United Republic of Tanzania

WHO

Country Cooperation Strategy

2016 - 2020

Table of Contents

Acronyms

CCS	Country Cooperation Strategy
CDC	United States Centers for Disease Control
CSSC	Christian Social Services Commission
CSO	Civil Society Organization
DFID	Department for International Development
DPG	Development Partners Group
FYDP	Five Year Development Plan
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GPW	Global Programme of Work
GSHS	Global School-Based Student Health Survey
HMIS	Health Management Information System
HRH	Human Resources for Health
HSSP	Health Sector Strategic Plan
IHR	International Health Regulations
MDGs	Millennium Development Goals
MKUKUTA	Kiswahili Acronym for the National Strategy for Growth and Reduction of Poverty
MKUZA	Kiswahili Acronym of the Zanzibar Poverty Reduction Plan
MOHCDGEC dren	Ministry of Health, Community Development, Gender Elderly and Chil- (MOHCDGEC)
NCD	Non-Communicable Diseases
NTDs	Neglected Tropical Diseases
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PPP	Public-Private Partnership
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SDGs	Sustainable Development Goals
STEPS	STEPwise approach to surveillance
SWAp	Sector-Wide Approach
TDHS	Tanzania Demographic and Health Survey
TFDA	Tanzania Food and Drugs Authority
THMIS	Tanzania HIV/AIDS and Malaria Indicator Survey
UN	United Nations
UNDAP	United Nations Development Assistance Plan
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Map of Tanzania

Preface

The implementation period for this Country Cooperation Strategy (CCS) will coincide with major developments not only in the United Republic of Tanzania but also globally. At the global level are the Sustainable Development Goals (SDGs) adopted in September 2015 at the United Nations General Assembly, one of which is on health. SDG 3 focuses on ensuring healthy lives and promoting well-being for all at all ages. Health is linked to 14 other SDGs. The SDGs are integrated and indivisible.

Universal Health Coverage is both a goal in itself and the means of achieving the overall health goal of ensuring equitable access to everyone the health services they need with financial protection. Universal health coverage needs to be seen as having an integrating role, underpinning the achievement of the other health targets and creating a balance among them.

Another important development is that the general elections in the United Republic of Tanzania in October 2015 ushered in a new head of state with exceptional vigour to improve the well-being of all Tanzanians. Health service provision was a common thread in the goals of all the political parties involved in the elections. With the country recording relatively strong economic growth and transitioning into a lower middle income status indications are that external development assistance is likely to decline. The new government will be expected to raise its contribution for health services. The United Nations Development Assistance Plan II (UNDAP II) has already shifted its programme focus given the dwindling of resources from its main source of funding for UNDAP I.

The SDGs cover all the priorities in the World Health Organization (WHO) 12th General Programme of Work, 2014–2019. In that context, some of the priorities foreseen for the work of WHO in the United Republic of Tanzania are strengthening of the capacity for early warning; risk reduction and management of national and global health risks in keeping with the provisions of the International Health Regulations (IHR) 2005; tackling non-communicable diseases and the unfinished Millennium Development Goals' agenda; and facilitating better coordination of the work on the social determinants of health.

This CCS will take advantage of all these developments to ensure that WHO contributes to the achievement of the health development objectives of the United Republic of Tanzania.

Dr Matshidiso Moeti

WHO Regional Director for Africa

Executive Summary

The 2016–2020 Country Cooperation Strategy, or CCS III, for the United Republic of Tanzania outlines the vision of the World Health Organization (WHO) for its work in the country over the next five years. It articulates how WHO will contribute to the country's achievement of its objectives for improved health outcomes.

The process for developing this CCS was participatory and was led by the WHO country office and supported by the WHO Regional Office for Africa and WHO headquarters. It involved a desk review of key national documents to determine the progress in the health sector and consultation meetings with selected ministries, departments and agencies within the government; the United Nations country team; development partners; and key academic institutions. The process was underpinned by the principle of country ownership, to reflect the expectations of the government and other stakeholders in the health sector and WHO, and was guided by the Guide for the formulation of a WHO Country Cooperation Strategy, 2014.

Several achievements were made during the implementation of CCS II such as the significant reduction in malaria prevalence – and consequently morbidity and mortality; reduction in child mortality, with the United Republic of Tanzania among the few countries in Africa to attain the Millennium Development Goal (MDG) 4; expansion of routine immunization coverage to above 90% for the oral polio, pentavalent and measles vaccines; and decline in HIV prevalence among adults aged 15–49 years from 7% in 2004 to 5.1%.

Despite these accomplishments, many health objectives are far from accomplishment: maternal mortality has not shown good progress, and at its current level of 410 deaths per 100 000 live births it is far from the MDG target of 193 deaths per 100 000 live births; there is a shortage of health workers throughout the country and the core capacities for the implementation of the International Health Regulations (IHR) 2005 have not been attained; rational use of medicines and ensuring adequate supplies of medicines remain challenges; non-communicable diseases (NCDs) are a major cause of illness and death; a definite shortage of funds exists for the health sector; and the allocation to the health sector of 9–10% of the government budget is below the Abuja target of 15%.

To accelerate the achievement of its health objectives, the government has included the health sector in the Big Results Now initiative, specifically the four key areas of the distribution of the human resources for health (HRH); health commodities; performance management; and maternal, neonatal and child health. Eleven underserved regions are targeted initially, and the other regions will be included gradually. The strategic objectives of the Health Sector Strategic Plan IV, 2015–2020 (HSSP IV) just finalized by the Ministry of Health, Community Development, Gender Elder and Children (MOHCDGEC), identify the broad priorities for the health and social welfare sector, while the strategic directions provide more details on what is intended. The strategic directions were found to be more relevant in determining the WHO strategic priorities.

The agenda for this CCS consists of a set of strategic priorities and focus areas for WHO cooperation with the United Republic of Tanzania. The focus areas detail exactly what WHO will do within each strategic priority. The following are the strategic priorities:

- Reducing the morbidity and mortality caused by communicable diseases through appropriate and effective interventions, including strengthening health systems and addressing environmental issues;
- Reducing the burden of NCDs through health promotion and reduction, prevention, treatment and monitoring of their risk factors;
- Contributing to reproductive, maternal, newborn, child and adolescent health (RMNCAH) and well-being and promotion of health through addressing the social determinants of health;
- Strengthening health systems to improve the quality, equity in access and utilization of health services;
- Providing support for developing the minimum IHR (2005) core capacities and strengthening the capacity to implement disaster risk management.

The strategic priorities will contribute to the achievement of HSSP IV, the United Nations Development Assistance Plan (UNDAP), the SDGs, the global level outcomes in the WHO 12th Global Programme of Work (GPW) and the six WHO leadership priorities. WHO will implement the CCS through biennial work plans.

Chapter 1: Introduction

The World Health Organization Country Cooperation Strategy, 2016–2020 (CCS III) outlines the medium-term framework for WHO cooperation with the Government of the United Republic of Tanzania. The previous two CCS's covered the period 2002–2005 and 2010–2015.

This CCS articulates the vision of WHO regarding how its work in the country will be conducted to best contribute to the improvement of the health status of the population in keeping with the national health development goals. It presents an analysis of the health challenges the country is facing, the solutions as identified by the national authorities and partners and the health priorities that guide WHO support within the framework of its mandate and core functions.

During the development of CCS III, the government was working on the second national Five Year Development Plan (FYDP II) for 2016/17–2020/21, whose theme is "nurturing industrialization for economic transformation and human development". FYDP II succeeds FYDP I of 2011/2012–2015/2016 and the National Strategy for Growth and Reduction of Poverty (MKUKUTA II) covering 2010/2011–2015/2016 that focused more on the growth of infrastructure and social services. CCS III is in line with the focus of FYDP II, which has nine objectives, one of which is to improve the quality of life and human well-being. FYDP II aims, among other things, to lower the under-five mortality rate to about 45 deaths per 1000 live births; maternal mortality to below 250 deaths by 2021, and the prevalence of HIV and AIDS to 3%, and to raise life expectancy at birth to 66 years. It will also ensure that by 2021 access to clean and safe water reaches 85% in the rural areas and 90% in the urban areas. CCS III will support the country through the Ministry of Health, Community Development, Gender Elder and Children (MOHCDGEC) to implement the key interventions aiming at reaching the health objectives.

CCS III is aligned with the Health Sector Strategic Plan IV, 2015–2020 (HSSP IV), and UNDAP, 2016–2020 (UNDAP II). In addition, it reflects the priorities identified in the 12th GPW, 2014–2019 approved by the 66th World Health Assembly in 2013. The activities, monitoring indicators and required resources for implementing the priorities identified for CCS III are detailed in the WHO biennium work plans approved jointly by WHO and national authorities.

The process for developing CCS III included a desk review of relevant documents, including literature on the implementation of CCS II. Data were also collected through questionnaires and in-depth interviews with different categories of staff in the MOHCDGEC and other stakeholders in the health sector. Consultation meetings were held with representatives of selected ministries, departments and other agencies within the government, the UN country team, development partners and key academic institutions. The process was grounded on the principle of country ownership to reflect the expectations of the government and other stakeholders in the health sector and WHO. It was guided by the Guide for the formulation of a WHO Country Cooperation Strategy, 2014.

[1]WHO Country Cooperation Strategy, 2002–2005, Tanzania, WHO, 2001.
[2]WHO Country Cooperation Strategy, 2010–2015, Tanzania, WHO, 2009.
[3]Health Sector Strategic Plan IV, 2015–2020, Ministry of Health and Social Welfare, 2015 (Final Draft)
[4]Twelfth General Programme of Work, 2014–2019: Not merely the absence of disease, WHO, 2014

The CCS III process was led by the WHO country office. It closely followed the development of HSSP IV and UNDAP II, which took place from the last quarter of 2014 to June 2015. On 21 January 2015 the WHO country office made a presentation on the CCS III process at the stakeholders' consultation meeting on the drafting of HSSP IV. The main objectives of the meeting were to integrate inputs from different sources, improve synergies among activities in the health and social welfare sector and fill any gaps in the development of HSSP IV. It also aimed to fully integrate the planned strategies of the Big Results Now initiative into the strategic plan. The CCS III presentation highlighted its development process, the role of its stakeholders in the process and its alignment with HSSP IV. The country office participated in subsequent consultation meetings, including HSSP IV Task Force meetings and the Sector-Wide Approach (SWAp) technical working groups, to ensure that the CCS was in line with the health sector priorities outlined in HSSP IV.

The country office was involved in all the consultation meetings for formulating UNDAP II from January 2015. It participated in the evaluation of UNDAP I, which assessed the delivery of the UNDAP outcomes and their broader contribution to the relevant MKUKUTA II and MKUZA II goals, as well as the advancement of human rights in the country. The process involved national stakeholders within the government, civil society organizations (CSOs) and development partners. The country office was included in the situational analysis in support of UNDAP II in March 2015, which had the overall purpose of identifying and documenting significant achievements and key development challenges and their underlying causes, including capacity gaps, to facilitate agreement on the potential areas for UN support. The final report, entitled Tanzania situation analysis in support of UNDAP II, is available for distribution.

On 26 March 2015 the country office worked with other stakeholders in the UN and the national authorities, which were government ministries, departments and agencies, to formulate the priorities for UNDAP II. Eighteen development challenges in the 11 sectors that are priority for the UN in the United Republic of Tanzania were presented so as to identify 3 priority areas from each sector. The country office participated with other UN implementing partners in identifying development challenges in health and nutrition, HIV/AIDS, water and sanitation, social protection, and disaster risk reduction and emergency preparedness sectors. A number of consultation meetings were then conducted to agree on the priority areas and strategic interventions for UNDAP II. All these processes fed into the development of CCS III.

Following its participation in the HSSP IV and UNDAP II processes and the drafting of the CCS III document, the country office conducted a stakeholders' consultation meeting on 11 August 2015 that involved the ministries of health for the mainland and Zanzibar, government departments and agencies, development partners and CSOs to agree on the strategic priorities and focus areas, so that the country office could move to the next step in the development of the CCS. The health SDG sub-goals, HSSP priorities and UNDAP outcomes were used in the meeting as a reference to determine CCS III's strategic priorities, while the WHO 12th GPW outcomes were used to determine the focus areas.

[5]Tanzania situation analysis in support of UNDAP II, United Nations Tanzania, 2015.

Chapter 2: Health and development situation

2.1 Political, macroeconomic and social contexts

The United Republic of Tanzania comprises Tanzania mainland and Zanzibar. The total surface area is 954 000 km^2. The population is estimated to be 49 253 000, of which 51% are female and 70.4% are rural. The sectors that fall under the management of the union have one ministry, while those such as health that are considered as non-union have two ministries, one each for the mainland and Zanzibar. The WHO country office works with the two ministries, that is the MOHCDGEC on the mainland and the Ministry of Health in Zanzibar.

The administration and management structure of the health services on the mainland follows the geographical boundaries of the regions and districts. The decentralization of the functions through devolution allocates the regions and local government authorities power over decisions on the management of resources within their areas of responsibility. This includes for staff recruitment, procurement, planning, budgeting and financial management. In Zanzibar, for health services management, only the administrative authority has been decentralized through deconcentration; all the other decisions are made at the ministerial level.

The United Republic of Tanzania is a member of African Union and other regional political bodies such as the Southern African Development Cooperation and the East African Community, both of which have a health desk. It is also a member of the Eastern, Central and Southern Africa Health Community.

The United Republic of Tanzania is among the least developed countries but now has a high GDP annual growth rate averaging 7%, and over the past five years has recorded relatively strong economic growth. The per capita income is US$ 950 and the Gini index is estimated at 37.8. The poverty level is estimated at 33.6% for rural areas and 21.7% for urban areas other than Dar es Salaam, where it is 4.2%.The country has a human development index of 0.488, ranking 152 out of 187 countries. With the discovery of gas deposits and the current favourable GDP growth, the country's chances of becoming a middle income country are high. However, about 80% of the economic transactions take place outside the formal sector, meaning that the country faces challenges in raising adequate revenue to meet government expenditure, including provision of health services.

2.2 Social determinants of health

Social determinants of health are the conditions under which people live that shape their daily life. These include factors such as income and wealth and their distribution, early childhood care, education, working conditions, job security, food security, gender-associated influences, social safety nets, and housing, including access to safe water and sanitation. Gender and education inequities greatly influence the health of women

[6]Global Health Observatory, World Health Organization, 2013

and children. In the United Republic of Tanzania, 19% of women have no formal education, almost twice the level for men of 10%. Prevalence for sexual and physical violence against women and children are alarming.

While the United Republic of Tanzania is said to be on track to achieve the Millennium Development Goal on enrolment in primary schools for boys and girls with a net primary enrolment rate of 94%, the school system still struggles to deliver quality education. The country has made little progress in reducing extreme hunger and malnutrition. The 2010 Global Hunger Index considers the situation as alarming. Children in rural areas suffer substantially high rates of malnutrition and chronic hunger, although urban–rural disparities have narrowed for both stunting and under-weight. The World Bank health statistics for 2013 indicate that stunting and under-weight have declined only marginally since 2010, from 42% to 34.7% and 16% to 13.4%, respectively. The challenge of providing clean water persists, and 30% of the population lacks access to clean water. The unemployment rate currently is 10.3%

2.3 Health status of the population

2.3.1 The health system

Health services are organized in a pyramidal structure with the primary care facilities at the base, the district hospitals at the next level, and the referral hospitals, which include regional and national/tertiary hospitals, at the apex. The management of the primary care services and district hospitals is devolved to the local government authorities while regional and national/tertiary hospitals are under the central government. Public and private health care providers are responsible for dispensaries, clinics and health centres. Dispensaries provide preventive and curative outpatient services, while health centres also admit patients and might provide minor surgical services.

At the community level the health services are provided by vertical programmes. Nongovernmental organizations and community-based organizations also are involved in outreach services. The MOHCDGEC is finalizing a training curriculum and training materials for community health workers, based on the community health services guidelines developed in 2013.

2.3.2 Disease burden

The health status of Tanzanians resembles that of their counterparts in most developing countries. Life expectancy at birth is estimated to be 61 years. Communicable diseases and maternal, newborn and childhood illnesses are the main causes of morbidity and mortality. Other common conditions are neglected tropical diseases (NTDs), NCDs and malnutrition.

The United Republic of Tanzania is among the 22 countries in the world with a high tuberculosis burden and it ranks sixth in Africa with case notification reaching 65,732 in 2013.

[7]The World Bank, IBRD-IDA; Tanzania Economic Update, July 2015
[8]Tanzania Household Budget Survey, 2011/12.
[9]Formal Sector Employment and Earnings Survey, 2014 Tanzania Mainland
[10]NBS Tanzania Demographic Health Survey 2010

The country's TB/HIV co-infection rate is estimated to be 37–39%. About 1.4 million people in Tanzania are living with HIV of whom 11% are aged 15–24 years and 58% are women. There has been a steady decline in HIV prevalence, falling from 7% to 5.1% among adults aged 15–49 years between 2003 and 2012. Generally, HIV prevalence among women, at 6.3%, is higher than among men, at 3.9%. The leading route of HIV transmission is heterosexual intercourse, accounting for over 80% of the new infections.

The burden of malaria has declined substantially, with seroprevalence decreasing from 18.1% to 9.5% between 2008 and 2015. Incidence rates on the mainland have also declined, going from 295 to 164 per 1000 population. Zanzibar has retained a malaria prevalence of less than 0.3% over the last five years and has seen a significant decrease in the number of cases and deaths. The incidence rates on the island decreased from 8 to 2 per 1000 population between 2005 and 2015. The decline has been associated with the unprecedented scaling up of long-lasting, insecticide-treated nets; indoor residual spraying; use of artemisinin combination therapies and continual training of health care workers on proper case management. A main challenge for Zanzibar is to prevent the resurgence of malaria.

The present maternal mortality ratio of 410 per 100 000 live births is far too high for the achievement of MDG 5. The main causes of maternal mortality are postpartum haemorrhage, eclampsia, puerperal sepsis and antepartum haemorrhage. Labour obstruction, uterus rupturing and unsafe abortions are contributing factors. Significant gains have been made in reducing infant and under-five mortality but not in neonatal mortality. The mortality rates for under-fives and infants are at 52 and 36 per 1000 live births, respectively. Malaria, malnutrition, pneumonia, diarrhoea, HIV and neonatal conditions account for over 80% of all childhood deaths. Neonatal deaths are mainly associated with low birth weight, premature births, birth injuries and birth asphyxia.

A cholera outbreak that has been active since August 2015 has spread to 23 regions of 30 regions in the country, affecting more than 23, 000 people and causing hundreds of deaths. The outbreak is unusual because it has occupied a vast geographical area within a short period. The pattern of the current outbreak is similar to that of the 1997 outbreak associated with El Niño rains, during which the country's case fatality rate of 2268 deaths from 40 226 cases was among the highest in East Africa.

Road traffic injuries have been on the increase and continue to take lives. Data from the Traffic Department indicate that from January 2011 to June 2015 traffic crashes claimed 16 850 lives and caused 77 735 injuries. Police data indicate that 3468 traffic deaths occurred during 2015 but their accuracy is in doubt since the Global road safety status report shows these to have been 16 000.

[11]Spectrum 2014 Tanzania (HIV Project & Spectrum Report, Tanzania 2014)
[12]Annual NTLP Report 2012 (Natural TB & Legacy Programme)
[13]NBS House Hold Budget Survey 2011/12
[14]National Community Based Health Programme Policy Guidelines, Ministry of Health and Social Welfare, 2013
[15]Global tuberculosis report, World Health Organization, 2013

The United Republic of Tanzania has hosted hundreds of thousands of refugees for decades, primarily from Burundi and the Democratic Republic of the Congo, but also from Somalia and other countries. This has posed serious challenges in providing them health care, education, food, water and sanitation, shelter and security.

According to the World health statistics report, 2015 the United Republic of Tanzania has recorded substantial successes in several programmatic areas but will require sustained efforts to maintain the new levels. Such areas include maternal health, where there has been a substantial reduction in infant mortality and neonatal mortality ratios, HIV and malaria. The neonatal, infant and under-five mortality rates of 21, 36 and 52 per 1000 live births, respectively, surpassed the Africa averages of 31, 60 and 90 per 1000 live births, respectively. Gaps still remain, for example in access to drinking water and sanitation facilities; in reducing malnutrition, which is responsible for resulting in stunting and under-weightiness; and in eliminating tuberculosis. Efforts need to be stepped up to increase access to and utilization of health services to address the high maternal mortality ratio. The densities of physicians, and nurses and midwives remain low at 0.3 and 4.4 per 10 000 population, respectively, and are worse than the regional averages of 2.7 and 12.4, respectively. The annual government expenditure on health remains below the global norm. Outbreaks of disease such as cholera, measles and diarrhoea remain a threat owing to the presence of their risk factors such as poor access to improved drinking water and sanitation, malnutrition, poor antenatal care and poor access to insecticide-treated nets.

2.3.3 Progress in the six WHO leadership priorities

Universal health coverage

The United Republic of Tanzania's health services are built upward from the grassroots level with community health care providers, dispensaries and health centres; then first-level hospitals; and finally regional referral, zonal and national hospitals, with the services provided by each level well defined. Owing to the constraints in human resources and supply of medicines and health products, not all primary health services function well. In certain areas the distance to the health services, especially for maternal and newborn care, is still long. The referral system does not always work as required, sometimes because of the lack of ambulances and other times because the referral level is not able to provide adequate services. Health service utilization is affected also by the high out-of-pocket expenditure, which is estimated at 27%. Only 12% of the population has health insurance. HSSP IV for the mainland, HSSP III for Zanzibar and the health financing strategy all aim to improve the population's access to good quality, equitable, affordable, sustainable and gender-sensitive health services.

[16]Tanzania HIV/AIDS and malaria indicator survey (THMIS), 2011–2012, National Bureau of Statistics, 2013.
[17]Ibid

Unfinished MDGs and the Sustainable Development Goals (SDGs)

The MDGs have remained a high priority in the national development agenda, including in the health sector strategies. There has been good progress in the achievement of health-related MDGs, especially MDG 4 on child survival. The United Republic of Tanzania is among the countries that have attained the MDG 4 target for under-five mortality of 54 deaths or lower per 1000 live births. However, progress has been limited in achieving MDG 5 on the reduction of maternal mortality, which currently is estimated at 410 per 100 000 live births, and MDG 1 on the reduction of childhood stunting, which remains at 35%. Good progress has been made in the reduction of malaria prevalence in children aged 6–59 months, which fell from 18% in 2007 to 10% in 2012 (THMIS, 2012); in the reduction of HIV prevalence in the general population, which declined from 5.7% in 2007 to 5.1% in 2012, and in the improvement of access to antiretrovirals by people living with HIV.

NCDs

NCDs are increasingly becoming a major cause of illness and death in the country, but comprehensive, representative data on them are limited. Health education and health promotion interventions are inadequate to control the risk factors for NCDs and avert their imminent epidemics. The MOHCDGEC has an NCD surveillance programme to monitor the trends in their major risk factors and to support an integrated approach to their reduction at the population level. The STEPwise approach to surveillance (STEPS) survey of 2012/13 showed that 14.1% of the adults on Tanzania mainland were tobacco smokers, 29.3% were alcohol drinkers, and only 2.8% ate the recommended five servings of fruit and/or vegetables on average per day. Furthermore, 26% were overweight, 9.1% had raised fasting blood glucose or were on medication for it, and 26% were hypertensive but more than a half of the were unaware of this.

IHR (2005)

An assessment of the country's core capacities for surveillance and response covering even the points of entry was conducted in 2010 and was followed with the development of annual action plans for core capacity strengthening guided by the annual monitoring reports. This was done in line with the provision of Articles 5 and 13 and Annex 1 of IHR (2005).

In the United Republic of Tanzania, IHR (2005) is implemented through the Integrated Disease Surveillance and Response (IDSR) framework. The country is now embarking on rolling out an electronic IDSR initiative, which will facilitate timely reporting. Improvements have been made in the laboratory capacity to handle IHR (2005) implementation. The national laboratory capacity has been strengthened to facilitate confirmation for Ebola virus disease and Middle East respiratory syndrome coronavirus, including pandemic influenza preparedness. Adherence to biosafety and bio-risk measures is enforced at national, zonal and regional levels through the implementation of the stepwise laboratory quality improvement processes.

[18]Health Sector Strategic Plan IV 2015-2020, Ministry of Health and Social Welfare

At the end of 2014 the United Republic of Tanzania, in collaboration with WHO and using the adapted WHO tool, conducted an assessment of the core capacities at the 13 points. 2 of which were in Zanzibar and 11 on the mainland. The assessment revealed that the core capacities at all the entry points were below the recommended average of 80%. This is a serious gap and will need to be addressed. The country had not attained the required functional capacities for implementing IHR (2005) by the target date of 2014. A formal request to WHO for extension of the period to 2016 was granted.

Increasing access to essential, high-quality, effective and affordable medical products

Zanzibar's Ministry of Health revised the national medicine policy in order to address the pharmaceutical sector's issues under a common framework. The standard treatment guidelines and the national essential medicines lists for the mainland and Zanzibar also were revised to promote the rational use of medicines. The electronic logistic management information system being developed is expected to increase efficiency in procurement and distribution of medicines, reduce wastage and improve availability of medicines at the government health facilities. However, access of medicines from the Medical Stores Department is impaired by the department's liquidity challenges associated with the depletion of its working capital. The government is working on measures to address this problem as specified in the Big Results Now initiative.

The regulatory framework for medicines, cosmetics and medical devices has improved over the years, especially in registration of medicines, licensing and inspection of manufacturers, the distribution process, control of importation and exportation of medicines, authorization of clinical trials, and pharmacovigilance. Challenges still exist, however, with counterfeit products still being marketed and the capacity of the Quality Control Laboratory being low on both the mainland and Zanzibar.

Social, economic and environmental determinants of health

The United Republic of Tanzania has a National Health Promotion Policy Guideline (2014) and its implementation strategy (2015–2020) that outline the actions to address the social determinants of health. HSSP IV advocates for evidence-based interventions and approaches in addressing the social determinants of health. The government has recently renewed its efforts to address the challenges in the education sector and to improve access to clean and safe water through the Big Results Now initiative.

2.3.4 Other government actions to support health services

The Big Results Now initiative is the government programme aimed at establishing a strong and effective system to oversee, monitor and evaluate the implementation of the five-year development plans and programmes and the achievement of the goals of the National Vision 2025 and MKUKUTA. Besides health, the sectors prioritized are education, infrastructure, water and agriculture. The initiative hinges on the principles of prioritization of sectors based on their impact, use of detailed monitoring tools, and

[19]Levels and Trends in Child Mortality, UN Inter-agency Group for Child Mortality Estimation, 2013
[20]Trends in Maternal Mortality: 1990-2013 Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division,
[21]World Health Organization, 2014

accountability for performance. The MOHCDGEC has prioritized the four key areas of distribution of human resources for health (HRH), health commodities, performance management, and maternal, neonatal and child health. The 11 regions to be targeted initially are Coast, Katavi, Kagera, Geita, Simiyu, Singida, Tabora, Shinyanga, Mara, Mwanza and Kigoma. These are considered the most underserved regions. The programme will be rolled out to the other regions gradually.

Apart from the four Big Results Now initiative key areas, HSSP IV has prioritized the following strategic directions:

- Investing in health promotion interventions that give emphasis to multisectoral approaches;
- Strengthening reproductive, maternal, neonatal, child and adolescent health (RMNCAH) services through a strengthened health system;
- Maintaining a high level of performance for disease control programmes and improving their integration;
- Focusing on community-based interventions; health promotion; and screening, early treatment and rehabilitation for the control of NCDs;
- Advocating for intersectoral action and active engagement in partnerships in addressing the social determinants of health;
- Collaborating with other ministries, departments and agencies in putting in place systems and structures for facilitating immediate response to crises using the modern means of communication;
- Further decentralizing social welfare by establishing a full-fledged department under the local government authorities.

2.4 Development cooperation and the United Republic of Tanzania's role in the global health agenda

2.4.1 Development cooperation and partnerships

The Joint Assistance Strategy for Tanzania is the national medium-term framework for managing collaboration between the government and development partners to achieve the national development and poverty-reduction goals. The strategy also defines the roles of non-state actors. It is harmonized with the country's international commitments and initiatives in aid effectiveness such as the Paris Declaration (2005).

The WHO country office, UN agencies, development partners, faith-based organizations and other stakeholders, and government ministries, departments and agencies work with the MOHCDGEC through the SWAp framework and guided by a memorandum of understanding. The technical committee for SWAp is multisectoral with representation from the MOHCDGEC, the Prime Minister's Office, regional authorities, the local

government, the Ministry of Finance, development partners, the Christian Social Services Commission, the Association of Private Health Facilities in Tanzania and representatives from CSOs. The implementation milestones are determined by the SWAp technical committee and approved by the SWAp policy meeting held once a year, at which the senior officials from the technical member institutions participate. The SWAp technical working groups monitor the implementation of the programmes and identify new areas for interventions. Annual and mid-term reviews evaluate progress towards the milestones and HSSP, respectively. The outcomes from mid-term reviews are utilised to develop the subsequent HSSP.

The development partners use several mechanisms to fund the health sector, some of them going directly through general budget support and others through the Health Basket Fund or projects. Global health initiatives such as the GAVI Alliance, the Global Fund for AIDS, Tuberculosis and Malaria and the United States Government provide funding for immunization, HIV/AIDS, tuberculosis and malaria programmes as well as supporting health systems strengthening. Funding by WHO is delivered to programmes and to health systems strengthening. The WHO country office participates in the key decision-making bodies' activities such as the technical working group meetings, extended MOHCDGEC management meetings, joint annual health sector reviews, technical committee for SWAp meetings, SWAp policy meetings and the Development Partners Group for health's (DPG-Health) activities. Even though the development partners collaborate through the SWAp framework, each of them operates in specific programmatic areas according to their specific niche, capacity and mandate (see Annex 2). More partners support programmes such as malaria, HIV, RMNCAH, HRH and health financing than other areas. NCDs and emergency preparedness have received little attention, and advocacy and resource mobilization will be required to ensure they receive funding support.

WHO's comparative advantage is in providing technical assistance and policy advice. Lately, support for implementing IHR (2005), handling disease epidemics, assessing the national capacities for disaster risk reduction and developing a road map for their improvement, advocating for NCDs, and mobilizing resources through the global health initiatives has come to the fore. WHO is a source of information on global health issues, best practices, health financing, human resource planning, and availability of health expertise internationally.

2.4.2 Collaboration with the UN system

The UN agencies and programmes in the United Republic of Tanzania developed and implemented UNDAP I, which ended in June 2016. They also developed UNDAP II, whose implementation began in July 2016. The agencies are committed to Delivering as One through harmonizing their programmes and human and financial resources. This avoids duplication and allows focusing on areas where they have the most impact. The programmes implemented through UNDAP I covered the 10 sectors of economic growth, environment, education, health and nutrition, HIV/AIDS, WASH, social protection, governance, emergencies, and refugees. Each sector programme was managed by a sector working group with one of the UN agencies identified as the

lead. The UN agencies that are involved in the health and nutrition programme working group are the United Nations Children's Fund (UNICEF), World Food Programme, United Nations Population Fund (UNFPA), UN-REACH and WHO. WHO has been playing the lead agency role for health and nutrition and also participating in social protection, HIV/AIDS, emergencies and WASH working groups.

The development of UNDAP II drew lessons from the evaluation of UNDAP I. One critical recommendation from that evaluation was for the UN to use its resources to demonstrate to the local government authorities how to solve problems using evidence and to plan for long-term sustainability. This was the basis for the inception by WHO of the Peer Learning Districts initiative, which has helped districts realize positive results through supportive supervision and peer learning. UNDAP II focuses on four thematic areas: inclusive growth, democratic governance, healthy nation and resilience.

2.4.3 The United Republic of Tanzania's contribution to the global health agenda

The United Republic of Tanzania actively participates in many global health governance forums such as the WHO Regional Committee for Africa, the World Health Assembly and the African Union health ministers' conferences. It has a health attaché in its Geneva embassy to closely follow issues related to health at WHO.

The United Republic of Tanzania was involved in the development of the UN Global Strategy on Women's and Children's Health, and its president and the Prime Minister of Canada were appointed co-chairs of the Commission on Information and Accountability for Women's and Children's Health established by the UN Secretary General following the adoption of the strategy. The commission, whose work was finalized in May 2011, came up with 10 key recommendations for improving the health of women and children. It emphasized that countries should develop effective ways of gathering important health data to be used for informed decision-making and a coordinated system for tracking health spending on women and children. It recommended establishing national and global oversight structures to strengthen the feedback mechanisms that support continuous improvement in the delivery of health services for women and children.

The president of the United Republic of Tanzania was appointed by the UN Secretary General to chair the High-level Panel on Global Response to Health Crises. He also chaired the African Leaders Malaria Alliance, and subsequently Dar es Salaam provided a home for the offices of the alliance's secretariat.

Through initiatives supported by WHO and other partners, the country has generated lessons that have been used at the global level, for example in primary health care; directly observed treatment short course for tuberculosis, including integrated community tuberculosis care and TB/HIV ENGAGE-TB approach; and development of the costing tool for a comprehensive cervical cancer strategy.

2.5 Health sector challenges

The United Republic of Tanzania's health sector is severely underfunded. The country spends about US$ 44 per capita in health care, which is low compared with the US$ 54 per capita recommended for developing countries by the high level Taskforce on Innovative International Financing for Health Systems. About 48% of the total expenditure on health is donor support. The fragmentation of health financing without mandatory prepayment mechanisms contributes to the high out-of-pocket expenditure, impeding progress towards universal health coverage. The utilization of funds during the implementation of CCS II was low, averaging 60–77%. This resulted from the changes in financial management instituted by WHO on the use of the Global System Management that took time for the government to get used to.

There is a widespread shortage of qualified health workers of about 50–70% at all levels, which is more severe in rural districts and is exacerbated by the increasing burden of disease. Similarly, disparities exist in the distribution of human resources between urban and rural areas.

Essential medicines and health technologies are frequently out of stock at the Medical Stores Department on the mainland, the Central Medical Stores in Zanzibar and the health facilities. The local pharmaceutical manufacturing base is weak. The medicines' regulatory frameworks, although improving, face challenges with regard to the human resource capacity and the quality of medicines and other health products.

The United Republic of Tanzania is still far from achieving MDG 5, and it has to sustain the gains in MDG 4 and address the inequities at the district level in child health interventions. The MDGs are still relevant, and there is a critical need to get well prepared for the SDGs. Also, the integration of gender equality and human rights into health programmes is weak. This may manifest in disease trends amongst women and other vulnerable groups including socioeconomically disadvantaged people.

Capacity for implementing IHR (2005) has not been fully built. For example, capacity for organized, quick response to emergencies and epidemics is not quite in place. The threat of the emerging epidemics and the re-emergence of diseases such as influenza, Ebola, dengue fever and other haemorrhagic fevers require this CCS to take that into account to ensure that the country has the capacity to respond to such emergencies. The country has committed to work with the WHO country office and other partners to strengthen IHR (2005) core capacities, humanitarian emergency response and implementation of the Africa Regional Disaster Risk Management Strategy.

The growing double burden of communicable and non-communicable diseases poses a serious threat and a burden to the health sector. This CCS is expected to ensure that capacity is built and advocacy is carried out for effective NCD prevention and control strategies, including those related to the social determinants of health.

Though most WHO partners acknowledge its mandate for global health and the value of its knowledge, technical expertise and global information on health, they do not seem to weigh these as favourably as they do its financial contribution.

Chapter 3: Review of the WHO cooperation in the last CCS cycle

The cooperation between the WHO country office and the country during the CCS II cycle was effective in supporting the country in its quest to achieve the MDGs. It involved the implementation of the four strategic agenda priorities and ten strategic priorities defined in that CCS. The review of the CCS II cycle was undertaken through a consultation process with government officials from the MOHCDGEC, the President's Office Regional Administration and Local Government and other government departments, development partners and UN agencies. The review used key informant interviews, stakeholder consultation sessions, mid-term review of HSSP III outcomes, WHO country office annual reports and the relevant national documents. The country office also actively participated in UNDAP I evaluation, which included a review of WHO work during that period. The report, entitled Tanzania situation analysis in support of UNDAP II, provides detailed information on this. The findings of CCS II review, including the key achievements, the lessons learnt and the challenges, have been used as inputs for the development of the strategic agenda for 2016–2020.

The strategic priorities were implemented in accordance with the WHO programme and budget cycles for 2010–2015. In the 2014/15 biennium there were 51 staff in the country office, among whom 52% were professional with expertise on public health, disease control and management, health systems development, monitoring and evaluation, etc. Administrative and management support was provided by the transformed country support unit, which enabled the country office to provide effective technical support for the 10 strategic priorities for CCS II. Overall, actual expenditure totalled 88% of the funds allocated. There were delays in funds disbursement owing to MOHCDGEC's failure to submit Direct Financial Cooperation reports on time. Technical expertise from the WHO Regional Office for Africa and the headquarters was called upon as necessary to fill gaps.

Several achievements were realized with regard to Strategic agenda 1: Strengthening the health system and service delivery. Technical support was provided to develop key national documents to strengthen the capacity of the health system. These included the Human Resources for Health Production Plan, 2014–2024; Tanzania Health Financing Strategy; Monitoring and evaluation framework of the Health Sector Strategic Plan III, 2014–2019 for Zanzibar; National medicine policy; Tanzania Pharmaceutical Manufacturing Plan of Action, 2014–2018 for the mainland; Community health workers' policy guideline and the Health Sector Strategic Plan IV.

The country office supported the capacity building efforts for health workers to improve their skills and knowledge in health care management and rational use of medicines. Other actions to enhance capacity were training in public expenditure analysis and review and national health accounts reporting; improving the delivery of health services through skill development and provision of equipment for RMNCAH, computers for the health management information system (HMIS) and electronic logistics management information systems; and improving the referral system.

[22]Tanzania National Nutrition Survey, Tanzania Food and Nutrition Centre, Ministry of Health and Social Welfare, 2014
[23]Health Sector Strategic Plan III 2009–2015, Ministry of Health and Social Welfare

With regard to Strategic agenda 2: Supporting national priority programmes, the country office supported the development of the RMNCAH road map and the Sharpened One plan for accelerating the reduction of maternal, newborn and child mortality. It contributed to the achievement of MDG 4 on reduction of child mortality through supporting immunization, integrated management of childhood illnesses, prevention of mother to child transmission (PMTCT) of HIV, and reduction of malaria morbidity and mortality by deployment of correct interventions and supporting emergency obstetric and neonatal care services.

The National Comprehensive and Integrated NTD Master Plan, 2012–2017 was developed and launched with a good partnership involving the government and international and national stakeholders involved in NTDs. The country office supported epidemic preparedness and response efforts through developing the second generation Integrated disease surveillance and response guidelines. Support was provided in building core capacities for implementing IHR (2005) and developing IHR (2005) action plan for 2014–2016, as well as for disease outbreak preparedness, prevention and control.

The achievements in implementing Strategic agenda 3: Supporting actions on social determinants of health, include the promotion of food safety and reduction of malnutrition through developing a national nutrition strategy and a national food safety policy. Support was provided also to the MOHCDGEC to assess the magnitude of NCDs in the country through facilitation of STEPS and global school-based student health surveys. The MOHCDGEC was supported to integrate gender equality and human rights aspects into health programmes through developing the national clinical management guidelines for the health sector's response to gender-based violence.

In implementing Strategic agenda 4: Supporting partnership for health development, the country office, as a member of the UN country team and a broker for health development, collaborated effectively with UN agencies to lead and coordinate the operation of the UNDAP Health and Nutrition Programme Working Group for 2011–2015 in health-related outcomes. The country office also contributed to the coordination of DPG-Health as its secretariat, to support the health sector priorities outlined in HSSP III and the development of HSSP IV.

The country office mobilized resources individually and in cooperation with other partners and UN agencies to support the implementation of the health sector priorities. These included resources for scaling up nutrition interventions, strengthening surveillance systems and implementing UNDAP I. The office cooperated with DPG-Health to mobilize resources for implementing HSSP III and developing HSSP IV. It played a strong role in enabling the country to get access to funding through the Global Fund, GAVI Alliance and RMNCAH Fund, as well to manage and implement grants.

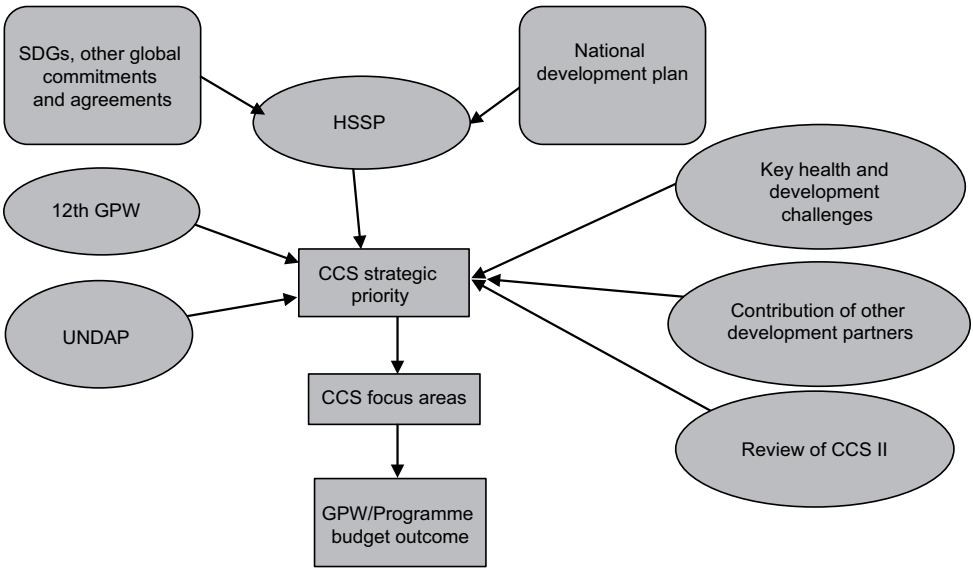
Abiding by the principles of the Paris Declaration on Aid Effectiveness, the country office collaborated with the MOHCDGEC and partners in harmonizing the work of the health sector under the SWAp framework, contributing to the work of the SWAp technical working groups to reach the agreed annual health sector milestones and establish monitoring and evaluation targets for HSSP III through mechanisms such as the joint annual health sector review, mid-term review and external joint evaluation.

The internal and external reviews undertaken with stakeholders on the WHO role as a development partner in the health sector reverberated the recognition of its role as the custodian of global health standards, norms, protocols and guidelines; its mandate in guiding countries in IHR (2005); as the source of evidence-based information on global health and documentation on best practices on health interventions, including health research and health financing; and as a resource for provision of technical assistance with its varied health expertise. Furthermore, they pointed out that as a neutral broker, WHO could provide objective and unbiased guidance in resolving health matters. However, the stakeholders pointed at various areas where WHO could improve. At the country level, WHO has not adequately been engaged in addressing the social and economic determinants of health, human rights, or gender and equity issues in spite its well-articulated guidelines in these areas. Some partners attributed this to the inadequate level of technical staff at the country office to undertake and expand the work. The stakeholders also suggested that it was important for WHO to join the Basket Fund Committee as other UN organizations had done, including UNFPA and UNICEF.

Chapter 4: Strategic agenda for WHO cooperation with the United Republic of Tanzania

The strategic agenda consists of a set of priorities and CCS III focus areas for WHO cooperation with the country. The CCS strategic priorities constitute what will be the medium-term priorities for the cooperation. WHO will concentrate most of its resources over the CCS III cycle to support these areas. The strategic priorities will contribute to the achievement of the HSSP IV objectives. The CCS focus areas contain details on what exactly WHO will do within each strategic priority. Besides HSSP, they will also contribute to UNDAP; SDGs; the Sendai Framework for Disaster Risk Reduction, 2015–2030; the global level outcomes in the 12th GPW and the six WHO leadership priorities (see Figure 1).

Figure 1: Inputs for CCS III strategic agenda



4.1 CCS III strategic priorities and focus areas

Five strategic priorities were identified and agreed on for CCS III by the national stakeholders to be addressed during the implementation of Zanzibar's HSSP III and the mainland's HSSP IV. Several challenges within the health sector identified in the mid-term review of the mainland's HSSP III and during the development of HSSP IV led to the definition of the priorities, which are as follows:

- Reducing the morbidity and mortality caused by communicable diseases through appropriate and effective interventions, including strengthening health systems and addressing environmental issues;
- Reducing the burden of NCDs through health promotion and reduction, prevention, treatment and monitoring of their risk factors;
- Contributing to RMNCAH and well-being and promotion of health through addressing the social determinants of health;
- Strengthening health systems to improve the quality, equity in access and utilization of health services;
- Providing support for developing the minimum IHR (2005) core capacities and strengthening the capacity to implement disaster risk management.

Table 1 shows how the CCS III strategic priorities are related to the WHO leadership priorities.

Table 1: CCS III strategic priorities' linkage with the WHO leadership priorities

CCS strategic priorities	WHO leadership priorities
Reducing the morbidity and mortality caused by communicable diseases through appropriate and effective interventions, including strengthening health systems and addressing environmental issues	Unfinished health-related MDGs and SDGs
Reducing the burden of NCDs through health promotion, and reduction, prevention, treatment and monitoring of their risk factors	NCDs
Contributing to RMNCAH and well-being and promotion of health through addressing the social determinants of health	Unfinished health-related MDGs and SDGs; Action on social, economic and environmental determinants of health;

Strengthening health systems to improve quality, equity in access and utilization of health services	Universal health coverage
Providing support for developing the minimum IHR (2005) core capacities and strengthening the capacity to implement disaster risk management	IHR (2005)

In the process of developing CCS III we recognized that SDG 3 was specifically related to health and its targets were close to the CCS's strategic priorities. SDGs 5, 6 and 13 are related to CCS III's strategic priority on RMNCAH and environmental health, and SDG 1 is related to the CCS's strategic priority on NCDs. The linkage between CCS III's strategic priorities and the SDG 3 targets is shown in the Table 2.

Table 2: CCS III strategic priorities' linkage with SDGs

SDG 3 targets	**CCS strategic priorities**
By 2030, end the epidemics of AIDS, tuberculosis, malaria and NTDs and combat hepatitis, water-borne diseases and other communicable diseases	Reducing the morbidity and mortality caused by communicable diseases through appropriate and effective interventions, including strengthening health systems and addressing environmental issues
By 2030, reduce by one third premature mortality form NCDs through prevention and treatment and promote mental health and well-being Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol	Reducing the burden of NCDs through health promotion, and reduction, prevention, treatment and monitoring of their risk factors

By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes. By 2020, halve the number of global deaths and injuries from road traffic accidents By 2030, substantially reduce the number of deaths and illness from hazardous chemicals and air, water and soil pollution and contamination	Contributing to RMNCAH and well-being and promoting health through addressing the social determinants of health
Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all	Strengthening health systems to improve the quality, equity in access and utilization of health services
Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	Providing support for developing the minimum IHR (2005) core capacities and strengthening the capacity to implement disaster risk management

The UNDAP outcomes that WHO will accomplish with other implementing UN agencies through the Delivering as One initiative also are linked with CCS III's strategic priorities (see Table 3).

Table 3: CCS III strategic priorities' linkage with UNDAP outcomes

UNDAP outcomes	CCS strategic priorities
Improved, scaled up and equitable use of proven HIV prevention, treatment, care and support interventions	Reducing the morbidity and mortality caused by communicable diseases through appropriate and effective interventions, including strengthening health systems and addressing environmental issues
Increased coverage of equitable, quality and effective nutrition services among women and children under five	Reducing the burden of NCDs through health promotion, and reduction, prevention, treatment and monitoring of their risk factors
Improved access to equitable, acceptable and affordable quality health services	Strengthening health systems to improve quality, equity in access and utilization of health services
Increased coverage of comprehensive and integrated social protection (interventions and services) for the poor and vulnerable Vulnerable groups have increased access to safe and affordable water supply sanitation and hygiene	Contributing to RMNCAH and well-being and promoting health through addressing the social determinants of health
Improved environmental, natural resources and disaster risk management	Providing support for developing the minimum IHR (2005) core capacities and strengthening the capacity to implement disaster risk management

The HSSP priorities are related to SDGs, they influenced the definition of the UNDAP outcomes and they are linked to the CCS III strategic priorities (Table 4).

Table 4: CCS III strategic priorities' linkage with HSSP priorities

HSSP priorities	CCS III strategic priorities
The health system will maintain the high level of performance of disease control programmes, reduce morbidity and mortality caused by infectious diseases while increasing efficiency through improved integration of activities.	Reducing the morbidity and mortality caused by communicable diseases through appropriate and effective interventions, including strengthening health systems and addressing environmental issues
On NCDs the country will focus on community-based prevention, health promotion, screening and early treatment, as well as rehabilitation.	Reducing the burden of NCDs through health promotion, and reduction, prevention, treatment and monitoring of their risk factors
The health system will be strengthened to provide quality services, which will contribute to achieving the goal of ending preventable maternal, newborn and child deaths and ensure universal access to sexual and reproductive and adolescent health services, and the health sector will advocate for intersectoral action and actively engage in partnerships in addressing the social determinants of health, including implementation of the approach.	Contributing to RMNCAH and well-being and promote health through addressing the social determinants of health
Council health services will constitute the backbone of the health services, and will provide the national essential health care intervention package (NEHCIP) while guaranteeing quality (3-star rating) and transparency (social accountability), and will sensitize the population to enrol in the single national health insurance and take part in management of council health services.	Strengthening the health system to improve quality, equity in access and utilization of health services
MOHCDGEC (in collaboration with other ministries, departments and agencies) will put systems and structures in place to be able to respond immediately to health related crises and epidemics, using modern means of communication to ensure global health	Providing support for developing the minimum IHR (2005) core capacities and strengthening the capacity to implement disaster risk management

The CCS III strategic priorities are consistent with the WHO 12th GPW and its focus areas have a one-to-one link with the GPW's outcomes (Table 5).

Table 5 CCS III strategic priorities and focus areas with its linkage to WHO General Programme of Work

Country Cooperation Strategy		WHO General Programme of Work Results Chain	
Strategic priorities	**Focus areas**	**GPW/Programme budget outcomes**	
Reducing the morbidity and mortality caused by communicable diseases through appropriate and effective interventions, including strengthening the health systems and addressing environmental issues	Strengthened intersectoral capacities for the management of environmental threats to health	Increased access to key interventions for people living with HV	Category 1
		Increased number of successfullly treated tuberculosis patients	
	Increased access to prevention, diagnostics, care, treatment and interventions for uberculosis, HIV and malaria	Increased access to first-line antimalarial treatment for confirmed malaria cases	
		Increased and sustained access to essential medicines for NTDs	
	Increased and sustained access to safe and quality essential medicines for NTDs	Increased vaccination coverage for hard-to-reach populations and communities	
Reducing the burden of NCDs through health promotion, and reduction, prevention, treatment and monitoring of their risk factors	Increased evidence to use for advocacy, leadership and multisectoral response on injuries, with a focus on risk factors, road safety, child injuries, and violence against children women and youth	Increased access to interventions to prevent and manage NCDs and their risks	Category 2
		Increased access to services for mental health and substance use disorders	
	Increased access to interventions to prevent and manage NCDs and monitoring of their risk factors	Reduced risk factors for violence and injuries with a focus on road safety, child injuries and violence against children, women and youth	
		Increased access to services to people with disabilities	
	Improved capacity for surveillance and interventions for reduction of nutritional risk factors	Reduced nutritional risk factors	
Contributing to RMNCAH and well-being and promoting health through addressing the social determinants of health	Increased access to high quality, reproductive, maternal, newborn, child and adolescent health interventions	Increased access to interventions for improving health of women newborns, children and adolescents	Category 3
		Increased proportion of older people who can maintain an independent life	
	Increased vaccination coverage for hard-to-reach populations and communities	Gender, equity and human rights integrated into the Secretariat's and countries' policies and programmes	
	Enhanced capacity for intersectoral collaboration to address the social determinants of health	Increased intersectoral policy coordination to address the social determinants of health	
Strengthening the health system to improve quality, equity in access and utilization of health services	Strengthened capacity to develop and implement appropriate policies and legislation for HRH planning, management, production and retention, and to adopt innovative health financing that ensures increased quality, access and equity of health services	Reduced environmental threats to health	Category 4
		All countries have comprehensive national health policies, strategies and plans updated within the last five years	
	Built capacity of the civil registration and vital statistics systems, including to support the strengthening of HMIS reviews, assessments, research and evaluation, to generate evidence for policy	Policies, financing and human resources are in place to increase access to people-centered, integrated health services	
		Increased access to and rational use of safe, efficacious and quality medicines and heath technologies	
	Increased access to, and rational use of, safe, efficacious and quality medicines and health technologies	All countries have properly functioning civil registration and vital statistics system	
Providing support for developing the minimum IHR (2005) core capacities and strengthening the capacity to implement disaster risk management	Built core capacities required for IHR (2005) in MOHSW and the local government authorities for all-hazard alert and response	All countries have the minimum core capacities required by IHR (2005) for all-hazard alert and response	Category 5
		Increased capacity of countries to build resilience and adequate preparedness to mount a rapid, predictable and effective	
	Increased capacity to manage health risks of emergencies and build resilience, including and preparedness for rapid and effective response to health-related disasters and emergencies and major epidemics and pandemics using the One Health approach	Countries have the capacity to manage public health risks associated with emergencies	
		All countries are adequately prepared to prevent and mitigate risks to food safety	
	Strengthened surveillance systems to identify paralysis due to wild poliovirus or type-2 vaccine-related poliovirus	No cases of paralysis due to wild or type-2 vaccine-related poliovirus globally	

4.2 Strategic actions for the implementation of CCS III

For WHO to respond to the country's priorities and needs, the agreed strategic priorities and focus areas will need to be accomplished through strategic actions. These strategic actions will lead to the outcomes stated in the focus areas, which in turn will contribute to the achievement of the strategic priorities.

Strategic priority 1: Reducing the morbidity and mortality caused by communicable diseases through appropriate and effective interventions, including strengthening the health system and addressing environmental issues

Focus area 1: Strengthened intersectoral capacities for the management of environmental threats to health

Country office strategic actions

- Develop and implement national policies, plans and strategies for the prevention, mitigation and management of the health impacts of environmental and occupational risks;
- Strengthen the capacity to prevent and manage the health impacts of poor water, sanitation, and hygiene;
- Monitor the status of water supply and sanitation to enable better planning and management of WASH interventions.

Focus area 2: Increased access to prevention, diagnostics, care and treatment and interventions for tuberculosis, HIV and malaria

Country office strategic actions

- Adapt and implement global policies, strategies, guidelines and recommendations on HIV, tuberculosis and malaria to ensure equitable coverage of the prevention, treatment, care and support services;
- Strengthen capacity in HIV, tuberculosis and malaria case diagnosis, management, monitoring and evaluation;
- Coordinate proposal development and local resource mobilization initiatives for HIV, tuberculosis and malaria programming.

Focus area 3: Increased and sustained access to safe and quality essential medicines for NTDs

Country office strategic actions

- Facilitate increased and sustained access to safe and quality NTD medicines through the WHO joint drug request, review and reporting mechanisms;
- Facilitate monitoring and reporting in preventive chemotherapy and intensified NTD management interventions and assess their impact;
- Innovate and create evidence on best practices related to integrated NTD control and elimination to inform programme management and planning.

Strategic priority 2: Reducing the burden of NCDs through health promotion, prevention, treatment and monitoring of their risk factors

Focus area 1: Increased evidence to use for advocacy, leadership and multisectoral response on injuries, with a focus on risk factors, road safety, child injuries and violence against children, women and youth

Country office strategic actions

- Support evidence generation and dissemination for advocacy on a multisectoral response to prevent injuries and violence;
- Support capacity building and implementation of multisectoral plans and programmes to prevent injuries, with a focus on achieving the targets of the United Nations Decade of Action for Road Safety, 2011 - 2020.

Focus area 2: Increased access to interventions to prevent and manage NCDs and monitoring of their risk factors

Country office strategic actions

- Convene multisectoral dialogues on policy options for the prevention and control of NCDs in line with the WHO Global Action Plan for the Prevention and Control of NCDs, 2013–2020 and the regional strategies, plans and frameworks;
- Develop and implement national plans, strategies and guidelines to reduce modifiable risk factors for NCDs, which are tobacco use, diet, physical inactivity and the harmful use of alcohol, as well as promoting mental health;
- Strengthen health care services for the management of cardiovascular diseases, cancer, diabetes and chronic respiratory diseases;
- Facilitate monitoring of NCD trends and related risk factors, including implementation of the WHO STEPS, global adult tobacco, global youth tobacco and global school-based student health surveys.

Focus area 3: Improved capacity for surveillance and interventions for reduction of nutritional risk factors

Country office strategic actions

- Enhance the capacity for the implementation of comprehensive action plans to support maternal, infant and young child nutrition;
- Adapt norms, standards and policy options for promoting cost-effective interventions to address the double burden of malnutrition;
- Build capacity for nutrition surveillance and monitoring.

Strategic priority 3: Contribute to RMNCAH and well-being and promote health through addressing the social determinants of health

Focus area 1: Increased access to high quality, reproductive, maternal, newborn, child and adolescent health interventions

Country office strategic actions

- Build the capacity for coordination and planning of RMNCAH interventions and for monitoring their progress, including for their annual reviews;
- Strengthen the implementation of policies, norms, standards and guidelines for RMNCAH;
- Build the capacity for provision of quality RMNCAH services in selected districts, through training, supervision, mentorship and provision of essential equipment and supplies.
- Strengthen the capacity for mainstreaming gender, equity and human rights into health programmes, plans and services.

Focus area 2: Increased vaccination coverage for hard-to-reach populations and communities

Country office strategic actions

- Implement activities related to the Reaching Every Child approach to ensure that all eligible children have access to and utilize immunization services;
- Strengthen the capacity in surveillance for vaccine-preventable diseases and in the use of immunization data for programme monitoring, reporting and response.

Focus area 3: Enhanced capacity for intersectoral collaboration to address the social determinants of health

Country office strategic actions

- Convene intersectoral dialogues to advocate for the implementation of social determinants to health approaches that promote governance in other sectors that positively impact on human health;
- Foster the application of approaches, guidelines and tools for mainstreaming the social determinants of health within programmes, policies and strategies.

Strategic priority 4: Strengthening health systems to improve quality, equity in access and utilization of health services

Focus area 1: Strengthened capacity to develop and implement appropriate policies and legislation for HRH planning, management, production and retention, and to adopt innovative health financing that ensures increased quality, access and equity of health services

Country office strategic actions

- Adapt and implement the WHO global strategy on people-centred and integrated health services, taking into account the global strategy on human resources for health;
- Build processes for equitable staff distribution and retention, and for maintenance of high performance standards for skilled staff to improve the quality of health services;
- Provide support for the implementation of the Human Resources for Health Strategic Plan, 2014–2019 and the Human Resources for Health Production Plan, 2014–2024.
- Advocate for health financing policies to ensure progress towards universal health coverage with a focus on financial protection, including for the adoption of the health financing strategy;
- Provide support for the implementation of the health financing strategy, including efforts to institutionalize health financing reforms through aligning health financing with the national public finance management and budget processes;
- Strengthen the institutional capacity to analyse, develop and implement health financing policies that incorporate lessons learnt from other countries.

Focus area 2: Built capacity of the civil registration and vital statistics systems, including to support the strengthening of HMIS reviews, assessments, research and evaluation, to generate evidence for policy

Country office strategic actions

- Advocate for the provision of effective tools and allocation of sufficient resources to strengthen the national, regional and district health information systems;
- Develop and implement strategies and action and investment plans for health information, civil registration and vital statistics;
- Build capacity and partnerships in developing and implementing the national eHealth strategy;
- Identify capacity strengthening needs and provide support in areas of governance for health research, health systems research and research ethics.

Focus Area 3: Increased access to, and rational use of safe, efficacious and quality medicines and health technologies

Country office strategic actions

- Revise and implement the national policies on contemporary, traditional and complementary medicines and other health technologies and foster their rational use, as well as optimize the use of antimicrobials and combat antimicrobial resistance;
- Build the capacity of the procurement and supply management systems and for the implementation and monitoring of the global strategy and plan of action on public health, innovation and intellectual property rights;
- Strengthen the national regulatory authorities for medicines, medical devices, biologicals and other health technologies.

Strategic priority 5: Providing support for developing the minimum IHR (2005) core capacities and strengthening the capacity to implement disaster risk management

Focus area 1: Built core capacities required for IHR (2005) in MOHCDGEC and local government authorities for all-hazard alert and response

Country office strategic actions

- Develop and implement a framework for the national focal point and enhance its capacity to coordinate and develop a guiding document for stakeholders to play their roles effectively;

- Establish a system of surveillance for hospital-acquired infections and antimicrobial resistance;
- Improve the diagnostic and confirmation capacity at national and zonal laboratories and in identified regions and district levels;
- Develop comprehensive guidelines for surveillance of public health threats at the points of entry, and preparedness and emergency contingency plans for the points of entry.

Focus area 2: Increased capacity to manage health risks of emergencies and build resilience, including adequate preparedness for rapid and effective response to health-related disasters and emergencies and major epidemics and pandemics using the One Health approach

Country office strategic actions

- Update the Multisectoral All-Hazard for Emergency Preparedness and Response Plan covering health-related disasters, epidemics and events with a public health impact;
- Strengthen the readiness of WHO country office for emergencies in line with the national (health) disaster risk management road map, the Sendai Framework for Disaster Risk Reduction and IHR (2005).

Focus area 3: Strengthened surveillance systems to identify paralysis due to wild poliovirus or type-2 vaccine-related poliovirus

Country office strategic actions

- Conduct a laboratory survey to identify laboratories with poliovirus or related materials;
- Ship acute flaccid paralysis specimens from the district to the national level;
- Actively search for acute flaccid paralysis cases in the health facilities and sensitize clinicians and traditional healers for identification and reporting.

Actively search for acute flaccid paralysis cases in the health facilities and sensitize clinicians and traditional healers for identification and reporting.

Chapter 5: Implementing the strategic agenda

5.1 Implications for the entire WHO Secretariat

It is pertinent to highlight the main factors that will influence the WHO presence in the United Republic of Tanzania during the CCS III period: first, the country will have acquired the lower middle income country status; second, the global community will be implementing SDGs; and third, global health security and NCDs will be major priorities in the global health agenda.

5.2 Implications for the country office

The WHO country office will utilize CCS III as a central document to guide its programming for 2016–2020. It will be the basis for the country office's biennial work plans, translating strategic objectives into country-specific expected results, and it will be used to foster dialogue with all stakeholders. It will also serve as a reference in resource mobilization. The CCS may be updated as necessary after consultation with national authorities and other key stakeholders.

The lower middle income country status that the United Republic of Tanzania will have during the CCS III period will mean that official development assistance, which formerly contributed 40% of the budget, will decline. It is anticipated that the WHO country office budget also will start declining. Furthermore, the UN will shift its focus towards:

- Playing a normative role of setting standards and promoting and monitoring the implementation of international agreements such as the SDGs;
- Providing technical support for the domestication and internalization of UN norms and values and the promotion of human rights;
- Working on upstream policy and advocacy issues, sharing evidence-based policy options to accelerate reforms, and leveraging budgets for vulnerable groups including children, young people and women;
- Supporting governments in the development of national and sector-specific strategic plans;
- Strengthening monitoring and evaluation capacity, supporting provision of research evidence and data analysis, and promoting innovation;

Enabling knowledge exchange and strengthening existing partnerships while deepening triangular and south–south cooperation.

We anticipate that this CCS will be implemented in a period of transitioning for the country office from the old to the new way of working and in a new environment. This will require reorientation of the country office staff to improve their skills and capacity to work in the new areas identified as priority, particularly outbreak alert and response,

including IHR (2005) and disaster risk management; NCDs; universal health coverage; and the unfinished MDG agenda. It also implies a retooling of the expertise in the team.

The cluster structure allows programme officers to work within and across strategic objectives when need arises. With the limitations expected with the budget, a deliberate effort will be made to allocate 80% of the resources to the 10 priority programmes, which are HIV, tuberculosis and malaria; RMNCAH; vaccine-preventable diseases; alert and response capacities; NCDs; access to medicines and health technology; strengthening regulatory capacity; national health policies, strategies and plans; and health system information. The country office has to develop its skills base for Intersectoral action and community mobilization in order to address the social determinants of health and mobilize more resources for programme implementation. Moreover, it will be necessary to strengthen the team's negotiation, advocacy and convening skills so as to play the leading role in the health sector.

5.3 Implications for the WHO Regional Office for Africa

The WHO Regional Office for Africa/Inter-country Support Team will ensure that the country office has the managerial and technical capacity required for the implementation of the strategic agenda by providing technical and administrative support to the WHO country operations that is customized to the national needs, in a responsive manner, and based on the CCS and biennial plans. The regional office will consider delegation of authority to the WHO Country Representative and the country office to ensure that sufficient flexibility exists for country-level implementation of the CCS. The procedures for channelling locally and externally mobilized resources should also be reviewed to avoid delays in their disbursement.

5.4 Implications for WHO headquarters

The WHO, in keeping with its mandate, will continue to provide the regional and country offices with global policy advice, directives on health development and guidance on global norms and standards. In line with the principle of One WHO, the WHO headquarters will work with the regional office to provide technical support and mobilize resources for the implementation of the CCS and to document the lessons learned from the CCS process and its impact on the WHO work.

5.5 Monitoring and evaluation.

WHO will monitor the implementation of CCS III using the established procedures and in partnership with the national authorities and other stakeholders. This will involve mid-term and end-of-biennium reviews, which will contribute to the WHO biennial programme budget performance assessment. These reviews may require curtailing or phasing out some programmes while at the same time identifying and initiating activities in new priority areas. In such a case WHO will adjust its collaborative activities accordingly. The opportunity of the annual UNDAP review will be used to monitor the CCS III progress.

Annex 1: Health indicators for Tanzania

WHO Region	**Africa**
World Bank income group	Lower middle income
Total population in thousands (2013)	49,253
% population under 15 (2013)	44.8
% population over 60 (2013)	4.9
Life expectancy at birth (2013) Male Female	63 61 65
Neonatal mortality rate per 1000 live births (2013)	21
Under-five mortality rate per 1000 live births (2013)	52
Maternal mortality ratio per 100 000 live births (2014)	410
% DTP3 immunization coverage among 1-year-olds (2014)*	97
% births attended by skilled health workers (2010)	48.9
Density of physicians per 1000 population (2012)	0.031
Density of nurses and midwives per 1000 population (2012)	0.436
Total expenditure on health as % of GDP (2013)	7.3
General government expenditure on health as % of total government expenditure (2013)	11.2
Private expenditure on health as % of total expenditure on health (2013)	63.7
Adult (15+) literacy rate total (2012)	73
Population using improved drinking-water sources (%) (2015)	55.6
Population using improved sanitation facilities (%) (2015)	15.6
Poverty headcount ratio at $ 1.25 a day (Per person) (% of population) (2007)	67.9
Gender-related development index rank out of 188 countries (2014)**	159
Human development index rank out of 188 countries (2014)**	151

Source: Global Health Observatory, http://www.who.int/gho/en//

* WHO/UNICEF Joint report Form, 2014

** Human Development Report, UNDP, 2014

Annex 2: Development partners on health and their programmatic areas of support

Development partners	Programmatic areas of support
Canada/DFATD	RMNCAH, HRH, Health Basket Fund member
United States Centers for Disease Control	HIV; blood safety; global health security; maternal, neonatal, and child health; Field Epi and Lab Training Programme; disease outbreaks; Ebola; prostate cancer; and health system strengthening, including human resources for health, institutional capacity building monitoring and evaluation, disease surveillance, and health information systems
United States President's Emergency Plan for AIDS Relief	HIV, TB, malaria, and health systems strengthening in mainland Tanzania and Zanzibar
DFID	Reproductive health, nutrition, malaria, WASH, Equity, gender-based violence, early child development, youth, social protection, innovation
Germany/GIZ	Social health protection, quality improvement focusing on sexual and reproductive health, decentralized health governance including HRH, cooperation with the private sector, strengthening CSOs focusing on youth
Germany/KfW	Maternal, neonatal and child health; social health protection/health care financing; reproductive health and HIV/AIDS
Embassy of Ireland	Quality and equity; vulnerable groups such as people living with disabilities, gender-based violence, nutrition, human resources for health, RMNCAH, Health Basket Fund, health care financing
Japan International Cooperation Agency	Regional health system (e.g. quality improvement management at Regional Referral Hospitals, 5 Sigma Kaizen-Total Quality Management; human resources for health, and reproductive health
Embassy of Denmark	Sexual and reproductive health and rights, public-private partnerships, Health Basket Fund member
Embassy of Switzerland	Social protection, public-private partnerships, global health initiatives, malaria, social accountability, good governance, Health Basket Fund member
UNICEF	Maternal, neonatal and child health, Health Basket Fund member

United Nations Development Programme	HIV national response, social protection, access and delivery of health technology, health care waste management (reduction of unintended release of persistent organic pollutants and mercury from the health sector), integrating HIV and gender-related issues into environmental impact assessment
UNFPA	RMNCAH including family planning, HRH/midwifery workforce; gender-based violence, data generation and use, Health Basket Fund member
UNAIDS	HIV
United States Agency for International Development	Emergency preparedness, human resources for health, global financing facility, maternal and child health, global financing facility, health care financing, health systems strengthening, HIV/AIDS
World Bank	Health financing, maternal, newborn and reproductive health, Health Basket Fund member
Italian Development Cooperation Office	HIV/AIDS, tuberculosis, emerging infectious diseases
Korea International Cooperation Agency	Maternal, newborn and reproductive health
African Development Bank	Human resources, East Africa's Centres of excellence in biomedical sciences (cardiovascular disease)

Annex 3: Stakeholders met during the CCS III development

Interviews with officials of the Ministry of Health and Social Welfare, February–April 2015

Name	Title
Dr Janeth Mghamba	Head, Epidemiology
Dr Renatha Mandike	Programme Officer, National Malaria Control Programme
Mr Henry Irunde	Chief Pharmacist
Bernard Konga	Director of Policy and Planning
Dr Ottilia Gowelle	Director of Human Resources
Mr Elias Chinamo	Acting Director of Preventive Services
Dr Donan Mmbando	Permanent Secretary
Dr Oberlin Kisanga	Head, Health Sector Reform Secretariat
Mr Raynold John	Administrator

Interviews with development partners on 1 April 2015

Name	Title	Organization
Carol Hannon	DPG Health Chair	Irish Aid
Susna De	DPG Health Outgoing Chair	USAID
Leticia Rweyemamu	DPG Health Secretariat	WHO
Pascal Kanyinyi	Programme Officer	KfW
Eimear McDermott	Health Programme Officer	Irish Aid
Karen Zamboni	Health Adviser	Irish Aid
Thomas Teuscher	Head Health Sector	SDC
Dr. Yahya Ipuge	Senior Health Specialist	World Bank
Catherine Shirima	Assistant Programme Officer	Japan International Co-operation Agency
Felister Bwana	Programme Specialist	UNFPA
Liz Tayler	Basic Services Team Leader	DFID
Lisha Lala	Health Adviser	DFID
Joe Goodings	First Secretary, Development	DFATD/Canada
Nina Siegert	Health Financing Policy Adviser	GIZ

Sriyanjit Perera	Health Information System Adviser	CDC
Dr Gilbert Mliga	WHO consultant	
Arin Dutta		Futures Group

Participants at the UNDAP evaluation meeting, March 2015

Name	**Organization**
Agness Michael Junga	National Steering Committee for Civil Society Organizations on HIV/AIDS
Cecilia Nzegariye	TCRS
Deogratius Peter Rutatwa	National Council of People Living with HIV
Feddy Mwanga	Engender Health
Josephat Kwela	TMEA
Sebalda Leshabari	TAMA
Lena Thiede	Germany Embassy
Maria va Berlekom	SIDA
Nicola Giordano	Italy
Romana Tedeschi	Switzerland
Sinikka Antila	Embassy of Finland
Takako Ogimoto	Japan
Tamaki Yoshida	Japan
Abel Mhehe Anthony	MLWD
Khamis Omar	Ministry of Finance
Asanterabi C. Sangeoi	PMO
Bahati B. Joram	Ministry of Water
Balandya Elikana	Ministry of Finance
Bernard Konga	MOHCDGEC
Bihindi N. Khatib	Ministry of Finance
Diana Makale	PMO
Dr Neema Rusibamayila	MOHCDGEC
Eliet Magogo	MFAIC
Eveline Kamote	MOHCDGEC
Fatma Urari	MoLE
George Lusekelo	Ministry of Finance
Jarome Kamwela	TACAIDS

Laurent Burilo	CHRAGG
Mary Massay	CHRAGG
Mathias Kabunduguru	PO, PSM
Mr Hiiti Sillo	TFDA
Richard K.S. Ngirwa	TACAIDS
Sophia Majangu	MCDGC
Subilaga Kaganda	TACAIDS
Slyeiman Mziray	GTZ

Stakeholders' consultation meeting on WHO CCS III and biennial programme budget 2016–2017, 11 August 2015

Name	**Title**	**Organization**
Dr Mohammed Dahoma	DPSHE	MOH, Zanzibar
Dr Angelina Sijaona	PDO	MOHCDGEC
Thomas Teuscher	Head, Health	Swiss Embassy
Elizabeth Shekalage	Registrar	MOHCDGEC, Pharmacy
Dr Gilbert Mliga	WHO consultant	
Dr Elias Kwesi	Assistant Director, EPRS	MOHCDGEC
Mr Joseph Matimbwi	Technical Adviser	GIZ
Jane Miller	Human Investment Team Leader	DFID
Kanem	Representative	UNFPA
Dr Grace Saguti	NPO/DPC	WHO
Dr Ritha Njau	NPO/MAL	WHO
Mary Hadley	DANIDA	Danish Embassy
Dr Sekela Mwakyusa	President	Paediatric Association of Tanzania
George Anthony	Legal Officer	TACOSODE
Dr Nemes Iriya	NPO/CAH	WHO
Mr Hussein Mavunde	Acting Assistant Director	MOHCDGEC
Mr Alvaro Rodrigez	Resident Coordinator	UN
Mary Chuwa	Treasurer	TAMA
George Loy	NPO/HIV-AIDS	WHO

Marcelina Mponela	Public Health Specialist	CDC
Ndemetrid Vermand	AD – NT	MOHCDGEC
Dr Josephine Ballati	DHS	CSSC
Hiiti Sillo	Director General	TFDA
Dr Donan Mmbando	Permanent Secretary	MOHCDGEC
Carol Hannon	DPG H Chair	Irish Embassy
Dr Warren Naamara	Country Director	UNAIDS
Andy O'Connell	Public Private Partnership Adviser	MOHCDGEC
Manjeun Amon	EC	MEWATA
Benard Konga	Director of Policy and Planning	MOHCDGEC
Dr Neema Rusibamayila	Director, Preventive Services	MOHCDGEC
Mr Mwizarubi Nyaindi	WASH	WHO
Dr Alphoncina Nanai	NPO/NTD	WHO
Abdul-latif Hija	DPPIZ	MOH, Zanzibar
Dr Richard Banda	Technical Officer – HIV	WHO
Dr G. Mutahyabama	Ag. DHR	MOHCDGEC
Ms Leticia Rweyemamu	DPG-H	WHO
Dr Rufaro Chatora	WHO Country Representative	WHO
Alice Monyo	HOD – Medical and Supplies	SIKIKA
Grace Dennis	PO – PMTCT	MOHCDGEC
Khadija Shaaban	External AID Coordinator	WHO
Aisha Mohammed	Head – MZE	MOH, Zanzibar
Halima Salum	DPS	MOH, Zanzibar
Dr Elizabeth Mapella	RCH	MOHCDGEC
W.J. Mwafungo	PHO – NACP	MOHCDGEC
Dr Amalberga Kasangala	Acting CNO	MOHCDGEC
Patricia M.K. Maganga	H – LSU	MOHCDGEC
Joyceline Kaganda	Acting Managing Director	TFNC
Dr Janeth Mghamba	AD – Epidemiology	MOHCDGEC
Dr Vida Mmbaga	Epidemiologist	MOHCDGEC
Dr Koheleth Winani	National – SMI	MOHCDGEC
Mr Maximillian Mapunda	HEC	WHO
Zachary A. Dida	ADRM	MOHCDGEC
Dr Khalid Massa	Ag. AD EAS	MOHCDGEC

Dr Angela Ramadhani	Programme Manager	NACP, MOHC-DGEC
Dr Julius Massaga	Ag. DG	NIMR
Dr Theopista John	FHP	WHO
Henry Irunde	Chief Pharmacist	MOHCDGEC
Dr Mohamed Jiddawi	Principal Secretary	MOH - Zanzibar
Dr Charles Massambu	Ag. DCS	MOHCDGEC
Ms Rose Shija	EDM	WHO
Dr Neema Kileo	HPR	WHO
Hashim Mahige	CT	WHO
Elias Masubmuko	PST	Vice President Office
Dr Georgina Msemo	Acting ADRCHS	MOHCDGEC
Dr Theophil Likangaga	Acting ADES	MOHCDGEC
Dr Fausta Mosha	Acting ADDS	MOHCDGEC
Jaliata Rangi	Programme manager	MEWATA
Dr Helen Semu	AD – HPS	MOHCDGEC
Dr Vincent Assey	AD – NS	MOHCDGEC
Dr Margareth Mhando	Acting CMO	MOHCDGEC
Catherine Sungura	Acting H/GCU	MOHCDGEC
Renatus Kiure	RCH	MOHCDGEC

Meeting with WHO staff to review CCS III draft document, 21 April 2015

Name	Title
Dr Rufaro Chatora	WHO Representative
Dr Theopista J. Kabuteni	NPO/FHP
Mr Emmanuel Johnson	Librarian
Dr Neema Kileo	NPO/HPR
Ms Tausi Yusuf	WR - Secretary
Mr Hashim Mahige	Caretaker
Mr Charles Hozza	Driver
Mr Ahmed Mlumba	Driver
Ms Elizabeth Mbeyela	Secretary
Mr Maximillian Mapunda	Health Economist
Dr Cyrialis Mutabuzi	Surveillance Officer
Mr Durell Mkuu	ICT
Dr G. Andemichael	Public Health Administrator / Liaison Officer
Mr Charles Lutandula	Messenger
Mr Christopher Kamugisha	Team Leader/IVD
Dr Grace Saguti	NPO/DPC
Mr Allen Garimo	Data Clerk
Dr Boniphace Makelemo	Surveillance Officer
Dr George Loy	NPO/HIV
Mr Mohamed Masoud	Finance Assistant
Mr Edwin Nyaindi	WASH
Ms Leticia Rweyemamu	DPG Health
Mr James Mwampona	Driver
Mr Ali Kinole	Driver
Dr William Mwengee	Surveillance Officer
Dr Anthony Kazoka	Surveillance Officer
Dr Ritha Njau	NPO/MAI
Dr Nuhu Yaqub	JPO
Ms Rose Shija	EDM
Dr Richard Banda	Medical Officer - HIV
Dr Isiaka Alo	Technical Officer - NUT
Ms Jenipher Nombo	Finance Assistant

Mr Amos Kurwijila	Logistics Clerk
Ms Naiz Mavura	PBFO
Ms Talha Saleh	Secretary
Dr Bhavin Jani	New Vaccine Surveillance Officer
Mr Bright Senkoro	Driver
Mr Tumaini Sagamba	Driver
Mr Francis Brown	Driver
Mr Saah Fayiah	Operations Officer
Mr Bumija Mbwambo	Travel Assistant
Ms Saada Ali	Secretary