REVOLUTIONARY GOVERNMENT
OF ZANZIBAR

MINISTRY OF HEALTH AND SOCIAL WELFARE

ZANZIBAR HEALTH SECTOR REFORM STRATEGIC PLAN II

2006/07 – 2010/11

Foreword

Since 2002 the Revolutionary of Government of Zanzibar has embarked on Zanzibar Development vision 2020 whose overall goal is to eradicate absolute poverty in the society. To attain this goal more emphasis will be required, among other things, on sound macroeconomic management policies aimed at creating a stable environment for growth (including investments and trade) that will subsequently promote sustainable livelihoods through chosen productive employment and work and the provision of basic social services including health care services.

The status of health in any country is a useful indicator of human development. The implication of this fact is that health care services must be made accessible to all Zanzibari and of good quality. In addition it must respond or be relevant to the needs of the people.

This is a formidable challenge for the Ministry of Health and Social Welfare in Zanzibar. The challenge is further compounded by the fact that the health needs of the people do not only change from time to time but also operate in an ever changing environment. The Ministry of Health and Social Welfare therefore has to position itself strategically so as to be able to address the ever changing community health needs in a dynamic environment.

This Health Sector Reform Strategic Plan II is a follow-up to the 1st Plan 2001/2-2005/6. The guiding principles of this plan include: A *multi-sectoral approach* to the planning, implementation, monitoring and evaluation of health services; *political commitment and civil society involvement; a* commitment to *reduce stigma and discrimination* in combating the HIV epidemic; adoption of a *human rights-based* approach; *sensitivity to the culture and social context of Zanzibar*. While firmly based on sound scientific evidence, health promotion strategies shall promote and protect positive aspects of the Zanzibar culture; active seeking and promotion of *community participation* in health; ensuring that comprehensive basic health services shall be *accessible to all*.

Therefore all programmes should fit into this plan. It has been carefully developed on the basis of a comprehensive situation analysis of the health sector in Zanzibar and its development pattern since 1993 when the reform process was initiated. The Strategic Plan has identified five key areas with clearly articulated objectives strategies and activities which must be implemented over the next five years. These areas are as follows: Strengthening Human Resources for Health; Decentralisation; Serving the vulnerable; Integration; transparency and partnership; Monitoring and evaluation.

The plan is the operationalization of the Health Sector Policy which has duly been approved by the Revolutionary Council and the House of Representatives and as such has the blessings of the relevant authorities.

However the service of implementing this Strategic Plan depends on cooperation and collaboration with all stakeholders. To mention a few, these include other government ministries and departments, partners/donors and more critically the community who are the ultimate clients/consumers of the services resulting from this plan.

In this way, the Ministry of Health and Social Welfare will be working on a health care delivery plan that is not only responsive to the needs of the clients but most importantly it has been prepared in a participatory way in partnership with the consumers themselves. It is my hope that this Strategic Plan will not be looked at as any another document but as an operational reference guide to direct our day to day activities.

I therefore encourage everyone to take this document seriously as it has the full backing of the Ministry of Health and Social Welfare and the Revolutionary Government of Zanzibar in general. It is a home grown initiative based on our problems and needs with interventions that will have for reaching implications for the health of our people and development as a whole.

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Minister for Health and Social Welfare
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Acknowledgements

With this Health Sector Reform Strategic Plan II everyone of us in the Ministry of Health and Social Welfare has every reason to be happy for it gives us a clear direction of where our efforts should focus for the effective and efficient delivery of health care services on an equitable basis over the next five years (2005/6 – 2010/11. We should take this challenge by diligently implementing the articulated objectives, strategies and activities.

The Strategic Plan is a step towards addressing the challenges the health sector in Zanzibar is facing particularly in connection with the changing environment or context. It encourages integration and coordination for the common of the whole sector.

One thing which is unique about this Health Sector Reform Strategic Plan II is that it has been developed by indigenous experts who have pain-staking working on the process. As such this plan is the product of the concentrated efforts of a number of organizations and individuals. The core team within the Ministry of Health and Social Welfare comprised of Dr. Omar M. Shauri (former PS), Dr. Malik A. Juma (Director General), Mr. Said A. Natepe (Director of Planning and Administration) Dr Mkasha H. Mkasha (Health Coordinator – Pemba). The entire staff of the Health Sector Reform Secretariat i.e Dr. Uledi M. Kisumku, Mr. Issa Abeid, Mr. Fadhil Abbas, Ms. Sharifa Awadh, Dr. M. Dahoma, Ms. Khadija Shaaban, Mr Ali Hassan, Mr. Abdullatif Haji, Mr. Hassan Makame, Ms. Subira Suleiman, Mr. Khamis A. Mwadin and Ms. Muna Omar.

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For all of them we really appreciate their commitment for this work and we are so grateful.

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Abbreviations

ACT	Artemesinin Combination Therapy (for malaria)
ADB	African Development Bank
AIDS	Acquired Immunodeficiency Syndrome
AJHSR	Annual Joint Health Sector Review
ARI	Acute Respiratory Infection
ASRH	Adolescent Sexual and Reproductive Health
AYA	African Youth Alliance
BCG	Bacillus C. Guerin (for TB)
CHS	College of Health Sciences
Danida	Danish International Development Agency
DHMT	District Health Management Team
EHCP	Essential Health Care Package
EMoC	Emergency Obstetric Care
EPI	Expanded Programme of Immunization
FHRP	First Health Rehabilitation Project
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GOZ	Government of Zanzibar
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HSF	Health Service Fund
HSPS	Health Sector Programme Support
HSRS	Health Sector Reform Secretariat
HSSP	Health Sector Strategic Plan
IDD	Iodine Deficiency Disorders
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
ITN	Insecticide Treated Net
MDG	Millennium Development Goals
MDT	Multi Drug Therapy
MKUZA	Kiswahili acronym for ZSGRP
MMH	Mnazi Mmoja Hospital
MOFEA	Ministry of Finance and Economic Affairs
MOHSW	Ministry of Health and Social Welfare
MTEF	Medium Term Expenditure Framework
NACTE	National Council for Technical Education
NBS	National Bureau of Statistics (Tanzania Mainland)
NCD	Non-Communicable Diseases
PCM	Partner Coordination Meeting
PEM	Protein Energy Malnutrition
PEPFAR	President's Emergency Fund for AIDS Relief
PER	Public Expenditure Review
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PHCU	Primary Health Care Unit

PHL	Public Health Laboratory
PLWHA	People Living With HIV AIDS
PMTCT	Prevention of Mother to Child Transmission (of HIV)
RCH	Reproductive and Child Health
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
SWAp	Sector Wide Approach
TDHS	Tanzania Demographic and Health Survey (1996, 2004/05)
TRCHS	Tanzania Reproductive and Child Health Survey (1999)
TTI	Transfusion transmissible infection
U5MR	Under Five Mortality Rate
UNICEF	United Nations Children's Fund
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
VAD	Vitamin A Deficiency
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
ZACP	Zanzibar Aids Control Programme
ZHMT	Zonal Health Management Team
ZHR	Zanzibar House of Representatives
ZHSRSP	Zanzibar Health Sector Reform Strategic Plan
ZMCP	Zanzibar Malaria Control Programme
ZPRP	Zanzibar Poverty Reduction Plan
ZSGRP	Zanzibar Strategy for Growth and the Reduction of Poverty

Table of contents

List of tables

List of figures

1. Introduction

In 2002, Zanzibar initiated a Health Sector Reform under the guidance of the Zanzibar Health Sector Reform Strategic Plan I 2002/03 – 2006/07. The reform was seeking to decentralise planning, prioritisation and integration of services to district level. In addition, it aims at ensuring the availability of equitable high quality health care services, which focus on priority diseases or burden of diseases, according to an essential health care package (EHCP). The EHCP adopts the principles of primary health care (PHC), based on strengthening health delivery at the community level and in Primary Health Care Units (PHCUs) and Centres (PHCCs).

A 2004 assessment of Zanzibar Health Sector Reform Strategic Plan I (ZHSRSP I) concluded that "in general, ZHSRSP I (2002/03 –2006/07) has not been implemented as programmed and failed to guide planning of Ministry of Health and Social Welfare (MOHSW) and stakeholders activities." This current document, a more comprehensive and feasible ZHSRSP II (2006/07 – 2010/11), has been developed a year before the end of the first plan period in order to address this concern, and to enable the sector programme to run concurrently with the new Zanzibar Strategy for Growth and Poverty Reduction (MKUZA).

1.1 Background information on Zanzibar

Zanzibar is a semi-autonomous region within the United Republic of Tanzania. It comprises two main islands, Unguja and Pemba, and a number of sparsely populated islets. After the 1964 revolution, Zanzibar joined with the then Tanganyika to form the United Republic of Tanzania. Zanzibar maintains its own government and is directly responsible for all non-union affairs, including health services.

Unguja Island covers an area of about 1,464 square kilometers and Pemba Island covers an area of about 864 square kilometers. There are five administrative regions, three in Unguja and two in Pemba island which are subdivided into 10 districts. There are 50 constituencies and 289 Shehias. The Shehia is the lowest administrative level of the government structure.

According to the 2002 Population and Housing Census, Zanzibar has a total population of 981,754 people with an annual growth rate of 3.1%. Unguja has a population of 620,957 and Pemba has 360,797. Viewed from a gender perspective, the female population is 502,006 while the male population is 482,610. The population structure shows that under-fives account for almost 16% of the population, while the proportion of the population below the age of 15 years is about 47%. The population in age groups 15-64, ie of working age, is estimated at 49%, with the remaining 4% being those aged 65 years and above.

Life expectancy at birth for Zanzibar was estimated in 2002 to be 57 years (National Bureau of Statistics). The 2004/05 Demographic and Health Survey estimated the infant mortality rate for Zanzibar over the preceding ten year period at 61 per 1,000 live births, while under-five mortality was estimated at 101 per 1,000 (NBS/ORC Macro 2005). These rates had both fallen since the previous survey in 1999, from 83 and 114 respectively (NBS/ORC Macro 1999). Maternal mortality is estimated at 377 per 100,000 live births[1] (UNICEF 1998).

[1] It should be noted that this figure represents the facility-based maternal mortality rate only.

Mortality and morbidity in Zanzibar continue to be dominated by preventable, communicable diseases such as malaria, tuberculosis, and diarrhoea, including an increase in the number of cholera outbreaks. Conditions related to pregnancy and childbirth, and respiratory infections in young children also contribute significantly. At the same time, Zanzibar has documented a marked increase in non-communicable diseases, such as diabetes mellitus, cardiovascular disease, and breast cancers.

HIV prevalence is 0.6% among sexually active adults (MOHSW 2002) with a significant presence of predisposing risk factors. Among certain risk groups, the rates are higher, indicating that Zanzibar has a concentrated epidemic.

Table 1 below presents a summary of the leading diagnoses in PHC Units in recent years. More information on the current situation is given in Section 5 on the priority health interventions.

Table 1 Leading diagnoses in Zanzibar PHC Units, 2002, 2003 and 2004

	2002	2003	2004	*% change '03 to' 04*
Malaria	46.2%	47.0%	44.6%	*-2.4%*
Bronchitis	6.5%	7.8%	7.2%	*-0.6%*
Pneumonia	4.4%	5.4%	5.8%	*0.4%*
Upper Respiratory Infections	5.4%	5.5%	5.8%	*0.3%*
Open wounds	5.0%	4.2%	4.5%	*0.3%*
Gastro-enteritis	3.5%	3.6%	4.1%	*0.5%*
Anaemia	3.0%	2.8%	2.4%	*-0.4%*
Other skin diseases	1.9%	1.9%	2.2%	*0.3%*
Conjunctivitis	2.9%	2.0%	2.1%	*0.1%*
Intestinal worms	3.1%	2.2%	1.9%	*-0.3%*
Other diagnoses	18.1%	17.6%	19.4%	*1.8%*

Source: MOHSW, Health Statistical Bulletins, 2002, 2003 and 2004

1.2 Development process for the ZHSRSP II

"Health Sector Reform Strategic Plan 2002/03 – 2006/07 is comprehensive but ambitious and may need a longer time frame for its implementation. MOHSW recognizes this and may consider prioritizing the 5 year strategic plan into realistic prioritized action plans." (Danida technical assistance report 2005).

In general, the first ZHSRSP 2002/03 –2006/07 has not been implemented as programmed. Some of the underlying strategies have been implemented, but at a much slower pace than anticipated. Understanding this, the MOHSW requested technical assistance to review the dynamics of the reforms and to look into the reasons why they have slowed down, and what should be done to put the process back on track. The first recommendation was to review implementation of the first ZHSRSP I and to develop a comprehensive and feasible ZHSRSP II 2006/07 – 2010/11.

The health sector comprises several stakeholder groups representing different interests. A strategic document that should mobilise all in the health sector in pursuit of a common vision required a highly participatory process. The team assigned to develop this Strategic Plan had to conduct extensive consultations and seek consensus among all stakeholders on key issues in health care service planning, management and provision. The drafting of this second

ZHSRSP was guided by the goals and objectives of Zanzibar National Health Policy. Consultative meetings were first conducted in Unguja and Pemba as a baseline to identify achievements, challenges and proposed way forward. More than 300 people were consulted, representing the senior management in the Ministry of Health and Social Welfare, facility managers, health care workers, representatives from Ministry of Finance and Economic Affairs (MOFEA), Ministry of Presidents' Office Local Government, the private sector, Development partners, and non-governmental organisations (NGOs).

The discussions held during these consultative meetings allowed the team to enquire from stakeholders about ways to improve the health reform process. The whole process was overseen by a Technical Committee made of representatives of various departments in the MOHSW.

1.3 Structure of the Strategic Plan document

The document is organised as follows:

Section 2 outlines both the process and the findings of the review of the first Strategic Plan period which formed the basis for the drafting of the current document.

Section 3 presents the development and health policy framework for the new Strategic Plan and a number of identified core themes for the coming five years.

Section 4 describes the current health system in Zanzibar, both in terms of health infrastructures, and the roles and responsibilities of different levels within the health system. It also touches upon planned changes to that system within the coming period

Section 5 outlines the priority interventions to be delivered through the health system, both current and planned for the five year period, giving targets where possible.

Section 6 summarises the key strategies regarding the various inputs and support systems for service delivery.

Section 7 presents an overview of the current financing of the sector, together with strategies for improving both the mobilisation of additional resources, and strengthening their allocation. The scope for efficiency gains is also discussed.

Section 8 describes the implementation arrangements for the ZHSRSP II

Section 9 outlines the monitoring and evaluation framework for the Strategic Plan.

2. Building on the first Zanzibar Health Sector Reform Strategic Plan

2.1 Achievements and challenges of ZHSRSP I (2002/03 – 2006/07)

For much of the period of the first Strategic Plan, financial and technical resources of the MOHSW were constrained due to the ongoing donor freeze initiated in 1995. Notwithstanding these hurdles, a number of achievements were recorded, summarised below according to each of the eleven reform areas around which ZHSRSP I was organised.

2.1.1 Reform area 1: Organisation and management

For the sector reforms to take off, the MOHSW must develop an enabling environment centered through sound organizational and management structures and process.

Achievements

- Over the past three years, the capacity of MOHSW headquarters has been strengthened substantially, through the establishment of the Health Sector Reform Secretariat (HSRS), designation of focal persons for reform areas, and the appointment of a number of core staff, including health economist, lawyer, and health planners.
- At the district level, District Health Management Teams (DHMTs) have been appointed in all districts, along with Zonal Health Management Teams (ZHMTs) for Unguja and Pemba. Training modules were developed for district health management, and all ten districts have undergone training.
- Central level staff has been oriented towards Medium Term Expenditure Frameworks (MTEF), and an MTEF has been produced for the past three years. A Public Expenditure Review (PER) was undertaken in 2003. Districts have produced a comprehensive district health plans since 2004.
- The College of Health Sciences (CHS) has been approved as a semi-autonomous institution and now has a functional academic board and council;
- In terms of monitoring and evaluation, there has been progress with a review of the Health Management Information System (HMIS), and the signing of a contract for continued external support in this area. Extensive renovation of the HMIS office, distribution of office equipments and computers, setting of server, process of setting local network has been carried out. The process of data setting is in place through the 'HISP' team. The units have designed and refined the data collection tools.
- Districts are also submitting quarterly progress reports on their activities. Routine and regular monitoring and supervision is now taking place between zonal and district health management teams, and within the district. Processes for central level review of progress are under development, and a first Partners Coordinating Meeting (PCM) was held in 2005.
- The establishment of the District Health Service Fund enabling ZHMTs and DHMTs to plan and prioritise interventions based on local needs assessments.

Challenges

- Although a reorganization of the MOHSW headquarters took place during 2004, this was not in accordance with the structure, which had been agreed in the proposed health sector reform.

- The planned move to make Mnazi Mmoja Hospital semi-autonomous has stalled.

2.1.2 Reform area 2 : Human Resources for Health (HRH)

The aim of HRH within MOHSW is to develop, manage and sustain an appropriate multi-disciplinary health work force, which is well-trained, motivated and equitably distributed according to health needs.

Achievements

- Completion of HRH headcount survey, resulted in the development of HRH situation analysis document, HRH policy and five-year HRH plan.
- Long and short term training within and outside Zanzibar took place to improve staff capacity.
- Training modules and curriculum for computer course were developed and computers distributed to Resource Centres under continuing education initiatives.
- New staff was employed following their graduation at CHS.
- During the period from 2002/03 to 2004/05 the capacity of the college was strengthened through training of tutors to improve the number of qualified and specialized staff. Over three years, the college introduced two new courses to meet demand, and to further improve self-reliance for HRH development.
- The most important achievement was to make the college semi-autonomous and the establishment of the CHS council to strengthen management and administration.

Challenges

- The inadequacy of HRH severely constrains implementation of health activities at all levels.
- Lack of accommodation at rural health facilities hinders equitable distribution of staff
- There is no proper incentive package for staff assigned on special responsibilities or sent to difficult stations, thereby affecting retention
- Allocation of staff does not consider staff expertise eg health personnel assigned to manage financial matters or to hold managerial positions without being provided with necessary skills.
- MOHSW training needs are not featured in the national Higher Education priority list.
- Personnel Information System at the MOHSW headquarters is not linked with districts and other MOHSW institutions.

2.1.3 Reform area 3 : Health Service Delivery

The health system in Zanzibar enjoys a commendable infrastructure with more than 95% of Zanzibaris living within five kilometres or less of a health facility. Health services are delivered through Directorates of the MOHSW and specialized vertical programs such as Reproductive and Child Health (RCH), Zanzibar AIDS Control Programme (ZACP) and the Malaria Control Program (ZMCP). Health services are decentralized, ie they are planned and implemented at district and community levels.

Achievements

- Standards for service delivery prepared for referral hospital, programmes and some preventive care services.
- Strategic plans and national guidelines for care and treatment for HIV/AIDS, TB and

leprosy, malaria, RCH, antimalarials, Non-Communicable Diseases (NCDs) were developed and are in use.

- Surveillance services established in HIV/AIDS, malaria, TB and leprosy
- Increased availability of essential drugs at health facilities.
- Increased immunization coverage to an average of above 80%.
- Organization of laboratory and radio-imaging services has improved through newly established Diagnostic unit within Directorate of Curative Services
- Important equipment and supplies procured through programmes, for example four X-ray machines for Primary Health Care Centres and two ultrasound machines for Mnazi Mmoja and Chake Chake Hospitals
- Situation analysis conducted as part of Roll Back Malaria
- Insecticide Treated Net (ITN) coverage for under-fives has increased from 0.3% in 2002 to 36.9% in 2005.
- Percentage of pregnant women sleeping under ITNS increased from 2.9% in 2002 to 34.5% in 2005.
- Percentage of pregnant women taking sulphadoxine pyrimethamine for malaria prevention has increased from 0.4% in 2004 to 47.8% in 2005.
- Introduction of long lasting nets.
- Effective introduction of Artemisenin Combination Therapy (ACT) for malaria
- Home deliveries decreased from 60% to 50% (TDHS, 2005)
- Increased Contraceptive Prevalence Rate by 15% (TDHS, 2005)
- Effective Introduction of HIV/AIDS care and treatment services including Prevention of Mother To Child Transmission (PMTCT) and Highly Active Anti-Retroviral Therapy (HAART) for people living with HIV/AIDS
- Zanzibar Blood Transfusion Service, based on voluntary repetitive non-remunerated blood donors, has been successfully launched in Zanzibar
- Universal infection prevention and control services have scaled up from Mnazi Mmoja Hospital to include Chake Chake Hospital
- Increased advocacy on mental health services
- National mental health coordinating committee established.

Challenges

- Financial and human resources are inadequate to implement planned activities.
- Inadequate public/private mix collaboration in planning and disease surveillance activities.
- Limited laboratory and radio-imaging capacity to support health delivery services.

2.1.4 Reform area 4 : Financial matters in health activities

Financing of public health care is one of the crucial endeavours facing MOHSW in implementing sector reforms. While acknowledging the principle of free health care at the point of delivery, various forms of user financing have been investigated. In this process, the MOHSW will strive to protect vulnerable groups. Furthermore, new mechanisms and relationships will be developed between different providers operating currently and in the future.

Achievements

- A draft report on the feasibility of various health financing options has been prepared.
- Preliminary work has been undertaken to develop guidelines and advocacy materials in

advance of the introduction of cost sharing (through user fees and the Community Health Fund).
- A social health insurance scheme is being designed under the Zanzibar Social Security Fund.
- A simple per capita-based allocation formula for allocation of district funding from the Health Service Fund (currently Danida funds) has been introduced.
- A Public Expenditure Review (PER) was undertaken in the health sector in 2003, and updated in 2006.

Challenges
- Government funding continues to be inadequate, inconsistently disbursed, and actual releases fall short of budget expectations.
- A study report on willingness and ability to pay for health services, based on work undertaken in 2002, was never submitted to the MOHSW and all documentation has been lost;
- The recent report on feasibility of financing options largely overlooked administration and set-up costs for cost-sharing, making it difficult to use as a practical step forward;
- There is a general lack of capacity in the area of financial management within the sector. Internal audit is weak, as shown by an increasing number of audit queries in the Ministry.

2.1.5 Reform area 5 : Material resources

Material resources are important components of health services delivery. Reviewed Pharmaceutical Sector Policy and Master Plan laid down ways and means of managing medicine and others material resources. With the advent of increased government, HSPS III, and other development partners' contributions, the situation of material resources marked improved.

Achievements
- The role and structure of the Drug Management Unit were reviewed, and more organized guidelines have been put in place.
- Short and long-term training have been conducted in the area of materials management, computer networking and rational drug use.
- Training on rational use of medicines was conducted for prescribers and dispensers in two districts (South and Central, Unguja).
- A functional National Drug Committee re-established.
- Antimalarials and Antiretroviral Drugs procured and distributed to health facilities.
- Standard Treatment Guidelines and Zanzibar Essential Medicine List have been reviewed and are currently in the process of being printed for later dissemination.
- Inventory system at Central Medical Store (CMS) has been reviewed and computerized.
- Deliveries and supervision of supplies and kits to the health facilities are done monthly.
- New truck has been procured for CMS.

Challenges
- Inadequate human and financial resources remain major challenges.
- Pharmaceutical Sector Policy and Master plan has not been effectively operationalised.

2.1.6 Reform area 6 : Health research

There is great need for new scientific information and solutions to ever-emerging technical and operational problems in the Zanzibar health sector. Research is required in both clinical/epidemiological aspects of diseases and ill health as well as in the operational management of health system in Zanzibar.

Achievements

- The government has recognized the importance of research by creating an interim Research Task Force (RTF), pending the establishment of a full Research Council. It is paying the costs of the task force. The RTF established collaboration and partnership with the Public Health Laboratory (PHL), National Institute of Medical Research (NIMR), College of Health Sciences, Mnazi Mmoja Hospital (MMH) and various universities.

Challenges

- No independent research has been undertaken by the RTF due to shortage of resources. Studies that have been undertaken so far have been through vertical health programmes, which can miss the national agenda.
- The Research Council is not autonomous, the legal framework for its existence is lacking. It cannot manage it own resources.

2.1.7 Reform area 7 : Health legislation

Between 2002 and 2005, the Ministry of Health and Social Welfare established Private Hospital and Pharmacy Boards, and the Medical and Dental Practitioners' Council. The main aim of creating these governing bodies is to ensure the promotion and provision of ethically sound quality health services to all Zanzibaris.

Achievements

- Supporting to functions of the already established councils for routine operation.
- Establishment of the CHS board in 2004
- Establishment of a Mental Health Board in 2005
- Review of composition of the Private Hospital Board and in doing so incorporated the post of assistant registrar of which was initially not in place.

Challenges

- Outdated laws that are not amended to keep pace with the times remain a challenge to the established boards
- Delays in transforming the CHS and Mnazi Mmoja Hospital (MMH) into a semi-autonomous are another challenge.
- Limited advocacy and sensitisation of the public on health laws and regulations

2.1.8 Reform area 8 : Strengthening health referral mechanisms

Health Sector Reforms aim at ensuring the availability of equitable and cost-effective health care services, targeted at the main contributors to the burden of disease. Ideally, these would be articulated as an essential health care package, clearly identifying the services which the population can expect to receive at different levels of the healthcare system. Primary Health Care (PHC) through service delivery at the community level and at Primary Health Care Units remains the cornerstone in Zanzibar, with Primary Health Care Centres and District

Hospitals providing first line referral facilities. These facilities cannot provide certain specialized services, which are normally provided for at secondary and tertiary levels, therefore MOHSW has put in place a mechanism of two way referral of patients from one level to another.

Achievements

- Directorate of Mnazi Mmoja Hospital has been established and has its own budget.
- All DHMTs have been strengthened in terms of human capacity, financial and material resources.
- Supply of drugs and other materials to all health facilities has been improved.
- Outreach services have been strengthened.

Challenges

- Shortage of communication equipment including transport.
- Inadequate human, material and financial resources.

2.1.9 Reform area 9 : Public and private partnership in health service delivery

Health Sector Reforms acknowledge the functional relationship and systematic formalization of networking between the public and private health care deliverers. Institutional efforts to forge partnership between the two sectors have been realized to a limited extent.

Achievement

- Implemented interventions in addressing the above have been limited to define the operational guidelines, developing supervisory checklist and conducting a study to identify the contributory role of private sector in health care delivery.

Challenges

- The main challenge experienced in the initial phase was limited capacity in forging linkages between the two sectors.

2.1.10 Reform area 10 : Social service/welfare

For various reasons, there exist in the communities in Zanzibar disadvantaged groups and individuals who are unable to get access to health care services. Such groups include inter alia the disabled, women and children, street children, and the poor in general. Due to poverty and other reasons, these vulnerable groups sometimes cannot get access to services to meet their basic needs. The changing social and economic context, coupled with poverty conditions, has resulted in a growing problem of drug and substance abuse in Zanzibar.

Zanzibaris who live in the small islands eg Tumbatu in Unguja and Fundo in Pemba also has disadvantage in accessing secondary and tertiary health care services.

The Directorate of Social Welfare in the MOHSW deals with matters concerning social welfare of the elderly, orphans and disabled people. It is also involved in medical and social rehabilitation of individuals who have had on-job accidents or have been displaced due to heavy rains or other disasters.

Achievements

- Social welfare officers have been allocated to every district to provide the required

services to the disadvantage and vulnerable groups.

- Focal person for mental health services deployed in all districts.
- Services for children living in a difficult circumstance established.
- An inventory list of most vulnerable children and older people in place.
- Situation analysis of the nature, type and magnitude of substance abuse in Zanzibar conducted.
- Pilot schools received information, education and communication (IEC) materials on drugs/substance abuse.
- Proposal for the establishment of a rehabilitation centre for persons addicted to various substances has been developed and distributed to potential partners for funding.
- Efficient collaboration with local NGOs and from outside produced fruitful results.

Challenges

- Limited integration between the Department of Social Welfare, DHMT and local government.
- Inadequate financial, material and human resources.

2.1.11 Reform area 11 : Development partner coordination and management of health sector resources and the reform process

The MOHSW recognizes the fact that Health Sector Reforms require not only deliberate policies on the part of the government for improved performance of service delivery but also that the performance improvement process itself requires to be managed effectively.

The purpose of coordinating the necessary institutional and managerial development is to enhance the realization of the planned outputs of the reform process while ensuring resources are effectively sourced and utilized.

The issue of effective management of resources and development partner coordination is critical because implementation success of the reforms will depend to a large extent on development partners' support. It is therefore paramount that concerted efforts be made as part of the reform process on how to coordinate the inflow of development partner support so as to ensure transparency and accountability in addition to directing the resources support to priority cost-effective health service delivery interventions and activities.

Achievements

- Mapping of development partners and their geographical and functional area of support has been undertaken.
- Initial process toward development partners' coordination has started by holding of a Partners Coordination Meeting in October 2005
- Successful first Zanzibar Annual Joint Health Sector Review undertaken in March/April 2006.
- Improvements in the Ministry of Finance and Economic Affairs collation of information on external financing.

Challenges

- Lack of an effective coordination framework between the government and Development Partners.

3. ZHSRSP II Context and Core Themes

3.1 Situating ZHSRSP II within the broader health and development policy framework

A number of national and international conventions, declarations, and policy documents have contributed to the preparation of this strategy. These include: the Constitution of Zanzibar; Zanzibar National Health Policy (1999); Vision 2020; the Zanzibar Poverty Reduction Plan; Millennium Development Goals (MDG); the Beijing platform; the Abuja Declaration; the Convention on the Elimination of all forms of Discrimination against Women; the Convention on the Rights of Children; and Education for All.

3.1.1 Health and the Zanzibar Strategy for Growth and Poverty Reduction (MKUZA)

The second Zanzibar Poverty Reduction Plan, entitled the Zanzibar Strategy for Growth and the Reduction of Poverty and referred to as the MKUZA[2] covers the period 2006 to 2010. Health, nutrition, and water and sanitation are all included under Cluster 2 of the MKUZA. Cluster 2 covers social services and well-being, and addresses broad issues of human capability. The overall goals in Cluster 2 relating to various health sector components are presented below in Box 1.

Box 1 MKUZA Cluster 2 Goals related to the Health Sector

Goal 2: Improve health status including reproductive health, survival and well-being of children, women, men and vulnerable groups
Goal 3: Increased access to clean, safe and affordable water
Goal 4: Improve sanitation and sustainable environment
Goal 6: Improve food and nutrition security among the poorest, pregnant women, children and most vulnerable groups

Each of these goals has a number of operational targets, some of which are related to health status and others to coverage of health services. Several are drawn from Millennium Development Goals (MDG) key indicators. These are reproduced in Table 2 below, and have been adopted by the health sector as can be seen in subsequent sections.

Table 2 Health Sector-relevant operational targets in the MKUZA

Goal	Targets
Goal 2	**A. Infant and child health** • Reduced infant mortality from 61/1000 in 2005 to 57/1000 in 2010 • Reduced mortality of children under five from 101/1000 in 2005 to 71/1000 by 2010 • Increased coverage of children immunized against measles by age one from 93% to 98% by 2010

[2] From the kiSwahili title Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Zanzibar

Goal	Targets
	B. Maternal and Reproductive Health • Reduced Maternal Mortality from 377/100,000 in 1999 to 251/100,000 in 2010. (MDG) • Increased percentage of births delivered in health facilities from 49% in 2005 to 60% in 2010 • Improve contraceptive prevalence rate from 10% to 15% for modern methods and from 15% to 20% for any method by 2010 (MDG)
	C. Communicable Diseases **(i) Malaria** • To raise the percentage of under-fives having prompt access to and receiving appropriate management for febrile illness within 24 hours from 13% in 2005 to 70% in 2010 • To increase the percentage of under-fives sleeping under ITNs from 37% in 2005 to 90% in 2010. • To reduce the case-fatality rate from 2.1% in 2005 to 0.5% in 2010. **(ii) HIV AND AIDS** • Reduced HIV prevalence among 15-24 years pregnant women from 1% in 2005 to 0.5% in 2010 (MDG) • Increase proportion of population with comprehensive correct knowledge of HIV/AIDS from 44% and 20% of men to 80% of the general population by 2010 (MDG) • Increased condom use among women at last higher risk sex from 34% in 2005 to 80% in 2010 • Reduction in stigma surrounding HIV/AIDS from 76% in 2005 to 60% by 2010 (measured as the inverse of the proportion of the population expressing acceptance of 4 measures as per TDHS) **(iii) TB** • To reduce the death rate from 8% to 5% in 2010 • To increase cure rates from 80% to 85% by 2010 • To increase HIV screening of tuberculosis patients from 20% to 100% by 2010
	D. Non Communicable Diseases • To undertake prevalence survey for key NCDs by 2010
	E. Substance Abuse • To undertake prevalence survey for substance abuse by 2010 • Operational detoxification and rehabilitation services for substance abusers by 2010
	F. Human Resource Development • 75% of primary health facilities to meet (to be) agreed norms for trained staff, with attention to gender balance, by 2010
Goal 3	• Increased access to clean, safe and sustainable water supply in urban areas from 75% in 2004/5 to 90% in 2010 • Increased access to clean, safe and sustainable water supplies in rural areas from 51% in 2004/05 to 65% in 2010
Goal 4	• Increased proportion of households with access to basic sanitation from 66.8% in 2005 to 83% by 2010

Goal	Targets
Goal 6	• Reduced prevalence of micro-nutrient deficiency among under-five children • Reduce prevalence of stunting among under-five children from 23% in 2005 to 10% by 2010 • Reduced prevalence of wasting among under-five children from 6.1% in 2005 to 2% by 2010 • Increased access to food support and nutritional supplements for PLHA and the most vulnerable pregnant women Reduced level of malnutrition among under-fives and pregnant women

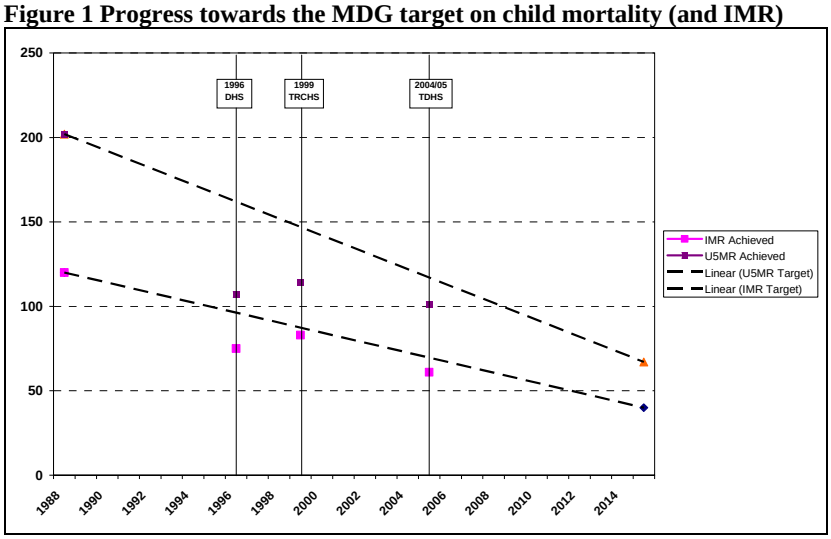
3.1.2 Zanzibar's progress towards the health Millennium Development Goals

Several of the MKUZA operational targets are based on the progress towards the Millennium Development Goals. This section summarises progress over the past years in respect of the MDG goals.

MDG Goal no 4, target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate (U5MR)

The 1988 Census indicated an Infant Mortality Rate (IMR) of 120 and an U5MR of 202. This suggests that the MDG target for U5MR would be 67. The 2002 Census data indicate that, half way to the MDG deadline of 2015, the rates had fallen to 89 and 141 respectively. In addition, the (tentative) Zanzibar results from the recent Tanzania Demographic and Health Survey of 2004/05 indicate an IMR of 61 and an U5MR of 101 per 1,000 live births. Based on a limited number, these are included in the figure below for illustrative purposes but should be treated with caution

Figure 1 Progress towards the MDG target on child mortality (and IMR)



3.1.3 The Zanzibar Health policy

The overall goal of Zanzibar health policy is to *"improve and sustain the health status of all Zanzibar people"* (GOZ 2002a, p 10). The intermediate objective is the reduction of both the absolute levels of morbidity and mortality from all major causes, and the disparities in those levels between different population groups and geographical areas (MOHSW 2002b, p14). Emphasis is given throughout to ensuring that vulnerable groups such as the poor, women of reproductive age, children, the disabled and the elderly are assured of access to high quality services. Strengthening of primary health care remains the primary strategy.

A number of guiding principles underpin this Strategic Plan:

1. A multi-sectoral approach to the planning, implementation, monitoring and evaluation of health services;
2. Political commitment and civil society involvement;
3. A commitment to reduce stigma and discrimination in combating the HIV epidemic;
4. Adoption of a human rights-based approach;
5. Sensitivity to the culture and social context of Zanzibar. While firmly based on sound scientific evidence, health promotion strategies shall promote and protect positive aspects of the Zanzibari culture;
6. Active seeking and promotion of community participation in health;
7. Ensuring that comprehensive basic health services shall be accessible to all.

3.2 Core themes for ZHSRSP II

In order to focus attention on certain aspects of the health system and its beneficiaries, a number of key themes have been identified for emphasis over the coming five year period. These are as follows:

- Strengthening human resources for health (HRH)
- Strengthening decentralised health service delivery
- Ensuring coverage for vulnerable groups
- Improving efficiency through integration
- Improved transparency, accountability and partnership.

3.2.1 Strengthening human resources for health

Although there is more discussion of the specific strategies for strengthening HRH in Section 6.1 below, it is worth highlighting some areas at this early point in the document.

Number and cadre of health workers

Efforts will be made during the coming years to improve the HRH position, particularly at PHCU level, with the appropriate number of staff and skills to be able to deliver the agreed package of services. The expansion of training of Public Health Nurse 'B' with midwifery skills is seen as key in the fight to improve maternal and infant outcomes, reducing reliance on the Maternal and Child Health (MCH) Aides currently in many facilities. Expansion of the College of Health Sciences will enable the college to accept a higher number of students by the end of the period, although graduation will be during the next phase.

Cost-effective means of improving staff skills are being explored by the MOHSW, with distance learning offering potential for all interested health workers to improve their knowledge and career prospects. Efforts are therefore underway to establish relevant courses, in conjunction with the ongoing strengthening of information communication technology and the district resource centres. A more general review of in-service training will be undertaken, with a view to improving coverage, content, and value for money, linked also to the priority theme of integration.

Deployment

As mentioned above, focus will be on improving the staffing of the PHCUs. The construction of two staff houses at strategically placed rural PHCUs is expected to improve deployment of key cadres, while the extension of opening hours in selected urban PHCU will

help to redress the relative over-staffing of the hospitals.

Work has already started to review workload in order to refine the staffing norms, which will enable a clearer view to be obtained of where the major gaps are. The revitalisation of the human resource database, as a tool both for HR management and improved information systems more generally, is also expected to facilitate improved deployment.

Incentives and retention
GOZ is in the process of commissioning a broader study on the right-sizing of the public service, which is expected to result in the retrenchment of unskilled workers, thereby releasing resources to improve the remuneration of the remaining public servants. However, the net effect on the health sector is not yet known.

The provision of staff housing is expected to have an incentive effect for staff posted to rural PHCUs, and efforts will be made to source funds to provide such housing at a larger number of facilities.

Finally, improved HR management, together with the information available through the database, and the introduction of systems for monitoring staff performance, are all expected to strengthen the upgrading and promotion process.

Management
As noted above, improvements in the management of HRH are expected over the coming five year period, due to a combination of factors. The ongoing restructuring of the MOHSW headquarters is expected to result in a more functional organisation, and the roles of the various Units involved in HRH, together with their inter-relationships, will be redefined accordingly. A number of staff is expected to benefit from post-graduate training. Maintenance and use of the database is also seen as a key strategy for improving the overall management of health workers and their development.

3.2.2 Strengthening decentralised health service delivery and management

Decentralisation is an ongoing process throughout government in Zanzibar. However, MOHSW and PO-RASF are at different stages of reform, and the benefits of such decentralisation have long been recognised in the health sector. Initial steps to deconcentrate sector management were taken during ZHSRSP I with the establishment of Zonal Health Offices on both Unguja and Pemba, and District Health Management Teams in all ten districts. It is envisaged that once broader devolution to district local government is implemented, the DHMTs will be in a strong position to manage the new institutional set-up.

Focus on the district health system is an essential step in the strengthening of Primary Health Care, which remains the cornerstone of the Zanzibar health sector. The majority of the contributing factors to the Zanzibar burden of disease are most cost-effectively and equitably handled at this level. The district serves as the interface between the population, as beneficiary of health services, and the MOHSW as the overall steward of the sector, with responsibility for setting of standards and guidelines, and for assuring access and quality. Local responses to varying environmental and behavioural factors are better handled within the district health system, and improved linkages with other sectors both at the Shehia and the district level will continue to be promoted (eg water, agriculture, education). MOHSW places great emphasis on strengthening involvement of stakeholders at all levels from the household

upwards, and in particular in strengthening the planning and management capacities at district level, in support of decentralised health service delivery.

Efforts will continue to further strengthen the incorporation of all programmatic/health service delivery activities within the existing district health plans, together with the various support activities such as technical supervision and in-service training which tend to be planned by the central technical programmes on behalf of the districts. Over the course of the five years, efforts will be made to move to more district demand-driven support services.

To ensure high quality of services that are effective and user friendly a Technical Working Group has been established with responsibility for the design and implementation of a simple operational national quality assurance framework that includes existing and new quality improvement initiatives. One of the initial major tasks of the Technical Working Group will be to guide a practical review of the essential health care package focusing on reaching consensus of services provided at different levels of the health system and improving the referral system.

The MOHSW has committed not only to the decentralisation of responsibilities, articulated in the district health plans, but also of resources. At present, government funding tends to flow in kind to the district level, but the introduction of the District Health Service Fund (HSF) is seen as a precursor for a possible multi-source grant for district health services. The needs-based allocation formula for the HSF resources has been refined in order to reflect varying under-five mortality and support costs (via district area), and budgetary restructuring will be pursued in order both to harmonise HSF and government funding modalities for district health services, and to facilitate improved reporting by geographical area.

3.2.3 Ensuring coverage for vulnerable groups

The draft MKUZA does not emphasise the need to reduce inequalities in the way that the original ZPRP did. However, it is acknowledged that one of the fastest ways of improving indicators is to tackle the worst off areas or population groups, i.e. going for "quick wins". The need to improve the access to and uptake of health services for priority groups, notably women, children and the poorest, remains an important theme within this new strategic plan.

Among the strategies to be employed are the following:

- Increased attention to be given to health services for women and children (RCH, IMCI, EPI). The PER indicated that funding which benefits these target groups and services is not always easy to track, as it may be channelled through other technical programmes (eg intermittent presumptive treatment with sulphadoxine pyrimethamine is seen as a malaria intervention, though it directly benefits pregnant women; PMTCT is seen as part of the HIV/AIDS service continuum rather than specifically an antenatal service). Notwithstanding these sources of funds, there is still need to improve the resource availability for reproductive and child health services, and specifically for improving access to emergency obstetric care, and scaling up community IMCI.

- Extension of core services to PHCU and community level where possible, for example provision of normal delivery services at second line PHCUs, enhancing community-based mental health services; improved outreach from the health facility;

- Services for specific vulnerable groups: eg substance abusers, the mentally ill, PLWHA

- Strengthening partnership with religious organisations, NGOs etc who work on behalf of vulnerable groups

- Inter-sectoral coordination at the Shehia level in identifying the vulnerable. Villages in Zanzibar are not large, and it is increasingly recognised that it is at this level that the poor can be most accurately and efficiently identified in order to improve the targeting of specific interventions. Within the health sector, this will become critical with the planned introduction of cost-sharing.

- Health Service Fund resources are already channelled to districts on a weighted capitation basis, with under-five mortality used as a proxy for health need. This implies that districts with higher mortality, are in greater need, and therefore require more resources. There is need to extend this approach further to incorporate government resources, and to progressively incorporate funding through the vertical programmes in the same way.

- Urban populations generally have better access to services, both through the physical proximity for hospital services, and the greater number of private facilities which can be accessed by the better-off. It is therefore appropriate that the strengthening of public facilities should target rural areas, one key example of this being the planned upgrading of rural second line PHCUs to offer delivery services.

3.2.4 Improving efficiency through integration

Technical health programmes in Zanzibar remain highly verticalised, with some commanding significant external resources. This has resulted in a regrettable situation whereby their planning and reporting activities are in some cases more closely aligned with funders than the MOHSW as a whole. With the development of annual comprehensive district health plans, efforts have been made to ensure communication between the technical programmes and the DHMTs, and to incorporate relevant activities (service delivery, in-service training etc), in the district plan. However, much work remains in this area.

The issue of integration is a potentially thorny one, with vested interests working against reform efforts. However, the efficiency gains and potential equity gains of rationalisation in certain areas are difficult to ignore, and the coming period will see renewed efforts by the central MOHSW to integrate and coordinate central support activities. Among the areas ripe for integration and coordination are the following:

- Procurement and distribution of essential drugs and supplies
- In-service training
- Supervision, monitoring and evaluation
- Support services; laboratory, maintenance, transport management
- Planning, budgeting and management.

Work to integrate activities in these areas will be linked as far as possible to the planned review of the Zanzibar Essential Health Care Package, and to the further development of the sector-wide approach in the sector.

3.2.5 Improving transparency, accountability, and partnership

Over the ZHSRSP II period, it is hoped that the existing partnerships will be strengthened, new partnerships formed, and that the transparency and accountability with which the MOHSW undertakes its operations will be enhanced. It is envisaged that two Partner Coordination Meetings will be held each year with a variety of partners and stakeholders, to review sector progress and to jointly agree the way forward. These are planned for September/October and March/April. Further to changes in the planning cycle on the mainland, and in the spirit of simplifying communications, with the first of these being the Annual Joint Health Sector Review, and the second being a smaller meeting.

The establishment of a number of Technical Working Groups in key areas from the start of the plan period – eg finance, human resources, sector monitoring – is further expected to improve the sharing of information with a variety of technical and financial partners (bilateral, multilateral, NGO etc) according to areas of interest and expertise. These are further elaborated in Section 8.2.

Partnership between the health facilities and Shehia structures is seen as essential for strengthening Primary Health Care. At the same time, efforts will be made to develop a framework for strengthening and formalising the relationship between the private, non-governmental, traditional and public health sectors, both at central and district/sub-district level.

4. The Zanzibar health system

Over the years, Zanzibar has developed an impressive public sector health infrastructure, based on a network of first and second line Primary Health Care Units in both urban and rural areas. These refer either to 30-bed Primary Health Care Centres (known also as cottage hospitals) and/or district hospitals, which in turn are supported by Mnazi Mmoja Hospital as the major referral point for the islands. Specialist inpatient psychiatric care is currently provided only on Unguja, at Kidongo Chekundu Hospital, while Zanzibar Town also benefits from a maternity hospital at Mwembeladu.

The numbers and distribution of public health infrastructure is summarised in Table 3 below.

Table 3 Public health facilities, 2006

District	PHCU		PHCC	District Hospitals	Other Hospitals	
	1st Line	2nd Line			Tertiary	Special
Urban	5	5			1	2
West	10	2				
North A	10	2	1			
North B	6	3				
Central	17	4				
South	7	2	1			
Wete	17	1		1		
Micheweni	9	3	1			
Chake Chake	11	2	1	1		
Mkoani	13	2		1		
Total	**105**	**26**	**4**	**3**	**1**	**2**

There is also a burgeoning private health sector, although in contrast to the public facilities, this is largely concentrated in the urban areas, notably Zanzibar town. A 2004 study identified the following distribution of such facilities

Table 4 Private health facilities, 2006

Health Facilities	Unguja	Pemba
Dispensaries/Clinic	83	13
General hospitals	3	
Special hospitals	-	
Total	**86**	**13**

In addition there are 59 private part 1 pharmacies (53 Unguja, 6 Pemba) and 203 part 2 drug shops or “over the counter stores” (100 Unguja, 103 Pemba).

4.1 The District health system

Although Zanzibar has administrative local government structures at both regional and district level, the planned devolution of responsibility for service provision to the district council level has not yet happened. Within the health sector, as indicated in Section 2.1 above, there has been deconcentration of responsibility and, to a more limited extent, resources, to the Zonal and then to district level. The intention for the plan period is to continue to strengthen the capacity of the DHMTs to comprehensively plan, budget, manage, and report on health services within their jurisdiction. It is hoped that this will also extend to the devolution of GOZ budgetary resources for district health services during the plan period.

During the first year of the ZHSRSP II a practical review of the essential health care package focusing of reaching consensus of services provided at different levels of the health system and improving the referral system will be carried out.

Community-based health care

Community-based health care takes place at two levels. On the one hand, outreach services from the health facility will continue to take place, and will be strengthened. These include both service provision (eg immunisation, home-based care) and health promotion activities (eg health education, assessment of water sources). Community-based Directly Observed Treatment for tuberculosis is planned in areas more remote from health facilities, while community-based management of mental illness is also a priority.

At the same time, the Shehia Health Committee is expected to play an increased role during the ZHSRSP II period. The principal responsibility of these committees is to serve as the link between the health facility, as entry point to the formal health system, and households and individuals, and to the multi-sectoral Shehia Development Committee, thereby enabling community input to overall socio-economic development within the locality.

It is also envisaged that strengthening of the human resource capacity at the health facility level will enable closer contact with the community, resulting in better capture of community-based information on vital statistics (eg births, deaths) which will in turn provide input for community discussion on particular local challenges to health and possible solutions.

Primary Health Care Units

The lowest level of public health facility is the Primary Health Care Unit (PHCU), of which there are two types.

First line PHCUs have an estimated catchment population of 3,000-5,000 and provide the following services:

- Basic outpatient services, including the management of common diseases and injuries
- Maternal and child health services, including growth monitoring, immunisation, antenatal, delivery services, and post-natal services
- Family planning and youth friendly services
- Health education, counselling and referral to service point for VCT, PMTCT etc environmental health services, eg assessment of water sources, water treatment, IEC on environmental management as part of vector control.
- Outreach services/community-based health care services, including home-based care and care of the elderly

Second line PHCUs offer a similar service package to the first line PHCUs, with the addition of:

- Facility-based delivery (currently being scaling up).
- Basic laboratory services, eg blood slide for malaria, haemoglobin, urine and stool tests
- Dental services

Over the course of ZHSRSP II, it is intended to expand access to services at PHCUs through a number of means: increasing the hours of operation in urban areas; redeployment of health workers from hospital to PHCU level; and expanding the range of services at primary level, notably the introduction throughout the isles of quality delivery services at second line PHCUs.

Primary Health Care Centres/Cottage hospitals
The four PHCCs were intended to provide basic inpatient care in areas distant from other hospital facilities. They have recently been upgraded with GFATM support to offer x-ray, as part of strengthening of services for the control of tuberculosis. Their service package includes

- Inpatient medical and basic surgical capacity (30 beds, split between 4 wards, ie Maternity, Female Male and Paediatric ward)
- Comprehensive emergency obstetric care (ie including caesarean section)
- Ambulance services for emergency referrals
- Psychiatric assessment and referral

District Health Management Teams
At the district level, the aim is to strengthen the capacity of DHMT to integrate and implement Health Sector Reform interventions into their general comprehensive health plan. The district health management teams are expected to:

- Make comprehensive district health plans for health interventions based on local needs assessments
- Seek to integrate services offered at district level
- Prepare health care workers and disseminate the Strategic Plan within their jurisdiction
- Ensure efficient links with community structures
- Manage communication and referrals between facilities in their districts
- The sustenance of support systems such as supportive supervision
- Monitor quality of care within their district including HMIS

4.2 Hospitals

Zanzibar has a total of four public hospitals and two specialized hospitals. Mnazi Mmoja Referral Hospital in Zanzibar town has a capacity of about 400 beds, while there are three District hospitals on Pemba: Wete, Chake Chake and Abdulla Mzee in Mkoani with bed capacity of 110, 120 and 80 respectively.

The specialized hospitals are Mwembeladu Maternity Home with a bed capacity of 34 and the Kidongo Chekundu psychiatric hospital with 110 beds, both of which are on Unguja, and

fall under the management of Mnazi Mmoja Hospital.

Zanzibar has three private hospitals; Marie Stopes Tanzania, Zanzibar Medical Group and Al-Rahma. All are located in Stonetown on Unguja.

District hospitals
The district hospitals in Wete and Mkoani (Abdulla Mzee Hospital) provide referral services either to Chake Chake, or directly to Mnazi Mmoja, depending on the condition.

One new district hospital is planned for Central district, Unguja, as a means of both improving access to first level referral services, and in order to decongest MMH which currently serves this population. It is expected that this will be built through a charitable foundation and handed over to GOZ on completion.

Referral hospitals
Each island has one referral hospital, Chake Chake on Pemba, and MMH on Unguja.

Mnazi Mmoja Hospital caters for specialist tertiary services for the whole country and renders primary and secondary health care for stone town population. MMH receives a variety of complicated cases from PHCU, PHCC, district hospitals and private health facilities of Unguja and Pemba. Furthermore MMH provides sole specialized out-patient services for Mental health, Ear-Nose-Throat, and Eye units.

Due to inadequate coverage by PHCCs (cottage hospitals) and lack of district hospitals in Unguja, MMH also provides majority of the first level referral services for the following districts: North B, Urban, West and Central District.

It is intended that during the course of this Strategic Plan Mnazi Mmoja Hospital will become at least semi-autonomous. External support has been identified to strengthen the management and the resource base of the hospital, and plans exist to decongest the hospital by strengthening primary service delivery in PHCU within the Town and West districts, thereby enabling it to focus better on its referral functions.

Hospital management and organisation
With the exception of MMH, other district hospitals and PHCC fall under the Director of Curative Services. District Health Management Teams (DHMTs) report directly to Zonal Medical Officer who reports to the Director of Preventive Services.

The Medical Superintendent at MMH reports to the relatively newly created Director of MMH. Kidongo Chekundu psychiatric hospital and Mwembeladu maternity hospital also fall under both MMH and the Directorate.

Plans to make MMH an efficient, autonomous referral institution have been carried forward from the previous Strategic Plan period into ZHSRSP II. A situation analysis is underway, and a strategic plan for the institution will be prepared during the first year of ZHSRSP II, and will guide future activity by both MMH itself and by the MOHSW in relation to the hospital. External support for these activities has already been identified.

4.3 Central level institutions

The Ministry of Health and Social Welfare
The MOHSW headquarters, currently comprising seven directorates, together with the units and programmes which report to them, is scattered throughout Zanzibar Town in a variety of buildings and offices. On Pemba, the Office of the Administrator, which has the status of a Directorate, is situated in Wete.

Since 1993, MOHSW policy documents have reflected a desire to restructure the administrative framework to support the desired health system. Many of the arguments put forward then are still valid. As stated in the ZHSPS I, "[t]he Organization and management within the Ministry of Health and Social Welfare is currently not that enabling in relation to the changes and environmental by which the health sector is experiencing. Concerns have been expressed to effect that the central structure of the Ministry of Health is centralized and "top heavy" in decision making. At the same time the peripheral areas villages, PHCUs, PHCCs and Districts are highly dependent on the centre even for critical functions such as planning and overall decision making. Service delivery management at this level is not responsive to local needs. Management capacity in terms of skills, tools and systems is inadequate."

The MOHSW was restructured in 2004, although not in line with proposals in the first ZHSRSP. The Health Sector Reform Secretariat have therefore recently proposed a new structure of the MOHSW focusing on making the administration less top heavy with fewer directorates in order to create a dynamic environment in favour of reform. The structure has been agreed and the approved organogramme for the MOHSW as a whole and for the individual Departments is reproduced at Annex A.

Over the course of ZHSRSP II, the role of the MOHSW, with support from partners, is envisaged as being to:

- Ensure that health care services are available to all citizens, at all times;
- Ensure that the required resources and capabilities are marshalled to enable health care workers to offer the services of good quality in an equitable manner;
- Deploy and manage human resources for health;
- Design, implement and enforce regulations to ensure meaningful participation of the private sector (for profit and not for profit sector, including traditional healers);
- Develop policies and guidelines using the best available evidence;
- Plan for, collection, and act on strategic information of relevance to the health delivery services;
- Conduct routine and periodic monitoring and evaluation activities to guide the implementation of reform interventions throughout the life of this Strategic Plan.

Zonal Health Offices
Although not strictly central, the lack of any government-wide administrative structure at the zonal level justifies the inclusion of the Zonal Health Offices in this sub-section. When first considering decentralisation, the MOHSW decided that there was neither the need nor the capacity to adopt regional structures on the Isles, opting instead for development of a management team covering each main island, Unguja and Pemba. These serve as the link between the districts and the MOHSW headquarters, with responsibility for supervision, monitoring, and through the Health Service Fund, channelling of operational funding to the

districts within their zones.

Other central level institutions
Other central level institutions include the following:

- College of Health Sciences, responsible for basic training of most health cadres in Zanzibar (see section 6.1)
- Central Medical Stores, which coordinates procurement, storage and distribution of drugs and medical supplies through its Unguja office, and the Pemba Zonal Stores (see section 6.2)
- The laboratory of the Chief Government Chemist
- The Public Health Laboratory on Pemba
- The Central Maintenance Unit
- The Central Garage
- National Blood Transfusion Centre
- Four homes for elderly, two in Unguja (Sebleni, Welezo) and two in Pemba (Gombani, Limbani)
- One orphanage in Zanzibar Town.

With the increasing need for quality control of pharmaceutical products and foodstuffs due to liberalisation and increasing inflows of a wide variety of commodities, the laboratory of the **Chief Government Chemist** has been singled out for strengthening over the coming plan period.

The **Public Health Laboratory** on Pemba has long served as a focus for both disease-specific and primary health care service-related research, with substantial investments having been made in its infrastructure over recent years.

5. Priority health interventions

5.1 Reproductive and child health

5.1.1 Reproductive health

The facility-based Maternal Mortality Rate was estimated in 1998 to be 377 per 100,000 live births (UNICEF), with direct causes of death identified as unsafe abortion, eclampsia, haemorrhage and obstructed labour. The 2006 RCH situation analysis indicates that surgical deliveries are currently available only at hospital level, with manual vacuum aspiration not routinely available even at hospital level (Hussein 2006). The availability of emergency referral is a major constraint to the availability of Emergency Obstetric Care (EmOC) on the islands.

Generally, antenatal coverage in Zanzibar is good, with 98% of women attending at least once during pregnancy, and 74% receiving at least one tetanus toxoid vaccination (NBS/ORC Macro 2005). Home deliveries have reduced from 63% in 1999 (NBS/ORC Macro 1999) to 50% in 2004 (TDHS 2005). However, postnatal care coverage remains relatively low at 46%, with disparity between Unguja (56%) and Pemba (34%). Abortion is the leading cause of admission in female general/surgical wards (Hussein 2006), yet post-abortion care is not available in all health facilities. Induced abortion is illegal, and the abortion case fatality rate is 2.2%.

The 2005 TDHS report indicates a contraceptive prevalence rate of 15% for any method, and 10% for modern methods, despite all health facilities providing the service.

In addition to expanding access and improving quality of existing services, there are plans to introduce infertility services and screening for reproductive cancers during the plan period. Quality Improvement and Recognition Initiative (QIRI) has been initiated in three districts, and is currently being extended both to other districts and throughout the service package, based on success in the RCH sphere.

Targets

- Scaling up of delivery services to all second line PHCUs by 2010
- Increase percentage of births delivered in health facilities from 49% in 2005 to 60% in 2010
- Expansion of Voluntary Counselling and Testing (VCT) services to all PHCC and hospitals
- Expansion of PMTCT from 3 to all to all PHCC and hospitals by 2010
- Reduce facility-based maternal mortality to 377/100,000 to 251/100,000 in 2010
- Improve contraceptive prevalence rate from 10% to 15% for modern methods and from 15% to 20% for any method by 2010

Core interventions

- Focussed antenatal care, including use of insecticide treated nets, intermittent presumptive treatment of malaria, syphilis screening, and individualised birth plans
- Quality delivery services (at second line PHCUs, PHCCs and hospitals)
- Neonatal care for infants and post-natal services for mothers
- Post-abortion care, including Manual Vacuum Aspiration at the PHCC level, and blood transfusion at hospital level

- Family planning information and service provision both through static provision and community-based distribution (pills and male condoms)
- Early referral of obstetric emergencies
- Basic emergency obstetric care at district level

5.1.2 Adolescent Sexual and Reproductive Health

In a participatory study in 2001 (Africare), adolescents identified their Sexual and Reproductive Health (SRH) problems to include early marriage, Sexually Transmitted Infections (STIs), HIV/AIDS, teenage pregnancies, substance abuse, and unemployment. The provision of youth-friendly sexual and reproductive health services has started in 15 PHCUs, and the need to strengthen this important area is generally recognised. SCF provided support for curriculum development and training of health providers, while African Youth Alliance (AYA) is providing services through RCH clinics in a limited number of PHCUs.

Targets

- Increased number of health facilities providing youth friendly services from 15 to 50
- Increased % of youth with reproductive health rights knowledge by 20% from the current level
- Increased % of 15-24 year olds with correct knowledge about HIV/AIDS by 20% from the current level

Core interventions

- IEC on adolescent sexual and reproductive health rights and services
- Other interventions integrated into regular RCH services

5.1.3 Management of common childhood illnesses

As noted earlier, infant and under-five mortality rates in Zanzibar remain high, although progress has been made in the last decade. An estimated 83% of deaths of children under 5 are due to childhood illnesses (Acute Respiratory Infection (ARI), malaria, diarrhoea measles & malnutrition) which further contribute to high morbidity levels. Children attending outpatient clinics often present with symptoms indicating a combination of two or more of these illnesses, with malnutrition contributing to half the deaths. For this reason, the MOHSW adopted the Integrated Management of Childhood Illness (IMCI) as a priority strategy in March 1999. Although data specifically for Zanzibar are not yet available, the strategy has been demonstrated to have had a significant effect in reducing childhood morbidity and mortality in pilot areas on the mainland (NBS/ORC Macro 2005).

Baseline data indicated that only 7% of caretakers give ORS to children with diarrhoea and that 30% of caretakers perceive some diseases cannot be treated in health facilities. To date, emphasis has been on the training of health workers on the integrated management of childhood illness and early referral of severe cases. A communication strategy will shortly be finalised, and focus during the next five year period will extend to the improvement of community and family care practices by empowering parents and other caretakers through behaviour change (community IMCI).

Currently, eight of the ten districts are implementing IMCI, five in Unguja and three in Pemba. About 395 health workers have been trained (i.e. 74% of the total), and IMCI has also been included in the pre-service curricula of general nurses, clinical officers and

community health nurses.

Targets

- Increase the percentage of under-fives having prompt access to and receiving appropriate management for febrile illness within 24 hours from 13% in 2005 to 70% in 2010
- Reduce infant mortality from 61/1000 in 2005 to 57/1000 in 2010
- Reduce mortality of children under five from 101/1000 in 2005 to 71/1000 by 2010
- Scale up IMCI to all districts by 2010
- Health workers in 100% of PHCU's trained in IMCI by 2010
- Implementation of community IMCI (C-IMCI) in 7 districts by 2010
- Implementation of referral care package in four hospitals by 2010
- In 100 shehias to increase the number of children under five and pregnant women sleeping under ITN to 90%
- Create 8 pilot early childhood care centres supported by communities in 4 districts.

Core interventions

- Education of parents and other child caretakers on appropriate home care of the sick child, adopt appropriate care seeking behaviours and preventive and promotive practices
- Training of health workers in all PHCUs to ensure appropriate case management of childhood illness, and early referral of complicated cases
- Develop communication strategy for C-IMCI
- Monitoring and evaluation of IMCI activities
- Collaboration with other related programmes and agencies.

5.1.4 Expanded Programme for Immunisation (EPI)

EPI in Zanzibar has as its goal the reduction of morbidity and mortality from vaccine-preventable diseases. It ensures provision of the routine childhood vaccinations against Diptheria, Pertussis, Tetanus (DPT), Hepatitis B, Poliomyelitis, Tuberculosis (BCG), and Measles. In addition, it is responsible for the Tetanus toxoid vaccination of pregnant women including women of reproductive age. At present, Zanzibar does not offer the *Haemophilus influenzae B* vaccination, although studies are currently underway to determine whether this should be introduced within the plan period.

Recent data indicate that coverage with all antigens was over 85%. For BCG the rate was 100%, while for DPTHB3 it was 88%, OPV3 88%, and measles 89.6%. For Tetanus toxoid 2, coverage is 22.6% among women of reproductive age, and 72.4% of pregnant women. There were no neonatal tetanus cases in 2005, compared with 2 in 2004. A measles campaign during 2005 achieved 85% coverage.

Targets

- Increase coverage of children immunized against measles by age one from 93% to 98% by 2010.
- Increase DPT-HepB 3 coverage from 88% to 95%
- Reduce dropout rate for BCG - measles from 26% to below 10%
- Increase measles coverage from 90% to 95%
- Eliminate maternal and neonatal tetanus by the end of 2007

Core interventions

- Immunisation of all children under 1 (and above where necessary), according to the existing schedules, through a combination of static service delivery and outreach
- Undertake periodic vaccination campaigns as required
- Immunisation of women of reproductive age against Tetanus Toxoid
- Provide rapid response to outbreaks of vaccine-preventable diseases
- Ensuring a functioning cold chain system at all levels
- Forecasting, procurement and distribution of vaccines and supplies
- Promotion of immunization safety.
- Social mobilisation for immunisation, including campaigns

5.1.5 Nutrition

Nutrition is seen as an outcome, a result of access to food, dietary intake, and care of the individual. Access to adequate food and health care are among the universally adopted human rights. Protein energy malnutrition (PEM), iodine deficiency disorders (IDD), vitamin A deficiency (VAD), and nutrition anaemia are the four main forms of malnutrition in developing countries, Zanzibar among them.

Malnutrition and specific micronutrient deficiencies contribute to infant, under-five, and maternal morbidity, lower productivity and higher mortality. The relative prevalence of PEM in Zanzibar, according to a 2004 study[3], was 17% underweight, 22% stunting, and 5% wasting. Vitamin A deficiency was 41%, while anaemia was 66% among children between 6-59 months. VAD among lactating mothers was 37.1%. These compare to global rate of 21%. As a result of these findings, mass supplementation campaigns have been undertaken every six months since January 2005. Coverage of 87.5% for Vitamin A and 84.7% for de-worming was reported for January 2006.

The prevalence of goitre for under 18 (primary schoolchildren) according to the 2001 IDD study[4] was 21% in Unguja and 32% in Pemba. Household utilisation of iodated salt at that time was 1% in Pemba and 64% on Unguja. Following rehabilitation of the plant in Pemba, and efforts to raise awareness, the rate had increased to 25% by February 2005.

Exclusive breastfeeding at the time of the 2001 IMCI study was observed to be 21% for children aged 0 – 3 months

Targets

- Increase the proportion of exclusively breastfed infants from 21% to 30%.
- Promote micronutrient consumption of Vitamin A from 87% to 95 %
- Increase salt iodisation from 25% to 60% on Pemba, and from 65% to 80% on Unguja
- Reduce prevalence of stunting among under-five children from 23% in 2005 to 10% by 2010
- Reduce prevalence of wasting among under-five children from 6,1% in 2005 to 2% by 2010

[3] IHRDC (2004). *Vitamin A Deficiency study*. Ifakara Health Research and Development Centre, Ifakara and Dar es Salaam

[4] TFNC/MOHSW (2001). *Iodine Deficiency Disorder study*. Tanzania Food and Nutrition Centre, Dar es Salaam and Ministry of Health and Social Welfare, Zanzibar

Core interventions

- Counselling on infant and young child feeding
- Supplementation of Vitamin A and de-worming of under-fives through both health facilities and Village Health Days
- Salt iodisation in Pemba
- Routine growth monitoring and promotion
- Supplementation of iron foliate to pregnant women

5.2 Health promotion and disease prevention

5.2.1 Health education and promotion

The major role of Health Education Unit is to educate, inform, motivate, and provide technical support that will facilitate health promotion activities, targeting the entire community to enable them to take possible actions to change habits and life styles which contribute to poverty, poor health and disease. Health promotion is about enabling people to increase control over and to improve their own health, thus promoting good health and social-well being of the communities.

People in the rural areas and peri-urban areas where majority live have little access to health education/promotion services due to insufficient health education/Promotion activities in these areas. Poorly ventilated houses, unprotected water supplies, HIV/AIDS scourge, maternal and under fives mortalities, health and gender inequalities are at high increase.

In this regard, there is a need to strengthen Health Education and Promotion activities and services, and to collaborate closely with the DHMTs in order to facilitate efficient implementation of health promotion service delivery to the communities.

Targets

- Enable the community members to strengthen their community actions
- Assist the district health care providers in developing their personal skills at their working places.
- Create supportive environment to the MOHSW vertical programmes and the private sector at large.

Core interventions

- Conduct informal trainings to both the community members and leaders in the early identification/detection of health and health-related problems in their localities.
- Organize workshops for district health care providers including DHMTs on community-based methodologies
- Integrate and provide technical support to MOHSW vertical programmes and other private sectors implementing health promotion activities.
- Carry out routine and periodic monitoring and evaluation of the implemented health promotion activities in all districts as part of integrated supervision.

5.2.2 Environmental health

For more than two decades, Zanzibar has experienced outbreaks of diarrhoeal diseases,

including cholera, due to inadequate environmental sanitation and hygiene practices. Among the activities undertaken to combat this situation are the following: refuse collection and disposal; safe disposal of liquid waste, vector control, safe water supply, and latrine coverage and use, and general hygiene promotion. The Environmental Health Unit also oversees activities relating to air pollution control, food control and quality, inspection of premises including buildings and industries, fumigation and spraying, and health education in these areas.

Targets

- To increase the proportion of households having access to basic sanitation facilities from 67% in 2005 to 83% in 2010
- To increase the proportion of households with access to safe water from 75% to 90% in urban areas and from 51% to 65% in rural areas
- To progressively reduce environmental pollution and contamination
- To respond rapidly to infestations of pests and disease vectors

Core interventions

- Health education on need for, and means of, improving environmental sanitation, water quality, and hygiene
- Water sampling and treatment
- Building of demonstration latrines, and household inspections
- Inspection of foodstuffs and of food-handling premises
- Fumigation and spraying for vector control
- Collaboration with other programmes regarding environmental interventions

5.2.3 School health

School health promotion programme is an integral part of the curriculum for both primary and secondary students, as well as a potential intervention for addressing the youth problems in schools.

The most important aspects of the school health promotion programme in schools are to assist children to learn how to prevent ill health, practice good health behaviour, good hygiene and good safety codes. Students also learn on how to take responsibility, negotiating skills and take good decisions. Children who maintain good cognitive skills can observe, listen, communicate and take decisions about their own health.

In this regard, therefore, the MOHSW and MOEVT have institutionalized a school health promotion programme in Zanzibar, with a memorandum of understanding to be signed in 2006.

Targets

- To reduce the incidence of communicable and non-communicable diseases among school children
- To detect at an early stage, and to correct all defects and disorders among school children.
- To develop school teachers capacity on health subjects and ensures good monitoring of students health status.

Core interventions

- Conduct training of school teachers on health topics according to the designed and developed health curriculum.
- Conduct screening programmes to school children that shall early detect ill health conditions.
- Develop comprehensive referral system for further consultation for both the handicapped and emergency conditions.
- Carry out monitoring and evaluation of the programme in all schools.

5.2.4 Occupational health

The Occupational Health Unit was created in 1991 in order to coordinate services for workers who are exposed to particular health risks at their place of work. The objective of the Unit is to promote and improve the health, safety and well-being of workers in all occupations in Zanzibar, through both preventive and curative interventions. The Unit is currently based within Mnazi Mmoja Hospital

Core interventions

- Early detection of environmental hazards and unsafe practices, identified through routine workplace inspections;
- IEC on matters relating to health, hygiene, safe working practices, and legal liability;
- Counselling to workers in order to reduce health, social and occupational problems;
- Medical examination of health workers in order to detect untreated pathological conditions and asymptomatic diseases
- Rehabilitation and resettlement of workers unable to work due to long-term illness or accident
- Maintenance of a good relationship with the Labour Office, Zanzibar Municipal Council and DHMTs on health and safety matters.

5.3 Communicable diseases

5.3.1 Malaria

Malaria has historically been the major cause of morbidity and mortality in Zanzibar, particularly among children. A new drug policy of artemesinin combination therapy (ACT) was introduced in 2002, and insecticide-treated net (ITN) was scaled up during the first ZHSRSP period, resulting in an increase in coverage from 3.4% in 2002 to 45.8% in 2005 (ZMCP 2005). As a result, there is some evidence that incidence of malaria, particularly due to *Plasmodium falciparum*, is now falling (MSF 2006). At the same time, the rapid fall in positive diagnoses in the health facilities involved in a pilot to introduce of rapid diagnostic testing indicates that the earlier presumptive diagnosis of all fever as malaria exaggerates the true position.

The Zanzibar Malaria Control Programme (ZMCP) is currently implementing its Strategic Plan for the period 2004 – 2008, the goal of which is "*to significantly reduce morbidity and mortality due to malaria in the population of Zanzibar with special attention to the most vulnerable groups - children under five, pregnant women, and the poor – and in doing so promote socio-economic development.*"

Targets

- To reduce malaria morbidity and mortality by 28% by 2010 through scaling up effective interventions
- To raise the percentage of under-fives having prompt access to and receiving appropriate management for febrile illness within 24 hours from 13% in 2005 to 70% in 2010
- To increase the percentage of under-fives sleeping under ITNs from 37% in 2005 to 90% in 2010.
- To increase the percentage of pregnant women sleeping under ITNs from 2.9% in 2003 to 90% in 2010
- To ensure that 90% of pregnant women attending antenatal clinics receive both IPT 1 and IPT 2 in the second and third trimesters respectively by 2010
- To reduce case fatality rate from 2,1 % in 2005 to 0,5 % in 2010
- To conduct indoor residual house spraying at a rate of 95% household coverage

Core interventions

- Prevention of malaria through promotion and targeted distribution of ITNs, together with other vector control methods (eg indoor residual spraying)
- Access to effective case management (including the introduction of Rapid Diagnostic Tests and the use ACT)
- Control and prevention of malaria in pregnancy through intermittent presumptive treatment, and expanding net use by pregnant women

5.3.2 Sexually Transmitted Infections (STIs) including HIV/AIDS

Support to STI services was being provided until early 2006 by Medicos del Mundo, but is currently being mainstreamed through the RCH Unit and the Zanzibar AIDS Control Programme.

The 2002 prevalence survey indicated that overall HIV prevalence on the islands was relatively low (compared to the mainland and neighbouring countries) at 0.6%, with the figure being higher among young adults and women. Among specific risk groups, the prevalence is higher. For example, among antenatal attendants the rate was 0.9%, among STI patients it was almost 6%, for intravenous drug users 12%, and among TB patients, 25%. An estimated 4% of hospital beds were occupied by HIV/AIDS patients (ZACP 2003). Vertical transmission, from mother to child, was estimated at about 4% of the total.

The main transmission route is unprotected heterosexual sex, indicating the need for efforts to be maintained to prevent the spread to the broader population. The 2001 Africare study found that 78% of youths felt that condom use was socially unacceptable, presenting a challenge which has yet to be overcome.

A recent study showed that substance abusers, and within that, intravenous drug users are particularly at risk.

Targets

- All PHCUs offering syndromic management of STIs by 2010
- All pregnant women screened for syphilis by 2010
- Reduce HIV prevalence among 15-24 years pregnant women from 1% in 2005 to 0,5% in 2010

- Increase proportion of population with comprehensive correct knowledge of HIV/AIDs from 44% and 20% of men to 80% of the general population by 2010.
- Increase in condom use among women at last higher risk sex from 34% in 2005 to 80% in 2010
- Reduction in stigma surrounding HIV/AIDS from 76% in 2005 to 60% by 2010 (measured as the inverse of the proportion of the population expressing acceptance of 4 measures as per TDHS).
- Achieve 1 VCT site per 20,000 people by 2010
- To attain 3,000 PLWHA on ART by 2011

Core interventions
- IEC and community mobilisation
- Condom promotion and use
- Provision of VCT services at 26 sites, and introduction of routine diagnostic testing
- Early diagnosis and treatment of sexually transmitted infections
- Management of opportunistic infections
- Provision of PMTCT services at all referral facilities (PHCC upwards)
- Comprehensive HIV/AIDS care for both adults and children, including the provision of antiretroviral therapy (ART) at hospital level
- Provision of nutrition support for PLWHA who are on ARV
- Ensuring availability of safe blood for transfusion throughout the Isles
- Home-based care for chronically ill patients

5.3.3 Tuberculosis

There has been a slow but steady increase in smear positive tuberculosis in Zanzibar in recent years, and there are concerns that among HIV positive persons, TB incidence is rising much faster. The distribution of the TB burden around the islands is not even, with cases more concentrated in urban areas. A prevalence survey is planned for 2006 in order to assess the overall magnitude of the problem.

The intention of the programme is to expand access to early diagnosis and treatment by scaling up core services throughout the isles. Multi-drug resistance is being noted, and appropriate action will be employed to limit this.

Targets
- To increase case cure rates of TB from 80% to 85% by 2010
- To reduce the death rate from 8% to 5% by 2010
- Extension of community-based DOTS to all districts by 2010
- To prevent a rise in multi-drug resistance through appropriate control strategies
- To increase HIV screening of tuberculosis patients from 20% to 100% by 2010

Core interventions
- Early diagnosis and treatment
- DOTS at both PHCUs and within the community
- Prophylaxis for HIV positive persons with Co-trimoxazole

5.3.4 Lymphatic filariasis

The prevalence of Lymphatic filariasis has historically been significant in Zanzibar, particularly in certain districts. During the ZHSRSP I plan period, regular mass drug administration was undertaken throughout Zanzibar to combat the widespread prevalence of Lymphatic filariasis.

District by district assessment has identified over a thousand patients still requiring hydrocelectomy. However, funding constraints restrict service delivery, and efforts have been made to source private funds to operate.

Specific targets

- Reduction in prevalence from 3% to 1%
- Treatment of all patients with hydrocele
- Provide home-based care management training to all lymphoedema patients

Core interventions

- Mass drug administration if/when indicated by data
- Scaling up of home-based care management training
- Surgical intervention (hydrocelectomy)
- IEC on causes and prevention of Lymphatic Filariasis

5.3.5 Schistosomiasis and soil-transmitted helminths

Schistosomiasis and soil-transmitted helminths are common public health problems in Zanzibar. Pemba to a greater extent is affected with Schistosomiasis while in Unguja the problem are localised largely in North region and Central district. At the start of the 1st ZHSRSP period, prevalence of both schistosomiasis and soil-transmitted helminths in affected populations was around 60%. Through an active mass treatment programme on Pemba, and school-based treatment programme on Unguja, there has been significant success in reducing these rates and associated morbidity.

Pilot activities are currently ongoing in selected areas to determine the effectiveness of environmental management, through removing vegetation in the boundaries of rivers, filling in of man-made swamps, and the introduction of clove leaves. Subject to a successful evaluation at the end of the one year period, these will be extended to all affected areas.

Targets

- To reduce prevalence of schistosomiasis from 45% to 15%
- To reduce prevalence of STH from 50% to 10%
- To reduce morbidity from schistosomiasis and STH through early diagnosis and treatment
- All affected communities to be involved in environmental modification

Core interventions

- Health education on prevention and control of schistosomiasis and STH, through the Sheha, school teachers, and health workers
- Diagnosis and treatment of schistosomisis and STH at PHC level
- Mobile ultrasound diagnosis at schools in heavily affected areas, to be extended to Shehia level once complete
- Vector control for schistosomiasis through environmental modification

5.3.6 Leprosy

The number of registered leprosy cases on treatment has been constant in recent years, with approximately 109 new cases being detected per year. In 2004, this was over 1 case per 10,000 population, i.e. above the WHO target for elimination. Late treatment seeking results in the unfortunate situation that patients have often already suffered disability by the time they report for medical help.

Multi-drug therapy (MDT) was introduced in 1988, in line with the WHO strategy.

Targets

- To increase cure rates from 80% to 90% by 2010
- To decrease the number of newly detected leprosy cases to less than 1 in 10,000 population by 2010
- To expand access to MDT in 100% of health facilities
- To achieve 90% community knowledge on leprosy by 2010
- To decrease disability grade II among newly diagnosed leprosy cases from 9,4% to 5% by 2010

Core interventions

- IEC for early recognition
- Case management at PHCU level and above
- Leprosy elimination campaigns in South and Micheweni Districts
- Rehabilitation of disabled patients.

5.4 Non-communicable diseases

The growing importance of non-communicable diseases (NCD) in the overall disease burden in development countries has been recognised in recent years. The situation in Zanzibar mirrors that of other countries, with an increase particularly in diabetes and hypertension being seen in the health facilities, and non–communicable diseases are predicted to potentially overtake communicable diseases by 2010 in terms of the disease burden. A NCD Unit was created within the MOHSW in 2002 to help address the problem, and an integrated NCD policy, program and guidelines is being developed. A major problem remains the lack of baseline data for the islands as a whole.

Changes in local dietary patterns are being associated with the increase in NCDs such as diabetes mellitus and hypertension, and there is an increase in obesity which is a contributory factor in both diseases. Attempts to control these are constrained by the popular cultural perception that obesity is associated with wealth.

Targets

- Establish baseline data on the burden of disease (prevalence study) and the main risk factors for the most common NCDs by 2010
- Increase community awareness on NCDs/conditions to 80 % by 2010
- 100% of districts implementing social mobilisation for the prevention and control of NCD/conditions by 2010
- Integration of prevention and management of the most common NCDs in all PHCCs and hospitals, and in selected second line PHCUs by 2010

Core Interventions

- Develop an integrated NCD policy, program and guidelines
- Building community awareness on NCD prevention and control through IEC
- Routine screening of at risk persons to be introduced at the PHCU level
- Strengthening of data collection, M & E and feed-back mechanism
- Establishment of an effective surveillance system on NCDs
- Sensitization of health personnel on relevant research findings

5.4.1 Diabetes

Despite the awareness that the prevalence of diabetes is growing in Zanzibar, in common with other countries, there is no population-based data on the magnitude of the problem. Figures from Mnazi Mmoja Hospital show a clear upward trend in total patient attendances from 4,500 in 2000 to 6,298 in 2004. The number of new cases appears to be relatively stable at around 250 per year.

Currently, the only services are provided at referral facilities through eight special clinics throughout the Isles, thereby requiring patients to incur costs of travel. Due to the nature of the hospital sector on Pemba, services are more rationally distributed there. Diabetes patients are specified among those with special dispensation once cost-sharing is introduced, due to the chronic nature of the disease.

5.4.2 Hypertension

As with Diabetes, there is no data on the extent of hypertension in Zanzibar except that reported by MMH. In 2005, 735 cases of hypertension were admitted to MMH. A quarter of these suffered cardio-vascular accident (CVA) , possibly due to hypertension or hypertensive vascular diseases.

5.4.3 Injuries and disabilities

Injuries and disabilities remain one of the top ten diagnoses in health facilities. Road accidents and fractures arising from the harvesting of cloves are among the major causes of injury. Casualty services remain limited, even at the hospitals.

5.4.4 Oral health

Although dental care is one of the added functions of a second line PHCU, only a few facilities are currently providing the service, due to a shortage of specialist staff and malfunctioning equipment.

5.4.5 Eye care

Available data on the prevalence of eye disease is seriously outdated, originating from a 1998 population-based rapid assessment. However, in the absence of more recent information, it continues to form the basis for activities relating to eye care. Based on that assessment, it is estimated that there are some 10,000 blind persons in Zanzibar, roughly 50% of whom are suffering from cataracts, 21% from glaucoma, 15% from corneal scars, trauma, corneal perforation, vitamin A deficiency and/or trachoma, and the remaining 14% from refractive error, diabetic and hypertensive retinopathy and fundus disorders. Trachoma is more

prevalent in the north-eastern part of Pemba and northern part of Unguja.

At present there is limited capacity on the islands to deal appropriately with these problems, with only one practising cataract surgeon, based in Unguja and who also has other responsibilities, and no routine screening activity available at PHCC level as intended. However, an agreement was signed in March 2006 with Sight-Savers International to strengthen both primary eye care, and the Eye Department at hospital level. Through this support it is expected that over the period of this Strategic Plan two ophthalmologists, two cataract surgeons and four ophthalmic assistants will be trained, enabling an expansion of service delivery, both static and outreach. It is hoped that 2,000 cataract operations will be performed annually by 2010, through periodic eye camps and regular outreach.

In addition, there are planned activities to raise awareness of both key decision-makers and the population at large on early treatment seeking for eye diseases, and to improve both the quality and coverage of the community-based rehabilitation programme for those persons who are blind or have low vision. Linkages with relevant NGOs have been strengthened, and through these it is expected that both access to and quality of education for blind and visually impaired children will be improved over the next five years.

5.5 Mental health, social welfare, and substance abuse

5.5.1 Mental health

The main mental health problems in Zanzibar are schizophrenia, acute psychosis, dementia, depression, mania, anxiety neuroses and unexplained anxiety disorders, mental retardation, and hyperkinetic disorders. The programme is also responsible for patients with neurological disorders such as epilepsy, particularly those showing evidence of psychosis, and for the management of acute psychosis arising from medical problems which are referred from general hospitals. In addition, there are an increasing number of drug abusers who require health services. However, the programme is severely under-funded, and there are problems in diagnosis, and in the capacity to adequately cater for patients' needs.

The main provider of specialised services is the psychiatric hospital in Zanzibar Town, Kidongo Chekundu (KCH), which caters both for outpatients and inpatients. On Pemba, there is a very limited inpatient capacity at Chake Chake Hospital, pending planned construction of a ward at Wete Hospital. In addition, all other facilities offer a limited range of mental health services. Selected PHCUs (20 at present, 12 on Unguja and 8 on Pemba), those with psychiatric nurses on the staff, are currently being strengthened to offer a wider range of services and drugs. At the community level, patients are visited in their homes through outreach services from KCH psychiatric hospital.

Targets

- Reduction in admission of unnecessary cases through strengthening of primary and outreach services
- Constant availability of core mental health drugs and supplies in the selected PHCUs.
- Improved community understanding of mental health problems, causes and solutions by 2010
- Establishment of adequate psychiatric inpatient capacity on Pemba by 2010.

Specific interventions

- Information education and communication regarding mental health and neurological disorders
- Primary care provision for neurological disorders
- Identification and referral of cases to higher level or designated PHCU facilities
- Improved collaboration with traditional healers to improve mental health coverage and referral, to include training
- Outreach specialist care from KCH to those able to remain at home

5.5.2 Social welfare

The Department of Social Welfare was returned to the remit of the Ministry of Health from the Chief Minister's Office in 2000, and is responsible for the provision of social services to the elderly, orphans, the disabled, and other vulnerable groups. Currently, 176 elderly persons are housed in 4 MOHSW homes, 2 on each island, while 45 orphans are cared for in the single GOZ orphanage. The Department manages the Workman's Compensation Fund which assists victims of accidents in the workplace, and there is also limited financial support for health services to the destitute. However, the budget for these services is very limited, and has been falling in recent years, resulting in some activities being dropped, eg the financing of prosthetic limbs for those in need.

District Social Welfare Officers are employed in all ten districts in Zanzibar, but fall under President's Office, Regional Administration and Special Forces, rather than MOHSW. Although they refer potential cases for assessment (workplace accidents) or for residential care (elderly, orphans) to the central Department of Social Welfare, there is no supervisory or reporting responsibility between the central and district level, which results in an unclear organisational structure, and potential inefficiency in the delivery of social services. There is also duplication with the Department of Community Development which falls under a separate Ministry again.

Specific targets

- Operationalisation of the MOHSW exemption policy in order to ensure that those in need have access to public health services
- Rationalisation of structures for social service provision within GOZ
- Resumption of support for prosthetics

Core interventions

- Provision of residential care to the elderly and to orphans
- Rehabilitation of persons with disability
- Funding for education of children with special needs in appropriate schools on the mainland
- Support to mothers and children in difficult circumstances
- Assessment of victims of accidents at work, and provision of compensation for those qualifying
- Probation services to child offenders
- Networking and collaboration with non-governmental organisations working with the target populations.

5.5.3 Substance abuse

The Department of Substance Abuse was created in 1996 under the Chief Minister's Office in response to the growing problem of alcohol and drug abuse in the islands, and transferred to the Ministry of Health in 2000. Data indicate that the problem is highest in the urban areas, but there is concern that with the increased availability and acceptability of alcohol and other substances as a result of the tourist trade, this is extending to other areas. A major constraint in addressing the issue of substance abuse is the absence of an overall baseline for the islands. An urban survey in Zanzibar (and Dar es Salaam) found that 2% of the population use cannabis, while the number of psychoactive substance abusers admitted to the psychiatric hospital has risen in recent years. Due to the linkages between substance abuse and mental health problems, and as a result of personnel and other resource constraints within the sector, the two issues have tended to be combined. At the same time, this has created stigma with some reluctance of abusers to seek care. Efforts have been made in recent years to mobilise resources to create a separate treatment and rehabilitation centre, but without success. A small detoxification centre is currently planned within the grounds of Kidongo Chekundu Hospital, and it is hoped that rehabilitation services will be initiated at least on a small scale within the same area.

Substance abusers are one of the Most At Risk Populations identified for the targeting of HIV/AIDS prevention and care interventions in Zanzibar. A recent survey of 508 (self-selected) substance abusers found that among the 198 intravenous drug users (IDU), HIV prevalence was 30% and Hepatitis C was 22% compared with 12% and 15% respectively among non-IDUs. These rates are much higher than among the general population. Efforts to assist these persons will be taken in collaboration with the Zanzibar AIDS Control Programme.

Targets

- To reach teachers in all districts with IEC on the dangers of substance abuse by 2010
- To establish baseline data on the prevalence of substance abuse in Zanzibar, distinguishing clearly between tobacco, alcohol, cannabis and other harder substances
- To reduce burden of HIV/AIDS affected and infected in the at risk group from 30% to 10%
- To implement operational detoxification and rehabilitation services for substance abusers by 2010

Core interventions

- IEC to the general population on the dangers of substance abuse
- Provision of specific IEC to teachers through the district Teaching Centres on identification and management of substance abuse among schoolchildren
- Provision of counselling and advice, through drop-in centre, including peer counselling by ex-substance abusers
- Referral for detoxification and related inpatient treatment
- Rehabilitation and training for former substance abusers
- Increase awareness of substance abuse in relation to HIV/AIDS in most at risk group.

6. Strengthening support systems for quality care

6.1 Human Resources for Health

Human resources are a critical factor for successful operationalisation of the ZHSRSP II. Although funding is needed to support the proposed interventions, such resources can not be implemented without properly skilled and motivated staff, in the required numbers, and appropriately deployed throughout the islands and the health system.

A detailed analysis of the human resource situation was undertaken in 2003 at all levels in the health sector to analyse both existing staff availability, and also the skill mix needed to implement reform interventions. Based on the findings, a detailed Five Year Plan for HRH was drawn up in 2004[5], based on the concepts of team rather than individual workers. The plan also considers staffing a network of facilities rather than individual health care facilities in a manner that enhances efficiencies in the utilisation of human resources and technology.

The following 8 priority areas have been identified in the HRH Five Year Plan:

1. Advocacy and promotion of the Five Year Plan
2. HRH development
3. Retention
4. Quality care at all levels
5. HRH data base
6. Capacity building for the College of Health Sciences
7. Mnazi Mmoja as a referral hospital
8. Monitoring and evaluation.

6.1.1 College of Health Sciences

As the primary health training institution on the islands, the CHS bears a heavy responsibility, yet the resources required to enable it to meet the needs of the Zanzibar health sector have been lacking to date. The budget has been relatively static at TSh80m per year falling to TSh51m in FY2005/06, and even then the 2006 PER indicated that of a maximum of 37% of the budgeted allocation has been released in the past five years. As a result the college has neither been able to offer the range of required courses, nor to accept the necessary intake to meet needs.

A recent inflow of support to running costs has enabled three key new courses to be introduced with effect from 2006. The cadre of Public Health Nurse "B" is expected to replace the Maternal and Child Health (MCH) Aides currently providing RCH services at primary level. The current intake of students is drawn from two sources: existing MCH aides who are upgrading, and new recruits.

Support to expand the CHS to facilitate the increased intake is currently in the pipeline both as part of the ADB-funded Second Health Rehabilitation Project, and from the Omani government which built the original college.

[5] MOHSW. *Human resource for health 5-year development plan 2004/05 – 2008/09*. Final draft October 2004

Table 5 Expected outputs from the CHS, 2006 to 2010

Course	2006	2007	2008	2009	2010	Total
General nursing and midwifery (MMW)	17	17	56	39	35	**164**
General nursing and psychiatry (NPSY	13	6	24	19	15	**77**
Medical laboratory technician sciences		16	35	25	35	**111**
Clinical officers		23	22	20	25	**90**
Environmental health officers		17	40	38	35	**130**
Public health nursing		25	31	30	30	**116**
Pharmaceutical sciences			29	30	30	**89**
Clinical dental		12	15	15	10	**52**
Nursing anaesthetist				15	15	**30**
TOTAL	**30**	**116**	**252**	**231**	**230**	**859**

Projected HRH requirements are currently based on a fixed facility norm, albeit based on a workload estimate in terms of contacts, and this needs to be reviewed early in the ZHSRSP II period in order to obtain more realistic targets for staffing and training. A workplace productivity study has recently been undertaken and the findings from this will help in this process.

6.1.2 Human resource database

The MOHSW established a Personnel Information System in the early 1990s, but shortage of funds has hampered regular update and use of the data. Technical and financial support has already been agreed to review and revise the database, in line with similar changes on Tanzania mainland, and to link it to the Health Management Information System (HMIS) currently being developed and strengthened. It is expected that this database will form the basis for improved HRH management, through identifying those due for training and promotion in a more systematic and transparent manner.

6.1.3 Quality of care

Efforts to improve the quality of care provided by health workers are critical if demand is to be created and sustained among the population. This is particularly an issue for delivery services, where a common complaint is that midwifery staff is rude and insensitive. A Quality Improvement Recognition Initiative, designed for RCH services, has been piloted in two districts with support from UNFPA, and this has proved both to have improved some objective measures of quality, and to be popular among the health workers and district managers implementing it. It is intended to adapt this tool for more general use, and to scale up use to all ten districts.

Targets

- Health facilities achieving the revised staffing norms
- HRH database up to date and managed appropriately
- NACTE recognition for the CHS by July 2007

Core interventions

- Provision and coordination of pre-service training both at CHS and on the mainland
- Appropriate selection and resource mobilisation for post-basic training
- Management and coordination of in-service training in all disciplines for health workers, through standardised and integrated courses at CHS, and as identified by Continuing Education Committees

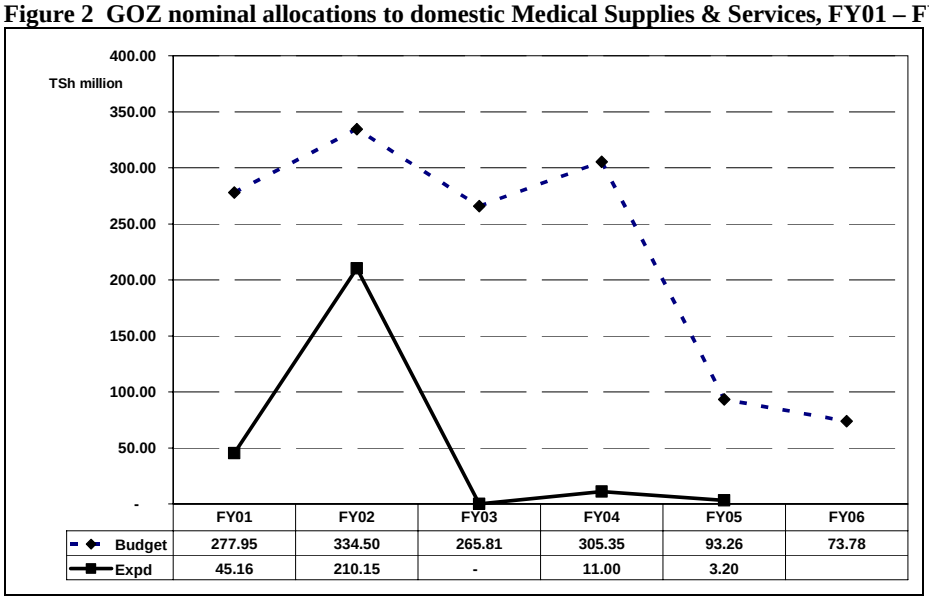
6.2 Material resources and Infrastructure

6.2.1 Essential drugs and health supplies

The continuous, quality assured supply of appropriate and affordable essential drugs and medical supplies is one of the cornerstones of the public health system. After a period of shortage, the supply in Zanzibar has much improved in recent years due to inflows from a variety of funding sources, notably GFATM, ADB and Danida. In addition, distribution has been facilitated by donation of a truck, and expansion of the Central and Zonal Medical Stores buildings is underway.

Unfortunately, it is impossible to present figures on the total spending on essential drugs and medical supplies due to fragmentation of the sources of funding between technical programmes, projects, and the MOHSW. The MOHSW budget, however, is very limited, and actual release of funding even more so, as shown in Figure 2 below.

Figure 2 GOZ nominal allocations to domestic Medical Supplies & Services, FY01 – FY06



	FY01	FY02	FY03	FY04	FY05	FY06
Budget	277.95	334.50	265.81	305.35	93.26	73.78
Expd	45.16	210.15	-	11.00	3.20	

Source: MOHSW 2006, PER

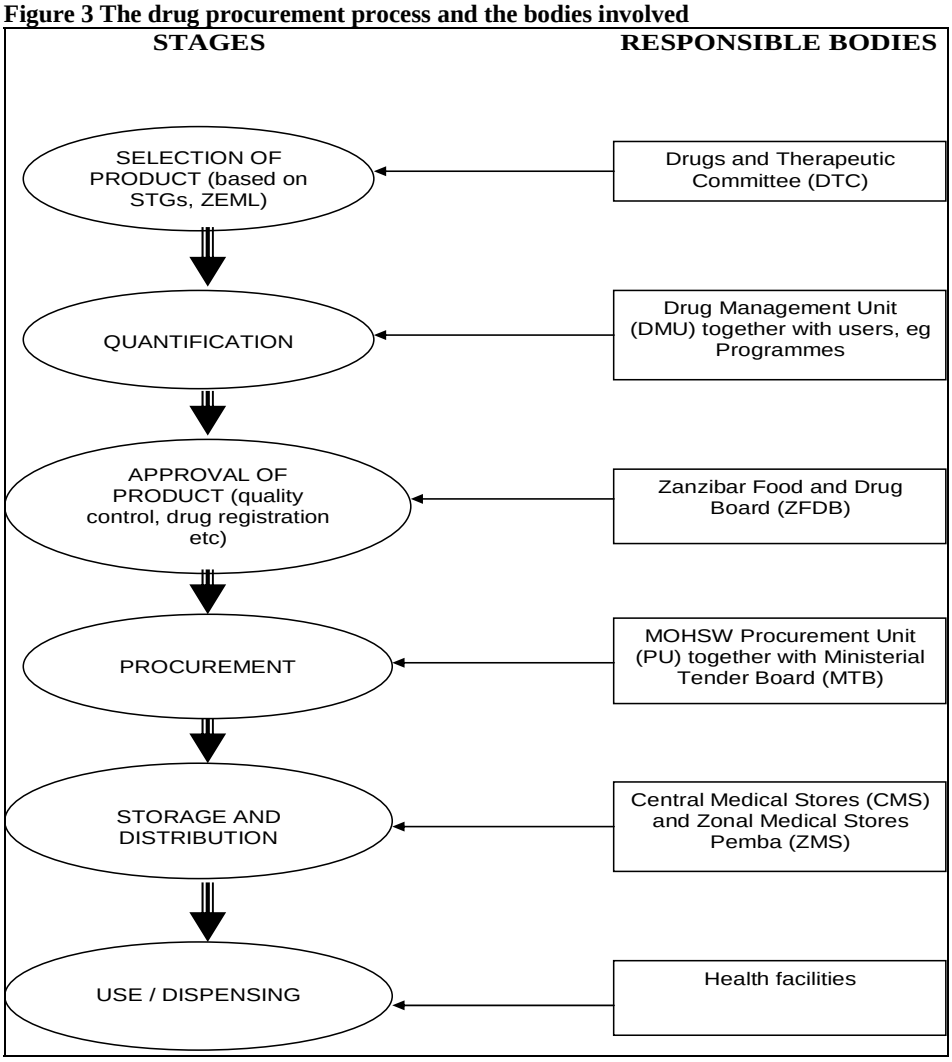
Estimates of total spending on drugs and supplies from the Public Expenditure Review indicate that around TSh 3.6bn was spent during FY2004/05, with GOZ contributing less than 1% of this. There are some concerns with the figure, but there are notable omissions such as family planning commodities and HIV/AIDS-related commodities, as well as possible over-estimates. This equates to roughly US$ 3.08 per capita.

In 2005, a new National Drug Policy and a revision of the Pharmaceutical Sector Master Plan for 2006 – 2011 were developed. The objective of the former is "*to make available to all Zanzibaris at all times, essential pharmaceutical products of quality proven effectiveness and acceptable safety, at a price that the individuals and the community can afford*". Activities early in the ZHSRSP II period relate to the dissemination and operationalisation of these documents, including the strengthening of the necessary bodies to achieve this, eg Drugs Management Unit, Central and Zonal Medical Stores, Pharmacy Board, and Drug and Therapeutic Committees at all levels.

Within MOHSW, the Drugs Management Unit (DMU) is responsible for all drug policy

matters and their implementation. The DMU is headed by a Chief Pharmacist who reports to the Chief Medical Officer, and who also serves as Secretary to the MOHSW Drug and Therapeutic Committee. The relationship between the various bodies involved in the process of ensuring availability of essential drugs and medical supplies is shown in Figure 3 below.

Figure 3 The drug procurement process and the bodies involved



Although not currently costed, the Pharmaceutical Master Plan outlines in detail the strategies and activities to be undertaken during the period of ZHSRSP II. Among these are the following:

- Strengthening the Drugs Management Unit for policy implementation, planning and coordination of the pharmaceutical sector;
- Strengthening of the procurement and distribution system for both drugs and supplies, and medical equipment, through development of an integrated, Ministry procurement plan and budget, including supplies currently ordered through vertical programmes
- Competitive tender for a new supplier who will provide both drugs and medical supplies, and technical support to strengthen associated management systems
- Improving the pharmaceutical information system, covering volumes, logistics, and financing of drugs and supplies

- A phased move from a "push" system to a "pull" system through progressive increase in the number and volume of drugs under the indent system
- Capacity strengthening for district and hospital staff for quantification of drugs and essential medical supplies in line with their needs
- Construction of a new Zonal Medical Stores in Pemba, and upgrading of storage facilities where necessary throughout the health system.
- Development and implementation of a system to monitor rational drug use.

6.2.2 Diagnostic and blood transfusion services

Improvement of diagnostic capacity in Zanzibar is an important component of strengthening service delivery. Accurate diagnosis, following early treatment-seeking, and backed up with appropriate treatment, is the key to reducing case-fatality. Responsibility for diagnostics currently falls under the Department of Hospital Services, but consists of a one person unit with no independent budget.

At present there is no professional council for laboratory staff, yet with the expansion of private health facilities this is an important area for regulation. What regulation of private laboratories is currently carried out, is undertaken through the Private Hospitals Advisory Board, but this is acknowledged to be insufficient to ensure quality. There is an interim body, the association of Zanzibar Medical Laboratory Scientific Officers (ZAMELSO), which is in the process of registering laboratory staff.

X-ray capacity at Mnazi Mmoja referral hospital has recently been improved with the replacement of the existing machine with the purchase of green sensitive films while the four PHCCs have also recently received X-ray machines as part of GFATM support, thereby taking services closer to the population.

Provision of safe blood is a key element in the reduction of transfusion-transmissible infections (TTIs), notably HIV and Hepatitis B and C. Funding has been secured through PEPFAR for strengthening the National Blood Transfusion Service as part of a broader programme for Tanzania, within which Zanzibar is one Zone. A central building to house a blood bank is under construction on Unguja, and equipment will be provided. There are no funds for such a blood bank on Pemba, although all facilities currently have refrigerators.

Targets

- Expansion of the Diagnostics Unit to include focal persons for the three areas: laboratory, imaging, and equipment by 2008
- Development of a national policy for laboratory and imaging services by 2008
- Renovation and equipping of the MMH laboratory commensurate with its status as the referral laboratory for the islands
- Establishment of a VCT centre of excellence at MMH by 2010
- Operationalisation of a fully functional referral laboratory at Chake Chake hospital by 2010
- Articulation of the essential laboratory package at each level as part of the revision of the EHP by 2008
- Improved availability of key laboratory personnel at all levels by 2010, including specialist pathologists for MMH
- Establishment of voluntary blood donor system by 2010, enabling abolition of the current

replacement donor system
- To ensure constant availability of safe blood for patients in need at all health facilities handling transfusion

Core interventions
- Routine laboratory investigations from second line PHCU level upwards
- Full blood count from PHCC level upwards
- Screening of all donated blood for TTIs
- Regular campaigns for volunteer blood donors

6.3 Infrastructure

6.3.1 Buildings

The health infrastructure in Zanzibar is impressive when compared to the mainland and to other low income countries in the region. A concerted programme of expansion in the 1960s and 1970s resulted in 100% of the population being within 10km of a public health facility, and 95% within 5km. Additional facilities have been built since this period, in response to the increase in population, and although the current figure is not known, the overall position is expected to have improved. Use of Geographic Information Systems to map health infrastructure and population will enable calculation of current coverage during the plan period.

In the light of this high coverage, very limited new construction is planned for the coming five year period. Gaps, as identified in the HDRS, include the need for a new PHCC to serve the population of Central district, and part of the North B population, and for development of dedicated psychiatric inpatient services in Pemba. These are proposed at Wete Hospital. There are plans, however, to strengthen existing primary level infrastructure with the addition of staff housing in a few strategic locations. Two houses per facility are envisaged, to a total of around 40 houses[6]. Twelve of these will be at the remaining second line PHCUs which are being expanded to offer delivery services, and therefore require round-the-clock staff availability. The remainder will be constructed at a limited number of first line PHCUs, thereby improving effective access to the populations within the catchment areas of these facilities.

There are further plans to strengthen the laboratory facilities at Chake Chake Hospital, in line with its role as the main referral hospital on Pemba, and to develop a centre of excellence for VCT Laboratory facilities at Mnazi Mmoja Hospital.

Although physical structures are in place in many shehias, many of them had fallen into disrepair after 1995, as a result of the constrained resource availability. Much work has been undertaken during the first ZHSRSP period to renovate and rehabilitate these facilities, particularly PHCUs. To date, 52 first line PHCUs have been renovated under the Danida-funded HSPS, while the ADB-funded FHRP has undertaken work to expand 10 of the 16 original second-line PHCUs to provide maternity services. A further six facilities will be extended, and staff housing constructed, during the plan period as part of the next phase of ADB support.

[6] Based on current agreed funding plans (ADB).

6.3.2 Transport and communications

Although MOHSW headquarters has the appearance of significant transport availability, many vehicles are relatively old, and maintenance has been constrained due to lack of funding in recent years. There is an absolute shortage of transport at the district level, and at hospital level, thereby hampering patient transfer, and also routine supervision and monitoring.

A situation analysis is currently underway to determine the extent to which there is an absolute shortage of vehicles or to which transport distribution and management might be the problem.

6.3.3 Strengthening the Maintenance Unit

The importance of routine preventive maintenance is recognised by health facility staff, and those responsible for transport and infrastructure at the central level. However, in the context of highly constrained central (flexible) funding, this area has been neglected in the past, resulting in higher expenses being incurred at a later date.

The MOHSW has two engineering units, one for vehicles and one for buildings and equipment. The MOHSW garage based in Mwanakwerekwe undertakes most maintenance on the vehicle fleet for the sector, while the Maintenance Unit based in MMH is responsible for both repair and to some extent, preventive maintenance of the health infrastructure on the two islands. There is a smaller unit on Pemba.

Both the buildings and the equipment for these two units is inadequate, and some of the premises over which the Maintenance Unit is scattered are being allocated to alternative uses. This is an area which was identified as requiring infrastructural development in the HDRS, although no funds have yet been sourced to facilitate this. Ideally, over the plan period, the two Units would be centralised in one location thereby enabling efficiencies in the use of materials and equipment where possible.

Within the Health Service Fund, 7% is allocated to maintenance, which is currently top-sliced and provided along with limited other funds to ensure an operating budget for the Maintenance Unit. The availability of such resources has improved preventive maintenance and minor repair at the service delivery level

6.4 Evidence-based decision-making

6.4.1 Health management information system

The Health Management Information System in Zanzibar has been in place for well over a decade, but is in need of updating in order to better support the functioning of a decentralised health system. Ongoing technical support has assisted in the revision of the data forms at health facility level, in collaboration with the technical programmes, and the process of agreement of a core set of indicators for PHC is underway. These are expected to meet the major needs of the programmes as well as of district management, and to rationalise the currently heavy burden on both frontline health workers and district health managers.

A database is currently under development that will incorporate routine health data, population /census data, information on health facilities and other infrastructural resources,

human resources (through linkages with the personnel information system), and finances. Targets will be integrated in the system, to enable continuous monitoring of progress in achieving health sector objectives.

There remains much work to strengthen the ability of health workers to analyse and use data at the point of collection, but a programme of capacity strengthening has been designed and will continue through the plan period. This includes the strengthening of the district, zonal, hospital and central level HMIS focal points and units.

Goals for the plan period are the following:

- To develop an integrated HMIS incorporating information on all aspects of the health service (rather than just diagnoses, utilisation, and coverage with key interventions);
- To develop a culture of indicator & information use at all levels of the health system; and
- To develop the necessary human and institutional capacity to achieve these.

6.4.2 Health research

The need for both operational and bio-medical research in the sector is well-known. At present however, there is no coordinated approach to research, despite the existence of a Research Council which was revived during the ZHSRSP I period with the help of a Task Force. Failure to institutionalise budgets and constraints on the time of members of the Task Force has resulted in the Council remaining marginalised.

Collaboration with a number of institutions has been established, although without formal links. These include the Public Health Laboratory on Pemba, National Institute of Medical Research, the College of Health Sciences, Mnazi Mmoja Hospital, and various universities. The islands appear to be more a passive recipient of research rather than having an active research agenda which is targeted at clearly identified needs.

Research capacity within the MOHSW is in urgent need of strengthening, not least as several individuals previously active in this area have recently left the system.

6.5 Legislation and regulation

Regulation and oversight of activities within the sector – both public and private sub-sectors - is one of the core roles and responsibilities of the MOHSW headquarters. A number of the existing laws and regulations governing health provision and health-related activity are outdated, and in some areas there is no legislative framework.

The MOHSW has two assigned junior lawyers who sit within the Health Policy and Legislation Unit, and who assist with drafting and submission of Acts of Parliament.

A number of issues relating to legislation have been identified during the process of developing the ZHSRSP II, as shown in Table 6. Activities are planned both for the drafting of new legislation, and for the review of existing health-related legislation, to ensure that it remains adequate and relevant for the changing environment. These need to be further prioritised, and resources identified to enable their enactment.

Table 6 Legislative change planned in the ZHSRSP II

Legislation	Current status/proposed change
Zanzibar Food and Drug Act, ZFDA	Revised Act passed by House of Representatives, awaiting Presidential signature
Traditional Medicine Act	First draft in place, awaiting stakeholder meeting
Public Health Decree	Cap 73 Public Health Decree was repealed with passing of ZFDA, which incorporated some content. Review proposed to establish new Environmental Health Act to cover other areas. .
	No legislation in place to control chemicals, whether domestic or industrial
Medical council	
Research Council needs to be made self-accounting	Council in place, but with no legal framework
To grant semi-autonomous status to College of Health Sciences	Concept paper approved, Board established
To grant semi-autonomous status to Mnazi Mmoja Hospital	Currently a Department of MOHSW; limited revenue-raising, but retention locally
To grant semi-autonomous status to Chief Government Chemist	Currently a Department of MOHSW; funds levied for some services but returned to Treasury

Further to the passing of appropriate legislation, there is also the need for effective regulation in line with the Act and any associated statutory instruments. Zanzibar has a number of Statutory Boards and Bodies whose are responsible for such regulation. Each of these is intended to be headed by a full-time Registrar, who in turn reports to Chair. The primary responsibilities of each body is outlined below.

Medical Council
The Medical Council was created following the passing of the Medical Practitioners and Dentists Act (No 12 of 1999). Its main functions are to register doctors, assistant medical officers and medical assistants who wish to practice in Zanzibar, to supervise adherence of the same to medical ethics, and to impose penalties on those who breach the ethical code.

Nursing Council
The Nursing Council was established under the Nurses and Midwives Act. The main functions are: to register all nurses who meet the standard of training required by the Act; to be responsible for curriculum and its review; to supervise all nurses and midwives; and to revoke the registration of any nurses or midwives found guilty of malpractice.

The Zanzibar Food and Drug Board
The Board replaces the existing Pharmacy Board (Pharmaceuticals and Dangerous Drugs Board) with the passing of the new Act. The main functions are to regulate all matters relating to the quality and safety of food, drugs, herbal drugs, medical devices, poisons and cosmetics; to establish a technical committee to register pharmacists and other pharmaceutical personnel; and supervision and regulation of the same personnel.

Private Hospital Advisory Board (PHAB)
The PHAB was established under the Private Hospital (Regulation) Act No 4 of 1994.

7. Financing the ZHSRSP II

7.1 Introduction

It should be noted from the outset that this Strategic Plan is not fully costed and, similarly, the expectation is that it is unlikely to be fully financed. The identification of a major financing gap achieves no practical purpose, and the document should therefore be viewed as providing a guiding framework for sector activity over the coming five years.

That said, it is possible to identify a tentative financing framework for the initial years of the plan period, based on the MKUZA financing frame together with existing plans and projections for complementary and external financing. Issues relating to the management and allocation of funding within the sector are also addressed in the following sub-sections.

7.2 Current financing of the health sector in Zanzibar

The health sector is currently financed from three main sources: GOZ, development partner contributions (multilateral and bilateral), and the public. According to the 2006 health sector Public Expenditure Review[7], the Government contribution accounted for 29% of spending in the sector in FY2004/05, while development partners accounted for the balance of 71%.

GOZ provide the core funding for the running costs of the health service infrastructure, including the salaries of public health sector workers, with personal emoluments accounting for just over 70% of budget and close to 90% of expenditure in FY2004/05.

The health sector has received between 8% and 9% of the GOZ total in recent years (excluding public debt), and the commitment to raise the allocation to the sector during the life of the first ZPRP was not met. Although the budget has been increasing in nominal terms, the real value has fallen since FY2003/04, and in per capita terms GOZ spend was estimated at US$4.19 in FY2004/05.

External funding dropped sharply after 1995, adversely affecting the implementation of health services in Zanzibar. However, there has been a recent inflow due in large part to the increase in funding from global health initiatives such as GAVI and GFATM, and also to the interest (largely American) in scaling up care and treatment for AIDS patients. Although development partner support currently finances over two thirds of public health expenditure in Zanzibar, systematic collation and consistent reporting of external finance remains a challenge throughout government, and the health sector is no exception.

The major current partners in the health sector, in terms of their financial support, include Danida, GFATM, the African Development Bank, and the United States government. The official FY2004/05 GOZ budget indicated a per capita foreign contribution of US$6.55 while the PER estimate for the same year was somewhat higher at US$10.34.

The manner in which the majority of external funding is channelled, ie through vertical technical programmes, is a major challenge to the MOHSW, as it presents an appearance of a

[7] The PER does not include public contributions through cost-sharing. These are currently negligible in relation to the financing frame.

well-funded sector, while many essential central support operations remain starved of resources in the face of a constrained (non-salary) government allocation. The exception to this is the Health Service Fund at the district level. Unlike other countries in the region, Zanzibar as yet has no central pooled funds to strengthen the achievement of essential reform objectives.

The 2000 Health Policy paved the way for the introduction of cost-sharing in the Zanzibar health sector. This was seen as a necessary strategy both for increasing the resource base of the sector, and to enhance community involvement in health planning and management as a corollary to financing.

Cost-sharing in the sector remains limited at present, with minimal revenue generated to date. Charges currently in place include those for issuing of infectious disease certificates, for some services of the Government Chief Chemist, and for X-rays and blood tests.

Subject to the identification of funding to support the necessary preparatory activities, the Ministry intends to introduce both user fees and a Community Health Fund, in order to mobilise funds to strengthen health service delivery. Guidelines for the introduction of cost-sharing were developed within the MOHSW in 2004, and a study was undertaken in 2005 to assess the potential for revenue from this source.

7.3 Resource mobilisation

7.3.1 Domestic government resources

Domestic resources are expected to continue to play a significant role in the financing of the sector, providing the majority of the base running costs such as personal emoluments and administrative expenses of the departments. However, there is no stated commitment to increasing the share of the sector, and the macroeconomic outlook for Zanzibar is uncertain. The positive economic environment on the mainland and the potential for increased general budget support is expected to have a small positive impact on domestic revenues for the Isles.

7.3.2 External resources

The prospects for increasing the volume of external resources in the sector are limited, given the increasing tendency of the larger bilateral and multilateral development partners to channel their funds in the form of General Budget Support through the mainland Ministry of Finance, from where 4.5% is transferred to Zanzibar. In the absence of any commitment by GOZ to increase the health sector share, it is difficult to see where additional funds might be sourced.

There is some limited scope for increased funding through a small number of bilateral partners such as USAID, or through the second phase of ADB support which is expected to come on stream in 2007. The sector is expected to continue to benefit from Danida support until at least FY2008/09, and it is likely that support will continue thereafter. Additional earmarked funds may be obtained through future rounds of the Global Fund or from GAVI, but these are difficult to predict at present.

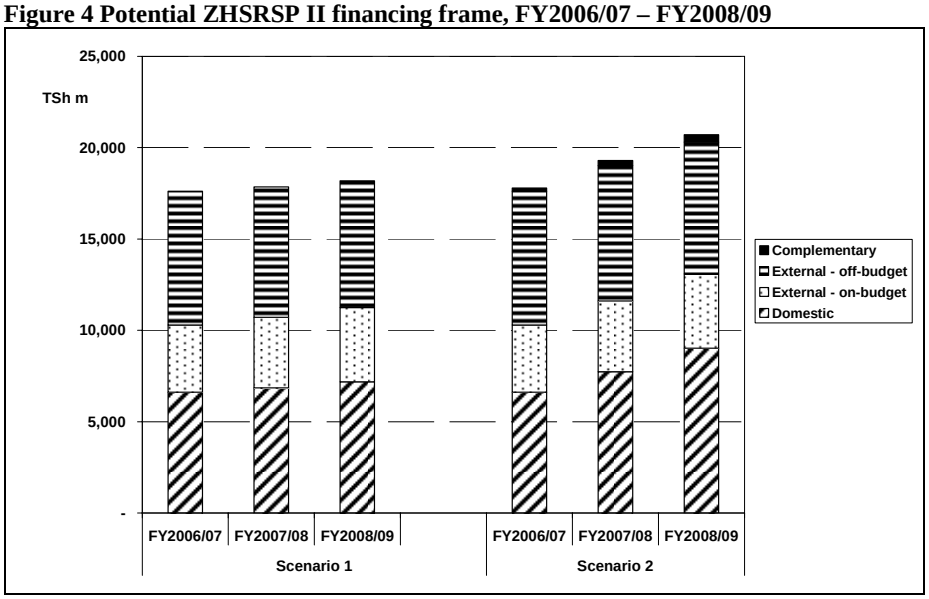
7.3.3 Complementary financing

The Health Policy provides the necessary legal backing for the introduction of cost-sharing in the health sector, and a limited number of public facilities have introduced fees for some services. While the expectation is that progress will be made during the plan period in establishing cost-sharing in some form, if the mainland is taken as the basis for estimation of the contribution to the overall resource envelope, the prospects are limited, in part due to high set up and administrative costs. There should be some benefit at the facility level however, which should not be underestimated in the context of constrained resources at the service delivery level. For example, MMH reported cost-sharing revenues of TSh 78.5m in 2005[8], ie equivalent to just over 50% of their annual GOZ OC budget of TSh 150m for FY2005/06.

7.3.4 Potential finance frame for FY2006/07 – FY2008/09

The financing frame presented below offers two scenarios. Scenario 1, the lower scenario, is based upon an assumption that the health sector will maintain but not increase its 8% share of FY2006/07 GOZ domestic spending which is projected in the MKUZA to rise by 6% and 5.4% in nominal terms respectively in the coming two years. Scenario 2 is more optimistic, and assumes that the sector is successful in lobbying for an increase in the share of the budget (and expenditure) to 9% in FY2007/08 and to 10% in FY2008/09[9].

Figure 4 Potential ZHSRSP II financing frame, FY2006/07 – FY2008/09



In terms of external financing, the lower scenario assumes a constant inflow of TSh 11bn, based on a crude mid-point between the FY2004/05 and FY2005/06 figures in the 2006 PER. This is split between on-budget, which maintains a constant share of the MKUZA projections for foreign development spending, and off-budget which is the residual. Scenario 2 allows for a modest 2.5% growth in the total foreign inflow per year, again split between on- and off-budget.

[8] Source: Data provided by MMH

[9] It should be noted that this is less optimistic than the Milestone agreed for FY2006/07 which pushes for an increase to 10% for the FY2007/08 budget.

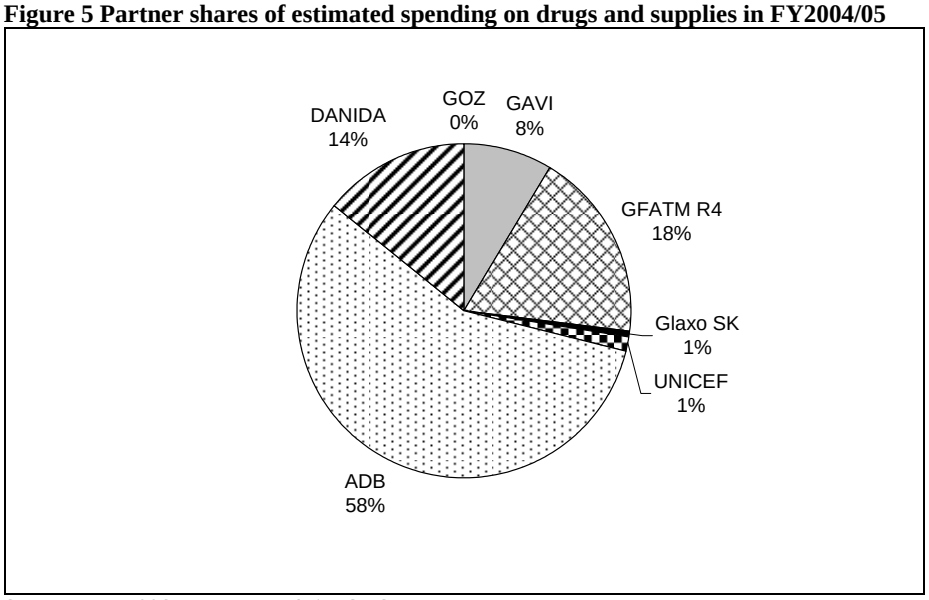
For complementary financing, Scenario 1 assumes no significant contribution in the next two years, while Scenario 2 includes 1% of the sub-total of domestic and foreign funds in the first year, rising to 2% in the third year. This is based on data in the Tanzania mainland PER for FY2005/06 which estimates that, after more than 10 years of cost-sharing, the contribution to the overall budget is 2% per year, while the share of expenditure is 3% per year.

7.4 Resource allocation

No less important than the volume of resources available to the sector is the manner in which they are allocated through the health system, geographically, and between competing priorities. One of the challenges identified during the development of this document was the absence of a transparent, participatory budgetary process, and shortcomings with the budgetary structure which hamper the necessary analyses[10].

Analysis of the GOZ budget indicates that the vast majority of resources are absorbed by health sector wages, salaries and the other allowances which make up the official PE budget. Of the meagre balance available for OCs, allocations for the running costs of PHCUs, PHCCs and hospitals, and for drugs and supplies, have fallen dramatically in recent years, both in nominal terms and as a share of the budget. This may however be a logical response to the increased availability of external resources for these areas. Figure 5 below shows the breakdown of 2006 PER estimated spending of TSh3.6bn on drugs and supplies in FY2004/05. It should be noted that estimated GOZ expenditure was TSh 3.2m representing 0.1% of the total.

Figure 5 Partner shares of estimated spending on drugs and supplies in FY2004/05



Source: PER 2006, Fig 14 HERA / MOHSW

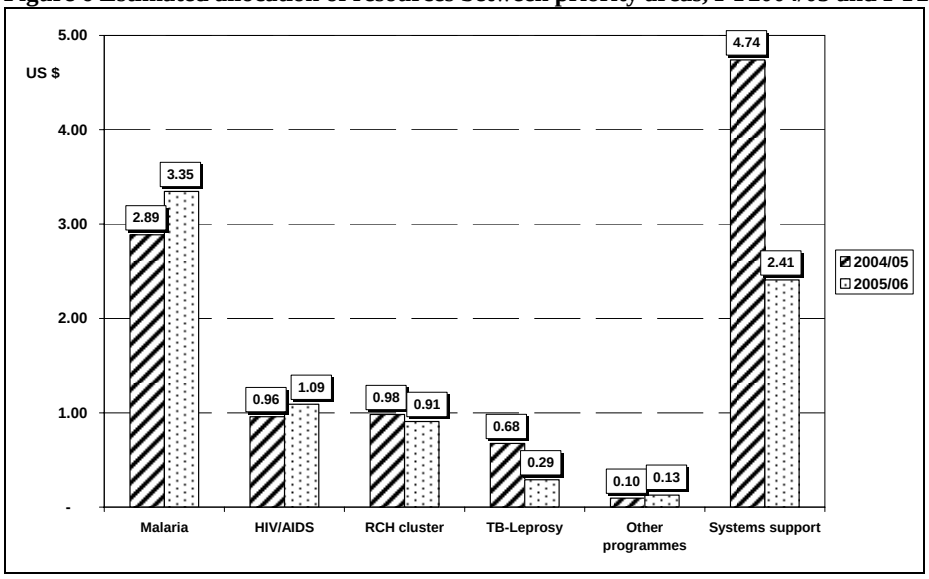
Data on the geographical allocation of resources is constrained by the GOZ budgetary system which does not clearly separate many allocations by district. It is also very cumbersome, and in some cases impossible, to allocate external (and domestic) spending by technical programmes to specific districts. The same applies to allocations between levels of the health

[10] PER

system, ie PHCU versus first and higher level referral hospitals. One intention over the Strategic Plan period is to further develop financial information systems which can routinely capture such allocations. Discussion of "appropriate" allocations by level of care and by geographical area will be related to the definition of the essential health care package which is planned for the first year of ZHSRSP II implementation, and it is hoped that such discussions will form part of the improved planning and budgeting process.

Allocation of the existing resources in Zanzibar has largely been driven by external, development partner priorities, as seen in the PER. While not diminishing the contribution of malaria to the overall burden of disease, it is debatable whether the differential in terms of resources earmarked for malaria and those for reproductive health shown in Figure 6 below is justified[11], even taking into account the fact that a number of malaria interventions contribute to improved reproductive health outcomes. The contrast with HIV and AIDS is also stark, even recognising that the epidemic is concentrated.

Figure 6 Estimated allocation of resources between priority areas, FY2004/05 and FY2005/06



Linked to the review of the essential health package, and to ongoing work on strengthening financial information, it is intended to seek means of improving the flexibility of the MOHSW in allocating resources more in line with priorities over the course of the plan period.

7.5 Improving efficiency of resource use

While efforts to mobilise additional resources are without doubt necessary, there is also some scope for improving the efficiency with which the existing resources are used. As noted above, much of the external contribution to the sector is channelled vertically, and this has resulted in the development of parallel and therefore inefficient processes for planning, monitoring, supervision and in-service training, among other areas. The intention of the MOHSW to improve integration within the sector is a direct response to this challenge. In

[11] It should be noted that the RCH cluster defined here also includes Child Health, including EPI, nutrition and IMCI. Resources targeted at reproductive health itself are therefore even less than the figures here show.

addition, it is internationally recognised that the primary level of the health system is the most cost-effective (and equitable) for service delivery. This is one of the justifications for the ongoing process of decentralisation within the sector, and efforts to further this will continue during the plan period.

7.6 Financial management

In order to gain the confidence of development partners in order to expand joint financing of the ZHSRSP II, it is necessary to demonstrate that management systems can deliver the necessary outputs and information required. Strong financial management is critical, and yet is an area where progress is still necessary throughout GOZ.

A Technical Working Group on health financing and financial management has been established within the MOHSW with the purpose of improving coordination and information relating to the mobilisation, allocation, and management of financial resources, with a focus on equity, efficiency, transparency and accountability Among its objectives are monitoring of budgetary allocations, and coordinating the PER.

The introduction of funding to districts and hospitals through the Health Service Fund has necessitated strengthening financial management at the Zonal level. It is envisaged that capacity building will continue in this area in order to enable the further devolution of resources to the DHMTs themselves over time.

8. Implementation arrangements

8.1 Partnerships in the health sector

8.1.1 Between Government of Zanzibar and development partners

Health Sector Reform Secretariat
The Health Sector Reform Secretariat (HSRS) will engage with the NGOs, the private sector and traditional healers' associations to share the content of this Strategic Plan and negotiate their participation in specific activities as outlined in this document. This process should lead to the commitment of non-governmental partners and the development of an action plan for the private sector and traditional healers

Partner Coordination Meetings
The Partner Coordination Meetings bring together partners engaged in the Zanzibar health sector to share information, exchange ideas, coordinate activities and to review progress in implementing (increasingly joint) plans. Meetings are held at least once a year in addition to the Annual Joint Health Sector Review.

Annual Joint Health Sector Review
The institution of an Annual Joint Health Sector Review (AJHSR) is intended to enable joint monitoring of sector performance. During the Strategic Plan period, it is expected that the AJHSR will receive an annual written performance report, together with an update on budgetary performance. The review will also set priorities for the following year at the strategic level, agreeing milestones (i.e. key process outputs) and, to the extent possible, determining broad allocations for the budget cycle.

A Technical Review will form part of this process, taking place earlier in order to feed in its findings to the main AJHSR. Proposal for the subject of the following year's Technical Review will be a standing item on the agenda of the main review.

8.1.2 Public Private Partnership for Health

Private for profit
Since the passing of the Private Hospital (Regulation) Act of 1994, Zanzibar has seen a mushrooming in the number of private clinics. The number of private pharmacies and drug shops has also grown rapidly since the Pharmaceuticals and Dangerous Drugs Act of 1986 came into force. Recent estimates suggest that there are 59 Part I and 203 Part II drug sales points in Zanzibar, of which the majority are located in the towns.

The private sector plays an important role in ensuring access to basic services, through absorption of demand from those able to pay. As such, it reduces waiting times at otherwise heavily over-subscribed public facilities, particularly in the urban areas. However, in order to protect the public from poor quality service provision, it is important that the MOHSW effectively plays its role of regulator, through the Private Hospitals Board, and the Pharmacy Board. One notable concern raised in the 2004 ADB study was the failure of private health facilities to follow national standard treatment guidelines for malaria following the switch to ACT, due to problems with patients' ability to pay for the new more expensive (but more effective) drugs. This points to the need for better collaboration in order to capitalise on the

strengths and to mitigate the weakness of the private sector in pursuit of the goals and targets of the sector as a whole.

Private not-for profit
There are also a significant number of non-governmental implementing agencies involved in the health sector. MOHSW and PORASF will also directly engage with such agencies, both in the private and the non-profit sub-sectors, to ensure harmonisation and, to the extent possible, standardisation of guidelines, tools and techniques. A forum for such co-ordination will be created and relevant staff co-opted to the various TWGs and the regular coordination meetings.

Traditional medicine
Zanzibar has a thriving traditional medicine sub-sector, with services provided by a variety of types of practitioner, and in a variety of settings.

Plans for the coming five year period include enactment of legislation to formalise the relationship with the MOHSW, and to regulate the activities of the sub-sector. A first draft of the Zanzibar Traditional and Alternative Medicine Act has already been prepared by a working group established for the purpose, and will be discussed by a broader stakeholder group prior to submission. Once the Act has been passed, a policy and associated guidelines will be developed, along with a code of conduct for traditional practitioners.

8.1.3 Inter-sectoral collaboration

While the MOHSW takes primary responsibility for the delivery of health services, and for health promotion activities to raise awareness, it is well known that key health-related activity falls under the remit of other government ministries and agencies. Notable examples include the following:

- Education – importance of girls'/women's education known in terms of impact on uptake of key health interventions for maternal and child survival and health
- Water – high incidence of water borne diseases
- Municipal councils – environmental management
- PO-RASF – devolution and shared responsibilities for eg the elderly

8.2 HSRS and Technical working groups

The Health Sector Reforms in Zanzibar and Tanzania in general are aimed at having an efficient and effective health system. Establishment of the Health Sector Reform Secretariat (HSRS) is one of the measures among others being introduced by the government to ensure effective implementation of Health Sector Reforms. Responsibilities of HSRS are on policy formulation review monitoring and evaluation administration and management of structures that are instrumental in the operation of the reforms eg Health Sector Programme Support and Health Sector Development Programme

As a means of strengthening partnership between various agencies involved in selected critical areas, both government and non-government, and to carry forward the reform process in a dynamic efficient manor, a number of technical working groups have been established. Others will be created as need arises. These bodies serve to coordinate activities within the given areas on a more routine basis. The chair from each group participates in the regular

HSRS meetings, thus facilitating feedback to the Ministry of Health and the Health Sector Reform Secretariat. TWGs determine their own meeting schedule according to need.

While the TWGs are kept deliberately small in terms of fixed membership, they have the option to co-opt other participants for issues of specific relevance. Currently TWGs exist in the following areas:

- Health financing and financial management
- Sector performance monitoring
- Human resources
- Quality assurance

Terms of reference are appended as Annex B.

8.3 Supervision

Zanzibar does not have a national guideline for health care supervision to act as a standard for health managers in District Health Management Teams and Zonal Health Management Teams. Currently supervision is being carried out from zonal and district level to health facilities but efforts are fragmented, without use of supervision tools and with limited feedback mechanisms in place. In addition, different people define or understand supervision differently which leads to lack of consistency and objectivity. Technical programmers carry out independent supervisions with limited subsequent communication to district and zonal level.

There is as of now no defined or predetermined national supervision tool to judge quality of performance and health care. EU has piloted a performance assessment tool, Quality Improvement and Recognition Initiative (QIRI), in three districts and the MOHSW are planning to adjust this tool to general use and scale it up to national implementation. In addition, WHO and MOHSW are in the process of implementing a integrated supervisory checklist.

During the period of the ZHSRSP II it is therefore a priority for the Ministry of Health and Social Welfare to develop a national guideline to set the standards, tools to be used, frequency of supervision and to coordinate efforts to measure the extent and impact of success in meeting national health objectives.

The National Health Care Supervision Guidelines are envisioned to serve as the conceptual framework for supervision and provide information for assisting health managers in the implementation of supervision activities. They should aim at assisting health managers in overseeing that planned activities and interventions are implemented in a more cost-effective and consistent manner. The overall aim is to make supervision an effective tool for on the job learning and professional updating of health workers skills at every level of health care.

9. Monitoring and evaluation

Routine monitoring and periodic evaluation (M&E) of sector progress is a critical element of the ZHSRSP II. The plan is being implemented in the context of a government commitment to meeting the MDGs, and as an integral component of the MKUZA. It is therefore natural that the M&E framework is consistent with these two initiatives, including both international and national indicators. Where necessary, these have been adapted for the Zanzibar context. In addition, the ongoing process of decentralisation within the sector calls for the clear monitoring of sub-sectoral progress, namely at the district and hospital level. Further development of the community-based information system is envisaged throughout the plan period with a view to eventually providing population-based and shehia level information for additional monitoring.

As noted earlier, the Ministry is committed to further development of a SWAp during the ZHSRSP II period. Although, at the time of writing, there is no actual pooling of funds, this is only one aspect of a SWAp and, although desirable, such pooling is arguably also not the most important element. Mechanisms for joint planning and reporting are fundamental, however. Partner agreement on shared M&E processes and indicators is a major step forward in harmonisation, with potential benefits both in terms of efficiency, through a more streamlined process, and the quality of information.

A number of structures exist or are under development for the routine monitoring of sector progress, and were described in Section 8 above. These include the Technical Working Groups, Health Sector Reform Secretariat meetings, Partner Coordination Meetings, and the Annual Joint Health Sector Review.

9.1 Indicators for the ZHSRSP II

The indicator set for the Zanzibar health sector is given below, separated by level of the health system. It comprises a mix of input, process and output indicators, with a limited number of periodic outcome indicators for measuring the impact of sector performance at the end of the plan period. It should be noted that baseline data for some of the indicators is not yet available, and indeed the precise definition and measurement of some of the indicators has not yet been finally agreed. Responsibility for defining, amending and updating the indicators falls to the Technical Working Group on Sector Performance Monitoring, and further work will be undertaken in this area as a priority. The indicators below should therefore be considered as **proposed** rather than final.

Table 7 Proposed national level indicator set

No	Type	Indicator	Purpose (what it measures)	Baseline FY2005/06	Target FY2010/11	Data source
1	Input	Health share of GOZ budget (excl CFS and foreign development)	Government commitment to the sector	8.0%	12.0%	GOZ budget docs; PER
2	Input	Per capita total (GOZ + external + complementary) allocation to Health (US$)	Total resource envelope	Bgt: $13.13	Bgt: $20	GOZ budget docs; PER

No	Type	Indicator	Purpose (what it measures)	Baseline FY2005/06	Target FY2010/11	Data source
3	Input	Share of GOZ + external finance to district health services [12]	Commitment to devolution	n/a	60%	PER
4	Input	% Total Resource Envelope on drugs and supplies	Allocation to key input	n/a	TBD	PER
5	Input	Population to trained health worker ratio	HR availability	243[13]	TBD	Human Resource Info System
6	Input	% PHCU meeting minimum staffing norms[14]	Effective access; HR distribution	n/a	60%	District plans/reports
7	Process	% of external funds on budget/plan/report	harmonisation	Bgt: 34% Report: n/a	Bgt: 60% Rpt: 60%	PER
8	Process	% of OC budget released	Budget implementation	59%	100%	PER; Appropriation Accounts:
9	Process	% facilities with no stockout of 5 tracer drugs/supplies (to include ACT, contraceptives, ORS? Cotrimoxazole?)	Service quality ; drug supply system functioning	n/a	95%	QIRI; routine supervision
10	Process	% HMIS returns complete and on time	Information system functioning	93.7%	100%	HMIS
11	Output	Per capita new OPD attendances per 1000 population (public + private if possible)	Utilisation (proxy for access)	0.4 (2006[15])	1.0	HMIS
12	Output	% deliveries attended by skilled personnel (MDG)	Access to quality delivery services	50%[16]	60%	TDHS
13	Output	Coverage of fully immunised children at 1 year	Coverage/access	85% (TDHS)	95%	EPI/HMIS
14	Output	Measles coverage at 1 year	Immunisation coverage (MDG)	87%	98%	EPI/HMIS
15	Output	% of first antenatal visits before 20 weeks	IEC effectiveness; coverage	57.5%[17]	75%	TDHS; HMIS
16	Output	% pregnant women and children using ITN <% households with at least one ITN?>>	Coverage with malaria prevention interventions	PW: 34.5% U5: 36.9%	PW: 90% U5: 90%	Coverage survey; TDHS
17	Output	IPT2 coverage	Coverage/access	31%[18]	90%	HMIS

[12] Needs agreement on definition, level of sophistication in calculation
[13] Source: 2007 Workforce Profile, Table 9 on p17. Further agreement needed on cadres to be included.
[14] Minimum staffing norms remain to be agreed as current proposals are too high for coming 5 year period.
[15] Recognised as an underestimate due to data constraints.
[16] From TDHS: includes PHN B but excludes MCH Aides.
[17] TDHS, those attending before 4-5 weeks.(Table 9.2, page 134)
[18] Based on a survey of 666 women as part of MOHSW *Roll Back Malaria Evaluation Report 2005*. TDHS does not distinguish between IPT1 and IPT2.

No	Type	Indicator	Purpose (what it measures)	Baseline FY2005/06	Target FY2010/11	Data source
18	Outcome	HIV prevalence among pregnant women aged 15-24 years (MDG)	Prevalence	1%	0.5%	ZACP
19	Outcome	Infant mortality Rate	Health status; impact	61 (2005)	57	TDHS
20	Outcome	Under-five mortality rate	Health status; impact	101 (2005)	71	TDHS
21	Outcome	Maternal mortality rate (facility-based)	Service quality	473 (2006)	251	HMIS
22	Outcome	% under-fives underweight for age	Health status	8.6%	4%	HMIS; TDHS
23	Outcome	% under-fives underweight for height	Health status	23%	10%	TDHS

District level

It is intended that at the district level, each DHMT will prepare an annual report against a limited number of indicators, as shown in Table 8 below. Baseline and targets will be determined at the district level. Compilation of this into a single table will enable comparison of performance in several key areas, and the highlighting of areas for further intervention in terms of technical support during the following year.

Table 8 Proposed district level indicator set

No	Type	Indicator	Purpose (what it measures)	Data source
1	Input	Total per capita (GOZ + external)	District resource envelope	GOZ budget docs; PER
2	Input	Population per trained health worker	HR availability	Annual plan/report; HRIS
3	Input	% PHCU meeting minimum staffing norms (eg 3 trained staff)	Access to services (quality)	Annual plan/report; HRIS
4	Process	No of facilities performing deliveries	Access to services (range)	HMIS; District profiles
5	Process	No of facilities reporting no stockouts of 5 tracer drugs/supplies	Access to quality services; Quality of drug management process in the district	QIRI; routine supervision
6	Output	Full immunisation coverage at 1 year		
7	Output	Measles coverage at 1 year	Immunisation coverage (MDG)	
8	Process	% facilities submitting complete and timely HMIS reports	HMIS quality	HMIS
9	Outcome	Malaria case fatality rate	Case mgt; early treatment seeking	

Hospital level

A similar proposal is made for the hospital level, with possible indicators given in Table 9 below.

Table 9 Proposed hospital level indicators

No	Type	Indicator	Purpose (what it measures)	Data source
1	Input	Total allocation GOZ + external)	Public resource envelope	GOZ budget docs; PER
2	Input	Cost-sharing revenue as % total resource envelope[19]	Revenue generation	Hospital financial report
3	Input	No of key positions vacant[20]	HR availability	Annual hospital reports; HRIS?
4	Process	Bed occupancy rate	Efficiency	HMIS; hospital report
5	Process	Average length of stay	Efficiency	HMIS; hospital report
7	Output	Caesarean rate (as % deliveries)	Comprehensive EmOC	HMIS
8	Output	No of patients on ARVs	Access to C+T	ZACP: HMIS?
9	Output	Referral rate (% admissions referred elsewhere)	Functional referral	HMIS
10	Outcome	Facility-specific mortality rate	Quality of care	HMIS

9.2 Information sources

The information from which the indicators will be derived comes from a variety of different sources. The routine HMIS is expected to deliver many of the indicators, although some distance remains in achieving the desired level of timeliness and completeness of reporting, hence the inclusion of an indicator specifically on this areas. Technical programmes will continue to produce more detailed reports for their own internal (and funders) purposes, though to the extent possible these will be streamlined and harmonised with the overall HMIS. MKUZA refers to the Participatory Service Delivery Surveys, which are expected to cover Health. It is not fully clear what these entail and how they will be managed

A number of periodic surveys are undertaken in Zanzibar, when funding permits. Key among these is the Demographic and Health Surveys (DHS) which focus on reproductive health and other key contributors to morbidity and mortality. For the first time, an extract of key findings for Zanzibar from the Tanzanian DHS was produced in 2005, enabling a clearer picture of the situation on the Isles, which differs in many respects from that on the mainland.

The Household Budget Survey also provides useful information, notably on household health seeking behaviour and out of pocket spending. Shortfalls in funding, and delays in producing the report, have hampered the use of this survey in the past, but it is hoped that the resumption of external assistance in recent years will help to overcome such constraints. Further work will be done to improve the health sector inputs to this particular survey.

[19] Needs agreement on how the resource envelope is defined
[20] Needs agreement on what these might be

9.3 Sector performance monitoring

Operationalization of M&E strategy shall take on board health related activities implemented at grass root level through health care facilities and other Community Based Institutions. District platforms for participatory monitoring and evaluation shall be developed and supported. Also a culture of cross fertilization of knowledge shall be among the underlying principles in building the capacities of all actors at facilities and district levels. Furthermore, the MOHSW intends to scale up the integration of strategic information in planning process. Hence program based information shall be processed and evidence based planning at district and zonal level will be promoted. Collected information shall take on board interests of all stakeholders as governed by both the National and International set indicators as outlined in the conceptual framework above.

Strategic information collected by existing programmes shall be collectively gathered through existing structures namely the DHMTs and ZHMTs. The then processed information will be submitted to the M&E unit for further processing and planning purposes. Bilateral feedback mechanism will be developed so as to ensure smooth implementation of the plan. Overall, evaluation will be done at mid-term and end of the outlined planning period and where necessary the planned will be updated to accommodate new scientific and technological advancement that are pertinent to quality care delivery.

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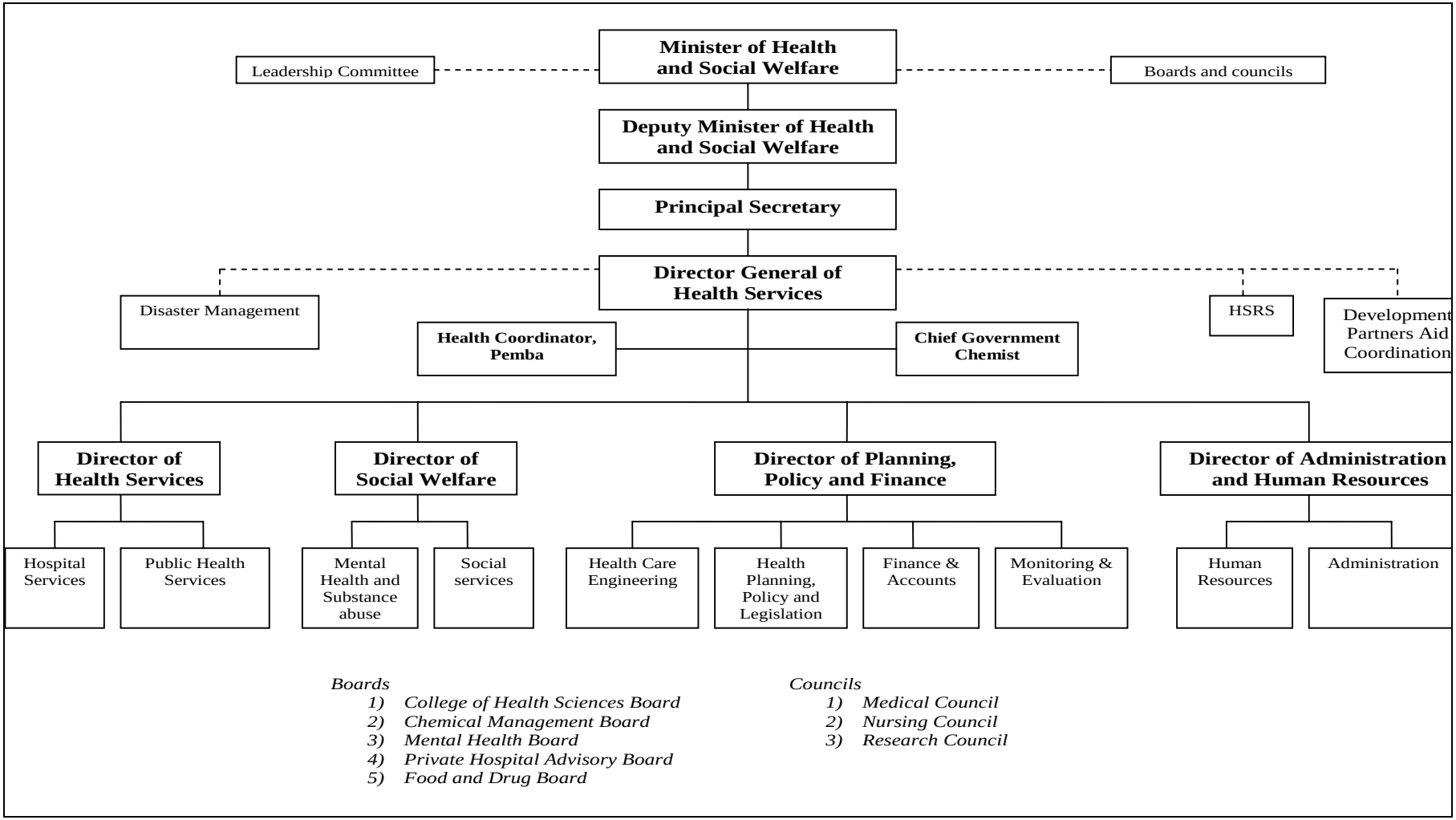
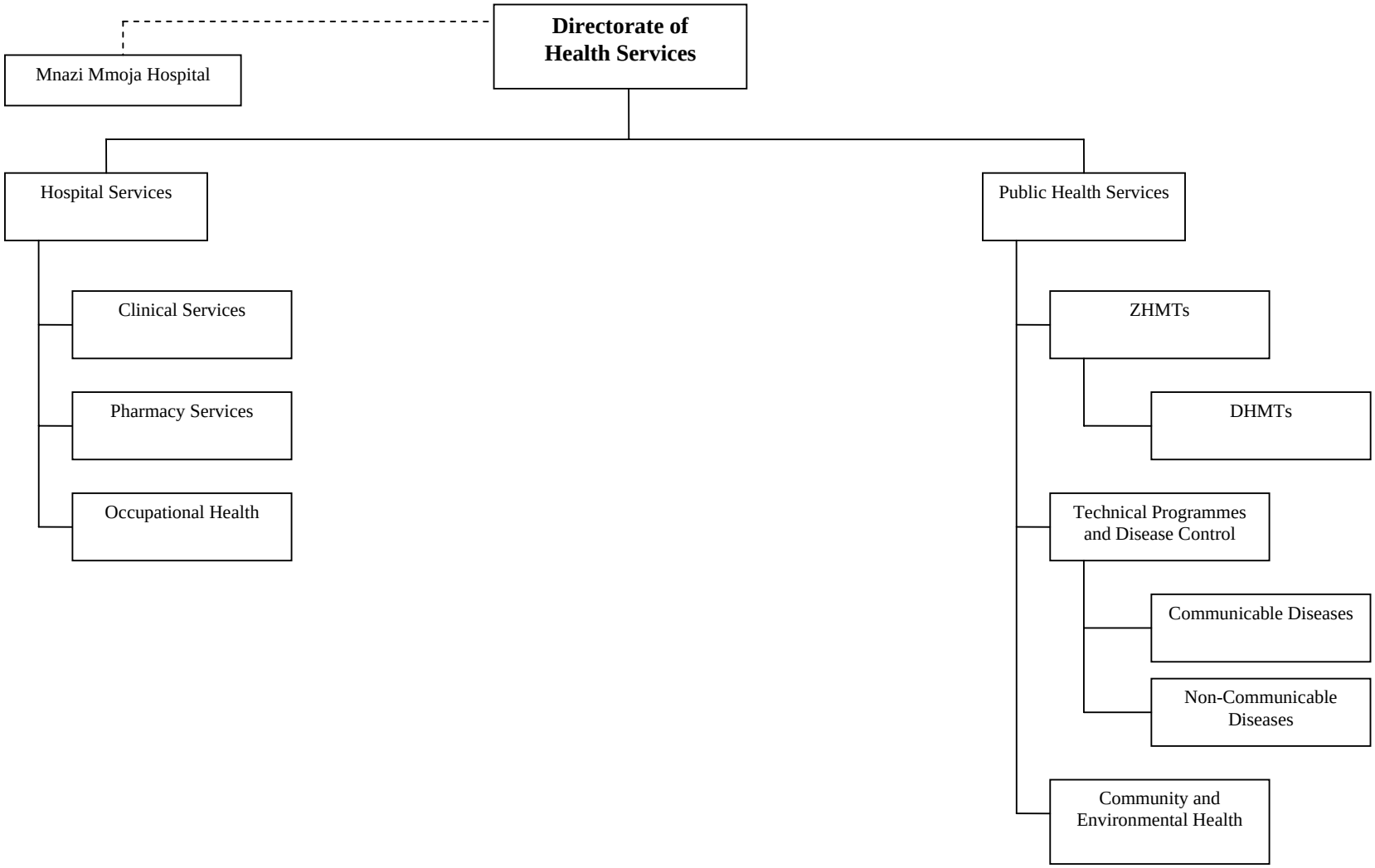
11. Annexes

11.1 Annex A: Proposed organogram of the MOHSW, September 2006

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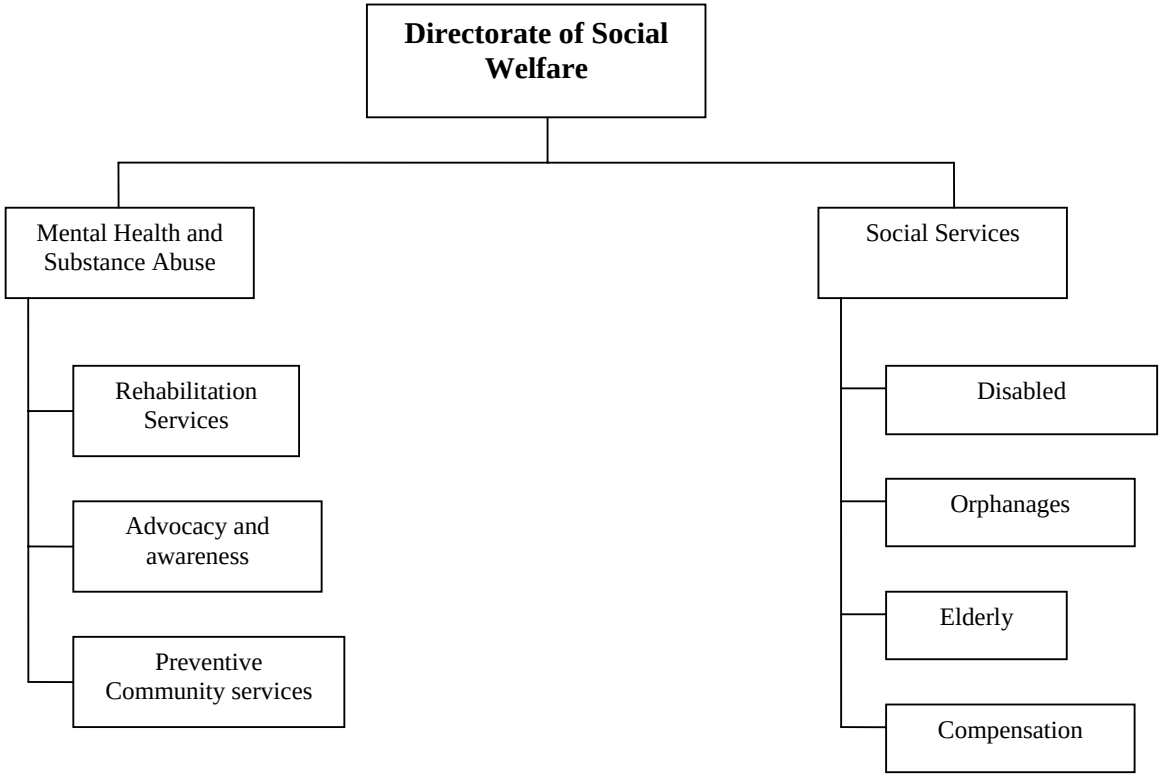
Mnazi Mmoja Hospital
Hospital Services
Public Health Services
Clinical Services
Pharmacy Services
Occupational Health
ZHMTs
DHMTs
Technical Programmes and Disease Control
Communicable Diseases
Non-Communicable Diseases
Community and Environmental Health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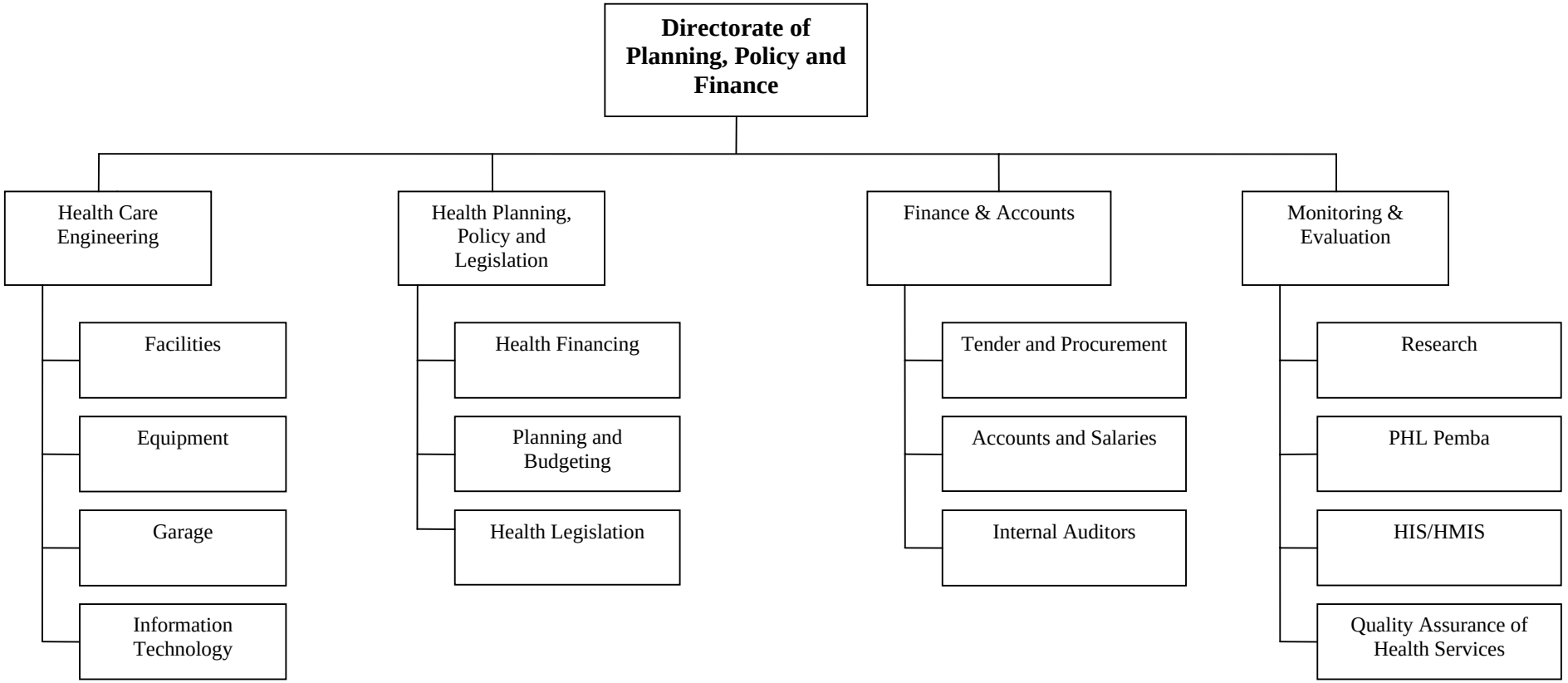
Social Services
Rehabilitation Services
Advocacy and awareness
Preventive Community services
Disabled
Orphanages
Elderly
Compensation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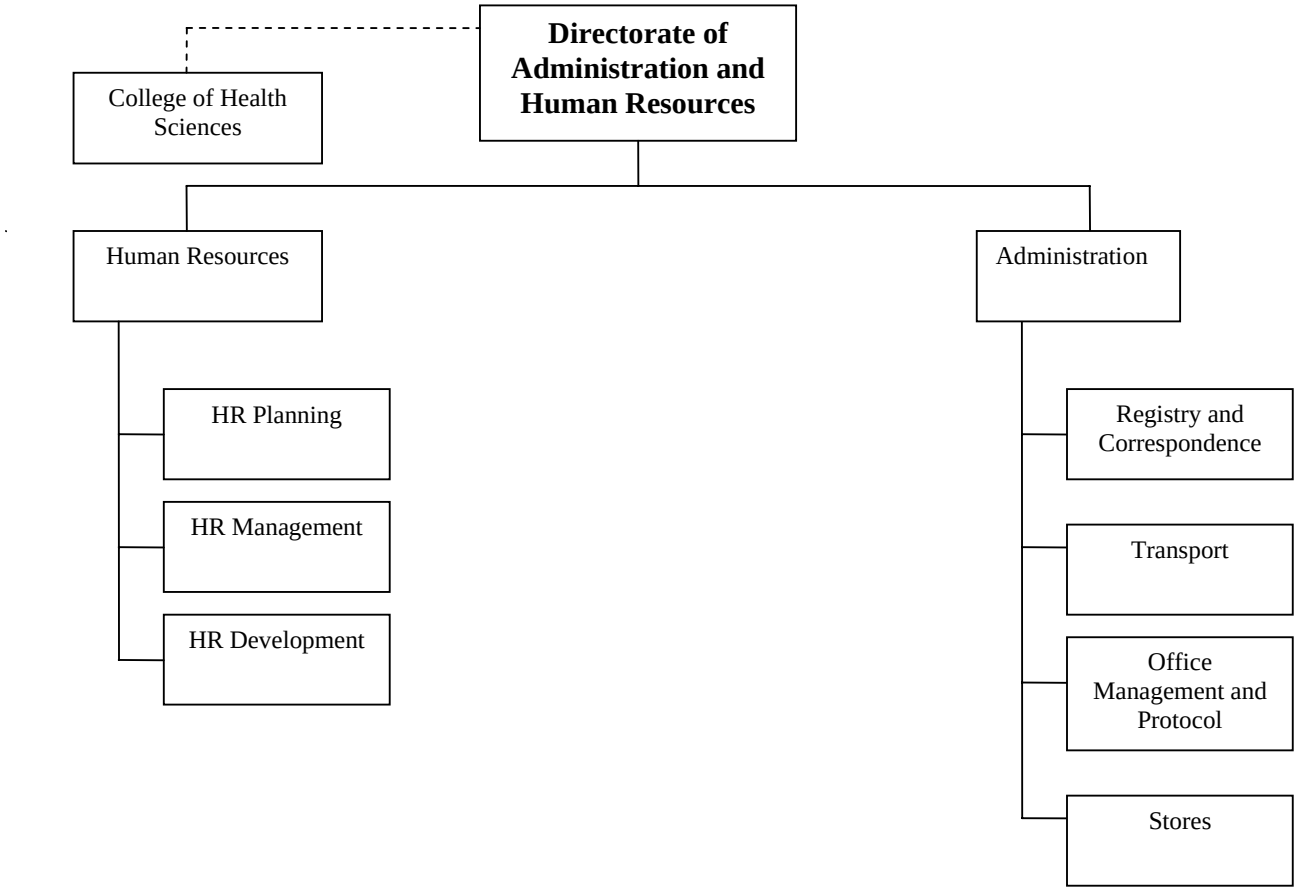
Health Care Engineering
Facilities
Equipment
Garage
Information Technology
Health Planning, Policy and Legislation
Health Financing
Planning and Budgeting
Health Legislation
Finance & Accounts
Tender and Procurement
Accounts and Salaries
Internal Auditors
Monitoring & Evaluation
Research
PHL Pemba
HIS/HMIS
Quality Assurance of Health Services


Directorate of Administration and Human Resources
College of Health Sciences
Human Resources
Administration
HR Planning
HR Management
HR Development
Registry and Correspondence
Transport
Office Management and Protocol
Stores

11.2 Annex B: Terms of reference for Technical Working Groups (TWGs)

11.2.1 TWG on Quality Assurance

Introduction

In Zanzibar public health services are delivered through Directorates of the MOHSW and specialized vertical programs such as Reproductive and Child Health, Zanzibar AIDS Control Program and Malaria Control Program. Health Sector Reforms, initiated in 2002, seek to decentralize planning, prioritizing and integration of services to district level. In addition, the Health Sector Reforms aim at ensuring the availability of quality health service delivery according to an essential health care package. This essential health care package focuses on the principles of primary health care (PHC) approach based on the community and primary health care Units (PHCUs) and Cottage Hospitals.

The Health Sector Reform Strategic Plan II concludes that "in general, HSRSP 2002/03 – 2006/07 has not been implemented as programmed and failed to guide planning of MOHSW and stakeholders activities." A more comprehensive and feasible HSRSP (II) 2006 – 2010 is therefore currently being developed.

Some achievements to improve the delivery of quality care services have been made over the past years, with technical and financial support from development partners. With regards to organization the capacity of MOHSW headquarters has been strengthened substantially, through the establishment of the Health Sector Reform Secretariat (HSRS). At the district level, District Health Management Teams (DHMTs) have been appointed and trained in all districts, along with Zonal HMTs for Unguja and Pemba. The College of Health Science (CHS) has been approved as a semi-autonomous institution and now has a functional academic board and council. Within MOHSW an overall five year Human Resource for Health Plan has been formulated. In terms of monitoring and evaluation, there has been progress with a review of the Health Management Information System (HMIS), and the signing of a contract for continued external support in this area.

Other achievements with direct impact on quality of care are

- Increased availability of essential drugs at health facilities.
- Role of Drug Management Unit was reviewed and more organized guidelines are to be put in place shortly. Short and long-term training conducted in the area of materials management, computer networking and rational drug use.
- Distribution and supervision of supplies and kits to the health facilities are done monthly.
- The establishment of the Health Service Fund enabling ZHMTs and DHMTs to plan and prioritize interventions based on local needs assessments.
- All DHMTs have been strengthened in terms of human capacity, financial and material resources.
- Quality Improvement and Recognition Initiative focusing on Reproductive and Child Health have been piloted in three districts.
- Standard Treatment Guidelines and Zanzibar Essential Medicine List have been reviewed and disseminated.
- Effective introduction of artesemin combination therapy for malaria.
- Effective introduction of HIV/AIDS care and treatment services including PMTCT and HAART for people living with HIV/AIDS.
- Several important equipment and supplies procured through vertical programmes such as 4 X-ray machines for Cottage Hospitals and 2 ultrasound machines for Mnazi Mmoja and Chake Chake Hospital.

- Procurement of basic equipments for PHCUs.
- The renovation of 54 first-line and 5 second-line PHCU.
- Directorate of Mnazi Mmoja Hospital has been established and has its own budget.

Quality improvement is a cornerstone of health sector reform in order to ensure adequate care for patients with respect of professional ethics. As described several strategies and initiatives aiming at improving health services have been introduced. However in the implementation of these strategies, quality has been taken implicitly and no particular attention has been given to quality improvement. There are no coordinated mechanisms in place to identify health system or health worker short comings in providing good quality of care. Supervision and monitoring of quality of care is still fragmented with no overall national policy.

There is therefore a need to establish a Technical Working Group with the following aim, objectives and proposed activities.

Aim

The aim of the Technical Working Group is to assist with the design and implementation of a simple operational National Quality Assurance Framework, including existing and new quality improvement initiatives, to ensure a high level of performance of health services that are effective, user friendly and of high quality.

Objectives

- To assist with the design and establishment of a simple Quality Assurance Framework based on, but not limited to, integrated supportive supervision, regular monitoring of rational drug use, medical audits and QIRI assessments.
- To spearhead, guide and co-ordinate a countywide quality improvement effort that includes establishing appropriate Quality Improvement Initiatives where needed.
- To assist with the implementation of quality auditing especially in priority areas with great sensibility to system performance, for example Maternal Mortality and Health.
- To enhance collaboration between different programmes in the development of guidelines and other products, and to ensure alignment, quality and adequacy of standards used at all levels of the health system.
- In collaboration with the Continuous Education Unit to coordinate Quality Improvement related training at all levels.
- To collect and disseminate national and international experience, techniques, data and references in regard to quality.

Activities

The list below is meant to be an inspiration to the TWG for possible activities to be taken on derived from the objectives. It is not to be perceived as an exhaustive list.

- Formulation of a national quality assurance framework.
- Formulation of a national guideline for integrated supervision.
- Review and update of the core packages of services offered at different levels of the health system.
- Adjustment of the QIRI tool to general use and to make a plan for national implementation.
- Enable/train facility, district and zonal staff in quality assurance.
- Study visits to the mainland Quality Assurance Unit and TQIF.
- Align health facility use of treatment guidelines for the top ten diseases.
- Facilitate regular national assessment of rational use of drugs.
- Identify and collaborate with resource centres i.e PHL and the zonal resource centre.
- Facilitate evaluation of quality in health care through operational research for quality improvement.

- Develop innovative procedures for rewarding health facilities based on performance.

Membership
- Health Sector Reform Secretariat
- Representative, Pharmacy
- Zonal Medical Officer, Unguja
- Zonal Medical Officer, Pemba
- Zonal Continuing Education Officer, Pemba
- Representative Nurse Council
- RCH Zanzibar

Co-opted members who will receive minutes and will be invited to meetings when relevant
- Alternating DMO from Unguja & Pemba
- WHO
- PHL
- Vertical Programme: Malaria Control and ZACP
- CHS
- Development Partners
- MMH

11.2.2 TWG on Health Financing and Financial Management

Introduction
The area of health financing is critical for the efficient and effective running of health sector operations, yet current activity in this area within the MOHSW lacks coordination. In the context of relatively constrained resources, communication on the various sources, flows, and allocation of funds is imperative in order to maximise the efficiency and equity with which those funds are employed for the benefit of health services and the population of Zanzibar.

In order to strengthen the capacity of the MOHSW to collate and manage information on health financing, to meet relevant reporting commitments both within and outside the sector, and to commission and coordinate activities relating to all aspects of the financing of the sector, it is therefore proposed that a Technical Working Group be established.

Purpose
- To coordinate activities, and make recommendations, relating to the mobilisation, allocation, and management of financial resources, with a focus on equity, efficiency, transparency and accountability

Objectives
- To review progress with activities in the POA and ZHSRSP relating to the development and implementation of health financing mechanisms, and submit appropriate information on the same to the Health Sector Reform Secretariat
- To provide advice on the management of the budget/MTEF process and to monitor allocations on a quarterly basis
- To provide advice on the design and implementation processes of cost-sharing and other complementary financing mechanisms, and to monitor impact
- To provide input to the strengthening of the information base related to the financing of the sector, particularly in relation to external and complementary financing
- To recommend the commissioning of studies relating to health financing, and to coordinate such research

- To provide input on health financing for all relevant plans and reports.

Membership
- Health Sector Reform Secretariat
- Desk Officer, MOFEA (from Budget or External Finance)
- Chief Accountant, MOHSW
- Health Economist, MOHSW
- Health Planner

Additional suggestions for co-opting as and when necessary
- Desk Officer, MOFEA (whichever of Budget/External Finance is not a fixed member)
- HSRS TA on financing etc
- Relevant WHO staff member
- Academic health economist/public finance economist from University

11.2.3 TWG on Human Resources for Health

Background
A shortage of Human Resources for Health in the appropriate numbers and with the required skills is acknowledged to be a major constraint in the implementation of health sector reform and the improvement of health service delivery throughout sub-Saharan Africa. Zanzibar is no exception, with the enviable health facility infrastructure failing to delivery quality services due in large part to the absence of trained staff. HR development, deployment, incentives, retention and management all require additional investment if this constraint is to be overcome. Given the importance of HRH in all aspects of health sector activity, it has been agreed that a Technical Working Group in this area should be established.

The overall aim of the HRH TWG is to oversee, coordinate and dissemination of information relating to activities in this area. HRH is one of the core themes of the Strategic Plan and therefore requires such a dynamic and pro-active body to ensure both the implementation and monitoring of the POA and ZHSRSP.

Proposed tasks
- Review proposals for training and HR management arising from both within the ministry as well as from outside through initiatives by development partners
- Review annual work plans for training and HR management
- Ensure/advocate for adequate funding for HR
- Review/advise on issues of salaries, incentives, deployment etc
- Write/endorse ToRs for technical assistance (TA) when necessary
- Review reports of annual implementation plans for training and HR management;
- Contribute towards any SWAp/HR reviews as required
- Coordinate research and TA activity related to HRH
- Review and endorse any policies related to HR for further referral to the MOHSW Executive Committee
- Review and endorse any proposals for initiating any new training (pre and post basic).

Proposed standing membership
- Head of HR Division – Chair
- Training Officer
- Personnel Officer

- Continuing Education Officer
- Academic Officer, College of Health Sciences

Proposed additional members to be co-opted as required
- Hospital Secretary, MMH
- Zonal Administrative Officers, Unguja and Pemba
- Relevant TA – WHO, USAID/Capacity, Danida, ADB

11.2.4 TWG on Sector Performance Monitoring

Introduction
As the Zanzibar health sector moves towards a sector-wide approach, one of the areas in which there is great potential for harmonisation, improved quality and efficiency gains is in the monitoring of the sector. At present, the various units and programmes of the MOHSW headquarters, and the respective service delivery levels, each provide a variety of reports in a number of formats for a number of different parties. Ensuring that there is a single, consistent and coherent picture of sector performance, which all parties can accept as the basis for monitoring their specific input, requires communication and coordination.

The Technical Working Group on Sector performance monitoring is expected to play a facilitating role in this area, ensuring that the right reports are produced with the right content, at the right time, and that they are received and used by the right audience.

Purpose
- To oversee the performance monitoring process in the Zanzibar health sector, from definition of indicators at different levels, to producing reports as required

Objectives
- To review progress with activities in the POA and ZHSRSP relating to development and implementation of systems for sector monitoring, and submit appropriate and timely information on the same to the Health Sector Reform Secretariat
- To assist and provide input to the proposing/reviewing of indicators for overall monitoring of health sector performance, at central, district and hospital levels, together with their means of verification. The indicators should be internationally comparably i.e. in line with the MDG and reflect the ZHSRSP and MKUZA.
- To provide timely and appropriate support to ensure that routine monitoring tools (eg supervision reports, HMIS reports, Statistical Bulletin, annual performance profile) are produced on time, and are complete, accurate and consistent
- To liaise with other units within the MOHSW to ensure that data requirements for sector performance reporting are fulfilled
- To advise on how to maintain a central repository for reports from all programmes and units (link with Resource Centre) and monitor the functioning of the same
- To provide support to the maintenance of a database of sector-relevant research (biomedical, operational and health systems) being undertaken in Zanzibar, and to produce annual abstract document
- To provide input on M&E for all relevant plans and reports
- To advise and/or propose topics/areas for technical review prior to the Annual Joint Sector Review

Proposed fixed membership

- Head of Continuing Education
- Statistical Officer
- HMIS Unit, Pemba
- Representative, Office of the Chief Government Statistician
- Chief Librarian / Head of Resource Centre

Possible additional members for co-opting as necessary

- MOHSW representative, ZPRP monitoring group
- Senior Health Adviser, Danida HSPS
- WHO, Health Metrics network focal point
- Other TA involved in HMIS/M&E
- Academic Officer CHS
- Nominated member of Planning Unit/HSR Secretariat
- Member of Research Council