

WHO Tanzania

Annual Report 2016



World Health
Organization

WCO Tanzania

Annual Report 2016



FORWARD

I am pleased to present to you the WHO Country Office Annual Report for 2016. The operating year, although challenging, witnessed substantial policy and programmatic achievements.. The report covers the contribution of WHO towards addressing the health challenges and disease burden in the country, as we continued to partner with the Government of Tanzania to support the national priorities in health.

The year saw a protracted cholera outbreak beginning in August 2015. By the end of 2016, a total of twenty eight out of the thirty administrative regions in the country had been affected by the cholera virus, resulting in the repurposing of programme priorities and staff members in the Country Office. All other activities had to be kept at minimal level in order to save thousands of innocent lives from avoidable deaths and illnesses that could result from the outbreak. WHO headquarters and the Regional Office for Africa joined the Country Office to mobilize support for the outbreak response. By the end of 2016, the epidemic situation had greatly stabilized with a continued decline of new cases and deaths.

In spite of the disruptions in implementation of the office annual work plan, the achievements worth mentioning include a) the completion of the two year human papilloma virus vaccine (HPV) demonstration project meant to provide evidence to inform national scale-up of HPV vaccination, b) conduct of a polio outbreak simulation exercise to test the capacity of national system for polio preparedness and response, c) launch of the Road Safety Journalism Fellowship to help strengthen the capacity of journalists in reporting road injuries and deaths, d) establishment of a multisectoral coordinating committee and development of a National Action Plan on antimicrobial resistance, e) creation of awareness across various media on the prevention and control of rabies in commemoration of the World Rabies Day, f) establishment of Nutrition Information System (NIS) integrated with existing HMIS through redesigning of nutrition indicators, building capacity of health workers and linking NIS to nutrition services in selected regions, and g) mainstreaming climate considerations in the Health sector strategic Plan IV including development of policy brief on Climate and Health.

Partnership, collaboration and harmonization have been the cornerstone of our successful engagement. The One UN-UNDAP framework also facilitated a common platform where the UN as a family collectively supported the government to strengthen health outcomes.

We trust that you will enjoy reading this 2016 Annual Report and we welcome any feedback you may have to help us improve future health service delivery to the Tanzania people.

Dr. Matthieu Kamwa

WHO REPRESENTATIVE FOR TANZANIA (a.i.)

ACKNOWLEDGEMENTS

Despite the threats posed by the cholera outbreak during the year which disrupted routine health activities, WHO Country Office was able to contain the scourge, and went ahead to record many strides in different areas of work. These results would not have been possible without the support of partners.

Our special appreciation goes to the President of the United Republic of Tanzania, His Excellency John Pombe Magufuli, who created a conducive policy environment for WHO to operate. Our sincere thanks are due to the President of Zanzibar; His Excellency Dr Ali Mohamed Shein, who played a crucial role in setting the pace for an early containment of the cholera epidemic.

We would like to express my sincere gratitude to the Minister of Health, Community Development, Gender, Elderly and Children, Hon. Ummu Ally Mwalimu, for her strong leadership and coordinating roles in ensuring members of her staff and other partners provided the needed support for health service delivery, and particularly the establishment of the Public Health Emergency Operations Centre (PHEOC) to coordinate emergency response activities in the country.

The office is indebted to the leadership of the former WHO Representative, Dr Rufaro Chatora, who was reassigned to South Africa in the same capacity effective 01 August 2016. We are thankful to him for his contributions towards improving the health of Tanzanians during his tenure in the country.

WHO also acknowledges the support of the staff members including experts deployed on mission during the cholera outbreak emergency response. Without them, nothing would have been achieved. We thank you all!

Finally, we wish to recognize the generosity of development partners, local organizations and community members for their unwavering support. We reassure them of our commitment to a more productive collaboration in the years ahead.

**Dr Richard Banda; Medical Officer, HIH/AIDS Treatment & Care.
Officer in Charge, WHO COUNTRY OFFICE, TANZANIA (August 2016 – March 2017)**

Table of Contents

<i>FOREWORD</i>	Error! Bookmark not defined.
<i>ACKNOWLEDGEMENTS</i>	Error! Bookmark not defined.
United Republic of Tanzania	4
Cholera Outbreak Response at a glance	4
Highlights of WHO Response	4
Lessons learnt from the Response	7
<i>Findings from a Cost Analysis of HPV Vaccine Demonstration in Tanzania favour the Use of Routine over Campaign Vaccination Mode</i>	9
<i>Tanzania Switches to a New 'Bivalent' Polio Vaccine</i>	10
<i>Polio Outbreak Simulation - a wakeup call to strengthen Polio outbreak preparedness</i>	11
<i>Strengthening Capacity for Quality Reporting on Road Safety</i>	12
<i>Antimicrobial resistance: a challenge to health, food security, and development</i>	15
<i>“Educate. Vaccinate. Eliminate.” to prevent Rabies</i>	15
<i>Promoting safe drinking water for all and a toilet for every household</i>	17
<i>Stronger nutrition surveillance for better detection and management of child undernutrition</i>	18
<i>Protecting health from climate change</i>	20
<i>Protecting and promoting health and safety of workers</i>	21
<i>Engaging communities in finding local solutions to health problems</i>	22



World Health Organization

Cholera Outbreak Response at a glance



25,119
AFFECTED

28 OUT OF 30 REGIONS AFFECTED



390
DEATHS

COORDINATION

- The WHO team was led by the WHO Representative.
- Technical support was received from HQ, AFRO and IST. A total of 41 international experts were deployed to Tanzania to support the outbreak.
- The WHO Office team was divided into six operational and technical sub-committees responsible for coordination, surveillance, case management, Water, sanitation & hygiene (WASH), social mobilisation and Logistics & laboratory.
- Formation of a multisectoral national coordination mechanism called the National Task Force (NTF).
- Establishment and deployment of a monthly multi-disciplinary Rapid Response Team (RRT) to support Cholera response in high-risk districts/regions.
- High level advocacy for coordination of response at subnational level through monthly Primary Health Care meetings
- High level advocacy that resulted in the release of 900million Shillings by national government to support outbreak response
- Establishment of a Public Health Emergency Operations Centre (PHEOC) to develop and implement operational procedures and guidelines for efficient implementation of the overall response
- Deployment of surveillance officers to strengthen early detection, prompt reporting and follow up of cases and deaths at the community level
- Capacity building for appropriate management of Cholera cases and infectious control in the treatment centres
- Capacity building and deployment of CHWs for sustained community engagement and mobilization
- Capacity building on water treatment and water quality monitoring
- Construction of 20 hand pump boreholes and 183 latrines as demonstrations for enforcement of relevant bye-laws on WASH
- Dissemination of public information on Cholera prevention and management through household visits, dissemination of Information, Education and Communication (IEC) materials, media campaign on TV, newspapers, radio etc.
- Conducted an assessment of socio-cultural factors associated with Cholera transmission, to inform targeted social mobilisation strategies
- Quantification of needed medicines and other health products, including regular dispatch of supplies to affected areas.

SUPPLIES PROVIDED

- 15 packs of DDK
- Water Guard 21,600,000 tablets
- 1,107 drums (45kg) of Chlorine
- 100 chlorine test kits
- 17,500 wall charts for Cholera Treatment Centres
- 5000 copies of National Cholera Guidelines,
- 500 units of Line List Booklets
- 150,000 packs of Oral Rehydration Salts (ORS)
- 482,195 doses of Oral Cholera Vaccine (OCV)
- 30 units of Cholera beds with 100 bed sheets
- 4 computer desktops, 1 printer and 2 LCD screens for the PHEOC, water tanks (5000 litres each)

OVERALL IMPACT

After 20 weeks of intensive response activities, reporting of Cholera cases was reduced from 28 regions to only one region (Dar es Salaam), and the number of new cases reduced significantly to a single digit per week.

Lessons learnt from the Response

In spite of the successes achieved in the containment of the cholera epidemic, the following lessons learnt will assist in rapid response to, and the control and containment of future outbreaks.

1. Leadership and coordination

To achieve effective outbreak response and containment, strong leadership is key to facilitate smooth coordination of response activities by the different sectors



Pix 1: President John Magufuli setting the example by collecting rubbish during the National Independence Day



Pix 2: WHO Representative, Dr Chatora meeting with the President of Zanzibar, His Excellency Dr. Ali Mohamed Shein, as part of high level advocacy for the Cholera response

2. Partnership and Coordination

To effectively respond to, control and contain any epidemic of a similar nature, requires contributions of every public-private-civil society stakeholder, across the different sectors.

3. Funding: Because an outbreak is never anticipated, there is usually insufficient budget appropriation, both by government and partners, to respond rapidly.

Since the country is not immune to this type of epidemic or other emergencies, efforts should be made at all times to budget for emergencies in annual government budget appropriation.

4. Buffer stocks of Emergency supplies: Having stock of emergency supplies to respond to Health emergencies is as important as having buffer funds to respond. Buffer stocks reduce delays from tendering and ordering supplies especially from offshore.



Pix 5: Partners in a coordination meeting

5. **A functional Public Health Emergency Operations Centre (PHEOC):** Whether there is an outbreak or not, the country should have a functional PHEOC, to monitor trends of disease outbreak across seasons, and in neighbouring countries possible of importation to the country.



Pix 3: Dr Chatora and colleagues, during a visit to the PHEOC

6. **Well capacitated and functional laboratories and isolation centres,** should be institutionalized, as part of the health system, and not to wait for an outbreak to occur before such is put in place. Such



Pix 4: Dr Chatora and team on assessment visit to a Cholera Treatment Centre (CTC) in Zanzibar



laboratories and centres should be equipped with relevant guidelines, IPC procedures, etc.

7. **Community awareness about disease outbreak prevention, control and management;** is necessary to reduce the

8. Continuous orientation and re-training of existing health workers, surveillance officers, IDSR officers, CORPs, etc., will ensure availability of core capacities of health workers to respond to emergencies.

Findings from a Cost Analysis of HPV Vaccine Demonstration in Tanzania favour the Use of Routine over Campaign Vaccination Mode

Tanzania recently completed a two-year human papilloma virus vaccine (HPV) demonstration project in Kilimanjaro, a region with 1.8 million people. Because the HPV vaccination targeted in and out-of-school 9 year old girls, Kilimanjaro region was selected due to its high school enrolment rates. The purpose of the HPV demonstration project was to provide evidence to inform a national scale-up of HPV vaccination.

In order to better understand logistical issues and increase awareness and vaccine increase uptake, the first year of the project purposely used a campaign setup targeting schools as vaccination points. However in the subsequent year a routine mode of HPV delivery was implemented and this was also informed by the experience from year one of the project. A post introduction evaluation was also carried out in the administration of the second dose of HPV vaccine and among other things proposed vaccine delivery a routine approach allowing health workers to integrate HPV vaccination into their work schedule.

A cost analysis showed that the cost per fully immunized girl through a campaign was nearly five times that of a routine mode (US \$14 vs US\$ 3). Based on the findings it was recommended that routine delivery of HPV vaccine during a scale-up would be more feasible and affordable at an average annual cost of USD 9.5 million.

Although a major cost item is the vaccine, due attention should be paid to operational costs which are often dependent on the delivery mode. Equally important is the need to review the readiness, capacity and capability of the system to normally and routinely deliver services. This project was funded by the GAVI with collaborative support of PATH and WHO to the Government of Tanzania in the of the project span.



A girl receiving a dose of HPV in Kilimanjaro

Tanzania Switches to a New 'Bivalent' Polio Vaccine

The year 2016 witnessed a major public health event when Tanzania joined the rest of the world in switching to a new polio vaccine as part of a final push to eradicate polio. The switch happened from the trivalent oral polio vaccine (tOPV) which protects against all three strains of wild polio virus and switch to bivalent OPV (bOPV), which protects against only two wild polio strains—types 1 and 3. The older version of the vaccine (tOPV) contains a strain of the polio virus, type 2, which has been eradicated and no longer needs to be introduced to children.



Switch implementation coincided with heavy rains making some roads impassable.

This was a carefully synchronized move when the health workers world over stopped using their traditional three-strain oral polio vaccine and switched to a simpler and safer two-strain vaccine. In Tanzania the activity involved thousands of health workers, government leaders, nongovernment organizations and stakeholders. A total of 2.4 million doses of bOPV were distributed to all the immunizing health facilities and nearly 100,000 doses of tOPV removed from the cold chain.

To make sure that the switch went smoothly as planned, independent monitors visited health facilities to check that the defunct trivalent oral polio vaccine was no longer in use, and the bivalent oral polio vaccine is used instead. The involvement of all stakeholders at all levels; including commitment of the government and appropriate implementation plans being in place were key to the success. The undertaking was a major milestone for Tanzania and in line with the Global Polio Eradication Initiative Polio Eradication and Endgame Strategic Plan 2013–2018.



A health worker traversing a flooded river to deliver vaccine to a health facility

Polio Outbreak Simulation - a wakeup call to strengthen Polio outbreak preparedness

The last case of wild Poliovirus in Tanzania was reported in 1996. Through effective engagement of stakeholders and political involvement, the Polio vaccine immunization coverage for the third dose has remained consistently over 90% from 2011-2016. During the same period, the country achieved the recommended annual targets for Acute Flaccid Paralysis surveillance indicators.

The most important step in maintaining a polio free status has been pursued through a combination of routine immunization, supplementary immunization campaigns and responding to possible outbreaks. It is in pursuant of these complementary strategies that a two-day tabletop polio outbreak simulation exercise was conducted in 2016. It was designed to help Tanzania review its national plans for responding to the detection of any type of Poliovirus, in line with the International Health Regulations (2005) guidelines. The exercise tested the capacity of national system for polio preparedness and response using seven progressive scenarios to mirror what could happen during a real-life situation. The scenarios were developed and facilitated by three experts from WHO headquarters and the Regional Office for Africa, as well as UNICEF Regional Office for West and Central Africa. Participants included senior officials and technical officers from the Ministry of Health in Mainland & Zanzibar, President's Office Regional Administration and Local Government, WHO Country Office, UNICEF Country office, Clinton Health Access International and Program for Appropriate Technology in Health.

The main areas of focus of the exercise included:

- 1. Demonstration of interaction between different stakeholders;*
- 2. Flow of information upon Polio case detection;*
- 3. Management of inter-related events during outbreak response;*
- 4. Key elements of a concrete outbreak response plan;*
- 5. Actions required to cater for immediate and pressing needs.*

The existence of a national structure for responding to outbreak, availability of a Polio response plan, and involvement of multidisciplinary experts from the MOHCDGEC were found to be important strengths. However, the lack of clear definition of roles and responsibilities of the different stakeholders, absence of a comprehensive response plan with timelines and monitoring framework, inadequate capacity for development of plans and limited media engagement in response; were the main shortcomings identified in the current system.

The consensus reached at the end was to review the national comprehensive Polio response plan, and conduct another simulation exercise before the end of the year. It is worth noting that the proposed simulation was postponed till the following year due to some constraints.



Vaccine carriers used during routine and supplementary immunization campaigns.

Strengthening Journalists' Capacity to write Road Safety stories

Road crashes is one of the major public health threats in the world today. Globally 1.24 million people are dying every year. In the 2015 Road safety Status report, the World Health Organization estimates that Tanzania had 16 211 road traffic fatalities resulting in a loss of 3.4% national GDP. Road traffic injuries and deaths can be prevented if there are good interventions to change how people behave on the road. It is therefore obvious that the policy makers and general public need to be educated on the risks associated with road use and the best available policy options to reduce the risks and impact of road crashes.

In collaboration with Tanzania Media Foundation, the Country Office launched the Road Safety Journalism Fellowship in 2016. The objective was to strengthen the capacity of journalists to produce comprehensive news and feature articles on road safety, and translate statistics on road injuries and deaths to human and public interest stories. The fellowship programme is part of the multi-country Bloomberg Initiative for Global Road Safety funded by Bloomberg Philanthropies.

With financial support from WHO, a group of ten Tanzanian journalists were enrolled into a fellowship training programme at the Tanzania Media Foundation. The training covered all dimensions of road safety such as data analysis, in-depth story writing, how to identify opportunities to expand and sustain coverage through interaction with local and international facilitators and mentors.

During the training, the ten journalists so trained produced a total of 40 road safety stories, which were published by various local and international media organizations. The articles provided detailed road safety data analysis, road user behaviours, and health and development impacts of these risk

factors. A programme documentary was also produced showing the role of different sectors in reducing road traffic crashes.

The fellowship programme led to the training of the first cohort of ten journalists. Other achievements of the Bloomberg Initiative in Tanzania included:

1. Enrolment of a second cohort of journalists for training
2. Establishment of a multi sectoral project coordination committee to provide oversight and advocate for reforms and law enforcement. The committee draws membership from the Tanzania Police Force, Ministries of



A journalism fellow sharing his work during the training session

- Health, Transport, Legal and Constitution Affairs, Law Reform Commission, Local Government Authority and the Civil Society.
3. Advocacy at national level to review Road Traffic Act and provide recommendations to change provisions related to (a) speed limits; (b) use of seatbelts; (c) child restraint; (d) helmets for motorcycle riders; and (e) alcohol or drunk driving.

Improving Emergency care for mothers, newborns and children

The reduction of maternal, new-born and child morbidity and mortality is a high priority for the Government of Tanzania, and for many regional and global organizations and partnerships.

The distribution of maternal and child mortality in Tanzania varied across zones and regions (Fig. 1). The Lake and Western zones are left behind in reaching mothers and children with essential interventions, thereby contributing significantly to the overall morbidity and mortality burden.

In order to narrow the gap, the Government of Tanzania is using the Sharpened Plan and One Plan II for reproductive, maternal, newborn, child and adolescent health (RMNCAH) to focus on zones with the highest maternal mortality burden. The Sharpened Plan identified key interventions and geographical area of focus in line with the Big Result Now (BRN) initiative.

To guide the delivery of effective interventions, the WHO country office supported the MOHCDGEC in carrying out assessment of Emergency Obstetric and New born care in selected regions to identify lessons learnt and gaps.

The assessment revealed:

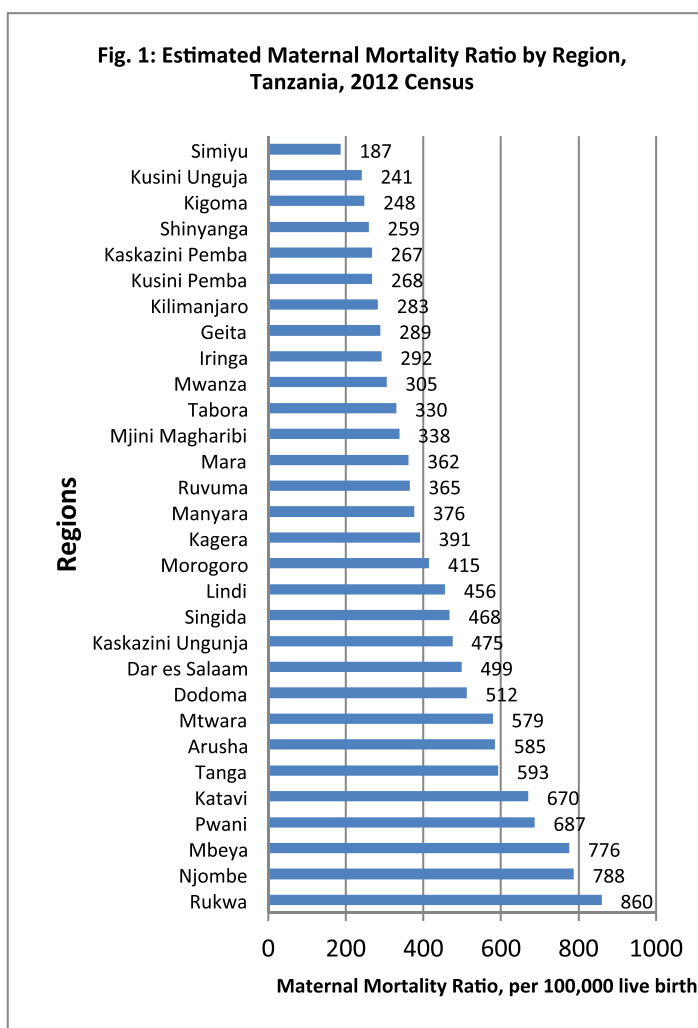
- a) Absence or inadequate emergency care;
- b) Lack of skills and knowledge
- c) non-availability of basic equipment;
- d) lack of emergency transport to support emergency care.

Tanzania in collaboration with partners has made commitment to intensify actions towards ensuring access to quality RMNCAH interventions. In fulfilling this commitment, WHO supported focused quality Emergency Obstetric and New born care, such as improving care of the sick child through improving availability of essential equipment and supplies, improving the referral system for hard to reach areas, capacity building for improving skills and knowledge and strengthening, partners' coordination for planning implementation and monitoring of interventions at national level and in selected districts.

Recognizing the importance of effective referral system, WHO supported procurement of 67 ambulances equipped with essential life-saving equipment. The ambulances were distributed to remote facilities that have records of high number of deliveries, in line with the Sharpened Plan and BRN.

The country office also procured equipment to support emergency care for mothers and children at the National Hospital and Peer Learning districts. The equipment included Oxygen contractors, neonatal resuscitation kits, ECG machines, Ultra sound machines and ventilators.

Fig. 1: Estimated Maternal Mortality Ratio by Region, Tanzania, 2012 Census



Delivery of Ambulances (Hon. Minister of Health at the

Antimicrobial resistance: a challenge to health, food security, and development

The United Republic of Tanzania is among the first African countries to echo the recent call made by world leaders during the 71st session of the UN General Assembly to curb the spread of infections that are resistant to antimicrobial medicines. Antimicrobial resistance happens when bacteria, viruses, parasites, and fungi develop resistance against medicines that were previously able to kill them.

Antimicrobial resistance is not a new problem but one that is becoming more dangerous. It is in view of this that the Ministry of Health, Community Development, Gender, Elderly and Children embarked on a process of tackling the problem to avoid regressing to the pre-antibiotic era. With technical support from WHO, a multi-sectoral coordinating committee under the One Health Approach was established along with four technical working groups in line with the objectives of the global action plan on antimicrobial resistance. This was followed by the development of a National Action Plan on antimicrobial resistance by a team of experts ahead of the 2017 WHA deadline.

A multi-stakeholders' meeting was held to validate and finalize the National Action Plan that was endorsed by the Minister for Health, Community Development, Gender, Elderly and Children.



“Educate. Vaccinate. Eliminate.” to prevent Rabies

World Rabies Day is an annual celebration aimed at raising awareness about rabies and highlight progress made towards eliminating the disease. The day (September 28) also marks the anniversary of Louis Pasteur's death, the French chemist and microbiologist, who developed the first rabies vaccine.

In 2016, the United Republic of Tanzania joined other countries to commemorate World Rabies Day under the theme: “Rabies: Educate. Vaccinate. Eliminate”, which emphasizes crucial actions that communities can take to prevent rabies. It also reflects the national commitment to eliminate all human deaths from dog-mediated rabies by 2030.

During the event, awareness creation activities were conducted in primary and secondary schools on the prevention and control of rabies, educating dog owners and providing vaccine cards and information leaflets on dog bite prevention and rabies prophylaxis. During the event, WHO Country Office provided 22,000 doses of dog antirabies vaccines, syringes and other supplies to the Ministry of Agriculture, Livestock Development and Fisheries to facilitate administration of the fifth and final round of mass dog vaccination. More than 1000 dogs were also vaccinated in the two regions. Joint supervisory visit was also conducted during the vaccination campaign to all project sites in Dar es Salaam, Morogoro, Lindi, Mtwara, Coast and Pemba Island to assess implementation and opportunities for sustained vaccinations beyond 2016.

It is worth noting that Tanzania is among the three countries in the world implementing a five-year rabies elimination demonstration project through a grant from the WHO/Bill and Melinda Gates Foundation. Implementation is through the Ministry of Agriculture, Livestock Development and Fisheries and the Ministry of Health, Community Development, Gender, Elderly and Children.



A dog receiving antirabies vaccine.

WHO Tanzania has continued to work with government ministries, the UN and bilateral agencies to support establishment and implementation of sustainable systems for One Health approach which will also address rabies control. In collaboration with Partners, a new One Health Strategy for Tanzania has been developed and endorsed. Funding for its implementation has been integrated into the National Costed Plan for Health Security. Authorities in all pilot districts have now agreed to include rabies interventions in their public and animal health plans and budgets.

Promoting safe drinking water for all and a toilet for every household

Unsafe water and poor hygiene and sanitation are significant contributors to deaths caused by diarrhoea every year. Protecting source of water from pollution is therefore critical to health.

On a national average, only 36.9% of households in Tanzania have access to piped water, while 42.7% drink water from unprotected sources¹. Some of the existing water utilities do not have sufficient capacity to procure chlorine or testing equipment for water treatment hence unable to conduct regular water quality monitoring.

Likewise, the national coverage of improved toilet facilities at household level in the country is equally very low. According to the National Bureau of Statistics (2014), household access to improved sanitation facilities (flush toilets and VIP latrines) is estimated at 15.7% (4.4% in rural areas), 7.8% of households have no toilet facility (11.3% in rural areas), 76% rely on unhygienic (traditional) toilets while 8% do not have any type of latrine.

To help narrow the gap in safe water supply,

1. the World Health Organization, through the Ministry of Water and Irrigation, procured and distributed the following:

a) 95 Free Residual Chlorine testers to 49 Councils in 15 regions in Mainland and 11 Councils in Zanzibar to avail public health officers and water engineers to facilitate regular spot checking for Chlorine levels in water.

b) 21,600,000 tablets of water guards for 514,285 households for 6 weeks cover,

c) 1,107 drums of High Test Hypochlorite granules, distributed among 83 district water authorities for use in treating water at source, and

d) 100 chlorine testers for district water authorities in cholera reporting districts of Mainland and Zanzibar.

2. Training of 186 Environmental Health Officers and district water technicians from 11 regions (10 from Tanzania mainland and one from Zanzibar), on testing equipment operation, methods of testing, testing water



WHO staff providing clean water to affected community during the Cholera outbreak

¹ United Republic of Tanzania: Housing Conditions, Household Amenities and Assets monograph – 2015.

chlorine levels, correct chlorine dosing for water treatment plants, reservoirs and tanks, care of the testing equipment, interpretation of results, and modalities for proper monitoring and reporting of measured Free Residual Chlorine (FRC) values. The regions and districts so trained have continued to regularly report chlorine levels using the standard tool that was developed and shared by WHO.

As a result of these efforts, 70% of the Urban and district water authorities started to treat (chlorinate) water at the recommended chlorine level before supplying to users.

3. The construction of 20 boreholes in 20 communities in two cholera hotspot regions of Mwanza and Mara. The 20 boreholes so constructed provided safe water to an estimated 108,000 people. The borehole project also provided technical training to over 40 Water technicians.
4. To ensure sustainability of household water chlorination, WHO advocated for social marketing of chlorine tablets (water guards and aqua tabs). Water guards are now marketed in pharmacies by Population Services International (PSI) at an affordable price in many regions of Tanzania. Targeted messages were prepared to address culturally informed myths, misconceptions, and beliefs against appropriate use of latrines and treatment of water by boiling or use of water guards. WHO also advocated for enforcement of public health bylaws to ensure that street food vending, which is rampant in most urban settings of the country, adheres to minimum public health safety requirements.
5. Against the background of poor access to hygiene and sanitation facilities, WHO funded the construction of 183 improved demonstration latrines (VIP and Pour flush) with hand washing facilities in 183 households in eight worst affected villages in the eight cholera hotspot districts in the regions of Mwanza, Mara, Dodoma and Morogoro. 200 local artisans were also trained on low cost latrine construction using local raw materials, to create a pool of local artisans to support household construction of latrines once the bylaws are enforced. The 183 demonstration latrines benefited 1,500 people. This initiative was implemented in collaboration with the MOHCDGEC and the National Institute of Medical research, respective local government authorities and community members in the Regions.

Stronger nutrition surveillance for better detection and management of child undernutrition

The National Nutrition Strategy 2011/12–2015/16 called for strengthening nutrition surveillance through routine monitoring and surveys. Under the Accelerated Nutrition Improvements (ANI) project, child growth monitoring was strengthened as part of routine surveillance within the health system in a process that entailed four main steps.

Assessing gaps and opportunities in nutrition surveillance within the health system

Reviews of nutrition surveillance in the country had reported a series of gaps in available data. Whereas nutrition prevalence data existed for the national level, few or no indicators were available at regional and district levels. Indications of wide geographical disparities, found through routine growth monitoring, suggested that this information would be important for planning.

Health management information systems (HMIS) provide an opportunity for the routine collection of nutrition data to trigger rapid response. A review of the HMIS data collection tool by the Ministry of Health and Social Welfare, supported by WHO and other partners, found that seven out of 15 registers used in

Health workers and government officials alike noted an increase in the quantity and quality of nutrition data collected. A greater proportion of health facilities reported through HMIS on nutrition indicators including the distribution of vitamin A and iron-folic acid supplements. Health workers gained confidence in performing routine nutrition surveillance.

health facilities collected nutrition indicators. These registers were: outpatient, inpatient, antenatal care, labour and delivery, postnatal care, child health and community information.

Redesigning nutrition indicators within HMIS

The nutrition indicators from the seven registers were consolidated into a single nutrition register.

Those indicators found to be incomplete, outdated or inconsistent with World Health Assembly global indicators were updated or revised to align with those included the Global Nutrition Monitoring Framework. For example, indicators for kwashiorkor, marasmus and marasmus-kwashiorkor were replaced by indicators for moderate acute malnutrition, severe acute malnutrition without oedema and severe acute malnutrition with oedema. Other indicators were added, such as overweight and obesity for school-aged children and women of reproductive age.

Strengthening capacity for nutrition surveillance within HMIS

Nutrition surveillance training modules were developed and rolled out by cascade training to staff in all 413 health facilities, including hospitals, health centres and dispensaries, in the ANI-supported districts. In total, 435 health workers were trained on anthropometric measurement, on growth monitoring and promotion, and on the updated WHO Child Growth Standards. In addition, anthropometric measuring equipment (mid-upper arm circumference (MUAC) tapes, height/length boards, weighing scales and age calculators) was procured for all health facilities.

The HMIS training manual was revised to reflect the updated nutrition indicators. In total, 957 health workers and members of Regional and Council Health Management Teams were trained. The HMIS desks at regional and district levels were provided the necessary hardware and software.

Linking nutrition surveillance to improved nutrition services

Strengthening skills and ensuring the availability of equipment enabled health workers to tailor counselling sessions and interventions to the needs of each child.

Through the ANI project, the training on surveillance was linked to other training



Practicing to measure the height of an infant

such as counselling on infant and young child feeding and management of severe acute malnutrition. Communication tools, job aids and supplies needed to manage micronutrient deficiencies and severe acute malnutrition were provided to further help health workers carry out their tasks.

Results of the process

The ANI project helped strengthen health worker skills on nutrition monitoring, provided equipment for health facilities, institutionalized nutrition surveillance within HMIS, and linked surveillance activities to capacity building on essential nutrition actions.

Health workers and government officials reported improvements in both the quantity and quality of nutrition data. Responses to the ANI perception surveys indicate that health workers gained an increased level of confidence in performing anthropometric measurements, plotting and interpreting growth charts and analysing nutrition data.

In addition, the HMIS platform showed an increase in the proportion of health facilities reporting on nutrition indicators, including the distribution of vitamin A and iron-folic acid supplements. More than 80% of health facilities now have the necessary equipment, and nearly all of them have confirmed their use. Trained health workers are able to collect and report data on wasting, stunting and underweight. Within six months, 1635 cases of severe acute malnutrition were treated, while the mothers and caregivers of those children were also counselled on optimum maternal, infant and young child nutrition.

The monitoring and supervisory tools in use by the regions were also revised to incorporate nutrition indicators. After having been pilot-tested, the revised tools are now being used in the ANI-supported areas.

Protecting health from climate change

Wherever you live, climate change threatens your health. Whether you live in a big metropolis, a coastal town, a village or on a small island, climate change threatens your health and well-being. Global warming induced by climate change dramatically disrupts some of life's basic essential requirements for health: water, air and food.

In recognizing the devastating impact of climate change, the Government of Tanzania has put in place a number of initiatives to address the challenges of climate change. These include the National Adaptation Programme of Action (NAPA -2007); National Adaptation Strategy and Action Plan (2009); and the National Climate Change Strategy (2012),

DFID in collaboration with WHO supported the country to mitigate the impact of climate change through a project entitled "Building Climate Change Adaptation in Health in Least Developed Countries through resilient Water, Sanitation and Hygiene". The project aims at building adaptation capacity to the impact of climate change and variability on Water, Sanitation and Hygiene (WASH).

Through the project, the health sector was able to mainstream climate change considerations in its Health Sector Strategic Plan IV. Additionally policy briefs were developed to inform review of the national health policy, advocacy sessions to senior management of the Ministry of Health were held and training sessions conducted for 23 Regional Health Officers. Guidelines were developed for the

Preparation and Implementation of Climate Resilient Water Safety Plans (CR – WSPs) in pilot sites including trainings.

Through support from the Norwegian Ministry of Foreign Affairs, Climate and Health, training package was developed and 20 Regional Health Officers and Regional IDSR Focal Persons were trained on the use of climate information and products for health planning as part of the implementation of the Global Framework for Climate Services Project. A policy brief on Climate and Health was also developed feeding into the review of the Health Policy.



A household rescuing its belongings from floods due to heavy rains.

Protecting and promoting health and safety of workers

Workers represent half the world's population and are the major contributors to economic and social development. Their health is determined not only by workplace hazards but also by social, individual factors and access to health services. Despite the availability of effective interventions to prevent and to protect occupational hazards and promote health at the workplace, large gaps exist between and within countries with regard to the health status of workers and their exposure to occupational risks.

In 2015, WHO supported the Ministry of Health to develop the National Workers Profile. The Muhimbili University of Health and Allied Sciences on behalf of the Ministry conducted the situational analysis on occupational health and safety services in Tanzania and developed the Country Workers Profile or Outlook. The report presents quantitative and qualitative information about the state of health of Tanzanian workers and its determinants.

This year, the Ministry of Health with WHO support convened a multi-stakeholders' meeting to share the report and come up with strategic priority actions for protecting and promoting the health of working people in Tanzania.

The report provided data about the overall demographic characteristics and health status of the working population in the country as well as about the main health determinants – occupational health and safety risks and their health impacts, work-related social determinants of health, behavioural and other risk factors at the individual level, as well as the coverage of workers with preventive and curative health services and financial protection.

Recommendations provided during the dissemination meeting resulted into development of a comprehensive national occupational health and safety action plan for health care workers. This is a tool that will guide the country in protecting and promoting the health and safety of the health care workers.



Health workers helping each other wear Personal Protective gear.

Engaging communities in finding local solutions to health problems

Empowering community with knowledge

When Same District in Kilimanjaro Region started reporting cholera cases, WHO Country Office immediately deployed its surveillance officer, Dr William Mwengee, to go verify the event and assess the response needs. He found the cases came from two wards namely Ruvu and Hedaru villages located along the Mbughuni River, inhabited by seasonal laborers of big onion farms in camps. Their main source of water was directly from the river. The sanitation of the areas was also poor with impassable roads during the rainy season.

On review of the cases and reported deaths, it was found that patients arrived late into the illness at the Cholera Treatment Centre (CTC). There was also a general lack of Oral Rehydration Solution (ORS) sachets in the CTCs and in the communities.

Twenty Community Health Workers (CHWs) and 9 village leaders from the affected wards were identified, trained and deployed to their respective sub-villages to support health promotion and community education including distribution of IEC materials, ORSes and water guards to their respective sub villages.

“Many cholera victims live in remote areas, receiving ORS from their local CHWs will help keep them hydrated as they seek medical care. Some patients travel hours to reach a health center by foot or by motor bike”, noted a Health care worker from one of the affected areas.

CHWs were instrumental in distributing water purification materials (water guard) to all households and promoting preventive measures such as hand washing at a community level. The trained CHWs managed to reach 845 House Holds (HH) out of 1200 in the affected wards with information on cholera disease and water guards for HH water treatment. After 5 days of intensive field activity, the number of cholera cases declined significantly and the district reported no new case of cholera.



Community sensitization on ORS use during Cholera outbreak response

Seeking to understand the sociocultural dynamics

World Health Organization in collaboration with Ministry of Health, Regional and District Health Authorities conducted an assessment of socio-cultural factors associated with Cholera transmission in Mwanza, Singida Regions and Zanzibar Island.

The assessment was conceived on the backdrop of a protracted Cholera outbreak which has affected 28 out of the 30 regions of the country. Despite the ongoing social mobilization initiatives in the

affected communities, it was observed that cultural and social beliefs contributed to continued Cholera transmission in some Regions and Districts.

The assessment attempted to understand for example the reasons for delays in seeking health care, non-use of latrines, non-use of treated or boiled drinking water. This was done through qualitative methodologies which involved conducting focus group discussions, key informant interviews and in-depth discussions with District and Community health workers, community leaders, representatives from women groups and affected community members. Communities in Singida, Mwanza and Zanzibar were involved in the assessment.

Findings revealed existence of the belief that Cholera is caused by witchcraft. "If one of your neighbors hates you, he or she can cause you to get the disease and you will die", said a participant during a focused group discussion. "Having a toilet and using it is difficult and even not possible because it is not possible to carry a toilet everywhere you go for example to take care of cattle" said another respondent. In some communities, it was believed that traditional healers can cure and prevent cholera as supported by some traditional healers that they have powers to prevent and cure cholera using traditional herbs and medicines.

While knowledge on cholera prevention and control was found to be deficient and coloured by traditional attitudes and beliefs, some communities organized themselves to respond to the cholera outbreak with support of organizations active on the ground. Results of this assessment were useful for strategic communication and social mobilization at community level geared to end the Cholera outbreak.



Community mobilizers posting IEC material on Cholera



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