WHO COUNTRY COOPERATION STRATEGY: UNITED REPUBLIC OF TANZANIA

2002–2005

WORLD HEALTH ORGANIZATION
Regional Office for Africa
Brazzaville


Uganda
Lake Victoria
Mara R.
Lake Naivasha
0 150 km
0 100 mi
Nairobi
Rwanda
Kigali
Bukoba
Musoma
Kenya
Lake Natron
Biharamulo
Mwanza
Moshi
Lake Eyasi
Bujumbura
Burundi
Shinyanga
Lake Manyara
Arusha
Pangani R.
Malagarasi R.
Nzega
Wembere R.
Kigoma
Tabora
Singida
Tanga
Pemba I.
Wete
Korogwe
Tanzania
Ugalla R.
Wami R.
Zanzibar
Zanzibar I.
Mpanda
Kisigo R.
Dodoma
Morogoro
Dar es Salaam
Lake Tanganyika
Kilosa
Ruvu
Indian Ocean
Mikumi
Rufiji R.
Mafia I.
Zaire
Sumbawanga
Iringa
Kidatu
Lake Rukwa
Great Ruaha R.
Kilombero R.
Ifakara
Kilwa Kivinje
Mbeya
Luwegu R.
Tunduma
Njombe
Lindi
Zambia
Lake Malawi
Lake Bangweulu
Mtwara
Masasi
Songea
Malawi
Rovuma R.
Mozambique
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ABBREVIATIONS

ADB	African Development Bank
BMHF	Bi- and Multilateral Health Forum
CCA	Common Country Assessment
CCM	Chama Cha Mapinduzi (Tanzanian political party)
CCS	Country Cooperation Strategy
CMH	Commission on Macroeconomics and Health
DAC	Development Assistance Committee
GDI	Gender Development Index
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GNP	Gross National Product
GDP	Gross Domestic Product
HBS	Household Budget Survey
HDI	Human Development Index
HIPC	Highly Indebted Poor Countries
HIV	Human immunodeficiency virus
HMIS	Health Management Information System
HPSG	Health and Population Sector Group
HRH	Human resources for health
IMF	International Monetary Fund
IMR	Infant mortality rate
ITNs	Insecticide-treated nets
KAP	Knowledge, Attitudes, Practices
MOFEA	Ministry of Finance and Economic Affairs
MSD	Medical Stores Department
MTEF	Medium-Term Expenditure Framework
NCDs	Noncommunicable diseases
NGO	Nongovernmental organization
NPES	National Poverty Eradication Strategy
PER	Public Expenditure Review
PHC	Primary health care
PRSP	Poverty Reduction Strategy Paper
RBM	Roll Back Malaria
SWAp	Sector-wide Approach
TAS	Tanzania Assistance Strategy
TDHS	Tanzania Demographic Health Survey
TDR	Tropical Diseases Research
TRCHS	Tanzania Reproductive and Child Health Survey
UNAIDS	Joint United Nations AIDS Programme
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
URT	United Republic of Tanzania
WB	World Bank
WHO	World Health Organization
WHR	World Health Report
ZPRP	Zanzibar Poverty Reduction Plan

1. Introduction

The WHO Country Cooperation Strategy (CCS) for the United Republic of Tanzania (URT) defines the broad framework for the World Health Organization's cooperation with the country for the medium term 2002–2005. The purpose of the CCS is to improve the efficiency and effectiveness of the work of WHO in conjunction with the government in order to achieve the desired health outcomes in the United Republic of Tanzania. It provides the strategic context for the programme of work for the URT as it relates to WHO at all its three levels (headquarters, regional and country), the United Nations Development Assistance Framework (UNDAF) and the Millennium Development Goals (MDGs).

The CCS is the result of a wide interactive process; the CCS team comprised representatives from all levels of WHO and representatives from the Ministries of Health in mainland Tanzania and Zanzibar. The CCS team held discussions with development agencies, NGOs, the Ministries of Health and other health-related sectors in the URT (see *Annex 1 for list*). The consultations focused on assessing the country's health situation and distilling out the national health priorities. The process also focused on the comparative advantage of WHO in responding to the health needs of the country, taking into consideration the priority health needs that were being addressed by various partners. Care was taken to adequately brief and debrief the national health authorities as the work progressed.

WHO has played a key role in the development of public health in the United Republic of Tanzania. Traditionally, WHO's work at the country level has been advanced mainly through technical support to the Ministries of Health. Recently, however, the Organization embarked on a number of reforms, including defining mechanisms for improving its effectiveness in Member States. In particular, the Organization is trying to devise better ways of working in and with countries, as well as deepening and broadening its partnership in matters of health development under the new Country Cooperation Strategy (CCS).

While the aim is to ensure WHO's greater responsiveness to country needs, the CCS also reflects its own values, principles and corporate and regional strategies. It also takes into consideration the objectives of the UN Millennium Declaration and the Millennium Development Goals (MDGs) related to: development and poverty eradication; protection of common environment; human rights, democracy and good governance; and protection of vulnerable groups. Furthermore, important elements include WHO's intentions to be more selective in its range of activities and to foster strategic thinking, putting greater emphasis on its role as a policy adviser and broker and lessening emphasis on direct programme implementation. WHO globally intends to broaden its partnerships at country level and work with other development partners in a complementary way.

The CCS process took into consideration the fact that the URT itself has been engaged in a process of health reforms since the early 1990s. It took into account other important frameworks and mechanisms that have emerged in the country in recent years such as the Tanzania Assistance Strategy (TAS), Poverty Reduction Strategy Papers (PRSP), sector-wide approaches (SWAps) and the Medium-Term Expenditure Framework (MTEF). The development of the CCS also took into account the WHO Corporate Strategy and the health aspects of the UNDAF.

2. Government and the People: Health and Development Challenges

2.1 General context

2.1.1 Political evolution

The United Republic of Tanzania has a total area of 945,000 sq km, of which 883,000 sq km constitute land; 881,000 sq km in the Mainland and 2,000 sq km in Zanzibar. Inland waters occupy 62,000 sq km.[1] It is composed of two states: Zanzibar and Tanzania Mainland (formerly known as Tanganyika). Both countries have experienced long periods of colonial domination and rule. From the beginning of the nineteenth century, Zanzibar was dominated by the Sultan of Zanzibar who was of Omanic origin, after which, in 1890, the Isles were ruled as a British Protectorate until 1963. On the other hand, Tanganyika, through the same period, was subjected to successive German (1890s–1921) and British (1921–1961) colonial rule.

Tanganyika achieved its independence from Britain on 9 December 1961. In 1963 the British government, in exercise of its protectorate role, placed the people of the Isles of Zanzibar under the charge of the Omani Sultan. This arrangement did not last for long. The Sultan was overthrown through a revolutionary struggle in January 1964 and Zanzibar became an independent republic. The leadership of the two new states worked hard and speedily towards the formation of a unified government.

The two countries successfully concluded their negotiations on the formation of the political and socioeconomic union. The Constitution establishing the Union between Mainland and Zanzibar came into force on 26 April 1964. It defines the territorial integrity of the URT as being composed of "the whole of mainland Tanzania and the whole of Tanzania Zanzibar including the territorial waters." The Constitution also recognizes two organs vested with executive powers: "(a) The Government of the United Republic of Tanzania; and (b) The Revolutionary Government of Tanzania Zanzibar".[2]

It is important to be cognizant of the fact that the Constitution has further defined the organs and functions that fall under the jurisdiction of the Union. Health organs and their functions are not established as Union matters. Consequently, in the URT there are two autonomous Ministries of Health, each headed by a Cabinet Minister, one for the Mainland and the other for Zanzibar.

In the subsequent sections of this document, the terms URT and Tanzania will be used interchangeably; otherwise the terms Mainland and Zanzibar will be employed in specific reference to either of them, when necessary. It is also important to note that Zanzibar itself is made up of two islands: Unguja and Pemba.

Since the time of independence Tanzania was following a one-party political system. Moreover, the ruling party "Chama Cha Mapinduzi" (CCM) was steering a socialist political ideology until the last half of the 1980s. Between 1985 and 1995, the country experienced a deepening economic crisis that also dictated the need for political and economic restructuring in the country. The country had its first multi-party presidential and parliamentary elections in 1995, which returned the ruling CCM party to power. The elections were again held towards the end of 2000 with similar results.

The transition to the pluralistic political process and culture has not been entirely smooth. There have been some skirmishes among political parties in the run up to the elections and during the immediate post-election periods. The tension that erupted in Zanzibar led to a marked decline in the participation of development partners in the affairs of the islands. Recently, however, great efforts have been made and

[1] Tanzania Assistance Strategy: A Medium-Term Framework for Promoting Local Ownership and Development Partnership.

[2] Constitution of the United Republic of Tanzania (1964).

progress achieved towards the establishment of a conducive political climate, which culminated in the signing of the all-important "MWAFAKA" (agreement), which institutionalizes the modalities for inter-party and government dialogue and collaboration. This is particularly important for Zanzibar, because it has re-ushered a new era of development assistance from the international community to the Isles after nearly a decade of virtual embargo. Otherwise, Tanzania is one of the countries that have enjoyed a long history of post-independence political and civil stability.

2.1.2 Demographic overview

The demographic profiles of the two members of the Union are basically the same, reflected in the population pyramid of most of the least developed countries. The population projections based on the 1988 census (a new census commenced in August 2002) estimated the total population of the URT at 34 million in 2000, of which 51% were women and 44% were children under 15 years of age.[1] The population of Zanzibar is estimated to be 1.0 million (550,000 in Unguja and 450,000 in Pemba Island).[3] The only difference in the demographic profiles of the Mainland and Zanzibar relates to the annual population growth rates, being 2.8%[4] and 3.0%,[3] respectively. The population distribution is predominantly rural in the Mainland (about 80%), while Zanzibar is less rural (57%).

2.1.3 Socioeconomic situation

The low per capita gross national product (GNP) of around US$ 280 (2000) indicates that Tanzania is one of the least developed countries in the world. The country is heavily dependent on the under-developed agricultural sector. In 2000, it was estimated that the agricultural sector contributed 44.6% of the GNP, against 15.7% and 39.4% by industry and social services, respectively.[1] However, with about 46% of the total land area being arable, the country has a rich potential for agriculture. Hydropower and mineral deposits (gold, diamonds, tin, iron ore, gemstones, coal and natural gas) represent further assets. The climate varies from tropical along the coast to temperate in the highlands. Tanzania has well-renowned game reserves and parks.

The current socioeconomic set up in the Mainland has been shaped by the economic and social reforms launched in 1986, which focused on market economy and participation of the private sector and civil society (NGOs, training and research institutions, religious institutions, among others). Since the mid-1990s the Mainland has been formulating a new, long-term development vision, which was launched in 1999 under the title "Tanzania Development Vision 2025". The main objectives of the Vision are: (i) high quality livelihood; (ii) peace, stability and unity; (iii) good governance; (iv) a well-educated and learning society; and (v) a competitive economy capable of producing sustainable growth and shared benefits.

As a result of the ongoing reforms, the overall economic picture in the Mainland has been improving gradually. For instance, the real gross domestic product (GDP) growth rate has increased from 4.0% in 1998 to 5.0% in 2000, and the per capita GDP increased from –1.1% in 1991/93 to over 2.6% in 2000.[1] The average annual inflation rate decreased from 27.3% in 1994/96 to 7.9% in 1999 and to around 6% in 2001. The average volume of external assistance per year increased from US$ 900 million in 1994/1997 to US$ 990.3 million in 1999. External aid represented 11.3% of the GDP in 1999.[1]

[3]Zanzibar Health Sector Reforms Strategic Plan (2002/3-2006/7), Revolutionary Government of Zanzibar, Ministry of Health and Social Welfare.

[4]Tanzania Reproductive and Child Health Survey, National Bureau of Statistics, 1999.

In Zanzibar the GDP growth has been sluggish and fluctuating in the period between 1995 and 2000. The extremes were 7.1% in 1996 and 0.5% in 1998.[5] One of the determinants was that the price of its major export, cloves, slumped drastically on the world markets. In addition to that, the Island experienced some political tension during the period 1995-2002, which led to the "aid boycott." As a result there was a decline in development assistance.[6] Since the beginning of 2002, however, the country started experiencing some easing in political tension, creating a positive climate for the resumption of development aid. The country has also recently been able to formulate its Development Vision, whose time horizon is 2020, starting in 2002. The vision is focused on the eradication of absolute poverty and the creation of an environment for sustainable development. More recently, the government has reported that "the general growth of the economy increased by 0.8% from 3.2% in 2000 at constant prices up to 4.0% in 2001".[7]

2.1.4 The burden of external debt

The external debt has increased annually in the Mainland, and by the end of June 2001, the stock of external debt was US$ 6.186 billion.[1] In the same period, Zanzibar's external debt was US$ 83.9 million, which has been guaranteed and serviced by the Union government. Meanwhile, due to the writing off of a Chinese loan, this amount was reduced by February 2002 to US$ 59.4 million, of which 78% is guaranteed by the Union. The government of Zanzibar guarantees the remaining 22%.[5]

The huge external debt has had a negative impact on the economy and is constraining government's efforts in fighting poverty and improving the health of the population. In order to redress the situation, the government has undertaken the required measures and actions in the light of the HIPC initiative, namely, the qualification through the decision point up to the completion point (November 2001) to become the fourth country to access full HIPC facility under the Enhanced Debt Relief Framework. The completion point has triggered the beginning of debt reduction which will stretch over a 20-year period by which time the current level of debt will be reduced by nearly half, or around US$ 3 billion.[8] It is expected that the debt cancellation will release resources that can be used to boost budget allocations to the social sectors, including health.

In spite of the progress made following economic and structural reforms, Tanzania's Human Development Index (HDI) remains lower than the average for sub-Saharan Africa (0.471) but close to that of least developed countries (0.445). In fact, the HDI for Tanzania has changed little in the past decade, being 0.422 in 1990, 0.427 in 1995 and 0.440 in 2000.[9] According to the Human Development Report 2002, Tanzania is ranked 151 in a list of 173 countries. Related to this is the Gender Development Index (GDI),[10] which is also very low at 0.410, placing the country at the low rank of 127. Thus, women's contribution to national leadership and development is far from being optimal.

2.2 Health profile

2.2.1 Disease burden

[5]Zanzibar Poverty Reduction Plan (ZPRP)- Thematic Papers for the launching of Zanzibar Poverty Reduction Plan, May.

[6]United Nations Common Country Assessment for Zanzibar, April 2001.

[7]Budget Speech MOFEA/Zanzibar, 2002-2003.

[8]Budget Speech by the MOF/Mainland, 2002/2003.

[9]UNDP – The Human Development Report 2002: deepening democracy in a fragmented world.

[10]UNDP – The Human Development Report 2001.

The health status of the peoples of Tanzania (Mainland and Zanzibar) is considered to be poor. Generally speaking, the health status is considered to be among the lowest in African countries with a similar economic base. According to the World Health Report 2000,[11] life expectancy at birth in 1999 was estimated to be about 44.4 years for males and 45.6 years for females. The Disability-Adjusted Life Expectancy (DALE) at birth was 36 years. This places the country at rank 176 out of 191 WHO Member States. The disease burden in the country, for the most part, is as a result of potentially preventable diseases such as HIV/AIDS, malaria, tuberculosis, reproductive disorders and childhood disorders as well noncommunicable diseases.

HIV/AIDS is not only the greatest single threat to Tanzania's security and socioeconomic development, but also to people's individual survival and well-being. The disease is currently imposing an ever-increasing burden on the country's financial resources through rising medical expenditures, absenteeism from work, training of replacement labour and labour shortages resulting from morbidity and mortality. Unless decisive policy actions are taken, HIV/AIDS is expected to significantly reduce Tanzania's economic growth prospects. The UN projections of 1998 showed that Tanzania's population would be almost 5 million people fewer in 2015 than it would be in the absence of AIDS, with a substantial increase in dependancy ratio.

In Tanzania, AIDS-infected persons occupy more than half of available hospital beds and it is estimated that each adult case treated in the health care system absorbs about US$ 290 per year in nursing and drug costs. The impact of the HIV/AIDS pandemic is felt in all social and economic sectors of the society, leading to significantly increased health costs, rising infant and childhood mortality, poverty and a growing number of orphans currently estimated at 2 million. The situation caused the URT President to declare the epidemic as a national emergency requiring a multisectoral response.

An estimated 1.8 million people were living with HIV/AIDS at the end of 2000, and cumulatively 600,000 full-blown AIDS cases have been reported since the beginning of the epidemic.[12] In the Mainland, close to 15% of persons aged 15-49 years are infected with HIV, while 60% of new HIV infections occur in the 15-24-year age group. HIV/AIDS is also spreading fast in Zanzibar, with reported cases having risen from 3 in 1986 to 2011 by October 2001.[13] Certain social circumstances cause women to contract HIV more frequently than men. The HIV/AIDS prevalence rates among blood donors have steadily increased over the years, rising from 5.8% to 9.2% among male donors and 7.2% to 13% among female donors between 1991 and 2000. The lack of a functioning blood transfusion system increases the risk of HIV-infected blood and this is a matter of great concern.

According to the National AIDS Control Programme, about 70,000 to 80,000 newborns are estimated to be contracting HIV annually from their HIV-positive mothers, contributing to the reversal in the trends of under-five and infant mortality as well as the mean life expectancy.

Despite a high level of awareness about HIV/AIDS, large numbers of people do not know that they are HIV-infected and continue to lead lifestyles which put them and others at risk. The epidemic is characterized by continuing stigma and denial at all levels of society as well as lack of access to critical information and means of protection for those who are most at risk.

In terms of the national response to the epidemic during the past years, a significant acceleration in activity has taken place: the declaration of HIV/AIDS as a national disaster by the President of the United Republic of Tanzania; the creation of a multisectoral institution known as the

[11]WHO – World Health Report 2000: More recently Health Life Expectancy (HALE).
[12]United Nations Development Assistance Framework (UNDAF) Tanzania, March 2001.
[13]Zanzibar AIDS Control Programme.

Tanzania Commission for AIDS (TACAIDS) under the Prime Ministers' Office; the creation of a donors' HIV/AIDS working group, and lastly, the introduction of the World Bank's Tanzania Multisectoral AIDS Programme (TMAP). The UN initiative for the District Response and, more recently, the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) are expected to make additional impact.

Malaria is a serious public health problem and remains the major childhood killer in Tanzania. It ranks as number one cause for inpatient and outpatient statistics. In Zanzibar, malaria was the leading diagnosed disease in 1999, accounting for 45% of all diagnosed diseases. For the URT, malaria accounts for 30% of the total disease burden. The transmission is stable perennial to stable seasonal over 80% of the land mass. About 26% of the territory is prone to epidemics. It is a major cause of under-five mortality, particularly in children aged less than two years, and inflicts a huge burden due to anaemia, especially in pregnant women.[14] The estimated number of malaria cases per year is 14–19 million and the estimated number of deaths per year due to the disease is 100,000–125,000, of which about 80,000 are children under the age of five years.[15] Malaria costs the country at least 3.4% of its Gross Domestic Product each year through reduced productivity in the workforce, absenteeism from work and education, the costs of treatment and direct costs of the deaths that result from the infection.[14]

Other communicable diseases continue to cause a serious disease burden on Tanzania as a whole. The prevalence of lymphatic filariasis varies from 2.9% in Dodoma to 46.4% in Morogoro. In Zanzibar it varies from 27% in Pemba to 32.5% in Unguja. The national tuberculosis/leprosy control programme reported 54,442 new TB notifications, of which 24,049 were smear-positive, up from 22,100 in 1997. Forty per cent of these new cases were HIV-positive. Onchocerciasis remains a serious problem for the Mainland as it is endemic in 14 of the 123 districts and exposes four million people to the disease in those endemic areas. In addition, the prevalence of noncommunicable diseases, including diabetes mellitus, hypertension and cardiovascular diseases, is increasing with the ever-changing lifestyles. They account for a considerable proportion of hospital admissions.

Child mortality and morbidity are major problems in the country. One out of seven children die before their fifth birthday, with two-thirds of the deaths occurring within the first two years of life. It is important to note that more than 75% of these deaths are attributable to easily preventable conditions/diseases which include malaria, pneumonia, diarrhoea, measles and malnutrition, often in combination (HMIS 1997). Mother-to-child transmission of HIV/AIDS is thought to be an important contributor to deaths in children. In the Mainland, the under-five mortality and infant mortality rates have increased from 137 and 88 per 1,000 live births in 1996 to 147 and 99 per 1,000 live births respectively in 1999.[16] In Zanzibar, the infant mortality rate is estimated to be 83 per 1,000 live births.

Despite major efforts made, access to quality *reproductive health* services remains a problem area as reflected in the high fertility rate of about 5.6 births per woman, high maternal mortality rates of 529/100,000 live births in Tanzania Mainland and 377/100,000 live births in Zanzibar. Neonatal mortality has been recorded at 42/1000 live births, and the contraceptive prevalence rate is 22% for women and 29% for men. Results from the sentinel surveillance show that HIV-prevalence among pregnant women ranges from 4.2% to 32.1%. The deliveries assisted by skilled attendants were 53% in 1991/92, 47% in

[14]Ministry of Health, National Malaria Medium-Term Strategic Plan, 2002, Dar-es-Salaam, Tanzania.

[15]Ministry of Health, National Malaria Control Programme, Tanzania Essential Health Project Mapping Malaria Risk In Africa (MARA), September 2000.

[16]Tanzania Reproductive and Child Health Survey (TRCHS), National Bureau of Statistics, 1999.

1996 (TDHS) and 44% in 1999 (TRCHS), although over 70% of pregnant women attended antenatal care clinics at least four times.

Noncommunicable diseases: Data from the three Adult Morbidity and Mortality Project areas of Dar es Salaam, Hai district and Morogoro rural district showed cause-specific mortality figures that were comparable to Mauritius and higher than the average for sub-Saharan Africa with regard to the contribution of diabetes and strokes.

Table 1: Cause-specific probabilities of death (45q15)

Cause	Dar es Salaam	Hai	Morogoro	Mauritius	Sub-Saharan Africa	Established market economies
Males						
Diabetes	1.6	0.4	0.9	1.6	0.13	0.20
Stroke	3.8	2.6	2.2	2.7	1.73	0.63
Females						
Diabetes	0.68	0.15	0.10	1.7	0.24	0.14
Stroke	3.4	1.4	0.97	1.2	2.16	0.42

Source: Ministry of Health Tanzania,1997.

2.2.2 Major issues impacting on health

In post-independence Tanzania two major strategic orientations impacted *positively* on health. These were: the adoption of primary health care in the 1980s and the earlier initiative of the Arusha Declaration (1967).[17] These approaches provided additional momentum to Tanzania's health development by focusing on critical issues of equity and the re-organization of the rural structures through "*Ujamaa,*" which means self-reliance.[18] At the same time there was a policy of providing free medical and education services by the State. These orientations led to a reduction in infant mortality from 250 per 1000 live births in 1961 to 99 per 1,000 live births in 1999. Other major achievements in the health sector included smallpox eradication and leprosy elimination.

Despite these health gains, and apart from the health conditions described in the previous section, a number of factors continue to impact *negatively* on the health of the people of Tanzania. These are the following.

Poverty: Poverty is the major human development problem and, consequently, the main impediment to the improvement of the people's health status. It is estimated that about 51% of the population are living below the poverty line, and on less than one US dollar a day; 30% of them are considered to be in absolute poverty. It is in line with this reality that the Mainland government has adopted a national strategy and objectives for poverty eradication and the Poverty Reduction Strategy Paper (PRSP). Poverty is largely a rural phenomenon in Tanzania. In rural areas incomes are lower and poverty is more widespread and deeper than in urban centres.

[17]The Arusha Declaration, 1967.
[18]Tanzania National Health Policy 1991.

Zanzibar launched its Poverty Reduction Plan in 2002, with emphasis on: (i) sectoral priorities for growth (agricultural and natural resources development); (ii) human capabilities, survival and social well-being; (iii) infrastructure; and (iv) community participation and democratic governance for poverty reduction strategies and programmes. General malnutrition, protein-energy malnutrition as well as various micronutrient deficiencies are not only important public health problems but are clear manifestations of the levels of poverty in the communities.

Literacy and gender: The literacy rate among adults, especially the poor, has gradually decreased in the last two decades. However, recent surveys[19] showed that the total adult literacy rate in 1999 was 63.4%. In adult females it was 67.1% while amongst males it was 70.6%. In general, the low literacy rates are impacting negatively on the health status of the people. In particular amongst women, the low rates are having an even more deleterious effect. Added to this are gender imbalances in employment, access to resources, participation in decision-making processes and legal status.

Water and sanitation: Lack of basic amenities, particularly clean water and adequate sanitation, also contribute to poor health in the country. Access to safe water is a major problem in the country as a whole but it is more particularly so in rural areas. About 68% of the urban population have access to piped water and less than half of them obtain 24-hour supply. In rural areas, about 45% of the population have access to safe water sources and about 30% of these facilities are non-functional. According to the 1991/92 Household Budget Survey (HBS), about 53% of the population used unprotected water sources. The same survey had showed that 49% of the rural Zanzibar households had no latrines while 90% of urban Zanzibaris used the traditional pit latrines in the absence of a centralized sewerage system. The 2000/2001 HBS, done in the Mainland only, showed an average of 54% of the households having access to safe water and an average of 7% of the households without toilets.

Drug abuse: While there are no conclusive national figures available**,** drug abuse is one of the significant social problems among young people in Zanzibar to the extent that a directorate has been established in the Ministry of Health to address the issue. An urban-based KAP survey carried out in Dar es Salaam and Stone Town, Zanzibar, in 2000 revealed use of *cannabis* by 2.0% of the population. In the same survey it was also reported that between 1997–1999, 44 psychoactive substance users, mainly heroin alone or a combination of heroin and cannabis, were registered at the Department of Drug Control. Between January and December 1999, the Mental Hospital in Zanzibar had admitted 47 new psychoactive substance abusers as compared to 27 in 1996 and 17 in 1994.

Land and population: Zanzibar is said to be among the most densely populated agricultural islands in the world. This, added to deforestation, means less available fertile land for agriculture, thereby impeding economic and human development. Added to this is the high population growth rate, estimated to be around 2.8% per annum for the Mainland and 3% for Zanzibar. This is one of the factors adversely affecting the development of the country and the capacity of the health system to keep pace.

Refugees: As a consequence of the conflict situation in the Great Lakes region, the refugee influx (estimated at 512,000 in 2002)[20] negatively impacts on the health sector. This puts extra load on the sector for diseases surveillance needs, service delivery and supplies.

2.2.3 Health systems

Health sector reforms and policies

[19] HBS 2000, DHS 1999 (NBS).

[20] Source: UNHCR.

The health system in Tanzania is organized within the context of ongoing reforms, which have been implemented in Tanzania Mainland since 1993. Decentralization has strengthened capacity at the district level to manage health services. Participatory structures have been created; the concept of the basic health care packages developed; and more resources generated through the common basket system seem to go to the districts. However, the socioeconomic environment (i.e. poverty, growing impact of the HIV/AIDS epidemics, increased burden of care on the public sector) is not conducive to achieving any significant success in the people's health status. The Zanzibar government also initiated health sector reforms in 1994, but their implementation was delayed because of the withdrawal of donor support in 1995. Recently, however, the government revisited the reforms as part of the Health Sector Strategic Plan, and the principal elements of the reforms are linked with the Zanzibar Poverty Reduction Plan (ZPRP).

The main thrust of the Health Sector Reform Strategic Plan 2002-2007 (Zanzibar) and the Medium-Term Strategic Plan 2002-2004 (Mainland) is on the following eight strategies:

(a) District health services – to improve access, quality and efficiency of primary health (district) services.
(b) Level two and level three hospital services – to improve their management, quality, efficiency and financial viability to support primary-level services, teaching and research.
(c) Role of Central MOH – to improve capacity for sector-wide management, policy development, analysis and national planning; development of guidelines; performance monitoring, evaluation and regulation of service delivery and practice.
(d) Human resource development – to develop human resources for health to implement health reforms effectively by improving skills and building management capacity at all levels of the health system.
(e) Central support systems – to strengthen the national support systems for drugs and medical supplies, medical equipment, physical infrastructure, health management, information systems and transport management.
(f) Health financing – to improve financing and finance management.
(g) Public/private mix – to promote the participation of the private sector in the provision of health services.
(h) Donor coordination - to develop and implement a system for donor/government involvement, coordination, monitoring and evaluation with emphasis on SWAps.

In both the Mainland and Zanzibar, it is clear that the reforms have not fully responded to the needs of the population. Access to quality health services remains an overriding concern, especially for the poor households and rural communities.

WHO, in its assessment of health systems performance (World Health Report 2000), found that Tanzania was performing poorly, except for the attainment in the fairness of financial contribution to health costs where the country's system was amongst the top 50 out of 191 countries. In the other parameters Tanzania scored poorly, i.e., it was amongst the lowest third out of the total. Table 2 gives a comparison of Tanzania with middle-level ranked and the highest-ranked countries against some of the parameters.

Table 2- A comparison of health systems performance parameters

Parameter	**Tanzania**		**Middle-ranked country**		**Highest-ranked country**	
	Rank	Actual Index	Rank	Actual Index	Rank	Actual Index

Life expectancy at birth	181	Male 44.4 Female 45.6	95 Lebanon	Male 63.7 Female 67.3	1 Japan	Male 77.3 Female 84.3
Disability Adjusted Life Expectancy at birth	176	Male 35.9 Female 36.1	95 Yugoslavia /Hg	Male 60.0 Female 60.1	1 Japan	Male 71.9 Female 84.3
Health expenditure per capita	174	$ 5.75	96 Gabon	$196	1 USA	$3,724
Fairness in financial contribution	48	0.96	95 Botswana	0.93	1 Colombia	0.99
Responsiveness	157	4.46	95 Dominican Republic	5.14	1 USA	8.10
Equity of child survival	172	0.53	95 USA	0.79	1 Chile	0.99
Overall health system	158	60	95 Panama	75.5	1 Colombia	93.4

Source: Adapted from "World Health Report 200 Tables 1-9.

Infrastructure and access

The government of the Mainland maintains an extensive health service infrastructure. According to 1999 health statistics abstracts,[21] there were 280 hospitals and specialized clinics, 479 health centres, 3,955 dispensaries and about 32,000 beds, with an average of 896 persons per bed. The ratio of a medically-trained doctor to the population was 1:20,000, and there was one nurse per 5000 people. Zanzibar had 6 hospitals with approximately 840-bed capacity, 103 primary health care units and 4 primary health care centres with a total bed capacity of 120, with doctor:population ratio of 1:13,115.[22] Even though the geographical coverage of the health care facilities was considered to be equitably distributed in all regions and districts and was easily accessible to at least 80% of the population, the quality of care was generally low.

[21] Health Statistics abstracts 1999, MOH.

[22]The Newsletter, 30 June 2000: Population and Development.

Support services

Drugs and medical supplies: The drug revolving fund (capitalization programme in hospitals), adaptation of the indent system in dispensaries and health centres and integration of the drugs and medical supplies needs of the vertical programmes into the MSD distribution system are ongoing activities. However, stock-outs of drugs and medical supplies is still a problem at all levels. Moreover, the country still depends heavily on foreign assistance to fund essential drugs and supplies, making sustainability a major factor.

Transport: Policy guidelines and transport management and monitoring systems covering the operation of local government transport nationally have been developed. The challenge is posed by the fact that transport availability in districts depends mostly on donor support. Plans to sustain transport maintenance and replacement need to be implemented in order to improve the referral system, supervision and implementation of programmes.

Health Management Information System (HMIS) has been established and adapted at all levels of the health system in Tanzania Mainland. In Zanzibar the review of the HMIS system is ongoing in order to make it more manageable for the frontline health workers as well as for its integration into the disease surveillance system. However, there are problems of limited capacities for generating reliable data, analysis, storage, retrieval, dissemination and use. As a consequence, decision-making in health is not generally evidence-based.

R*esearch:* Several research networks and institutions have been established. However, there are insufficient funds to further their research agenda. In spite of the efforts made by the National Health Research Forum, mechanisms to utilize the outcomes and results of research for policy development remain weak.

Human resources for health (HRH)

The HRH policy (1996) and the five-year plan (1996/2001) were developed in the initial stage of health sector reforms in Tanzania Mainland. The MPH and district health management courses have been established as part of the HRH plan to equip Council Health Management Teams and other managers with planning and management skills. Training of professional health workers is being improved through a review of curricula in line with the reforms requirements. However, major problems prevail, including the inequitable distribution of health staff, especially in Zanzibar and in rural health facilities in the Mainland, lack of human resources information (database) for planning and absence of incentive packages to attract and retain health professionals in underserved remote areas. It is recognized that the brain drain, especially in Zanzibar, is a matter of great concern as it is impacting on the quality of health care. Limited studies are also showing that HIV has adversely impacted on the HRH situation in the Mainland.[23]

Essential health services

Advances have been made in the implementation of essential health services such as family planning, polio eradication, measles surveillance, and in introducing the new malaria and the Integrated Management of Childhood Illness (IMCI) protocols. Private sector health facilities have been increasingly involved in the control of malaria through the training of clinicians and nurses in the new malaria treatment policy and management of severe malaria. EPI coverage has improved from 79% in 2000 to 86% in 2001. Although health education and promotion are progressing, cases of water-borne diseases such as cholera still prevail. Malnutrition remains a burden, especially in rural-poor communities. Some

[23]MOH/NIMR study 2002.

of the current parallel, uncoordinated and duplicative training initiatives started under various vertical programmes that target same health workers are not cost-effective.

Public health sector financing

As pointed out earlier, for a long time the government of Tanzania shouldered the responsibility of financing health care in the public sector. According to World Health Report 2000, the total expenditure on health as a percentage of the GDP was 4.8%. According to the MOH (Mainland), the government health expenditure per capita is US$ 5.8 (fiscal year 2002–2003). Recurrent costs absorb 60% of the health budget; the remaining 40% is left for capital investment. The National Health Accounts (NHA) data are not fully documented, but WHO is facilitating the development of the necessary instruments.

The government's allocation to the health sector has consistently grown over the last few years; increase in actual expenditure was even higher.[24] Table 3 provides trends in health budget allocations for both Tanzania mainland and Zanzibar:

Table 3 – Total health budget (in million shillings)

	1995/96	***1996/97***	***1997/98***	***1998/99***	***1999/00***	***2000/01***	***2001/02***
Tanzania Mainland (Source PER 2002)			100,590	124,580	133,990	177,100	210,280
Zanzibar (Source MOFEA, 2001)	1,770	1,973	2,581	2,778	2,958	4,121	5,463

Table 4 provides the projection of the total future resource envelope for the health sector (Mainland MOH) over the next five years, including external aid, which will be dealt with in detail in Section 3.

Table 4 – Projected future resource envelope (in million shillings. Source PER 2002)

Resource envelope	***2000/01***	***2001/02***	***2002/03***	***2003/04***	***2004/05***
MOH / Central govt. (recurrent, development and central basket)	47,500	65,900	90,900	111,500	133,200
Local Govt (recurr., develop. and council basket)	43,200	52,300	67,900	79,200	91,500
Off budget (other foreign assistance, cost-sharing, CHF, NHI)	91,200	95,100	72,100	54,700	31,900

[24]PER/Health sector, 2002.

Total (million)	181,900	213,300	230,900	245,400	256,600

In 1994 the Mainland government introduced a proposal for health care financial reforms, which identified different financing mechanisms for addressing the problem of inadequate resources for the health sector. The mechanisms proposed included community health fund, hospital drug revolving fund, user fees, and a national health insurance scheme. The Mainland government is experimenting with some of these financing mechanisms, but many of the poor households nonetheless lack access to essential health services since they are too poor to finance their own access. The poor households face a major dilemma because even what the government offers is too little for their needs. Zanzibar, on the other hand, has been following the policy of "free health services" despite huge deficiencies already being experienced. In reality, however, patients have been paying for some services at the point of delivery, prompting the government to start exploring alternative source of financing. There is a policy which encourages greater involvement of the private sector in service provision, although its overall impact on meeting the health needs of the population has not yet been assessed.

The government of Tanzania has studied the report of the Commission on Macroeconomics and Health and fully understands the challenging implications it throws up for closing the gap from the current US$ 5.8 per capita health expenditure to the estimated US$40 on a phased basis by the year 2015. A new hope in the area of health financing has been created by the establishment of the Global Fund to fight AIDS, Tuberculosis and Malaria.

3. Development Assistance and Coordination

There are many development partners in Tanzania and this has necessitated the introduction of strong coordination mechanisms. By the same token, Tanzania appears to be heavily dependent on external assistance. The overall health expenditure is about US$ 200 million per year, of which 50% comes from development assistance funds.

3.1 Major development agencies in the health sector

The main bilateral agencies currently active in the health sector in the Mainland include: Belgium, Canada, Denmark, Germany, Ireland, Italy, Japan, the Netherlands, Norway, Switzerland, UK and USAID. All bilateral and multilateral aid to the country is coordinated within the Poverty Reduction Framework. The resource envelope from external development partners' funds is shown in Table 5.

Table 5 - External development partner funds in Tanzania Mainland: (in million shillings. Source PER 2002)

Channel	***2000/01***	***2001/02***	***2002/03***	***2003/04*** **(estim.)**
Govt. via basket	18,711	28,496	28,528	28,528
Govt. non-basket	18,958	13,936	25,968	25,968
Govt. off-budget	45,079	40,128	30,504	30,504

NGOs	14,334	7,200	4,000	4,000
Total	**97,084**	**89,760**	**93,000**	**93,000**

As already pointed out, the period 1995-2002 saw a marked decline in the activities of development partners in Zanzibar. However, the African Development Bank (ADB), UNICEF, UNFPA, WHO, the Aga Khan Foundation, SCF/UK and UNDP continued to support several health development activities in the Islands during that time. In Zanzibar the UN contribution to the health sector during 2002–2006 is estimated at US$ 5.8 million.[25] Following the launch of the Zanzibar Poverty Reduction Plan (ZPRP) in May 2002, some bilateral development partners have indicated interest in supporting Zanzibar in its reforms and poverty reduction efforts.

3.2 Coordination mechanisms

From the donor perspective, the first attempt in this direction was represented by the Health and Population Sector Group (HPSG), formed in the early 1990s by bilateral and multilateral development partners to improve consultation and exchange of information. The Group was subsequently co-opted by the Tanzanian Development Assistance Committee (DAC) when it formed its sector working groups and expanded its membership to include a few NGOs and officials of the MOH and the Planning Commission.

Later, as Tanzania designed new strategies for economic and social development, sectoral development programmes were defined for specific line ministries (Health, Education, Agriculture, Roads and Rural Development), whereby the government took the lead in the coordination efforts.

The key approach to donor coordination in the health sector on the Mainland is anchored on the sector-wide approaches (SWAps), which emphasizes joint and comprehensive planning and programming. The government created a SWAps Committee in 1999, whereby the work of all development partners (bilateral, multilateral, NGOs, and the private sector) is being coordinated. The adoption of SWAps has resulted in the pooling of some donor funds with the government (Basket Fund) in support of health sector development. Funds committed for the fiscal year 2002–2003 amount to US$ 40 million.[24]

Whereas all stakeholders are represented in the Health SWAps Committee, each stakeholders' group has its own forum for consultation to complement the SWAps. Multilateral and bilateral partners joined in the so-called Bi- and Multilateral Health Forum (BMHF), formerly known as the Health and Population Sector Group (HPSG).

In addition, the UN System in Tanzania is coordinated by the Resident Coordinator, where WHO, UNDP, the World Bank, UNICEF and UNFPA are the major players in health. This coordination has led to the development of the UNDAF strategic framework 2002–2006 based on the country assessment contained in the Tanzania Assistance Strategy (TAS), universally accepted as the Tanzania UN-Common Country Assessment (UN-CCA) for the Mainland. In Zanzibar the UN-CCA was released in April 2001.

While the mechanisms for donor coordination are seen to be in place, some concerns still remain:

(a) Few donors are so far participating in the common basket initiative.

[25]UNDAF Health Zanzibar, March 2002

(b) Equal emphasis has not been placed on all aspects of SWAp mechanism.

(c) The health budget and the Public Expenditure Review (PER) do not reflect all resources from various sources.

(d) The high dependency on external assistance could jeopardize sustainability.

3.3 Major health challenges

As a result of the situational analysis previously described, and acknowledging the contribution of poverty to ill-health, the following major challenges have emerged:

(e) Improving the health system to address the need for better quality care: translating policies into actions and results promoting evidence-based planning, integrating the services and strengthening support mechanisms such as drugs and human resources among others.

(f) Reducing the burden of disease: paying special attention to delivering essential health services and addressing major problems, such as HIV/AIDS, malaria, maternal and child mortality as well as the new challenge posed by noncommunicable diseases.

(g) Providing a supportive and enabling environment through legislative reform and the application of health promotion strategies.

(h) Improving the capacity and resources for preparedness and response to outbreaks and emergencies at all levels.

(i) Based on the differences in the levels of health development, addressing the special health and human resource needs of Zanzibar in the context of reforms.

(j) Ensuring sustainability of programmes by advocating for increase of national resources for health.

4. WHO Current Country Programme

Cooperation between WHO and Tanzania began in 1949. However, the WHO office was not established in the country until 1963. Until 1994 the WHO representation was only token, consisting of the WHO Representative (WR), an information officer and support staff.[26] Over time the office has expanded greatly, and is now having a strong team of 17 professional and 24 support staff, covering both the main office and the Zanzibar sub-office (s*ee Annex 2 for organogram).*

Administrative support encompassing disbursement of funds and procurement of equipment and supplies is crucial as it forms the cog that moves the programme implementation wheel. With this support it has been possible to service workshops and meetings directly, leading to timely disbursements and preparation and submission of reports. The increased delegation of authority from the Regional Office (AFRO) to the WRs in recent years has significantly improved the responsiveness and level of support to the implementation of country programmes. However, problems remain in the areas of recruitment of short-term staff and administration of local fellowships.

4.1 WHO Regional Office and headquarters support

The responsiveness of headquarters and AFRO and other WHO regions to requests for support has been viewed as the real strength of WHO globally as well as in Tanzania. Between January 2000 and

[26]The Oslo Group Study, 1997.

May 2002, the office received a total of 88 missions from both headquarters and AFRO covering a large number of programme areas. Some of these missions were initiated at the request of the national authorities and others as technical back-up for various programmes. However, the timing and insufficient advance planning for such missions can cause difficulties for both the national authorities and the Country Office. Better coordination at the three levels of the Organization can enhance the usefulness of these missions. Other forms of support included assistance in emergencies.

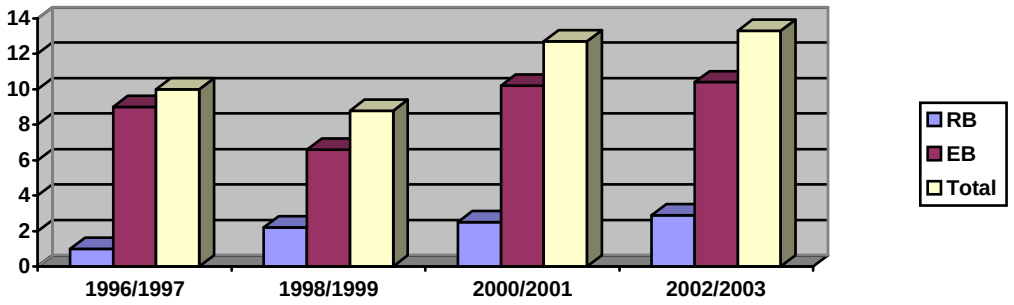
There are still instances of the non-involvement of the Country Office in the development and implementation of some of the HQ-supported activities. Unfortunately, this creates the avoidable impression that the Country Office is not the sole coordinating mechanism for all WHO activities in the country.

4.2 Financial resources for the Country Office

The total operational budget of the Country Office in the 2002–2003 biennium amounts to US$ 13,666,946 (Regular budget–US$ 2,894,600; Other Sources funds– US$ 10,772,346). At present, 30% of the budget is devoted to support activities in Zanzibar and the remaining 70% is for the Mainland. With regard to priority Areas of Work (AOW), 89.7% of the budget covers 20 AOWs, the top five being Immunization and Vaccine Development (40%), Organization of Health Services (16%), Prevention and Control of Communicable Diseases (11%), Malaria (6%) and HIV/AIDS (4%), while Country Office Operations absorbs 10.3%.

Figure 1 displays the trends in the country budget during the biennial periods 1996–1997 to 2002–2003. The Regular budget showed a significant increase from about US$ 1 million in 1996–1997 to around US$ 2 million in 1998-1999. Since that time, however, because of the policy of virtually zero growth, the Regular budget allocations to the country have not changed dramatically. The extrabudgetary (Other Sources) funds have been increasing steadily from just over US$ 8 million in the 1996–1997 biennium to its present levels.

Figure 1: Trends in the country budget over time (in US$ millions)



Source: WHO Tanzania Annual reports

4.3 Human resources

Out of the 17 professional staff, seven are fixed-term. The remainder are short-term staff, mostly funded through Other Sources funds. Given that most of the programmes supported by staff with Special Services Agreement contracts (SSAs) are priority areas of the Ministry of Health, their sustainability and continuity could only be assured when the government had sufficient capacity.

There is a wide range of skills among the existing WHO professional staff that includes: postgraduate qualifications in paediatrics, public health, epidemiology, health management, community health, parasitology/entomology, maternal and child health, demography, as well as policy and planning. However, a skills review needs to be conducted to determine whether there are any gaps based on the new and emerging health needs of the country and new strategic orientations of WHO. There is potential to tap resources existing elsewhere within the country.

In terms of support staff, according to WHO guidelines, one secretary should service two professional officers. With the current staffing position, there is a shortage of three secretaries, which greatly hampers the work of the professional staff.

4.4 Priority areas of work

WHO is perceived by partners as an honest broker and a close adviser of the government on health matters, underscoring its normative and advocacy roles. As such WHO's role is central in health sector development, including the reform process. WHO also provides financial and technical support for specific programmes. Within the framework of poverty reduction, the areas of work to be covered are identified in consultation with the government. Government officials undertake implementation, with technical and financial support from the country team. Given the fact that the budget is not increasing much, further prioritization will be necessary.

Table 6 shows the Areas of Work included in the WHO Country Plan of Action during 2002–2003.

Table 6: Areas of Work covered by the WHO Country Office and their share of budget

Area of Work	Budget US$	%
1.Immunization and vaccine development	5,443,774	39.83
2. Organization of health services	2,168,500	15.87
3. Communicable diseases prevention, eradication and control	1,451,600	10.62
4. Malaria	886,627	6.49

5. Child and adolescent health	580,000	4.24
6. HIV/AIDS	559,000	4.09
7. Essential drugs and medicines	405,000	2.96
8. Disability prevention and rehabilitation	145,045	1.06
9. Mental health and substance abuse	112,000	0.82
10. Health promotion	106,500	0.78
11. Making pregnancy safer	86,000	0.63
12. Evidence for health policy	70,000	0.51
13. Resource mobilization and external partnerships	57,000	0.42
14. Protection of the human environment	37,000	0.27
15. Blood safety and clinical technology	30,000	0.21
16. Tobacco	30,000	0.21
17. Communicable diseases surveillance	28,000	0.20
18. Emergency preparedness and response	28,000	0.20
19. Tuberculosis	23,000	0.17
20. Information management and dissemination	14,000	0.10
COUNTRY OFFICE OPERATIONS	*1,405,900*	*10.29*
Total budget	***13,666,946***	

4.5 Main WHO contributions to health development in URT

Some of the key contributions made by the Country Office to health development in the URT include:

(a) **Support to health sector reforms.** WHO has been very supportive in the reform process, helping the country in formulating a human resource plan for the Mainland, identification of the Essential Health Package, catalysing the debate on the integration of health services as well as facilitating the review of various Acts in line with health reforms.

(b) **Research development**. Between 1999 and 2002, WHO sponsored research work and provided research grants totalling US$ 4 million to individual scientists and institutions in Tanzania. The main areas covered were: tropical diseases research and training (TDR); women's health, gender and violence; Roll Back Malaria; and research in human reproduction. Research results have been used to influence policy changes in the health

sector, e.g. efficacy studies have been conducted, with WHO's technical and financial support, which have shown a 60% chloroquine resistance. This has led to policy changes in both the Mainland and Zanzibar.

(c) **Capacity building.** A recent analysis showed that between 1990 and 2001, WHO awarded a total of 110 fellowships to Tanzanian nationals for both long- and short-term courses. The return rate of people trained through this support, at 80%, is one of the best in the African Region. In the last biennium, 449 officers were funded for inter-country workshops as participants or facilitators. Support to district capacity-building has enhanced effective Council Health planning and management. The IMCI strategy has been institutionalized in the MOH structures with the reform districts incorporating IMCI in the district health plans. Correct case management of sick children by trained health workers is now over 80%, resulting in a reduction of IMR in some communities by as much as 40% *(Multi-country evaluation preliminary results 2002).*

(d) **Disease Control.** Technical support has been provided for outbreak investigations as well as necessary supplies. WHO has helped the MOH in the development of integrated disease surveillance (IDS). In the eradication of diseases, community-based mass drug distribution for lymphatic filariasis exceeded the target of 80% coverage.

(e) **Blood safety.** WHO provided a consultant to assess the current situation of blood safety on the islands, which also came up with a phased plan for implementation in order to set up a blood transfusion system. However, more resources will be needed to set up the system.

(f) **Resource mobilization.** The success of negotiations for the Italian/WHO and Belgium/UNAIDS initiatives on HIV resulted in the spearheading of the health sector response to HIV/AIDS and the implementation of activities in 19 districts in the Mainland as well as in Zanzibar. Funds have been secured from the GFATM to support the national malaria control programme in scaling up the use of insecticide-treated nets (ITNs) countrywide in the Mainland and for the implementation of the new malaria treatment policy in Zanzibar.

(g) **Development of plans, policies and guidelines.** Guidelines have been developed for health promotion and environmental health and sanitation. The Mainland has developed a National Malaria Strategic Plan, which includes going to scale with ITNs as one of the major strategies.

4.6 Main challenges for WHO country office

In operational terms, the challenge for WHO could be how to support the two Ministries of Health in the United Republic of Tanzania in response to the differences of and variations in their needs. To the outside world, the URT is perceived as one country. In reality, however, the oneness is only applicable to Union matters; health, in particular, is not a Union matter. It is obvious that the Mainland and Zanzibar are at different stages of health development. The CCS provides an opportunity for WHO to review its operations in this unique situation, especially with respect to programme planning and resource allocation issues, and how the two Ministries of Health should relate to WHO managerial organs.

The coordination of visiting missions needs further work in order to avoid "parachuting" of external support without due notice to the Country Office. Ample time and both-way communications are necessary to avoid embarrassment when the national authorities have to be asked for appointments/clearances at the last minute. This leads to disruption of officers' schedules and stretching

of the Country Office's resources. Continual addressing of this situation at different levels is strongly desired.

5. WHO Corporate Policy Framework: Global and Regional Directions

WHO has been - and is still - undergoing changes in the way it operates, with the ultimate aim of performing better in supporting its Member States to address key health and development challenges. This organizational change process has, as its broad frame, the WHO Corporate Strategy.[27]

5.1 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 and the Policy Framework for Technical Cooperation with Member Countries of the African Region outline key features through which WHO intends to make the greatest possible contribution to health in the world, and indeed in the African Region. The Organization aims at strengthening its technical, intellectual and policy leadership in health matters, as well as its management capacity to address the needs of Member States.

5.2 New emphases[27]

The WHO Corporate Strategy emphasizes the following WHO responses to the changing global environment:

(a) adopting a broader approach to health within the context of human development, humanitarian action and human rights, focusing particularly on the links between health and poverty reduction;

(b) playing a greater role in establishing wider national and international consensus on health policy, strategies and standards by managing the generation and application of research, knowledge and expertise;

(c) triggering more effective action to improve health and to reduce inequities in health outcomes by carefully negotiating partnerships and catalysing action on the part of others;

(d) creating an organizational culture that encourages strategic thinking, global influence, prompt action, creative networking and innovation.

5.3 Strategic directions[27]

On the basis of these new emphases, WHO has set out four strategic directions for its contribution to building healthy populations and combating ill-health. These strategic directions, which are interrelated, provide a broad framework for the technical work of the Secretariat:

(a) reducing excess mortality, morbidity and disability, especially in poor and marginalized populations;

(b) promoting healthy lifestyles and reducing risk factors to populations;

[27] WHO EB105/3. A Corporate Strategy for the WHO Secretariat.

(c) developing health systems that equitably improve health outcomes, respond to peoples' legitimate demands, and are financially fair;

(d) developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

5.4 Core functions[27]

The typology of WHO core functions, presented below, is based on the comparative advantage of the Organization at all its levels:

(a) articulating consistent, ethical and evidence-based policy and advocacy positions;

(b) managing information, assessing trends and comparing performance of health systems; setting the agenda for and stimulating research and development;

(c) catalysing change through technical and policy support in ways that stimulate action and help to build sustainable national capacity in the health sector;

(d) negotiating and sustaining national and global partnerships;

(e) setting, validating, monitoring and pursuing proper implementation of norms and standards;

(f) stimulating the development and testing of new technologies, tools and guidelines for disease control, risk reduction, health-care management and service delivery.

5.5 Global and regional priorities[28]

In order to be more effective and efficient in its interventions, the Organization has selected a limited number of global priorities on which to focus over the four-year period (2002–2005). The global priorities selected on the basis of those criteria are: malaria, HIV/AIDS and TB; noncommunicable diseases (cancer, cardiovascular diseases and diabetes); tobacco; maternal health; food safety; mental health; safe blood; and health systems.

The WHO African Region[29] is facing enormous health challenges in relation to health. The WHO Regional Office for Africa has decided to focus its attention on 12 priorities closely related to the 11 global priorities, but adapted to the regional context. These 12 priorities are: HIV/AIDS; tuberculosis; malaria; maternal health; child and adolescent health; strengthening of health systems; blood safety; humanitarian and emergency action; health promotion; noncommunicable diseases control including mental health; and poverty and health.

5.6 Making WHO more effective at country level

The expression of WHO Corporate Strategy at country level will vary from country to country. Taking into consideration country-specific health and development challenges, the involvement of other

[28] WHO: General Programme of Work 2002-2005.

[29] The work of WHO in the African Region, Strategic Framework 2002–2005.

external partners, WHO's current work in and with the country, and the global and regional policy frameworks, WHO will look at getting the balance right between its key functions at the country level. This means the Organization will act more as an adviser, a broker and a catalyst and will involve itself in routine implementation in case of specific, clearly identified initiatives, with a time-limited perspective. A working typology of WHO functions at country level has been developed based on the broader core functions presented above.

The specific functions at country level are:

(a) supporting routine long-term implementation;

(b) catalysing adoption of technical strategies and innovations; country-specific adaptation of guidelines; and seeding large-scale implementation;

(c) supporting research and development; policy experimentation; development of guidelines; stimulating monitoring of health sector performance; and trends assessment and anticipation;

(d) sharing information; generic policy options and positions; guidelines and standards; case studies of good practice; and advocacy;

(e) providing specific high-level policy and technical advice; serving as broker and arbiter; exercising influence on policy, action and spendings of government and development partners.

6. STRATEGIC AGENDA FOR URT: 2002–2005

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 plays a central role in the maintenance of health of its people. It is the State that is the guarantor of equity in the provision of public health goods. The support given by WHO should strengthen the government's institutional capacity. To this end, the technical capacity of WHO will always be at the disposal of the State. WHO will work with all partners to advocate for more investments in health, as well as for addressing some of the negative determinants of health, including gender inequities.

Recognizing that poverty is a major determinant of ill-health in Tanzania, both as a cause and as an effect, WHO will make special efforts to assist the government to develop mechanisms to reach the poor and maximize the contribution of health to poverty reduction. It will therefore advocate for health services that are pro-poor. In addition, special efforts will be made to support those interventions that target diseases associated with poverty. Furthermore, WHO will assist in devising special measures to protect the poor from the impoverishing effects of health care expenditures and minimize the financial barriers to health care.

In line with its new corporate policy and the measures taken to re-evaluate its comparative advantage, WHO will, over the next four years, take a more selective and strategic approach to its work in Tanzania.

However, the broader mandate of WHO will still be respected and applied as and when necessary if requested by the national authorities; for example, in the areas of food safety, environmental health and sanitation and disaster preparedness and response.

It should be noted that WHO will continue to work mainly with the Ministry of Health, according to the current basic agreement between the two parties, while acknowledging the importance of collaboration with other stakeholders.

In accordance with WHO strategic directions and guiding principles as well as in response to identified national health challenges, the WHO Country Office will carry out the following functions:

(a) *Supporting implementation of priority health programmes:* WHO will continue to provide support to selected priority programmes such as HIV/AIDS, EPI, malaria, reproductive health and child health.

(b) *Catalysing adoption of technical strategies and innovations and country-specific adaptation of guidelines:* The Country Office will continue to support the adaptation of technical guidelines, manuals and procedures and identify opportunities for their application in relevant interventions.

(c) *Supporting research and development:* The WHO Country Office will continue to support research as well as economic evidence analyses for priority interventions in order to assist policy formulation and planning, taking into account the recommendations of the Commission on Macroeconomics and Health (CMH, 2002).

(d) *Sharing information: guidelines and standards, case studies of good practices and advocacy:* Based on its universal access to sound, updated and reliable health information, the Country Office will improve its role in sharing and disseminating information for proper action. In addition, good practices in health will be identified and promoted.

(e) *Providing specific high-level policy and technical advice.* As the lead technical agency in health, WHO will play its role in influencing health policy formulation and exercise its brokerage role in health and health-related matters in the country. It will contribute to the strengthening of partnerships among stakeholders in the context of a sector-wide approach.

Taking into account the above, the Country Office will address the following priority components of the Strategic Agenda:

- Health systems development in the context of ongoing reforms
- Essential health services

In relation to each component, specific sub-components have been identified within which WHO is expected to provide its support during the period covered by the present Strategic Agenda, consistent with its comparative advantage.

6.1 Health systems development

WHO support to health systems development will be based on the major challenges identified in Section 2 of the document, as well as the strategic directions identified in the Medium-Term Strategic Plan (MTSP) 2000–2004, while also considering the national health priorities as stipulated in the health sector reform and poverty reduction strategies for both Mainland (2000) and Zanzibar (2002). The two PRSPs are at different stages of implementation, but in terms of their content they address similar objectives and WHO's support will be cognisant of these differences. This component considers five sub-components that will receive special attention.

(a) Organization of health services

Recognizing the importance of a functional and efficient health system to the effective implementation of programmes, WHO will:

(i) support MOH in their development of new policy directions as indicated by emerging health trends;

(ii) assist with the revision of health laws;

(iii) develop standards and guidelines for support to the integration of health services;

(iv) facilitate the operationalization of district health systems;

(v) support the development of basic health care packages.

(b) Human resource development

Taking into consideration the critical importance of the human capital to the appropriate delivery of health services, WHO will contribute to the:

(i) situation analysis, mapping out distribution of existing human resources across the country and identification of human resource needs;

(ii) development of an institutionalized programme for upgrading managerial skills of health professionals in charge at national, regional and district levels;

(iii) guiding the formulation of HRH policies and plans, addressing the issues of retention and equitable distribution, and ensuring appropriate skills mix.

(c) Research and health information, management and dissemination

Health development is seriously handicapped by the absence of reliable information on which to design health plans and programmes and to make decisions on the basis of evidence. WHO is committed to improve this situation. It will:

(i) support the National Health Research Forum to conduct/maintain an updated inventory of existing research studies;

(ii) support the country in identifying research gaps including the use of PRSP indicators and make recommendations to address them;

(iii) support research on key health issues and facilitate the dissemination and application of research findings;

(iv) support the development of integrated HMIS and disease surveillance in order to improve the availability of accurate health data for decision-making.

(d) Essential drugs and medicines

There are many issues affecting the availability of cost-effective essential drugs. Some of these are related to resource constraints and others to managerial factors. In determining where WHO could be of greatest advantage in this area, it was decided that it could best serve the country by:

(i) supporting the review of policies and regulations and improve quality assurance;

(ii) developing mechanisms to ensure an effective drug supply management system, including rational use of pharmaceuticals and accessing affordable antiretrovirals (ARVs);

(iii) guiding the development of standards to encourage safe practices of traditional medicine.

(e) Promoting strategic partnerships

The adoption of SWAps in 1998–99 has set a conducive environment for coordination of donor support. It has also necessitated the creation and strengthening of mechanisms for joint planning, monitoring and evaluation among partners in health while the MOH continues to assume the leadership role. Therefore, WHO will:

(i) support partners' efforts in health-related activities and advocate for health to be meaningfully addressed in the development agenda;

(ii) act as a broker for appropriate allocation of partners' resources to address priority health issues;

(iii) maintain an active role in the coordination mechanism and utilize its brokerage function to promote wider participation of all partners, including the private sector and NGOs.

6.2 Essential health services

(a) Communicable disease control

While HIV/AIDS has been assuming alarming proportions in recent years, malaria remains a serious problem for both the Mainland and Zanzibar. Other communicable diseases also contribute significantly to the disease burden. WHO will continue to support the government in strategic and programmatic endeavours in this regard. WHO will therefore :

(i) support activities for the prevention and control of HIV transmission through effective management of sexually transmitted infections, prevention of mother-to-child transmission of HIV and voluntary counselling and testing. The needs of and challenges faced by health workers will be given special attention. WHO will also strengthen strategic partnership in the delivery of comprehensive health care and support operational health research and surveillance;

(ii) continue to support efficacy studies on malaria/TB and monitor drug resistance, while at the same time advocating for increased resource allocation to malaria control, both internally and from external sources;

(iii) support the development of an epidemic preparedness and response plan, including an early warning system and resources to respond.

(b) Noncommunicable diseases prevention

It is recognized that people's changed lifestyles and practices have led to a considerable increase in the disease burden resulting from noncommunicable diseases (NCDs). It is also recognized that this area requires increased attention and that health promotion plays an important role in the prevention and control of NCDs. WHO will therefore:

(i) advocate for the application of existing health promotion policy guidelines in favour of healthy lifestyles, including accident and injury prevention;

(ii) support the MOH in determining the magnitude of priority NCDs and the development of national strategies to address them.

(c) Reproductive and child health

Maternal, infant and child mortality rates are important indicators for monitoring poverty reduction in the URT. All of these indicators remain unacceptably high and their reduction is an important priority of the government. WHO will support government efforts in this regard by:

(i) addressing maternal mortality by facilitating the incorporation of the Making Pregnancy Safer (MPS) strategy into plans of action;

(ii) supporting IMCI expansion to more districts in view of the success already registered in the pilot districts;

(iii) supporting district capacity-building, including data management and evaluation of the EPI programme as well as surveillance.

(d) Blood safety

The blood transfusion system currently operational in Tanzania is replacement donation and yet blood is needed in all clinical departments routinely and in emergency situations. The regional strategy adopted by the WHO Regional Committee advocates for the organization of a voluntary non-remunerated system whereby blood transfusion is seen as both a therapeutic and preventive service in this era of HIV/AIDS. Tanzania needs a lot of support in this area through education and information of the public on their civic responsibility for regular blood donation. Human resources and infrastructural development also would require support. WHO will therefore:

(i) support the URT in strengthening/setting up a functional blood transfusion service;

(ii) assist the government in resource mobilization as well as formulating strategies for sustainability.

7. Implications of the Strategic Agenda

The operationalization of the proposed strategic response, within the context of the functional approaches of WHO, would require substantial actions at each of the three levels of the Organization. The implications are summarized below:

7.1 For WHO country office

A fundamental task for the WHO Country Office will be to ensure that there is a common understanding among its staff, the government and all partners with regard to the concept of the CCS and its implications on WHO programming at the country level.

In order to respond to the priorities identified in the strategic agenda, the Country Office will need to review its human resources capacities, essentially in terms of competencies audit, post descriptions and staff development programme. It will also need to adjust its operational mechanisms to allow for the kind of programmatic integration reflected in the said strategy.

In the light of the priority health issues reflected in the strategy as far as Zanzibar is concerned, it would be necessary to strengthen the administrative and technical capacities of the sub-office. Mechanisms and procedures in the main office will need to improve in order to allow for greater efficiency in supporting the Zanzibar sub-office. It would be necessary to maintain at least the current level of funding support from Other Sources for the priority health areas (HIV/AIDS, malaria, IMCI, EPI and reproductive health), and mobilize resources to support new priorities identified in the strategy, such as health system reforms in Zanzibar and noncommunicable diseases.

The Country Office will continue the dialogue internally and between WHO and the Ministry of Health to reach agreement on defining the geographical focus and the *Areas of Wo*rk, in order to ensure greater equity and impact.

7.2 For Regional Office and headquarters

AFRO should provide guidelines and allow greater autonomy to the WR for locally-recruited short-term staff to avoid delays in implementation of activities and unnecessary overload of paperwork.

In order to meet the country's needs, AFRO and headquarters would be expected to increase technical backstopping to the Country Office in a coordinated manner.

AFRO and headquarters should continue to review ways of providing greater flexibility in budget allocation and management at the Country Office-level in order to better respond to the dynamics of change likely to occur in Tanzania.

The Programme Support costs (PSC) that AFRO and headquarters are receiving from the disbursement of funds from Other Sources should be shared with the Country Office. Furthermore, the procedures for channelling locally mobilized resources should be reviewed in order to avoid delays in disbursement.

Recruitment of additional human resources, mainly for Zanzibar, will require further allocations to the country budget.

In consultation with the national authorities, AFRO and headquarters should review the current administrative arrangements for supporting the URT. This should be done in the light of the country's peculiarity of having two autonomous Ministries of Health.

7.3 Cross-cutting implications

It is evident that WHO will have to operate in a complementary and synergistic way at all levels in order to be more effective in the implementation of this strategic agenda.

It would be necessary to review the contents and process of approval of the budget for the period 2002–2005 for the URT to make it consistent with the present strategic agenda.

8. Conclusion

The United Republic of Tanzania is comprised of the Mainland and Zanzibar. There are two Ministries of Health with separate administrative arrangements and distinct but not unrelated health agendas.

The URT ranks among the poorest countries in Africa. Perhaps because of this, it attracts many donors with various interests in health. In fact, donor contributions account for the greater proportion of the health budget. The government has had to devise a coordination mechanism to effectively manage the various agendas and resources.

It is important to recognize that the government is in the process of major health and other reforms supported by its many partners and designed to deal with the priority problems of the country.

The health sector priorities include the fight against HIV/AIDs, malaria, tuberculosis and major communicable diseases, strengthening the health system especially at district level and improving Safe Motherhood and child health.

Within this context, WHO has developed the Medium-Term Country Cooperation Strategy (CCS) to better focus and guide its work in the URT. The process of developing the CCS allowed for several partners to be engaged, and provided, both to the CCS team and the Country Office staff, tremendous learning opportunity.

In the same way as it involved other partners in the process of developing the CCS, WHO remains committed to work with those partners, and to mobilize necessary resources to operationalize the various components of the CCS.

The WR and other WHO staff extend their appreciation to everyone who participated in or provided support to the development of the CCS.

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ANNEX 1

List of Persons Met During First and Second Missions

No.	Name	Agency	Function
MINISTRY OF HEALTH MAINLAND			
1.	Dr Z. Berege	MOH	Ag. Permanent Secretary
2.	Dr G. L. Upunda	MOH	Chief Medical Officer
3.	Dr G. R. Mliga	MOH	Director, Human Resources Development
4.	Mr M. Mapunda	MOH	Senior Officer, Policy Planning Department
5.	Mr N. Mvungi	MOH	Ag. Director of Administration and Personnel
6.	O. M. Soli	MOH	Registrar, National Food Control Chain
7.	Ms Joyce Safe	MOH	Chief Nursing Officer
8.	P. M. Karomba	MOH	Ag. Chief Internal Auditor
VICE PRESIDENT'S OFFICE – POVERTY REDUCTION UNIT – MAINLAND			
9.	Dr B. Likwelile	VP	Director
10.	Mr D. Mbilima	VP	Officer
UN AGENCIES - MAINLAND			
11.	Mrs Inyang Harstrup	UNDP	UN RR a.i
12.	Dr Elly Ndyetabura	UNDP	Health Specialist – HIV/AIDS
13.	Ms Connie Affonso	Programme Associate	RC's Office
14.	Ms Nicole Menage	WFP	Country Director
15.	Ms Evelyne Mkanda	WFP	Programme Assistant – HIV/AIDS
16.	Dr H. Basstanie	UNAIDS	Country Programme Advisor
17.	Mr Teferi Seyoum	UNFPA	Representative
18.	Dr B. Ljungqvist	UNICEF	Representative
19.	Dr M. Shekar	UNICEF	Health Officer
BILATERALS			
20.	Lisbeth Loushban	USAID	Country Health Sector Advisor
21.	G. Templeman	Netherlands Emb.	Counsellor
22.	Freda Bos	Netherlands Emb.	Programme Officer
23.	M. H. Makame	Irish Aid	Health Advisor
24.	G. Falsirollo	Italian Embassy	Health Advisor
25.	F. Molteni	Italian Embassy	Programme Manager – DGCS Italian Cooperation
26.	Finn Schleimann	Danish Embassy	Regional Technical Advisor – Health
27.	Dr B. Schmidt-Ehry	GTZ/KfW	Coordinator – Health
NGOS			
28.	F. A. Binagwa	CARE	Chief of Party – VSHP
29.	Dr Elly Nangawe	CSSC	Deputy Director
30.	N. J. Karoma	Hubert Kairuki	Advisor/Researcher
31.	Mr Amin Bapoo	Aga Khan Foundation	Country Manager
32.	Dr M. Ravindra	Aga Khan Health Services	Director

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No.	Name	Agency	Function
MINISTRY OF HEALTH - ZANZIBAR			
33	Dr Omar M. Shauri	MOH	Principal Secretary
34.	Dr Uledi Kisumku	MOH	Deputy Principal Secretary
35.	Juma R. Juma	MOH	Director, Preventive Services
36.	Rabia M. Hamdani	MOH	Director, Social Welfare
37.	Mwaka A. Said	MOH	Director, Planning and Administration
38.	Haji A. Bonde	MOH	Ag. Chief Chemist
39.	Sharifa A. Salmin	MOH	Continuing Education Officer
40.	Issa A. Mussa	MOH	Health Development, Policy Planning
41.	Kai B. Mbaruk	MOH	Personnel Unit
42.	Juma A. Juma	MOH	FHR – Project Coordinator
MINISTRY OF FINANCE – ZANZIBAR			
43.	Amina Kh. Shaban	MOF	Deputy Principal Secretary
44.	Hussein S. Khatib	MOF	Commissioner – External Finance
45.	Rashid Kibao	MOF	Commissioner – Budget/Economic Management
46.	Saada M. Salum	MOF	Senior Officer – External Finance
47.	Fatma Gharib	MOF	Financial Analysis – External Finance
CHIEF MINISTER'S OFFICE – ZANZIBAR			
48.	Hon. S. Othman	Chief Minister's State	Hon. Minister of State
49.	Mr Ali R. Juma	Chief Minister's Office	Director, Planning and Administration
UN AGENCIES – ZANZIBAR			
50.	Ibrahim Koroma	UNDP	UNDP Coordinator Officer
51.	Harold Randall	UNICEF	Resident Project Officer
WHO STAFF			
52.	Dr W. Mwambazi	WHO	WR
53.	Dr F. Zawaira	WHO	PHCA
54.	Dr Eileen P-Mshana	WHO	NPO, MPN
55.	Dr C. Atsyor	WHO	EPI
56.	Dr T. John	WHO	NPO, IMCI/RH
57.	Mrs R. Njau	WHO	NPO, Mal
58.	Dr M. Amri	WHO	NPO, DPC
59.	Dr K. Nyamryekung'e	WHO	NPO, HIV/AIDS
60.	Dr Z. Lauwo	WHO	Surveillance Officer – EPI
61.	Ms. Rose Shija	WHO	NPO, EDM
62.	Dr M. Kibona	WHO	Surveillance Officer – EPI
63.	Dr Pyande Mongi	WHO	NPO, IMCI/RH
64.	Mr W. Mntenga	WHO	NPO, HIP
65.	Dr N. Iriya	WHO	NPO, IMCI

Annex 1

CCS Debriefing Meeting with Government/Partners
29th July 2002 – Bwawani Hotel, Zanzibar

No.	Name	Agency	Function
1.	Dr Omar M. Shauri	MOHSW	Principal Secretary/Chairman
2.	Dr H. A. Attas	MOHSW	Ministerial Adviser
3.	Dr Thani Filfil	MOHSW	Director Curative Services
4.	Mwaka A. Said	MOHSW	Director Planning and Admin.
5.	Abdullah S. A.	MOHSW	Programme Manager (Malaria)
6.	Yusuf H. Makame	MOHSW	EPI – Programme Manager
7.	A. H. Juma	MOHSW	Ag. Head Nutrition Unit
8.	Khalfan A. Mohamed	MOHSW	Programme Manager (Filariasis)
9.	Juma. A. Juma	MOH	ADB Project Coordinator
10.	Mohamed Bhaloo	Aga Khan Foundation	Liaison Officer – Zanzibar
11.	Dr Haruni Waziri	SM/MOH	Manager RH Programme
12.	Sharifa A. Salmin	MOHSW	Continuing Education Officer
13.	Jokha Kh. Juma	College of Health Sciences	Academic Officer
14.	Haji Ameir Bonde	MOHSW	Ag. Chief Chemist
15.	Khamis H. Khamis	MOHSW	Training Coordinator
16.	Juma R. Juma	MOH	Director, Preventive Services
17.	Ms. Fatma Balosi	MOH	IMCI Coordinator
18.	Amina Kh. Shaban	MOFEA	DPS
19.	Ali Foum	MOH	Helminth Manager
20.	Mohamed Dahoma	MOHSW	ZACP – In Charge
21.	Mahmoud Mussa	MOHSW	Mental Health Officer
22.	Salum Abubakar	MOHSW	Environmental Officer
23.	Hon. Mwinyihaji Makame	MOHSW	Minister
24.	Uledi Kisumku	MOHSW	Deputy PS
25.	Rabia M. Hamdani	Rep. of SWD	Director
26.	Hassan M. Mcha	Dep. Sub. Abuse	Coordinator
27.	Harold Randall	UNICEF	Resident Project Officer
28.	Dr H. Chwaya	UNICEF	NPO
29.	Sulman M. Selele	MOHSW	TB/Leprosy Coordinator
30.	Mtumwa Kassim	MOH/HE	Manager Health Education
31.	Issa A. Mussa	MOHSW	HD/HDP&L
32.	Ali R. Juma	CMO	DPA

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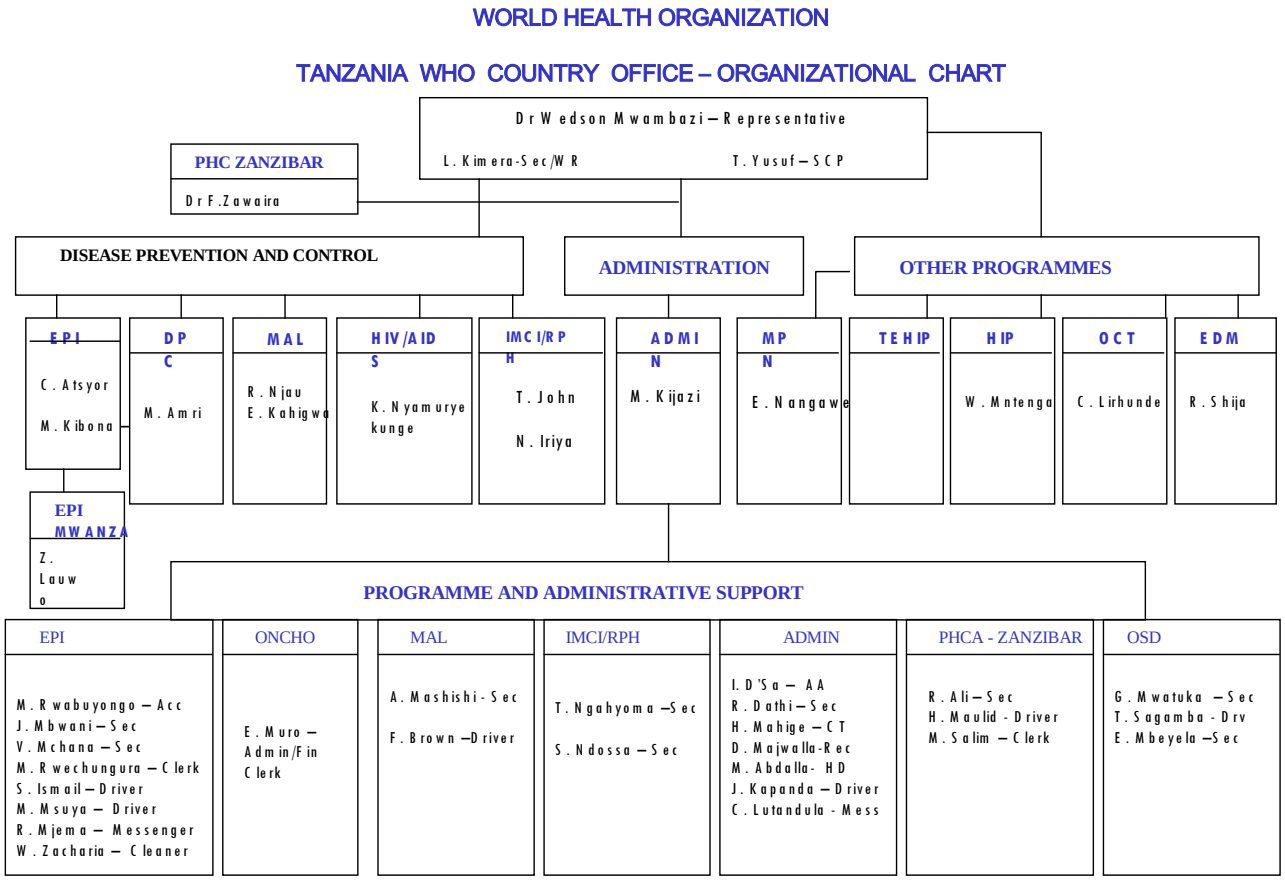
CCS Debriefing Meeting With Government/Partners
30th July 2002 – Sea Cliff Hotel, Dar es Salaam

No.	Name	Agency	Function
1.	Dr G. L. Upunda	MOH	Chief Medical Officer/Chairman
2.	Dr A. Mzige	MOH	Director, Preventive Services
3.	Regina Kikuli	MOH	Ag. Director of Policy Planning
4.	Dr G. Mliga	MOH	Director, Human Resources
5.	Elly F. Ndyetabura	UNDP	Programme Specialist
6.	W. Mntenga	WHO	Programme Officer
7.	Ritha Njau	WHO	Malaria Programme Officer
8.	Rose Shija	WHO	EDM Officer
9.	E. Kahigwa	WHO	Malaria Programme Officer
10.	Theopista John	WHO	IMCI/RH Officer
11.	Dr N. Iriya	WHO	IMCI Officer
12.	E. Mwaikambo	Hubert Kairuki Univ.	Vice Chancellor
13.	M. Kijazi	WHO	Administrative Officer
14.	Dirk Brems	Belgian Embassy	Attache International Cooperation
15.	Dr E. Nangawe	CSSC	Ag. Director
16.	S. B. Buberwa	Planning Commission	Director
17.	M. H. Makame	Irish Aid	Health Advisor
18.	Binagwa Fulgence	CARE	Chief of Party
19.	Dia Timmermans	Royal Netherlands Embassy	Senior Health Advisor
20.	Thor Oftedal	UNFPA	Deputy Representative
21.	Helen Prytherch	GTZ	Technical Assistant
22.	D. Mwisongo	NIMR	Research Scientist
23.	M. Billanov	Save the Children Fund	Director
24.	Dr D. Mbilima	Vice President Office	Civil Servant
25.	Paul Smithson	DFID	Health Advisor
26.	Isiye Ndombi	UNICEF	SPC
27.	Dr Senga K. Pemba	MOH	Health Education

ANNEX 2



WR: WHO Representative; **SWR**: secretary to the WR; **SCP**: Secretary Country Programme; **EPI**: Expanded Programme on Immunization ; **DPC**: Disease Prevention and Control; **MAL**: Malaria Programme; **IMCI**: Integrated Management of Childhood Illnesses; **ADM**: Administration Unit; **PHC**: Primary Health Care; **MPN**: Managerial Process for Health Development; **TEHIP**: Tanzania Essential Health Intervention Project; **HIP**: Health Information and Promotion; **RPH**: Reproductive Health; **OCT**: Occupational Therapy; **EDM**: Essential Drugs and Medicine. This Chart shows both permanent and temporary staff.