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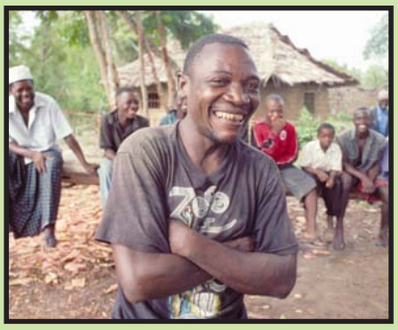

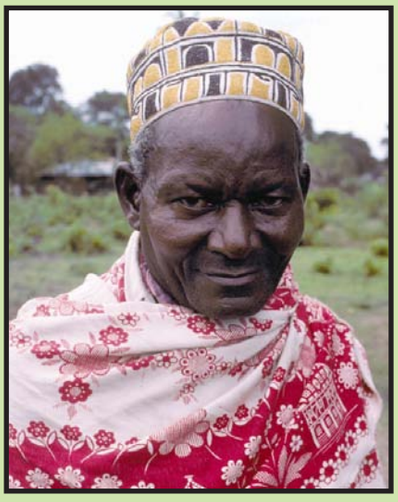

- **DISTRICT PLANS IMPLEMENTATION**
- TOOLS ROLL-OUT
- **ACHIEVEMENTS IN FIGHTING DISEASES**

A Newsletter of the IDRC/MOH Tanzania Essential Health Interventions Project

Front and Back Covers:

Happy faces of residents of Rufiji district where the Tanzania Essential Health Interventions Project (TEHIP) has been testing, since 1997, how and to what extent evidence can guide decentralized planning of the health sector.

A colourful Malaria Day ceremony was marked in Dar es Salaam on April 25, 2003. The guest of honour, Tanzanian Vice - President Dr. Ali Mohamed Shein (centre) expressed Tanzania's commitment to fighting the disease in all fronts. He is flanked by the Minister for Health Anna Abdallah (right) and the Dar es Salaam Regional Commissioner Yusuf Makamba (left). Read article on page 12.

TEHIP News is published by the Tanzania Essential Health Interventions Project (TEHIP), a joint initiative of Tanzania's Ministry of Health and Canada's International Development Research Centre (IDRC). Contents do not necessarily reflect the views of partners working together in the development and implementation of the project.

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COMMENTARY

Evidence-based planning: A beacon of hope

By Anna Abdallah

Anna Abdallah

As the developed world is making headway into a new era of all-round technological advances with glee and relish, ironically, in the Third World we are still grappling with basic, but more often than not, deadly health problems. The crisis is compounded by the devastating HIV/AIDS problem and the re-emergence of diseases that were once on the verge of being wiped out. This is happening at a time when the battle against hallmark Third World diseases such as malaria, cholera, etc. is a far cry from being won. The situation is more appalling because the catalogue of diseases is broadening against the backdrop of limited finances and growing –inequality.

As the myriad of health problems continues to wreak havoc on peoples' health and economies in most developing countries, priorities need to be set to bail out populations from the worst conditions. During the last decade many countries, both developed and developing, have undergone extensive re-thinking and modifications to their national health policies through what are called health sector reforms. In Tanzania these changes are part of the overall public sector reforms being undertaken by the government to improve public service delivery.

In line with the health sector reforms, for the past six years, a research and development partnership involving Tanzania's Ministry of Health and Canada's International Development Research Centre (IDRC) has been working on an evidence-based approach to district health planning and improved health service delivery. Through the rigorous efforts of the Tanzania Essential Health Interventions Project (TEHIP) and Council Health Management Teams (CHMT's) in two districts of Tanzania, evidence has been sought and realised to help in priority setting and allocation of resources. Solid evidence was comprised of carefully gathered population-based information on the burden of disease, cost effectiveness of interventions, capacity of the health system and community preferences. The bottom line of the endeavours is that health can be improved by planning spending more efficiently and that even a small health budget can yield good results.

It has come to light that one of the areas that has been neglected in the past is the provision of local information for evidence in order to facilitate prioritisation and rational allocation of scarce resources at the district level. With data drawn from the Demographic Surveillance Systems (DSS) which collect regular and continuous population-based information, it was possible thus to mold and roll-out reliable tools which district planners' can easily use. The burden of disease tool, for example, turned district health planners' outlook from mere budgeting to actual prioritisation and allocation of their scarce resources into cost-effective interventions addressing all the major components of the prevailing burden of disease.

It is estimated that 80 percent of the burden of disease comes from pre-mature mortality and is also the cause of much of the underlying disability that makes up the remaining 20 percent. The good news, however, is that in typical rural Tanzanian districts it has been established that available cost effective interventions can address over 85 percent of the total burden of disease. A stitch in time saves nine and so will the findings of TEHIP. Interventions are available and what is obviously needed is to improve the overall health systems so as to be able to deliver them more effectively and with wider coverage.

The bottom line of the endeavours is that health can be improved by planning spending more efficiently and that even a small health budget can yield good results.

What has been demonstrated so far in terms of managing district level health resources; establishing priorities and planning the allocation of resources; and translating district plans into essential health interventions, gives us hope of minimizing the overall disease burden, and hope should be the last thing we lose.

** Anna Abdallah is Tanzania's Minister for Health.*

Money counts, priority matters

Minister for Health speaks on Health Systems Development Priorities

The problem of health systems in developing countries is not simply the lack of money but where to put that money. One of the challenges facing developing countries is that resources for health care do not match the numerous health problems beleaguering the nations. But with increasing funding from donor countries and agencies, especially in fighting major killer diseases such as Malaria, HIV/AIDS and TB, the need for a sound health system to efficiently utilize the funds is crucial.

Addressing the International Forum on Innovative Partnerships and Global Health Issues held in Montreal, Canada on May 8, 2003, Tanzania's Minister for Health, Hon. Anna Abdalla raised a number of questions with regard to funding of health systems development priorities.

"Do we have health systems robust enough to use those funds effectively and efficiently in fighting HIV/AIDS, TB and Malaria? Do we have sufficient human resources to scale up coverage? Do we have resources to strengthen the health system and not just the diseases it is urged to fight?" She asked.

The Minister wondered whether it might be possible, for example, for some of the disease targeted money to be used in building strong health systems. Such systems are those that are able to fulfil societal goals of improving and protecting people's health, fairness of financial contributions, responding to people's expectations and reducing inequalities.

Hon. Abdalla whose presentation focused on Health Systems Development Priorities for Developing Countries with respect to the Tanzania's experience, outlined some of the challenges facing the public health system. They include limited finances, growing inequality, HIV/AIDS, the rapid spread of epidemics, re-emerging disease, the continuing scourge of malaria and the rising level of non-communicable diseases.

The Reforms in Tanzania expect districts to move beyond just simply managing diseases, to managing the entire health system from a perspective of health equality and equity.

She welcomed on-going efforts to set health investment priorities more strategically to address areas where needs are greatest. "The reforms in Tanzania expect districts to move beyond just simply managing diseases, to managing the entire health system from a perspective of health equality and equity, "she said. For the districts, she pointed out, it means a greater focus on selecting cost-effective interventions that address the largest shares of the burden of disease.

To realize an effective working health system, one of the main areas to be given priority is capacity building of both health planners and health workers. "The performance of a good working health care system depends on a knowledgeable, skilled and motivated workforce responsible and capable of delivering services at a high coverage.

The Minister hailed the funding support of the International; Development Research Centre (IDRC) and the Canadian International Development Agency (CIDA) in assisting with the design and development of tools to support decentralized district health planning and improved health service delivery.

The Tanzania Essential Health Interventions Project (TEHIP), a research and development partnership involving Tanzania's Ministry of Health and IDRC with financial support from CIDA, was established in 1997 to test innovations in planning, priority setting and resource allocations at the district level in Tanzania.

MINISTER'S CALL FOR DEVELOPING COUNTRIES

Extract from the speech delivered in Montreal, Canada on May 8, 2003 by Tanzanian Minister for Health, Anna Abdallah:

- A significant amount of new money needs to be dedicated to strengthening the basic health systems in developing countries to allow scaling up the coverage of existing essential health interventions.
- A corollary and pre-requisite to this first need is that a significant amount of money must be made available to scale up available human resources to deliver these services.
- Health spending must reflect evidence-based priorities rather than agendas of donors and vertical programmes to ensure maximum use of the limited financial resources.
- Funding priorities need to be based on district-owned plans aimed at developing the health system, rather than dealing with a series of vertical disease programmes which can often create a competitive situation.
- Secure long term funding for recurrent costs including staff salaries, capacity building and continuing education must be addressed.
- Global health funds must engage a strengthening of health systems and must be fully integrated into the nationally owned poverty reduction strategies that can address the needs of the most vulnerable.
- Priority investment in human resources must be recognized in order to carry through public sector reforms that can lead to raising the quality and access to health service delivery. This includes initial training, retraining, continuing education as well as development of new curricula to address and update health workers in the new health interventions and guidelines.
- If health information systems are to play their role effectively as instruments to improving health management, they must be designed to support decisions and actions of health personnel and be part of an integrated poverty monitoring information system. They also need to supply population based information as well as practical health facility management information.

More aggressive response a must in fighting AIDS

Tanzanians should speak openly on the adverse effects of HIV/AIDS and ways to combat the scourge, the Chairman of the Mwalimu Julius Nyerere Foundation, Dr. Salim Ahmed Salim has said.

He said it was disheartening to see that most Tanzanians were not ready to face the challenges brought about by HIV/AIDS and come up with strategies aimed at controlling its spread. Tanzania with a population of about of 33.5 million is estimated to have more than 2 million HIV positive individuals, the first case having been diagnosed in 1983.

In his address to the Nation to mark the World AIDS Day, on December 1, 2002, Dr. Salim warned that continuous silence on the pandemic would lead the country to devastation. 'We must accept that the HIV/AIDS pandemic is amongst us. We are supposed to tackle this problem head-on. We must speak out openly about how it affects us as well as ways and means to combat the pandemic,' he told a rally at Samora Memorial Stadium in Iringa where the climax of the World's AIDS Day was observed at the national level.

Dr. Salim who is the former Secretary-General of the Organization of African Unity (OAU), said it would be useless to point fingers at each other and wait until 'our children, parents, relatives and colleagues at workplaces die.' He wondered why the HIV/AIDS problems was not being taken seriously despite the fact that it is killing people every day.

He appealed to those who considered themselves safe from HIV/AIDS to take precautions and strive to chart strategies to combat the scourge instead of leaving the problem to others.

'For how long should we keep quiet when this enemy (HIV/AIDS) continues to ravage our families?' he asked.

Chairman of the Mwalimu Julius Nyerere Foundation, Dr. Salim Ahmed Salim

Dr. Salim called on every individual to contribute fully in campaigns against HIV/AIDS and ensure that people living with the disease are not discriminated against.

He urged Tanzanians to take HIV/AIDS as a more dangerous and formidable enemy than even the war against aggressor Idi Amin Dada of Uganda in the 1970s.

'HIV/AIDS is a threat to national security. We are under attack and are being destroyed. If we are not serious, we will be wiped out.' He further warned, calling for a more aggressive response among Tanzanians.

Meanwhile, the Minister of Health, Hon Anna Abdallah has said that Tanzania has a good stratetegic plan to combat HIV/AIDS but what is required is practical actions to achieve the expected results. "Much time has already been lost in talking and writing. Since the first cases were diagnosed in Tanzania , it is already 21 years... the scale of the epidemic is now formidable," she said in her opening address to the Government/Partners Joint Annual Health Sector Review Meeting held in Dar es Salaam from April 28-30, 2003.

Under five mortalities prominent in Rufiji District priority health problems

High under five mortality is priority health problem number one in Rufiji District.

Dr. Saidi Mkikima
Rufiji District Medical Officer

Reduction of under five mortality features as the number one priority in the 2003 Rufiji Comprehensive Council Health Plan. Infant and under five mortality rates are high but now declining in the district which is striving to provide essential clinical and public health packages at the community, dispensary and health center levels.

The infant mortality ratio (death per 1,000 live birth) was recorded as 100.1, 72.3 and 68.9 for 1999, 2000 and 2001, respectively. The under five mortality ratio was 131.5, 119.9 and 113.1 for 1999, 2000 and 2001 respectively.

The Council Health Management Team (CHMT) was able to rank the district's health priority problems making use of the District Burden of Disease Profile, produced annually, to feed into the district planning cycle.

The profile simplifies and communicates complex information on the local Burden of Disease by transforming it into easy to read graphs, tables and charts.

The 2003 plan aims at providing the CHMT, the plan's main implementors, with enabling conditions to deliver quality health care and to supervise the lower level health facilities.

The District, with a population of 207,000, provides preventive and curative services through two hospitals, four rural health centres and 50 dispensaries.

To implement the plan a total of TShs 1.5 Billion (about US$1.5 Million) was requested from various sources including the government, international development agencies, non governmental organizations and local government.

The plan was prepared in line with the District Health Planning Guidelines, the National Health Policy reflecting the Health Sector and Local Government Reforms.

The CHMT in collaboration with partners in the health sector prepared the plan with reference to resources such as the District Burden of Disease Profile, the Health Management Information System (MTUHA) reports, National District Health Planning Guidelines, Rufiji Demographic Surveillance System (RDSS), District Annual Reports, School Mapping Report (2001), National Essential Health Intervention Package and Village Council Reports.

The district health priority problems for 2003 rank as follows:

1. High under five mortality rate
2. High prevalence of Malaria
3. High Tuberculosis/Leprosy prevalence
4. High maternal mortality rate
5. High Sexually Transmitted Infections/HIV transmission rate
6. High prevalence of diarrhoeal diseases
7. High prevalence of eye infections
8 Inadequate health delivery system.

Cascade system rolls out to Bagamoyo District

The Integrated Management Cascade that has yielded positive results in Morogoro and Rufiji Districts has rolled out to Bagamoyo District in the Coast Region.

The Cascade is a handy tool that has been piloted in the two TEHIP project districts to delegate some of the Council Health Management Team (CHMT) duties to selected Health Centres and Dispensary staff to supervise health facilities in their areas of operation.

A workshop was recently held in Bagamoyo to prepare the ground for the establishment of the system in the district which has one district hospital, four health centres and 41 dispensaries owned by the government, private institutions and voluntary agencies.

The Bagamoyo District Medical Officer (DMO), Dr. Hamisi Nanjenu said the Cascade system would be a useful tool for the district in view of the fact that the district area is extensive and most of the health facilities are in remote locations. The district has an area of 9,842 sq. km and its population was estimated at 246,754 in 2002.

Because of the scarce human and financial resources at the district's disposal, delegating some of the CHMT's duties to staff at health facilities would make supervisory work more efficient and effective, said the DMO.

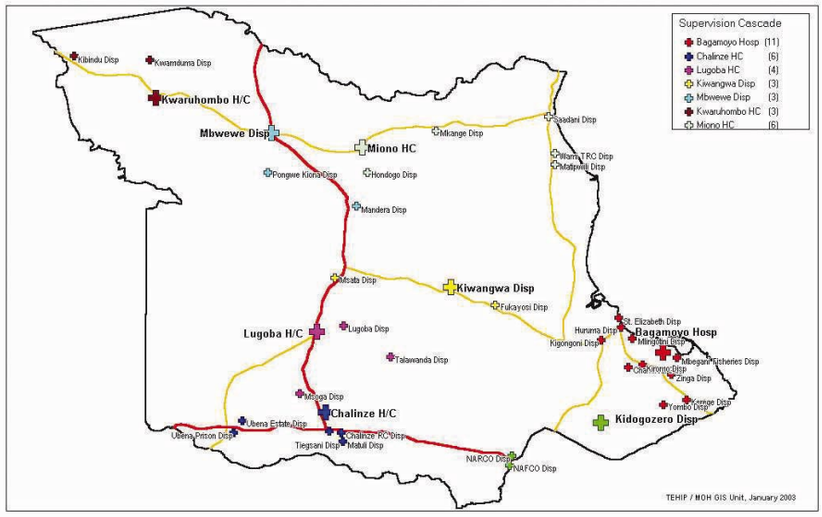
The Cascade system implemented in Morogoro and Rufiji districts since 1999 reduces the work load of the CHMT especially in districts that have many health facilities to be supervised quarterly. It is envisaged that the Cascade system would enhance activities aimed at tackling identified health priorities such as high infant mortality rates, malnutrition, malaria, AIDS and diarrhoeal diseases.

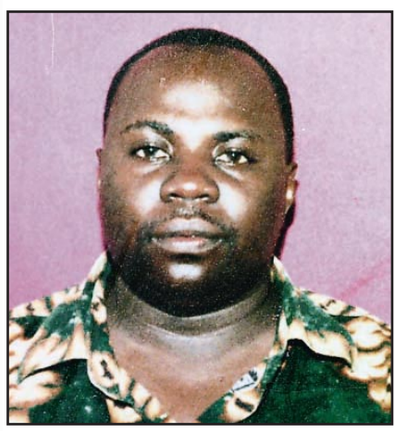
Duties delegated in the Cascade System include:

- Supervision of the Health Management Information System (HMIS) as per the supervisory matrix.
- Follow-up of some patients, for example those with chronic diseases.
- Reporting of disease surveillance.
- Rapid follow-up of epidemics (e.g. cholera).
- Supervision and monitoring of outreach and mobile services.
- Quality assurance.
- Supervision of planned preventive maintenance.
- Feedback on supervision activities to CHMT and writing of quarterly technical and financial reports.

Edward Nzigilwa, one of the participants of the workshop said that the Cascade System would also help health workers take stock of what is taking place outside their stations.

BAGAMOYO DISTRICT: Supervision Cascade





The Bagamoyo District Medical Officer (DMO), Dr. Hamisi Nanjenu

STEPS FOR CASCADE SYSTEM IMPLEMENTATION

1. **Orientation of the Council Health Management Team (CHMT) on**
   - Objectives
   - Concept
   - Modalities of cascade system operation
   - Identification of Cascade Nodes and leaders
2. **Orientation to district leaders, Primary Health Care Committee members, District Management Team and Councillors.**
   - Orientation about the cascade system
   - Logistics, including capacity building of cascade leaders
3. **Conduct meetings between CHMT and cascade leaders.**
   - Orientation on cascade system
   - Roles and responsibilities
   - Identification of other cascade key staff in their respective areas
   - Prepare Route Matrix
4. **Sensitization of ward development committee members on cascade system.**
5. **Sensitization of satellite staff and stakeholders.**
   - Orientation on cascade system
   - Introducing cascade leaders and Key staff
6. **Establishment of district cascade task force committee. This could include:**
   - District transport officer - Chairperson
   - HMIS coordinator for data quality as surance
   - Accountant - for monitoring payment processes, i.e. receiving requests from cascade node leaders, processing vouchers, cheques and handing them to cascade leaders.
   - Evaluation/replanning
7. **Ensure resources are put in place.**
   - Conduct needs assessment
   - Capacity building of cascade staff
8. **Plan for implementation.**

Taking stock of third year of comprehensive planning

Bagamoyo District which started implementing the Health Sector Reform Programme in June 2001 has made some significant strides in health services delivery.

Gains achieved in the implementation of the district's 2002 Comprehensive Health Programme include control of disease outbreaks, improvement of immunization coverage, rehabilitation of health facilities, adoption of a cost sharing scheme in three health centres, improvement in medical supplies and stepping up supportive supervision, an essential ingredient in ensuring quality of care.

The 2002 achievements have served as a springboard for the 2003 Comprehensive Council Health plan which aims at improving health and nutritional status of the people through community awareness in health care service delivery.

According to the plan, health priorities identified in previous years such as high infant and maternal mortality rates, malnutrition, malaria, HIV/AIDS and diarrhoeal disease still remained major contributing factors to poor health status in the district.

To implement the 2003 health plan the council intends to continue addressing intervention measures to priority health problems which include inadequate health and nutrition, education, poor environmental sanitation, poor household food security, inadequate safe water supply, illiteracy and poverty.

Measures to address the identified priority problems are listed down as:

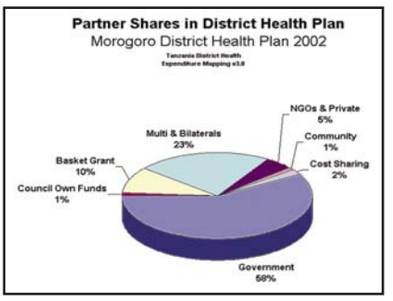
- Renovation/Rehabilitation of health facilities.
- Community mobilization.
- Malaria prevention and control .
- Capacity building of health staff.
- Improving disease surveillance and reporting systems.
- Increasing immunization coverage.
- Improving community health promotion and disease prevention.
- Establishment of council health boards and health facility committees.
- Recruitment of qualified health workers to fill staffing gaps.
- Enhancing establishment of user fees to health centres and Community Health Fund (CHF).

The Council Health Management Team will utilize financial resources available from the health "basket grant" to implement these interventions. Action plans focus on utilization of US$ 126,500.50 that has been allocated to “cost centre levels” which include council hospitals, urban health centres, rural health centres, dispensaries, community initiative and the District Medical Office.

The planning process involved several collaborating partners from the community and non governmental organizations and drew inputs from the Government Development Vision 2025 and Local Government Authority Reform, Poverty Alleviation and Health Sector Reform policies.

Monitoring and evaluation is strengthened through setting up the Cascade system whereby the Council Health Management Team (CHMT) members and staff in-charge of health centres collectively undertake routine supervision on a monthly basis.

District Health Accounts Tool released for wider dissemination



More districts in Tanzania are expected to come up with more realistic and comprehensive council health plans following the Ministry of Health's initiatives to roll out the use of the District Health Accounts Tool (DHA).

The DHA tool designed to help CHMTs analyze their budgets and expenditures by providing a one-page summary and several graphical "pictures" of aspects of their annual plans, was developed in the course of implementation of the Tanzania Essential Health Interventions Project (TEHIP) and is being used effectively in Rufiji and Morogoro districts.

Personnel from all six districts of Kagera Region, west of Tanzania, involved in preparation or assessment of the Comprehensive Council Health Plans (CCHPs) attended a training workshop in Bukoba from September 30 to October 3, 2002 to familiarize themselves with the use of the tool which can also interface with the Burden of Disease Profile.

The workshop provided an opportunity for personnel from the Zonal Training Centres (ZTCs) not only to disseminate knowledge and skills on the use of the DHA tool to the Council Health Management Teams (CHMTs) and related personnel but also to explore possibilities of making the tool more user-friendly.

The workshop attended by18 CHMTs members, their accounting personnel, Regional Health Management Team members and a representative from the office of the Regional Administrative Secretary comprised two major units. The first unit covered the theoretical basis of the tool's components and applications and the second one offered the opportunity for participants to acquire practical experience in using the tool.

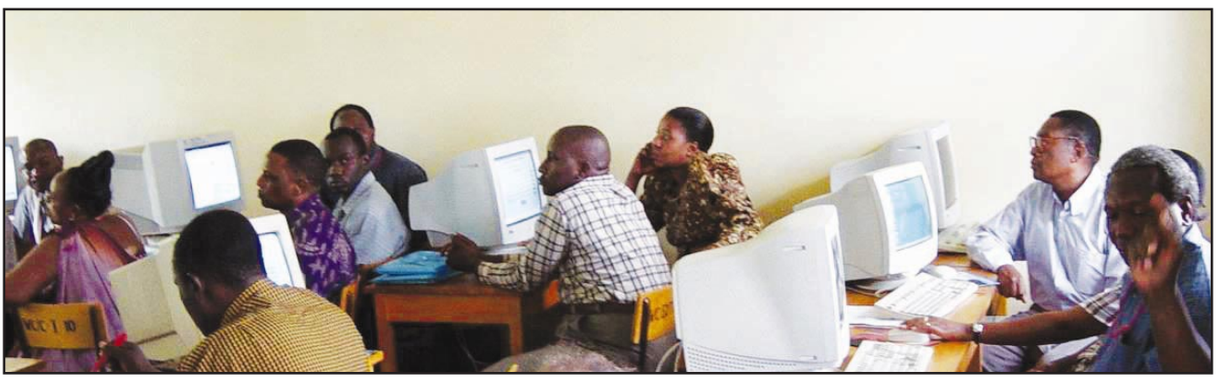
The workshop drew facilitators from ZTCs based in Mwanza, Iringa and Morogoro as well as resource persons from TEHIP, Kagera RHMT, MoH, the University College of Land and Agricultural Studies (UCLAS), Centre for Educational Development in Health, Arusha, (CEDHA), Tabora, Kigoma and Mtwara.. During the workshiop trainees were able to:

- Analyze the CCHP budget for their own district 2002 Comprehensive Council Health Plans.
- Interpret and discuss the out puts generated by the tool to determine where adjustments to the budget could have been made.
- Generate tables and graphs that enabled them to visualize whether the Council Health "Basket Grant" allocations were in line with MoH guidelines and ceilings and against the Burden of Disease.

The knowledge and hands on components of the course were put to practical use, and some results achieved, even before participants dispersed to their respective work stations. While CHMT representatives made tentative plans to familiarize their colleagues with the DHA tool, RHMT representatives made plans, to provide support to the DHMTs in using the tool.

The tool has already proven useful in Morogoro and Rufiji districts planning and its attributes include:

- providing basic analysis of budget and expenditure to check against



The District Health Accounts workshop covered the theoretical basis of the tool's components and applications and also offered the opportunity for participants to acquire practical experience in using the tool.

Participants and facilitators of the First District Health Accounts workshop held in Bukoba, Kagera Region in 2002.

DISTRICT HEALTH ACCOUNTS TOOL

With its emphasis on filtering, simplifying and analysing the budget, the District Health Accounts Tool fulfils several needs, including:

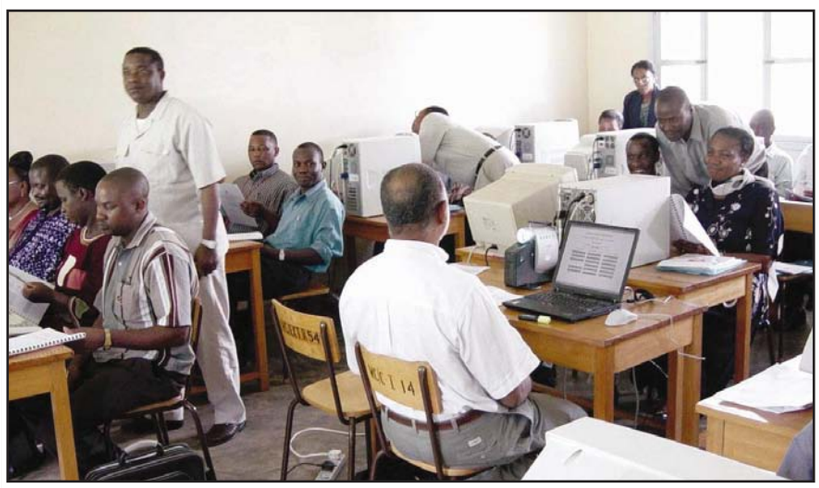
- providing basic analysis on budget and expenditure to check against plan priorities;
- linking budget to the prevailing bur den of disease determined through the local sentinel demographic surveillance system;
- capturing contributions of all poten tial sources of revenue, including government, donors, non-govern mental organizations, community, and the private sector;
- showing allocations to major inter ventions and activities;
- comparing the planned buget to actual expenditure at the end of the year;
- satisfying accountability and trans parency.

plan priorities.

- showing the total amount of financial resources a CHMT has budgeted and how these resources are divided proportionally.
- capturing contributions of all potential sources of revenue, including government, donors, non-governmental organizations, community and the private sector.
- showing allocations to major interventions and activities.
- comparing budget lines to actual spending.
- satisfying accountability and transparency.

Participants expressed appreciation for the usefulness and relevance of the tool. The urgent need for its wider dissemination was underscored by the workshop facilitators who suggested explicit involvement of the Directorate of Human Resources Development of the MoH in the organization of training pertaining the tool's use as part of a continuing education strategy.

The exercise was the first of its kind to be conducted under ZTCs of the Ministry of Health.



Participants of the Second Kagera District Health Accounts Workshop at work.

MoH establishes structures to engage community voice

The Ministry of Health, in collaboration with the President's Office - Regional Administration and Local Government (PORALG), Regional Secretariats and Local Government Authorities, is in the process of establishing Council Health Service Boards and Health Facility Committees.

The structures, aimed at strengthening the community voice in health service provision and ownership of facilities, are important tools of decentralization. Through these boards and committees, districts will be empowered to manage health services.

Addressing the Government of Tanzania/Partners Joint Annual Health Sector Review meeting held in Dar es Salaam on April 28, 2003, the Minister for Health, Hon. Anna M. Abdallah said the ultimate goal is community ownership of the facilities.

"To many people it is a new concept, but my Ministry (together with related initiatives in health care financing such as the National Health Insurance, Community Health Fund, Cost Sharing and Drug Revolving Fund) believes it will go a long way towards improved quality of Health Services to our people," she said.

Guidelines for establishing Council Health Services Boards, Hospital Governing Committees and Health Centre and Dispensary Committees have been finalized and the three top council staff for each of the 37 Phase One Councils have been given an orientation on the functions of the new structures.

The Minister also noted that rehabilitation of the health infrastructure network comprising hospitals, health centres and dispensaries was long overdue. "This major undertaking requires the support of our partners and first hand involvement and participation of the local councils and communities to ensure that the facilities will be maintained," she stressed.

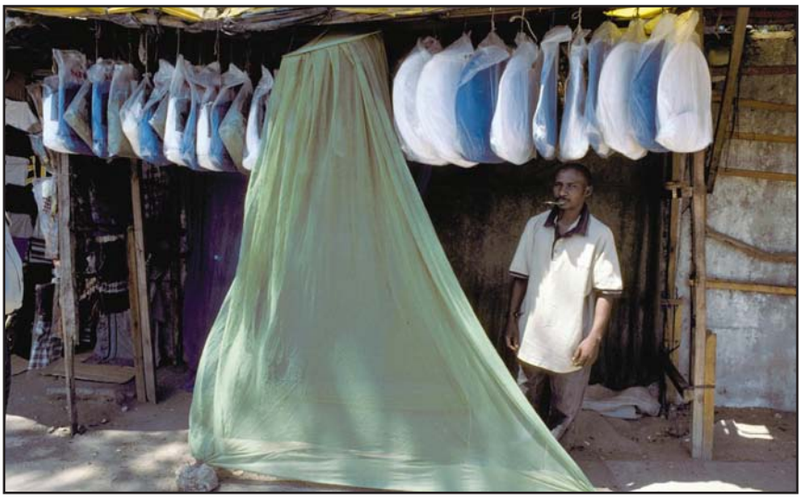
TEHIP, which since 1997 has been integrating research and development efforts in developing new tools and approaches that would enable CHMTs to make their own realistic local plans, used community driven facility rehabilitation in Rufiji and Morogoro districts as an entry point to engage the 'community voice' in health planning and implementation process.

In both districts the CHMTs achieved tangible results by promoting ownership of local health facilities and imparting appropriate skills to local communities on labour-based construction and maintenance.

The Review Meeting participants generally agreed that involvement and participation of local governments is the key to ensuring sustainable ownership by communities.

Rehabilitation of the health infrastructure is long overdue. However, a facelift of some of the facilities like the one above in Morogoro district have helped restore the confidence of communities and health workers.

WHO/UNICEF hail Tanzania's contribution in fighting Malaria



Insecticide treated nets are now widely used in Tanzania and available at affordable prices.

The African Malaria Report has acknowledged Tanzania's contribution in the progress already made in combating malaria which is holding back the development of many African countries.

The report hailed efforts in Tanzania to market, on a wider scale, the use of Insecticide Treated Nets (ITNs). The proper use of ITNs, combined with prompt treatment for malaria at community level can reduce malaria transmission and can reduce overall infant death by as much as 60 per cent.

A three-year community pilot project in Tanzania, the report says, has seen the proportion of infants sleeping under ITNs rise from 10 per cent to 50 per cent and the child death rate fall by more than 25 per cent.

ITN research conducted at the Ifakara Health Research and Development Centre contributes to the recent achievements on the global war on Malaria.

The African Malaria Report released on April 25, 2003 by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) says the death toll from malaria remains outrageously high-with more than 3,000 African children dying daily.

It also stressed that new effective anti-malarial drugs are not yet accessible to the majority of those who need them and that only a small proportion of children at risk of malaria are protected by highly effective ITNs.

The report, was officially launched by President Mwai Kibaki of Kenya in commemoration of Africa Malaria Day. It highlights the urgent need to make effective anti-malarial treatment available to those most at risk.

"The Roll Back Malaria Initiative has made considerable progress since it was launched in 1998, but we need to increase efforts to combat this devastating disease which is holding back the development of many African countries," states Dr. Gro Harlem Brundtland, Director-General of WHO. "Malaria continues to tighten its grip on Africa. By scaling up our efforts, we can reverse this trend."

An estimated 20 per cent of the world's population - mostly those living in the world's poorest countries - is at risk of contracting malaria. Malaria causes more than three hundred million cases and kills at least one million people every year. Ninety per cent of deaths due to malaria occur in Africa, south of the Sahara, and most deaths occur in children under the age of five.

"Malaria kills an African child every 30 seconds, and remains one of the most important threats to the health of pregnant women and their newborns," said Carol Bellamy, Executive Director of UNICEF. "We have the knowledge and the potential to achieve our target of reducing the global burden of malaria by half by 2010, but we need much greater investment and political commitment."

The Africa Malaria Report challenges the global community to step up the momentum by:

- Increasing global investment to support implementation of programmes to control malaria in endemic countries;
- According higher priority to malaria on the health agenda of endemic countries;
- Encouraging greater private sector

involvement in the national supply and distribution of quality anti-malaria drugs,and inseticide treated nets;
- Ensuring the availability of the new generation of highly effective antimalarial combination drug treatments to populations at risk.

Community health workers and mothers of young children in more than ten districts in Uganda have been trained to recognize the symptoms of malaria and seek immediate treatment as part of a home-based approach to the management of malaria. This approach encourages the active participation of local medicine sellers and the pharmaceutical industry in malaria control efforts. Interim results suggest a definite decline in the number of out-patient malaria cases in children under five. Ghana and Nigeria have also introduced this home-based approach.

"The African Malaria Report" shows how the partnership, established to roll back malaria, is increasing support for endemic countries' fight against this disease. The global partnership is at a crucial juncture; it needs to sustain and surpass the support galvanized to date. Our challenge is to live up to the commitments made five years ago and not fail yet another generation of African children. This would be unacceptable." stated Dr. Nafo-Traore, Executive Secretary, RBM Partnership Secretariat.

The Report makes use of INDEPTH data from a network of DSS sites in Africa as well as the Mapping Malaria risk in Africa.

Meanwhile, speaking during a colourful ceremony to mark Africa Malaria Day in Dar es Salaam, Vice President, Dr. Ali Mohamed Shein said Tanzania is committed to taking measures to ensure that goals aimed at controlling the disease are realized. Africa Malaria Day was held at Southern Africa Development Community (SADC) level in Dar es Salaam. It was preceded by a motor rally across SADC member states to roll back malaria flagged off by South African President Thabo Mbeki at KwaZulu, Natal Province on April 11, 2003.

A motor rally across SADC member states to "Rollback" malaria was welcomed into Tanzania by people of all walks of life in Mbozi district, Mbeya Region.

Background on Roll Back Malaria

Roll Back Malaria (RBM) was launched in 1998 with the declared objective of halved the global burden of malaria eliminated by 2010. Its founding partners - the United Nations Development Programme, UNICEF, The World Bank and WHO - agreed to share their expertise and resources in a concerted effort to tackle malaria worldwide, with a particular focus on Africa.

According to WHO, since the launch of Roll Back Malaria, international spending on malaria has more than trebled to a current figure of US$ 200 million a year. Comprehensive strategic plans to tackle malaria have been developed in more than 30 African countries with endemic malaria and significant additional resources have been secured to implement these plans from the new Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM).

The RBM initiative is a global partnership including malaria endemic countries, bilateral and multilateral donors, the private sector, and NGOs, and has succeeded in raising global awareness of malaria, generating increased resources and achieving consensus on the tools and priority interventions required to control the disease.

At the Abuja Summit in Nigeria on 25 April 2000, 44 African leaders reaffirmed their commitment to roll back malaria and set interim targets for Africa. They challenged other world leaders to join them in recognizing the importance of tackling malaria as a disease of poverty.

Following the Abuja summit, 25 April was declared "Africa Malaria Day", and a subsequent UN resolution declared 2001 - 2010 "The Decade to Roll Back Malaria, especially in Africa", giving prominence to malaria in the United Nations' Millennium Development Goals.

Of 44 countries that signed the Abuja Declaration in 2000, 25 endemic countries in Africa have submitted successful proposals to the Global Fund to fight AIDS, Tuberculosis and Malaria for funding support to scale-up implementation of their national malaria control plans.

Eighteen endemic countries have now reduced or eliminated taxes and tariffs on anti-malarial products including mosquito nets and insecticides - helping to make these essential products more accessible.

Malaria declared new IMCI target

Dr. Ali Mzige

The Ministry of Health has announced that malaria will be integrated in all childhood disease management at health facilities, a move aimed at reversing the alarming rate at which children are suffering and dying from the disease in the country.

Under the plan, malaria screening and treatment will be routinely undertaken in attending all under five-year-old sick children.

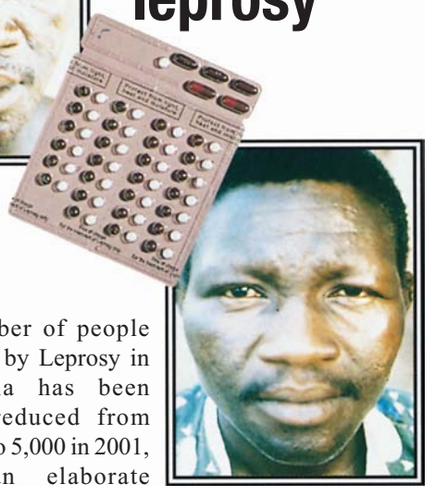
The Director of Preventive Services, Dr. Ali Mzige said that the first National Malaria and Integrated Management of Childhood Illness (IMCI) conference in Dodoma has already set the ball rolling. Among participants of the conference were District Medical Officers and other experts in childhood illnesses and malaria. Dr. Mzige said District Medical Officers and other experts from lower levels have specifically been chosen because they will be key players in implementing essential health interventions.

Under the Health Sector Reforms, districts have been given the responsibilities for planning and implementing essential health interventions.

Malaria is the leading killer disease in Tanzania attacking about 16 million people every year of whom 100,000 die. About 25 per cent of the deaths are those of children under five years. It accounts for between 30 and 40 per cent of patients seeking medical attention from health facilities and contributes to an annual loss of Tsh.121bn/=, which is about 3.4 per cent of the GDP.

Tanzania on the verge of wiping out leprosy

Before



After

The number of people affected by Leprosy in Tanzania has been significantly reduced from 40,000 in 1977 to 5,000 in 2001, thanks to an elaborate programme on TB and Leprosy being implemented country-wide under the auspices of the Ministry of Health.

Addressing a rally to mark the World Leprosy Day on January 25 at Shirati Hospital in Mara region, the Deputy Minister of Health Dr. Hussein Mwinyi said Tanzania was close to finally wiping out the disease.

The Deputy Minister however noted that this would only be possible if early symptoms were reported to relevant medical authorities in good time. "The disease is curable contrary to misguided beliefs that it is inherited," Dr. Mwinyi said.

According to the World Health Organization (WHO), leprosy should be wiped from the face of the earth by the year 2005.

The Minister said that since we have only 5,000 leprosy cases at the moment, it is very possible for us to eliminate the disease by that year.

Among the common symptoms of leprosy are development of skin patches and skin nodules, thickening of nerves and lack of skin sensitivity.

The Deputy Minister called on medical personnel countrywide to educate the people on the symptoms of the disease so as to facilitate early treatment.

FACTS ABOUT LEPROSY

- More than 5,000 people were sick with leprosy in Tanzania in 2001.
- Bacteria cause leprosy.
- Leprosy mainly affects the skin and nerves. If untreated, it may cause permanent disabilities.
- The Government of Tanzania aims to eliminate leprosy as a public health problem by 2005.
- Leprosy is spread through the air when infected people cough or sneeze during close and prolonged contacts.
- Early diagnosis and proper treatment of leprosy prevents patients from getting disabilities.
- Leprosy is curable with MDT, which is available in all health facilities free of charge.
- Leprosy can be cured within 6 to 12 months of treatment with MDT.
- Leprosy can only be cured in health facilities.
- Treated leprosy patients who have disabilities are no longer infectious; therefore they should not be isolated.

Trachoma is the world's leading cause of preventable blindness.

ITI working vigorously to eliminate Trachoma

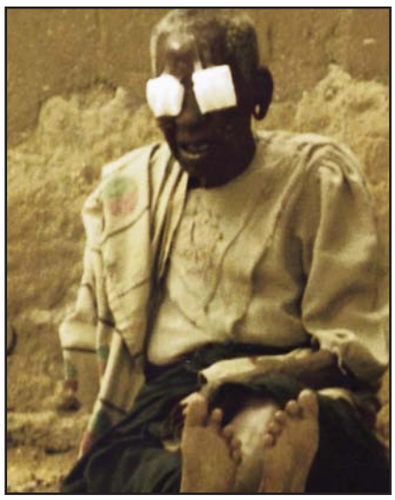
Evaluations indicate that trachoma prevalence has been reduced by more than 50 percent in some areas of Tanzania where disease control programs are being implemented by the government with support from the International Trachoma Initiative (ITI).

ITI, dedicated to the elimination of blinding trachoma, launched its first country programs in Morocco and Tanzania in 1999. ITI is also implementing programs in Ethiopia, Ghana, Mali, Morocco Nepal, Niger, Sudan and Vietnam.

Founded in 1998 by the Edna McConnell Clark Foundation and Pfizer Inc., ITI supports national efforts through implementation of a strategy commonly known as SAFE. Trachoma has blinded up to 6 million people in the developing world.

The SAFE strategy comprises: Surgery which addresses the needs of people at imminent risk of blindness; Antibiotics used against active disease by treating infection in individuals and suppressing transmission in the community; Face washing breaks the circle of reinfection and disease transmission; and Environmental change as an essential part of trachoma elimination locally and globally.

"The SAFE strategy integrates easily with other efforts aimed at improving health and hygiene . In fact, SAFE may have benefits beyond trachoma control related to other health problems such as helminth infection and diarrhoeal diseases," noted Dr. Peter Kilima, Regional Coordinator, ITI, in his presentation to the African Health Research Forum held in Arusha from November 12 to 15, 2002.



Surgery has restored sight to many trachoma patients.

Trachoma, the world's leading cause of preventable blindness, is caused by the bacterium *Chlamydia trachomatis*, which can spread easily on hands or clothing or by flies that have come in contact with discharge from the eyes or nose of an infected person.

The disease generally occurs in poor countries where people have limited access to water and health care. It affects the inner upper eyelid and cornea. Repeated infections from childhood may lead to loss of sight during adulthood.

ITI's early success reflects the importance of partnership among private companies, international agencies, and governmental and non -governmental organisations.

LESSONS

According to Dr. Joseph Cook who led the growth and development of ITI since 1998, the Trachoma Initiative implementation offers a number of lessons that can strengthen the fight against disease and other threats.

- Disease-control programs must rest on solid scientific evidence.
- Programs should be locally organized and respond to local circumstances.
- Treatment should be closely linked with prevention and the development of a strong public health infrastructure.
- The program must fit within a broader agenda of health promotion, disease control and health equity.

TEHIP News

TEHIP News is a development oriented newsletter published by the Tanzania Essential Health Interventions Project (TEHIP). It is aimed at linking health development workers and researchers, especially those struggling with questions about how best to allocate human and financial resources to maximise the health status of populations in low income countries. TEHIP hopes that the newsletter will stimulate new ideas and enthusiasm. The newsletter is free of charge to institutions and individuals working to promote health and development. The newsletter is also available on the IDRC website: www. idrc.ca/earo/.To be included in our mailing list write to:

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