WHO COUNTRY COOPERATION STRATEGY
2010-2015

TANZANIA
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<th>ACRONYMS</th>
<th>FULL FORM</th>
</tr>
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<tbody>
<tr>
<td>ACT</td>
<td>Artemisinin-Based Combination Therapy</td>
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<td>ART</td>
<td>Anti Retroviral Therapy</td>
</tr>
<tr>
<td>CCA</td>
<td>Common Country Assessment</td>
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<tr>
<td>CCS</td>
<td>Country Cooperation Strategy</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>DPT-HB3</td>
<td>Diphtheria Pertusis Tetanus-Hepatitis B3</td>
</tr>
<tr>
<td>DOT</td>
<td>Directly Observed Treatment</td>
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<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GBS</td>
<td>General Budget Support</td>
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<tr>
<td>GDI</td>
<td>Gender-related Development Index</td>
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<tr>
<td>GHI</td>
<td>Global Health Initiatives</td>
</tr>
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<td>GSM</td>
<td>Global Management System</td>
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<tr>
<td>HAART</td>
<td>Highly-Active Anti-Retroviral Therapy</td>
</tr>
<tr>
<td>HACP</td>
<td>Hazard Analysis and Critical Points</td>
</tr>
<tr>
<td>HKI</td>
<td>Hellen Keller International</td>
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<tr>
<td>HIPC</td>
<td>Heavily-Indebted Poor Countries</td>
</tr>
<tr>
<td>HIS</td>
<td>Health Information System</td>
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<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
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<tr>
<td>HRBA</td>
<td>Human Rights-Based Approach</td>
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<tr>
<td>HRH</td>
<td>Human Resources for Health</td>
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<tr>
<td>HSSP</td>
<td>Health Sector Strategic Plan</td>
</tr>
<tr>
<td>IRS</td>
<td>Indoor Residual house-Spraying</td>
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<td>IST</td>
<td>Intercountry Support Team</td>
</tr>
<tr>
<td>ITN</td>
<td>Insecticide-Treated Net</td>
</tr>
<tr>
<td>JAST</td>
<td>Joint Assistance Strategy for Tanzania</td>
</tr>
<tr>
<td>LLINs</td>
<td>Long Lasting Insecticide-Treated Nets</td>
</tr>
<tr>
<td>MDA</td>
<td>Mass Drug Administration</td>
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<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MDR TB</td>
<td>Multi-Drug Resistant Tuberculosis</td>
</tr>
<tr>
<td>E XDR-TB</td>
<td>Extremely Drug Resistant Tuberculosis</td>
</tr>
<tr>
<td>MOFEA</td>
<td>Ministry of Finance and Economic Affairs</td>
</tr>
<tr>
<td>MOHSW</td>
<td>Ministry of Health and Social Welfare</td>
</tr>
<tr>
<td>NEPAD</td>
<td>New Partnership for Africa’s Development</td>
</tr>
<tr>
<td>NMRA</td>
<td>National Medicines Regulatory Authorities</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>--------------</td>
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<tr>
<td>NTD</td>
<td>Neglected Tropical Diseases</td>
</tr>
<tr>
<td>PMO-RALG</td>
<td>Prime Minister’s Office-Regional Administration and Local Government</td>
</tr>
<tr>
<td>PoA</td>
<td>Plan of Action</td>
</tr>
<tr>
<td>PPP</td>
<td>Public Private Partnership</td>
</tr>
<tr>
<td>REMO</td>
<td>Rapid Epidemiological Mapping of Onchocerciasis</td>
</tr>
<tr>
<td>STH</td>
<td>Soil-Transmitted Helminths</td>
</tr>
<tr>
<td>SWAPs</td>
<td>Sector-Wide Approaches</td>
</tr>
<tr>
<td>TFNC</td>
<td>Tanzania Food and Nutrition Centre</td>
</tr>
<tr>
<td>THMIS</td>
<td>Tanzania HIV and Malaria Indicator Survey</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
</tr>
<tr>
<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
</tr>
<tr>
<td>URT</td>
<td>United Republic of Tanzania</td>
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<tr>
<td>WCO</td>
<td>WHO Country Office</td>
</tr>
<tr>
<td>WHO-AFRO</td>
<td>WHO Regional Office for Africa</td>
</tr>
<tr>
<td>AFRO/IST</td>
<td>WHO African Region/Intercountry Support Team</td>
</tr>
<tr>
<td>WHO/TDR</td>
<td>World Health Organization/ Tropical Diseases Research</td>
</tr>
<tr>
<td>ZHSRSP</td>
<td>Zanzibar Health Sector Reform Strategic Plan</td>
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</tbody>
</table>
The WHO Country Cooperation Strategy (CCS) crystallizes the major reforms adopted by the World Health Organization with a view to intensifying its interventions in the countries. It has infused a decisive qualitative orientation into the modalities of our institution’s coordination and advocacy interventions in the African Region. Currently well established as a WHO medium-term planning tool at country level, the cooperation strategy aims at achieving greater relevance and focus in the determination of priorities, effective achievement of objectives and greater efficiency in the use of resources allocated for WHO country activities.

The first generation of country cooperation strategy documents was developed through a participatory process that mobilized the three levels of the Organization, the countries and their partners. For the majority of countries, the 2004-2005 biennium was the crucial point of refocusing of WHO’s action. It enabled the countries to better plan their interventions, using a results-based approach and an improved management process that enabled the three levels of the Organization to address their actual needs.

Drawing lessons from the implementation of the first generation CCS documents, the second generation documents, in harmony with the 11th General Work Programme of WHO and the Medium-term Strategic Framework, address the country health priorities defined in their health development and poverty reduction sector plans. The CCSs are also in line with the new global health context and integrated the principles of alignment, harmonization, efficiency, as formulated in the Paris Declaration on Aid Effectiveness and in recent initiatives like the “Harmonization for Health in Africa” (HHA) and “International Health Partnership Plus” (IHP+). They also reflect the policy of decentralization implemented and which enhances the decision-making capacity of countries to improve the quality of public health programmes and interventions.

Finally, the second generation CCS documents are synchronized with the United Nations development Assistance Framework (UNDAF) with a view to achieving the Millennium Development Goals.

I commend the efficient and effective leadership role played by the countries in the conduct of this important exercise of developing WHO’s Country Cooperation Strategy documents, and request the entire WHO staff, particularly the WHO representatives and divisional directors, to double their efforts to ensure effective implementation of the orientations of the Country Cooperation Strategy for improved health results for the benefit of the African population.

Dr Luis G. Sambo
WHO Regional Director for Africa
WHO Country Cooperation Strategy, second edition 2010–2015 (CCS II), endeavours to enhance the quality and effectiveness of the work of WHO in the United Republic of Tanzania (URT), contributing to the national efforts to reduce poverty through improved health outcomes. It defines WHO’s strategic agenda in Tanzania for the next six years, in line with the WHO Country Focus Policy. This CCS II was developed through a participatory process involving the two Ministries of Health and Social Welfare (Tanzania Mainland and Zanzibar) and their key stakeholders.

Although some health indices such as the maternal and neonatal mortality rates in URT remain poor, notable improvements have been registered in the recent past in child health, with reduction in under-five mortality and infant mortality, increased coverage of Vitamin A supplementation, and improved nutritional status of children. However, a drop in immunization coverage over the past three years threatens the gains in child mortality. Furthermore, a slight decrease in HIV prevalence among adults aged 15-49 years from 7% in 2003 to 5.8% in 2007 in Tanzania Mainland was noted. A significant reduction in malaria incidence has been achieved in Zanzibar as a result of scaling-up of the multiple interventions.

Poverty remains a significant underlying factor influencing health status, with more than half of URT’s population living below the poverty line of USD 1 per day. The country is facing a critical Human Resource for Health crisis, with a shortage of skilled personnel in public facilities estimated at 65%. Multiple contributory factors have continued to interplay in worsening the situation. The health information system is operating at slightly above 50% efficiency and information use for decision-making is still less than 50%. Government expenditure on health as a percentage of total government expenditure for Tanzania Mainland increased from 9% in 1999 to 10.8% in 2007, but it is still below the Abuja target of 15%. Both ministries of health in Tanzania Mainland and Zanzibar have developed Health Sector Strategic Plans to further guide health sector planning and ensure increased implementation of the health sector reform programme.

Both governments have formulated a long-term vision: “Tanzania Development Vision 2025” and “Vision 2020” for Zanzibar, with mid-term poverty reduction strategies to guide activities of both governments and development partners within the framework of the Alignment and Harmonization detailed in the Joint Assistance Strategy for Tanzania (JAST). To coordinate the financing, planning and monitoring of activities among stakeholders in the health sector, a Sector-Wide Approach (SWAp) was initiated in the mainland bringing together bilateral, multilateral partners, non-state actors and health service managers and policy-makers.

The CCS I addressed priority components of the Strategic Agenda: Health system development in the context of ongoing reforms and Essential health service support, focussing on five key areas. The major achievements, and lessons learned in CCS I, as well as emerging health challenges have been summarized in this document.

The strategic agenda of CCS II includes:
1. strengthening health systems and service delivery;
2. support for national priority programmes;
3. support actions on social determinants of health;
4. strengthening partnerships for health development.
The WHO Country Office (WCO) will implement the CCS II through the biennial plans, developed in collaboration with and linked to the annual plans of the Ministry of Health and Social Welfare (MoHSW).

Monitoring of this CCS will follow existing mechanisms for monitoring the implementation of biennial plans. A mid-term review will be conducted after three years of implementation and a final evaluation shortly before the end of the implementation period. The results of the reviews will be disseminated to both Ministries and partners and also used to develop the strategic focus of CCS III.
The United Republic of Tanzania (URT) is composed of Tanzania Mainland and the State of Zanzibar. Consequently, there are two independent Ministries of Health and Social Welfare in the URT, each with a cabinet minister. In Tanzania Mainland, health services follow the administrative organization, with 21 regions, 113 districts and 133 local authorities; in Zanzibar, there are two health zones with ten districts.

The WHO Country Cooperation Strategy II (CCS II) 2010–2015, aims to improve the quality and effectiveness of the work of WHO in Tanzania, supporting the Government’s efforts to eradicate poverty through improved health outcomes. It sets out the strategic agenda for WHO in Tanzania for the next six years, taking cognizance of the recent WHO Country Focus Policy and WHO Medium-Term Strategic Plan. Through the CCS II, WHO aims to be more responsive to country needs and expectations guided by WHO’s comparative advantage, taking into account the activities of other development partners and actors.

The first CCS was developed for URT in 2002 for four years, ending in 2005. Since then, there have been new orientations in the national and global development agenda affecting the way WHO, the Government and health development partners provide support to the health sector. These orientations include the Millennium Development Goals (MDGs), the Eleventh General Programme of Work (a global health agenda) 2006–2015, the WHO Medium-Term Strategic Plan (MTSP) (2008–2013), the Strategic Orientations for WHO Action in the African Region, the National Strategy for Growth and Poverty Reduction (in Kiswahili: MKUKUTA and MKUZA), the Health Sector Strategic Plan 2008–2015 (HSSP III), the United Nations Development Assistance Framework (UNDAF 2006–2010), UN reforms and the principles of the Paris Declaration on Aid Effectiveness. New opportunities for funding have been put in place such as the Heavily-Indebted Poor Countries (HIPC) debt relief and the Global Health Initiatives. In addition, a new development in the health sector was marked by the formulation of the Ten-year Primary Health Services Development Programme 2007–2017 (in Kiswahili- MMAM). The new orientations necessitate a review of CCS I and subsequent development of CCS II to constitute a reference base for biennial plans of the WHO Country Office (WCO), developed jointly with the two Ministries of Health in line with the strategic agenda.

The new CCS will facilitate practical applications of the principle of integrated programmatic technical support to the country and effective operation of the Country Office, including better working relations with UN agencies within the ongoing UN reforms in Tanzania.
SECTION 2

COUNTRY HEALTH AND DEVELOPMENT CHALLENGES

2.1 GENERAL CONTEXT

Since independence, URT has enjoyed political stability and economic growth. By 2006, the country had achieved a GDP increase of 6.7% per annum thereby increasing the total government budget. The GDP per capita increased from US$ 277 in 2003 to US$ 324 in 2006 and to US$ 414 in 2007 based on current prices. The country has invested substantially in the public sector, including health reforms that have embraced public-private partnership and decentralization of the entire public sector.

2.2 DEMOGRAPHY PROFILE AND CHARACTERISTICS

The demographic profiles of the two States in the URT are similar, as reflected in the population pyramid pattern of least-developed countries. The total population of the URT was estimated at 39.9 million in 2008, of which 51% are women and 44% children under 15 years of age. Projections for 2009 indicate a total population of 41.9 million inhabitants, of which 44.4% (18.6 million) are children under 15 years. The population of Zanzibar is estimated at 1.2 million (63% in Unguja and 37% in Pemba Island).

The total fertility rate of URT remains high at 5.7 and the annual population growth rate is 2.47%, with a crude birth rate of 39.0 and crude death rate of 12.9 per 1000 inhabitants (2005–2010). Life expectancy at birth is 51.4 years for men and 53.6 for women. The annual number of births is estimated at 1 600 000, of which only 8% are registered. Approximately, 57.8% of the population is estimated to live under the poverty line of US$ 1 per day. The population distribution is predominantly rural, with only 23% living in urban areas.

Gender equity

URT’s gender-related development index (GDI) has improved slightly over the last decade, from 0.410 in 2000 to 0.464 in 2005. However, the country is still placed at a very low rank of 138 out of 177 countries. This low ranking GDI directly reflects great gender inequalities in terms of literacy rates, school enrolment, access to health care and per capita GDP.

5 UN Population Division (http://esa.un.org/unpp)
7 Tanzania Service Provision Assessment (TSPA) 2006.
### 2.3 KEY HEALTH PERFORMANCE INDICATORS

Table 1 below summarizes some key indicators with disaggregation to Mainland and Zanzibar, wherever data is available.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Tanzania Mainland</th>
<th>Zanzibar</th>
<th>Tanzania Mainland</th>
<th>Zanzibar</th>
<th>Tanzania Mainland</th>
<th>Zanzibar</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>147&lt;sup&gt;a&lt;/sup&gt; 153&lt;sup&gt;d&lt;/sup&gt;</td>
<td>141&lt;sup&gt;d&lt;/sup&gt;</td>
<td>133&lt;sup&gt;d&lt;/sup&gt;</td>
<td>101&lt;sup&gt;d&lt;/sup&gt;</td>
<td>91&lt;sup&gt;b&lt;/sup&gt;</td>
<td>54&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Infant mortality rate (deaths/1000 live births)</td>
<td>99&lt;sup&gt;d&lt;/sup&gt;</td>
<td>89&lt;sup&gt;d&lt;/sup&gt;</td>
<td>83&lt;sup&gt;d&lt;/sup&gt;</td>
<td>61&lt;sup&gt;d&lt;/sup&gt;</td>
<td>58&lt;sup&gt;b&lt;/sup&gt;</td>
<td>54&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Neonatal mortality rate (deaths/1000 live births)</td>
<td>36&lt;sup&gt;a&lt;/sup&gt;</td>
<td>32&lt;sup&gt;&lt;sup&gt;&lt;/sup&gt;&lt;/sup&gt;</td>
<td>29&lt;sup&gt;b&lt;/sup&gt;</td>
<td>29&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal mortality ratio (deaths per 100,000 live births)</td>
<td>377&lt;sup&gt;c&lt;/sup&gt;</td>
<td>578</td>
<td>No data</td>
<td>362&lt;sup&gt;c&lt;/sup&gt;</td>
<td></td>
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<tr>
<td>DPT-HB3 Coverage in Children 12-23 months</td>
<td></td>
<td>90%&lt;sup&gt;f&lt;/sup&gt;</td>
<td>85.6%&lt;sup&gt;f&lt;/sup&gt;</td>
<td>83%&lt;sup&gt;f&lt;/sup&gt;</td>
<td></td>
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<tr>
<td>HIV/AIDS prevalence (15-49 years)</td>
<td></td>
<td>7%</td>
<td>0.6%</td>
<td>5.7%</td>
<td>0.8%</td>
<td></td>
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<tr>
<td>Tuberculosis case detection rate (URT)</td>
<td>52%&lt;sup&lt;g&lt;/sup&gt;</td>
<td>50%&lt;sup&lt;g&lt;/sup&gt;</td>
<td>51%&lt;sup&lt;g&lt;/sup&gt;</td>
<td></td>
<td></td>
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<tr>
<td>Tuberculosis treatment success rate (URT)</td>
<td>78%&lt;sup&lt;g&lt;/sup&gt;</td>
<td>82%&lt;sup&lt;g&lt;/sup&gt;</td>
<td>87.4%&lt;sup&lt;g&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Malaria cases incidence /100,000</td>
<td>500 000&lt;sup&lt;d&lt;/sup&gt;</td>
<td>29,076&lt;sup&lt;d&lt;/sup&gt;</td>
<td>657 453&lt;sup&lt;d&lt;/sup&gt;</td>
<td>26 946&lt;sup&lt;d&lt;/sup&gt;</td>
<td></td>
<td></td>
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<tr>
<td>Malaria prevalence</td>
<td></td>
<td>18%</td>
<td>0.8%</td>
<td></td>
<td></td>
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<tr>
<td>Births assisted by skilled personnel</td>
<td>46%</td>
<td>51%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Unmet needs for family planning</td>
<td>22%</td>
<td>31%&lt;sup&gt;e&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Vitamin A supplementation level (% children aged 6-59 months)</td>
<td>85%</td>
<td>89%&lt;sup&gt;e&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stunting (chronic malnutrition)</td>
<td>44% (1996)</td>
<td>38%</td>
<td>23%&lt;sup&gt;e&lt;/sup&gt;</td>
<td></td>
<td></td>
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<tr>
<td>Access to clean and safe water within 30 minutes spent collecting water (% population)</td>
<td></td>
<td>37.1% (rural)</td>
<td>77% (urban)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Access to basic sanitation</td>
<td></td>
<td></td>
<td>87%</td>
<td></td>
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</tbody>
</table>

Except where indicated, the data for 2004/5 are sourced from the Demographic and Health Survey.

- URT source TRCHS 1999.
- URT HIV Malaria Indicator Survey 07/08.
- Facility-based estimates.
- Road map for MNCH in Zanzibar 2008-2015.
Child, adolescent and maternal health

Under five and infant mortality have declined significantly in Tanzania (see Table 1). Possible contributing factors may be related to general development efforts and cost-effective public health interventions. Neonatal mortality has remained stagnant and maternal mortality persists at a high level. High maternal and neonatal death rates reflect poor access to and poor quality of care during antenatal, perinatal and postnatal periods. Estimation of maternal mortality for Zanzibar was not done due to the small size of sample population in the last DHS. However, facility-based maternal mortality was estimated at 362 in 2007. Less than 50% of women in URT deliver with the attendance of a skilled professional. Basic equipment and supplies for conducting normal deliveries are available in only 13% of facilities offering delivery services. The gains in child mortality are currently threatened by a drop in immunization coverage in the past 3 years.

Adolescents and young people remain at risk of sexual and reproductive ill health due to HIV/AIDS, teenage pregnancies and unemployment. Youth-friendly services are rare and integration of the youth into reproductive health services is inadequate and under-resourced.

Nutrition and Food Safety

Malnutrition is estimated to be an underlying cause of 50% of under-five mortality. Vitamin A supplementation coverage among children aged 6–59 months gradually increased from 14% in 1999 to 46% in 2004, and to 85% and 89% in Tanzania Mainland and Zanzibar respectively in 2005. Nevertheless, 38% of Tanzanian children under five are still stunted, reflecting chronic malnutrition, while 72% are estimated to be anaemic, reflecting both the burden of malaria, worm-infestations and micronutrient deficiencies. Only 41% of children are exclusively breastfed until 6 months. The proportion of low birth weight, and anaemia in pregnancy is also high.

Food safety and food quality control is an area that needs to be strengthened in both Tanzania Mainland and Zanzibar. The country lacks relevant food safety policy and adequate legislation to cover food safety and quality. Low compliance with Good Manufacturing Practices (GMP), especially among small-scale manufacturers (who constitute around 74% of all food manufacturers in the country) is a challenge. Trained inspectors to enforce adherence to the Hazard Analysis and Critical Points (HACP) system are insufficient. Poor food handling practices are widespread, contributing to diarrhoeal diseases.

Essential Medicines

The National Medicine Policies in both Tanzania Mainland and Zanzibar were revised in 2008. Although the budget for medicines has been increasing steadily since 2002, with almost 150% increase for the financial years 2002–2005, it is still inadequate, leading to shortages of essential medicines. Medicine prices are also high, especially in NGO and private facilities with cumulative price mark-ups of up to 60%. Procurement and forecasting weaknesses have continued to affect regular supply of medicines at health facilities.
HIV/AIDS and Tuberculosis

HIV prevalence rate among the 15–49 years age group in Tanzania Mainland has slightly decreased (see table). Among this population group, 37% of women and 27% of men have been tested for HIV and received results. HIV prevalence is still higher among women than men (7% and 5%, respectively). Only 53.3% of men reported using a condom at the last high-risk intercourse. Zanzibar is still experiencing concentrated epidemic, with HIV prevalence of 0.6%. Recently, a rapid assessment survey documented high HIV prevalence of 12.9% among substance users in Zanzibar. Coverage of HIV/AIDS prevention, treatment and care services is still low in both Tanzania Mainland and Zanzibar.

Tuberculosis case notifications have stabilized for the past three years at about 50% of expected WHO case detection estimates. The treatment success rate has reached the WHO global TB control target of 85%. More than 50% of TB patients in the country are co-infected with HIV.

Malaria

Malaria is a leading public health problem in Tanzania Mainland, contributing to 39.4% of the total OPD attendances. It is the leading cause of death in children under-five, contributing to 36% of all deaths in this age group and similarly the leading cause of death in children aged five years and above.

Zanzibar has shown a marked decline in malaria incidence since the scaling-up of multiple interventions, including the introduction of ACTs in 2003, free access of Long-Lasting Insecticide-Treated Nets (LLINs) to vulnerable groups and deployment of Indoor Residual Spraying (IRS). Hence, in Zanzibar, malaria is no longer the number one cause of child mortality. Malaria prevalence stands at 0.8% in under-fives.

Neglected Tropical Diseases

Published data in Tanzania Mainland suggest that all regions have schistosomiasis infection with prevalence ranging from 12.7% to 87.6% around Lake Victoria. There is high prevalence of soil-transmitted helminths (STH), with prevalence rates up to 100% in certain ecological settings such as Kagera, Mwanza, and Tabora. The 2004 results indicated that Lymphatic Filariasis (LF) is endemic in all districts of the country. Rapid Epidemiological Mapping of Onchocerciasis (REMO), conducted in (1999) and refined in 2004, indicated that approximately 4 million people in Tanzania Mainland are at risk. The prevalence of Onchocerciasis was as high as 63.6% in certain focal endemic areas, including Mbeya, Iringa, and Morogoro. The prevalence rate of active trachoma is 25.4%, and 2.7% for blinding trachoma.

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16 Tanzania HIV and Malaria Indicator Survey (THMIS) 2007-2008.
18 THMIS 2007-2008: VCT services coverage reached 37% of women and 27% of men aged 15–49 years in Mainland. STI services are currently offered in 66% of all health facilities in Mainland. PMTCT coverage has been unequal across the 4871 sites providing RCH services (95.4% are primary health facilities and 4.6% are hospitals) in Mainland. As of December 2007, less than 40% of the total of eligible patients in Mainland, estimated at 440 000, were enrolled in ART. There are 27 functional VCT sites unequally distributed in Zanzibar. Condoms are distributed for free by STI clinics and RCH services in public health facilities. In Zanzibar, 300 PLHAs are presently on ART.
19 Tanzania Coastal District Health profile 2006: MOHSW; Rufiji DSS report by Ifakara Health research and Development Centre.
In Zanzibar, Lymphatic Filariasis was endemic, with the prevalence rate ranging from 5% to 30% in 2002, later dropping to below 1%, following successive Mass Drug Administration (MDA) from 2002 to 2006. Schistosomiasis is still endemic in Zanzibar, mainly in Pemba, with a prevalence rate of more than 80%. Soil-transmitted helminthiasis is also highly prevalent with the prevalence rate close to 40%. There has not been any MDA for both of these conditions since 2006. Trachoma is endemic as well as Rabies.

Tanzania has achieved global Leprosy elimination target of <1 case/10 000 inhabitants at the national level. The plans are to implement targeted leprosy elimination at district level and maintain quality leprosy services in the country.  

Noncommunicable diseases

Noncommunicable diseases are on the rise, particularly in the urban areas, where 25% of the population resides, with obesity among urban women tripling from 4% in 1991 to 12% in 2004. The effects of increasing risk factors, including unhealthy lifestyles, have led to an explosion of diabetes mellitus, hypertension, and ischaemic heart diseases. Increased use of Highly-Active Antiretrovirals (HAART) is also contributing to an increase in noncommunicable diseases. Public attention to cervical and breast cancers has recently gained media publicity, challenging epidemiological analysis to determine their priority ranking.

Epidemics and emergencies

Tanzania shares borders with eight countries and is prone to epidemic disease outbreaks such as plague, measles, meningitis, cholera and Rift Valley Fever. Furthermore, owing to its geographical profile, the country is at risk of a number of disasters with health emergencies, including floods, tsunami, volcano eruption, earthquakes and displaced populations. Recent systemic and sectoral efforts on emergency preparedness and response in the country need strengthening and better coordination judging from the experience of managing the Rift Valley Fever outbreak in late 2006 to early 2007, where mortality among humans and animals impacted the economy. The occurrence of emerging and re-emerging diseases such as yellow fever, poliomyelitis, Ebola and Marburg in neighbouring Democratic Republic of Congo and Uganda pose great threats of cross-border transmission. Avian and pandemic influenza is similarly a threat. A Multisectoral Emergency Preparedness Plan is being developed, with coordination of the Prime Minister’s Office.

Community health practice

Due to variation among districts in access to health facilities and problems associated with transport costs, as well as the human resource crisis, several vertical programmes have initiated community components for health promotion, community management of simple conditions such as home-based care and community IMCI. For example WHO approach to community TB care has been implemented in two districts in Tanzania Mainland, Zanzibar and Pemba with great success: The plan is to scale-up Community TB care to cover all districts with less access to health facility-based DOT. However, there is lack of coordination between vertical programmes although several programmes have conducted training of community workers. There is also lack of supervision, monitoring, and feedback as well as supplies for counselling and care at community/household level.

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Traditional Birth Attendants have also continued to function, with or without training and support. Fifty-four percent of pregnant women deliver at home 11% of whom are delivered by TBAs and 26% by relatives. In line with the national health policy and strategies, there is a need to redefine the roles and functions of TBAs to ensure safety considerations and avoid delays in accessing skilled management of deliveries.

Traditional medicine is covered by law but enforcement of the regulations is weak, thus giving room to the emergence of malpractices.

Household health practice is an insufficiently explored area; defining the scope and content to include issues of prevention and treatment of malnutrition, behaviour change communication on health, the obligations, rights and roles of various players in support and monitoring are vital. Yet, the Household Budget Survey, an opportunity to inform household production of health, has not been adequately exploited.

2.4 SUMMARY OF HEALTH SYSTEMS ANALYSIS

Health Sector Reform

The health sector reform programme has focused on decentralization by devolution, financial reforms, including cost sharing, pre-payment and health insurance, public/private partnership as well as integration of vertical health programmes into the general health services. The reform programme aims at improving the access, quality and efficiency of primary health services (dispensary, health centre and district hospitals), as well as strengthening and reorienting the secondary and tertiary service delivery in line with the primary health care approach. Zanzibar similarly introduced a reform process guided by the Zanzibar Health Sector Reform Strategic Plan I (ZHSRSP I 2002/2003–2006/2007), emphasizing decentralization and availability of high quality health services with a focus on reducing the burden of disease and introducing a national essential health-care package relying on cost-effective interventions. Progress of the reform processes has been slower in Zanzibar due to various factors, including funding.

In Tanzania Mainland, the health sector reform implementation had doubled the public per capita spending on health between 1999 and 2008. The sector has made improvements in financial management systems, decentralization, strengthened harmonization between development partners and alignment with government policies.

Critical health systems issues

Human Resources for Health

Tanzania currently faces a serious human resource crisis that is negatively affecting the ability of the sector to deliver effective and quality health services. Widespread shortage of qualified health workers exists at all levels (Table 2), though more severe in rural districts. There are disparities in the distribution of human resources between urban and rural areas. The shortage is exacerbated by the increasing burden of disease.

24 PER 2007 and Joint external evaluation of the Health sector in Tanzania.
Table 2: Human resource status by facility levels in public health facilities

<table>
<thead>
<tr>
<th>Facility Level</th>
<th>Number</th>
<th>Health Professionals</th>
<th></th>
<th>Shortage %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Required 2006</td>
<td>Available 2006</td>
<td>Shortage 2006</td>
</tr>
<tr>
<td>Referrals/Specialized Hospitals</td>
<td>8</td>
<td>8546</td>
<td>4477</td>
<td>4069</td>
</tr>
<tr>
<td>Regional Hospitals</td>
<td>21</td>
<td>7266</td>
<td>2481</td>
<td>4785</td>
</tr>
<tr>
<td>District Hospitals</td>
<td>95</td>
<td>22 458</td>
<td>7364</td>
<td>15 094</td>
</tr>
<tr>
<td>Health Centres</td>
<td>331</td>
<td>11 916</td>
<td>4908</td>
<td>7008</td>
</tr>
<tr>
<td>Dispensaries</td>
<td>3038</td>
<td>30 380</td>
<td>9384</td>
<td>20 996</td>
</tr>
<tr>
<td>Training Institutions</td>
<td>72</td>
<td>1711</td>
<td>449</td>
<td>1262</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3565</td>
<td>82 277</td>
<td>29 063</td>
<td>3214</td>
</tr>
</tbody>
</table>

Source: MOHSW (2006)

Efforts made by the Mainland Ministry in ensuring allocation of staff to different levels are constrained by low output of qualified staff, poor distribution, poor remuneration, poor infrastructure, and lack of an attractive retention scheme. Implementation of the Primary Health Service Development Plan, which aims at increasing health facilities from 5795 in 2006 to 13 039 by 2017, shall increase demand for human resources significantly. Despite ongoing efforts by the Government to address poor retention and motivation of health workers, the remuneration of health workers remains largely unattractive, limiting the capacity to recruit, deploy and retain qualified staff.

The human resources crisis arose from a combination of underlying factors, including weak planning and forecasting capacity, retrenchment and employment freeze policies, the occurrence of brain drain within and outside the country, chronic under-funding and limited involvement of the private sector in policy and strategy development, despite having a significant share in training of health personnel. In response, a human resource policy and strategy have been developed, with plans for addressing several pertinent issues, including private sector involvement.

Health Information System

The Health Management Information System (HMIS) is the largest routine data collection system under the MoHSW. It is expected to collect information from all health facilities, but reporting is often incomplete. However, the system remains weak and fragmented, with lack of feedback between various levels. Information from the system is often irretrievable due to inadequacy of the existing databases and insufficient capacity for data analysis and interpretation. Several disease-specific programmes have de-linked from the HMIS and set up their own information systems. As a result, the health sector remains over-reliant on surveys for planning and monitoring.

Measures to improve the HMIS in Zanzibar are on course, as all districts have been computerised and functioning of data bases centrally has been enhanced. However, as is the case in Mainland, the use of information for decision-making is not yet an established routine.

Other health information sources include Demographic Surveillance Systems (DSS) and Health Systems Research under the MoHSW, the Demographic and Health Surveys (DHS), the Population and Housing Census and the Household Budget Surveys, which are coordinated by the National Bureau of Statistics (NBS) in collaboration with the MoHSW. Vital Registration (VR) is another source of indicators, which is administered through the Ministry of Justice and Constitutional Affairs, but the information is often incomplete, low in coverage and not
regularly updated. Population-based surveys such as the DHS and the Tanzania HIV and Malaria Indicator Survey (THMIS) provide critical information on the status of the health impact indicators, which are comparable globally but at a high cost. The other weakness of surveys according to the 2007 assessment is the periodicity, which was found to be inadequate or less frequent.  

The lack of an overall HIS policy and HIS strategic plan to ensure the coordination of the different HIS sub-systems is a critical limitation. Regarding human resources, there are limitations in terms of capacity in the core health information sciences, inadequate skills mix at the central HIS administrative unit and lack of dedicated HIS staff at the regional and district levels.

A more fundamental problem on health information is the extent of utilization of the information available, as illustrated in a snapshot of findings of HIS assessment (MOHSW 2007) in Table 3 below.

**Table 3: Dissemination and use of information**

<table>
<thead>
<tr>
<th>Dissemination and Use</th>
<th>47%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analysis and use of information</td>
<td>51%</td>
</tr>
<tr>
<td>Policy and advocacy</td>
<td>53%</td>
</tr>
<tr>
<td>Planning and priority setting</td>
<td>48%</td>
</tr>
<tr>
<td>Resource allocation</td>
<td>43%</td>
</tr>
<tr>
<td>Implementation and action</td>
<td>38%</td>
</tr>
</tbody>
</table>

**Health Sector Financing**

The URT faces a dual challenge of under-funding and poor resource allocation. Despite some improvements in health sector funding (the allocation of government expenditure to health increased from 9% in 1999 to 10.8% in 2007), it still falls short of the Abuja target of 15%. Moreover, the per capita expenditure of US$ 14 on health, is also far below the US$ 34–40 target recommended by the Commission for Macroeconomics and Health for low-income countries in sub-Saharan Africa. In addition to increased domestic resources, the average annual volume of external assistance for the health sector increased from US$ 46.48 million in 2003 to US$ 122.91 million in 2005/2006. The proportion of external aid for the health sector increased to reach 41% of the total government budget in FY2004/2005. The existence of off-budget spending limits the discretionary powers of the Government to allocate resources. The table below presents the values and percentages of the two categories. It is estimated that the domestic share of on-budget sources rose from 46% in 1999 to 56% (including GBS) in 2006.

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26 Source: UNDAF.
27 The on-budget resources thus consist partly of donor money and revenues raised by the Government of Tanzania, while off-budget resources consist mainly of donor funding and funds collected through cost-sharing initiatives in government health facilities.
Table 4: Public expenditure on health in Tanzania Mainland: on-budget and off-budget estimates, in USD million in real terms

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>On-budget</td>
<td>90.3 (63%)</td>
<td>153.4 (71%)</td>
<td>204.0 (76%)</td>
<td>345.9 (81%)</td>
</tr>
<tr>
<td>Off-budget</td>
<td>53.3 (37%)</td>
<td>63.4 (29%)</td>
<td>66.5 (24%)</td>
<td>81.7 (19%)</td>
</tr>
<tr>
<td>Total</td>
<td>143.6</td>
<td>216.8</td>
<td>270.5</td>
<td>427.5</td>
</tr>
</tbody>
</table>

Government funding for the health sector in Zanzibar has remained largely stagnant at approximately 8% of total government spending over the past four years, corresponding to a slight drop in total per capita spending in real terms to approximately US$ 3.85 for FY2005/2006. In Zanzibar the major sources of financing are; government contribution of 36% in FY 2005/2006; contribution of 63% by development partners in the same year; and cost-sharing revenues representing the final 1%.

The analysis of financial resources allocated between 2005 and 2007 reveals a disproportionate allocation of resources to the secondary and tertiary hospitals in relation to primary health services, thus indicating inequity with an urban bias. However, since the introduction of the new formula for the health block grants in 2004, the gap has narrowed down. But, the inequity persists, as out-of-pocket expenditures for health remain high, thus disproportionately burdening the poor. This is further compounded by the fact that 69% of the total health expenditure is private spending, of which nearly 80% represents out-of-pocket expenditure.

Major health challenges
This situation analysis identifies the following list of challenges:

Human resources for health
The country faces a serious human resources crisis in the health sector, as it functions with only one-third of projected capacity, with attendant inequitable distribution, poor retention and limited budgets.

Health care financing
A gap exists between available resources and health sector needs. However, neither the gap nor the packages of public and private health services have been costed. Ensuring predictable funding and increasing the on-budget proportion of bilateral and global health initiatives remain a challenge. Rising costs of health interventions (such as anti-malaria, antiretroviral and newly-developed vaccines) and the need to ensure universal access present an equity challenge. A further challenge is ensuring efficiency in resource allocation and expenditure.

37 Report on “Delivering as One”.
39 Unless otherwise indicated, data source for this table is TDHS.
Health information

Health information is characterized by limited availability and reliability of sentinel and HMIS data and over reliance of the sector on survey data for planning and monitoring purposes. There is a need for increased investment in a coherent HMIS, with data disaggregated by age and sex. Knowledge management, data analysis, interpretation and use need to be addressed. Coordination of HIS initiatives and harmonization of data bases and other technical inputs present policy and strategy challenges.

Service delivery

Hospital reforms are needed, as hospitals are under-funded, lack qualified staff and adequate supply of essential medicines. Supportive supervision, adherence to standard operating procedures and improved referral call for greater attention. Health facilities are in need of rehabilitation and upgrading, as many of them lack space to accommodate new initiatives, running water, electricity and communication equipment.

The performance and efficiency of the forecasting, procurement, supply, quality control and cold chain maintenance for essential medicines and vaccines are inadequate.

Disease-specific challenges

Extending care and treatment services beyond the hospitals requires capability for ART handling at a basic level, which is currently limited by human resource and other systemic constraints. Access to HIV/AIDS prevention, care and treatment services for Most-At-Risk Population (MARP) is still a challenge in Zanzibar.

TB case detection, weak supervision and implementation of multidrug-resistant (MDR-TB) and extremely drug-resistant (XDR-TB) tuberculosis control programmes remain major challenges.

Changing from monotherapy to ACTs requires complex measures within the public and private sector to ensure more effective malaria control. Strengthening parasitological diagnosis is critical, given the introduction of these high cost drugs. Inadequacy of resources for malaria prevention remains a challenge.

Implementation of international health regulations and integrated disease surveillance and response, including noncommunicable diseases needs strengthening. Preparedness for outbreaks of emerging and re-emerging infections, including pandemic influenza and other health related emergencies, also needs to be strengthened.

Community health

Coordinated engagement and mobilization of communities and households for enhanced and safer community health practice is needed so as to benefit the health system in terms of gains in efficiency and effectiveness. Existing structures like Health Facility Committees could be more useful in linking community health care to health facilities, but their functionality is suboptimal.

40 The timeframe for the MKUKUTA and MKUZA is 2006-2007 to 2010, thus targets are to be met in 2010 contrary to the MDGs, which are targets for 2015.
3.1 OVERALL TRENDS IN DEVELOPMENT ASSISTANCE

Development strategies for URT are articulated in two documents; the National Strategy for Growth and Reduction of Poverty (NSGRP or MKUKUTA in Swahili) 2005/2006–2009/2010 and Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRP or MKUZA in Swahili) 2005/2006–2009/2010 for Tanzania Mainland and Zanzibar respectively. The MDGs have been fully mainstreamed into the MKUKUTA and MKUZA, making it the overall guiding frameworks for investment. The Joint Assistance Strategy for Tanzania commits to aligning support from development partners with the MKUKUTA and MKUZA, using government systems and processes. It also presents a common assessment framework for determining levels of finance, which will improve predictability of aid. The JAST also spells out the partnership principles designed to guide development partner behaviour and support for both strategies. The principles outline the modalities for support, with preference for general budget support as the mechanism to enhance the effectiveness of development assistance. Presently, the modalities for development assistance include general budget support, sector budget support or health basket funding and project support.

Government, development partners and private funds constitute the dominant expenditures in the health sector. However, the proportions of each contributor keep changing annually. In 2002/2003, households were the major sources contributing 47%, followed by donors (27.4%) and the Government (25.5%). In 2005/2006, it was the opposite, with development partners contributing 44.1% of Total Health Expenditure (THE), the Government 28.1% and households 27.8%. Domestic funds support the recurrent budget, including wages and other recurrent costs, while the development budget is more heavily supported by foreign funding. Off-budget funds are predominantly foreign, with domestic contributions, made through cost-sharing schemes in the sector (excluding the National Health Insurance Fund [NHIF]) representing only 2.4% of total projected off-budget resources. Within foreign funding, basket funding is increasingly playing an important role in supporting day-to-day operations within the health sector, through grants to Local Government Authorities (LGAs) and development budget support to the central level of the MoHSW.

Stakeholders’ areas of investment contributing to the health sector are presented in Annex 4. Local NGOs, FBOs and the Association of Private Health Facilities in Tanzania (APHTA) make significant contributions, but more in terms of health service delivery and advocacy. In addition to bilateral and multilateral development assistance, URT receives funds from global initiatives such as the GFATM and GAVI, and other mechanisms. The contribution of the health sector to the GDP increased from 7.6% in 2003/04 to 5% in 2005/2006.

3.2 THE SECTOR-WIDE APPROACH FOR HEALTH DEVELOPMENT

The MoH and its development partners (DPs) in the sector agreed to the implementation of a common health sector strategic plan through a sector-wide approach (SWAp). The SWAp arrangement also helps to discuss project formulation implementation and evaluation. The Health Sector Strategic Plan III 2009/2010–2013/2014 has just been completed. WHO, together with other development partners, were fully involved in its formulation. Together with HSSP III, the Primary Health Services Development Programme (PHSDP or MMAM in Swahili) forms a guide on investment in the sector. Zanzibar recently developed a ZHSRSP II 2006/2007–2010/11, aimed at providing better guidance for the planning of the MoHSW and other stakeholders in the health sector.

In addition to defining the objectives of the SWAp on Tanzania Mainland, a Memorandum of Understanding (MOU) has been signed, which defines the shared obligations, modalities and structures for cooperation among the partners, as well as procedures for amending or terminating the MOU. The MOU recommends that all the resources available for health should be utilized within the framework of the agreed Health Sector Strategic Plan and in accordance with the priorities set therein.

The JAST advocates for channelling most of the funding through general budget support. Many partners opted for sector budget support or health basket funding, although some still fund projects. The sector registered a mixed picture in project expenditures as a percentage of external funding, which were 34% in 2004/2005, 46% in 2005/2006, 21% in 2006/2007 and 35% projected expenditures for 2007/2008. This pattern disrupts commitment towards budget support. Global initiatives such as GAVI, PEPFAR and GFATM address critical health needs in the country, but are not yet compliant with the alignment and harmonization principles pursued by the JAST. The Ministry of Finance and Economic Affairs introduced output-oriented budgeting in order to improve accountability and performance for the different sectors, which has been adopted in the health sector.

3.3 MECHANISMS FOR COORDINATION

The implementation of the Health Sector Strategic Plan, and related strategies and plans, including but not limited to the MMAM, various priority disease control strategies, the Medium-Term Expenditure Frameworks (MTEFs-MOHSW, PMO-RALG), national/training institutions, hospitals, regional, and Comprehensive Council Health Plans (CCHPs), etc. are monitored jointly by the Government (MoHSW, PMO-RALG, MoFEA), development partners, the private sector, and civil society Organizations, through joint annual health sector reviews, the technical committee of the sector-wide approach, and the specific technical working groups (committees). They comprise the sector dialogue for health.

The Joint Annual Health Sector Reviews (JAHSR) are undertaken by all stakeholders in September each year. The JAHSR is preceded by a technical review, which addresses performance of key programme areas while the JAHSR receives the report on health sector performance for the completed FY, the annual sector plan and discusses priorities for the budget of the subsequent FY. The technical working groups are tasked to work throughout the year, focusing on programme implementation, actions and undertakings agreed upon in the JAHSR.
3.4 COORDINATION OF THE HUMANITARIAN RESPONSE

The national platform for disaster and risk reduction, composed of the Government, development partners and the civil society, is a key instrument for advising the National Steering Committee on disasters and risks. WHO is a member of the committee, which is responsible for policy development and decision-making on humanitarian assistance.

3.5 UNITED NATIONS COUNTRY TEAM

The United Nations, the Common Country Assessment (CCA), the UNDAF and «One UN» Joint programmes present a concerted effort to harmonize UN’s programme of work and align it to national programmes. The UN plays a key role in the monitoring of MDGs and providing appropriate response to humanitarian emergencies.

3.6 CHALLENGES AND OPPORTUNITIES

Although the country is generally implementing policies and strategies that should foster good performance and economic growth, the prospects for sustained growth is highly fragile because of its dependence on agricultural products, which rely on rainfall. The system is also characterized by inefficiencies, resulting in resource wastage. Although there is slight improvement in the utilization of approved budget, the absorption capacity still remains low due to system-wide weaknesses. Practices that emphasize financial accountability but exclude technical audit to ascertain achievement of objectives have sometimes led to wastage of funds. Inadequate mechanisms for ensuring sustainability of activities funded by development partners may lead to the reversal of recorded achievements.

Persistent off-budget funds and project funds have compelled the Government to reconsider its allocation to the health sector, and subsequently putting sector allocation at risk. Development partner conditionalities, earmarking, inadequate coordination of development assistance inflows and insufficient stewardship are all factors undermining the effectiveness of development assistance.

The great potential of the private sector in service provision and health financing needs to be better organized and supported in a more predictable manner.

Increased investments in health by global health initiatives have of late opened a window for strengthening health systems, thereby providing an opportunity for advocating for their alignment and operating within the SWAP arrangement. The commitment of the development partners to making aid more effective, as stipulated in the Paris Declaration and SWAp structures should be exploited. The WCO has to meet the challenge of living up to the expectations of partners and the Government, which calls for the mobilization of additional resources and competent staff to respond to requests in a timely manner.
WHO POLICY FRAMEWORK:
GLOBAL AND REGIONAL DIRECTIONS

WHO is undergoing organizational reforms with the ultimate aim of performing better in supporting its Member States to address key health challenges, including the achievement of the MDGs. The organizational change process is reflected in the WHO Corporate Strategy.

4.1 GOAL AND MISSION

The mission of WHO remains “the attainment by all peoples, of the highest possible level of health” (Article 1 of WHO Constitution). The Corporate Strategy, the 11th General Programme of Work 2006–2015 and the Strategic Orientations for WHO Action in the African Region 2005–2009 outline key policy directions to guide WHO actions in countries. The overall thrust is to facilitate the strengthening of technical and policy leadership in health matters and improvement of the management capacity to address the priority needs of Member States.

4.2 CORE FUNCTIONS

WHO mandate and core functions comprise:

- provision of health leadership;
- engaging in partnerships;
- shaping research agenda;
- setting norms and standards;
- articulating ethics and evidence-based policy options;
- provision of technical support and institutional capacity building;
- health situation monitoring and trend assessment.

The CCS document is designed to enable WHO respond to important challenges and future opportunities in health in the country, in line with its mandate and core functions.

4.3 GLOBAL HEALTH AGENDA AND PRIORITIES

In order to address health-related policy gaps in social justice, responsibility, implementation and knowledge, the Global Health Agenda identifies seven priority areas. They include:

1. investing in health to reduce poverty;
2. building individual and global health security;
3. promoting universal coverage, gender equality, and health-related human rights;
4. tackling the determinants of health;
5. strengthening health systems and equitable access;
6. harnessing knowledge, science and technology;
7. strengthening governance, leadership and accountability.

In addition, the Director General of WHO has proposed a six-point agenda including Health Development, Health Security; Health Systems; Evidence for Strategies; Partnerships; and Improving the Performance of WHO. She also indicated that the success of the Organization should be measured in terms of results on the health of women and the African population.

The Global Priority Areas, as outlined in the 11th General Programme of Work, include:

1. providing support to countries in moving to universal coverage with effective public health interventions;
2. strengthening global health security;
3. generating and sustaining action across sectors to modify the behavioural, social, economic, and environmental determinants of health;
4. increasing institutional capacities to deliver core public health functions, under the strengthened governance of ministries of health;
5. strengthening WHO’s leadership at global and regional levels and supporting the work of governance at country level.

Drawing from the Result-Based Management Framework, WHO, at all levels, follows a limited number of strategic objectives, as outlined in the six-year Medium-Term Strategic Plan 2008-2013. These priorities contributed to the formulation of this CCS document, with the focus on the following challenges facing the Organization:

- universal coverage;
- effective public health interventions;
- global health security;
- social and economic determinants of health;
- core public health functions;
- governance and leadership.

Recognizing the centrality of human resources for health for the effective operation of country health systems, as highlighted in the World Health Report 2006, the WHA adopted the global recommendations and guidelines on task shifting to enhance the production and availability of health workers.

### 4.4 REGIONAL AGENDA AND PRIORITY

Based on the need to work with countries and partners, the WHO Regional Office identified a set of priorities and actions that will improve people’s health in the African Region. The regional priorities took into account, the global documents and resolutions of the WHO governing bodies, the health-related MDGs, the NEPAD health strategy, resolutions on health adopted by Heads of State of the African Union and the organizational strategic objectives outlined in the MTSP. These regional priorities have been expressed in the “Strategic
Orientations for WHO Action in the African Region 2005-2009”. This CCS document identifies with these priorities, which are scaling-up essential health interventions related to priority health problems, enhancing awareness and response to key health determinants plus advocacy, partnerships and resource mobilization, including revitalization of PHC and health systems strengthening as adopted in the Ouagadougou Declaration.

4.5 MAKING WHO MORE EFFECTIVE AT COUNTRY LEVEL

The CCS seeks to further consolidate the Country Focus Policy. Hence, steps have been taken to align with country identified priorities, guided by the National Health Policy, the National Primary Health Services Development Programme (MMAM),\textsuperscript{31} the Human Resources for Health Strategic Plan (2008–2013),\textsuperscript{32} the Health Sector Strategic Plan III (2009–2013),\textsuperscript{33} the UNDAF (2007–2010),\textsuperscript{34} the National Strategy for Growth and Reduction of Poverty (MKUKUTA\textsuperscript{35} for Tanzania Mainland and MKUZA\textsuperscript{36} for Zanzibar), and the principles of the Paris Declaration. In line with the alignment and harmonization, the WCO will use guidance from the Joint Assistance Strategy to facilitate development of relevant partnerships in the health sector.
SECTION 5

PAST AND CURRENT WHO COOPERATION

5.1 WHO COOPERATION OVERVIEW

The WHO Medium-Term Strategic Plan (2008–2013) provides guidance to Country Offices, Intercountry Support Teams, Regional Offices and headquarters to identify biennial plans re-focussed around 13 strategic objectives, a drastic re-prioritization from 36 areas of work covered previously. Within the context of the WHO Country Focus Policy planning at country level derives from priorities of the Ministries of Health within which jointly-agreed Office Expected Results are aligned to Regional and Organization-wide Expected Results, thus facilitating working as One within the Organization.

WCO provides direct technical support to the MOHSW, which interacts with other ministries such as PMO Regional Administration and Local Government Authorities, Finance, Education, Water and Irrigation, Community Development, Gender and Children and Livestock Development and Fisheries. WHO’s policy and strategy brokerage vis-a-vis the Government is attained by virtue of collaboration and consultations with various stakeholders and development partners in health within the framework of common working arrangements of the SWAP and agreed division of labour. Under CCS I, the WCO was able to maximize the utilization of the common arrangements to achieve the following areas.

5.2 REVIEW OF CCS I

The CCS I was an important tool for guiding the development of work plans that respond to country priorities and a focus for maintaining the strategic direction of WHO. The CCS I identified broad key areas of focus and addressed them, following priority components of the Strategic Agenda: health system development in the context of ongoing reforms and essential health services.

Under CCS I, WCO made several achievements, thereby contributing to the attainment of better health for the people of URT. In line with WHO’s normative core function, technical support was provided to the Government in the development of key strategic documents to guide health care delivery, including HSSP III, Zanzibar Food, Drugs, and Cosmetics Act, National Health Systems Profile, Human Resource Policy and Strategic Plan, quality improvement framework and infection prevention and control guidelines, TB policy guidelines, Malaria Strategic Plan, Integrated NTD Strategic Plan, National Sanitation and Hygiene Action Plan, Maternal, Newborn, and Child Health Roadmap and EPI Multi-Year Plan. Support was also provided for the development of guidelines for implementation of various programme interventions, including district health planning and health facility planning and management training modules.

WHO supported national capacity building in various technical aspects, which resulted in the improvement of knowledge and skills of in-service health workers implementing the various programmes. WHO also provided support for the development of a curriculum for a
new diploma-awarding health promotion course, which is ongoing. Various curricula were reviewed and updated. A Resource Centre was established, accessible to staff and the general public for reference. A website was also created for the WCO and it carries updates on technical issues, key events, and achievements within URT. The site is also a source of information on different health matters.

In the context of implementation of priority programmes, WHO supported the health sector response to HIV, including the scaling-up of HIV/AIDS counselling, testing, treatment and care services as well as HIV/AIDS control activities at the work place. Implementation of TB/HIV activities was initiated and capacity built for management of Multi-Drug Resistant TB. Anti-malarial drug policy change from monotherapy to the highly-effective Artemisinin Combination Therapy was facilitated, contributing to improved malaria case management. Implementation of facility-based IMCI was scaled-up and community IMCI initiated, which helped to reduce under-five and infant mortality. WHO supported the strengthening of routine immunization and maintenance of quality vaccine-preventable disease surveillance. This has resulted in maintenance of indigenous polio transmission interruption.

WHO contributed to the strengthening of the monitoring and evaluation systems in both Tanzania Mainland and Zanzibar, and supported the implementation of integrated disease surveillance and response. WHO facilitated the generation of tracking reports on progress of the MDGs for Tanzania Mainland and Zanzibar and their utilization at policy level fora. A second round of National Health Accounts and Service Availability Mapping were supported. In addition, WHO supported clinical research, situation analysis and operational research in the areas of malaria, pharmaceuticals, vaccines, HIV/AIDS, maternal and child health, and road safety. WHO provided technical support for operational research, which resulted in the development of the paediatric formulation of Artemether/Lumefantrine, and establishment of quality assurance laboratory for malaria rapid diagnostic tests (RDTs), which can also serve countries in the region.

WHO supported the Sector-wide Approach and participated actively in the different SWAP structures. The WCO assumed the role of permanent secretariat for the development partners Group in health. A Maternal, Newborn and Child Health Partnership was established, of which WHO is a member. Annex 2 presents the detailed achievements in each focus area.

In spite of the above achievements, a number of challenges were encountered, including the following:

- Low knowledge of the CCS among partners and other stakeholders for various reasons, including high staff turnover. This has resulted in missed opportunities for resource mobilization and low budget execution.
- The time spent on planning, meetings, and processes of achieving consensus limited speedy implementation.

**Lessons learnt from CCS I**

The very wide scope of the agenda in CCS I constrained the possibilities for its prioritization. This may have resulted in spreading resources too thin across many areas of work, thus reducing its visibility and impact. Resource mobilization and allocation to respond to the CCS agenda at country could not match the demand from planned activities.

The delay in publishing and releasing of the CCS I document had profound negative effects, given the partners’ insufficient familiarity with the content of the document before it expired. This resulted in unclear understanding of the roles and core functions of WHO among partners during the CCS I period.
Performance, in terms of technical efficiency, was constrained by the low level of available resources; on the other hand, this enhanced efficiency of their allocation, judging by the broad range of achievements, as summarized in Annex 2.

5.3 WHO STRUCTURE AND WAYS OF WORKING

The Country Office manages WHO core functions and provides leadership in the areas of advocacy, partnership and representation, policy development, technical cooperation, administration and management. It is within the context of the core functions that the WHO brokerage roles are identified and provided.

The WCO in URT has a main office in Dar es Salaam, sub-office in Zanzibar and three field offices for EPI surveillance in Mwanza, Tanga and Iringa. The office is headed by the WHO Representative (WR) and operates with programme officers and support staff, (see Organizational Chart in Annex 3).

The responsiveness of HQ, AFRO, IST and other WHO Regions to requests for support has been viewed as a real strength of the One WHO.

The country regularly hosted missions from HQ, AFRO and IST at the request of the national authorities in consultation with the WCO. While the overall coordination of the missions has improved, there are still occasional instances where some missions have occurred without adherence to the procedures.

During the implementation of CCS I, efforts were made to link the biennial work plans with the MTSP. Some progress has been achieved in forging closer linkage and clustering of programmes, but the challenges persist. There is therefore, a need to develop clear working arrangements to ensure efficient decision-making and coordinated resource management.

In the implementation of CCS I, a number of issues regarding health equity, ethical standards, gender, pro-poor approaches and human rights emerged with potential impact on WHO programming. The WCO currently uses participatory planning and has started intensifying gender mainstreaming and application of HRBA in health.

The WCO is actively involved in promoting active partnership. It supports the efforts of partners in health-related activities and advocates for health to be meaningfully addressed in the development agenda. It also acts as a broker for the appropriate allocation of partners’ resources to address priority health issues, plays an active role in the coordination mechanism and utilizes its brokerage function to promote wider participation of all partners, including the private sector and NGOs.

“Delivering as One” (DaO) is the core of the UN reform agenda in Tanzania, in which WHO plays an active role. WHO’s contribution to the reforms is at level of involvement in JPs and effective engagement in policy dialogue.37
In accordance with its Constitution, the WHO mission in the United Republic of Tanzania is to support the people to attain the highest possible level of health. The type of support given will be based on the premise that the State, as the guarantor of equity in the provision of public health services, plays a central role in the maintenance of the health of its people. With due recognition of the alignment and harmonization principles of the Paris Declaration, the support given by WHO should help strengthen the Government’s institutional capacity and be fully guided by the priorities set. The technical capacity of WHO will always be at the disposal of the country. WHO will work with all partners to advocate for more value for money investments in health, as well as promoting intersectoral collaboration and engagement in addressing important social determinants, which impact negatively on health, including poverty, gender inequities, environmental hazards, illiteracy, risky lifestyles, violence, unsafe transport and malnutrition.

Building on the basic agreement between the WHO and the URT, the cooperation will give due importance to the collaboration with other stakeholders, within the context of the aid architecture and different dialogue fora as spelt out in the JAST. Of particular importance is the collaboration in the UN “Delivering as One” approach, the development partners group (main and health-related sub-groups), the SWAP and the Basket Fund Committee.

The strategic agenda is guided by global and regional initiatives and will prioritize support for the implementation and attainment of the NSGPR and MDG targets. This strategic agenda for the WHO Country Office is based on issues identified in the review of CCS I, the comparative advantages and core functions of WHO, as well as the priorities set out by the Government. The strategic agenda is also based on the domains of WHO support, as highlighted in the Global Programme of Work and aims at supporting achievement of the health-related Millennium Development Goals. It includes the following:

1. strengthening health systems and service delivery;
2. supporting national priority programmes;
3. supporting actions on social determinants of health;
4. strengthening partnerships for health development.

6.1 STRATEGIC AGENDA 1: STRENGTHENING THE HEALTH SYSTEM AND SERVICE DELIVERY

In line with the recommendations of the Ouagadougou Declaration, the WCO will support strengthening of the health system and revitalization of primary health care, with particular emphasis on improving access, equity and quality of health services.
6.1.1 Strategic Priority 1: Strengthening the capacity of health systems

i. Human Resources for Health

WHO will provide technical support to the Government in its efforts to improve the management of Human Resources for Health through effective partnerships and collaborative initiatives with stakeholders, with a focus on:

- policy monitoring, reviews and long term planning to improve training, deployment, career development and retention of health workers in both public and private sectors;
- capacity building, at national and district levels, in the generation, analysis and use of information on Human Resource for Health information for planning and management;
- strengthening the management capacity of human resources within the health sector;
- supporting the adaptation and appropriate implementation of task-shifting guidelines to address some of the HRH gaps, while upholding quality of services;
- supporting the updating of pre-service curricula and management of health training institutions in both the public and private sectors;
- supporting more effective and efficient in-service training through integrated training packages;
- exploring and demonstrating innovative approaches to pre-service and in-service training;
- supporting HRH operational research.

ii. Health Financing

WHO will support Government’s efforts to mobilize resources in the health sector to improve equity of access to health services, management of additional funds and enhance efficiency and effectiveness in the use of financial resources via a comprehensive financing strategy, with a focus on:

- strengthening skills and generating evidence for resource mobilization from the Government, development partners and other health financing options;
- providing technical guidance to the MoH in implementation of Public Expenditure Reviews, national health accounts and other costing studies to inform policy dialogue and decisions;
- building the capacity to track government budget allocation and spending for health;
- facilitating the development, application and review of a national social protection initiative to guarantee universal access to health care through:
  - advising MOHSW on institutional measures for adaptation;
  - working with UN and bilateral partners to identify systemic measures for making the initiative work;
  - supporting effective implementation of waivers and exemption mechanisms on cost-sharing policy;
  - providing technical support for expansion of pre-payment health insurance schemes;
- Providing technical support to the MoH for strengthening its stewardship role in the health sector.
iii. Health Information Systems

WHO will support the Government to develop a comprehensive Monitoring, Evaluation and Research strategy for the health sector, with a focus on:

- strengthening capacity for tracking progress on attainment of the health-related Millennium Development Goals and health sector performance;
- tracking equity in access and provision of health services;
- strengthening Integrated Monitoring and Evaluation, taking into account harmonization of tools, software, databases and other technological inputs;
- strengthening the capacity for epidemiological data analysis and use of information at relevant levels;
- providing technical support for the development and implementation of the HIS strategic plan, including strengthening vital statistics registration, HMIS and IDSR, population-based surveys and other sources of health information;
- providing technical support for improved functionality of the national Health Management Information System, including IDSR, through innovative technologies and approaches;
- monitoring immunization coverage and impact on target diseases through maintenance of high quality EPI surveillance;
- supporting operational research, and generation, packaging and dissemination of evidence for policy and planning at all levels, through engagement of WHO Collaborating Centres and research institutions.

6.1.2 Strategic Priority 2: Scaling-up health service Delivery

WHO will mobilize and provide technical support to the Government and partners in their efforts to increase availability, accessibility, utilization, equity and quality of health services and interventions, with a focus on:

- facilitating availability and provision of technical support for review, adaptation and implementation of international norms, standards and guidelines for improving service delivery;
- supporting Ministries of Health in implementation of the national quality improvement framework, including accreditation standards for both public and private health facilities, and monitoring contribution of capacity building to quality improvements in service delivery;
- supporting the revitalization and implementation of the hospital reforms to contribute to improved quality of service delivery;
- building capacity for procurement and supply management, review of forecasting and stock management processes, and strengthening measures to enforce quality and safety controls for essential medicines and health technologies;
- Providing technical support and building capacity for selection and appropriate use of medical products, vaccines and technologies;
- Supporting the strengthening of the regulation of traditional health practitioners and improvement of the quality and safety of traditional medicines.
6.1.3 Strategic Priority 3: Community-based health services and health promotion

WHO will support the Government and partners in their efforts to strengthen health promotion and community participation in health improvement, with a focus on:

- sharing national and international evidence and best practices regarding effective strategies for community involvement and participation in health, behavioural change for health promotion and disease prevention;
- supporting the demonstration, documentation and dissemination among stakeholders of the best practises for community involvement and participation in health and providing technical support for scale-up as appropriate;
- providing technical support for the review and documentation of the functionality of facility committees and hospital boards and utilization of these structures to strengthen community linkages with the health system;
- providing technical support in capacity building and scaling-up of health promotion;
- supporting the involvement of the civil society in addressing health issues at community level;
- supporting the development of a comprehensive national approach to community-based health care and household production of health that integrates initiatives of various programmes.

WHO will support the Government’s initiative to implement the Primary Health Services Development Programme as part of the revitalization of the Primary Health Care Strategy, in line with the Ouagadougou Declaration, with a focus on:

- strengthening multisectoral collaboration in the revitalization of the PHC;
- promoting innovative ways of strengthening community participation and involvement in health;
- strengthening the linkage of community and home-based health care to health facilities, as part of the continuum of care;
- rationalizing and supporting the planning of enhanced coverage and equity of access to primary health care services, through maximizing the use of service availability mapping data;
- strengthening the referral care services at the district, regional, and national levels.

6.2 Strategic Agenda 2: Supporting National Priority Programmes

WHO will support the Government in strengthening the national priority programmes for addressing diseases and conditions that contribute greatly to morbidity, mortality and disability, and impact negatively on economic production and national development. The emphasis in this area will be placed on ensuring that programme support contributes to health systems strengthening and greater harmonization with national and subnational health systems, structures and processes. Integrated approach to priority disease prevention and control will also be promoted and enhanced.
6.2.1 Strategic Priority 4: Supporting the reduction of maternal, newborn, and child mortality

WHO, in collaboration with UNICEF and UNFPA, will provide technical support to Government and its partners to ensure the scaling-up of cost-effective interventions for improving the health and well-being of women, men, adolescents, pregnant women, newborn and children with a focus on the following areas:

- facilitation of Ministries of Health and institutions in the adaptation of standards, guidelines and tools for improving maternal and newborn health, sexual and reproductive health and child survival, and provision of technical support for their implementation;
- evidence generation, documentation and dissemination of best practices for improving quality of maternal, newborn and child health, including sexual reproductive health services;
- provision of technical support for strengthening immunization of children and women to combat vaccine-preventable diseases;
- introduction of innovative approaches for improving MNCH/SRH, including technical guidance on introduction of new vaccines;
- strengthening of the partnership involving ministries, development partners and other key stakeholders (public/private and communities) to ensure a coordinated national response to reduce maternal and childhood morbidity and mortality;
- building the capacity of institutions, associations and individuals for advocacy (championing) for maternal, newborn and child survival and reproductive health and rights;
- provision of support for monitoring the implementation of the national One Plan for maternal, neonatal, and child survival.

6.2.2 Strategic Priority 5: Supporting the country to combat communicable and noncommunicable diseases

Technical assistance will be provided to enhance access to the continuum of prevention, care, treatment and support for HIV/AIDS, TB, Malaria, Neglected Tropical Diseases, and noncommunicable diseases in the following focus areas:

- capacity building for adaptation, dissemination and implementation of standards, guidelines and tools for prevention and management of communicable and noncommunicable diseases;
- improving access to quality treatment, care and supportive services for HIV, Malaria, TB and other diseases, including strengthening drug resistance monitoring;
- providing technical support to strengthen the capacity of laboratory services, building technical competence in the use of rapid diagnostics, where necessary, and supporting quality improvement efforts, including full operationalization of the quality assurance schemes;
- supporting implementation of the integrated control for Neglected Tropical Diseases;
- providing technical support and advocacy for integrated prevention and control of noncommunicable diseases (NCDs), including establishment of systematic surveillance of risk factors and NCDs;
- building the capacities of institutions, associations and individuals to champion and
advocate for preventive and curative efforts for communicable and noncommunicable diseases;

- facilitating health system strengthening measures that will enhance efficiency and effectiveness of delivery of services on ATM, NTDs and NCDs.

### 6.2.3. Strategic Priority 6: Epidemic Preparedness and Response

WHO, in collaboration with other partners, will provide technical support to the Government to strengthen disaster preparedness and response to epidemics, natural and man-made disasters, with a focus on:

- supporting capacity development, review and implementation of national and subnational emergency preparedness and response plans, including the National Polio Importation Response Plan;
- strengthening the national and subnational capacity to respond to emergencies, including outbreaks of emerging and re-emerging infections, natural and man-made disasters in a timely manner;
- providing technical support for capacity building for operationalization of International Health Regulations 2005 through the IDSR framework and at ports of entry;
- developing capacities for preparedness and response to mitigate public health effects of climate change.

### 6.3 Strategic Agenda 3: Supporting Actions on Social Determinants of Health

WHO will support actions on social determinants of health, in collaboration with the Government, other UN agencies, the civil society and related line ministries, to promote better health through reduction of the social determinants, with a focus on the following areas:

#### 6.3.1 Strategic Priority 7: Supporting the Government in addressing the risk factors for noncommunicable diseases, with a focus on:

- providing technical guidance and addressing lifestyle-related health risk factors, including control of tobacco, alcohol consumption, other substance abuse, physical inactivity and unhealthy diet for prevention of noncommunicable diseases;
- promoting, advocating for, and supporting a multisectoral approach to NCD prevention and control;
- exploiting fully the Framework Convention on Tobacco Control guidelines to achieve comprehensive tobacco control in Tanzania;
- supporting innovative health promotion and behaviour change communication approaches.
6.3.2 **Strategic Priority 8: Contributing to the efforts of the Government and other partners in the promotion of food safety and reduction of malnutrition, with a focus on:**

- supporting the strengthening of the national surveillance system to monitor the effect of the food crisis on health;
- supporting the development and implementation of the national regulation, standards, and control mechanisms for food fortification and guidelines for both curative and preventive nutritional strategies;
- actively engaging in the national partnerships for stakeholders to ensure a comprehensive approach to nutrition and food safety (National Food Fortification Alliance and DPG Nutrition, etc.);
- supporting the implementation of national food safety and nutrition policies and strategies;
- providing regular updates on new developments in nutrition and food safety and its linkage to poverty reduction and health.

6.3.3 **Strategic Priority 9: Supporting the Ministry of Health to integrate gender equality and rights into health programmes, with a focus on:**

- capacity building for mainstreaming of both human rights-based approach and gender in health, including attention to the disabled, the poor and other disadvantaged groups;
- supporting the generation and use of sex disaggregated data.

6.3.4 **Strategic Priority 10: Supporting Tanzania to ensure environmental sustainability with a focus on:**

- supporting improvement of health care waste management and insecticide/pesticides disposal;
- supporting implementation of the Kampala Declaration on Sanitation and Healthy Cities/Settings Initiative;
- capacity development for infection control.

**6.4 STRATEGIC AGENDA 4: SUPPORTING PARTNERSHIP FOR HEALTH DEVELOPMENT**

WHO will support the strengthening and/or development of partnerships in the health sector and beyond, to ensure better synergy, effectiveness and efficiency in health development. In this regard, WHO will focus on:

- playing its leadership role in health-related technical matters in the country and in the UN;
- strengthening health coordination among UN and secretarial services to the development partners group, and brokering policy dialogue and strategic engagement on health matters;
- providing regular technical briefs to the development partners group in health on pertinent technical issues;
• supporting the ongoing UN reform process and implementation of the “One UN” in the context of partnership to deliver the MDGs, through joint programmes;

• capacity building for implementing public-private partnership (PPP) in health including:
  • generating consensus on the PPP within the Government, development partners, and the private sector, and agreement on the scope of services to be delivered under the PPP, including a mix of preventive and curative services;
  • monitoring the process, quality, effectiveness and efficiency of the PPP to guide evidence-based decision-making in strengthening the partnership;

• strengthening intersectoral collaboration and involvement in promoting health and addressing determinants of health;

• advocating for the conduct of Health Impact Assessment as prerequisite for passing different legal bills and approving developmental projects.
SECTION 7

IMPLEMENTING THE STRATEGIC AGENDA

The implementation of the strategic agenda will be based on the three key strategies outlined in Chapter 6. It also recognizes the principles of the current framework for Aid coordination, alignment and harmonization, as suggested by the Paris Declaration and advocated by the Government through the Tanzania Joint Assistance Strategy and the ongoing processes of working within the umbrella of the “One UN”. In addition, capacity assessment has been undertaken, providing recommendations that have implications for implementation of the strategic agenda by the WCO.

Based on these processes towards the coordination, alignment and harmonization of Aid and technical assistance in the health sector, and the WHO reprofiling report, the operationalization of the strategic agenda will require substantial actions at each of the three levels of WHO. The implications are summarized below.

7.1 WHO COUNTRY OFFICE

The Country Office will be responsible for implementing CCS II, through biennial work plans. These work plans will be linked to the MOHSW annual plans and UN joint programmes.

The initial action of the WHO Country Office will be to publicize, advocate for and promote the CCS in the context of the ongoing processes outlined above, and demonstrate to all stakeholders in the health sector that the CCS complements the ongoing processes and initiatives.

The WCO will mainly engage in upstream discussions and actions on health development issues highlighted in the agenda, and limited downstream actions, as necessary, with the core aim of fulfilling technical responsibility in advising on major public health matters, catalysing critical action, capacity building, monitoring implementation, and demonstrating effective and innovative approaches in health. The WCO will continue to perform and strengthen the functions of the DPG-H Secretariat.

Recognizing the presence of partners with substantial resources, WHO will take advantage of the new Aid Architecture to ensure coordinated input to health sector support, while ensuring provision of technical support, based on WHO’s comparative advantage. The WCO will continue to advocate for the use of the health basket fund and enhanced efficiency, transparency and accountability in the utilization of available resources.

With regard to human resources, the current staffing level seems to be adequate to implement the proposed strategies. However, there is a need to continue implementing the recommendations of the staff competence assessment mission referred to above. In addition, technical support will be harnessed from WHO/IST, AFRO and HQ offices, when necessary.

Adequate funding will be critical for implementation of the strategic agenda to improve health outcomes. Implementing the strategic agenda will require substantial increase in funds allocated to the WCO. The regular budget of the WCO, which may remain the same or
slightly increase during this period, is not adequate to support the whole strategic agenda. Additionally, extrabudgetary resources will be needed to facilitate full implementation of the identified priorities. This calls for more active resource mobilization at country level to complement regional and global efforts. Negotiations with various partners in the sector will be critical to ensure a more harmonized approach to providing support to the sector.

The Country Office, through WHO and the MOHSW annual retreats, will continue to dialogue with ministries and development partners on how the strategic objectives in the action plan will play a catalytic role in the entire health sector plan towards improvement of public health and attainment of the MDGs. Critical considerations in this respect will be providing timely orientation to staff on corporate consensus regarding alignment with country processes and «One UN» process, as well as mobilizing resources locally through specific sources such as Global Health Initiatives. With the introduction of Global Management Systems (GSM), the staff will need training to manage the new system and the MOHSW will also need to be oriented on the performance of the new system to enable the ministries to engage WHO systematically, according to country needs.

### 7.2 REGIONAL OFFICE, INCLUDING INTER COUNTRY SUPPORT TEAMS

Technical support will be sought from AFRO, when required. During the planning process, AFRO and HQ will be consulted to ensure that we have one WHO country work plan. In addition, country plans will be harmonized with those of the Intercountry Support Team and Regional Office work plan to enable rapid and timely access to technical support. It is expected that WHO/AFRO will support resource mobilization for countries and provide strategic information on possible opportunities to assist with resource mobilization within the country. Furthermore, AFRO will support networking with other regions for interregional exchange of best practices, ensure the timely transfer of information on matters of public health and organize technical assistance, where this cannot be provided by the Region.

AFRO will also monitor the implementation of the Regional Agenda and support the Country Office in facilitating smooth operation of financial management procedures of the “One UN” joint programmes.

### 7.3 WHO HEADQUARTERS

WHO headquarters (HQ) will develop global guidelines providing technical specifications and setting standards. In addition HQ will:

- support networking, particularly in the area of Global Health Initiatives (GHI);
- Complement AFRO technical assistance, in response to country requests in a coordinated manner;
- support the country to mobilize resources to implement CCS II, and provide information and intelligence on strategic issues;
- monitor implementation of the global health agenda;
- provide guidance on global policy issues and global health security, linkages to social determinants of health and ensure the maintenance of a coherent corporate culture.
SECTION 8

MONITORING AND EVALUATION OF CCS II

The CCS II monitoring will be aligned with the WHO M and E system. The strategic agenda will be used to develop the Biennial PoAs, which will be monitored, using the existing tools for generating the semi-annual monitoring, annual and biennial evaluation reports.

CCS II will undergo a mid-term review after three years of implementation and a final review shortly before the end of the implementation period to evaluate its impact.

Since the implementation periods of CCS II and HSSP III coincide, it is envisaged that the final review of CCS II and formulation of HSSP IV will feed into the development of CCS III. The review results will be disseminated to MoH and partners.
## ANNEX 1: KEY INDICATORS IN 1999 AND 2005

<table>
<thead>
<tr>
<th>Indicator</th>
<th>1999 (ML/ZNZ)</th>
<th>2005 (ML/ZNZ)</th>
<th>National Targets</th>
<th>MDG Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant mortality rate (/1000 live births)</td>
<td>109/83</td>
<td>83/61</td>
<td>50/57</td>
<td>40</td>
</tr>
<tr>
<td>Under-five mortality rate (/1000 live births)</td>
<td>162/114</td>
<td>133/101</td>
<td>79/71</td>
<td>47</td>
</tr>
<tr>
<td>Neonatal mortality rate (/1000 live births)</td>
<td>45/35</td>
<td>34/29</td>
<td>-/ -</td>
<td>-</td>
</tr>
<tr>
<td>Prevalence of children under five stunted (%)</td>
<td>44/36</td>
<td>38/23</td>
<td>20/10</td>
<td>23.3</td>
</tr>
<tr>
<td>Prevalence of underweight in under fives (%)</td>
<td>30/26</td>
<td>22/19</td>
<td>-/ -</td>
<td>14.4</td>
</tr>
<tr>
<td>Prevalence of anaemia in under fives (%)</td>
<td>-</td>
<td>72/75</td>
<td>-/ -</td>
<td>-</td>
</tr>
<tr>
<td>Prevalence of exclusive breastfeeding up to age six months (%)</td>
<td>11†</td>
<td>41†</td>
<td>-/ -</td>
<td>-</td>
</tr>
<tr>
<td>Children under five who slept under ITN the night before the survey (%)</td>
<td>10/3††</td>
<td>16/20</td>
<td>26/38†††</td>
<td>-/ -</td>
</tr>
<tr>
<td>Proportion of children vaccinated against polio at age 1 (%)</td>
<td>78/75</td>
<td>79.9/82</td>
<td>.95</td>
<td>90</td>
</tr>
<tr>
<td>Coverage of DPT3 among one year olds (%)</td>
<td>81/83</td>
<td>86/88</td>
<td>85/95</td>
<td>-</td>
</tr>
<tr>
<td>Maternal mortality ratio (/100 000 live births)</td>
<td>-</td>
<td>578****</td>
<td>265/251</td>
<td>133</td>
</tr>
<tr>
<td>Births attended by skilled birth attendants (%)</td>
<td>36/37</td>
<td>45/51</td>
<td>80/60***</td>
<td>90</td>
</tr>
<tr>
<td>HIV/AIDS prevalence among adults (%)</td>
<td>9.4*</td>
<td>7/1</td>
<td>&lt;/0.5</td>
<td>&lt;5.5</td>
</tr>
<tr>
<td>Public health sector spending per capita (US$)</td>
<td>4.1**/-</td>
<td>9.2**/-</td>
<td>-/ -</td>
<td>43</td>
</tr>
</tbody>
</table>

*source: MDG implementation report 2006; ** PER 2006; *** MKUZA target is on % of deliveries in health facilities without skilled attendance; **** Due to the small sample size, DHS does not estimate separate maternal mortality for ZNZ and ML; † TDHS 1999 and 2004/2005 provides aggregated estimates and does not specify rate for Mainland and Zanzibar separately; †† The indicator used in TDHS is “households where all children slept under bednets with or without insecticide treatment the night before the survey; †††Indicators from the 2008 Tanzania HIV/AIDS and Malaria Indicator Survey (2007-2008)."
## ANNEX 2: ACHIEVEMENTS UNDER CCS I

<table>
<thead>
<tr>
<th>AREA OF FOCUS</th>
<th>ACHIEVEMENTS</th>
</tr>
</thead>
</table>
| **Supporting implementation of priority health programmes** | • Supported technical inputs that galvanized health sector HIV/AIDS response, focused on universal care and treatment, roll out of counselling and testing services, HIV/AIDS at work place, PMTCT monitoring and evaluation system, and testing algorithms for HIV and other blood-transmissible pathogens  
• Capacity building on TB/HIV, Community TB Care (CTBC), MDR-TB, Public Private Mix (PPM) and cross-cutting issues (Global Fund R 3) and review of NTLP Manual to incorporate TB/HIV; CTBC and MDR-TB guidelines  
• Supported the development of the Road Map for Maternal New Born and Child Health for both Mainland and Zanzibar and institutionalization of capacity building to scale-up child health interventions (IMCI/Malaria)  
• Supported the change of malaria treatment policy from monotherapy to Artemisinin-Based Combination Therapy (ACT) in both the Mainland and Zanzibar  
• Supported the development of a new National Malaria Medium-Term Strategic Plan (2008–2013), which focuses on evidence-based interventions, including malaria diagnosis and treatment with ACT, universal accessibility to Insecticide-Treated Bed Nets (ITNs), working with private sector agents and the use of Indoor Residual House-Spraying (IRS) in epidemic-prone districts. The ultimate goal is phased elimination of malaria in line with the global initiative that advocates for a rapid scaling-up of interventions to achieve the Global Malaria Programme targets of universal coverage of 80% by 2010 and the Millennium Development Goals by 2015.41  
• EPI support on data tools, development of Country Multi-year Plan (2006–2010) and surveillance of vaccine-preventable diseases (polio, measles, neonatal tetanus, paediatric bacterial meningitis and childhood diarrhoea due to the Rota virus)  
• Finalization of integrated NTDs strategic plans for Mainland and Zanzibar. |
| **Catalysing adoption of technical strategies and innovations and country-specific adaptation of guidelines** | • Development of guidelines on Malaria & IMCI, Severe Acute Malnutrition, IMCI, improving quality of paediatric care, Kangaroo mother care, essential newborn care, adolescent health standards, medicines and medical equipment donations and safe disposal of unwanted pharmaceuticals, pharmaceutical inspection for Zanzibar, and quality manual for the Mainland, TB policy, TB/HIV integration; Community TB care and MDR-TB.  
• Facilitated launch of HIV/AIDS guidelines on management of STIs and other reproductive tract infections, health sector workplace HIV/AIDS programmes; provided, initiated HIV testing and counselling, home-based care, management of HIV/AIDS. |
| **Supporting research and development** | • Supported the development of a paediatric formulation of Artemether/Lumefantrine through clinical trials (WHO/TDR)  
• Supported the establishment of a quality assurance laboratory for Rapid Diagnostic Tests (RDTs) for malaria diagnosis  
• Supported the development of the malaria vaccine decision-making framework  
• Participated in the development and implementation of WHO/TDR TB-HAART multi-country study  
• Supported the formative research on maternal and newborn care at community level. The information gathered helped to develop maternal and newborn interventions in the MNCH road map  
• Supported the study on medicine prices and the monitoring system for medicine availability and medicine prices to provide evidence for affordability of medicines and availability trends  
• Adaptation of a new policy for diarrhoea management in children and development and implementation of operational research for improvement of newborn care in the community  
• Supported a situation analysis for health research coordination in Zanzibar  
• Facilitated collection of national road safety data as a contribution to the Global Road Safety Report 2009 |
| **Sharing information** | • Supported the strengthening of the monitoring and evaluation systems in both Ministries.  
• Facilitated the implementation of the Services Availability Mapping (SAM)  
• Supported the satisfactory conduct of the second round of the National Health Accounts  
• Supported the strengthening of the Integrated Disease Surveillance and Response  
• Establishment of the child health booklet  
• Creation of a Web site for the WCO  
• Establishment of an organized resource centre accessible to staff and the general public |

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| Providing specific high-level policy and technical advice | - Technical support to MOHSW in developing the HSSP III  
- Supported generation of the National Health Systems Profile  
- Supported the review of national medicine policies in Mainland and Zanzibar  
- Provided technical input in the development of the Zanzibar Food, Drugs and Cosmetics Act of 2006, the Zanzibar Traditional and Alternative Medicine Act of 2008 and its policy as well as various regulations for essential Medicines and traditional Medicines  
- Supported the development of the Human Resources Policy and Strategic Plan for both Mainland and Zanzibar  
- Provided technical support for establishment of the HR Observatory Working Group  
- Provided technical guidance on ITN policy to support universal access  
- Facilitated the Global Stop TB Partnership Board meeting, which led to the recommendation to form a Stop TB Partnership in Tanzania, with the WCO as Secretariat  
- Facilitated the preparation of a Sanitation and Hygiene National Action Plan towards achieving the MDGs  
- Facilitated the generation of MDG progress tracking reports for Tanzania Mainland and Zanzibar and their utilization at policy-level forums  
- Facilitated assessment of Health Information sub-systems as a forerunner to developing a Health Information System and M and E policy and strategic plan  
- Facilitated introduction of a new curriculum on Health Promotion. |
### ORGANIZATIONAL CHART ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Administrative Assistant</td>
</tr>
<tr>
<td>PA-WR</td>
<td>Personal Assistant to WHO Representative</td>
</tr>
<tr>
<td>AO</td>
<td>Administrative Officer</td>
</tr>
<tr>
<td>CAH</td>
<td>Child and Adolescent Health</td>
</tr>
<tr>
<td>CAT</td>
<td>Care and Treatment</td>
</tr>
<tr>
<td>CT</td>
<td>Care Taker</td>
</tr>
<tr>
<td>DPC</td>
<td>Disease Prevention and Control</td>
</tr>
<tr>
<td>DPG</td>
<td>Donor Partners Group</td>
</tr>
<tr>
<td>EDM</td>
<td>Essential Drugs and Medicines</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Programme on Immunization</td>
</tr>
<tr>
<td>FA</td>
<td>Finance Assistant</td>
</tr>
<tr>
<td>FHP</td>
<td>Family Health Programme</td>
</tr>
<tr>
<td>HBC</td>
<td>Home-Based Care</td>
</tr>
<tr>
<td>HCO</td>
<td>HIV Country Officer</td>
</tr>
<tr>
<td>HEC</td>
<td>Health Economist</td>
</tr>
<tr>
<td>HFS</td>
<td>Health Financing and Social Protection</td>
</tr>
<tr>
<td>HIP</td>
<td>Health Information and Promotion</td>
</tr>
<tr>
<td>HRH</td>
<td>Human Resources for Health</td>
</tr>
<tr>
<td>HSP</td>
<td>Health Systems and Policies</td>
</tr>
<tr>
<td>ICT</td>
<td>Information and Communication Technology</td>
</tr>
<tr>
<td>KMS</td>
<td>Knowledge Management and Sharing</td>
</tr>
<tr>
<td>LAB</td>
<td>Laboratory</td>
</tr>
<tr>
<td>MAL</td>
<td>Malaria</td>
</tr>
<tr>
<td>MPN</td>
<td>Managerial Process for National Health Systems Officer</td>
</tr>
<tr>
<td>NPO</td>
<td>National Professional Officer</td>
</tr>
<tr>
<td>NTD</td>
<td>Neglected Tropical Diseases</td>
</tr>
<tr>
<td>PHA</td>
<td>Public Health Advisor</td>
</tr>
<tr>
<td>SAF</td>
<td>Secretary Administration and Finance</td>
</tr>
<tr>
<td>PA</td>
<td>Programme Assistant</td>
</tr>
<tr>
<td>SO</td>
<td>Surveillance Officer</td>
</tr>
<tr>
<td>TOB</td>
<td>Tobacco</td>
</tr>
<tr>
<td>TUB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>WR</td>
<td>WHO Representative</td>
</tr>
</tbody>
</table>
# ANNEX 4: DEVELOPMENT PARTNER’S ACTIVITIES/INVESTMENTS CONTRIBUTING TO HEALTH

<table>
<thead>
<tr>
<th>Agency</th>
<th>Activities in the Health Sector (Programmes, Projects, Partners)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Netherlands</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Health Basket Fund (HBF)</td>
</tr>
<tr>
<td></td>
<td>2. General Budget Support (GBS)</td>
</tr>
<tr>
<td></td>
<td>3. Health System Strengthening</td>
</tr>
<tr>
<td></td>
<td>4. PSI (Condoms)</td>
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<tr>
<td></td>
<td>5. Contribution to President’s Malaria Initiative (PMI)</td>
</tr>
<tr>
<td></td>
<td>6. Fistula (together with Women Dignity and AMREF)</td>
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<tr>
<td></td>
<td>7. National Aids Control Programme (TA)</td>
</tr>
<tr>
<td><strong>Ireland</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. HBF</td>
</tr>
<tr>
<td></td>
<td>2. GBS</td>
</tr>
<tr>
<td></td>
<td>3. Ifakara Resource Centre</td>
</tr>
<tr>
<td></td>
<td>4. CCBRT – Rehabilitative medicine</td>
</tr>
<tr>
<td></td>
<td>5. Health Equity Group</td>
</tr>
<tr>
<td></td>
<td>6. PSI: Water purification project</td>
</tr>
<tr>
<td><strong>Denmark</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. GBS</td>
</tr>
<tr>
<td></td>
<td>2. 80% HBF and Local Government Development Grant (LGDG)</td>
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<tr>
<td></td>
<td>3. 20% 5 TA (Danish Contracts; could be moved into the TA Pool, if there is one)</td>
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<tr>
<td></td>
<td>4. HSPS Mainland - 3 focus areas:</td>
</tr>
<tr>
<td></td>
<td>· Hospital reform</td>
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<tr>
<td></td>
<td>· Public Private Partnerships (PPP)</td>
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<tr>
<td></td>
<td>· Drug chain management. All in the Ministry; through the Exchequer; nothing outside (except CSSC, APHTA core funding in line with the PPP)</td>
</tr>
<tr>
<td></td>
<td>5. HSPS Zanzibar</td>
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<tr>
<td><strong>Canada</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. GBS</td>
</tr>
<tr>
<td></td>
<td>2. HBF</td>
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<tr>
<td></td>
<td>3. Health Workforce Initiative</td>
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<tr>
<td></td>
<td>4. 3 support NGOs:</td>
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<tr>
<td></td>
<td>· Mary Stopes</td>
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<tr>
<td></td>
<td>· CCBRT (pooled fund for strategic level)</td>
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<tr>
<td></td>
<td>· YAV (pooled fund for strategic level)</td>
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<tr>
<td><strong>Japan</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. GBS</td>
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<tr>
<td></td>
<td>2. Regional Health Management Teams (RHMT)</td>
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<tr>
<td></td>
<td>3. HIV/AIDS</td>
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<tr>
<td></td>
<td>4. Human Resource Information Management System together with CIDA and US</td>
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<tr>
<td><strong>World Bank</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Grant and loan</td>
</tr>
<tr>
<td></td>
<td>· 35/m loan currently</td>
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<tr>
<td></td>
<td>· 40/m in pipelineMalaria: grantdiscussion to establish a multisectoral financing mechanism for decentralized structures</td>
</tr>
<tr>
<td></td>
<td>· TMARC – HIV/AIDS</td>
</tr>
<tr>
<td><strong>USAID</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. All off-budget activities:</td>
</tr>
<tr>
<td></td>
<td>2. HIV/AIDS - PEPFAR</td>
</tr>
<tr>
<td></td>
<td>3. Projects in Malaria</td>
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<tr>
<td></td>
<td>4. Family Planning</td>
</tr>
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<td></td>
<td>5. MCH</td>
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<td></td>
<td>6. Training</td>
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<td></td>
<td>7. HSS</td>
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<tr>
<td></td>
<td>8. Accredited Drug Dispensing Outlets/TFDA</td>
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<tr>
<td></td>
<td>9. Research</td>
</tr>
</tbody>
</table>
**UNFPA**

1. Since 2005, UNFPA changed its’ approach:
   - HBF
   - Reproductive and Child Health
   - Prevention of HIV/AIDS now in the focus
   - National level on HMIS
   - Service Delivery
   - HSS in Dodoma demand creation
2. “One UN” support Zanzibar

**UNICEF**

1. Child Rights Focus
2. Nutrition
3. Water and sanitation
4. Hygiene
5. MCH
6. EPI
7. Malaria7 learning districts (innovation)
8. “One UN” support Zanzibar

**Switzerland**

1. GBS
2. HBF
3. Community-Based Health Initiatives (CBHI),
4. ITN Cell (Malaria)
5. Community Health Fund (CHF)
6. Traditional Knowledge for Health
7. Ifakara Health Institute (IHI)

**Germany (GTZ and KfW)**

1. HBF
2. PPP
3. HIV/AIDS
4. CBH Insurance
5. Family Health Project

**ADB**

1. 3 Regions Maternal and Child Health Project
2. First Health Rehabilitation Project - Zanzibar