].

SDG 3 – Good Health and Well-Being: Mental Health		
Indicator	Data	
Age-standardized suicide mortality rate per 100,000 population (both sexes)	8.32 (2016)	8.15 (2019)
WHO estimated disability-adjusted life years per 100 000 population for mental health and substance use disorders	847.6 (2015)	970.6 (2019)
WHO estimated disability-adjusted life years per 100 000 population for mental health disorders only	2,727.86 (2017)	1,721.6 (2020)
Cases of psychosis treated (in-patient and out-patient)	-	55,246 (2020)
In-Patient mental health admissions per 100,000 population	6.86 (2014)	12.25 (2017)

Outpatient mental health service visits per 100,000 population	54.95 (2014)	971.43 (2020)
Total number of mental health professionals	278 (2017)	760 (2020)
Mental health professionals per 100,000 population	0.51 (2017)	1.31 (2020)
Psychiatrists per 100,000 population	0.056 (2015)	0.07 (2020)
Psychologists per 100,000 population	0.009 (2014)	0.03 (2020)
Nurses working in mental health per 100,000 population	0.36 (2015)	0.85 (2020)
Number of mental health research articles published	21 (2016)	28 (2019)
Mental health research output as a % of total country output	3.42% (2016)	3.49% (2019)
The government's total expenditure on mental health as % of total government health expenditure	4% (2015)	4% (2019)

Figure 3: Mental Health Indicators for Tanzania

Gender Equity

Gender equity in Tanzania presents a complex social landscape. According to Tanzania's 2023 VNR, intimate partner violence surged in 2022, with 64.4% of women and girls aged 15-49 reporting experiences of violence from current partners within the past 12 months [17]. Cultural factors significantly contribute to this trend, as deeply ingrained gender norms normalize behaviours such as Female Genital Mutilation (FGM) [17]. Low awareness of gender-based violence (GBV) within communities and an unwillingness to disclose incidences of violence also play a role [17]. The COVID-19 pandemic coincided with increased rates of GBV, especially FGM among young girls. Reasons for this included increased stress related to economic hardships and periodic school closures [17].

According to WHO's global health observatory, Tanzania has a limited extent of implementation of mental health services and medico-legal services for victims of violence, including sexual violence [27]. Unsurprisingly, GBV cases also take exceptionally long processing times and even though free legal services for GBV exist, many survivors lack information on how to access them [44]. Fortunately, the presence of police gender and children's desks at police stations and at the municipal level have reduced barriers in reporting violence [45]. Instead of approaching the station's main police desk, survivors can seek help in a private setting and speak to trained officers that are intricately linked with healthcare teams and social services that ensure they receive appropriate support [45]. Tanzania's difficulty in collecting and utilizing gender-disaggregated data also impairs efforts to address GBV and impacts women's health outcomes [46-48]. For instance, without such data, health policies and programs fail to adequately address the unique healthcare needs of women and allocate appropriate resources for culturally appropriate modes of treatment delivery [46-48].

Tanzanian women also confront various obstacles hindering their economic empowerment and quality of life [49]. Rural areas, where the majority reside, suffer from a scarcity of healthcare resources, services, and clinics, exacerbating disparities [17, 49]. Additionally, rural women endure limited access to resources and information, burdened by discriminatory social norms and unpaid care responsibilities [50]. Meanwhile, traditional gender roles confine women to household duties, contributing to time poverty and restricting their engagement in paid work. Factors such as early marriages and childbirth further impede educational attainment, reducing opportunities for formal employment compared to men [50]. Moreover, female entrepreneurs encounter barriers like inadequate childcare support, exclusion from male-dominated sectors, and limited access to capital [50, 51].

In Tanzania, women remain underrepresented in the science, technology, engineering, and mathematics (STEM) fields. Barriers such as inadequate academic preparation, gender stereotypes, and early family responsibilities, hinder their pursuit of STEM education [52]. However, awareness of the gender gap in STEM is growing, alongside increasing opportunities for women in STEM [53]. Unfortunately, the digital gender divide persists. This is due to lower access and utilization of technology among women, compounded by limited technology literacy [54].

In agriculture, women face disparities in accessing modern technologies that could enhance productivity and income [49-51]. Nevertheless, Tanzania's expanding internet connectivity, the presence of communal internet cafes, and the use of social networking platforms like Instagram and WhatsApp present opportunities to enhance women's technological engagement and economic progress and bridge the digital gender gap [55, 56].

SDG 5 – Gender Equity		
Indicator	Data	
% of women and girls aged 15-49 subjected to violence from current partners within the past 12 months	57% (2019)	64.4% (2022)
% of women and girls aged 15-49 subjected to violence from former partners within the past 12 months	33.2% (2019)	36.4% (2022)
% of women and girls aged 15-49 subjected to violence by a current or former partner in their lifetime	-	38% (2018)
% of women aged 15-49 subjected to violence within the past 12 months	38% (2016)	30.1% (2022)
Minimum legal age for marriage (female)	14 (2002)	18 years
Minimum legal age for marriage (male)	18 (2002)	18 years
% of girls and women between the ages of 15-49 that underwent female genital mutilation (rural)	13.1% (2019)	12% (2022)
% of girls and women between the ages of 15-49 that underwent female genital mutilation (urban)	5.5% (2019)	7% (2022)
Reported cases of violence against women	30,772 (2020)	20,897 (2021)
Reported cases of violence against children (girls)	9, 810 (2017)	4,058 (2022)
Reported cases of violence against children (boys)	3,647 (2017)	732 (2022)
Proportion of seats held by women in single or lower houses of government	36% (2015)	37.4% (2023)

Figure 4: Gender Equity Indicators for Tanzania

Climate Change

Rising temperatures and sea levels, longer dry spells, and intense rainfall have made Tanzania the 26th country most vulnerable to climate risks [17]. Majority of Tanzania's extreme weather events have taken place since 2015 and include record-breaking rainfalls, high temperatures, intense winds, and hailstorms [57]. For example, in April 2019 Tanzania's highest daily maximum temperature, 38.4 °C, was recorded in Mtwara [57]. With forest loss rate of 469,000 hectares per year, Tanzania is also experiencing rapid deforestation. Currently it has lost 38% of its total forest cover [58].

Country records have indicated that over 70% of all natural disasters taking place in Tanzania are climate change related [57]. These events not only claim the lives and livelihoods of people but also put a huge cost burden on the government in terms of disaster response and recovery [17, 57] In the face of such vulnerability, poor technological advancement also presents a significant economic weakness [17, 57]. Many roads and bridges that have undergone huge damage due to flooding in various regions demonstrate that the country's infrastructure is susceptible to weather extremes [17, 57]. The degradation and depletion of natural resources and ecosystems also affects Tanzania's ability to utilize nature-based solutions in fighting the impacts of climate change [59]. Even though the number of deaths, missing persons, and persons affected by disaster dropped from 202 per 100,000 population to 161 and Tanzania has put into place the National Environmental Masterplan for Strategic Interventions 2022-2032, areas critical to Tanzania's survival are showing signs of the risks posed by climate change [17, 60].

Regarding health, increases in precipitation and temperature have resulted in infectious disease epidemics across different regions of Tanzania [61]. Such changes in climate have also prompted the distribution of vector-borne diseases in new areas. Malaria, for instance, is becoming more common in areas that were previously malaria-free

due to prolonged rainfalls, the presence of stagnant water, and warmer temperatures [61]. Moreover, Tanzania has experienced more than four dengue outbreaks within the past six years. Tanzania's Health National Adaptation Plan to Climate Change 2018-2023 expects more to come, stating that climate change has made the environment of some areas in Tanzania more favourable for the virus and vector responsible for Dengue, thus increasing its spread and incident rate across the nation [61]. Within sub-Saharan Africa, Tanzania has the second highest disease burden of schistosomiasis. By affecting the suitability of freshwater bodies for hosting parasite and snail populations, climate change is projected to increase schistosomiasis infection rate in most parts of the country. Fortunately, Tanzania has designated a focal point responsible for climate change and health within the Ministry of Health [25-27].

Accounting for 70% of the country's natural disasters, flooding is among the top hazards related to climate change in Tanzania [61]. Following floods, drinking water contamination and limited access to appropriate sanitation services led to outbreaks of water-borne infectious diseases such as cholera, diarrhea, and dysentery [57]. Cholera is a significant disease of concern, with Tanzania experiencing a major outbreak since August 2015. As of August 2017, a total of 26,355 cases and 415 deaths were reported [61]. On the other hand, over the last 40 years Tanzania has experienced recurring, severe droughts [57]. In addition to greater chances of malnutrition due to decreased food security, droughts can also lead to poor access to safe drinking water, thereby posing another mechanism of water-borne disease outbreak [57].

Tanzania's economy is highly weather-dependent and natural resource-intensive with low adaptive capacities, thus making it vulnerable to changing temperatures and weather patterns [62]. For instance, agriculture in Tanzania is dominated by smallholder farmers. Majority of Tanzania's rural population also relies directly on agriculture for their livelihoods [57]. Low agricultural productivity increases the use of synthetic chemicals that not only further soil degradation but are also injurious to health [62]. However, synthetic chemical use is not the only way environmentally poor choices impact human health. Take, for instance, that the total ambient and household air pollution attributable death rate per 100,000 population was 50.97 in 2019 [25-27]. That year, 17,524 deaths were related to unsafe water, sanitation, and hygiene (WASH), which translates to a mortality rate of 30.2 per 100,000 population [25-27]. It is estimated that there will be an 8-13% decrease in national food production by 2050 [55]. Due to heat stress, damages from flooding, post-harvest losses, and erosion, this loss is valued at 27 billion USD [57, 61]. At present, the impacts of climate change on the agricultural sector can already be seen. This includes changes in agro-diversity, ecological changes for pests and diseases, and increased weed competition with crops for moisture, nutrients, and light [57, 61].

Fortunately, opportunities to use indigenous knowledge practices in climate change adaptation exist [63]. Promoting and making use of such traditional practices are not easily counted but can contribute to the attainment of sustainable development goals in Tanzania. Unfortunately, climate change is not very well understood by the public [17]. Low levels of climate change awareness led to the environmentally poor use of energy resources and unsustainable consumption and production practices among consumers and producers [17]. Data, technology, and infrastructural constraints also exist. These include a lack of relevant infrastructure for recycling and managing waste, insufficient technological development, poor information management, limited availability of data related to climate change in specific areas, non-climate-smart infrastructural developments, and inadequate research and development focusing on environment and climate change [17]. Consequently, limited technological innovation and finances prevent the acquisition of resources important for strategies such as the harnessing of renewable energy and the development of climate-resilient infrastructure [17].

SDG 13 – Climate Action		
Indicator	Data	
Number of deaths, missing persons, and persons affected by disaster per 100,000 population	223 (2019)	162 (2022)
Number of deaths, missing persons, and persons affected by climate change related disasters per 100,000 population	202 (2019)	161 (2022)

% of local governments that adopt and implement local disaster risk reduction strategies	15.43 (2019)	16.5% (2022)
% of adoption and implementation of national disaster and risk reduction strategies in Tanzania	0.6% (2017)	0.65% (2018)
Total ambient and household air pollution attributable death rate per 100,000 population	-	50.97 (2019)
Deaths related to unsafe water, sanitation, and hygiene (WASH) per 100,000 population	-	30.2 (2019)
Proportion of land area covered by forest	54.29 (2015)	51.6% (2020)
Forest area under independently verified forest management certification (thousands of hectares)	142.73 (2015)	245.8 (2022)
National recycling rate (measured in tons of material recycled)	3,101 (2019)	2,009 (2022)

Figure 5: Climate Change Indicators for Tanzania

HHSDG POLICY

Mental Health

The Mental Health Act of 2008 serves as Tanzania's primary, and most recent, mental health legislation [64]. Since the topic of mental health is impacted by many factors that change over time, this is an area that will need intervention. From a human rights perspective, however, this document does a decent job of clarifying how severe cases and situations are dealt with. However, given that stigma and misinformation hinder help-seeking behaviour, mental health hospital visits are a last resort. Consequently, this document does not provide information applicable to those facing challenges. Fortunately, the 2020 Standard Operating Procedures for the Provision of Psychosocial Care and Support Services fills the gaps left by the 2008 Act [65]. This document outlines various strategies for promoting general mental well-being, intervening before cases escalate in severity, and utilizing community educational programs to challenge entrenched misconceptions surrounding mental health and illness.

The Tanzania Health Sector Strategic Plan 2021-2026 provides some direction for mental health services [66]. Even though the director of the non-communicable diseases (NCD) branch in Tanzania's MOH is a psychiatrist, there remains a lack of widespread mental health awareness among policymakers, potentially explaining why Tanzania still lacks a standalone policy for mental health [36, 67, 68]. Leveraging the mental health expertise within the ministry's NCD branch poses an opportunity to bring mental health as a priority area into the political agenda and support the facilitation of integrating mental health services into primary care [68, 69]. The universal health coverage bill also presents an opportunity to enhance access to care by including coverage for mental health services [70].

Gender Equity

Tanzania has demonstrated a strategic approach to addressing gender issues through targeted policies, such as the National Plan of Action to End Violence Against Women and Children (NPA-VAWC) 2017-2022 and a separate document dedicated to combating FGM [20, 71, 72]. This aligns with the overarching goals of Vision 2025, which prioritizes human development and a fully developed economy. As well, gender considerations have been integrated into key outcome areas and targets of Tanzania's Poverty Reduction Strategy Papers I and II, the 2017 Social Protection Policy for Tanzania Mainland, the 2017 National Health Policy, and phase 3 of NPA-VAWC [73].

Legally, Tanzania also recognizes gender equality as fundamental and prohibits discrimination based on gender [17]. Although there is no standalone legal gender document, gender considerations are embedded within various laws, including the Law of Marriage Act 2002, which previously permitted marriage at the age of fourteen. However, a landmark court case led by Ms. Rebeca Gyumi, and the Msichana Initiative resulted in the abolition of child marriage provisions and raised the minimum marriage age to eighteen for both genders [74, 75].

Efforts are underway to review and update key gender policies, reflecting the country's commitment to adapt to evolving challenges [17]. Opportunities for progress include advancing the gender policy review to address bottlenecks and leveraging political commitments to further prioritize gender equity [17]. On that note, Tanzania also grapples with instances of violence against women in political parties, where female politicians face physical and

psychological violence and encounter bribery demands, posing a significant obstacle to gender equality in the political arena [76].

Climate Change

Tanzania has robust policy, legal, and institutional frameworks for the management of its natural resources and to address climate change's detrimental impact across multiple sectors [17]. These include the National Environment Policy 2021, the National Climate Change Response Strategy 2021-2026, the Nationally Determined Contributions 2021, and the National Environmental Master Plan for Strategic Interventions 2022 – 2032 [17]. Along with this, Tanzania is also a signatory to several regional and international climate and environmental agreements, such as the UN Framework Convention on Climate Change and the Paris Agreement [17]. As well, Tanzania signed the Glasgow Women's Leadership Statement at the 2021 UN Climate Change Conference to expand the role of women and girls in responding to climate action [17]. Given that there is a significant relationship between climate change and GBV, the acknowledgement of gender in combating climate change is a significant strength that will support the implementation of effective climate change adaptation and mitigation strategies [77].

The revised National Environment Policy 2022 has identified a list of threats to environmental sustainability in the country. These include land degradation, loss of wildlife habitats and biodiversity, deterioration of aquatic systems, deforestation, environmental pollution, natural disasters, inadequate municipal waste management, climate change, and inadequate environmental governance [17]. Circular economy practices like waste management strategies are opportunities that exist. Tanzania also has several laws and regulations that support climate action and environmental sustainability. The National Environmental Management Act 2004 is the overall environmental instrument that provided the establishment of the National Environmental Management Council [78]. It also lays out the foundation for all other sector-specific laws and regulations related to natural and environmental management in the country. Participation in various global multilateral agreements on the environment also allows cooperation with the international community.

Despite a strong political will to address climate change, the country faces several challenges that limit its adaptation and mitigation capacity. Weak and inadequate coordination in the implementation of environmental laws in areas like pollution and illegal exploitation of resources has remained a constant challenge in Tanzania, leading to the increasing environmental degradation. Poor and uncoordinated implementation and enforcement of various policies have also remained a great challenge in a country's environmental sustainability. Meanwhile, climate change has not been considered in the institutional coordination structure at the national level [17]. Moreover, the government has not made a separate policy that focuses only on climate change, which is necessary if the cross-cutting issues of climate (e.g., gender) are to be effectively addressed. The lack of specific policies and personnel dedicated to climate change indicates that the level of climate change knowledge among decision-makers is inadequate and can explain why climate change has not been given sufficient priority within the government system. If not addressed, such inadequate prioritization will continue to pose a significant threat to achieving the HHSDGs. Given that climate change impacts multiple sectors, tackling climate change through existing global partnerships with multinational agencies and governments is an important way forward [17].

HHSDG FINANCING AND PROGRAMMING

Mental Health

Target 3 under SDG 9 – Industry, Innovation, and Infrastructure focuses on enhancing scientific research and technological capabilities [1]. In 2018, 0.03 articles per 1,000 population was published in academic journals [79]. While the number of published research articles on mental health jumped from 21 in 2016 to 28 articles in 2019, mental health research output accounted for less than 4% of the country's total research output, showing that this does not align with Tanzania's growing need of evidence-based care supported by current and reliable mental health data, thus posing challenges for healthcare providers [34, 41, 81]. In 2020, the government's expenditure on mental health comprised only 4% of its total healthcare spending [34]. Accordingly, up-to-date mental health data is also needed to instill an accurate understanding of mental wellness within the political sector, thus leading the way to improvements in financing and strengthening the overall mental health management system [41, 70, 80]. Often, competing interests, such as sexual and reproductive health, take precedence over mental health in budget

allocation within the health sector, necessitating innovative strategies to integrate mental health into broader health initiatives [69]. On that note, the lack of a national budget for mental health is also a significant economic weakness, as is the limited availability of scholarships for students who wish to study in the field and post-graduate positions for those who want to pursue a career in mental health [79]. Private sector investment in mental health also remains limited due to perceptions about profitability and societal stigma [34]. However, engaging private sector stakeholders and educating them on the need and demand for mental health services is an opportunity to show them the potential for future earnings and motivate them to invest.

Another study conducted at Temeke Municipal Hospital investigated the availability of medication for mental health in Dar Es Salaam and found that the unpredictable availability of psychotropic medication was due to inadequate funding, poor resource prioritization, and procurement delays [81]. Given that there wasn't a continuous supply of medication available in-hospital, patients were instructed to purchase them elsewhere, often at an excessive cost [81]. This aligns with findings from a study aimed at integrating treatment for alcohol use disorder within primary healthcare in Tanzania, which also revealed that the availability of medication for common mental health conditions was insufficient [82]. The authors recommended improvements in mental health governance, whereby more funding from hospital budgets are allocated for mental health departments so that medication purchase is aligned with patient volumes and needs. Other recommendations included strengthening the implementation of the basic drug kits policy to ensure the availability of all needed medicines in primary health services and increasing the MOH's budget for mental health to improve the availability of and accessibility to psychotropic medications [82].

Gender

Tanzania ranks 40th globally and 9th in Africa for women's representation in parliament, with notable female leaders such as President Samia Suluhu Hassan and National Assembly Speaker Dr. Tulia Ackson [17, 83]. While promising, a persistent concern is the stagnation of women's parliamentary representation despite an increase in parliamentary seats [84]. However, under President Hassan's leadership significant support has been extended to women and girls, including a commitment to increase educational investment to 20% of GDP by 2025, the introduction of the Samia Scholarship for vulnerable girls, and the reversal of policies excluding pregnant girls and young mothers from attending school [85, 86].

Regarding gender responsive budgeting, gender targets have been integrated for the first time in the Ministry of Finance and Planning's Public Financial Management Reform Programme [17]. As well, a core team has been established in this ministry to provide technical guidance on gender responsive budgeting, namely, to accelerate the mainstreaming of gender perspectives into the operational mechanisms of all ministries, departments, and agencies [17]. Alongside this, Tanzania has also witnessed a rise in resources offered by CSOs to bolster women's economic advancement, including business grants, professional mentorship programs, and skills-building opportunities [44, 85]. As well, numerous CSOs in Tanzania are dedicated exclusively to addressing gender issues [17]. Simultaneously, the Tanzania Women and Leadership Database, overseen by the MoCDGWSG, serves as a national repository of information concerning women in leadership, decision-making, and professional roles [87]. This initiative not only fosters women's professional networks and access to opportunities, but also challenges stereotypes regarding women's qualifications for leadership and formal employment to facilitate their recruitment into such positions [17, 87, 88].

Initiatives such as free legal services for GBV survivors, the Social Institution Gender Index Report, and advocacy campaigns like "The 16 Days of Activism Against GBV" have heightened awareness of GBV and its prevention [44, 89]. However, the lack of accessible information about accessing free legal services for GBV survivors hampers their ability to seek support. Leveraging reputable data from sources like the UN Women Database presents an opportunity to develop evidence-based policies and programs for the future [90].

Climate Change

Tanzania faces limited access to finance from within the country and from what was promised by international agreements [17]. The dependence on international climate finance makes any climate strategies and programs within the nation vulnerable to negative changes in the global climate financing framework. Other limitations to addressing climate change challenges in Tanzania include a slow rate of accrediting institutions to facilitate the realization of climate funding, an inadequate mobilization of climate finance from domestic and international sources based on Tanzania's needs and potential, the cost of transitioning to clean and renewable energy for Tanzania, and limited financial resources for the implementation of sustainable practices for small and medium-sized enterprises [17].

The high number of CSOs working on climate change and environmental issues in Tanzania presents an important opportunity for the uptake and acceleration of the country's strategies, policies, and programs for climate adaptation and mitigation to achieve sustainable development [91]. Therefore, to advance in the HHSDGs, community engagement, public education, and international collaboration should be fully utilized.

DISCUSSION

The Social Determinants of Health

This report demonstrates how the social determinants of health play a key role in the overall well-being and quality of life of Tanzanians [92]. Complex challenges, such as climate change, gender inequity, and mental health related concerns, adversely affect, either directly or indirectly, income, employment, job security, food security, infrastructure, social inclusion, education, and access to healthcare [17]. Tanzania is among the top 30 countries most vulnerable to climate change and signs show the immense impact that it has been having on the mental health of its citizens [17, 36]. Discussing mental health and seeking mental health care is taboo in Tanzania, yet a substantial portion of the population deals with mental health challenges. Unfortunately, stigma, long-held superstitions, and misinformation prevent these individuals from engaging in help-seeking behavior [36, 37]. FGM is an example of another area that is impacted by outdated cultural beliefs [17]. In addition to FGM, the increase in domestic violence and GBV linked to climate change is another mechanism through which the health and wellbeing of women and girls are severely impacted [77]. Experiencing violence of any kind is detrimental to one's mental health. Accordingly, mental health neglect and barriers to care, climate change vulnerabilities jeopardizing health, and gender imbalances that manifest as GBV and limited decision-making for women significantly influence Tanzanian health outcomes. Therefore, initiatives to advance HHSDG progress in Tanzania must consider the ongoing threats that climate change poses, as well as the mental health concerns of the population through a gender lens [16].

National Trends and Inequalities

Rural Tanzanian communities, compared to their urban counterparts, are disproportionately more impacted by the challenges of gender inequity, mental health, and climate change [49-51]. Moreover, rural women are substantially more impacted than urban women, with women bearing an overall greater burden than men [49-51]. Rural remote areas, compared to the rest of the nation, have a poor availability of healthcare facilities and poor referral systems [17]. Rural and remote areas also lack adequate infrastructure and trained professionals for mental health, thus leaving these communities even more underserved [34]. Given that mental health literacy is scarce within rural communities, misconceptions regarding mental ill-health are also more pervasive [36, 37]. These include attributing mental health issues to supernatural causes such as demons, witchcraft, or curses [37]. The stigma that comes with this type of misinformation lowers levels of help-seeking behavior and leads to inadequate disease management, which then impairs quality of life [36]. Based on this information, research centered around how the barriers to mental health care change when gender or geographical disaggregation is applied is an important avenue to help address HHSDG inequalities across the nation.

Regarding GBV, the percentage of women and girls aged 15-49 who experienced sexual violence is higher among rural women [17]. Furthermore, in 2022, 12% of girls and women between the ages of 15-49 underwent female genital mutilation in rural areas, whereas only 7% underwent female genital mutilation in urban areas [17]. Unfortunately, the availability and coverage of legal services to support survivors is especially inadequate in rural areas, where individuals also have less awareness of the resources that exist.

Income inequality between women and men is higher is rural areas than in urban areas [17]. Interestingly, an exception to this is Dar Es Salaam, where inequity is higher than other urban areas and rural areas [17]. Household spending is another area where the urban-rural divide can also be seen, with the average monthly expenditure much higher in urban areas. Compared to male-headed households of which 13.5% of household members have a bank account, only 9.5% of household members in female-headed households have a bank account [17]. Overall, access to basic services such as healthcare, education, water, and electricity, is far more favorable for urban dwellers [17]. Unsurprisingly, poverty, even though it decreased from a headcount rate of 26.4% in 2018 to 25.7% in 2020, is concentrated in rural areas, areas where 81% of the country's poor live [17].

As mentioned above, systemic gender discrimination and societal expectations related to gender roles cause the adversities of extreme weather events due to climate change to be more strongly experience by women [77]. Existing gender disparities also exaggerate the effect of climate change on women's economic progress. For example, the country's 2023 VNR reports that a major challenge in achieving SDG 2 – Zero Hunger was gender inequality in accessing agricultural resources, training, and decision-making [17]. Therefore, as climate change impacts the agricultural productivity of small-scale farmers, women are at a more severe economic disadvantage [17]. A vast majority of rural women and men are employed within the agricultural sector. With Tanzania experiencing intense rainfall, long dry spells, and increasing temperatures, climate change has a greater detrimental impact on the livelihoods of rural community members [48, 51, 77]. Future research can focus on investigating the extent to which women in rural communities experience the repercussions of the compounding effects that mental health, climate change, and gender inequity have on one another.

Creating the CHOICE Tanzania Think Tank

The stakeholders selected and nominated to join the CHOICE Tanzania Think Tank were those that scored high on the recruitment criteria, which evaluated their technical knowledge, current HHSDG engagement, years of experience in HHSDG work, and personal attributes (appendix 6).

Key monitoring and evaluation documents were created to support the successful execution of the project. The project's Theory of Change, for example, provided a framework to understand how change can be made (appendix 7). By way of an IF/THEN format, the CHOICE Tanzania Project's Theory of Change mapped out the cause-and-effect relationship between creating a Think Tank, achieving the project's short- and long-term objectives, and meeting the overall goal of improving Tanzania's HHSDG performance and moving closer to the targets and priorities outlined in Agenda 2030. For example, IF Think Tank members accomplish the activities listed in their membership terms of reference THEN they will generate meaningful, high-quality, and reliable climate change, mental health, and gender equity data that is comprehensive, relevant, and reflective of local realities. Furthermore, IF policies and programs are developed with up-to-date data, THEN they will be impactful and effective because they are addressing the actual, real-life situation of communities AND will put key stakeholders and development partners in a better position to close the gap between Tanzania's current reality and Agenda 2030's vision for the nation. Following this, IF updated HHSDG policies and programs are implemented across Tanzania, THEN HHSDG initiatives will be more effective in educating communities and reducing misinformation in the topics of mental health, climate change, and gender equity. Finally, IF there are improvements in climate change adaptation strategies, reductions in the barriers to seek mental health services, and increases in the acceptance and practice of gender equity in Tanzania, THEN there will be improvements in the nation's HHSDG performance and better movement towards Agenda 2030.

INTERIM RECOMMENDATIONS

Closing the Data Gap

Consultations conducted with key HHSDG stakeholders led to the finding that there is a big need for up-to-date mental health, gender equity, and climate change-related data. Collecting nationwide data has immense value because it provides context on the actual situation across different regions and demographic groups, which allows for the development of effective evidence-based policies that consider these differences rather than implementing a "one size fits all" strategy.

Uniform Data Interpretation

A major barrier faced during the baseline situation analysis was finding differences in the interpretation of the same pieces of HHSDG between different HHSDG stakeholders. For example, according to 2023 data published by the UN, Tanzania is having major challenges in thirteen of the SDGs [25]. However, the 2023 VNR document published by the Tanzanian Government stated that "The United Republic of Tanzania confirms that there has been good progress in goals 2-8 and 16 and relatively moderate progress in goals 1, 9-15, 17" [17]. Given this challenge, research questions that can investigate the discrepancies include (1) what criteria can be set when evaluating Tanzanian HHSDG data? and (2) what protocol can be put into place to ensure uniform ways of interpreting and communicating Tanzanian HHSDG data across different sectors and between different organizations within the same sector?

Policy

Even with the existence of many policy documents on the environment and climate change, many gaps towards their implementation remain [17]. Accordingly, educational initiatives to promote public and decision-maker climate change awareness/understanding is important in getting the buy-in needed to implement these policies effectively [17]. Using the current political commitment to gender equity, as evidenced by the president's actions, can be a way to address the physical and psychological violence that women in politics face [71]. Policies and protocols can be also established to ensure gender balance within formal sectors that are male dominated [77]. Such regulations should also be implemented within the agricultural sector to improve economic prospects for women [77]. Finally, Tanzania is demonstrating a great gap in mental health service provision. Funding for mental health is poor, as are existing strategies to combat stigma and misinformation [34]. To see progress, a significant political commitment is needed, with the formulation of a mental health policy as the first of many needed steps.

WAY FORWARD / NEXT STEPS

The present paper highlights the current state of mental health, gender equity, and climate change in Tanzania. Findings highlight many gaps that need to be addressed for the nation to show better progress towards meeting Agenda 2030. Several areas that the CHOICE Tanzania Think Tank can address include a) the absence of current national mental health data, b) the lack of gender-disaggregated mental health data, c) the absence of an up-to-date mental health policy document, d) inconsistencies in interpreting HHSDG data among different stakeholders, e) the disproportionate impact of mental health, gender inequity, and climate change on rural communities, f) the disproportionate impact of mental health, gender inequity, and climate change on women, and g) the prevalence of misinformation, superstitions, and cultural beliefs contributing to the stigma surrounding mental health and perpetuating harmful gender practices like FGM. However, this review has also revealed several areas of opportunity. Considering these areas during the establishment of interventions and plans can pave the way forward for progress in the areas of mental health, climate change, and gender equity. An in-depth analysis of the strengths, weaknesses, opportunities, and threats (SWOT analysis) of each thematic area conducted by the CHOICE Tanzania Think Tank is another way forward to understand the political, economic, social, technological, environmental, and legal factors that have led to Tanzania's present mental health, gender equity, and climate change state.

APPENDICES

Appendix 1: Select list of HHSDG policies in Tanzania

Thematic Area	Name	Year
Health	National Health Policy	2017
Health	Tanzania Health Sector Strategic Plan	2021-2026
Health	National Strategic Plan for Non-Communicable Diseases	2016-2020
Mental Health	The Mental Health Act	2008
Mental Health	Standard Operating Procedures for the Provision of Psychosocial Care and Support Services	2020
Gender Equity	National Plan of Action to End Violence Against Women and Children	2017-2022
Gender Equity	National Anti-Female Genital Mutilation Strategy & Implementation Plan	*2021-2025*
Gender Equity	Law of Marriage Act	2002
Climate Change	National Environmental Policy	2021
Climate Change	Revised National Environmental Policy	2022
Climate Change	National Climate Change Response Strategy	2021-2026
Climate Change	Health National Adaptation Plan to Climate Change	2018-2023
Climate Change	National Environmental Master Plan for Strategic Interventions	2022-2032
Climate Change	Nationally Determined Contributions	2021
Climate Change	Environmental Management Act	2004

Appendix 2: Regional comparison of SDG progress

Country	SDG Index Rank	SDG Index Score	VNR
Tanzania	134/166	56.8%	2019, 2023
East African Development Community Members			
Burundi	147/166	53.9%	2020
Kenya	123/166	60.9%	2017, 2020
Rwanda	126/166	60.2%	2019, 2023
South Sudan	166/166	38.7%	Never completed a VNR
Uganda	141/166	55.0%	2016, 2020
Democratic Republic of the Congo	151/166	52.6%	2019
Southern Africa Development Community			
Angola	155/166	50.8%	2021
Botswana	118/166	62.7%	2017, 2022
Comoros	154/166	51.7%	2020, 2023
Eswatini	132/166	57.9%	2019, 2022
Lesotho	143/166	54.9%	2019, 2022
Madagascar	156/166	50.3%	2016, 2021
Malawi	135/166	56.3%	2020, 2022
Mauritius	93/166	68.0%	2019
Mozambique	149/166	64.3%	2018, 2021
Namibia	109/166	64.3%	2018, 2021
Seychelles	N/A	N/A	N/A

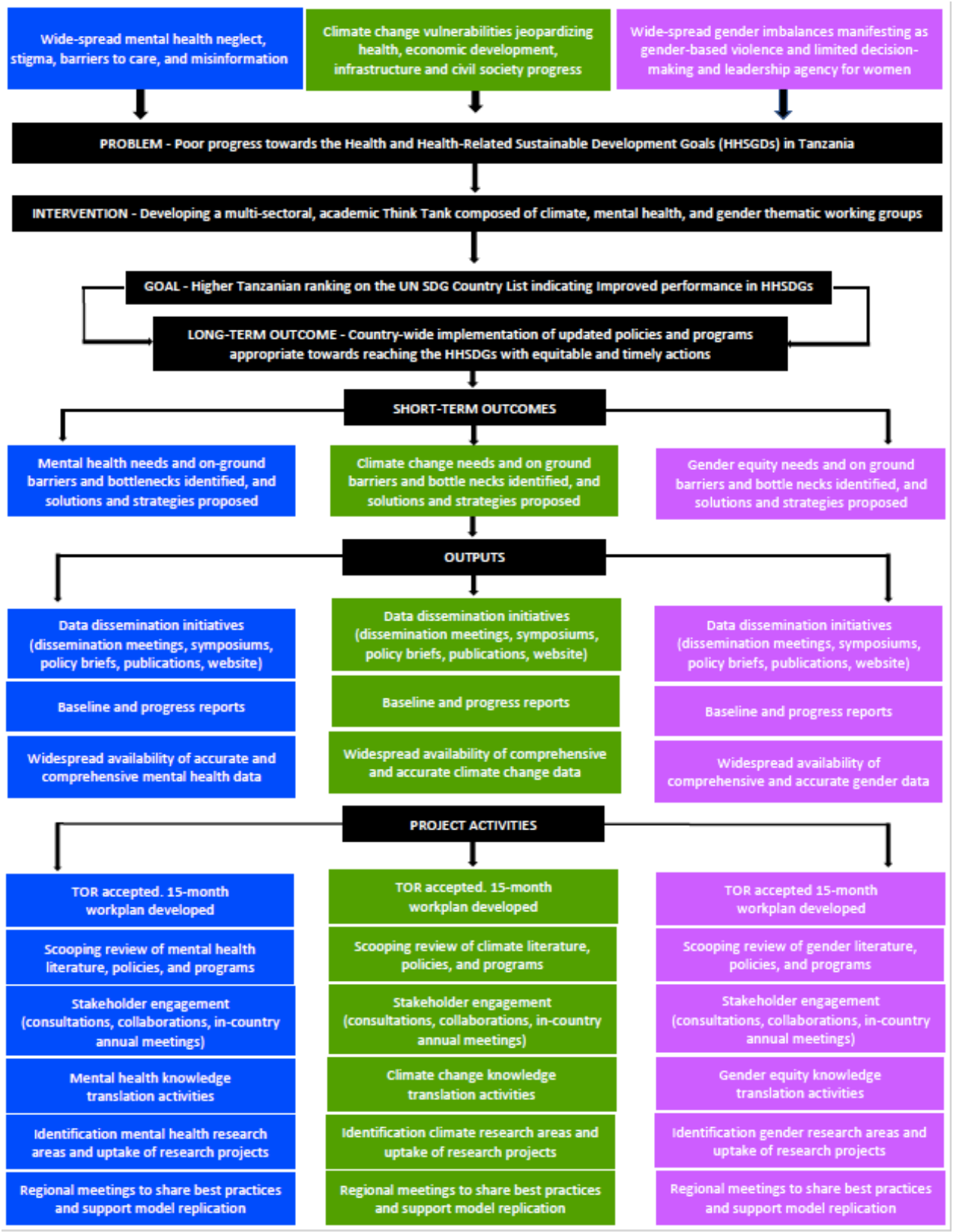
South Africa	110/166	64%	2019
Zambia	145/166	54.3%	2020, 2023
Zimbabwe	138/166	55.60%	2017, 2021

Appendices 3-5: Policy and Financing for Mental Health, Gender, and Climate Change

Appendix 6 – The CHOICE Tanzania Think Tank Membership

Member	Think Tank Role	Professional Role & Organization	Sector
Dr. Ahmed Jusabani	Project Lead, Team Coordinator	Physician, Aga Khan Hospital Dar es Salaam and Assistant Professor of Radiology, Aga Khan University	Healthcare Academia
Mr. Sisawo Konteh	Project Advisor	Chief Executive Officer, Aga Khan Health Services Tanzania	Healthcare Public Health
Ms. Sophia Kara	Project Manager	Health Systems Strengthening Consultant, Aga Khan Foundation Canada/ Aga Khan Hospital Dar es Salaam	Healthcare Public Health
Menta Health Thematic Working Group			
Dr. Tumbwene Mwansisya	Mental Health Lead	Associate Professor of Psychiatry and Mental Health, Aga Khan University	Academia
Mr. Phinehas Mussai	Mental Health Coordinator	Assistant program officer, Regional Psychosocial Support Tanzania (REPSSI)	Civil Society
Dr. Faustine Ndugulile	Mental Health Member	Physician and Member of Parliament, Tanzania Ministry of Health	Healthcare Government Public Health
Ms. Judith Urio	Mental Health Member	Coordinator, Tanzania Sustainable Development Platform	Civil Society
Gender Equity Thematic Working Group			
Ms. Anna Kulaya	Gender Lead	Lawyer and National Coordinator, Women in Law and Development Africa	Law Civil Society
Ms. Sarah Pima	Gender Coordinator	Executive Director, Human Dignity and Environmental Care Foundation	Civil Society
Ms. Catherine Kazambazi	Gender Member	Head of Knowledge, Research, and Analysis, Tanzania Gender Networking Platform	Civil Society
Ms. Doris Mollel	Gender Member	Founder, The Doris Mollel Foundation	Civil Society
Mr. Goodluck Willy	Gender Member	Human Rights and SDGs Program Officer, United Nations Association of Tanzania	Civil Society
Climate Change Thematic Working Group			
Dr. Pius Yanda	Climate Lead	Professor, University of Dar es Salaam	Academia
Mr. Tondelo Gunglundi	Climate Coordinator	Net Zero and Environment Lead, Aga Khan Hospital Dar es Salaam	Healthcare
Ms. Maria Matui	Climate Member	National Coordinator, Gender Climate Change Tanzania Coalition	Civil Society

Appendix 7 – The CHOICE Tanzania Project Theory of Change



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