ZANZIBAR HEALTH SECTOR STRATEGIC PLAN III

2013/14-2018/19

THEME:

THE RIGHT TO QUALITY HEALTH CARE FOR BETTER HEALTH OUTCOMES.
Foreword:
The Revolutionary Government of Zanzibar aspires to have the highest quality of life for her citizens. Ensuring access to quality and affordable health services has been the prime strategy in realizing a healthy nation. This goal could only be achieved through concerted efforts of all including individuals, communities, organizations, our co-operating partners, community owned resource person and other gate keepers to mention but some. This has placed the health sector to be among the key national priorities that catalyses the realization of national economic growth.

The development of health sector Strategic Plan III [HSSP-III] is a great success and guidance to ensure that delivery of health service is of high quality, accessible to all and at an affordable manner. Henceforth, the formulation of the HSSP-III has, at greater length, consider the changes in disease dynamics and trends, modes of disease transmission and Burdens, notable rise of Non-communicable diseases, evidence based planning, the disputable roles of non-state actors as well as the crucial roles played by communities without which the national gain will never be realised. Principally, the strategy has underpinned the need of integrating services delivery as part of enhancing health systems in Zanzibar.

The Plan provides the basic framework that will guide efforts of the Ministry of Health and all stakeholders over the next five [5] years in contributing to the attainment of both national and international goals. In line with system strengthening, the HSSP-III underscores the need to promote quality assurance, overcoming resource related barriers [namely human, technical and financial], performance based service delivery schemes, translating Essential Healthcare Package services; reducing risk factors to ill-health as well as promotion of social behavioural change communication to all Zanzibaris.

The successful implementation of this plan will depend on the continued dedication and professionalism of Health care workers, assiduous commitment from Development partners, integrity and collaboration with Private sector, integration and decentralization of health services and supporting systems. Worth noting is the fact that The HSSP-III has translated our Health sector policy hence amalgamates issues that have been identified therein. This makes the strategy to be a vital tool and a point of reference in aligning and designing schemes for service delivery, resource mobilization and alternative health care financing options. Periodic auditing and verification of the HSSP-III will mark the gains that the health sector is covering as part of ensuring that we are on the right track.

With prudence and commitment we can jointly make a difference to the lives of Zanzibaris.

Hon. Juma Duni Haji
Minister for Health
Zanzibar.
Acknowledgement:

The HSSPII is a navigating tool for the health sector in the next five years (2013/14-2018/19) as it shall bridge and build on the gains accrued while implementing ZHSRSP II & I respectively. Moreover, the plan shall define the strategic path from which the health sector will measure it successes, emerging challenges and document any best practice emanating from implementing the HSSP-III. Furthermore, this strategy has accommodated issues and policy guidelines that have been underpinned in cluster II of the MKUZA II [i.e. Zanzibar Strategy for Growth and Reduction of Poverty II- ZSGRPII] and has also accommodated key areas of Millennium Development Goal [in particular MDG 4, 5 and 6] as part of realizing the national growth.

This strategy has at greater length address issues that forms the bases of health. This includes: primary health care interventions, community engagement, health system strengthening inclusive of infrastructural development and maintenance, promotion of quality services through strengthening of governing instruments such as Councils and health Boards, accreditation and active involvement in Quality assurance schemes. All these are geared towards translating the Ministry’s Vision which is “To attain a healthy population with reliable, accessible and equitable health care services to all Zanzibaris”.

The Ministry is particularly grateful to the Development Partner Group [DPG] for their technical and financial support especially during the formulation of the HSSP-III. Gratitude also goes to Health sector reform secretariat for coordinating the formulation process. Gratitude is also extended to all heads of Programmes, units within the Ministry of Health, Private Sector Agencies, Civil society Organization for their commitment during the formulation of this strategy. The Ministry wishes to extend a warm vote of thanks to members of technical working groups and individually staff who provided valuable inputs, guidance and insight in this plan.

Special gratitude goes to the following team members for their orchestrated role and diligence in making this HSSP-III a live document. These include: Ms Dhameera Mohammed Khatib, Mr. Omar M. Omar, Mr. Ali Hassan Suleiman. Ms Sharifa Awadh Salmin. Mr Issa A. Mussa. Ms Khadija Said Simai. Ms Attiye J. Shaame, Subira S. Khatib, Suleiman Ally [IT], Mr Rashid Kombo Khamis, Ms. Michelle Jacob, Mr. Abdul-latif Kh. Haji and Mohammed Dahoma. Lastly, I would like to thank all those who in one way or another have positively contributed to the realization of this document.

Mohammed S. Jiddawi MD.
Principal Secretary
Ministry of Health – Zanzibar.
EXECUTIVE SUMMARY

The Ministry of Health, Zanzibar had embarked in the reform process since the beginning of 1990’s and these became fully fledged in early 20s. In due course, two Strategic Plans have been formulated and implemented based on the 1999 Zanzibar Health Policy (the Health Sector Reform Strategic Plan I 2002/03 - 2006/7 and Zanzibar Health Sector Strategic Plan II 2006/7 - 2010/11). The reform is seeking to decentralize planning, prioritizing and integration of services to district level. In addition it aims at ensuring the availability of equitable high quality of health care services to all Zanzibari which focuses on burden of disease and according to an Essential Health Care Package.

The ZHRSP II has come to an end, the situation lead to a major review. The exercise was done through a consultative process that involved a number of technical people from various levels came from within and outside the ministry. Main assessment methods employed included literature review where key ministerial documents were profoundly visited, interviews, focus group discussion, consultative field visits and observations to validate desk review findings were conducted to different MDAs, international organization and NGOs of both Unguja and Pemba. The situation analysis report was shared internally to the HSR secretariat and other partners for further review of which all inputs were incorporated. The analysis has an intention to bring in a broad vision that resulted from efforts made during the implementation process of Strategic Plan II (2006/7 – 2010/11). The situation and response analysis entail both positive and negative impacts that were clearly observed and summarized where six key priority areas for Strategic Plan III - 2013/14 -2017/18) were formulated as follows:-

1. **Organization Management and Working environment [health system Governance]**

   The area outlines several strategic interventions that include the governance of the national health system. Strengthening planning capacity by putting in place a strong planning and monitoring section to ensure better performance of all planned activities that reflects and translate health sector policies. The National Health Councils and Boards, led by the Minister, will provide the stewardship in regulating professional standards and ethics. The Health Sector Strategic Coordination Forum (HSSCF) within HSRS will facilitate the execution of HSSP-III. The Support will cover the areas of communication, coordination, delegation, participation and harmonization as part of strengthening the overall governance of the Health Sector.

2. **Human resources for health**

   During the implementation period of HSSP-III much emphasis will focus on the Improvement of Human Resources in term of both quantity and quality for health care services. The Department of Human Resource and Administration [HRA] will do even more in strengthening and adherence to Human Resources (HR), Development and Management Plans including development of mechanisms for retention of health care workers and specialists at all level of health care provision.

   The Ministry will ensure availability of adequate number of skilled personnel through various training. The College of Health Sciences, Zanzibar will continue to train frontline health cadres that are still needed to serve the population at primary level while higher learning programs will be affiliated to the State University of Zanzibar (SUZA). Zanzibar Medical School will do the same. All programs provided will be accredited by the National councils (NACTE and or TCU). Training programs that are not available in Zanzibar including private, students will be sent abroad.
3. Health Service Delivery

The Geographical health infrastructure in Zanzibar has been distributed into primary, secondary and tertiary levels of health care services. The distribution allows good access to primary services of which 95% of population living within or less than 5km to the nearest public health facility. Health facilities at this level provide preventive, treatment and care services for diseases and health conditions including malaria, upper respiratory infections, injuries, water and food borne diseases. At this level health programs are being implemented in supporting targeted health interventions aimed at delivering cost effective quality primary health care services to all as defined in the Essential Health Care Package [EHCP]. The capacity for secondary level to serve as referral centre for primary level facilities (PHCU, PHCU+ & PHCC) to some extent is inadequate. The RGoZ has seen the need for transforming and restructuring this level of care to fully fledged district hospitals. This will include upgrading of all cottage hospitals to become district hospitals while Mkoani and Wete District Hospitals shall serve as Regional Hospital. Other new district hospitals will be built. In addition, Chake Chake hospital will become a referral hospital for Pemba while Mnazi Mmoja hospital shall be transformed into a National Referral Centre for Zanzibar. The primary objective towards this transformation is to ensure increased access to quality comprehensive specialized quality care to all in need.

4. Procurement of Medicines, non medical related pharmaceuticals commodities and health infrastructures

The Ministry of Health through the office of Chief pharmacist and the Central Medical Stores (CMS) is responsible for procurement of commodities in collaboration with Procurement Unit of the MOH. The CMS is therefore responsible to supply commodities to all public health facilities. The current health procurement system is being challenged by: limited qualified human resource, absence of forecasted needs accompanied by unreliable quantification of drug and supplies. There is no Ministerial procurement plan leading to ad hoc procurement practices which at times results in having frequent stock outs, inadequate adherence to Procurement practices, absence of competition and at times questionable value added. The Ministry has now embarked on the process of introducing framework contract.

The Ministry has set several measures to resolve these challenges. These include: Continuing process of transforming the Central Medical Stores to operate as semi autonomous institution that will increase the capacity to procure, store, distribute safe and quality efficacious drugs to the entire population; to develop good process and procedures on receiving, safe storage and efficient distribution of essential medicines and medical supplies to the entire country that will ensure their availability and accessibility at all time; strengthen partnership and collaboration between alternative medical practitioners and health institutions in areas of drug monitoring and research. The cold system for storage of drugs [warehouse] in Pemba will be also strengthened.

5. Health Care Financing and Sustainability

Health Care Financing and Sustainability for the ministry of health is one among key area of importance. The ministry needs to find different ways and means of soliciting funds to address financing gap for health sector. This strategic plan has put much emphasis on increasing financial resources through adoption of various health financing options which are fair and sustainable. Other strategies to attain this will include Financial risk protection; Efficiency in service delivery and quality of services; and fairness and social inclusion.
6. Health Information and Research

The successful implementation of strategic plan III will be to systematically track the progress of the planned activities. This will be done through formative and summative evaluation with using structured three dimensional models that include Input, Process and Results that further generate Outcome and Impact. Formative assessment will be used to evaluate Input, Process while Summative will evaluate Outcome and Impact. The Framework has been developed to assist successful implementation based on 2011 Health Sector Policy. This shall be used by monitoring selected performance indicators of ZHSP III according to prioritized health sector milestones.

Monitoring and Evaluation

The designed Monitoring and Evaluation Framework will be able to capture, amongst variety of its outstanding information through Annual Public Expenditure Review reports; Annual health bulletin; Sector Performance Report; Health research information through census and variety of health related surveys. The M&E Division together with Strategic Coordination Forum will work hand in hand to facilitate the monitoring process.
**Acronyms**

<table>
<thead>
<tr>
<th>acronym</th>
<th>description</th>
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<tbody>
<tr>
<td>ACSM</td>
<td>Advocacy Communication and Social Mobilization</td>
<td>MKUZA II</td>
<td>Swahili Acronym for Zanzibar Strategy for Poverty Reduction and Economic Growth</td>
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<tr>
<td>ACT</td>
<td>Artemisinin Combination Based Therapy</td>
<td>MMH</td>
<td>Mnazi Mmoja Hospital</td>
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<td>AFP</td>
<td>Acute Flaccid Paralysis</td>
<td>MMR</td>
<td>Maternal Mortality Rate</td>
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<td>Acquired Immuno Deficiency Syndrome</td>
<td>MNMR</td>
<td>Maternal, Newborn and Child Mortality Reduction</td>
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<td>Ante Natal Care</td>
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<td>Maternal and Neonatal Tetanus</td>
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<td>Ministry of Education and Vocational Training</td>
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<td>Behavioral Change Communication</td>
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<td>Ministry of Health</td>
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<td>BTL</td>
<td>Bilateral Tubal Ligation</td>
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<td>Ministry of Health and Social Welfare</td>
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<td>Crude Birth Rate</td>
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<td>Memorandum of Understanding</td>
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<td>Cluster of Differentiation 4</td>
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<td>Comprehensive Eye care Services</td>
<td>MUAC</td>
<td>Mid Upper Arm Circumference</td>
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<td>Tanzania Commission for Universities</td>
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<td>DALYS</td>
<td>Daily Life Adjusted Years</td>
<td>NEQAS</td>
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<td>Danish International Development Agency</td>
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<td>Non-Governmental Organization</td>
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<td>OPD</td>
<td>Out Patient Department</td>
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<td>Occupation Safety and Health</td>
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<td>EAC</td>
<td>East African Community</td>
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<td>EHP</td>
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<td>ENT</td>
<td>Ear, Nose and Throat</td>
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<td>EPI</td>
<td>Expanded Programme on Immunization</td>
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<td>FBOs</td>
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<td>FM</td>
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<td>FP</td>
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<td>FSW</td>
<td>Female Sex Workers</td>
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<td>GCP</td>
<td>Good Clinical Practice</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GFATM</td>
<td>Global Fund for AIDS, Tuberculosis and Malaria</td>
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<td>GIS</td>
<td>Geographic Information System</td>
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<td>HBC</td>
<td>Home Based Care</td>
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<td>HC</td>
<td>Health Center</td>
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<td>HCW</td>
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<td>HIS</td>
<td>Health Information System</td>
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<td>HIV</td>
<td>Human Immuno deficiency Virus</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>Health Sector Strategic Plan</td>
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<td>HR</td>
<td>Human Resource</td>
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<tr>
<td>PCR</td>
<td>Polymerase Chain Reaction</td>
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<tr>
<td>PCV13</td>
<td>PCV13 (Pneumococcal Conjugate) Vaccine</td>
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<td>PER</td>
<td>Public Expenditure Review</td>
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<td>PHAST</td>
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<td>PHCC</td>
<td>Primary Health Care Centre</td>
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<td>PHCU</td>
<td>Primary Health Care Unit</td>
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<td>PHL – IdC</td>
<td>Public Health Laboratory – Ivo De Carneri</td>
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<td>PMTCT</td>
<td>Prevention from Mother to Child Transmission</td>
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<td>POFEDP</td>
<td>President’s Office, Finance, Economy Development and Planning</td>
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<td>PPP</td>
<td>Public Private Partnership</td>
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<td>QA</td>
<td>Quality Assurance</td>
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<td>RCH</td>
<td>Reproductive and Child Health</td>
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<td>RDS</td>
<td>Respondent Driven Sampling</td>
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<td>RDT</td>
<td>Rapid Diagnostic Test</td>
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<td>RED/REC</td>
<td>Reaching Every District /Reaching Every Child</td>
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<td>RGoZ</td>
<td>The Revolutionary Government of Zanzibar</td>
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<td>RTA</td>
<td>Road Traffic Accidents</td>
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<td>SADC</td>
<td>Southern Africa Development Community</td>
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<td>SAM</td>
<td>Severe Acute Malnutrition</td>
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<td>SAPEL</td>
<td>Special Action Project for the Elimination of Leprosy</td>
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<td>SDP</td>
<td>Service Delivery Points</td>
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<td>STI</td>
<td>Sexual Transmitted Illnesses</td>
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<tr>
<td>SUZA</td>
<td>State University of Zanzibar</td>
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1 PCV13, is a vaccine that covers 13 pneumococcal serotypes, which cause the majority of pneumococcal infections in young children
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<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<td>HRH</td>
<td>Human Resource for Health</td>
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<td>Human Resource Information System</td>
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<td>Health Sector Reform Strategic Plan</td>
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<td>Health Sector Strategic Coordination Forum</td>
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<td>HTC</td>
<td>HIV Testing &amp; Counselling</td>
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<td>ICU</td>
<td>Intensive Care Unit</td>
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<td>IdCF</td>
<td>Ivo De Carneri Foundation</td>
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<td>IDSR</td>
<td>Integrated Disease Surveillance and Response</td>
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<td>Intravenous Drug Users</td>
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<td>IDWE</td>
<td>Integrated Disease Weekly Ending</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>IHTLP</td>
<td>Integrated HIV and TB and Leprosy</td>
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<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
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<td>IMR</td>
<td>Infant Mortality Rate</td>
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<td>IRCH</td>
<td>Integrated Reproductive and Child Health</td>
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<td>IRS</td>
<td>In-door Residual Spray</td>
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<td>IT</td>
<td>Information and Technology</td>
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<td>ITN LL</td>
<td>Impregnated Treated Nets</td>
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<td>IUCD</td>
<td>Intrauterine Contraceptive Device</td>
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<td>LEC</td>
<td>Light-Emitting Electrochemical Cell</td>
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<td>LLINs</td>
<td>Long-Lasting Insecticide Nets</td>
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<tr>
<td>SWOT</td>
<td>Strengths, Weaknesses, Opportunity and Threats</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>TDHS</td>
<td>Tanzania Demography and Health Survey</td>
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<td>THMIS</td>
<td>Tanzania HIV, Malaria Indicator Survey</td>
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<td>World Health Organization</td>
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<td>Zanzibar Bureau of Standard</td>
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<tr>
<td>ZDPGs</td>
<td>Zanzibar Development Partners Group</td>
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<td>ZEPRP</td>
<td>Zanzibar Emergency Preparedness and Response Plan</td>
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<td>ZFDB</td>
<td>Zanzibar Food and Drug Board</td>
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<td>ZHMTs</td>
<td>Zonal Health Management Teams</td>
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<td>ZHSRSP</td>
<td>Zanzibar Health Sector Reform Strategic Plan</td>
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<td>ZILS</td>
<td>Zanzibar Integrated Logistic System</td>
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<tr>
<td>ZMCP</td>
<td>Zanzibar Malaria Control</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MARPs</td>
<td>Most At Risk Populations</td>
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<tr>
<td>MB</td>
<td>Multi Bacillary</td>
</tr>
<tr>
<td>MDAs</td>
<td>Ministry Department and Agencies</td>
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<tr>
<td>MDGs</td>
<td>Millenium Development Goals</td>
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<tr>
<td>MDR-TB</td>
<td>Multi-Drug Resistance Tuberculosis</td>
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<tr>
<td>MEEDS</td>
<td>Malaria Early Epidemic Detection and Surveillance</td>
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<td>M-HEALTH</td>
<td>Mobile- Health</td>
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SECTION ONE

1.0 General overview of Zanzibar:

1.1 Background information

1.1.1 General information:

Zanzibar, a semi-autonomous country, made up of two sister Islands (Unguja and Pemba) and forms part of the United Republic of Tanzania. Zanzibar has a population of 1,303,568 people with a crude birth rate (CBR) of 38.1 births per 1,000 live births and total fertility rate of 5.3 children per woman. Life expectancy at birth has shown a positive upward trend from 53 years (2003) to 60 years (2008). The Ministry of Health Zanzibar governs all matters related to health within the islands. In early 90’s, the Ministry embarked in the reform process which became fully fledged in 2002. The Zanzibar Health Sector Reform Strategic Plan I (ZHSRSP I) 2002/03–2006/7 which was followed by ZHSRSP II 2006/7 – 2010/11 were established based on the 1999 Zanzibar Health Policy. The reform sought at decentralizing planning, prioritizing and integrating health services at district level. In addition, the reform aimed at ensuring the availability of equitable high quality of health care services to all Zanzibaris with special focuses on priority diseases or burden of diseases and according to an Essential Health Care Package.

1.1.2 General Economic information

Zanzibar’s economy in 2011 has performed well through the crisis and the global recovery has shown real Gross Domestic Product (GDP) growth rate of 6.8 percent compared with growth of 6.5 percent in 2010. The GDP at constant price has risen to TZS 1,198 billion in 2011 from TZS 946.8 billion in 2010. The service sector (transport and communication services, public service, education, trade and health) continued to lead in contribution to the recorded growth although its registering growth of 8.9 percent in 2011 was marginally lower compared to 9.3 percent in 2010. In 2011 per capita income averaged a growth 22.7 percent rising from TZS 960,000 in 2011 to TZS 782,370 in 2010 which is equivalent to USD 560 in 2010 up from USD 617 in 2011. In 2010/2011 the Total Domestic Revenue collected was 99.7 billion TZS compared to 142.6 billion TZS of 2009/2010 which records an increase of 40 percent. Total government expenditures for the year 2010/11 increased to TZS 387.1 billion as compared to TZS 325 billion of the year 2009/10 which is 6.1 percent increase, this was caused by increasing of both recurrent and development expenditures.

1.1.3 Overview of Zanzibar Health Sector

The Ministry of Health Zanzibar leads and regulates the functionalities of the health sector. The MoH supports, coordinates and regulates all interventions whose primary objective is to improve the health of the population of Zanzibar. Although the MoH has the overall primary stewardship of health matters in Zanzibar other government ministries execute activities that either directly or indirectly have an impact to the health of the Zanzibaris. Concurrently, the health sector is also supported by development partners, the private sector, faith-based organisations (FBOs), and nongovernmental organisations (NGOs) in ensuring access to quality health services are rendered to all in need.

---

2 National Housing Population Census 2012
3 NBS, TDHS 2004/05
4 Zanzibar Human Development Report 2009
5 OCGS-2011
6 POFEDP-2011
1.1.4 Public Health Sector Administrative Arrangement:
The Revolutionary Government of Zanzibar (RGoZ) through the Ministry of Health (MoH) has [since 1964] been implementing different approaches on organization and management structure that oversee the day to day sectoral implementation of activities. Administratively the central level; apart from the high policy making leadership (composed of the Minister, Deputy Minister, the Principal Secretary and the Director General\(^7\)); the Ministry of health is made up of a number of operating departments and programs (see the Organogram Annex 1). These include the department of:

1. Policy, Planning & Research;
2. Administration and Human Resource
3. Preventive Services and Health education;
4. Curative Services;
5. Central medical Stores;
6. Mnazi Mmoja Hospital;
7. Health - Coordinator Pemba;
8. Chief Government Chemist, and
9. Chief Pharmacist

1.1.5 The core functions of the MoH at central level
The core functions of the MoH at central level include developing and overseeing the following:

i. Policy analysis, formulation and translation;
ii. Strategic planning;
iii. Setting standards inclusive of monitoring procedures for quality assurance;
iv. Resource mapping, mobilization and appropriate allocation based on identified needs and Disease dynamics;
v. Advising other ministries, departments and agencies on conditions of public health importance;
vi. Capacity development and technical support provision at all service delivery points;
vii. Provision of nationally coordinated services including health emergency preparedness, response inclusive of disease epidemics;
viii. Coordination of health research and applications of research findings for policy and planning purposes; and
ix. Monitoring and evaluation of the overall health sector performance.
x. Promote designing, executing and translating scientific and operational health research for better planning process
xi. Oversees and translate the implementation of the Public health Act as part of promoting the health of the citizens.

1.2 Health sector policy guiding frameworks:
At the outset, the implementation of the HSSP takes in consideration the guidance from key national and international policies and goals as detailed below:

---
\(^7\) The MoH Organogram
1.2.1 International Policies and goals
The most influential International commitments providing direction to the HSSP-III are the MDGs, the African Health Strategy 2007-2015, the Paris Declaration, Accra Accord and Abuja Declaration.

1.2.1.1 Millennium Development Goals

The RGoZ being part of URT has committed herself to achieve the MDGs by 2015. Four MDGs are directly related to health [MDG 1, 4, 5 &6] on the other hand the health sector contributes to the remaining MDGs as reflected in the Table below:-

**Table 1: Health Related Millennium Development Goals**

<table>
<thead>
<tr>
<th>MDG GOALS</th>
<th>AREA OF INTERVENTIONS</th>
</tr>
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<tbody>
<tr>
<td>Goal 1</td>
<td>Eradicate extreme poverty and hunger (malnutrition)</td>
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<tr>
<td>Goal 4</td>
<td>Reduce child mortality</td>
</tr>
<tr>
<td>Goal 5</td>
<td>Improve maternal health</td>
</tr>
<tr>
<td>Goal 6</td>
<td>Combat AIDS, malaria, Tuberculosis and other diseases</td>
</tr>
<tr>
<td>Goal 7</td>
<td>Ensure environmental sustainability (T – 10: Halve by 2015 the proportion of people without sustainable access to safe drinking water and sanitation) (Proportion of population with access to improved sanitation, urban and rural)</td>
</tr>
<tr>
<td>Goal 8</td>
<td>Develop a global partnership for development (T – 17: Access to affordable essential drugs in developing countries (Proportion of population with access to affordable essential drugs on a sustainable basis)</td>
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</table>

The HSSP-III includes many strategies and interventions that are oriented towards speeding up the achievement of health-related MDGs. While great strides have been made to meet these goals, more investments are needed so as to realize or be on track on reaching the MDGs. This Strategic plan intends to provide a roadmap towards the realization of the same.

1.1.2.2 Africa Health Strategy 2007 - 2015

The HSSP-III is also guided by the Africa Health Strategy 2007-2015, which provides strategic direction to Africa’s efforts in creating better health for all along with an overarching framework to enable coherence within and between countries, civil society and the international community. The Strategy emphasises the need to strengthen health systems, provide the poor with services and thereby contribute to equity. It focuses on the health of women and children, where great challenges remain. It suggests that apart from the necessary attention for AIDS, malaria and TB, the substantial disease burden posed by other communicable and non-communicable diseases should not be overlooked. It
also encourages sector-wide approaches to guarantee alignment of donor funding with nationally determined plans and priorities.

1.1.2.3 Abuja Declaration, Accra Accord and the Paris Declaration

The United Republic of Tanzania has in general signed up to the Abuja Declaration committing 15% of disposable GDP to the health sector. Furthermore, donor commitment to the Paris Declaration for aid harmonisation (2005) and Accra Accord for aid effectiveness (2008) has resulted in improved donor co-ordination.

1.2 National policies:

1.2.1 Vision 2020:

The Vision’s 2020 section on health emphasizes the provision of basic health services to all people without discrimination. Priority shall be directed to preventive services, combating epidemics, special maternal and child care services and the dissemination of health education for all. Areas of focus include raised standard of health and nutritional standard; efficient provision of health services together with careful utilization of the meager available resources; promote safe delivery system, planned motherhood and child survival; promote the provision of child immunization; increased resource allocation to preventive services; enhance capacity to respond to epidemic; where appropriate and safe practices for traditional health practitioners; environmental protection; promote private partnership and mitigating emerging diseases and disease conditions [including TB/HIV] etc.

1.2.1.2 Zanzibar Strategy for Growth and Reduction of Poverty

The Strategy is aimed at improving the first Zanzibar Poverty Reduction Plan I & II [ZPRP] in terms of process and content. It identifies ten principles that would guide its strategic interventions and actions with a view to ensuring integrity and synergies of the Strategy. The purpose is to bring about rapid growth and improvement of the well-being of the people it provides a medium-term framework for achieving the goals set out in Vision 2020 and provides the national priorities within which sector specific strategic plans should be developed. It constitutes three clusters namely:

i. Growth and Reduction of Income Poverty;
ii. Social Services and Well-being; and
iii. Good Governance and National Unity

1.2.1.3 Health sector policy

The MoH reviewed the health sector policy in 2011 and came up with guiding policy statements with defined objectives and explicit areas of focus. The health sector policy has underpinned the following objectives to be addressed in line with other national and international guiding policies and pillars. These include:

---

8 MKUZA I & MKUZA II
1.3 MINISTRY OF HEALTH POLICY OBJECTIVES [2011]

1. **Health sector governance**
   **Policy objective:**
   Promote integration, transparency, accountability, community participation and involvement in decision making in health matters at all levels.

2. **Health services delivery**
   **Policy objectives:**
   Improve referral systems within the health settings at all levels including private health sector participation on universal access to comprehensive care, treatment and prevention of Communicable and Non Communicable diseases in a coordinated, efficient, equitable and dignified manner.

3. **Social Services**
   **Policy objective:**
   Improve integration and management of social services among different actors at all level.

4. **Human Resource for Health**
   **Policy objective:**
   - Increase adequate number of skilled and competent personnel, at all levels of health care system.
   - Promote personnel right

5. **Infrastructure**
   **Policy objectives:**
   - Develop and adhere to infrastructure development plan which supports equity and sustainability in preventive maintenance and rehabilitative services.
   - Improve transport and communication network within MOH

6. **Essential medicines, medical and non-medical supplies**
   **Policy objectives:**
   - Increase access to quality essential medicines, medical and non-medical supplies and promote their rational use at all level of health care.
   - Promote best practices of traditional and alternative medicine.

7. **Health legislation and regulation**
   **Policy objective:**
   Promote the application of health laws, regulations and ethical standards in health and health related matters.

8. **Health Information**
   **Policy objective:**
   Promote the management establishment of Health Information System that will enhance evidence-based decision-making.

9. **Innovations and researches**
   **Policy objective:**
   Promote research activities in the ministry.

10. **Health Financing**
    **Policy objective:**
    Increase financial resources through adoption of various health financing options which are fair and sustainable.

11. **Cross – cutting themes**
    **Policy objectives:**
    - Promote the application of gender and human rights approach in the health care system.
    - Improve environmental sanitation and health care waste management in health facilities and other public and private places.
In line with the above policy objectives, the MoH has identified the following key health needs and priorities within the new policy. *All these efforts aim at decreasing morbidity and mortality with a positive impact on quality life and increase on life expectancy of the Zanzibaris.* These include:

### 1.3.1 Health Needs

i. Enhance capacity of professional boards and councils for effective monitoring codes of conduct and professional ethics  
ii. Establish/strengthen quality assurance mechanisms at all levels that shall enforce adherence to standard protocols and guidelines  
iii. Enhance gender mainstreaming and human rights in all health aspects  
iv. Coordination and integration approach on related health programmes  
v. Facilitate decentralization process through increase collaboration with other health related sectors  
vi. Improve resource mobilization and financial management to ensure adequate resource availability, efficiency and cost-effectiveness  
vii. Initiate coordination mechanisms to harmonize modalities of working with various partners  
viii. Ensure access of quality health services and social protection to the disadvantaged and other vulnerable groups  
ix. Improve staff deployment, job orientation and mentorship of Health care workers to adhere to standard protocols for referral of patients at all level of health service delivery.  
x. Accelerate reduction of Maternal and neonatal mortality through increasing access to delivery services especially in rural areas.  
xi. Increase access and quality diagnostic of HIV and AIDS, TB and Malaria prevention, care and treatment as per Essential Health Care Packages  
xii. Change focus on emerging health problems from curative to preventive approach  
xiii. Strengthen human resource development, management and retention schemes  
xiv. Adequate resource allocation to address nutrition issues  
xv. Innovation and integration of research activities  
xvi. Increase access to quality essential medicines, medical products and equipment  
xvii. Enhance coordination and collaboration with health partners]  
xviii. Promote the utilization of technology namely e-health  
ix. Ensure quality health information

### 1.3.2 Main priorities of the policy

i. Strengthen decentralization of health care system.  
ii. Formulate Conceptual frame-work for Quality assurance.  
iii. Address gender and human right issues in promoting access to health services  
iv. Strengthen Health Care Financing including soliciting funds to address financial gap for health sector  
v. Improve the coordination of health activities across different ministerial departments, programmes and harmonization of off-budget transactions.  
vi. Equitable resources allocation for health at all level of care.  
vii. Increase supply and management of health professionals.  
viii. Improved public health practices including public health promotion, emergency preparedness and response.  
ix. Prevention, management and rehabilitation on disability.  
x. Strengthen Laboratory and diagnostic services.
xi. Strengthen Pharmaceutical Section to increase access to Pharmaceutical products of good quality, proven effectiveness and acceptable safety at a price that individuals and the communities can afford.

xii. Strengthen Public–private partnership

xiii. Strengthen safety blood services

xiv. Enforce implementation of laws, regulations, guidelines and community health standard

xv. Ensure implementation of regulations and public service act being followed by all health service providers

xvi. Strengthen investigation and detection of commodities for human consumption

1.4 Health sector guiding laws and regulations:

In line, with the above national and international policies and goals, the implementation of HSSP-III will also be guided by the International Health regulations, national laws and regulations as part of enhancing of good governance. These national laws and regulations include:

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<th>Guiding law or regulation</th>
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<td>The Establishment of the Chief Government Chemist Laboratory Act, 2011</td>
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<td></td>
<td>Traditional and Alternative Medicines Act, no.8 of 2008.</td>
</tr>
<tr>
<td></td>
<td>Environmental and Public Health Act, 2012. Also accommodating international Health Regulations</td>
</tr>
<tr>
<td></td>
<td>Nurses and midwife Act [1986]</td>
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<td></td>
<td>Pharmaceuticals and dangerous Drug Act [1986]</td>
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<td></td>
<td>Private hospital [regulatory Act- 1994]</td>
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<td></td>
<td>Mental Protection Act [2001]</td>
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<td></td>
<td>Traditional and alternative Medicine Act [Act No 8 of 2008]</td>
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<td></td>
<td>Quarantine Act [1958]</td>
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<tr>
<td></td>
<td>The Zanzibar Occupational Safety and Health Act No.8, 2005</td>
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<td></td>
<td>The Zanzibar Employment Act No.11, 2005.</td>
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<tr>
<td></td>
<td>The Zanzibar Social Security Act No.2, 2005</td>
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<td></td>
<td>The Zanzibar Labour Relations Act , No I -2005</td>
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<tr>
<td></td>
<td>The Workers compensation (amendment) Act No 5, 2005</td>
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<tr>
<td></td>
<td>The Public service Act No.2, 2011</td>
</tr>
<tr>
<td></td>
<td>The Zanzibar Disability (Rights and Privileged) Act No.9, 2006.</td>
</tr>
<tr>
<td></td>
<td>The Children Act No.6, 2011</td>
</tr>
<tr>
<td></td>
<td>b. Iodated Salt Regulations of 2011</td>
</tr>
<tr>
<td>National strategies and plans</td>
<td>The Zanzibar Emergency Preparedness and Response Plan [ZEPRP-2011]</td>
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<tr>
<td></td>
<td>The Zanzibar Disaster Communication Strategy [2011]</td>
</tr>
</tbody>
</table>
SECTION TWO

2.0 SITUATION AND RESPONSE ANALYSIS ON HSSP II

2.1 Rationale
In the last decade, the Ministry of Health Zanzibar\(^9\) has been translating the health sector policy through the implementation of two Health Sector Strategic Plans (ZHSRSP I 2002/3-2006/7 and ZHSRSP II 2006/7-2010/11) respectively. In the course of implementing these strategic plans, Zanzibar has also witnessed a change in disease patterns and associated underlying causes. These experiences, coupled by external and internal factors as well as the country’s ratification to international agenda led to the revision of the health sector policy in 2011. In line with the formulation of the new policy, and acknowledging the fact that the ZHSSP II has come to an end, it is imperative that the MOH should draw a new five years Strategic plan III for 2013/14 – 2018/19 to address the health care and service needs of the country geared towards having a healthy Zanzibari population.

2.2 Methodology
The exercise for formulating Strategic plan III started by assessing the implementation of Strategic Plan II. This was made possible through a consultative process that involved a number of technicians from at various levels. A total of seven teams each led by a senior health professional undertook the assessment exercise. These teams worked on seven key areas namely:

i. Organization Management and Working environment,
ii. Prevention and Health Education,
iii. Health care service delivery,
iv. The Non State Actors,
v. Emerging conditions,
vi. Health care financing and sustainability; and

Main assessment methods employed included literature review where key ministerial documents were profoundly visited, interviews, focus group discussion, consultative field visits and observations to validate desk review findings. Consultative meetings and sessions with different MDAs, international organization and NGOs of both Unguja and Pemba were also undertaken. Data were later on processed, translated, triangulated and synthesized and formed the basis for the formulation of the strategic document. The preliminary report was shared internally to the HSR secretariat and other partners for review and forwarded inputs were incorporated.

The Situation Analysis has been prepared to provide clear picture on the realization of the national health goals and priorities to all implementers of health and their stakeholders. This analysis on great aspect has an intention to bring positive change that has originated from efforts made during the implementation process of Strategic Plan II (2006/7 – 2010/11). In the course of situation and response analysis, both positive and negative results were observed and summarized.

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\(^9\)The Ministry of Health has in the past been also called “the Ministry of Health and Social welfare”.
3.0 General performance in implementing HSSP II 2006/07 – 2011/12

3.1 Health sector performance

The RGoZ has committed herself to realize the Millennium Development Goals [MDGs]. This has been done through the Zanzibar Strategy for Growth and Reduction of Poverty [MKUZA I &II]. All these two major interventions have been monitored to reflect country performance on realizing growth and national development.

3.1.1. Millennium Development Goal (MDG)

The UN (2000) Millennium Development Goals Programme committed countries rich and poor to eradicate poverty, to promote human dignity and equality, to achieve peace, democracy and environmental sustainability. Concrete targets to promote development and reduce poverty were set and should be achieved by 2015 or earlier. Eight goals were set; three of which are directly related to health while the others have an indirect impact on health.

The progress towards meeting the indicators for the three directly health related goals (Goal 4 “reduce child mortality”, Goal 5 “improve maternal health”, Goal 6 “combat HIV/AIDS, malaria and other diseases”) and of the health indicators indirectly related to health (Goal 1 “reduce poverty”) in Zanzibar is illustrated in Table below.
### Table 3: Achievement towards Implementation of Health Related Millennium Development Goals (MDGs)

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</thead>
<tbody>
<tr>
<td><strong>Goal 1: Eliminate poverty</strong></td>
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</tr>
<tr>
<td>% of underweight for age in children under 5 years*</td>
<td>19.5</td>
<td>39.9</td>
<td>Nil</td>
<td>19.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>19.9</td>
<td>Satisfactory</td>
<td>National surveys</td>
<td></td>
</tr>
<tr>
<td>% of stunting in children* under 5 years</td>
<td>24.8</td>
<td>47.9</td>
<td>Nil</td>
<td>23.1</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>30.2</td>
<td>Unsatisfactory</td>
<td></td>
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</tr>
<tr>
<td><strong>Goal 4: Reduce child mortality</strong></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Under-five mortality rate*</td>
<td>67</td>
<td>202</td>
<td>141</td>
<td>101</td>
<td>*</td>
<td>*</td>
<td>79</td>
<td>*</td>
<td>73</td>
<td>Promising</td>
<td>Census/National Survey</td>
<td></td>
</tr>
<tr>
<td>Infant mortality rate*</td>
<td>40</td>
<td>120</td>
<td>89</td>
<td>61</td>
<td>*</td>
<td>*</td>
<td>54</td>
<td>*</td>
<td>54</td>
<td>Promising</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of 1 year-olds immunized against measles</td>
<td>100</td>
<td>Na</td>
<td>Na</td>
<td>82</td>
<td>87.1</td>
<td>88</td>
<td>86.5</td>
<td>95.8</td>
<td>77.7</td>
<td>85.7</td>
<td>On track</td>
<td>HMIS Routine</td>
</tr>
<tr>
<td><strong>Goal 5: Improve maternal health</strong></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Maternal mortality ratio **</td>
<td>130</td>
<td>Na</td>
<td>Na</td>
<td>Na</td>
<td>528</td>
<td>365</td>
<td>422</td>
<td>279</td>
<td>287</td>
<td>284.7</td>
<td>More effort needed</td>
<td>HMIS facility based</td>
</tr>
<tr>
<td>Proportion of births attended by skilled health personnel</td>
<td>90</td>
<td>Na</td>
<td>Na</td>
<td>51</td>
<td>62.5</td>
<td>47</td>
<td>44.5</td>
<td>43.1</td>
<td>49.2</td>
<td>47.1</td>
<td>Unsatisfactory</td>
<td>National surveys</td>
</tr>
<tr>
<td><strong>Goal 6: Combat HIV/AIDS, malaria and other diseases</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Malaria prevalence rate*</td>
<td>&lt;49</td>
<td>49.2</td>
<td>46.2</td>
<td>44.6</td>
<td>*</td>
<td>*</td>
<td>&lt;1</td>
<td>*</td>
<td></td>
<td></td>
<td>Achieved</td>
<td>THMIS/ZM CP_MIS</td>
</tr>
<tr>
<td>TB prevalence</td>
<td>&lt;24</td>
<td>24</td>
<td>Na</td>
<td>51</td>
<td>Na</td>
<td>Na</td>
<td>Na</td>
<td>Na</td>
<td>Na</td>
<td>Na</td>
<td>National Survey is needed</td>
<td>ZTLP</td>
</tr>
<tr>
<td>TB death Rate</td>
<td>5.5</td>
<td>Na</td>
<td>Na</td>
<td>Na</td>
<td>7.1</td>
<td>5.1</td>
<td>6.0</td>
<td>6</td>
<td>3.7%</td>
<td>On track</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TB cure rate</td>
<td>Na</td>
<td>Na</td>
<td>Na</td>
<td>Na</td>
<td>85.0</td>
<td>82.0</td>
<td>88.9</td>
<td>83.3%</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malaria Death Rate **</td>
<td>Na</td>
<td>Na</td>
<td>Na</td>
<td>Na</td>
<td>Na</td>
<td>0.022</td>
<td>0.01</td>
<td>0.002</td>
<td>0.0</td>
<td>0.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Goal 8 Develop A Global Partnership For Development:
Target 17: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries.

<table>
<thead>
<tr>
<th>% share of the government budget to the health sector</th>
<th>8.10%</th>
<th>8.00%</th>
<th>9.60%</th>
<th>9.40</th>
<th>9.30%</th>
<th>5.30%</th>
<th>6.79%</th>
<th>6.35%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per capita total (Government, External and complementary) allocation to health</td>
<td>26,937</td>
<td>27,205</td>
<td>25,308</td>
<td>28,322</td>
<td>25,853</td>
<td>22,599</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MoH Chief Accountant’s Office & POFEDP Budgeting Departments

Note: * Indicators are available from TDHS and National Census, ** Available information from Health facilities.
3.1.2 MKUZA II monitoring:
The Ministry of Health (MOH) has taken considerable effort in monitoring MKUZA II and ZHSRSP II targets using routine data collected by Health management Information system [HMIS]. Outlined below are key performance indicators for the health sector from 2010-2011.

Table 4: MKUZA II Health and Health Related Indicators

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>TARGET</th>
<th>2010</th>
<th>2011</th>
<th>SOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: INFANT AND CHILD MORTALITY (Reduce infant and under five mortality by 2015)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce neonatal mortality</td>
<td>From 31/1000 in 2008 to 15/1000 by 2015</td>
<td>29</td>
<td>*</td>
<td>DHS</td>
</tr>
<tr>
<td>Reduce infant mortality</td>
<td>From 54/1000 in 2008 to 48/1000 by 2015</td>
<td>54</td>
<td>*</td>
<td>Census/National Survey</td>
</tr>
<tr>
<td>Reduce under-five mortality</td>
<td>From 79/1000 in 2010 to 50/1000 by 2015</td>
<td>73</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>B: MATERNAL AND REPRODUCTIVE HEALTH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase the proportion of births attended by skilled health personnel</td>
<td>From 51% in 2004 to 90% by 2015</td>
<td>49.2</td>
<td>47.1</td>
<td>HMIS/National Survey</td>
</tr>
<tr>
<td>Increase percentage of births delivered in health facilities</td>
<td>From 50% in 2008 to 60% by 2015</td>
<td>42.2</td>
<td>43.2</td>
<td>HMIS</td>
</tr>
<tr>
<td>Maternal mortality ratio reduced</td>
<td>From 473/100000 in 2007 to 170/100,000 by 2015</td>
<td>287</td>
<td>284.7</td>
<td>HMIS- facility based</td>
</tr>
<tr>
<td>Increased use of modern contraceptive</td>
<td>From 9% in 2004 (TDHS, 2004/05) to 20% by 2015</td>
<td>12.4</td>
<td>*</td>
<td>TDHS</td>
</tr>
<tr>
<td>C: COMMUNICABLE DISEASES</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV prevalence rate among 15-24 years pregnant women reduced</td>
<td>From 0.6% in 2008 to 0.3% by 2015</td>
<td>0.3</td>
<td>*</td>
<td>ZACP- Surveillance ANC</td>
</tr>
<tr>
<td>HIV prevalence rate among general population maintained below 1%</td>
<td></td>
<td></td>
<td></td>
<td>ZACP- Surveillance ANC</td>
</tr>
<tr>
<td>HIV prevalence rate among MARPs reduced by half 2015</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>HIV Prevalence among MSM reduced</td>
<td>From 12.3% in 2008 to 6.1% by 2015</td>
<td></td>
<td></td>
<td>ZACP- IBBS Survey</td>
</tr>
<tr>
<td>HIV Prevalence among IDUs reduced</td>
<td>From 15.1% in 2008 to 7.5% by 2015</td>
<td></td>
<td></td>
<td>ZACP- IBBS Survey</td>
</tr>
<tr>
<td>HIV Prevalence among CSW reduced</td>
<td>From 10.8% in 2008 to 5.4% by 2015</td>
<td></td>
<td></td>
<td>ZACP- IBBS Survey</td>
</tr>
<tr>
<td>Malaria transmission reduced</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incidence of malaria cases reduced</td>
<td>From 0.9% in 2008 to 0.5% 2015</td>
<td>0.53</td>
<td>0.2</td>
<td>Routine HMIS</td>
</tr>
</tbody>
</table>

29
<table>
<thead>
<tr>
<th>Objective</th>
<th>Baseline</th>
<th>Target</th>
<th>Achieved</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of under-five sleeping under ITNs increased</td>
<td>From 80% in 2009 to 100% by 2015</td>
<td>71</td>
<td>*</td>
<td>Malaria indicator survey</td>
</tr>
<tr>
<td>TB/HIV co-infection cases reduced</td>
<td>25% in 2009 to 12% by 2015</td>
<td></td>
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<tr>
<td>Reduce number of TB cases</td>
<td>369 in 2007 to 250 by 2015</td>
<td>270</td>
<td>280</td>
<td>ZTLP annual report</td>
</tr>
<tr>
<td><strong>D: HUMAN RESOURCES FOR HEALTH</strong></td>
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<tr>
<td>Proportion of skilled health personnel providing quality EHCP services with particular focus on primary level increased</td>
<td>from 52.6% in 2009 to 60% by 2015</td>
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<tr>
<td><strong>GOAL 2.5 IMPROVE NUTRITIONAL STATUS OF CHILDREN AND WOMEN, WITH FOCUS ON THE MOST VULNERABLE GROUPS</strong></td>
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<tr>
<td>Underweight in children aged 6-59 months</td>
<td>19% in 2010 to 15% by 2015</td>
<td>19.9</td>
<td>*</td>
<td>National survey</td>
</tr>
<tr>
<td>Stunting in children aged 0-59 months</td>
<td>23% in 2010 to 20% by 2015</td>
<td>30.2</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>Anaemia in children aged 6-59 months</td>
<td>75% in 2010 to 60% by 2015</td>
<td>1.79</td>
<td>1.4</td>
<td>HMIS</td>
</tr>
<tr>
<td>Anaemia in pregnant women aged 15-49 year</td>
<td>63% in 2010 to 40% by 2015</td>
<td>1.73</td>
<td>2.3</td>
<td></td>
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<tr>
<td><strong>Goal 2.3: IMPROVED ACCESS TO WATER, ENVIRONMENTAL SANITATION AND HYGIENE</strong></td>
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<tr>
<td>The proportion of households with access to basic sanitation increased</td>
<td>from 83% in 2009 to 90% by 2015</td>
<td>*</td>
<td>*</td>
<td>National survey</td>
</tr>
</tbody>
</table>
3.2 Health system performance:

The Ministry of Health through the health sector policy has put in place six (6) main system building blocks\(^{10}\). The strategy will utilize the same to monitor the implementation of different interventions for entire sector through various approaches i.e. meetings, routine data collection, annual performance reports etc. outlined below please find summary of documented health sector system performance.

3.2.1 Organization, Management and Working environment:

The ZHSSPII clearly outlined the need of enhancing the health infrastructure as part of ensuring quality and upgrade standards of services at service delivery points. Generally, remarkable infrastructural developments have been undertaken at all levels during the implementation period to satisfactorily allow the flow of services and motivate service providers as well the served clientele. Some of the marked key successes include:

i. Improved capacity of MOH in the area of Human resource in terms of strategy development, policy guidelines and availability of skilled professional for some specialties, a Five Year Human Resource Development Plan 2004/5 – 2008/9 was in place to guide the development of health care workers.

ii. Improvement of MOH infrastructures through the construction and renovation of various buildings including health facilities and staff houses, expansion of College of Health Sciences (CHS), construction of various programme buildings, refurbishment of MOH headquarters, and

iii. Recognizing Public Health Laboratory (PHL – IdC) as WHO collaborating Centre for control of Schistosomiasis and Soil transmitted diseases.

iv. Establishment of various fora for partner collaboration such as Zanzibar Annual Joint Health Sector Review – ZAJHSR, Partners Coordination Meeting and Zanzibar Development Partner Group for Health (ZDPGs\(^{11}\)) to increase transparency and ensure proper coordination and integration of government and partners’ inputs.

v. Establishment of Procurement Management Unit within the MOH has significantly improved procurement of medical and non-medical supplies.

vi. Establishment and strengthening of key services (e.g. Blood bank, access to ART services, radio imaging – computerized Tomography [CT scan], strengthening laboratory services (quantity and quality of services covered especially at MMH and other Service delivery Point (SDP)).

vii. Currently, the MoH departments have been adequately housed at the new administrative block within the MOH\(^{12}\) headquarters. At the Zanzibar College of health Sciences two teaching blocks that accommodate 530 students were constructed, student’s dormitories and staff houses were renovated and the perimeter/boundaries have been partly fenced by bricks.

\(^{10}\) MOH: Policy - 2011

\(^{11}\) Donor coordination meeting was revived in 2004/5, with the main purpose of calling key actors and stakeholders to discuss the annual Plan of Action. This was later on dissolved after the formulation of four technical working groups under the Health sector reform secretariat (Sector Performance, Health Care Financing, Quality assurance and Human resources for Health).

\(^{12}\) Renovation funding source – ADB and Danida
A new medical stores wing has been constructed in Pemba and a large central Medical warehouse under the Central Medical Store Department is being finalised at Maruhubi\textsuperscript{13}. Other notable achievements related to service infrastructural developments include:

i. At Mnazi Mmoja referral hospital there was major renovation and expansion of the departments and units. Placement of Computerized tomography for diagnostic imaging (CT-Scan), Construction of Gold standard VCT, renovation of the Central pathology laboratory, extension of maternity wing, extension of Ear Nose and Throat (ENT) wing with operating theatres, Renovating and scaling up of Dental department, Renovation of physiotherapy unit, Renovation of theatres and ICU and establishment of central oxygen supply system;

ii. Construction of Zanzibar National Blood Transfusion building and establishment of Blood Transfusion Services (NBTS) at Sebleni Unguja;

iii. Construction of administrative block and kitchen at Kidongo Chekundu mental hospital;

iv. Construction and establishment of health care engineering unit;

v. Construction and Renovation of health facilities in both isles including New 40 twin staff houses and 6 PHCU+;

vi. Construction of Mental Health wing at Wete,

vii. Renovation of Laboratory at Chake, Wete and Micheweni hospital;

viii. Placement of solar panel in some of health facilities and staff houses in Pemba; and

ix. Construction of PMTCT building at Kivunge;

Despite the above general strengths and successes, the Ministry has been observing some challenges which include:-

i. Shortage of essential medicines and equipment particularly in hospitals and capacity to undertake medicament and supplies forecasting and quantification.

ii. Inadequate financial resources to implement and sustain key interventions and activities

iii. Weak human resource management base (Inadequate – quantity, quality of skilled HR workforce, improper allocation and weak HR retention and motivation schemes)

iv. Shortage of local scientists/researchers within the Ministry of Health

v. Inadequate and malfunctioning referral system and diagnostic services

vi. District Health Management Teams do not have the basic qualifications that will empower them to undertake their designed mandates. On the other hand the issue of capacity of DHMT members has at times emerged to be a major challenge in line with expected deliveries.

vii. Inefficient and non-responding Monitoring and Evaluation mechanisms in some implementing units and programs

viii. Inefficient and non-effective Professional boards and councils to effectively monitor codes of conduct and professional ethics

ix. Less sensitive and inadequately mainstreamed Gender issues for effective health service delivery.

x. Government funding allocation for health is not at par with needs and sector priorities; costing work is yet to be promoted for actual health care financing gaps.

\textsuperscript{13}This construction is jointly supported by Danida and USAID. The real cost is 1.9B Tshs.
xi. Limited/inadequate integrated planning and management mechanism constrained by fragmentation of vertical programmes and projects which are mostly donor spearheaded.

xii. Slow progress within the central government to decentralize service management

xiii. Inadequate resource allocation for continuing quality and sustainable service provision (finance, human and materials) at all levels (continuum of care issues)

xiv. Ad-hoc response to Emergencies and reactive health impact assessment

xv. Prevention, management and maintenance services for is not profound to carter for those most in need.

xvi. Inadequate coordination, collaboration and networking with other related sectors

3.2.2 Human Workforce [Human Resource for Health]

Human resources is the most important asset in any organisation as they provide the organisation with their talents, skills, creativity and drive, thus enhancing the attainment of organization goals. While Human Resource for Health has ever since been a major concern in Zanzibar, the management of such resources was not well dealt with. The Ministry was having inadequate HRH information and guidelines that could used to develop and manage health work force. Apart from all these, units that were directly related to human resources worked in fragmentation. One of the great MOH achievements during the implementation of ZHSRSP II was the establishment of the Human Resource for Health Division (HRHD) in 2009. The division has four sections namely:

i. HRH Planning,
ii. HRH Management,
iii. HRH Development; and
iv. Continuing Education.

The major role of the division is to ensure availability of the right number of human resource with the right skills serving at the right place. The Deployment Committee was formed to facilitate fair distribution of personnel. Other observable achievement include the development of a five year human resource plan that targets at ensuring qualified personnel are assigned their respective tasks. In addition, the general objective of the training and development function in the Ministry is to attract, recruit and retain qualified, motivated and competent employees and develop them further into efficient and effective performers in their current as well as future jobs/duties. The initiative to encourage and support employees training shall be offered through, different approaches in collaborative efforts between the HRH division, zonal centres and training facilities. These efforts include:

i. Identifying training needs in line with sector priorities in a given period,

ii. Identifying training opportunities for the employees of different categories,

iii. Sponsoring training in full or part, depending on resource availability,

The establishment of minimum staff requirements and HRH data basis other achievement where the ministry can identify the needs and priority carders needed in each section and units within the Ministry. In the process of increasing human resource base for health, the MoH transformed the College of Health Sciences into a semi-autonomous institution. Establishment of new Zanzibar medical School and Bio-engineering course are also part of outstanding achievement.
The main operational challenges facing the health sector workforce include:

i. The inadequacy of HRH severely constrains implementation of health activities at all levels.

ii. Lack of adequate accommodation in some rural health facilities hinders equitable distribution of staff.

iii. There is no proper incentive package for staff assigned on special responsibilities or sent to difficult stations [hardship allowances schemes], thereby affecting retention.

iv. Allocation of staff does not consider staff expertise e.g. health personnel assigned to manage financial matters or to hold managerial positions without being provided with the basic necessary skills. This is a cut across experience.

v. No annual performance appraisal scheme introduced to date.

vi. MOHSW training needs are not featured in the national Higher Education priority list.

vii. Personnel Information System at the MOHSW\textsuperscript{14} headquarters is not adequately linked with districts and other MOHSW\textsuperscript{15} institutions.

3.2.3 Health service delivery

The ZHSRSP II has underscored the importance of improving efficiency through integration of related health programs. Some efforts were made to strengthen this intervention including the development of Training guidelines as well as National Supervision guidelines. Experiences have shown that Technical programmes carry out independent supervisions with limited horizontal communication to district and zonal level. This resulted into multitude of supervisory visits done to a unit and an overload of form fillings for various programmes resulting in confusing and or overworking HCW at facility level.

The process of collaboration and coordination was found to be poor in almost all levels. There was a clear fence between financially loaded programmes compared to those which depend on Government revenues alone. Of recent, some departments have started to reintroduce platforms for exchange of information and even share resources especially in areas where units or programme activities intersect. There is a positive shift in organisation culture towards “we and our approach” compared to the earlier egocentric focus. To scale up coordination to programmes with similar background, the executive committee of MoH merged some of the related programme. The major challenges facing fused programme is how best they can share resources, undertaking integrated reporting and joint mobilisation of financial resources.

The Ministry has realized the burden on emerging conditions that affected the lives of people especially in urban setting and being a major threat to the community at large. Hospital records have indicated a dramatic increase of cardiovascular conditions, fractures and cancers of cervix from 3.6 %– 8.9 % and 1.6% – 4.5% in 2006 and 2009 respectively; while diabetes mellitus shows an increase from 17.6% – 18.1% in every ten thousand people from 2007 and 2008 (HMIS). Cervical cancer clinic was established at MM Hospital in 2004. The clinic receives patients from all districts and according to statistics the number of women screened was 2,490 and out of which 130 tested for Visual Inspection using acetic Acid (VIA) and Visual Inspection using acetic Acid VILI +, 614 with mixed infection and 49 were referred for further management\textsuperscript{16}. The MoH lacks capacity to assess the overall burden of these diseases and conditions. These are normally assessed using the Disability-Adjusted Life Years (DALYS) which

\textsuperscript{14} Former name of the Ministry of Health and at times has been interchangeably used to reflect the same.

\textsuperscript{15} Ibid.

\textsuperscript{16} Data obtained from MMH Cancer Clinic 2004 -2011)
provides a comprehensive and comparable assessment of mortality and loss of health due to cardiovascular diseases, injuries, cervical cancer, and risk factors for public health implication and appropriate interventions.

The preliminary report on Step survey done in 2011 on NCDs & Associated risk factors in Zanzibar shows high prevalence of combined risk factors; Dietary practices – most common cooking oil used is vegetable oil with 47.5% and coconut oil 35.4% both rich in saturated fat. Mean number of serving of fruits and vegetables is 1.7 per day compared with recommended frequencies 3-5 times daily.

Report from Police headquarters Zanzibar indicates a high number of deaths due to Road Traffic Accidents (RTA): 2009 a total number of RTA was 834 and 98 deaths; 2010 total RTA 931 with 115 deaths and 2011 total RTA 849 with 81 deaths. The observed downward trend on RTA and associated deaths during the year 2011 was influenced by the introduction of new initiative – “Polisi Jamii”. Urban West is the most affected Region17.

Health promotion activities have been undertaken by using various methods including: radio, television, and health education sessions during clinic visits or through community meetings. The aim was to increase awareness and knowledge on health related matters as well as promoting community participation in health care delivery and utilization of health services. In addition, the strategy aimed at mitigating myths, misconceptions that hamper people from accessing services when there is a need to do so. Varieties of IEC materials have been distributed in all health facilities in the country conveying different health messages. Relatively, these efforts have contributed to the noted increase on health awareness, demand and utilization of health services but with limited behavioural change.

The Health promotion unit in the MOH remains responsible to coordinate all health promotion activities in the country; however, the unit lacks expertise in some fields. Additionally it was noted that the techniques that are being used are incompatible with ongoing country development hence activities somehow lacks social acceptance. There is need to move into modern level of Behavior Change and Communication where knowledge and reasoning are the key elements for behavioral change.

Diagnostic services [medical laboratory and radio imaging services]
The provision of laboratory services to support delivery of quality health care services has been affected by the shortage of human resources. This is mainly due to low outputs from health training institutions, high attrition of personnel (especially from the public sector), inadequate funding, insufficient and inappropriate [outdated] equipment. In addition, the Public Health Laboratory [PHL] in Zanzibar is not functioning at its optimal level due to various reasons. These include Human resource shortage [quality and quantity], nature of service rendered as a reference laboratory and administrative management. These need to be address intensely in HSSP-III.

Similarly, Medical imaging also face same kind of challenges, including shortage of human resources, inadequate supervision and a lack of appropriate infrastructure and limited quality equipment to cater for the needy population. At times the unit receives donation of equipment without accompanying guidance

17 Communication with the statistician from the Police Traffic headquarters
on procedures, and the absence of provision for the disposal of radiological waste, which poses a serious threat to the environment and to health. Even though the recent public health Act specifies on the management and disposal of medical waste but there are limitation on the effective disposal of radiological waste and equipment. To date the monitoring of radiological emission in health setting is undertaken in collaboration with the Atomic energy section of the URT.

**Quality Assurance:**

A number of programmes and units are engaged in internal and external quality assurance schemes. These includes National Quality Assurance [NEQAS] and Regional Quality Assurance schemes. Examples of such interventions include: Chief Government Chemist observing the QA assessment on submitted samples, CD4 QA Assessment, Data auditing, validation and verification especially through GFATM support. Laboratories which are assigned to do quality assurance: lack required [optimal] skills and specialties in terms of staff, equipment and supplies. Areas that lack qualified HR include: consumer protection, water and food safety, Criminal investigation, control of zoonotic diseases and emerging epidemics. The ministry has the QA desk within the HSRS. Currently, the desk only monitors programmatic implementation. There is need to set a QA desk which shall track and offer guidance on quality of services rendered at a much broader base.

### 3.2.4 Medicament, Reagents and Supplies:

**Procurement of Medicines and related pharmaceuticals:** are governed by the Zanzibar National Medicine Policy (2008) and the essential drug list. In addition, several guidelines have been developed to translate the implementation of Health policy. Danida was the main partner (since 2004) supporting the procurement of essential medicine, medical and non-medical supplies for the Ministry. The support covered almost 85% of the actual demand. In 2011, the MoH experienced a major stock out of medical supplies all over the islands which led the government to secure emergency funds so as to rescue the situation. In the financial year 2012/13 the GoZ has paid much attention in this particular area and allocated sufficient fund which were complimented by Danida. Episodes of drug stock outs and, at times, stocks piling of medicines are experienced due to dependence on single supplier (Medical Store Department- MSD) and inadequate routine information about drug consumption levels to enable proper quantification of drug requirements i.e. drug forecasting challenges. Additional factors that challenges the procurement system for medicament and supplies include; lengthy procurement processes, poor specifications, weak logistical information systems, inadequate and unpredictable funding for medicines and inadequate infrastructure contribute to shortages of drugs

**The Logistic supply** system in the MOH over the years has encountered a lot of inconveniences. The supply was of wrong quantities at the wrong place and times and sometimes of questionable quality. Receiving through the “push” system, a standard kit assembled by MSD and pushed to Primary Health Care facilities regardless of whether they were ordered or not; the contents and quantities were always fixed. To many implementers it was a supply of unwanted items. Due to the observed short comings from this system it was recommended to change the system of supply and hence the pull system was introduced in piloted health facilities. This will be scaled up based on the piloted result to all 134 public health
facilities so as to meet the needs of all Zanzibari. The Zanzibar Integrated Logistic Supply System (ZILS) has now been scaled up countrywide but the challenges remains strengthening of security at HFs premises, monitoring compliance of rational drug use practices by health providers and integrating ZILS data and information with HMIS.

**Equipment and Transport**

Presently there is no comprehensive guideline for medical and non medical equipment within the MOH; however there is an existence of standard lists of equipment in specific units/departments. The Health care Engineering Unit is responsible for the maintenance of all equipment within the Ministry. Transport services are being coordinated by the transport officer although national programs are overseeing their own vehicles. Key challenge is that the unit is headed by a non-qualified officer e.g. someone with recognised qualification from institute of transport management. The coverage of communication materials have been improved whereby internet services are available to all PHCC. There is minimum coverage of telephone and fax services at all levels. A major foreseeable challenge lies on sustaining such these noble interventions. Worn out ambulances and other key transport equipment majority of which are procured through partners [donor support]

3.2.5 **Health Care Financing and Sustainability:**

Health care financing is much more than a matter of raising money for health. It is also a matter of who is asked to pay, when to pay, and how the raised money is spent. In order to realize the policy objectives of accessible equitable and affordable quality health services we need to have a well functioning health financing system. In recognizing this, the Ministry through its strategic plans I & II, has proposed to carry out studies on acceptability and affordability to explore different health care financing options funding and provide health care services to the people. The implementation of most recommended options remain in vain

3.2.6 **Health Information and research:**

3.2.6.1 **Health information**

Monitoring and evaluation together are essential tools to systematically track implementation of planned activities, assess results and based on the results, provide evidence based decisions on how strategies have worked to realize the planned results.

During the implementation of the previous Strategic Plan, monitoring was done predominantly by programs and progress was tracked though sector performance. It was however; revealed that evaluation exercises were not being planned and systematically carried out by many programmes unless initiated by donors to see the impact of their funding. At central level, no comprehensive monitoring and evaluation mechanism is in place and the current M&E system cannot efficiently track quality of rendered services in line with international standards.

The establishment of Health Management Information System (HMIS) where service related data captured is identified as one amongst the major achievements of health sector in terms of having in place the organized health information. Despite some existing gaps in terms of quality of generated information,
the unit is providing almost all service related data which is the mainstay of the health sector as service oriented entity. Data collection is now centralized and service data are managed and reported from a single repository - avoiding excessive data collection, overloading of staff, uncoordinated formats, duplication, inconsistencies and same data being erroneously reported differently at different times.

The data management system which is said to be an “Open Source” allows data entry through Access database and analysis using Excel spreadsheet whereby users enjoy production of variety of cross-tabulations, data element calculations and measurement of different indicators using pivot tables.

A tangible product that the Ministry and different users are proud of, is the well informative Health Information Bulletin produced annually at HMIS and readymade reports on various health issues through customary reports or special designed reports available on request. While HMIS is covering data on communicable, non-communicable diseases, the Epidemiology Unit is capturing and reporting data on epidemics and outbreaks. These two units (HMIS and Epidemiology) are major thrusts currently in place that can support providing part of essential information required to furnish the proposed central M&E system.

The main challenges facing the M&E section include:

i. Incomplete data coverage with some data components from health sector like human resource data, laboratory, medical stores information and service related information from some of private health facilities remain uncovered.

ii. The Medical Record Unit responsible for in and out patients’. Collected data at MMH is not known whether it is under the control of HMIS or MMH, though the work of data collection and management for the whole health sector is said to be under the mandate of HMIS. Hence there is need to smooth this out.

iii. There is lack of commitment and cooperation to some clinicians especially at MMH where a number of diagnosis are left unfilled and there seem to be inadequate support from the ministry for establishing medical records in Pemba and scaling up such records in other hospitals.

iv. Acute shortage of competent staff for effective undertaking of HMIS activities. Key staff required includes Biostatistician, Epidemiologist and Demographer with one extra IT expert to comprehensively collect, computerize, analyze, interpret, disseminate health information and advice the ministry on necessary actions to be taken based on the evidence depicted from such information.

3.2.6.2 Zanzibar Medical Research

Published Information on medical research in Zanzibar have been documented as early as in 1920. To date multitude of medical research, assessment and intervention have been undertaken, documented and published. Despite such a realization the capacity to undertake research in Zanzibar is very limited. These challenges are being faced both at individual and institutional levels. This led WHO to undertake in-house training to research committee members on ethical matters so that the committee could be registered as a recognized Institution Review Board [IRB]. This has in turn built up the capacity to review and reach wise decision on submitted protocols as outlined in the table below.
Table 5: Reviewed Protocols by ZAMREC from 2011 – June 2013

<table>
<thead>
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<th>REVIEWED PROTOCOLS</th>
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<td>Approved protocols</td>
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<td>Disapproved</td>
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</tbody>
</table>

**Achievements:**

The main achievements of the undertaking research within the health sector include:

i. Raised awareness to the MOH that research is part and parcel of development in treatment and care of patients, control of communicable and non-communicable diseases and the management of health services in general.

ii. Raised awareness that all medical and health related research protocols need to be reviewed by independent expert committee for the scientific value, relevance and ethics in the Zanzibar context.

iii. Initiated links with local and external investigators and research institutions.

iv. Development of the Standard Operating Procedures (SOPs) complying with the internationally recognized guidelines as required for Ethics Review Committee.

v. Establishment of its own website.

**Challenges:** key challenges facing the health sector in designing, overseeing and ensuring quality ethical health research include:

i. Notable attrition of ZAMREC members plus part time and voluntary work of the committee members has weakened the committee’s integrity and activities.

ii. Lack of a budget line for ZAMREC in the Health sector Annual budget which has made it difficult to perform some of its important tasks e.g. active monitoring of researches through oversight visits to ensure adherence of health research ethics.

iii. Lack of permanent employees (supporting staff) to serve the day to day administrative duties.

iv. Lack of appropriate office building with enough space for holding its regular meetings.
3.3 Burden of Diseases [BOD]

Zanzibar is still observing high level of burden of diseases. Furthermore, the period of implementing ZHSPII noted a dramatic shift in disease patterns in Zanzibar. There has been a downward trend on some of the infectious diseases. This shift has also been accompanied by an upsurge of Non-communicable diseases. In view of this, Zanzibar is undergoing transition on the nature and type of diseases that are being currently reported and managed. This has been partly attributed by societal changes and shifts to middle levels of income in line with the incremental national growth.

Traditionally, Zanzibar has been documenting unacceptably high maternal Mortality Ratio [>230/100,000 live births], high under-five mortality rates and also notable epidemics of vaccine preventable disease particularly measles. Appreciably, Zanzibar has successfully control Malaria transmission and accompanying complications. Previously, malaria was among the leading top ten diseases. It used to contribute highly on OPD attendance [contributing > 40%], higher rates of hospital admission [especially for the underfives], a major cause of haemolytic anaemia [iron deficiency anaemia] and even death. The burden of HIV and TB is still around 1% though there are signs that HIV is slightly on the increase especially in urban settings. It is envisaged that the introduction of treatment as prevention strategy coupled by high BCC and focused programmatic intervention on Key populations might help Zanzibar to realise the three zero strategy.

The most commonly newly reported diseases among the underfives include: Upper Respiratory Tract Infections (URTI), Pneumonia, Diarrhoeal disease (exclude cholera and dysentery), skin diseases, conditions of the Ears Nose and Throat (ENT) and Head and neck, Intestinal worms, Eye diseases, Urinary Tract Infections (UTI), Trauma/ Injuries, Chicken pox, Dental diseases, Anaemia, (Moderate Acute Malnutrition) and Dysentery [see figure below].

Figure 1: Top Reported Diagnosis for Children Under 5 Years in Zanzibar

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On the other hand, the most common diagnosis for new patients 5 years and above reported from all health facilities (private and public) are URTI, ENT head and neck, Skin other than leprosy, pox, Diarrhoea (other than cholera and Dysentery), Dental Diseases, Trauma/Injuries, UTI, Intestinal worms, hypertension and eye diseases as reflected in figure below:

Figure 2: Top Reported Diagnosis for New Patients of 5 Years and Above in Zanzibar

Despite documented vaccination coverage, Zanzibar still do document pocket of measles outbreaks particularly in areas where coverage is low or among the unvaccinated. For example in 2011 there was outbreak in Zanzibar where a total of 1,211 Measles cases were reported. Out of these their vaccination statuses were as follows: 274 were vaccinated, 621 were unvaccinated and 316 were unknown. Fortunately the epidemic was not accompanied by any fatality. Chake Chake district in Pemba reported highest number of measles cases. Similarly, the West district in Unguja also reported highest number of measles cases.

The disease burden associated with Cholera has been highly reduced due to massive administration of oral cholera vaccine accompanied by a relative improvement of sanitary services. In 2011 there was no single case of cholera reported at any health facility in Zanzibar, whereas in previous years cholera epidemics were experienced (605 cases in 2009 and 248 cases in 2010) as reflected in table below:

Non-Communicable Diseases [NCD]:

Diabetes is one among the emerging Non Communicable Diseases (NCDs) affecting all age groups and both sexes. In the past few years, this disease had been increasing dramatically with multiple complications such as neuropathy, heart diseases and strokes, eye complications leading to blindness and diabetic foot ending in amputation. In 2011, a total of 6,474 patients were registered at Mnazi Mmoja
Diabetic clinic. Of whom 44.04% were male while 55.96% were female. Children made 1.96% of the newly diagnosed clients. Furthermore, among the documented diabetic complication entails: Hypertension [44.8%], diabetic neuropathy (30.7%), erectile dysfunction [10.0%], diabetic foot [7.1%] and Diabetes in pregnancy [3.2%]. Zanzibar has documented an increase in cancers especially cervical and breast cancers and the trend is on the rise.

Report from Police headquarters Zanzibar indicates a high number of deaths due to Road Traffic Accidents (RTA): 2009 a total number of RTA was 834 and 98 deaths; 2010 total RTA 931 with 115 deaths and 2011 total RTA 849 with 81 deaths.

For three consecutive years Zanzibar’s top ten causes of admission remain almost the same. In 2011 pneumonia became the leading cause of hospitalization [16.2%] followed by diarrhea disease [16.1%]. Hypertension [7.2%] and diabetic [2.2%] are also among the NCD that are also leading causes of hospitalization. As in past few years, malaria did not appear in 2011 leading ten causes of admissions

Zanzibar hospital fatality rate in general has decreased from 4.1% (2010) to 3.3% (2011) for all reported diseases\textsuperscript{20}. Hospital fatality rate has decreased dramatically in Pemba Zone from 7.7% (2010) to 3.5% (2011) while in Unguja zone there has been a slight increase from 2.6% (2010) to 2.9% (2011). Leading cause of hospital deaths include: pneumonia [9.0%], Severe Anaemia (7.0%), Hypertension (6%), septicaemia (4%) and Cerebral Vascular Accident (4.0%) as outlined in the figure below:

\textbf{Figure 3: Top Ten Causes Of Deaths in Hospitals, 2011 (N = 1943)}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure3.png}
\caption{Top Ten Causes Of Deaths in Hospitals, 2011 (N = 1943)}
\end{figure}

\textsuperscript{20} ibid
3.4 Health care services delivery in Zanzibar.

Zanzibar has a good distribution of public health facilities while the distribution of private health care facilities is predominantly noted in major towns and municipalities of both Unguja and Pemba [see GIS map below]. The facilities are of different levels which allow easy access to health care services. However, in recent years there has been enormous increase of private health facilities especially in Urban and West district. These have created a backup and plays complementary role especially when there are service shortages in public facilities.

Figure 4: Distribution of health facilities in Zanzibar [public & non-public facilities]^{21}
The public sector has been gradually (since 1970) expanding its infrastructure aiming at having in place equitable distribution of facilities. To date about 95% of the population is living within or less than a 5km radius to a public health facility. Currently, the Geographical distribution of health infrastructure in Zanzibar is 100 PHCU, 34 PHCU+, 4 PHCC, 3 District hospital, 2 specialized hospitals and 1 tertiary hospital (See figure No.xx below)

Figure 5: Levels of health care service provision

![Levels of health care service provision](image)

a. **Primary Health Care**: This is the level whereby basic health care services are provided; it is also the level in which health promotion activities are mostly carried out. Such activities include, integrated RCH packages (immunization, reproductive health, PMTCT), sanitation and hygiene, nutrition etc. The services are routinely taking place at facility and community level. Services provided in the community include outreach program for immunization, growth monitoring, Home-Based Care and health promotion activities through health education sessions, school health and health inspections.

The health facilities at this level are of 3 types: PHCU, PHCU+ and PHCC. These facilities provide services as indicated in EHCP for primary level. The selected 34 PHCU+ are designated to provide

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additional services such as delivery, pharmaceutical, laboratory and dental services. Currently, only 1 PHCU+ is providing the full set of services while delivery services are provided in 18 PHCU+s and 5 PHCUs (Table 1 above). PHCC act as referral level for PHCUs and PHCU+ which provides in and outpatient services. Diagnostic services including ultra sound and X-Rays is also part of OPD services provided at this level. PHCCs have the average capacity of 30-beds.

b. **Secondary care:** This level consisted with district hospitals. These facilities are only located on Pemba Island. There are a total of 3 district hospitals that serve a 2nd referral level. The hospitals have the capacity of 80-120 beds. The services provided at this level are in-patient medical and basic surgical services, Radio-diagnostic services particularly x-ray, laboratory, pharmacy, psychiatric and ambulance support along with primary care services. In addition, clinicians assess, manage and refer emergency cases to the next higher level service delivery point.

c. **Tertiary care** facilities include 2 specialized and one referral hospitals. The specialized hospitals are Mwembeladu maternity home (with 34-bed capacity) and Kidongo Chekundu psychiatric hospital (110-bed capacity), which are managed by the referral hospital, Mnazi Mmoja hospital (MMH – 400-bed capacity). In Pemba, Chake Chake hospital serves as the main referral hospital for other district hospitals and PHCCs in Pemba. While MMH serves as the national referral hospital for Zanzibar.

3.4.1 **Mnazi Mmoja Hospital:**

MMH is the main referral hospital for Zanzibar but it also stands as a directorate by itself. It has a bed capacity of 546 spread over three campuses. While it provides specialty care to all of Zanzibar, MMH chiefly operates as a primary and secondary level hospital for the island of Unguja, especially the North B, West, Urban, and Central populations all of which lack adequate access to cottage or district hospitals. About 95% of all outpatients at the hospital are self-referrals and only about one third from the Urban District, making the Hospital largely a primary health care facility.

MMH has 18 clinical departments/units (MMH campus); including internal medicine, pediatrics, obstetrics and gynecology, surgery, orthopedics, ophthalmology, otolaryngology, dentistry, radiology and laboratory. MMH runs several specialty clinics each week including gynecology, surgical, ENT, acupuncture, physical and occupational therapy, diabetes and hypertension and HIV/STD clinics. It also has two campuses (Mwembeladu Maternity Home and Kidongo Chekundu mental Hospital).

Service provision in most of the departments, especially intensive care and neonatology, is limited either due to the deficiency of qualified clinicians, appropriate equipment or often both.

MMH operates at a bed occupancy level of approximately 70% although the pediatric and obstetrical units operate at 90 – 110% occupancy while the medical and surgical wards have significantly lower bed occupancy rates. Also, patient demand for surgeries is higher than the amount of services provided because of staffing shortages. The mental hospital operates at an occupancy rate of 50% - 60% of total beds but almost half of their beds are not operational due to disrepair of the ward making the true occupancy rate closer to 100%. The main conditions attended at the hospital include diarrhoea disease, incomplete abortions and maternal conditions, hypertension, respiratory infections, urinary tract infections, trauma and anaemia.
Key challenges identified during the assessment include; inadequate financial resource allocation, limited skilled human resource to offer quality health care services, poor health care attitudes, inadequacy of governing ethical bodies to respond to high quality of service provision in line with good clinical practices. Additional challenges include: insufficient infrastructure, old and outdated equipment [also absence of some essential equipment] at various levels of service delivery, absence of reliable transportation system, and limited engagement of e-health.

3.5 Performance Of Sampled Health Programmes [2006-2011]:

Majority of public health services are rendered through respective programmes and or in collaboration with Health management teams in Zanzibar. In view of the complexity of programmes and programme needs, the MoH has merged some related programmes. This has been done after considering programme commonalities, their contribution to realising MKUZA II and MDGs, the existing human resource base, maximising efficiency and the potentiality of offering comprehensive one roof services in the very near future. Outlined below are some of the key public health interventions which provided basis for the formulation of HSSP-III. These include:

3.5.1 Zanzibar Malaria Control Programme [ZMCP]

The programme has strived to maintain the prevalence below1% through various interventions. These Heavy strategic investments on malaria mitigations included: Increased malaria surveillance for pre-elimination phase through Malaria Early Epidemic Detection System [MEEDS], proper malaria case management using combination therapy and parasitological diagnosis, Indoor Residual House spraying, Enhanced entomological surveillance [including vectorial capacity assessment], Larvicidng, Continuous Distribution of Long lasting insecticide treated mosquito nets and enhanced community engagement in malaria elimination strategies. These investments have been increased on annual basis for a decade with positive outcomes [as outlined in the figure below]:

![Figure 6: Malaria Interventions coverage and impact](image)

On the other hand, Entomological surveillance on vectorial capacity has been consistently reported low Sporozoite rates. Unguja has reported zero Sporozoite rate for the last two years in all seven sentinel sites while the rates for Pemba had been 0.01% for 2010/11 respectively.
Malaria related Morbidity: A close follow up on malaria disease patterns showed, a down ward malaria specific admission trend in all Malaria sentinel hospitals as reflected in the graph below.

Figure 7: Malaria Admissions at Zanzibar Hospitals (n=7), 1999 – 2011

Source: Zanzibar Malaria Control programme: 2012

Malaria Mortality: the reduction of Malaria morbidity and hospitalization was accompanied by an increase on survivability [malaria related longevity and death aversion] on highly studied Malaria endemic areas which are also been marked as sites with poor socio-developmental indicators. These areas are north A and Micheweni as reflected in Kaplan-Meir curves in figures below

Figure 8: Age-specific cumulative mortality* per 1000 live births in North A and Micheweni, 1999 - 2008
Figure 9: Kaplan-Meier survival curves for children born during the pre- and post-intervention periods in North A.

Figure 10: Kaplan-Meier survival curves for children born during the pre- and post-intervention periods in Micheweni.
Generally, Comprehensive Malaria interventions have resulted in a significant decrease of Malaria associated mortalities in Zanzibar as reflected in the figure below. This downward trend is for the period of a decade.²³

Figure 11: Trends of Malaria deaths to persons below and above 5 years in Zanzibar from 2002 – 2012

²³ Data from Zanzibar Malaria Control Programme [ZMCP]
Table 6: Summary of ZMCP Activities from January 2007 to June 2012

<table>
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<td>75.88</td>
<td>93.3</td>
</tr>
<tr>
<td>Specificity</td>
<td>94.02</td>
<td>94.0</td>
<td>97.43</td>
<td>97.43</td>
<td>98.06</td>
<td>99.87</td>
</tr>
</tbody>
</table>

In 2011, Malaria seasonal fluctuation was observed in some health facilities which led to an increase of confirmed cases. This situation has settled down in 2012. On the other hand children underfives are less affected compared to those aged five years and above. In general malaria cases have been stable especially in recent years.

<table>
<thead>
<tr>
<th>Entomology sentinel sites (7) monitored</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outdoors catch</td>
<td>606</td>
<td>602</td>
<td>660</td>
<td>770</td>
<td>166</td>
</tr>
<tr>
<td>Indoor catch</td>
<td>354</td>
<td>151</td>
<td>553</td>
<td>290</td>
<td>112</td>
</tr>
<tr>
<td>Pit trap catch</td>
<td>395</td>
<td>467</td>
<td>416</td>
<td>314</td>
<td>96</td>
</tr>
</tbody>
</table>

Sporozoite rate on Unguja has been consistently zero reported for the last two years in all seven sentinel sites while on Pemba was 0.01 for 2010/11. This is in line with epidemiological data for prevalence and positivity rate at a rate of less than one percent indicating decreased malaria transmission on both islands.

<table>
<thead>
<tr>
<th>Health facilities timely reporting on MEEDS data</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>-</td>
<td>3(32%)</td>
<td>10 (19.2%)</td>
<td>21 (24%)</td>
<td>23 (43.2%)</td>
</tr>
<tr>
<td>Weekly report</td>
<td>-</td>
<td>10(100%)</td>
<td>43(84%)</td>
<td>90(100%)</td>
<td>90(100%)</td>
</tr>
</tbody>
</table>

Number of positive cases reported and investigated/confirmed from (144) public and (3) private facilities

<table>
<thead>
<tr>
<th>Number of positive cases reported and investigated/confirmed from (144) public and (3) private facilities</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaria prevalence (%)</td>
<td>0.8</td>
<td>No household survey</td>
<td>No household survey</td>
<td>0.07 (Malaria Indicator Survey)</td>
<td>No survey</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of LLINs distributed for malaria prevention</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>LLINs distributed across Zanzibar</td>
<td>24,520</td>
<td>196,442</td>
<td>92,983</td>
<td>29,853</td>
<td>32,440</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of community group at Shehia level trained on malaria interventions</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td>CORPs Trained</td>
<td>20</td>
<td>15</td>
<td>8</td>
<td>15</td>
<td>27</td>
</tr>
</tbody>
</table>

Source: ZMCP-2012
3.5.2 Integrated Reproductive and Child Health Programme [ZIRCHP].

The programme has been integrated to include four [4] key programmes with the aim of providing holistic and integrated services to women and children. The integrated programmes include:

   i. Reproductive and Child health [RCH] inclusive of family planning services
   ii. Expanded Programme of Immunization [EPI]
   iii. Integrated Management of Childhood Illness [IMCI]
   iv. Prevention of Mother to Child Transmission of HIV [PMTCT] that was formally under the ZACP

Main challenges facing IRCH particularly in the area of Reproductive and Child Health is the use of family planning method (modern) and increased number of home deliveries. Despite a huge number of unmet needs (35%) for family planning service, use of modern contraceptive is unsatisfactory. The 2010 TDHS indicates the prevalence rate of Family Planning stands at 12.4%. The observed rate has a minimal increase of 2% compared to the last survey 2004/05 TDHS. The fluctuation of high MMR could be also associated with high rate of pregnant mothers who delivery at their home places. The 2010 TDHS depicts more than half of deliveries are home deliveries [not attended by skilled /trained attendants].

The Maternal, Newborn and Child Health Status:

Recent midterm assessment on the Road Map operational targets provides an indication which corresponds to what was noted in the Tanzania Country Report on the Millennium Development Goals (2010). The report revealed that MDG 4 was on track and might be achieved whereas the MDG 5 appeared to be off track and may not be achievable by the year 2015 respectively.

In reviewing the progress on MDG 4 which aims at reducing child mortality, three operational targets were reviewed; these were:

   a. The Under five mortality rate,
   b. the Infant mortality rate, and
   c. The Immunization coverage of DPT HB3 and Measles vaccine.

All these showed the trend of U5MR slowly going down. Similar downwards trends have been observed for the Infant Mortality Rate and Immunization coverage as depicted on Fig x and FigY below respectively. The trend looks promising.

---

Figure 12: Trends of Under five Mortality Rate in Zanzibar from 2005 to 2010

Source: HMIS 2008; TDHS 2010

Figure 13: Trends of Under five Mortality Rate in Zanzibar from 2005 to 2010

Source: DHS 2008; TDHS 2010
Figure 14: Immunization trends of DPTHB3 and Measles Coverage 2008 to 2011

Sources: HMIS/TDHS

However, the MDG5 as stated above, review process analysed the two indicators namely Maternal Mortality Ratio and Proportion of Births Attended by Skilled Health Personnel. Figure xxx and yyy shows the trend of these two indicators which do not appear promising to be realised in the very near future [2015]. Rigorous efforts are required to reach 2015 targets.
Figure 15: Trends of MMR in Zanzibar (Institutional) from 2008 to 2011

Source: HMIS 2008, 2010 and 2011

Figure 16: Proportion of Births attended by skilled health personnel in Zanzibar

Source HMIS 2008, HMIS 2011
Main challenges facing IRCH include a huge number of unmet needs especially for family planning service. High coverage on FP services is on Depo-Provera but this decreases markedly when one looks

<table>
<thead>
<tr>
<th>S/no.</th>
<th>Unit measure</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>Family planning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td>Family planning new clients acceptance %</td>
<td>3.4</td>
<td>4.3</td>
<td>3.8</td>
<td>3.3</td>
<td>5.25</td>
<td>5.3</td>
</tr>
<tr>
<td>1.2</td>
<td>Injection Depo #</td>
<td>59,726</td>
<td>62,454</td>
<td>151,543</td>
<td>67,992</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3</td>
<td>Oral contraceptive #</td>
<td>16,945</td>
<td>17,002</td>
<td>56,642</td>
<td>21,862</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4</td>
<td>Condoms #</td>
<td>3,434</td>
<td>4,958</td>
<td>7,886</td>
<td>2,642</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5</td>
<td>Implanon #</td>
<td>1,774</td>
<td>2,823</td>
<td>4,053</td>
<td>1718</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.6</td>
<td>IUCD #</td>
<td>169</td>
<td>391</td>
<td>293</td>
<td>144</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.7</td>
<td>BTL/MLP #</td>
<td>176</td>
<td>261</td>
<td>71</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>002</td>
<td>Safe motherhood</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>ANC first visit coverage before 16 weeks (HMIS) %</td>
<td>38</td>
<td>33.9</td>
<td>11.5</td>
<td>10.2</td>
<td>19.6</td>
<td>19.5</td>
</tr>
<tr>
<td>2.2</td>
<td>ANC first visit coverage (HMIS) %</td>
<td>93</td>
<td>90.7</td>
<td>79.7</td>
<td>77.3</td>
<td>74.6</td>
<td>83.8</td>
</tr>
<tr>
<td>2.3</td>
<td>Hospital delivery (HMIS) %</td>
<td>38.3</td>
<td>39.7</td>
<td>39.8</td>
<td>42.2</td>
<td>43.2</td>
<td>49</td>
</tr>
<tr>
<td>2.4</td>
<td>Health facilities providing delivery services (HMIS) #</td>
<td>11</td>
<td>16</td>
<td>24</td>
<td>28</td>
<td>35</td>
<td>39</td>
</tr>
<tr>
<td>2.5</td>
<td>Birth attended by skilled personnel (HMIS) %</td>
<td>47</td>
<td>44.5</td>
<td>43.1</td>
<td>48.6</td>
<td>47.1</td>
<td>51.5</td>
</tr>
<tr>
<td>2.7</td>
<td>Maternal Mortality ratio (Facility based) (HMIS) per 100,000 live birth</td>
<td>365</td>
<td>422</td>
<td>279</td>
<td>288</td>
<td>284</td>
<td>221.3</td>
</tr>
<tr>
<td>2.8</td>
<td>Neonatal death (Facility based) (DHS) per 1,000 live birth</td>
<td>29</td>
<td>23</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.9</td>
<td>Post abortion care facilities #</td>
<td>10</td>
<td>10</td>
<td>14</td>
<td>38</td>
<td>41</td>
<td>41</td>
</tr>
</tbody>
</table>

Source: HMIS-2012
for permanent methods. Hospital based delivery has been below 50%. This has been continuously low and somehow correlates with the noted high Maternal Mortality rates as outlined above.

**Immunization coverage:**

The overall immunization coverage (Penta3) dropped from 89 percent in 2010 to 85.2 percent in 2011 which is below the national target (90%). However, three districts in Unguja (South, Urban, and Central) reported to be above coverage. West district has sharp decrease in coverage which alarming for more investigation. All districts in Pemba are below the target except Wete (100%). Zone wise Unguja (92.2%) is above the target while in Pemba (76.7%) is below the target. This calls for more invested efforts so as to mitigate preventable fatalities and accompanying complications

**Table 8: Immunization coverage trends for <1 year old by districts, 2009 to 2011**

<table>
<thead>
<tr>
<th>Antigen</th>
<th>BCG (%)</th>
<th>Penta – 3 (%)</th>
<th>Measles (%)</th>
<th>Fully Immunized (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chake chake</td>
<td>97</td>
<td>114</td>
<td>103</td>
<td>79.1</td>
</tr>
<tr>
<td>Micheweni</td>
<td>82.1</td>
<td>83.2</td>
<td>81.5</td>
<td>66.4</td>
</tr>
<tr>
<td>Mkoani</td>
<td>70.7</td>
<td>76.9</td>
<td>71.7</td>
<td>63</td>
</tr>
<tr>
<td>Wete</td>
<td>109</td>
<td>109</td>
<td>135</td>
<td>88</td>
</tr>
<tr>
<td>Pemba</td>
<td>89.4</td>
<td>95.4</td>
<td>96.2</td>
<td>74</td>
</tr>
<tr>
<td>Central</td>
<td>104</td>
<td>104</td>
<td>115</td>
<td>116</td>
</tr>
<tr>
<td>North A</td>
<td>83.8</td>
<td>86.6</td>
<td>88.2</td>
<td>76.3</td>
</tr>
<tr>
<td>North B</td>
<td>81</td>
<td>87.5</td>
<td>88.8</td>
<td>73.2</td>
</tr>
<tr>
<td>South</td>
<td>81</td>
<td>86.4</td>
<td>97.8</td>
<td>112</td>
</tr>
<tr>
<td>Urban</td>
<td>214</td>
<td>201</td>
<td>213</td>
<td>90.3</td>
</tr>
<tr>
<td>West</td>
<td>114</td>
<td>122</td>
<td>98.5</td>
<td>102</td>
</tr>
<tr>
<td>Unguja</td>
<td>133</td>
<td>132</td>
<td>127</td>
<td>99.9</td>
</tr>
<tr>
<td>Zanzibar</td>
<td>112</td>
<td>114</td>
<td>113</td>
<td>87.5</td>
</tr>
</tbody>
</table>

*Source: HMIS bulletin -2011*
Prevention of Mother to child transmission of HIV:

PMTCT services were initiated in Zanzibar in July 2005. Since then access to PMTCT services has increased such that services are accessible to all facilities as reflected in table below. The programme has also shifted from mono-therapy coverage to drug multi drug coverage. Based on projections, around 80% of pregnant women are currently accessing PMTCT services in Zanzibar. Generally, there is a downward trend on the diagnosed HIV pregnant women in the last five years. Moreover, there is an increase in number of exposed infants who are tested for vertical HIV transmission and on average vertical transmission is around 7.02%. This is extremely high in line with invested efforts and in realizing the three zero goal.

Table 9: Provision of PMTCT services from 2007 – 2012

<table>
<thead>
<tr>
<th>PMTCT</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of sites</td>
<td>9</td>
<td>15</td>
<td>29</td>
<td>39</td>
<td>50</td>
<td>140</td>
</tr>
<tr>
<td>Women tested</td>
<td>18,109</td>
<td>30,836</td>
<td>38,464</td>
<td>40,187</td>
<td>35,181</td>
<td>32,996</td>
</tr>
<tr>
<td>Women tested positive</td>
<td>228</td>
<td>337</td>
<td>309</td>
<td>269</td>
<td>357</td>
<td>218</td>
</tr>
<tr>
<td>Percentage positive among the tested pregnant women</td>
<td>1.26</td>
<td>1.09</td>
<td>0.80</td>
<td>0.67</td>
<td>1.01</td>
<td>0.66</td>
</tr>
<tr>
<td>Women received Nevirapine</td>
<td>234</td>
<td>251</td>
<td>292</td>
<td>265</td>
<td>276</td>
<td>177</td>
</tr>
<tr>
<td>Infant tested for PCR</td>
<td>-</td>
<td>124</td>
<td>158</td>
<td>196</td>
<td>185</td>
<td>143</td>
</tr>
<tr>
<td>Infant PCR positive</td>
<td>-</td>
<td>13</td>
<td>14</td>
<td>6</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
<td>Percentage of infants diagnosed with HIV</td>
<td>-</td>
<td>10.48</td>
<td>8.86</td>
<td>3.06</td>
<td>10.81</td>
<td>3.50</td>
</tr>
</tbody>
</table>

3.5.3 Integrated HIV/ AIDS, TB & Leprosy Control Programme

The programme has scale up its HCT services by nearly three-fold [from 27 VCT sites in 2007 to 76 sites -2012]. Also the number of clients seen has also increased. Similarly the HBC coverage has increased 2.2 Folds and works closely with CSO and CBOs with FBO engagement. Similar observations have been noted under PMTCT services and the programme has strived hard to cover the key populations [namely the Commercial Sex Workers [CSW], Injecting Drug User [IDU] & Men who have Sex with Men [MSM]]. These special programmes have been introduced in 2010 [Table 10 below].

A good coverage of people who access care [94%: 6793 from the projected 7200]. The numbers who access ART have been on steady increase. The same is noted on children who access ART. Number of

25 By definition: anyone aged <14 years who access HIV/AIDS care and treatment services.
exposed children who undergo PCR for Early infant diagnosis has been relatively the same with year 2011 documenting high vertical transmission 10.8% [20/185] HIV infection monitoring through different surveillance patterns in both, the general as well as the key population has remained within the same patterns.

Table 10: Summary of integrated Zanzibar AIDS control Programme activities from January 2007 to September, 2012

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HCT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of sites</td>
<td>27</td>
<td>30</td>
<td>43</td>
<td>47</td>
<td>56</td>
<td>76</td>
</tr>
<tr>
<td>People counsel and tested</td>
<td>29,687</td>
<td>34,140</td>
<td>59,071</td>
<td>79,650</td>
<td>88,071</td>
<td>61,270</td>
</tr>
<tr>
<td><strong>HBC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of districts with HBC services</td>
<td>-</td>
<td>8</td>
<td>10</td>
<td>10</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>People served</td>
<td>-</td>
<td>964</td>
<td>213</td>
<td>1697</td>
<td>1862</td>
<td>2199</td>
</tr>
<tr>
<td>No of HF with HBC providers</td>
<td>-</td>
<td>123</td>
<td>123</td>
<td>123</td>
<td>123</td>
<td>127</td>
</tr>
<tr>
<td><strong>STI</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of sites</td>
<td>44</td>
<td>44</td>
<td>44</td>
<td>50</td>
<td>228</td>
<td>228</td>
</tr>
<tr>
<td>People treated</td>
<td>674</td>
<td>1131</td>
<td>1885</td>
<td>1008</td>
<td>21143</td>
<td>3486</td>
</tr>
<tr>
<td>MARPs activities MSM Tested</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>374</td>
<td>572</td>
<td>238</td>
</tr>
<tr>
<td>FSW Tested</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>513</td>
<td>503</td>
<td>299</td>
</tr>
<tr>
<td>IDU Tested</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>363</td>
<td>346</td>
<td>35</td>
</tr>
<tr>
<td><strong>CTC</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of sites</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>8</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>No enrolled Adult and children</td>
<td>1984</td>
<td>2868</td>
<td>4451</td>
<td>3472</td>
<td>5935</td>
<td>6793</td>
</tr>
<tr>
<td>No on ART Adult and children</td>
<td>882</td>
<td>1322</td>
<td>2174</td>
<td>2866</td>
<td>3185</td>
<td>3868</td>
</tr>
<tr>
<td>Children enrolled</td>
<td>211</td>
<td>284</td>
<td>369</td>
<td>441</td>
<td>532</td>
<td>587</td>
</tr>
<tr>
<td>Children on ART</td>
<td>93</td>
<td>143</td>
<td>190</td>
<td>235</td>
<td>300</td>
<td>376</td>
</tr>
<tr>
<td><strong>LABOARTORY SERVICES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No of lab providing supporting CTC</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>8</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>CD4 tests done</td>
<td>1651</td>
<td>2296</td>
<td>2921</td>
<td>4449</td>
<td>4824</td>
<td>3709</td>
</tr>
<tr>
<td>CD4 test results &gt; 200cells/µl</td>
<td>520</td>
<td>592</td>
<td>680</td>
<td>940</td>
<td>617</td>
<td>1142</td>
</tr>
<tr>
<td><strong>STRATEGIC INFORMATION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANC Surveillance</td>
<td>-</td>
<td>0.89%</td>
<td>-</td>
<td>0.6%</td>
<td>0.6%</td>
<td>-</td>
</tr>
<tr>
<td>RDS STUDY ON MARPS [IBBSS]</td>
<td>MSM: 12.3%</td>
<td>FSW: 10.8%</td>
<td>IDU: 16%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>MSM: 2.6%</td>
<td>SW: 19.3%</td>
<td>IDU: 11.3%</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

*Source: ZACP- 2012*
3.5.4 Primary Eye Care Services:

With the exception of 2008, 2011 and 2012, all years (2006 – 2012) the number of clients covered for OPD has remained high. Good results have also been recorded for outreach services. Access to cataract surgery has also been good as reflected in Table 11 below. Community education campaigns as well as paediatric accessing cataract surgery has also been on the increase. Early screening for children and early correction adds value to families and the public at large.

Table 11: Summary Report of Eye Care Activities from January 2007 to 2012

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL PATIENTS TREATED IN HOSP/OUT REACH.</td>
<td>35,063</td>
<td>41,777</td>
<td>4,517 Outreach only</td>
<td>38,521</td>
<td>33,826</td>
<td>16,656</td>
<td>5,632 Outreach Only.</td>
</tr>
<tr>
<td>OPTHALMIC OPERATION DONE</td>
<td>527 Cataract</td>
<td>813 Cataract</td>
<td>865 Cataract surgery done</td>
<td>881 Cataract surgery done</td>
<td>377 Cataract surgery done</td>
<td>837 Cataract 263.Glaucoma</td>
<td></td>
</tr>
<tr>
<td>PAEDIATRIC CATARACT SURGERY</td>
<td>0</td>
<td>0</td>
<td>38 children referred to Muhimbili for surgery.</td>
<td>63 Referred to Muhimbili for surgery.</td>
<td>19 children operated at MM Hosp. by MCBI.</td>
<td>30 Children were operated.</td>
<td>13 children operated</td>
</tr>
</tbody>
</table>

3.5.5 Inspection (Water and Food safety)

The Zanzibar inspection system is characterized by the existence of multiple agencies with overlapping mandates and with little collaboration among themselves. This leads into an inefficient use of resources due to duplication and gaps in the coverage of important food safety issues. Within the health sector there are different units which are engaged on food inspection activities. These include the ZFDB, DHMTs, Environmental Health Unit and Epidemiology Unit. Concurrently, Ministries responsible for livestock and fisheries, trade ministry, Zanzibar Municipality and District Councils do undertake the same duties and at times within the same institutions.

There are number of legislations that are currently operating and at times contradicting and or overlapping each other. These developed laws govern food safety, quality and security; but also there has been a huge overlap amongst those legislations leading to unclear line of responsibilities among various actors. In addition, necessary means to ensure the safety of water and food has been inadequate. This includes lack of adequately trained human resources as well as poor inspection and laboratory monitoring facilities.

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26 SITRAN report- MoH, 2012
3.5.6 **Hygiene and Sanitation**

Various participatory approaches addressing hygiene and sanitation have been introduced for adoption targeting at community behavioral changes. The major anticipated outcome is positive behavioural change linked to people’s knowledge. As a result, the engaged approaches have minimal influence in behaviour changes as applied methods predominantly engages IEC techniques rather than BCC intervention strategies. Issues such as community socio-economic status, availability of hygiene and sanitation options/facilities, environmental/geographical status and community values were not considered during the planning and operational phases. To date, most of these approaches have yielded only community awareness than bridging sustainable behaviour changes.

Based on programmatic improvement and introduction of PHAST and mass Oral cholera vaccination, trends in transmission of cholera, diarrhea, and worm infestation in some areas have declined.

3.5.7 **Occupational Health Unit**

A challenging observation noted is based on the fact that more than one institution is doing premises inspection though with different objectives [see Table 12]. There is an overlap on premises inspection that is being dealt with by ZFDB [mandated by law], Occupational health and epidemiology unit but the teams/units do not collaborate or coordinate their field findings. HSSP-III need to address this and harmonise the inspection guideline and re-define individual roles in line with the Public health Act, 2012.

Concurrently, the same contradicting roles are noted between the occupational health unit and the Department of Occupation safety of MLEC. The current, OSH guideline should address these issues.

<table>
<thead>
<tr>
<th>Table 12: Data on Occupational Health Unit Activities from 2006-2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IA</strong></td>
</tr>
<tr>
<td>Hotels, Tea rooms, Food shops, Bakeries, Butchers shops, Factories, Carpentry shops, etc.</td>
</tr>
<tr>
<td>17</td>
</tr>
<tr>
<td><strong>IIA</strong></td>
</tr>
<tr>
<td>Staffs from: Hotels, Restaurant, G. house Bar, Factories, P. companies, Butcher, Bakeries, Food vendors, etc.</td>
</tr>
<tr>
<td>2094</td>
</tr>
</tbody>
</table>

3.5.8 **Medical Waste Management**

Different methods and techniques for disposing health Care Waste have been put in operation at different health care delivery points, but none of them are of optimal quality. At health facility level [lower levels],
medical waste including sharps is dumped without any segregation into an open pit. The pits are usually very shallow and in most cases are not fenced. No land filling technique is applied. Burning of waste and or covering the pits with earth soil is the main waste management method applied at health facility level.

Small scale incinerators were built at Districts and Cottage Hospitals but only few of them are in good functional state. A state of art incinerator has just been installed at Kivunge Cottage Hospital. The incinerator has a long exhaust pipe and with minimal gas emission. Protection of incinerator operators against biological hazards is extremely low. This needs to be addressed in the coming -HSSP-III.

At a tertiary level, the health care waste management has been a great concern due to frequent breakdowns of incinerators. The MMH incinerator is dilapidated and there is an urgent need to install a new one. Currently, medical waste management at MMH [which also offer services for private clinics and hospitals] is not environmental friendly and is done at the banks of the Indian Ocean. With many competing priorities building a case to have increased budget allocation that would allow the procurement of a new incinerator is an additional challenge facing the health sector. Moreover, there is no transportation system or guidelines that prescribe medical waste transportation between points.

3.5.9 Disease prevention (Port Health)

Port Health Services monitors and evaluates all foodstuffs, disinfectants, hazardous substances and medicines entering Zanzibar through official ports. Also the unit monitors and controls the potential importation of contagious diseases. Such these infectious diseases include: yellow fever, cholera, plague, other emerging epidemic [viral etc] and other identified diseases of public health importance. The Port Health in Zanzibar is responsible for the four official seaports (Malindi, Mkokotoni, Wete and Mkoani) and the two airports (Abeid Aman Karume airport in Unguja and Chake Pemba). Additionally, there has been regular inspection of sea vessels that seek entry in Zanzibar. Such vessels are also checked for rodents and a valid De-ratting Exemption Certificate and usually an infected vessel is fumigated. Port health needs to fully implement international health regulations. Efforts to address emerging epidemics and cross border diseases have been invested in collaboration with other MDAs at both regional and country level. Training on IHR implementation has been done to limited number of health staff.

The great challenge faced includes inadequate human resource to undertake these specialized duties as well as existence of varieties of unofficial ports of entry that can hardly be monitored.

3.5.10 Disease surveillance:

Disease surveillance is one of the major priorities of the Ministry. Implementation of IDSR aimed at enhancing capacity for timely and comprehensive responses to disease management efforts. However, decreased budgetary support from the government compromised these primary good intentions. Renewed

\footnote{INCINERATOR MODEL P25 M1 (MEDICAL) - has up to 300kg capacity per batch load and can burn up to 100kg per hour. This unit is a top loading design and has a heavy duty refractory cement lining (rated at over 1500 degree C for maximum heat retention.}
efforts from government and other stakeholders are necessary to sustain and expand progress achieved through implementation of IDSR.

3.5.10.1 Outbreak management and control:

A multisectoral epidemic preparedness and response committee has been formed at a central level and coordinated by the Office of the Second Vice President. The committee has been playing a central role in planning and organizing responses against natural disasters and epidemics while facing challenges in the process. Due to limited resources and lack of comprehensive disaster preparedness plan, it usually takes long before staging a quick and effective intervention while addressing disasters. Furthermore, shortage of skilled staff to effectively manage epidemics is an additional challenge that calls for integrated and orchestrated efforts. In most cases, when disease outbreaks occur, it remains the role of the Ministry of health to control such an outbreak with extremely slim resources.

3.5.10.2 Disaster preparedness

This is among the component that has not been clearly stipulated in the ZHSRSP II. The recent developed policy document on Zanzibar Disaster Management Policy 2011 has highlighted various aspects on public safety for each sector. Moreover, each sector need to define their roles and find out essential linkages in strengthening capacity and collaboration between sectors within Zanzibar based on areas of comparative advantages. The revised Health Policy 2012 has put emphasis on disaster preparedness by putting strategic objectives that will ensure public safety. The health sector has only prepared [partially] herself to address basic disease related epidemics. These are mostly those of traditional health related nature such as cholera and measles.

Management of Disasters including Epidemics is another area that lack skilled staff to effectively provide the needed services when need arise. The Ministry faces challenge to integrate and coordinate efforts for managing different situations. In most cases, when disease outbreaks occur, it remains the role of the Ministry of Health to control such an outbreak with extremely slim resources. There is need to strengthen health sector response to disaster especially in terms of Physical infrastructure, Human resource and reasonable financial backup for the same. The comprehensive disaster preparedness plan is of paramount importance.

Of recent, Zanzibar has been witnessing a change of trend and type of disasters these include massive lives lost as a result of ships capsizing. Within the past year there have been two major ship capsizing disasters [ Mv. Spice Islander\(^{28}\) - 190 death, 600 survivors and 40 were very critical and Mv. Skagit\(^{29}\) - 69 confirmed dead and 77 missing]. There is need to strengthen health sector response to disaster especially in terms of Physical infrastructure [including large mortuaries], Human resource [quantity and quality] and reasonable financial backup for the same.


3.5.11 Health Promotion

Health promotion activities have been undertaken by using various methods including: radio, television, and health education sessions during clinic visits or through community meetings. The aim has been to increase awareness and knowledge on health related matters as well as promoting community participation in health care delivery and utilization of health services. In addition, the strategy aimed at mitigating myths, misconceptions that hamper people from accessing services when there is a need to do so. Varieties of IEC materials have been distributed in all health facilities in the country conveying different health messages. Relatively, these efforts have contributed to the noted increase on health awareness, demand and utilization of health services but with limited behavioural change.

The Health promotion unit in the MOH remains responsible to coordinate all health promotion activities in the country; however, the unit lacks expertise in some fields. Additionally it was noted that the techniques that are being used are incompatible with ongoing country development hence activities somehow lacks social acceptance. There is need to move into modern level of Behavior Change and Communication where knowledge and reasoning are the key elements for behavioral change.

3.5.11.1 Community health education

The community health promotion activities have been undertaken by using various methods including: radio, television, and health education sessions during clinic visits or through community meetings. The aim was to increase awareness and knowledge on health matters as well as promoting community participation in health care delivery and utilization of health services. In addition, the strategy aim at mitigating myths, misconceptions that hampers people accessing services when there is a need to do so. Varieties of IEC materials have been distributed in all health facilities in the country conveying different health messages. Relatively, these efforts have contributed to the noted increase on health awareness, demand and utilisation of health services.

The Ministry’s health promotion unit remains responsible to coordinate all health promotion activities in the country; however, the unit lacks skilled personnel in the field. Additionally it was noted that the techniques that are being used are incompatible with the time and hence the activities somehow lacks social acceptance. Currently, it is difficult to relate causality on any positive behaviour change resulting from health promotion efforts. The unit still offers IEC level of intervention and has not yet moved to the level of BCC where knowledge and reasoning are the basis of causality associated behavioural change.

NB: Health Promotion Unit has not to date been given its due role hence it has not yet been considered as hub in coordinating IEC/ BCC activities within MOH

3.5.11.2 School Health Interventions:

The school health programmes has been in place for decades. The programme mainly targeted children and those at younger age who suffer varying but significant degree of ill health with negative or compromised cognitive powers. Central to these challenges are; parasitic infections, water related health problems malnutrition, HIV/AIDS/STI, child obesity, teenage pregnancy, sexual harassment, drug abuse among others.

However, the current pace in undertaking the activities is not convincing as it is hampered by:
i. Lack of enforcing guidelines from local governments
ii. Absence of a school health policy and an MoU between the MoH and MoEVT.
iii. Poor coordination amongst the MoH programmes/Units conducting school health programmes is still an issue as it leads to duplication of activities, improper resources utilization and ultimately the interventions become unsustainable.
SECTION FOUR: SUMMARY ANALYSIS OF HSSP II

3 HSSPII SWOT ANALYSIS

The SWOT analysis has four major elements: Strengths, Weaknesses, Opportunities and Threats. The strengths and opportunities can be built on while weaknesses and threats constitute the agenda that HSSP-III must address. Principally, external and internal analyses are factors that determine the Ministry’s capabilities. In the SWOT analysis strength and weaknesses refer to internal environment analysis while threats refer to external analysis.

Table 13: SWOT on Organization Management and Working environment

<table>
<thead>
<tr>
<th>KEY AREA</th>
<th>STRENGTH</th>
<th>WEAKNESS</th>
<th>OPPORTUNITIES</th>
<th>THREATS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Most objectives and outcomes realised</td>
<td>i. Top heavy administration arrangements with some overlapping roles and responsibility&lt;br&gt;ii. ZHSSPII had no clear M&amp;E plan hence no midterm review to monitor its implementation.&lt;br&gt;iii. Limited knowledge and ownership of ZHSSPII by key stakeholders&lt;br&gt;iv. Poor communication to enhance utilization of ZHSRS II on ministry’s plan and implementation&lt;br&gt;v. Inadequate HR capacity to mobilise and manage multi-partner funding</td>
<td>i. Existence of stakeholders willing to support MOH.&lt;br&gt;ii. Availability of new health policy&lt;br&gt;iii. Supportive infrastructure.&lt;br&gt;iv. Availability of Ministry and partners decision making forum e.g. AJHSR meeting</td>
<td>i. Donor driven and high donor dependency&lt;br&gt;ii. Donor interest e.g. supporting Same Sex relationships.</td>
</tr>
<tr>
<td>Functional HSR secretariat</td>
<td>i. No clear demarcation line Technical Working Group [TWGs] members are more of implementers than advisers</td>
<td>i. TWGs could serve as the MoH think tank</td>
<td></td>
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<tr>
<td>Presence of laws in health and health related matters includes food inspection and safety and foods premises</td>
<td>i. Low enforcement of health laws and regulation&lt;br&gt;ii. Inadequate platforms to coordinate health laws and health related activities within MDAs</td>
<td>i. Presence of various sectors conducting health/ health related activities&lt;br&gt;ii. Re-establishment of East African Community and other regional bodies [SADC etc]</td>
<td>i. Overlapping roles and responsibilities among implementers&lt;br&gt;ii. Implementer’s follow laws which are not harmonised</td>
<td></td>
</tr>
<tr>
<td>Decentralisation efforts in term of de-concentration within MOH.</td>
<td>i. Low implementation of decentralization policy to the parent ministry (Ministry response for Local Government.)</td>
<td>i. Presence of decentralization policy within the Government</td>
<td>i. Slow pace towards decentralization through devolution or</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>de-concentration</td>
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<td>-----------------------------------------------------------------</td>
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<td>-----------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
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<tr>
<td>Existence of partnership between public and private sector</td>
<td>i. Lack PPP Policy (profit &amp; none for profit)</td>
<td>i. Existence of Private and other non-state actors that provide health services</td>
<td>i. Unpredictability on sustainable efforts of most private institutions</td>
<td></td>
</tr>
<tr>
<td>Presence of regulatory councils e.g. Nurses, Medical, Traditional and alternative medicine.</td>
<td>i. Still low impact of what they are doing</td>
<td>Reviewed Public Health Act</td>
<td>Limited opportunity for collective planning and decisions-making</td>
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<tr>
<td></td>
<td>ii. Poor coordination, networking, partnership and involvement within and outside MOH</td>
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</tbody>
</table>
## Table 14: SWOT Analysis on Human Resources for Health

<table>
<thead>
<tr>
<th>KEY AREA: Human Resources for Health</th>
<th>STRNGTH</th>
<th>WEAKNESS</th>
<th>OPPORTUNITIES</th>
<th>THREATS</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Existence of Zanzibar Medical School in collaboration with Matanzas University of Cuba.</td>
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<tr>
<td>ii. Existence of HRH division within MoH</td>
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<td>iii. Administrative shift for ZCHS to semi-autonomous institution.</td>
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<td>iv. Highly trained staff available in some fields and sections</td>
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<td>v. Initiation of Private health related training institutions.</td>
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<tr>
<td>vi. Availability of MoH deployment committee</td>
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<tr>
<td>vii. Existence of an up dated Human Resources Data base.</td>
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<tr>
<td>i. Lack of institutional plan on human resources development</td>
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<tr>
<td>ii. Non-responsive motivation package.</td>
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<tr>
<td>iii. Inadequate HRH at all levels of care</td>
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<tr>
<td>iv. No mechanism in place to appraise health professionals as part of career development.</td>
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<td>v. Inadequate retention schemes.</td>
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<td>vi. Lack of defined career path.</td>
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<tr>
<td>vii. HRH allocative efficiency not optimal</td>
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<tr>
<td>viii. Inadequate qualified tutors at the College of Health Sciences.</td>
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<tr>
<td>ix. No policy guideline to support continued medical education</td>
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<tr>
<td>x. Under utilization of available human resources</td>
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<tr>
<td>xi. No effective performance appraisal</td>
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<tr>
<td>xii. Poor ethical adherence and compliance by some workers</td>
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<tr>
<td>viii. Lack of vibrant continuing education unit.</td>
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<tr>
<td>ix. There is no official mechanism of coordination and collaboration with privately operated training health institutions.</td>
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<tr>
<td>Adherence to the National and International strategic documents during planning for HRH needs</td>
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<tr>
<td>i. Existence of Zanzibar Medical School.</td>
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<tr>
<td>ii. Close collaboration with other medical schools [Matanzas].</td>
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<td>iii. Access to high education loan [board].</td>
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<tr>
<td>iv. Reforms environment with fiber network accessible in all over Zanzibar</td>
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<tr>
<td>v. Availability of training Colleges in Zanzibar and mainland.</td>
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<td>vi. Intramural private practice allowed as means to keep staff within the hospital.</td>
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<tr>
<td>vii. Availability of development partners willing to support HRH</td>
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<tr>
<td>i. Unpredictable allocation of fund from GoZ</td>
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<tr>
<td>ii. Partner withdrawal due to fatigue.</td>
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<tr>
<td>iii. High HR burn out rate [especially brain drain]</td>
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<tr>
<td>iv. Wastage of meager financial resources due to poor capacity to run the e-health systems</td>
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<tr>
<td>v. Brain drain to private institutions in - country</td>
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<tr>
<td>vi. High turnover/outflow compared to recruitment pace.</td>
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<tr>
<td>vii. HRH policies and procedures guidelines (Government standing orders) are not used</td>
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<tr>
<td>viii. increase of private health care facilities which drain staff from the Ministry of Health</td>
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<tr>
<td>i. Increased RGoZ commitment to retain and remunerate HCW</td>
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<tr>
<td>i. Absence of defined career [path] plan.</td>
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</tbody>
</table>
Table 15: SWOT Analysis on Health Service Delivery

<table>
<thead>
<tr>
<th>KEY AREA: Health Service Delivery</th>
<th>STRENGTH</th>
<th>WEAKNESS</th>
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<th>THREATS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZHSRSP II widely describe and identified potential areas that can address preventive issues</td>
<td>i. Inadequate resources</td>
<td>i. Presence of numerous partners</td>
<td>Uncertainty on meeting the set targets</td>
<td></td>
</tr>
<tr>
<td>Presence of Health promotion unit</td>
<td>ii. Inadequate skilled personnel to translate policy guidelines</td>
<td>i. Availability of mass media (radio and television), ii. Existence and easy to engage into electronic media.</td>
<td>i. Untimely and inadequate availability of HRH and equipment. ii. Overcoming cultural barrier and misconception.</td>
<td></td>
</tr>
<tr>
<td>Presence of community and school health programmes</td>
<td>iii. Health Promotion Unit is not considered as hub in coordinating IEC/ BCC activities within MOH</td>
<td>iii. Potentiality to scale up m-health.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good coverage of Primary service delivery outlets within 5 km radius</td>
<td>i. Inadequate resources</td>
<td>i. Existence of school health programme ii. Community willingness to accept changes and transformation. iii. Presence of Private sectors, CBO, CSOs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate response to disease outbreak</td>
<td>ii. Inadequate skilled personnel to translate policy guidelines</td>
<td>i. Misconceptions among community members.. ii. Overcoming gate keepers and other community owned resource persons.</td>
<td></td>
<td></td>
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<td>Good coverage of Primary service delivery outlets within 5 km radius</td>
<td>i. Inadequate resources</td>
<td>i. Existence of school health programme ii. Community willingness to accept changes and transformation. iii. Presence of Private sectors, CBO, CSOs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adequate response to disease outbreak</td>
<td>ii. Inadequate skilled personnel to translate policy guidelines</td>
<td>i. Misconceptions among community members.. ii. Overcoming gate keepers and other community owned resource persons.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>New outbreaks e.g. Ebola, avian flu, yellow fever etc.</strong></td>
<td><strong>Presence of disaster mgt unit at VP2 office.</strong></td>
<td><strong>Partners willingness and support</strong></td>
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<td></td>
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<tr>
<td>ii. Poor control of port of entries</td>
<td>iii. Endorsement of Zanzibar “Disaster Management Policy” at the Second Vice President Office will facilitate coordination with other sectors.</td>
<td>iii. Political stability, good governance and commitment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii. Inadequate human and other equipment for emergency responses</td>
<td>iv. Absence of emergency plan and budget</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Experienced clinicians available in management hospital teams</strong></th>
<th><strong>The reform process in place and in favour of decentralization of authority</strong></th>
<th><strong>Government bureaucracy may slow down implementation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>i. No autonomy in managing its affairs</td>
<td>ii. Partners support</td>
<td></td>
</tr>
<tr>
<td>ii. Management structure bureaucratic</td>
<td>iii. Hospital Reform Training Modules available in mainland.</td>
<td></td>
</tr>
<tr>
<td>iii. Few managers have training in management</td>
<td></td>
<td></td>
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<tr>
<td>iv. Limited transparency and accountability</td>
<td></td>
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</tbody>
</table>

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<thead>
<tr>
<th><strong>Presence of ZFDB has strengthened the quality standard of food, drugs and cosmetics.</strong></th>
<th><strong>Revenue generation.</strong></th>
<th><strong>Potential contradiction with other actors</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Inadequate HR.</td>
<td>ii. Membership of Zanzibar Food and Drug Board (ZFDB) to East African Community, Southern Africa</td>
<td>ii. Demoralization due to resource scarcity and limited authority and interferences.</td>
</tr>
<tr>
<td>ii. No defined physical office structure for ZFDB.</td>
<td>iii. Development Community (SADC) and East Central and Southern Cooperation</td>
<td></td>
</tr>
<tr>
<td>iii. ZFDB law need revision and update.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th><strong>Good commitment of health workers at primary health care units</strong></th>
<th><strong>Increased RGoZ commitment to retain and remunerate HCW</strong></th>
<th><strong>Brain drain</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Due to limited number of qualified practitioners, unskilled health staff performs skilled activities.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th><strong>Existence of quality improvement initiatives and performance based financing</strong></th>
<th><strong>Presence of Community health strategy</strong></th>
<th><strong>Capacity and willingness to sustain QA methods</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Inadequate ownership of health programmes esp. at district level</td>
<td>ii. MoH decentralisation mechanism</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Presence of private hospital and dispensaries which complement the government efforts</strong></th>
<th><strong>PPP need to be enhanced if health systems are to be strengthened.</strong></th>
<th><strong>Cost implications and appreciation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Inadequate collaboration with government structures especially when it involves referrals</td>
<td></td>
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</table>
Table 16: SWOT Analysis on Mnazi Mmoja referral hospital

<table>
<thead>
<tr>
<th>KEY AREA</th>
<th>STRENGTH</th>
<th>WEAKNESS</th>
<th>OPPORTUNITIES</th>
<th>THREATS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mnazi Mmoja referral hospital</td>
<td>Some committed staff in place</td>
<td>Poor customer relationship</td>
<td>Reform process initiated and supported by MOH</td>
<td>Too many inappropriate referrals</td>
</tr>
<tr>
<td></td>
<td>Space available</td>
<td>Inadequate medicines and medical supplies</td>
<td>ii. Potential to recruit good staff from among the trainees at the College of Health Sciences</td>
<td>ii. Inadequate funding</td>
</tr>
<tr>
<td></td>
<td>Availability of some Diagnostic services</td>
<td>Inadequate equipment and equipment maintenance</td>
<td>iii. Existence of intramural private practice</td>
<td>iii. Inappropriate exemption criteria</td>
</tr>
<tr>
<td></td>
<td>Some specialists available for technical assistance</td>
<td>Poor working environment for staff</td>
<td>iv. Continued donations from various organizations</td>
<td>iv. Emergence of private hospitals (loss of equipment, supplies and personnel time)</td>
</tr>
<tr>
<td></td>
<td>Good collaboration with Number of National referral hospital in Tanzania mainland.</td>
<td>Inadequate number of skilled staff</td>
<td>v. Funds rising opportunity (Cost sharing)</td>
<td>v. Poorly performing lower level hospitals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of management standards and guidelines</td>
<td>vi. Emergence of private health insurance.</td>
<td>vi. Lack of open space for hospital expansion</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inadequate supervision of services</td>
<td>vii. Supportive Ministry of Health</td>
<td>vii. Donor fatigue</td>
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<tr>
<td></td>
<td></td>
<td>Inadequate clinical audit</td>
<td>viii. Partners willing to help.</td>
<td></td>
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<td></td>
<td></td>
<td>Poor monitoring of patient care and customer satisfaction</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Low staff morale</td>
<td></td>
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<td></td>
<td></td>
<td>Lack of policy on disaster management</td>
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<tr>
<td></td>
<td></td>
<td>Limited space availability</td>
<td></td>
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<td></td>
<td></td>
<td>High number of support staff than qualified</td>
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<td></td>
<td></td>
<td>Facilities inadequate for provision of tertiary clinical care</td>
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<td></td>
<td>Poor time management.</td>
<td></td>
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<td></td>
<td></td>
<td>Poor communication between MMH and referring hospitals</td>
<td></td>
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<td></td>
<td></td>
<td>External referrals sometimes not objective.</td>
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<td></td>
<td></td>
<td>Inadequate relationships with hospitals regionally and internationally</td>
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<td></td>
<td></td>
<td>Limited exploitation of possible funding options</td>
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<tr>
<td></td>
<td></td>
<td>Unreliable transport for referral</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Inexistence of replacement plan of health worker</td>
<td></td>
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<tr>
<td></td>
<td>Under funding (less than</td>
<td>Existence of Non State Actors willing to work with the MM Hospital</td>
<td></td>
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<tr>
<td></td>
<td>Hospital National</td>
<td>Various referral attempts such as mpesa and D-tree and Extension of wired mothers programme</td>
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<td></td>
<td></td>
<td>Sustainability on</td>
<td></td>
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<tr>
<td>50% of the requirement obtained from the Central Government</td>
<td>Strategic plan in place to guide the implementation</td>
<td>fund availability</td>
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<tr>
<td>Shortage of specialists, modern facilities, adequate drugs and related supplies</td>
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</tbody>
</table>
Table 17: SWOT Analysis on Procurement of Medicines, non-medical related pharmaceuticals commodities and health infrastructures

<table>
<thead>
<tr>
<th>KEY AREA: Procurement of Medicines, non medical related pharmaceuticals commodities and health infrastructures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STRENGTH</strong></td>
</tr>
</tbody>
</table>
| i. Existence of a Central Medical Stores Department | i. Too bureaucratic unit  
ii. Unit has no operating budget.  
iii. Absence of national health sector procurement plan.  
iv. Inadequate tracking system for drug utilization | i. Availability of some donors e.g. Danida, WHO willing to support some initiatives  
ii. Presence of Procurement and disposal act  
iii. Increase RGoZ budgetary allocation on medicament and supplies procurement and distribution | i. Donor dependency  
ii. Corruption |
| ii. Availability of basic supplies at facilities | | | |
| iii. Availability of the Procurement Unit at MOH | | | |
| Existence of Health care Engineering Unit [HCEU] | i. Limited number of qualified and skilled professionals.  
ii. Inadequate resource allocation.  
iii. Absence of functional maintenance plan for infrastructure and other related equipment.  
iv. No functional preventive maintenance plan  
v. No central inventory tracking system | • Maximizing on the biomedical course (which is in pipe line. | i. Inefficient Central Medical Stores |
| i. Existence of a good number of physical infrastructure | i. Meager resource allocation for infrastructural development.  
ii. Some structures are gender insensitive.  
iii. Most of physical structures do not have title deeds. | i. Maximize on GoZ budget mechanism.  
ii. Presence of Govt policy to upgrade some structures to district and regional hospitals.  
iii. Intramural Private Practice in place  
iv. Partners willing to assist in renovations | i. Funds predictability.  
ii. Capacity to preserve sensitive equipment |
| ii. Presence of preventive maintenance plan.  
iii. Existing trained personnel | | | |
Table 18: SWOT Analysis n Health Care Financing and Sustainability

<table>
<thead>
<tr>
<th>KEY AREA: Health Care Financing and Sustainability</th>
<th>STRENGTH</th>
<th>WEAKNESS</th>
<th>OPPORTUNITIES</th>
<th>THREATS</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Availability of GoZ budget.</td>
<td>i. GoZ funding caters more of institutional overheads [salary more]</td>
<td>i. Need to pair for with partners for skill sharing and development schemes.</td>
<td>i. Donor dependency</td>
<td></td>
</tr>
<tr>
<td>ii. Presence of Global Fund mechanism that could be tapped on. To strengthen health systems</td>
<td>ii. Inadequate HR capacity to mobilise and manage multi-partner funding</td>
<td>ii. Heath identified as a national priority-potential for more funding [internally &amp; external]</td>
<td>ii. HR with financial skills attracted more to non-health high paying job</td>
<td></td>
</tr>
<tr>
<td>iii. Swell number of HR with required basic skilled financial management capacity produced in the country [Zanzibar &amp; Tanzania].</td>
<td>iii. Inadequate capacity for auditing at global level.</td>
<td>iii. MOH considering establishment of health insurance</td>
<td>iii. Low and unpredictable budget allocation from the government.</td>
<td></td>
</tr>
<tr>
<td>iv. Internal income generation exists through Intramural Private Practice</td>
<td>iv. Delays in initiating alternative health care financing system/mechanism.</td>
<td>iv. A potential to expand the private market for MMH services</td>
<td>iv. Global economic crisis and high inflation rate.</td>
<td></td>
</tr>
<tr>
<td>v. Management interest in financial reforms</td>
<td>v. Inadequate transparency on financial issues</td>
<td></td>
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</tr>
</tbody>
</table>

<p>| | | i. Varying DP fund disbursement systems [often complex and challenging or parallel] | i. The use of tele-medicine could potentially save a lot of funds in terms of MEA. | i. Reliance on DP funding. |
| | | ii. Cost sharing and waiver system not formalized. | ii. DHS Sub-vote Basket to attract more funding to districts through increased transparency and to lead to recruitment of qualified accountants. | ii. Analysis of budget lines shows that very few funds are left for primary and hospital care when looking at expenditure breakdowns. |
| | | iii. Total actual expenditure does not reflect health sector priorities. | iii. Introduction of a National Health Insurance Scheme as an efficient and effective source of revenue for the public health sector. | iii. Highly Expenditure and funding projections for the coming years total running cost exceeds total RGoZ funding. |
| | | iv. Donor restriction of buying the drugs to only one source (MSD) it is a big challenge to the MOH | | iv. Lack of a Fixed Asset Register may lead to the loss of Government properties. |
| | | v. No financial sustainability plan for most programs/units interviewed. | | |
| | | vi. No procurement plan at MoH. | | |
| | | vii. Lack of qualified accountants at district level. | | |</p>
<table>
<thead>
<tr>
<th>KEY AREA: Health Information and Research</th>
<th>STRENGTH</th>
<th>WEAKNESS</th>
<th>OPPORTUNITIES</th>
<th>THREATS</th>
</tr>
</thead>
</table>
| Realization of some MDG and MKUZA indicators | i. Shortage of skilled personnel in various fields.  
ii. Achievements highly accrued through external funding and support | • Existence of development partners | i. Predictability of partners continued support. |
| i. Existence of research unit Supportive laboratories available  
ii. Presence of public health laboratory with research focus. | i. In adequate research culture  
ii. Low utilization of research finding.  
iii. Few qualified researchers  
iv. No research policy  
v. No funds for research  
vi. Poor record keeping  
vii. No research Act. | i. Supportive MOH and Health Policy  
ii. Presence of non-public health research NGOs viz. ZAMREC | |
| Disease monitoring, surveillance, surveys and research | i. Vertical data monitoring with multiple of data forms filling.  
ii. Limited electronic data back-up system [integrated].  
iii. Limited utilization of surveillance data for intervention planning [Surveillance not piloted or navigated by field findings]  
iv. Limited involvement of private sector. | i. Programme engagement in research and evaluation.  
ii. Availability of m – health opportunity IDWE, MEEDS, ZILS, M-HEALTH, Z-pesa referral system | i. Weak harmonization between MoH and others MDAs on researching, monitoring,  
ii. Prevention, and controlling of zoonotic disease and out-break |
SECTION FIVE: HSSPIII PRIORITIES

5.0 PRIORITIES FOR THE HSSP-III

The situation and response analysis has mapped out main challenges and successes of HSSPII. The aim of HSSP-III is to build up on the accrued success during the implementation of HSSPII, address the noted challenges and accommodate new and emerging risk behaviours and accompanying disease outcomes and conditions. The following are the major recommendations from the evaluation of the HSSPII:

5.1 Effective management of Human Resource for health:
The health sector is experiencing high staff turnover with great loss of capable skilled staff to offer quality services to all those in need. This has a bearing in the number of clients sent overseas for medical care. HRH challenges could be addressed in-house if staff motivation and retention packages are put in place. Moreover, high turnover affects the institutional memory. Over the period of the HSSP mechanisms need to be put in place in order to retain staff as well as to address the critical staff shortages at all levels.

5.2 Enhancement of decentralization of health services management and planning:
The HSSP-III shall address quality of district hospitals and accompanying referral systems so as to bring services close to communities. Decentralization by devolution shall be the pivotal to services provision where central level will develop and govern policies and related matters. While the periphery will supervise the execution of such policies.

5.3 Increase coverage and access to quality care services at all levels:
There is need to scale up the utilisation of the essential health care packages in line with the level of health care service delivery. The EHP need to accommodate technological advancement, changing disease patterns and available resources. The package should address needs for non-communicable diseases such as cardiovascular disease and diabetes, mental and oral health interventions as well as malignancies. With increased life expectancy and changes of lifestyles the need to introduce geriatric care services as part of EHP is of paramount importance

5.4 Effective management and procurement of medicament, supplies and health equipment:
The drug supply system needs to be strengthened. Therefore the pull system should be promoted versus the push drug supply system. The annual framework contract of drug procurement should be the target and the system should minimise the culture of ad hoc and emergency tender for drug procurement. HRH should be well trained on effective drug forecasting. The electronic logistics management information system [ZILS] need to be promoted and sustained to generate accurate data at facility level and departments have to provide accurate and complete specifications.

5.5 Increase access to health services to special populations and groups:
The new HSSP need to address issues of equity, including gender related challenges. Preventive and curative health care should target hard to serve, key populations and the vulnerable groups, e.g. adolescents seeking sexual and reproductive health care and antiretroviral treatment, orphans and other vulnerable children, women and girls RCH care services.
5.6 Quality assurance

Currently the role of QA played by the HSRS quality grouped need to be placed in a special desk that shall oversee comprehensive QA issues at macro level. Approaches on quality improvements need to be strengthened and become systematic. The implementation of interventions at all level should be based on need and public health priorities.

5.7 Enhancement of Public private partnership

Enhancement of Public private partnership and recognition of Non-State Actors in offering health services need to be acknowledged and given due attention in HSSP-III. Coordination and collaboration platform shall be enhanced and nurtured.

5.8 Strengthening of Health Boards and Councils:

In ensuring quality and client satisfaction more investment on health councils and boards shall be done. The HSSP-III should rejuvenate ethical issues to safeguard the health professions in totality.

5.9 Strengthening Health financing sustainability mechanism:

The HSSPII should advocate for more budget allocation in line with sector priority and as part of realizing MDGs and MKUZAI. Basket fund and additional health care financing options shall be explored and employed as guided by evidence and national strategies.

5.10 Enhancement of Monitoring and evaluation system

Monitoring and evaluation system in line with the Health Information system aiming at enhancing evidence based decision making. The M&E system need to be expanded to monitor quality of care. The use of a broad baseline survey linked to impact evaluation should be among the norms of the health sector and the role of research in determining the progress of the health sector should be more explicit. *Health promotion and Disease Prevention*

5.11 Health promotion and Disease Prevention

Increase, emphasis on health promotion and disease prevention, as the majority of the diseases affecting Zanzibaris are preventable. The participation of community in health interventions should be encouraged.

5.12 Increase community ownership

Increase community involvement and ownership in health intervention should be encouraged in line with Ouagadougou declaration on primary health care and health system in Africa.²⁰

5.13 Promote utilisation of e-health

Initiation of e-health system in Zanzibar has started in areas of wired mother and m-pesa for pregnant mother transportation schemes [through m-health programmes]. In addition, e-learning is being practiced at Zanzibar Medical School while telemedicine is part of the routine at the radio-imaging department. *In view of this, it is imperative that the health sector should maximize on this novel opportunity and scale up e-health in implementing HSSP-III.*

SECTION SIX:

6.0 VISION, MISSION AND CORE VALUES OF HSSP-III

6.1 Introduction

The formulation of the Health Sector Strategic Plan III (HSSP-III) emanates from the review of the health sector policy and the expiration of the ZHSRSP II 2006/7 – 2010/11. The HSSP-III intends to cover the period between 2013/14- 2018/19 and it shall provide guidance to key strategic interventions that are outlined in the Zanzibar Health Sector Policy and the Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRP). The ZSGRP document forms part of strategies to implement the long term development plan, the Vision 2020. The focus is on ensuring the attainment of sustainable growth that will reduce both the income and non-income poverty to the majority of Zanzibaris. The strategy is in line with the international goals, commitments, and targets, including the Millennium Development Goals (MDGs)\(^3\). It provides a framework to inform health sector reforms and interventions in support of the government mission to continually improve the health of the population and thereby help to reduce poverty. The HSSP-III will be implemented through the Medium Term Expenditure Framework (MTEF), which is linked to the national budget.

The HSSP-III shall serve as a guiding document for the development of district, hospital, individual departments and units as well as other health sector strategic plans accompanied by their annual implementation plans. Furthermore, this HSSP-III will enhance gains made under the implementation of HSSPII and shall maximize on the evidence based information gather within and outside the country. This strategy shall also address additional areas documented while undertaking the Situation and Response analysis.

6.2 HEALTH SECTOR VISION AND MISSION:

The Vision statement of the MoH is:

A healthy Zanzibari population with reliable, accessible and equitable health care services.

While the Mission statement of the health sector is:

To provide strategic leadership by the Ministry of health Zanzibar that will ensure all Zanzibaris secure their right to quality and equitable health services rendered in a cost effective and affordable manner.

The overall Goal of the health sector is “To improve the health status of people in Zanzibar in order to contribute to the socioeconomic development of the county”.

The **general objective** of the HSSP-III is to strengthen the functions of the national health system of Zanzibar so as to improve the performance of:

1. Access to health services (availability, utilisation and timeliness)
2. Quality of health services (safety, efficacy and integration)
3. Equity in health services (with special attention to the disadvantaged groups)
4. Efficiency of service delivery (value for resources).

In order for the HSSP-III to realize its performance, the following set of system related key areas have been earmarked as areas of focus in the coming HSSP-III. These key areas include:

Table 20: Key Areas for the Health Sector Strategic Plan III

<table>
<thead>
<tr>
<th>KEY AREA</th>
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<tbody>
<tr>
<td>1. Organization Management and Working environment [Health System Governance]</td>
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<tr>
<td>2. Human Resources for Health</td>
</tr>
<tr>
<td>3. Health Service Delivery</td>
</tr>
<tr>
<td>4. Procurement of Medicines, non medical related pharmaceuticals commodities and health infrastructures</td>
</tr>
<tr>
<td>5. Health Care Financing and Sustainability</td>
</tr>
<tr>
<td>6. Health Information and Research</td>
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</tbody>
</table>
The implementation of the HSSP-III that will be undertaken by the above six key areas aims at enhancing quality of life and in the long run attain both the MDGs and MKUZA II. While implementing the HSSP-III the following core values will also be taken in consideration:

### 6.3 CORE VALUES:

The HSSP-III will be executed within the framework of the following core values which will be a thrust towards achieving the envisaged vision:

1. **Government leadership:** The RGoZ through the MoH will be taking the stewardship role to ensure the effective and quality implementation of the HSSP-III as part of realizing ZSGPR II.

2. **Human rights based approach and equity:** All the people of Zanzibar shall have equal right to access health services without distinction by race, gender, disability, religion, political inclination,
economic and social status or geographical location. The rights of health care users and their families, providers and support staff shall be respected and protected.

3. **Gender sensitivity**: Gender issues shall be mainstreamed in the planning and implementation of all health programs and tracked for impact.

4. **Ethical considerations**: The ethical requirement of confidentiality, safety and efficacy in both the provision of health care and health care research shall be adhered to.

5. **Efficiency and results orientation**: Adherence to the practices of ensuring plans and activities are tailored to realize desired outcomes and make prudent and economic use of resources. Opportunities shall be identified to facilitate the integration of health service delivery where appropriate to address client needs efficiently and effectively.

6. **Accountability and transparency**: The health sector is obliged to demonstrate high level compliance with agreed local and international standards, professional ethics and to abide to high level of transparent decision making, open review, receive and respond positively to critiques as well as encompassing full participation of stakeholders in drawing decisions which affect them.

7. **Inter-sectoral collaboration**: In addition to the MoH there are also other Government Ministries and Departments and CSOs that play an important role especially in addressing social determinants of health; hence inter-sectoral collaboration shall be promoted.

8. **Community Participation**: Community participation shall be encouraged in the planning, management and delivery of health services.

9. **Evidence-based decision making**: Interventions shall be based on proven and cost-effective national and international best practices.

10. **Partnership**: Public Private Partnership (PPP) shall be encouraged and strengthened to address the determinants of health, improve service provision, create resources (e.g. training of human resources) and share technologies among others.

11. **Decentralization**: Health services management and provision shall be in line with the Local Government decentralization efforts which entails devolving health service delivery to district health leadership.

12. **Appropriate technology**: All health care providers shall use health care technologies that are appropriate, relevant and cost effective.

13. **Environmental protection**: All intervention shall ensure that environment is protected and with minimal to non-pollution or emissions.

### 6.4 THE NEW DIRECTION OF HSSP-III

The primary purpose of the HSSP-III is to build up on the gains accrued during the implementation of HSSP II. This entails scaling up on the best practices and address both the lesson learnt and maximize on the missed opportunities. This strategy does also accommodate new scientific advents that have been made and are advocated at regional and global level. Furthermore, the HSSP-III has also embedded new initiatives which include:
1. **Performance-based financing scheme (PBF)** where rewards to best performing health facilities and staff for their good performance (increased utilisation and quality of services), emphasizing output financing mechanisms rather than input financing, will be introduced and established.

2. **Strengthen health systems and HRH** in particular as a key element in promoting quality of delivered health care services.

3. **Alternative health care financing schemes** that will include Insurance and pulling of partners resource in basket fund for district interventions are among new issues advocated by HSSP-III.

4. **Integrated health promotion** techniques and scaling up of community empowerment through the recently launched community strategy. Particular emphasis will be placed on promoting positive health styles and disease prevention.

5. **Enhancement of quality assurance systems** that promotes clients service charter, promotion of customer services on delivered health care together with promotion on accreditation of services are among issues underpinned in this HSSP-III.

6. **Integration of related programmes and interventions** [services]

7. **Enhancement of health sector decentralization** process and promotion of good governance

8. Reinforce referral systems and continuum of care to include hospice care

9. reduction of maternal mortality and promotion of facility base delivery and attendance by skilled health care worker

10. Addresses changes in disease dynamics and pattern to address non-communicable diseases and injuries while acknowledging the need to continue addressing communicable diseases.

11. Enhanced utilisation of information and technologies and service delivery to include e-learning, m-health, patient transfers and GIS application on disease patterns.

**6.5 Way Forward, Key Areas, Strategic Objectives and Targets:**

Generally, the HSSP-III has articulated priority issues for future strategic directions. These forms the basis for the health sector contribution to MKUZA strategy and anticipated to carter for the coming five years from 2013/14-2018/2019.

In view of the above, the health sector priorities could be summed up and presented as follows:
Table 21: Summary of Health sector priorities

<table>
<thead>
<tr>
<th>HEALTH SYSTEM PRIORITIES</th>
<th>PUBLIC HEALTH PRIORITY INTERVENTIONS</th>
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</thead>
<tbody>
<tr>
<td>1. Organization Management and Working environment [health system Governance]</td>
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<tr>
<td>2. Human resources for health</td>
<td></td>
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<tr>
<td>3. Health Service Delivery</td>
<td>1. Primary health care services.</td>
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<tr>
<td></td>
<td>2. Integrated maternal, neonatal and child health.</td>
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<td></td>
<td>3. Communicable diseases, especially Malaria, HIV and AIDS, STIs and TB.</td>
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<td></td>
<td>4. Non-Communicable Diseases (NCDs).</td>
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<td></td>
<td>5. Disease surveillance.</td>
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<td>7. Health service referral systems.</td>
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<td>8. Health promotion &amp; behaviour change communication.</td>
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<td>9. Port health services</td>
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<td>10. Occupational health</td>
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<td></td>
<td>11. Primary eye care services</td>
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<tr>
<td>4. Procurement of Medicines, non medical related pharmaceuticals commodities and health infrastructures</td>
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<tr>
<td>5. Health Care Financing and Sustainability</td>
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<tr>
<td>6. Health Information and Research</td>
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</table>

In line with the above outlined setup the HSSP-III presentation has been set to reflect the new focus where health system strengthening is the focus of the strategy. In view of this each of the above outlined system represent a chapter/section that has the following key issues: An outcome, a section of interest which has been detailed to capture: background information, justification for including such a section in this strategy, general objective, strategies that will be used to realise the objective and finally the proposed indicators which each unit will be measured.
7.0 HSSP-III- STRATEGIC INTERVENTIONS

7.1 Health System Governance

<table>
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<th>OUTCOME 1:</th>
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<tr>
<td>Health sector capacity to steward the effective implementation and monitoring of the Health sector Strategic plan III increased by more than 80% by 2018.</td>
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</table>

7.1.1 Institutional capacity building:
In strengthening the MoH institutional capacity, it is vital that targeted interventions are directed into the following major areas:

a. Planning:

The planning capacity of MoH need to divert its attention and areas of focus from output and activity based to outcome and impact base. These can be done through the annual plans with validated indicators and targets and reliable budget allocation based on health sector priorities as outlined in the MTEF. All key stakeholder need to feature out in district and or central plans with their budget allocation and sources. Zanzibar has been undertaking Annual joint reviews but the same system need to be introduced to oversee district health planning mechanism. The newly introduced basket funding at district level shall form the basis towards harmonization of intervention at community and district level aiming at minimizing duplication of efforts and ineffective use of meager resources.

There is need to strengthen the M&E section at the planning department so as to ensure performance of planned activities need to shift to relatively higher stage where objectives and outcomes are the ones that are being monitored. There is need to harmonise with the HMIS on the realization of national and international indicators or targets. The health economic unit of the planning department should take a lead to:

   a. Undertake Cost benefit analysis in most of the proposed interventions
   b. Prioritize of interventions based on disease burden and where we could realize the added value of the invested resources.

b. HSSP-III evaluation:

The Planning department will take the lead in the production and timely dissemination of HSSP-III and it accompanied M&E framework and reports to all key actors. Moreover, the culture of developing a joint Annual Work plan with all actors and stakeholders and quarterly performance evaluation shall be enhanced. Through the HSRS, the MoH shall undertake comprehensive mapping exercise of all health sector service providers and establish their respective levels of competency. This exercise will also cover the private sector and civil society.

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32 In line with Bango Kitita performance and reporting frame work
In addition, the MoH in collaboration with the DPG health will adopt standardized planning and budgeting tools for district and national levels that reflect health sector priorities as well as sub-sector plans. The MoH will support districts in the production of costed annual work plans. Joint annual health sector reviews with extended participatory base will be undertaken to assess the implementation progress of annual plans and of the HSSP-III.

c. **The Health Sector Strategic Co-ordination Forum (HSSCF):**

The contributed gains realised from the effective role of the HSRS need to be further enhanced by increasing the capacity and support of the similar organ to facilitate the execution of the HSSP-III. For HSSP-III to succeed, the MoH need to set the health sector agenda and establish a multi-disciplinary team of thinkers and movers to monitor and oversee the strategy implementation. These will then report to the MoH executive committee and offer technical guidance which will then be translated and implemented. The Support will cover the areas of communication, coordination, delegation, participation and harmonization as part of strengthening the overall governance of the Health Sector.

7.2 **Enhancing Health Sector Governance:**

**Background:**

Proper provision of services to the entire society depends on effective organization and management, the same applies to the implementation of the HSSP-III whereby the provision of health services highly depend on functional organization and proper management of all areas. The current situation of de-concentrating and delegating the managerial functions to health zone\(^{33}\) and district is crucial in enhancing the capacity of health sector to deliver quality services at the periphery and communities in particular.

Therefore, the management and governance of health service delivery in Zanzibar is characterized by:

1. **Public facilities** – which are divided into primary, secondary and tertiary services, these are predominantly governed by the public sector and at times in collaboration with private and or CSO.
2. **Non-public facilities:** these constitute privately owned and operated health facilities, facilities operated by Parastatal and those operated by CSO. These are governed by councils [for private hospitals and private pharmacies councils]
3. **Professional Boards and councils:** for monitoring quality and ethical practicing for medical and dental practitioners, nurses, environmental health practitioners, traditional healers, Pharmaceutical practitioners and any other related board.
4. **Quality Assurance institutions/unit:** Zanzibar Medical Research Council, Zanzibar Food and Drug Board, Chief Government chemist and HSSCF.

\(^{33}\) Zone in health system management has been used to denote the administration system for Unguja and Pemba respectively.
**Justification**

Public participation in health matters is vital to efficient and effective governance of the health sector. There is a need to adhere to transparency in decision making at all levels. The legal aspects and respect for human rights should always be applied this need to be fostered through the establishment of client and services charter.

In this context, the MoH suggestion of continuing with its reform in the areas of structuring the organization and management should link with the managerial professionals, state and non state organization and community interested in delivery of health services. These include an establishment of the client services charter, establishment of coordinating platforms and increase the involvement of the community and other health related stakeholders in decision making. Strategically there is a need to reduce the top heavy administration hierarchy targeting at minimizing avoidable administrative overheads.

**Broad Objectives**

*Increase MoH capacity to plan, integrate and monitor the provision of quality services by >70% from baseline using internal and external resources by 2015.*

**Strategies:**

1. Develop capacity for planning and programme monitoring at central and district levels
2. Develop platforms and capacity for harmonized Annual plans at central and district levels
3. Promote sector policy review and partner coordination platforms
4. Strengthen the MoH decentralization operation mechanism
5. Strengthen Annual joint health sector performance reviews
6. Strengthen the re-definition of the roles of HSRS
7. Strengthen the capacities of health boards/councils
8. Enhance the establishment of client service charter policy guideline.
9. Enhance health management system in line with district reforms
10. Strengthen the translation of public health Act of 2012

**Indicators**

1. Number of planning officers trained on planning at different levels within MoH.
2. Number of decision making forum involved stake-holders established.
3. Percentage of departments, programmes and units with established the client/services charters
4. Number of annual review conducted
5. Proportion of health boards/councils strengthened
7.3 **Health Sector Boards and Councils**

**Background**

The health sector Zanzibar realized an existence of Professional Boards and council as important organs on maintaining and promoting transparency, accountability, community participation and involvement in decision making at all levels. Therefore MoH has also delegated some of her tasks to selected health institutions to maintain quality and standards of practices for health professionals and providers of health commodities. These include the:-

- Zanzibar Food, Drugs & Cosmetic board;
- Private Hospital board;
- Public Health Laboratory;
- Zanzibar Medical Council,
- Zanzibar Nursing and Midwifery council.
- Traditional and alternatively medicine
- Environmental health Board

All advisory boards are reporting directly to the Minister responsible for health while councils are reporting to the Director General of the Ministry of Health. Unfortunately, few of the boards are performing optimally, while those that are established at community levels lacks legal backup.

**Broad objective**

*Increase institutional capacity of professional boards and councils to provide quality services and monitor codes of conduct and professional ethics by >80% by 2018.*

**Strategy**

1. Establish and strengthen boards and councils within their defined respective regulatory roles.
2. Strengthen and support institutions (boards, councils and committees) responsible for enforcement of health laws, regulations and ethics
3. Develop by- laws, policy and guidelines on health care delivery services by involving community’s councils, boards and other relevant parties.
4. Established coordination and experience sharing platforms between professional boards.
5. Establish co-ordinating platform between boards and private institutions that provide health services (Association of private health services).
6. Develop Laws to establish councils and related professional governing bodies e.g. for laboratory technicians and radiographers etc]

**Indicators:**

- Proportion of Health professional boards and councils updated
- Number of official fora established to discuss and integrates existing and established professional boards and councils
- Number of laws and regulations governing health services delivery enacted
- Number of professional board and council linked.
7.4 Zanzibar Food Drugs and Cosmetics Board

Background

The ZFDB is the regulatory body whose main function is to control the quality and safety of food, drugs and cosmetics products in Zanzibar. The ZFDB operates in accordance with the Zanzibar Food, Drugs and Cosmetics Act, No. 2 of 2006 which repeals and replaces the Pharmaceutical and Dangerous Drugs Act No. 6 of 1986 and the Public Health Decree, Cap 73 of 1939. The ZFDB has been officially launched in January 2007.

Justification

The health sector in Zanzibar heavily relies on importation of Food and Drug and Cosmetics Products from overseas. However due the increasing of Globalization, trade liberalization, abuse of trademarks, circulation of substandard and counterfeit products, and over use pesticides, the existence of ZFDB targets at reducing the importation and use of counterfeit pharmaceutical products and cosmetics that have harmful outcome to the residents of Zanzibar. Existing law does not offer penalties that would refrain individuals from undertaking same activities once they have indicted. Hence this creates systemic weaknesses that need to be corrected.

Broad objective

*Increase 100% access to quality and safe food and food products, pharmaceutical and cosmetic products by all residents of Zanzibar by 2018.*

Strategies

1. Strengthen capacity of inspection and surveillance of Food, Drugs and cosmetics.
2. Strengthen the ZFDB diagnostic infrastructure to detect meet the set standards for imported and locally manufactured food, drugs and cosmetics.
3. Strengthen database for registration of food, drugs and cosmetics products, owners and their premises.
4. Establish quality assurance for international recognition of the laboratory.
5. Strengthening harmonization between Chief Government Chemist laboratory [CGCL] and the Zanzibar Bureau of Standards [ZBS].

Indicators

i. Number of Food, Drugs and cosmetics inspected and Counterfeit Products obsolete.
ii. Existence database for registration of food, drugs and cosmetics products, owners and their premises.
iii. Number of external quality assurance undertaken.
7.5 Private Hospital Board

Background

The private hospital board has been established since 1994 under the Act passed by the Zanzibar House of the Representative. At that time many private hospitals were available in the Zanzibar and the Ministry of Health is obliged to supervise the quality of services rendered by these institutions and protect the general public from sub-quality services or malpractice.

Justification

Increasing number of private hospital and dispensaries in line with established Act need to be monitored and ensure that there is adherence and compliance to existing laws and ethical standards while offering services.

Broad Objective

*Increase number of accredited Private Hospitals and dispensaries from 0% to 100% by the year 2018/19.*

Strategies

i. Improve quality of health services provided by private facilities.
ii. Ensure the provision of services are done by qualified and skilled HRH
iii. Promote the establishment of private diagnostic services [inclusive of radio imaging, laboratories, mortuaries etc]
iv. Strengthen linkages between public and private sector through training, coordination platforms, research involvement
v. Strengthen the referral mechanism between private and public sectors and vice versa
vi. Promote the establishment of private medical/paramedical teachings hospitals and related institutions in Zanzibar.

Indicators

i. Proportion of hospitals/ Clinics inspected
ii. percentage of inspected building which meet standard (Hospitals/ Dispensary/pharmacy)
iii. Number of private diagnostic services established and referral made,
iv. Number of coordination platforms conducted
v. Number of private health training institutions established

7.6 Public Health Laboratory - Ivo De Carneri (PHL-IDC)

Background

The Public Health Laboratory - Ivo de Carneri (PLH-IdC) was established in 1997 by the Government of Zanzibar following recommendations made by the late Professor Ivo de Carneri and it was named in his memory. PLH-IdC is operated through a partnership agreement between the Ministry of Health of Zanzibar (MoH) and the Ivo de Carneri Foundation (IdCF), a legally recognized Non-Governmental Organization based in Milan, Italy. PLH-IdC is placed under the Director General.
PHL-IdC core functions include: conducting public health research and to offer policy guidelines in line with the research findings in Zanzibar, assist surveillance of outbreaks, support monitoring of diseases control Programmes, facilitating training of health staff both within the country and abroad. The PHL has been working in close collaboration with other research centers in Tanzania namely: Amani Research Institute, Ifakara Research Institute, Muhimbili University Dar es Salaam, NIMR (National Institute of Medical Research) and College of Health Sciences in Zanzibar.

**Broad Objective**

*To increase the health status of the people of Zanzibar through research, designing controls and monitoring of endemic and epidemics diseases in Zanzibar.*

**Strategy**

1. Establish linkage with other research institutions interested in undertaking public health research in Zanzibar.
2. Establish the legality of PHL (PHL existence should be by Law).
4. Improve human resources management, strengthening scientific core and administration (identification of candidates, training in accordance with PHL specific needs).
5. Strengthen network with other scientific institutions interested in implementing researches and studies in Zanzibar.

**Indicators**

1. Number of linkages established
2. Number of research projects undertaken in the last 5 years
3. Number of research projects planned and approved to be undertaken for the next 5 years
4. Number of publication and research papers released per year
5. Number and types of training conducted and or facilitated under PHL auspices

**7.7 Zanzibar Medical Council:**

**Background**

The Medical Council Board has been formed under the Act no. 12 of 1999 for the Medical practitioners and Dentists.

**Justification**

The need to ensure adherence to ethical practice is of paramount importance in any profession. The same applies for the Medical and dental practitioners. In line with increased number of private practicing in Zanzibar and acknowledging the globalization efforts where practitioners could practice anywhere in the world, the need to have a functional monitoring organ is inevitable. This Board is mandated by law to register, monitor and take necessary ethical measures to ensure quality of rendered services by individual practitioners and protect the end users of medical services at all levels [public and private alike].
**Broad Objective**

*To increase 100% adherence to medical and dental standards and professional codes of conduct by all registered practitioners in Zanzibar by 2018.*

**Strategies**

i. Ensure all registered medical and dental practitioners adhere to medical ethics and professional codes of conduct.

ii. Facilitate the legal framework to license allied health professions [e.g. Assistant medical and Assistant dental officers, clinical officers and dental therapist]

iii. Promote the registration of qualified medical practitioner and Dentist in the country

iv. Establish platforms for experience and research findings sharing among practitioners in Zanzibar

v. Establish network with other medical councils in and outside Zanzibar for experience sharing and future collaborations

**Indicators**

1. Percentage of new doctors and dentist registered or licensed
2. Proportion of registered/unregistered doctors reported to have malpractice reported.
3. Number of experience platforms held.

**7.8 Zanzibar Nursing and Midwifery Council:**

**Background:**
Zanzibar Nursing and Midwifery council is a structure that was established under the Act No. 9 of 1986 (the review is under process) which is responsible for regulating nursing and midwifery services within the public and private sectors in Zanzibar. It has been established for the purpose of ensuring provision of quality nursing and midwifery services to all groups in need.

**Justification**
Nursing and midwifery services are among the vital means of attaining quality health in Zanzibar. They form the backbone of health systems in the country and provide platform to tackle health problems that cause poverty and ill-health. In order to achieve the set objectives, the council mainly works on major areas of: system strengthening through existing regulations and related policies, promoting professional education, evidence-based research and performance management to strengthen the contribution of nursing and midwifery services to the health sector at large.

**Broad Objective**
*Increase capacity of registered nurses to offer professional quality services in line with the established ethics and codes of conduct in supporting the health care delivery system in Zanzibar by > 80 by 2018.*
Strategies:

1. Coordinate nursing and midwifery education in line with health sector nursing and midwifery needs in Zanzibar.
2. Promote career specialization among nurses to higher/advance degrees.
3. Promote ethical practicing and adherence to code of conducts among Nurses.
4. Promote enabling environment for quality nursing and midwifery practices and services in public and private sectors.
5. Enhance nurses appraisal programme
6. Promote research among nurses for evidence based effective nursing practices.

INDICATORS

1. Percentage of qualified and skilled nurses offering nursing services in public and non-public settings.
2. Proportion of nurses annually promoted for their quality work
3. Percentage of complaints filed against registered nurses
4. Number of research conducted by nurses or nursing associations

7.9 Traditional and Alternative Medicine

Background
Traditional and Alternative medicine council has been established by the Government under the Ministry of Health on the Act no. 8 of 2008.

Justification
Alternative medicine has existed in Zanzibar for a long time even prior to the establishment of modern medicine. To date various alternatives medical practitioners do practice in Zanzibar and some in rudimentary conditions. The need to publicly acknowledge and monitor the practicing and protect the public wellbeing is among the priority of the health sector. Moreover, Traditional birth attendant play significant role in home deliveries where > 50% of birth occurs. With such a background there is an unequivocal need to ensure close collaboration and regulation between modern and alternative medicine practitioners in Zanzibar.

Broad Objective
To increase access to ethical alternative medicine practice by all the population in need.

Strategies
i. Promote access to justified traditional medicine care [hospice] to all in need
ii. Review and update the existing Zanzibar Traditional medicine Act
iii. Strengthen registration of tradition practitioners, shops, clinics “Viringe”
iv. Strengthen monitoring of quality and virtuous standard of services
v. Strengthen collaboration and referral system between modern and alternative medicine practicing in Zanzibar.
vi. Promote scientific [pharmacovigilence] monitoring of prescribed herbal medicine used by alternative medicine practitioners.

vii. Promote research to ensure quality of traditional medicine.

**Indicators**

1. Revised enacted traditional medicine law
2. Number of registered traditional practitioners, shop and clinics
3. Number of traditional practitioners reported in the legal system against mal-practicing.
4. Number of referral made
5. Number of side effects reported [drug related]
6. Number of herbal medicine analysed.

**7.10 Zanzibar Medical and Research Ethics Committee:**

**Background**

A committee for the review of medical research protocols for studies to be conducted in Zanzibar was formed in the late 1980 out of personal initiatives of one of the then prominent scholars working in Mnazi Mmoja Hospital of the Ministry of Health and Social Welfare (MOHSW). This committee was accepted and supported by the MoHSW34, although it was not integrated as a structural unit in the Zanzibar Health Management System. In other words, the committee functioned like an Association of medical and public health professionals in MoHSW, without regular budget allocation or permanent office or staff. The committee files moved from the office of one secretary to another every time a secretary was replaced by another, from the period of formation of the committee until 2006. It is now envisaged that the unit being under the Department of policy and planning will receive adequate and proper attention.

**Justification**

In many biomedical researches involving human beings, the study participants are the most vulnerable of the stakeholders involved. They are at risk of physical, social and emotional exploitation. This is largely due to the high esteem in which health professionals and researchers are held by the lay public, which can easily be abused. In addition, there are special groups such as minors, refugees and mentally challenged individuals who are even more prone to exploitation in research. For these obvious reasons international community has emphasized the need to protect participants of medical researches through critical review of all proposed medical and related researches. There is need for regulation of research activities through establishment of Institutional Review Committees or Boards such as Zanzibar Medical Research Ethics Committee (ZAMREC). There is also a need to increase collaborative researches involving external institutions/organizations of diverse societal backgrounds, to help having different interpretations of ethical issues. This ideal desired situation is yet to be realized in many resources constrained institutions mostly in developing world such as Zanzibar due to lack of or inadequate operational mechanisms to ensure each clinical research conforms to ethical standards.

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34 This was the former name of the ministry: Ministry of health and social welfare
Broad Objectives
To establish a legally authorized ethical committee capable of ensuring protection of research participants in line with national and international research standards by 2018/19.

Strategies
i. Establishment of legal mandate for ZAMREC
ii. Training and education in research ethics for committee members and potential researchers
iii. Promote capacity to undertake effective ethical review and oversight of researches to ensure protection of human participants
iv. Establishing mechanisms for communication and networking with other ERC and academic and research institutions
v. Development of mechanisms to interact with communities [on simplified version of disseminating research findings]

Indicators
i. ZAMREC Act enacted.
ii. Number of protocols reviewed
iii. Proportion of new researchers trained on Good research practices and ethics.
iv. Proportion of annual added affiliation and networking with research institutions

7.11 The Non State Actors [NSA]

Background
The Non State Actors refer to private registered entities, Non-Governmental Organizations (NGOs), Community-Based Organizations (CBOs) Faith-Based Organizations (FBOs), traditional/alternative healers, academic institutions etc. Health related NSAs clearly have a significant role to play in improving the health of the population. However, in most cases, NSAs have been operating in a traditional model or in isolation in providing services and to a relatively small population. As a way to improve the existing collaboration, the Ministry wishes to encourage NSAs to focus more on a collaborative approach so as to support the invested sectoral efforts.

Justification
Due to the fact that NSAs services are used by people of all statuses, thus NSAs need to be considered in the national health policy and planning framework. Although, a central characteristic of NSAs is fragmentation and lack of reliable data on the quality and range of services provided; it is therefore challenging address their relative contribution in improving the health for the society. These and other challenges, have contributed to a general lack of knowledge about how to engage with NSAs, be they for profit or not for profit. It is of paramount importance for the MOH to technically support the NSAs in improving their implementation capacity and create platforms that will address some of the aforementioned challenges in a comprehensive manner.
**Broad Objectives:**
*To increase collaboration with NSAs by >70% from the current level so as to provide more accessible, higher quality, affordable and better value healthcare by 2016*

**Strategy**
1. Establish an effective collaboration mechanism between NSAs and the Ministry of Health.
2. Develop coordination platform between public, private and other health related Civil society organisation in Zanzibar

**Indicators**
1. Number of NSAs’ planning submitted and in cooperated in the MOH Plan of Action
2. Numbers of NSAs collaboratively work with MOH.

**7.12 The Chief Government Chemist:**

**Background**
The Chief Government Chemist Laboratory is an institution that was established in 1908\(^{35}\) with the main purpose of undertaking scientific analysis of different samples, scientific consultation and research activities especially in area of health and agriculture. The laboratory had initially been operating under the Ministry of Agriculture until 1994 when it was shifted to the Ministry of Health where it is operating up to date. Being the referral laboratory, it plays a key role in offering policy decision and at times judgmental ruling on undertaking sample analysis.

**Justification**
The establishment of government laboratory is necessary for performance of scientific analysis of various samples that will give the required information for the safety and protection of the health the society and its environment. Identification and quantification of suspected materials is the most important step for reaching proper and timely decision. Monitoring of dangerous materials such as weapons and hazardous chemicals in ensuring safety and security of the society require effectiveness of such laboratory. Proper guidance for handling of the widely used chemicals and chemical products that include agro-chemicals, industrial and consumer chemicals are among the roles of the laboratory.

**Objective**
*To increase institutional capacity to be able to ensure 100% quality and reliable laboratory diagnostic services for protection of human health and environment.*

**Strategies**
1. Strengthen the infrastructure of CGCLA that will meet high quality analysis results
2. Strengthen human resource capacity for higher performance of their roles
3. Strengthen safety for people and environment by establishing chemical management

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^{35} Anecdotal information.
4. Facilitate fully autonomous of the government chemist institution
5. Strengthen regional and international collaboration through quality assurance establishment
6. Strengthen and maintain harmonized operation between CGCLA, ZFDB and ZBS

**Indicators**
1. Percentage of the CGCLA infrastructure observed
2. Number of laboratory staffs trained and apply their profession in their duties
3. Percentage of safety from chemical risks
4. Percentage autonomous of the government laboratory
5. Number of regional and international meeting attended and provide technical inputs for good laboratory performance
6. Percentage harmonized operation of CGCLA, ZFDB and ZBS
SECTION EIGHT

8.0 HEALTH WORKFORCE [HUMAN RESOURCE FOR HEALTH]

**Outcome 2: Qualified and skilled human resource for health available and retained at more than 70% of health care delivery system by 2018.**

Background and Justification

The Revolutionary Government of Zanzibar is implementing the poverty reduction strategy (MKUZA II) in which health features as important components. Human resources for health is a critical component of the implementation of this strategy, in terms of both the quantity and quality of health services required. As such, the availability of skilled health workers at all levels of the health care delivery system is of paramount importance. Also among the highest priorities in the National health policy is to have adequate number of skilled health personnel who are motivated, highly committed and practice professionally.

In line with MKUZA II objective the strategies identified allow us to ‘improve HRH capacity retention and management of skilled personnel to provide quality service especially at primary level”. Furthermore the identified strategies allow us to *get the right staff with the right skills doing the right tasks in the right place at the right time*”.

Broad Objectives:

1. To increase HRH capacity, retention and management of skilled personnel to provide quality services at all levels.

2. To increase the annual outputs of the health training institutions, to mitigate the critical shortages of qualified health workers.

Strategies

1. Advocate at central GOZ to ensure the availability of HRH through :
   a. *Strengthening capacity of the CHS to provide enough skilled health workers*
   b. *Establishing new courses at the CHS that will cater for the needs of the health sector HRH*
   c. *Exploring and implement e-learning and telemedicine strategies as appropriate*

2. Advocate at central GOZ to prepare a proper and conducive environment for staff retention and motivation to provide effective services
   i. Develop and implement retention strategies especially for hard to reach areas
   ii. Establish performance based financing at primary level
   iii. Strengthen existing career development and promotion strategies for key health professional, nurses and allied health professionals
   iv. Promote the rights and safety of all health personnel at the workplace in line with OSH Act.
   v. Strengthen the utilization of the HRIS for planning and management (including deployment) of HRH
   vi. Deploy appropriate skilled health personnel to ensure implementation of the EHCP
   vii. Promote Staff appraisals systems to assess individual performance
3. Strengthen mechanism to recruit, deploy and retain health/medical specialists.
4. Promote the establishment of non-public medical/health training institutions in Zanzibar.
5. Provide mechanism, guidance and technical support to private medical/health training institutions established in Zanzibar.
6. *Increase number of skilled health personnel through long term and short term training, on job orientation and induction.*

**Indicators:**

i. Percentage of PHCU meeting minimum staffing requirements (newly approve)
ii. Proportion of skilled staff retained with first three years of training [post training]
iii. Proportion of staff appraised against their job descriptions annually.
iv. Number of non-public training institutions established.
v. Proportion of health facilities with Patients Charter displayed and system for assessing patient satisfaction.
vi. Number of qualified specialist recruited and deployed.
vii. Number of private medical/health training institutions which have received MoH support.

### 8.1 Human Resource for Health Training Institutions in Zanzibar

#### 8.1.1 College of Health Sciences - Zanzibar

**Background**

The College of Health Sciences was created by the Zanzibar House of Representatives with the ACT Number 10 of 1998. The College has its own council and it is among the two Government institutions in Zanzibar where health related cadres are trained. The graduates are mainly employed by the Ministry of Health Zanzibar. The college now have seven diploma cadres namely Nursing, Clinical medicine, Medical laboratory, Environmental health, Pharmaceutical sciences, Dental therapy newly one Biomedical engineering and certificate in Public Health Nurse. Now college has the total number 1074students up-to-date.

**Justification**

The continuing need for health professionals, the rapid increase in Zanzibar population and the rapid expansion of the health sector in Zanzibar have motivated the College to prepare to expand and improve quality and efficiency and deliver a more client-friendly service. Investing in human resources for Health is a shared objective of the partners working to improve health services in Zanzibar. The task of preparing, recruiting and retaining high quality health workers needs even more investment, therefore a carefully planned strategy needs to be in place in line with ministry goals.

**Broad Objective**

*To provide training, consultancy and conduct research in health disciplines and fields for provision of quality health services.*
Strategies:

1. Improve the quality of the College’s teaching programmes.
2. Establishing link between SUZA and CHS & The Zanzibar Medical School [ZMS] and other related institutions.
3. Promote annual enrolment according to national requirements.
4. Develop in-service training courses in line with health sector needs.
5. Recruit and develop college staff.
6. Improve students’ and teachers’ access to essential learning materials and new advents.
7. Strengthen the CHS infrastructure and the maintenance thereof.
8. Secure a fair subvention from the Government.
9. Strengthen e-learning in the CHS.

Indicators:

1. Number of competence based curriculum to all programme in CHS.
2. Number of in-services trained yearly.
3. Number of student recruited yearly.
4. Number of new infrastructure erected.
5. Proportional increase of revenues.
6. Number of building and equipment maintained annually against standard.
7. Proportion of e-learning program recognized by civil service commission.

8.1.2 Zanzibar Medical School

Background:

The proposal of establishing Zanzibar Medical School in Zanzibar was introduced to Cuba Government by visited mission from Tanzania in 2004. After series of discussions, in 2007, the Revolutionary Government of Zanzibar through its Ministry of Health established Medical School (ZMS) to address the critical human resource shortage. This was done following the agreement between the Medical University of Matanzas in Cuba and Zanzibar government to support this institution (Medical School) in future years. The ZMS is the one among three medical schools of this accredited university based in Cuba. This academic institution comprises of lecturers from Cuba who work closely with local staff and it uses a Cuban Model approach for teaching.

The training institution has a campus in Unguja and Pemba, whereby the school has enrolled 50 students, 38 in Unguja and 12 students in Pemba. The school is recruiting the students with capabilities to successfully complete the training and also to increase the likelihood that the graduates will work as medical doctors in Zanzibar on completion of their studies.
Justification

The recent comprehensive review of the health workforce in Zanzibar (Training Plan for health facilities 2011/2021) indicates that 74 Zanzibari Medical Doctors (minimum qualification degree in medicine) are currently working in Zanzibar (Unguja and Pemba). Of these 11 Medical Doctors are in Administrative positions that provide support to patients on ad-hoc basis. With the observed growing population (1.3 mil. people in 2011), doctor population ratio for Zanzibar ranges from 1:15,165 (all doctors) to 1:48,994 (active doctors). The result being that the traditional role of the Medical Doctor in diagnosing and treating patients is shifted to Assistant Medical Officers, Clinical Officers and nurses in the primary care facilities. Taking into account the number of medical student currently in training (in ZMS and abroad) the additional number required to be trained is 152 and therefore there is a great need for the ministry to start Medical School so as to increase the number of Medical doctors that will fill the gap for the benefit of Zanzibaris. It is envisaged that the school will later on be transferred to the State University of Zanzibar [SUZA]

Broad Objectives:

To increase the availability of sufficient Medical Doctors that will provide quality medical care to the people of Zanzibar by 75% by 2018.

Strategies

i. Facilitate the registration, recognition and accreditation of the ZMS by TCU.
ii. Ensure availability of sufficient resources to provide quality training for medical students
iii. Provide quality training for medical students using the new programme of training doctors in Zanzibar.
iv. Promote adherence to international standards of academic integrity.

Indicators

i. Accreditation of ZMS [TCU]
ii. Proportional increase in resource allocation
iii. Number of student uptake and drop outs.

8.1.3 Private and other Health Training Institutions

Background:

The crucial role played by Private Health Institutions and other types of institutions (faith based) on contribution of the number of health workforce is well recognized by Zanzibar Health Sector. Due to the critical shortage of health workforce manifested in Zanzibar situation, private health training institutions is very essential in complementing the HRH production gap that challenges the health sector in Zanzibar. It is envisage that with the current trend noted in Tanzania at large and Zanzibar in particular, The RGOZ through the health sector will have to accommodate the existence of such facilities/institutions and define mechanisms of coordination and collaboration. Moreover, the need to define areas of linkages and networking in building up the health system in Zanzibar needs due attention. Currently, Zanzibar has only
one Private health institution namely the Zanzibar School of Health. It is the duties of the MoH to work closely in ensuring standards are met in line with TCU guidelines.

Justification

Zanzibar is experiencing a new wave of the emergence of Private Health Training Institutions which are not reflected in any of the guiding documents of the health sector. Such an emergence creates a challenging gap especially in areas of coordination and calibration of professional skills. This calls for an immediate synergistic policy and strategic guidelines that will address the noted vacuum [gap]. Unequivocally, the need to fill this observed HRH gap calls for additional means of producing the new generation of HRH. The health system needs to ensure that the mechanism for quality, collaborative and strategic production of HRH is established in the country. Such establishment underscores the need for the sound and quality focus at the point of HRH producing institutions. Moreover, student exchange programmes, field practice and internship are among areas that need to be legally regulated for the better future.

Broad Objectives

To increase effective production of quality and competent health workforce that meets >70% of the national and international standards for all private health institution by 2018.

Strategies

i. Initiate/enhance coordination forum to exchange and sharing of the professional know how
ii. Enforce adherence to standard curriculum to increase productivity in health care delivery
iii. Work in partnership with other health institutions to enhance availability of desired number of health workforce

Indicators

i. Number and type of functional coordinating forum established
ii. Number of Private Health Institutions formally recognized by MoH
iii. Proportion of medical and allied health students produced by Private Health Institution within and outside Zanzibar
SECTION NINE

9.0 HEALTH SERVICE DELIVERY

Outcome 3: Access to comprehensive quality health services Increased to all citizens by more than 80% from the current level by 2018.

Background

The scope of service delivery comprises of promotive, preventive, curative and rehabilitation care services provided at various levels in the country. Respectively, these levels also form the hierarchy of referral system in Zanzibar. More than 95% of the populations live within a five kilometer distance from a nearby public health facility. In 1992, the Government of Zanzibar reintroduced private practicing majority of which are located in urban and peri-urban areas, hence serving fewer population compared to those district or areas located at rural settings.

Primary health care levels (PHC)

This is the lowest level of public healthcare structure in Zanzibar. They mainly provide basic outpatient services, including management of common diseases and injuries, Maternal and Child health services, including growth monitoring, immunization, antenatal, delivery services, and post-natal services, Health education and environmental and other community health services. The Primary Health care facilities are further divided into three [3] levels of services:

i. PHCU which provides basic primary health care within the estimated catchment population of about 3,000-6,000;

ii. PHCU+ serves within estimated population of 6000 – 10,000 for low density areas and 10,000 – 20,000 for high density area. Apart from the services provided by other PHCUs, PHCU+ they are supposed also to provide four additional services. These are delivery, laboratory, pharmacy and dental services.

iii. PHCCs: Primary healthcare Centre (PHCC) which is the referral point for all PHCUs. This can provide higher services with inpatient facilities of 30 beds capacity together with medical and surgical treatment, comprehensive emergency obstetric care, x-ray and ambulance services for emergency referrals. Currently there are four PHCC, commonly called cottage hospital, two in Unguja and two in Pemba

The primary aim of the government to strategically establish these facilities is to provide cost-effective health care services within the vicinity of families and their corresponding house-holds. These form the formal platform where health services interface with communities. Ideally, this is where the health sector also interacts with other public and non-public sectors to address social determinants of health and cross-cutting health issues [including epidemics] in Zanzibar. In this light, health facilities provide prevention,
treatment and care services for health conditions that include water and food borne diseases, such as cholera, dysentery and typhoid, and other health conditions such as malaria, pneumonia, cardiovascular disease, HIV and AIDS, domestic injuries and related violence, accidents and mental health problems.

Despite the fact that the PHCUs are sites where high impact interventions in key health programs are being implemented, targeting at reducing the disease burden, capacity constraints are challenges to the health system. Key implementation bottlenecks include:

a. inadequate and inequitable distribution of human resource for health service delivery at the primary level, both in numbers and in skills mix;
b. inadequate integration and coordination of vertical programmes;
c. inequitable geographical coverage of health services, especially in remote rural areas; and
d. An ill-functioning referral system.

Broad Objective
To deliver cost-effective, quality primary health care services to all [100% coverage] by 2018 as defined in the Essential Health Care Package.

Strategies:

a. Develop capacities of facilities to provide comprehensive and integrated services for both out-patient and in-patient clients at facility levels.
b. Establish the PHCU appraisal mechanism targeting at improving quality of services.
c. Strengthen community capacity and participation in monitoring the development and performance of facilities.
d. Improve functional referral systems, both horizontally and vertically, including referrals between private and public health facilities.
e. Establish linkages with community through the community health strategy
f. Enhance quality assurance schemes that include receiving feedback from clients
g. Promote facility linked data management, joint supervision and mentoring.

Indicators

i. Number of facilities providing integrated services.
ii. Functional referral system in place
iii. Number of PHCU appraised.
iv. Proportion of facilities which have engaged communities in service improvement schemes.
v. Number of joint supervision and mentoring conducted.

9.1 Essential Services for PHCU Level:

9.1.1 Integrated Reproductive and Child Health Services

Background
In the past decade, the Ministry of Health has addressed Reproductive and Child Health issues through various programmes. These programmes include Reproductive Health (which mainly dealt with Adolescence Sexual reproductive Health, safe motherhood, Post abortion Care and family planning),
Expanded Programme on Immunization, Integrated Management of Childhood Illnesses and Prevention from Mother to Child Transmission of HIV/AIDS. Since all these mentioned programmes worked towards achieving the same goal of reducing maternal, neonate and child morbidity and mortality, they were integrated into one, so as to ensure maximum efficiency and effective use of resources [value for money]. Hence, the programme is now known as Integrated Reproductive and Child Health Programme.

**Justification**

The maternal, neonate and child deaths in Zanzibar has markedly been contributed by limited access to quality health services, poor referral system, inadequate availability of commodities; equipment and supplies, and inadequate funding envelope for MNCH services. Other factors include: inadequate involvement and participation of community in planning, some negative socio-cultural beliefs and practices [myths and misconceptions], gender inequalities, poor health care seeking behaviors, inadequate meaningful involvement of males in planning and offering of MNCH services and low household education and income.

The national response to reducing maternal, newborn and child mortality is articulated in the MKUZA and operationalised through the National Road Map Strategic Plan (2008 - 2015) whose primary objective is to accelerate the reduction of maternal, newborn and child deaths in Zanzibar. Accordingly, the Revolutionary Government of Zanzibar has identified Maternal, Newborn and Child Mortality Reduction (MNMR) as one of its priorities and it is featuring in the Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRP).

**Broad Objectives:**

*To contribute in reduction of maternal and Under five mortality rates by > 50% from the current level by year 2018/19.*

**Strategies:**

1. Strengthen access and quality of skilled attendants who offers Integrated RCH services at facility level.
2. Strengthen and improve access to quality adolescent reproductive health services.
3. Advocate for quality MNCH services.
4. Strengthen basic obstetric care services at PHCU level.
5. Improve accessibility of quality family planning services.
6. Scale up and expand additional RCH services including: permanent methods for FP, screening for cervical cancer, mitigating sexual and gender based violence and male reproductive health services.
7. Improve knowledge on MNCH among men and women.
8. Improve quality and user friendly PMTCT services in health facilities providing RCH services.
9. Improve adolescent sexual reproductive health friendly services.
10. Strengthen M&E system for MNCH activities at all levels.
xi. Improve IMCI services through distance learning and community IMCI.

Indicators:

i. Number of births attended by skilled Health personnel compared to total births in a year.
ii. Coverage of Antenatal care (at least one visit and at least four visits).
iii. Proportion of health facilities providing quality basic emergency obstetric care services (skilled human resource, equipment and supplies).
iv. Contraceptive prevalence rate.
v. Proportion of clients with unmet need for family planning.
vi. Proportion of HIV positive pregnant ANC attendees delivering in the health facilities.
vii. Percentage of RCH facilities providing PMTCT services.
viii. Functional Monitoring and Evaluation system in place.
ix. Number of health facilities providing comprehensive Youth friendly services.
x. Percentage of health care workers who use IMCI guidelines in managing children

9.1.2 Immunization Services:

Background

The government gives special attention to the prevention, control and where possible, the elimination of communicable diseases that are of public health importance as well as safe motherhood and child survival. Immunization services are one among the priority intervention within the health sector in Zanzibar. Expanded Programme on Immunization (EPI) contributes substantially to the achievement of the Millennium Development Goal 4 which aims at reducing childhood mortality with a target of reducing the under-five mortality rate by two-thirds, by the year 2015. Approval was granted for pneumococcal and rotavirus vaccine introduction in 2013. The RGoZ plans to introduce Pneumococcal vaccine (PCV13) and rotavirus (RotaRix) in the 1st quarter of 2013. Concurrently, the MoH plans to introduce Measles second dose vaccines by 2014.

Justification

The immunization coverage in Zanzibar has reached the global set target of over 80% at district level with basic targets of DPT-HepB-Hib3 coverage of ≥ 80% since 2008. The national DPT-HepB-Hib3 vaccination coverage has increased from 86% in 2006 to 92% in 2011. However, in the last three years, Zanzibar has noticed a decrease in district coverage performance by 20% [districts reporting low vaccination coverage]. This affects the herd immunity hence increases the chances for disease outbreaks. Since the target is to reach the vaccination coverage of above 95%, the Ministry of health will ensure the implementation of the “Global Immunization Vision and Strategy 2006-2015 developed by WHO and UNICEF” envisions a world in which every child, adolescent and adult has equal access to immunization services

Broad Objective

Increase and sustain the national coverage of DTP-HepB-Hib3 above 95% by 2018.
Strategies
To achieve the desired goal of above 95% coverage several strategies are set to be implemented in the coming five years including:-

1. Strengthen the implementation RED/REC strategy to improve and sustain high immunization coverage
2. Strengthen capacity on programme management at national, District and service delivery level on Routine immunizations, SIAs logistic/cold chain and surveillance activities
3. Enhance community demand and participation for immunization
4. Ensure effective introduction of Pneumococcal vaccine (PCV13) and Rotavirus by 2013
5. Support operational research annually so as to see the need of modifying programme policies and improving performance by 2014
6. Promote TT vaccination in school to ensures sustainability of MNT country elimination status

Indicators:
The most important indicators for immunization activities will base on routine immunization, surveillance, logistic and cold chain system of the programme in which the following indicators will be monitored

1. National and District Penta 3 percentage coverage.
2. Percentage of districts with > 80% coverage
3. National Penta 1-Penta 3 dropout rate
4. Percentage of Districts detected measles suspected cases
5. Number of AFP, NNT and measles cases detected and investigated
6. Percentage of districts with adequate number of functional cold chain equipment
7. Proportion of averted morbidity and mortalities of vaccine preventable diseases

9.1.3 Malaria Control Programme

Background
The Ministry of Health through Zanzibar Malaria Control Programme has implemented several interventions as described in the previous Strategic plan. The Overall objective of the previous plan was to reduce the burden of malaria disease by increasing the use of control interventions. The malaria strategic plan did implement guidelines which integrated other programmes such as reproductive and child health delivery services. The Ministry of Health and Zanzibar Malaria Control Programme have achieved the global, MDGs and Abuja targets for malaria control, including the attainment of near zero deaths due to malaria. Therefore, this noble achievement takes Zanzibar to another new paradigm of targeting complete elimination of local malaria transmission in the country.
Justification

The previous Strategic plan was emphasizing on interventions coverage and prevention of malaria to the Zanzibar population. According to the Zanzibar Health Sector Reform Strategic Plan II 2006/07 – 2010/11, the Ministry was targeting to achieve coverage of basic interventions on the following targets.

i. To raise the percentage of under-fives having prompt access to and receiving appropriate management for febrile illness within 24 hours from 13Percent in 2005 to 70 Percent in 2010
ii. To increase the percentage of under-fives sleeping under ITNs from 37 Percent in 2005 to 90Percent in 2010.
iii. To reduce the case-fatality rate from 2.1 Percent in 2005 to 0.5 Percent in 2010.

The new Malaria Strategic Plan (2012 -2018) will focus mainly on disease surveillance and sustain coverage and use of all intervention.

Broad objective

To halt new Malaria infection in Zanzibar by 100% by 2018

Strategies

1. Strengthen monitoring and surveillance activities at points of entries to prevent the reintroduction of malaria cases in the Isles
2. Maintain use of IRS in targeted areas and promote use of ITNs/LLINs to all population
3. Improve staff capacity on malaria surveillance and response in all districts
4. Strengthen functional coordination structures for malaria elimination at national, district and Shehia levels
5. Develop mechanism for malaria sustainable financing strategy. agenda

Indicators:

i. Number of malaria cases reported and investigated in all entry points (outcome)
ii. Number of people protected by IRS in the targeted areas (outcome)
iii. Percentage of people sleeping under LLINs (output)
iv. Proportion of districts conducting active case-based surveillance within three days (process)
v. Percentage of detected epidemics contained within one week of onset (process).
vii. Number of malaria-free Shehias (outcome)
viii. Number of confirmed malaria deaths (outcome)
ix. Number of locally acquired confirmed malaria cases (outcome)


Background

In considering disease management and control as an integral part of public health, MoH has integrated HIV/AIDS, TB and Leprosy with the aim of pooling knowledge, expertise and resources to mitigate harmful consequences of stigma, including discrimination and social exclusion and provision of quality health services. Generally, HIV prevalence in Zanzibar is low (0.6% ) based on THMIS 2007/08, but is
remarkably higher among Key Populations including: intravenous drug users (IDU) with a prevalence of 11.3%, female sex workers (FSW) 19.3% and men having sex with men (MSM) 2.6% as found in IBBS 2012. This therefore classifies Zanzibar’s HIV epidemic as a concentrated type of epidemic.

On the other hand, the TB incidence rate has been increasing steadily, the number of tuberculosis cases notified in Zanzibar has steadily increased from 75 in 1988 to about over 546 in 2011, with an annual increase between 2% - 5% with Urban West region alone contributing to more than 60% of all forms of TB cases notified or diagnosed in the country. Currently, documented HIV/TB co-infection is at 25%36. Annual detection rate of leprosy in Zanzibar is about 109 patients. Patients with grade 2 disability are 12.5% in 2008 and it was not less than 10% for five consecutive years. However, in 2006 Tanzania was declared to have reached National leprosy elimination target but in Zanzibar still there are some pockets in 4 districts with high prevalence of leprosy. These are South, Central, West and Micheweni districts.

**Justification**

IHTLP gives priority to early case finding and treatment for HIV/AIDS, TB and leprosy thereby saving a large number of lives, preventing many disabilities and reducing in numerable human sufferings. Zanzibar Health Sector HIV and AIDS Strategic Plan (ZSHSP) 2012-2016 and Zanzibar TB and leprosy Programme (2010 – 2015) strategic plans, have underpinned the need to intensify their efforts further in the control of these diseases thus contributing to the country’s wider efforts to meet vision 2020, the Poverty Eradication Strategy goals and the millennium development goals. Since Zanzibar is classified as HIV concentrated epidemic country, the emphasis is on addressing HIV among the Key and vulnerable populations. The programme is also striving to achieve and maintain the WHO targets set for TB of detecting 70% infectious cases and treatment success 85% by 2014 based on Global Strategy to Stop TB, intensifying TB/HIV activities and management of drug resistance TB. In the case of leprosy, the programme will increase efforts to reduce the disability grade 2 by 35% by 2014. Special activities supported such as targeted LEC and SAPEL on specific districts with high burden are expected to accelerate this process.

**Broad objectives:**

1. To prevent the spread of HIV infection among the most at risk population and the general population while providing quality continuum of care to all in need.
2. To control the occurrence of TB/Leprosy disease in the country until they are no longer public health problem by providing equitable, accessible and gender sensitive health services.

**Objective1.**

*To prevent the spread of HIV infection among the most at risk population and the general population by > 70% by 2018.*

**Strategies**

1. Expand access and utilization of STI, HIV and AIDS prevention, treatment, care and support services
2. Strengthen capacity of all hospitals to perform safe blood transfusion

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36 Data from Integrated HIV/TB leprosy programme-2012
3. Encourage participation of People Living with HIV and AIDS to prevent re-infections and transmission of HIV with adequate consideration of human rights (Prevention with Positive).
4. Improve utilization of STI services among Key Population and General Population
5. Increase number of health facilities that are providing comprehensive TB/HIV collaborative activities and number of health facilities implementing the package of HIV prevention in health care settings.
6. Strengthen utilization of quality HTC services of the general, key and vulnerable population
7. Strengthen laboratory capacity to support quality HIV services delivery
8. Ensure regular and adequate availability of all the necessary drugs and supplies for HIV and AIDS services commodities in all health facilities providing the services

**Indicators**

i. Number of people counseled and tested and received their results
ii. Number of women and men with an STI or reproductive tract infection (RTI) presenting at health facilities who are diagnosed according to National guidelines
iii. Percent of sexual partners of individuals with an STI or reproductive tract infection (RTI) treated at health facilities whose sexual partners are notified of their infection
iv. Percent of Key Populations who are living with HIV
v. Number (and %) of HIV positive adults and children receiving a minimum of one clinical service
vi. Number (%) of adults and children with advanced HIV infection currently receiving ART
vii. Number of adults and children NEWLY enrolled on ART
viii. Percentage of adults and children with HIV known to be on treatment 12, 24 and 60 months after initiation of ART

**Objective 2: To control by 80% the occurrence of TB/Leprosy disease in the country until they are no longer public health problem by providing equitable, accessible and gender sensitive health services.**

**Strategies**

1. Pursue high quality DOTS/MDT Expansion and enhancement.
2. Strengthen collaborative TB/HIV activities with special focus on congregate settings.
3. Strengthen management of MDR-TB
4. Strengthen health system capacity including infection, prevention and control of TB
5. Engage all health care providers in line with the International Standard for TB Care.

**Indicators**

i. Estimated TB incidence rate (per 100,000 population)
ii. Estimated incidence rate SSP cases TB (per 100,000 population)
iii. TB Cure rate and Treatment success rate
iv. TB Death rate
v. Number of TB patients tested for HIV  
vi. Percentage of HIV positive among all TB Patients  
vi. Percentage of HIV positive among TB patients tested for HIV  
viii. Number of new leprosy cases identified  
ix. Percentage of Multi Bacillary patients completing 12 doses of MDT amongst those expected to complete their MDT treatment.

9.1.5 Nutrition Improvement Programme:

**Background**

Nutrition is an integral part of MKUZA II and of Health Sector Strategic Plan. It is imperative that the commitments made in these plans and strategies are honoured; that nutrition is placed on the policy agenda of the Ministry of Health.

In Zanzibar, 30% of children are stunted and 20% are underweight; these levels are ‘high’ according to WHO criteria. The prevalence of acute malnutrition, also known as wasting, is 12% which indicates a ‘serious’ public health problem according to WHO. Worryingly, the prevalence of severe acute malnutrition the most life-threatening form of malnutrition is 4.5%. This prevalence may appear low, but it translates to 9,500 children, up to half of whom will die if they do not receive appropriate treatment.

Micronutrient deficiencies are also common. Almost two-thirds of children suffer from anaemia (69%). Less than one half of households consume adequately iodated salt, increasing the risks that young children will suffer intellectual impairment. Levels of iodized salt consumption are particularly a concern in Pemba where salt is produced but only 24% of households consume adequately iodated salt. Vitamin A deficiency is a public health problem, but more seriously in Pemba (53.2%), and in particular, in North region of Pemba (62.5%). In Urban/West region the prevalence of vitamin A deficiency is 49.8% which is becoming a concern in the area. Also, the prevalence of Non communicable diet related diseases revealed that Overweight was 36.6 percent, diabetes 2.2 percent and hypertension 33 percent.

**Justification**

Malnutrition is slowing progress towards economic growth and poverty reduction in Zanzibar. It does this by threatening the lives, health, growth and development of children, lowering school performance, and reducing work productivity in adulthood.

This is a critical time for nutrition. With the global economic crisis, climate change, volatile food prices and HIV pandemic, urgent actions are needed now – more than ever before – to protect nutritional status. Cost-effective interventions are available and feasible. Failure to take action to improve nutrition will thwart Zanzibar’s good intentions to promote growth, equity and poverty reduction.

**Broad Objective:**

*To improve nutritional status of the Zanzibaris by >70 to contribute to the national economic growth by 2018.*
Strategies
i. Ensure Vitamin A supplementation and deworming to every child aged six months to five years twice yearly.
ii. Reduce anemia through routine iron-folate supplementation for pregnant women, deworming and micronutrients supplementation for young children
iii. Strengthen management of malnourished cases (both moderate and severe acute malnutrition) at all health facilities
iv. Promote salt iodization in Zanzibar.
v. Improve infant and young child feeding through effective nutrition education and counseling services.
vi. Reduce non communicable diet related diseases through effective education and counseling in collaboration with NCD program and Health Promotion Unit.
vii. Promote enrichment of food with micronutrients (food fortification).

Indicators:
  i. Number and percentage of under-fives children received Vitamin A capsules and deworming tablets.
  ii. Number of treated cases of severe Acute malnutrition [SAM] at facility level
  iii. Percentage of households using iodated salt.
  iv. Percentage of under six months children who are exclusively breastfed.

9.1.6 Neglected Tropical Diseases Control Program:

Background:
Neglected Tropical Diseases (NTDs) are a group of chronic disabling infections affecting more than 1 billion people worldwide, primarily poor populations living in tropical and subtropical climates, with children being the most vulnerable to infection. In Zanzibar such diseases include Lymphatic Filariasis, Schistomiasis, Soil-Transmitted Helminthiasis and Trachoma. Beyond their negative impact on health, NTDs contribute to an ongoing cycle of poverty and stigma that leaves people unable to work, go to school or participate fully in family and community life.

Justification:
Neglected Tropical Diseases are one of the key areas of concern in Zanzibar. With respect to the National Over-arching Policy - Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRP II) 2010 – 2015. This shows the health sector’s commitment in tackling NTDs. It is high time now that the programme should be alienated to provide holistic services to the entire society.

Broad Objective:
Control by more than 80% and Eliminate transmission of earmarked Neglected Tropical Diseases prevailing in Zanzibar by 2018.

NTDs Control Strategies
1. Strengthen government ownership, advocacy, coordination and partnerships
2. Enhance planning for results, resource mobilization and financial sustainability of the national NTD programme
3. Scale-up access to interventions, treatment and capacity building
4. Enhance NTD monitoring and evaluation, surveillance, and operations research

**Indicators:**

i. Number of NTDs prevailing in Zanzibar eliminated (Lymphatic filariasis, Schistosomiasis, trachoma) according to National NTD strategic plan.
ii. Number of NTDs prevailing in Zanzibar controlled (Soil transmitted Helminthiasis etc)
iii. Number of NTD cases properly managed (LF)

### 9.1.7 Primary Eye Care Programme

**Background**

Comprehensive Eye Services (CES) refers to the programme of offering services related to the sight problems and treating for the same. The programme is directed towards rehabilitation or training HCW on effective management for eye conditions. This is done through appropriate health education, treatment or surgery. Since 1990s Ministry of Health has received both long and short term support from different partners to address eye problems within the Islands. Some of the major investments made include Improvement of infrastructure, development of human resource and provision of equipment and supplies. Currently, the eye care services have been scaled up to the community level by establishing and equipping Primary Eye Care (PEC) unit which is also responsible for Outreach Eye Services

**Justification**

Blindness has profound human and socio economic consequences in all societies. The costs and impact of productivity, and rehabilitation and education of the blind constitute a significant economic burden, particularly in developing countries. Furthermore blindness is often associated with lower life expectancy thus the prevention and cure of blindness can provide enormous savings for an already burdened health system and facilitate societal development. It is imperative that these issues are addressed urgently because they impact on the government’s policy of Poverty Reduction and a needlessly blind person cannot easily engage in meaningful socioeconomic development endeavors.

**Broad Objective**

*Reduce the avoidable blindness from 0.4% in 2007 to 0.2% by the end of 2017.*

**Strategies**

1. Strengthen preventive activities of eye diseases.
2. Improve Clinical management of Eye diseases at all levels of service delivery.
3. Improve availability of affordable and low cost spectacles.
4. Enhance capacity of health care workers on management of eye disease.
5. Strengthen Monitoring, Research and surveillance.
Indicators
i. Proportion of people with avoidable blindness prevented
   ii. Percentage of people with eye disease managed and cured
   iii. Proportion of people with long standing eye disease rehabilitated.

9.1.8 Environmental Health

Background
The Environmental Health Unit is obligated to address sanitation and hygiene matters across the country. For improving environmental health, the unit has the main role of raising community awareness on hygiene and sanitation, in collaboration with the department of public health ensure the translation and enforcement of Public Health Act, Management of solid, liquid and gaseous wastes, Vector control, Extension of coverage of improved latrine, Air pollution control, Water and food safety, Inspection of premises including buildings and industries and fumigation and spraying

In 2012, the unit has made positive strides in accomplishing its objectives by playing an important role in facilitating the formulation of the Zanzibar Public Health Act and Environmental Health Practitioners Act. The unit has also promoted latrine coverage through PHAST and low-cost sanitation technologies initiative.

Justification
For long, Zanzibar has been experiencing environmental challenges which affected the health of community members. The problem has been aggravated by the current increase of development projects influenced by economic development, effects of global warming, high population growth and unforeseen disasters. The unit is pivotal in navigating the country to overcome challenges attributed by health damaging pollutants existing in the environment. Moreover, the interventions by the unit are very instrumental for enabling the country to meet the sanitation linked goals stipulated by the Zanzibar Strategy for Growth and Poverty Reduction II (ZSGRP II).

Broad Objective
Increase capacity of population to reduce and avoid harmful environmental health related risks by >50% from the current levels by 2018.

Strategies
i. Enhance capacity of the environmental health unit in promoting sanitation and sanitation standards in the country.
   ii. Promote use of sanitary facilities
   iii. Promote utilization of clean and safe water.
   iv. Promote behavioral change in the community by way of sanitation-based health education.
   v. Promote coordination of air pollution control interventions.

Indicators
i. Number of environmental health risks and impact assessment.
ii. Proportion of households with access to basic sanitation.
iii. Proportion of the community practicing hand washing
iv. Number of reported water borne and fecal oral disease outbreaks

9.1.9 Health Promotion

Background
Health promotion unit is a under the Department of Preventive Services and Health Education of Ministry of Health Zanzibar. The unit is responsible for coordination of all health promotion activities within the Ministry of Health and health related institutions in Zanzibar. It is subdivided into Public Health Information, School Health program and Community Base Health Care.

Justification
Over the years, within the Ministry of Health, a wide range of health education and health promotion activities have been carried out by health programmes, often culminating to duplication and inappropriate utilization of resources. Various ministries multilateral organizations, bilateral agencies and other partners have also participated in a number of ways in supporting and or conducting health promotion activities in the country. However, supports that have been directed have not been adequately address resource gap for effective health promotion interventions. Health Promotion is therefore necessary to bring changes in the way of addressing determinants of health in our country.

Broad Objective
*Increase capacity of the HPU to provide comprehensive, efficient and effective health promotion interventions to empower communities, families and individuals to develop and practice healthy lifestyles by > 80% by 2018.*

Strategies
i. Enhance capacity of human resource for advocacy, production and dissemination of health promotion materials.
ii. Establish and run Afya FM radio for public health promotion campaign.
iii. Establish and equip health learning materials development section
iv. Institute comprehensive school health program
v. Ensure people with special needs and groups are reached with appropriate health education messages
vi. Build capacity of community committees to implement Community Health Strategy
vii. Strengthen health promotion office/sub unit in Pemba
viii. Strengthen capacity to monitor and evaluate health promotion interventions and campaigns.
ix. Promote the application of the community health strategy.
x. Establish a health education/promotion designing and printing unit

Indicators:
1. Number of Health promotion unit staff trained on Health promotion disciplines (short and long term courses)
2. Number of radio health programmes aired by Afya radio
3. Functional Health learning material producing unit
4. Number of schools reached with behavioral change educational sessions
5. Number of schools reached for health inspection
6. Number of functioning Shehia Health Custodian practicing CHS package

9.1.10 Disease Surveillance

Background:
Zanzibar Epidemiology and Disease Surveillance - Unit is under the director of Preventive Services and Health Promotion (DPS) of the Ministry of health, it is responsible for tracking, monitoring, controlling and offering technical guidance to Ministry and other implementing programmes on prevention of both communicable, non-communicable diseases and other health related events.

Justification:
Disease surveillance is one of the major priorities of the Ministry. Implementation of IDSR aimed at enhancing capacity for timely and comprehensive responses to disease management efforts. However, decreased budgetary support from the government compromised these primary good intentions. *Renewed efforts from government and other stakeholders are necessary to sustain and expand progress achieved through implementation of IDSR.*

Objective
To increase public health surveillance capacity to monitor and control epidemics and other diseases of public health importance in order to reduce morbidity and mortality associated outcomes by >70% from the current level by 2018.

Strategies
1. Strengthen the country’s capacity to conduct effective surveillance for both communicable and non-communicable diseases:
2. Strengthen the country’s capacity to respond to and control epidemics by providing necessary logistic support
3. Strengthen monitoring and evaluation of the surveillance system.

Indicators
i. Proportion of HCW with capacity to undertake effective disease and epidemic surveillance
ii. Percentage of laboratories with capacity to monitor and or track advance levels of disease epidemics.
iii. Proportion of vital logistics reported to be out of stock.

9.1.11 Emergency Preparedness and Response

Background
The health sector plays a key role in emergency and disaster preparedness and response in the country. This sector is always called and relied upon to response. It is expected to take the lead in dealing with disease outbreak or epidemic, also provide essential back up support during rescue operation. Timely and
efficient attention to the health care needs of the population affected by a disaster is one of the highest priorities in the overall management of major emergencies and disaster.

**Justification**

Zanzibar has experienced trends of disaster which leads massive loss of lives due to ships drowning. Geographical location of Zanzibar increases the vulnerability or exposure to hazards such as floods, tropical storms, and tsunami. Not only that but also beauty nature of the Islands has attracted many visitors to come in Zanzibar to enjoy holidays and business activities. These interactions may provide opportunity for the transmission of highly infectious diseases such as Ebola, Yellow fever and other haemorrhagic fever. Therefore, health sector needs to be prepared to take a lead and minimize disruption of basic health services in Islands when disaster strikes.

**Broad objective**

Increase institutional capacity to monitor and effectively respond by >80 to emerging public health conditions and natural disaster by 2017.

**Strategies**

1. Strengthen capacity on emergency preparedness and response to health workers at various levels.
2. Establish coordination system within and outside the MOH for timely response during emergency.
3. Mobilize resources necessary for emergency response.

**Indicator**

i. Number of functional of health sector Emergency Preparedness and Response team
ii. Existence of Emergency Preparedness and Response Unit within MoH
iii. Existence of Health sector EPR Plan
iv. Number of MoH staffs undergo training on disaster management
v. Number and types of equipment procured for emergency preparedness and response.
vi. Number of meeting for emergency preparedness and response conducted.

9.1.12 Non–Communicable Disease Services:

**Background**

Non-communicable Diseases (NCD) is a broad term involving variety of diseases and conditions that affect the lives of community especially in low and middle income societies. The realization of life style related diseases and conditions are estimated to change its epidemiological pattern for the ten leading causes of morbidity from 6-7 in 1999 to 1&4 in 202037. In Zanzibar, NCD refers and include cardiovascular diseases, Diabetes, Cancer, Mental illness, Oral health and Road Traffic Accident which are the major health burden of the country.

37 WHO Evidence Information and Policy, 2000
Justification

The evidence of the growing burden of NCDs has been documented worldwide. While the diseases are regarded as being a significant health problem in Zanzibar, it is also recognized that such diseases are major threat to the community at large. The main risk factors for NCDs namely smoking, alcohol intake, unhealthy diet and low physical activity are prevalent in both rural and urban communities. There is ample scientific evidence to support the fact that NCD can be prevented. Hence, there is need to focus more on primary prevention at population level targeting interventions to reduce exposure to tobacco, reduce alcohol intake, reduce salt intake, promote healthy diets and physical activity.

Objective:
To halt the fast growing epidemic of non-communicable diseases by 50 % by 2018

Strategies:

i. Strengthen access to Prevention and Promotion services to mitigate NCDs [NCD risk reduction related interventions].
ii. Improve Clinical Management and adherence to treatment at all level of health care delivery points
iii. Improve coordination and collaboration with NGOs, Professional Bodies & Other Stakeholders
iv. Strengthen Monitoring, Research and Surveillance
v. Strengthen Human resources capacity to to ensure quality provision NCD interventions at all levels.

Indicators:

i. Number and type of health promotion materials addressing the main NCD risk factors.
ii. Number of health facilities equipped with minimum clinical equipments and tools for assessment and management of NCD and NCD risk factors.
iii. Number of self-guided intervention packages to help patients with NCD and NCD risk factors
   Number of trained health care workers in the management and prevention of NCD
iv. Number of NCDs scientific paper / reports published
v. Percentage reduction of negative NCDs related life style

9.2 OTHER RELATED PRIMARY LEVEL INTERVENTIONS

9.2.1 Occupational health

In Zanzibar, occupational health services are performed under Occupational Health Unit in collaboration with the department of Occupation Safety and Health [OSH] as mandated by the public Health Act (Public Health Act 2012) and Occupational Health Safety Act [2005].
**Justification**
Most of the workers have little awareness on occupational health issue and most of them were affected by their work and its environment. In recognition to this the Government established occupational health services to ensure health and safety and wellbeing of all workers in their work places by doing inspection of the work places, medical examination of the workers, health promotion and counseling in order to reduce occupational health hazards.

**Broad Objective**
*Promote and maintain of the highest degree of physical, mental and social safety of workers in all high risk occupations by the year 2017.*

**Strategies**
1. Promote awareness creation on occupational health issues.
2. Strengthen HR capacity to inspect occupational services and medical examination of all employees [public and non-public] in line with OSH laws and guidelines.
3. Ensure rehabilitation and resettlement of workers who are unable to work due to long term illness and accidents.
4. Strengthen inter sectoral collaboration with OSH department [MLEC] and employer association and other related MDAs in enhancing workplace safety and health of employees.

**Indicators**
1. Number of occupational health programmes aired and IEC material developed and distributed.
2. Number of premises inspected
3. Percentage of workers screened
4. Number of stakeholder’s meeting conducted to harmonize the inspection and redefined roles in line with occupational health.
5. Number and type of training provided to health care workers

**9.2.2. Port Health Unit**

**Background**
Port health unit, is under the Department of Preventive services in Ministry of Health, which consist of three sub unit: Vaccination centre, Air and Seaport Health. Key roles played by this unit include: monitoring and evaluation health measures, hazardous substances, control of goods, and importation of diseases and vector/pests of medical importance. Also the unit performs regular ships inspection and fumigates affected vessels. Key challenges include: staff shortage, inadequate infrastructure and working equipment.

**Justification:**
All point of entries in Zanzibar are not designated to meet public health standards, especially on conveyances inspection, to manage variety of public health risks and related events. The unit needs to be strengthened and equipped so as to be in appropriate position to perform inspection and issuance of sanitation certificates. Moreover, there is need to revisit the units working tools including regulations, administrative acts, protocols and standard operating procedures.
Broad Objectives
*To Minimize importation and exportation of diseases, and vectors of medical importance in Zanzibar by 2016*

Strategies
i. Strengthen capacities of health professionals to implement International Health Regulations are in place by the year 2016
ii. Scale up access to quality vaccination services to travelers in both Islands [of Unguja and Pemba].

Indicators
i. IHR law customized and in use
ii. Proportion of point of entries with medical equipment and inspection kits available
iii. Percentage of trained personnel for inspection of conveyances
iv. Number of point of entry emergency response plan in different level established.
v. Numbers of inoculation centers established

9.3 Secondary and tertiary levels of health care delivery systems in Zanzibar:

Background

Currently, Secondary level (District Hospitals) serves as the first referral centre for PHCUs; and the tertiary level which is the main referral centre in Zanzibar. Recently the RGoZ has forwarded an agenda of transforming and restructuring secondary level of care to fully fledged district hospitals. These shall serve as referral centres for respective districts hence increase geographical accessibility to specialised quality of care within the vicinity of all those in need. This move entails upgrading of all cottage hospitals to become district hospitals while Mkoani and Wete District Hospitals shall serve as Regional Hospital. In addition, Chake Chake hospital will be a referral hospital for Pemba while Mnazi Mmoja hospital shall be transformed into a National Referral Centre for the entire Zanzibar. The primary objective towards this transformation is to ensure increased access to quality comprehensive specialised care to all.

Justification

Although there is good coverage of primary healthcare facilities in Zanzibar, there is still a significant gap in availability of secondary health care services in Unguja and Tertiary referral services in Pemba. This has got several implications in the health service delivery in both Unguja and Pemba in relation to the served population. Furthermore, the current hospital referral system is non-responsive and does not serve the intended purpose. This is largely attributed to the insufficient capacities at lower levels, including shortages of health workers, erratic supply of essential drugs and medical supplies, and inequities in the
distribution of essential physical infrastructure and equipment to offer services that are appropriate to their level, and also due to the limited scope of services offered by facilities at lower levels.

Outreach services rendered by the PPP have markedly complemented efforts offered by static health facilities. These services have contributed to the improvement of access to services in hard to-reach areas and also reduced the indirect cost barriers, such as transport and time costs, food and accommodation for in-patients and relatives, faced by the poor people in rural areas in accessing health care. In strengthening the health care delivery system in Zanzibar, the HSSP-III targets at strengthening the secondary and tertiary levels of health care.

**Broad Objective**

*Increase capacity of secondary and tertiary levels of health care system in Zanzibar to offer quality services in both public and private facilities by 50% from the current level by 2018.*

**Strategies**

2. Transform MMH into a semi-autonomous institution
3. Develop and implement an appropriate Hospital Reform Programme that will include:
   4. Review and strengthen hospital referral health services, horizontally and vertically.
   5. Strengthen mobile health services, including the mobile hospital services, tele-medicine services, and routine and ad hoc outreach health services at all levels.
   6. Strengthen hospital management capacity in areas of financial and accounting management software systems; and exploring opportunities for alternative health care financing systems [e.g. cost sharing, insurance schemes etc.
7. Promote private sector participation in the provision of specialized health care services, through innovative modalities, including Public-Private- Partnerships.
8. Strengthen capacity of the tertiary hospital to be a base of medical training institute with capabilities of managing advanced medical conditions aiming at minimizing medical tourism.
9. Developing and ensuring the implementation of an operational plan for accreditation and certification process at all levels of the health system
10. Provide and maintain appropriate infrastructure for disposal of medical waste

**Indicators**

1. Number of districts with secondary level health facility
2. Proportion of district hospitals with minimum required professional staff
3. Percentage of Hospitals with functional referral mechanism
4. Proportion of health facilities with proper infection prevention and control measures
5. Percentage of health facilities with adequate stock of medicine supplies in the last 6 months
6. Number of patients referred to out of the country Hospitals for medical treatment
7. Number and Types of newly established laboratory services.
8. Percentage of health care facilities accredited and certified for better performance.
9. Types of specialized health services offered by private sectors
9.4 MEDICAL DIAGNOSTIC SERVICES

Background

Medical Diagnostic services in Zanzibar are an integral part of the health care provision. These include medical laboratories, radio imaging and other related supporting systems. This implies that medical laboratories are usually attached to health facilities. Specifically, there are 42 public health facility laboratories and 72 private health facility laboratories\(^{38}\). The capacity of the laboratory is dependent on the level of health service. Like the health system, therefore, the laboratory network follows a pyramidal structure supervised by Mnazi Mmoja Pathology Laboratory with four inferior levels as follows:

- **Level 5:** Mnazi Mmoja Pathology Laboratory
- **Level 4:** Semi-specialized referral center and research services – this includes the national programs: ZMCP, Pemba Public Health Laboratory, ZNBTS, NTD, .
- **Level 3:** Intermediary laboratories – district laboratories.
- **Level 2:** Basic/peripheral laboratories – including all laboratories in health centers (HC).
- **Level 1:** PHCU and Private Dispensaries.

Concurrently, radiological services have been established at district and cottage hospitals as well as at the Mnazi Mmoja referral hospital. The CT scan has been recently installed at MMH referral hospital.

9.4.1 Medical laboratories:

Justification

The National Medical Laboratory Strategic Plan and the Maputo Declaration on Strengthening of Laboratory Systems of January 2008 recommends standardization of laboratory services at every level of the laboratory network. Based on this and the need of standardizing equipment and techniques, Zanzibar has developed her own standards of Medical Laboratories [November 2011]. Hitherto, the four different levels were mandated to provide minimum package of tests as detailed in the Zanzibar Medical Laboratory Standards. Despite human resource and the weak infrastructure base, Zanzibar medical laboratory system has developed considerable capacity to undertake a range of laboratory services.

Broad Objectives

*Increase 80% of laboratory capacity to support quality, clinical diagnosis and monitoring diseases outcome by 2018.*

Strategies

i. Strengthen capacities for diagnostic services and infrastructures at all levels
ii. Strengthen Human resource capacities for quality laboratory services
iii. Improve management of supply chain.
iv. Strengthen efficient laboratory Referral network
v. Strengthen Laboratory Total Quality Management System including private laboratories.

\(^{38}\) Zanzibar Laboratory Situation Analysis Report [MoHSW-2009].
Indicators
i. Number of Laboratory and imaging facilities providing quality services
ii. Number of people investigated at different facilities Percent increase of functional Laboratory logistic systems in place
iii. Number of laboratory with operational referral
iv. Number of laboratory with effective monitoring systems

9.4.2 Radio-imaging:
Justification
At present radio-imaging services are inadequate compared to population needs. Functional radiological services are limited to basic x-ray services, ultra sound and CT Scan that are mainly available in main hospitals and in few private facilities]. This has created major challenges in offering these services including limited number of radiologists frequent breakdown of equipment which at times makes the services not accessible resulting in delay management of patients or patients not accessing the right management at a right time.

Objective:
Increase 100% access to high quality medical imaging services for optimal delivery of clinical care services at all levels by 2018.

Strategies
1. Enhance capacity of medical imaging personnel in routine and specialized services
2. Strengthen working environment and surrounding infrastructure for effective storage of radiological equipment and undertaking radio-diagnostic interventions
3. Explore technological advances in medical imaging and possibilities for adaptation to Zanzibar situation.
4. Enhance continuous monitoring of radiological standard operating guidelines, to ensure adequate and proper use of medical imaging equipment
5. Strengthen functional system for effective radiation protection.
6. Enhance capacity for radiological waste disposal

Indicators
1. Proportion of facilities with skilled radiological personnel]
2. Number of new radio imaging equipment installed and or maintained
3. Percentage of health facilities utilizing Standard operating procedures.
4. Number of facilities with effective infrastructure/mechanism for radiological waste disposal
5. Types of technological advances in medical imaging adopted.

9.5 QUALITY ASSURANCE

Background
Quality assurance is pivotal to successful quality health care delivery system. Quality assurance addresses all elements of health service delivery and is an essential marker for a successful HSSPIII implementation
and evaluation process. It ensures the contribution of the health to MKUZA II and MDG goals and their indicators respectively.

**Justification**
To realise this, the health system in Zanzibar is being challenged by multitude of factors, these include, quality and infrastructural design of most of our facilities, f

i. frequent breakdown of equipment and failure to adhere to equipment maintenance plans and calibrations systems,

ii. inadequate qualified human resources, and

iii. Constrained health management system.

The health sector has started to mitigate these issues and progressive strategies with defined interventions have been developed to strengthen the quality of the rendered health care services.

**Objective:**
*Design and implement a comprehensive integrated approach to quality improvement at all levels of health care service delivery by 2018.*

**Strategies:**

i. Strengthen the quality assurance task force to monitor quality of rendered services

ii. Develop framework to improve quality in standards and accreditation mechanism on various services at all levels

iii. Introduce performance base framework management system

iv. Initiate customer satisfaction approach in health care service provision to ensure improve client and service provider satisfaction

**Indicators**

i. Proportion of serviced monitored at various levels

ii. Percentage of major services delivery points [such as laboratories procedures] accredited

iii. Percentage of units/sections practicing performance base framework [management]

iv. Proportion of clients satisfied with the delivered quality of services [service –clients assessment]
General MoH Procurement system

The procurement system of the MoH has been relatively strengthened by the establishment of the central procurement unit [in 2006] within the ministry headquarters. The unit is responsible for ensuring smooth procurement of medicament, supplies, reagents and equipment for the health sector in Zanzibar. Moreover, the unit is also responsible for facilitating medical ceilings needs to guide the monthly distribution system and to ensure adherence to the Government Procurement Act of 2005, and for the procurement of goods that are of large quantity or that involve a large amount of money, beyond USD 10 thousand. Usually this type of procurement is conducted through a tendering process, such as open domestic bidding and open international bidding, except for single source procurement. There is also a Tendering Board that governs the process. The Procurement Management Unit faces several challenges, including inadequate budget allocation, bureaucracy, inadequate qualified and skilled personnel and no operating budget.

10.1 Drugs and Medical Supplies:

Basic drug production in Zanzibar

In 1980s, Zanzibar used to produce basic drugs but currently all drugs and reagents are being imported. Even the urge to promote internal drug production is high but this will be bitterly positioned outside the MoH. It is the view of this Strategic plan to facilitate the establishment of such institution by promoting non –Public sector to view it as part of the developmental investment.

10.1.2 Medicament and equipment procurement and storage systems:

Procurement of medicines and related pharmaceuticals is governed by the Zanzibar National Medicine Policy (2008) and the essential drug list. All drugs have to be procured through the Medical Stores Department (MSD) in Dar es Salaam, with a delivery system that has often been found unreliable. In Zanzibar, there is no pharmaceutical industry; the Central Medical Store is responsible for storing and distributing pharmaceuticals and related items within the public health sector. Since 2004 Danida has been the main partner supporting the procurement of medicines, medical and non-medical supplies in Zanzibar. The support covered almost 85% of the actual demand. The RGoZ has of recent increased its budget allocation for drugs to be at par with that allocated by Danida. The government with the support from Danida and USAID have recently finalised and launched a big pharmaceutical warehouse.
The current health procurement system is being challenged by the absence of forecasted needs accompanied by reliable quantification of the same, no ministerial procurement plan leading to ad hoc procurement practices and high turnover of procurement specialists within its unit. The system now looks on addressing health sector needs through the framework contract as a mechanism to refrain from block or allotment procurement which at times results in having frequent stock outs.

10.1.3 Distribution of medicament and supplies

Periodically, there are notable challenges of distributing drugs to the periphery or transferring drugs to Pemba, where also there is no good warehouse and the cold storage system for the vaccines is faulty. Moreover, the current push system does is not cost effective resulting in drugs being piled up in certain facilities they could be of use somewhere else. In view of this there is a move towards establishing a pull system. The later has challenged the mechanism of tracking the drug flow to the end user.

10.1.4 Destruction of expired and counterfeit drugs

Monitoring of sub-quality and counterfeit drugs through the ZFDB has yielded positive results but the system lacks and internal environment friendly drug destruction incinerators. This has resulted into some medicament to be shipped off to mainland Tanzania for destruction with negative cost implications. The ZILS is yet to function maximally and its sustainability also raises additional questions especially when one considers the available resources [human and financial].

10.2 Traditional medicine:

The CMS and the office of chief pharmacist work in close collaboration with the traditional medicine council. There is need to scale up this technical collaboration for the better future for all Zanzibaris.

**General objective:**

*To increase capacity to procure, store and distribute safe and quality efficacious drugs to the entire population at affordable cost by 80% by 2017.*

**Strategies:**

i. Develop good process and procedures on receiving, safe storage and efficient distribution of essential medicines and medical supplies to the entire country that will ensure their availability and accessibility at all time form 30.5% in 2012 to 95% in 2014

ii. Establish transparent storage system that enables each user of CMS to be fully aware of the movement of medicines and medical supplies from 0% in 2012 at least >75% by 2015

iii. Enhance the capacity for quality control of drugs, medicament and supplies

iv. Provide an adequate financial, physical, technical and human resource capacity develop and maintain the required ST-IC systems at all levels

v. Enhance an equitable distribution and accessibility of Essential medicines to all parts of the country.

vi. Strengthen the utilisation of essential drug list for planning and procurement process.

vii. Develop capacity to destroy sub-quality and counterfeit drugs internally

viii. Strengthen partnership and collaboration between alternative medical practitioners and health institutions in areas of drug monitoring and research.
ix. Strengthen cold system storage system [warehouse] in Pemba.

INDICATORS

1. Number of stock received with relevant document, batch number and Expiry date.
2. Percentage of decreased stock out of tracer drugs
3. Proportion of Health Facilities received stock through the pull system
4. Proportion of counterfeit and or expired drugs destruction established
5. New warehouse for Pemba in use.

10.3 Medical Equipment:
Currently, medical equipment are procured based on individual departmental needs and availability of funds from all potential sources. On ad hoc basis consultation to the heath care engineering unit are brought on board. Concurrently, the absence of the equipment procurement and maintenance master plan aggravate this situation. The system is being challenged by the limited presence of qualified human resource for biomedical engineering, inadequate staffed sub-unit in Pemba, absence of health sector equipment policy guideline or manual, the changes and advancement of technologies and the limited and erratic access to financial resources.

Objective:
*Increase health sector capacity to access and sustain medical equipment and related armamentarium at all level by 2018.*

Strategies:

i. Develop the health sector equipment policy and accompanying equipment procurement plan
ii. Establish a standardised equipment list for each level of health care delivery
iii. Develop a system for fixed asset registry for medical equipment
iv. Strengthen capacity of the health care engineering unit to repair and maintain medical equipment and accompanying infrastructure.
v. Developed HR package for HCEU in line with the procured and installed equipment
vi. Improve spare parts procurement and management systems.
vii. Advocate for routine preventive maintenance system for medical equipment.
viii. Strengthen medical equipment workshops

Indicators:

i. Number of programmes and facilities utilizing the developed health sector equipment policy.
ii. Standardised equipment list
iii. Proportion of facilities and programmes utilizing the fixed equipment registry
iv. Number of HCW trained on biomedical engineering
v. Number and type of new equipment procured.
10.4 Infrastructure and Transport

10.4.1 Infrastructure.

Principally, it is the duty and responsibility of the Ministry of Health to oversee and maintain quality of most of the exiting and would be erected infrastructures. This is done through the engineering unit wing of the MoH. The unit has basic HRH challenges but is also responsible for undertaking building maintenance as well as biomedical engineering maintenance work at all level. The unit have three section: Unguja zone, Pemba zone and Mnazi Mmoja Hospital.

Objective

To increase preventive maintenance for the health sector infrastructure to be able to offer conducive working environment by > 80 by 2018.

Strategies

1. Establish outsourcing mechanism on some of the services
2. Enhance the unit capacity to be able to offer quality maintenance services at a wider base and range [multi disciplinary]
3. Strengthen revenue generation and equipment availability as part of sustaining infrastructural interventions.
4. Promote HCEU capacity to offer services outside the health sector

Indicators

i. Number of outsourced services
ii. Proportion of staff with multi disciplinary skills
   Percentage increase in collected revenue and sustainable revenue generation plans

10.4.2 Transport

The Transport unit is under the department of Administration and Personnel. Ideally, the unit is supposed to coordinate the whole transport operationalisation system within the Ministry. But due its capacity and the capacity of the heads of the units limits the role of this unit to [i] driver placement and reallocation [ii] fuel control and at minimal [marginal to be precise level. Majority of the MoH drivers have not received training from recognized training institutions. Also the heads of the units have not receives any certified training on transportation maintenance and this is the challenge to the whole system in this modern world.

Strategies

1. Strengthened coordination and coordination between Ministerial units with transport units
2. Strengthen capacity of transport management through modern system, qualified and skilled human resources and equipment.
3. Coordinate all MOH transportation activities
4. Establish transport inventory and transport fixed asset registry
Indicators

i. Percentage of units coordinating clearly with the transport unit
ii. Percentage of staff with certificate from qualified transport institutions
iii. Functional Transportation inventory and fixed registry in place.
Section Eleven

Outcome 5:
Increase real health sector funding per capita from USD15.3 to USD29.2 by 2018

11.0 Health Care Financing and Sustainability

Background:

Resource Envelope of the Health Sector
The health sector in Zanzibar is currently financed through the Government (40.9%), Development Partner contributions (57.5%) and informal fees for service (1.6%) (PER 2011). While the total funds available have increased over the past five years, as compared to 2010, the total funding envelope declined by 3.3% in 2011, with a 5.8% fall in the Government contribution (PER 2011).

Government Funding
Government funding for the health sector comprises 5.8% of the total RGoZ envelope (PER 2011). This is significantly lower than the 15% target recommended in the Abuja Declaration. Furthermore, running costs of the health sector, under the current systems, exceed the Government’s contribution; it is estimated that an allocation of 10.7% of RGoZ funds is required to cover all health sector running costs (PER 2011).

The major contribution to health care financing by the Government is through human resource remuneration, accounting for over 80% (Personnel Emoluments, PER 2011) of Government funding in the health sector.

Development Partner Funding
The health sector in Zanzibar is heavily reliant on Development Partner funding. The main contributors to the sector are DANIDA, the African Development Bank (ADB), the Global Fund and the United States. Under these donor agencies the funding for specific programmes is due to end in the next two years with DANIDA funding secured until 2014, ADB funding secured until 2012, Global Fund Round 6 for HIV until 2013, and uncertainty remains over the status of continued PMI and PEPFAR funding.

Per Capita Funding
Total real funding per capita has decreased from 2009 by more than TZS 5,000. Given this decrease and steady population growth (3.1%), real per capita funding for health is at a five year low at TZS 22,600 (USD 15.3) per capita. WHO (Commission on Macroeconomics and Health, 2001) estimated that providing minimal essential health care services would require expenditure in 2007 at least 34 U.S. dollars (USD) per capita per year in low-income countries.

Justification
Stable and sustainable health financing is an essential component for achieving important population health goals. The overall Health Policy mission statement is to ensure that all Zanzibaris have access to quality and equitable health services rendered in a cost effective and affordable manner. The health
financing strategy should be guided by objectives related to efficiency in resource mobilisation; financial risk protection; efficiency in service delivery and quality of services; and fairness and social inclusion.

**Objectives:**

To increase health sector financial resources allocation through the adoption of various health financing options in line with the Zanzibar health sector policy by 2018.

The Ministry of Health aims to produce a long term strategy that:

i. Ensures a more stable and sustainable source of revenue;

ii. Minimises out-of-pocket expenditure for health care;

iii. Ensures increased equity in access to services;

iv. Promotes efficiency and equity of resource allocation and use of health services of an acceptable quality.

v. Improve performance, results and the quality of services through an outputs-based financing approach.

**Strategies and Interventions**

Both MKUZA II and the Zanzibar Health Policy outline the strategic direction for the health sector in the form of core strategies and policy statements, respectively.

**A. Strategies**

1. Increase government budget, ensuring a gradual increase towards the target recommended in the Abuja Declaration, and improve efficiency of government resource allocation for health (Zanzibar Health Policy)

2. Develop and implement a comprehensive health care financing strategy (MKUZA II)

3. Search for alternative ways of sustainable health financing, which shall guarantee equity through universal access to health services (Zanzibar Health Policy)

4. Implement an equitable Government health budget allocated to health districts based on an allocation formula, in support of primary health care (Zanzibar Health Policy)

5. Align donor funding with MoH strategies, plans and priorities and strengthen coordination of donor funding for health

6. Account for the main sources and uses of national resources for health strategic interventions

7. Use evidence and information for health financing policy

**B. Strategic Interventions**

i. Mobilise funds to ensure the availability of improved services to the general public by implementation of a Health Insurance Scheme

ii. Implement Performance-Based Financing (PBF), using the principles of payments against outputs to increase performance, efficiencies and quality of care. Strengthen advocacy and efforts between the MoH and POFEDP to increase the share of total government expenditures allocated to the health sector
iii. Use effective Annual Plan of Actions (POA) and Medium Term Expenditure Framework (MTEF) at all levels based on health priorities and health needs of the population in annual and strategic budgeting

iv. Implement sound financial management tools, budget controls and budget management at the point of service delivery

v. Mobilise additional resources to cover health care, non-communicable diseases prevention, health promotion and other related health problems such as road traffic accidents

vi. Harmonisation of donor funding through pooling arrangements (DHSS Subvote Basket)

vii. Advocate for more predictable funding from medium to long term from development partners

viii. Align donor funding with health sector priorities 2013-17 by using the MoH annual and medium term planning and budgeting process and tools

ix. Use pre-payment schemes and social health protection to improve quality of health services

x. Establish and implement National Health Accounts (NHA) or other types of comprehensive financial flow and expenditure tracking surveys

xi. Integrate health financing information, costing results and other evidence in formulating health financing policies

xii. Improve local human resource capacity in the area of health economics/health care financing

**Indicators:**

i. Real funding per capita

ii. RGoZ health expenditure per capita

iii. Donor contribution to public health per capita

iv. Private health expenditure

v. Government contribution to the health sector as a percentage of the total RGoZ funding envelope

vi. Percentage of the population covered by Social Health Insurance

vii. Percentage of health facilities covered by the entire PBF package
SECTION TWELVE

12.0 HEALTH INFORMATION AND RESEARCH: MONITORING THE IMPLEMENTATION OF HSSP-III

Background
Monitoring and Evaluation (M&E) are essential tools to systematically track the progress of implementation of planned activities and the assessment of results overtime. Based on such results, monitoring and evaluation provide evidence based information for planning and decision-making and to guide on how strategies have worked to realize the planned objectives.

The successful implementation of this strategic plan should therefore be guided by a well designed Monitoring and Evaluation Framework that will be able to capture, amongst variety of its salient information including:

i. The routine health information system (HIS) through designed Strategic and Monitoring Plan
ii. The routine health services information through HMIS and programmes Monitoring and Evaluation systems
iii. Data that flow as by-product of health care administration
iv. The episodic health research information through census and variety of health related surveys

Justification

The Health Sector Strategic Plan (HSSP-III) is a long term plan involving all players in health care system and other stakeholders with interests in health care delivery and systems. Under these circumstances, the implementation of this plan will therefore requires concerted efforts of different implementers from programmes and health care institutions in Zanzibar and a robust centralized M&E system to track and assess the fragmented information from implementing programmes and institutions for well consolidated results.

The current situation in Zanzibar health care system revealed the presence of Monitoring and Evaluation Systems at programme levels whereby each programme strive to monitor and evaluate its own interventions but are not technically aggregated into a comprehensive sector-based monitoring and evaluation system. The presence of such a system is expected to track the overall performance in attempt to consolidate health related information from different implementers of HSSP for effective overall monitoring and periodic evaluations of the health care system in Zanzibar. The HSSP-III is supposed to contain all interventions planned for the coming 5 years and its overall monitoring and evaluation though will gradually be done through programmes and health care institutions during their implementation process in piece meals; but its overall implementation should be eventually assessed by the health sector M&E system.

**Broad objective:**
*Increase institutional capacity to monitor quality and implementation of ZNSPIII by >80% by 2018.*

**Strategies:**
i. Strengthen capacity to track HSSP-III implementation progress and design necessary interventions.

ii. Strengthen capacity to Monitor and Evaluate health sector interventions at various levels.

iii. Enhance the institutionalisation of integrated data auditing systems

iv. Develop M&E health information sharing and dissemination platforms

v. Advocate for evidence based planning and policy decision making

vi. Strengthen the institutionalisation of Health information system.

vii. Enhance the integration of disease monitoring system for early warning signs

viii. Promote peer review documentation and publication of HIS findings

ix. Develop ZHSSPIII M&E plan

x. Strengthen web base reporting and monitoring

**Indicators:**

1. Number of outputs monitored
2. Percentage of outcomes realised
3. Number of audits conducted
4. Number of M&E operating platforms
5. Number of policies and decision reached based on evidence.
6. Functional HIS
7. ZHSSPIII plan in use.
SECTION THIRTEEN:

13.0 THE IMPLEMENTATION OF THE HSSP-III

Successful implementation of the HSSP-III will depend on active participation of different actors (Public and NSA as well as community) and availability of adequate resources. These include qualified human resources at all levels, good supportive working space, reliable information, timely availability of adequate funds and strengthened Organization and management. The coordination among implementers at all levels from the chief accounting officer [centrally], to middle level managers and the front workers is crucial for this endeavor. Furthermore, the implementation also calls for a costed plan with clearly defined monitoring and evaluation systems.

The strategic plan is intended to cover a five years period, which will be translated into an annual plan of action. The plan will be evaluated annually and midterm review shall be undertaken 2.5 years after launching. The planning unit shall on behalf of the Principal Secretary be responsible on the plans of work as well as to monitor its implementation. Also, heads of Departmental heads as well as heads of sections shall ensure that work plans are developed and implemented. The lower level [grass root] will be engaged in the planning cycle and they shall be the one undertaking the implementation. This bottom up approach in decision making shall be promoted.

13.1 Role and responsibilities of key stakeholders on implementing HSSP-III

13.1.1 Role of the National level:

The core function of the MoH at central level is to oversee:

i. the formulation and execution of Health Policies, laws and their translation;
ii. Overseeing the overall implementation of the Strategic plan through the formulation of key monitoring platforms and technical working groups
iii. Development and adhering to qualities and operating standards inclusive of quality assurance schemes
iv. Resource mapping, mobilization and appropriate allocation based on identified needs and Disease dynamics;
v. Advising other ministries, departments and agencies on conditions and diseases of public health importance inclusive of epidemics, natural disasters
vi. Capacity development and technical support provision at all service delivery points;
vii. Provision of nationally coordinated services including health emergency preparedness, response inclusive of disease epidemics;
viii. Coordination of health research and applications of research findings for policy and planning purposes; and
ix. Monitoring and evaluation of the overall health sector performance.
x. Promote designing, executing and translating scientific and operational health research for better planning process
xi. Oversees and translate the implementation of the Public health Act as part of promoting the health of the citizens.
13.1.2 Role of Zonal and District Level

13.1.2.1 Functions of the Zonal Health Management Team [ZHMT].

i. Interpretation of health policies, acts, regulations, directives and procedures of carrying out health services in the zone

ii. Co-ordinate and support District Health Management Teams technically

iii. Form a technical link between the MOHSW, donors and districts in all matters of health services delivery.

iv. Co-ordinate and assist the district to identify the training capacity in order to meet the training needs of health workers in the zone.

v. Co-ordinate the implementation mechanism for monitoring and evaluation of health workers performance

vi. Supervision of the district hospital, cottages.

vii. Assist the district in the control of epidemic diseases and establish a focus for emergency activities in the zones

viii. Supervise, enforce and monitor ethical codes of conduct for health practice in the zones.

ix. Carry out regular supportive supervision to each district

x. Arrange and carry out routine and on job training in the zones.

xi. Evaluation of the outcome of training done in the zones

xii. Facilitate availability of health resources at each level of service provision (health personnel, material supplies, reagents and equipment etc) according to the minimum national set standards / Guidelines.

13.1.2.2 Roles of the DHMT

i. To prepare comprehensive district health plan in line with the National District Health Planning Guidelines

ii. Facilitate community involvement in the planning process using participatory approaches.

iii. Facilitate and co-ordinate public/private mix in the district.

iv. To ensure that the comprehensive district health plan is implemented by them, the hospitals, PHCC, PHCU and communities

v. Ensure provision of transport, drugs, vaccines, medical supplies and equipment to the hospitals, health centres and dispensaries.

vi. Train and sensitize health workers and communities to overcome the health problems

vii. Prepare schedules for outreach and conduct services

viii. Explore additional sources of funding, improve collection and control council health funds

ix. Oversee that health acts and ethical codes are adhered to in the district

x. Do professional work in the hospital as part time

xi. Carry out supportive supervisory visits in the health facilities

xii. Ensure every health facility in the district has an emergency and disaster management plan according to available resources and capability.
13.1.2.3 The Non-State Actors [NSA]:

The HSSPII shall take on board NSA who shall be
a. Informed or involved in consultation on policies and strategies, on priorities for cooperation
b. Forge active partnership in service mapping, delivery, monitoring so as to ensure wider access and sustain quality for provided services
c. Where applicable provide technical and other related resources in order to support local development processes
d. Involved in implementation of projects and programmes in areas that concern them based on areas of comparative advantages.
e. Actively engaged in developing mechanism for Public private partnership
f. Coordinate and assist the MoH in the identification of areas of research and use of findings to improve health services.

13.2  ANTICIPATED LIMITATION OR RISK ON IMPLEMENTATION OF THE HSSPIII

13.2.1 Pre-condition.
Development of the strategic plan is based on situation analysis which did undertake a thorough review of different documents, interviewing of sectors and non sectors implementers. Knowledge, the enormous information as well as the commitment of the coordinating platform and active engagement of other HCW and related MDAs will shape the implementation pace and mark potential areas that call for advance investments. High commitment and increased financial allocation and timely availability of technical support are of paramount importance for the good take off of the HSSP-III.

13.2.2 Assumption.

a. Government to increase its resource allocation to health sector financing from 5.8% to 12% by 2018
b. Ministry policy doesn’t change and cause negative interference on implementation of the SP.
c. Continuation of donors’ support within the health sector.
d. Stable Social, Economic and Political environment within the country
e. Willingness of communities to participate and contribute fully on sectoral development
f. Related MDA to continue working with the Ministry of Health.
g. Local government Department continues to work with the Ministry of Health especially in harmonising comprehensive decentralisation
h. Sustainable availability of qualified human resources for health including support staff.

13.2.3 Risk.
There are no high risks, but two worth mentioning. These are timely and adequate availability of funds for the sector and the possibility to get high level of collaboration from other ministries and stake holders.
Figure 18: Organogram of the Ministry of Health

Source: Directorate of Administration and Human Resource