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HSPS IV (2009 – 2014)

Annex 2:

Support to the health sector in Zanzibar

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Main Programme Document
Annex 1: Support to the health sector in Mainland
Annex 2: Support to the health sector in Zanzibar
Annex 3: Support to the multi-sectoral response to HIV/AIDS

This Volume contains Annex 2, the component description for Component 2: Support to the health sector in Zanzibar

Table of Content

i. Acronyms and abbreviations i
ii. Executive summary iii
iii. Cover page vii
1. Introduction 1
2. Brief situation analysis: Sector context 1
2.1. National context 1
2.2. Significance of the sector 2
2.3. Institutional set-up of the sector 4
2.4. Key sector policies, legislation and programmes 4
2.5. Sector financing 6
2.6. Donor coordination 9
2.7. Cross-cutting issues and priority themes 9
2.8. Key Challenges 10
3. Strategy 14
3.1. Summary of past experience & achievements 14
3.1.1. District health services 14
3.1.2. Procurement of pharmaceutical products, management of infrastructure 16
3.1.3. Human resources for health 18
3.1.4. Quality assurance 20
3.1.5. Community health 22
3.1.6. Evidence-based decision making 24
3.1.7. Private sector activities and public-private collaboration 25
3.1.8. Resource mobilisation, health financing 26
3.2. Challenges & opportunities 27
3.2.1. District health services 27
3.2.2. Procurement of pharmaceutical products and maintenance of infrastructure 28
3.2.3. Human resource management and development 30
3.2.4. Quality assurance 31
3.2.5. Health promotion, including community health and school health 32
3.2.6. Evidence-based decision making, HMIS 32
3.2.7. Public-private collaboration 33
3.2.8. Health financing and monitoring sector performance 34
3.3. Strategic approach 34
3.4. Brief narrative summary of component 35
3.5. Capacity development support 38
3.6. Strategy for integrating HSPS support into government systems 39
4. Objectives, outputs and main activities 41
4.1. Sub-component 1: Support to the Health Service Fund 41
4.2. Sub-component 2: Earmarked central sector support to systems development, management and strategic interventions 43
4.3. Sub-component 3: Support to NGOs and public-private partnerships 46
5. Budget 48
6. Sustainability and replicability issues 50

7. Implementation arrangements **51**
7.1. Management and Organisation 51
7.2. Financial management and procurement 53
7.3. Monitoring, reporting, reviews and evaluations 54
8. Assessment of key assumptions and risks **56**
9. Implementation plan **57**
Appendices **58**
Appendix 1: Progress towards health sector milestones 60
Appendix 2: Job description for Senior Health Adviser 63
Appendix 3: Job description for Adviser Human Resources for Health and Quality Assurance 66
Appendix 4: Job description for Junior Professional Officer Health Promotion 68
Appendix 5: Terms of reference for Steering Committee 70
Appendix 6: Detailed budget (tentative) 71
Appendix 7: Key references 72

i. Acronyms and abbreviations

ADB	African Development Bank
AJHSR	Annual joint health sector review
AKF	Aga Khan Foundation
ANC	Antenatal care
ANGOZA	Association of NGOs in Zanzibar
CBO	Community-based organisation
CDHP	Comprehensive district health plan
CE	Continuing education
CEU	Continuing Education Unit (MOH&SW)
CFS	Consolidated fund services
CHS	College of Health Sciences
CMS	Central Medical Stores
CS	Cost-sharing
CSC	Civil Service Commission
CSO	Civil society organisation
Danida	Danish International Development Assistance
DC	District Commissioner
DHMT	District Health Management Team
DHS	Demographic and Health Survey
DKK	Danish krone
DMU	Drugs Management Unit
DP	Development partners
DPP	Director(ate) of Policy and Planning
EHCP	Essential health care package
FY	Financial year (from July to June in Tanzania and Zanzibar)
GAVI	Global Alliance for Vaccines Initiative
GDP	Gross Domestic Product
GFATM	Global Fund for the fight against Aids, Tuberculosis and Malaria
GOZ	Government of Zanzibar
HCEU	Health Care Engineering Unit
HMIS	Health management information system
HRD	Human resource development
HRH	Human resources for health
HRIS	Human resource information system
HRM	Human resource management
HSF	Health Service Fund
HSPS	Health Sector Programme Support (Danida funded)
ICT	Information and communication technology
IMR	Infant mortality rate
IT	Information technology
ITN	Insecticide treated mosquito net
JAST	Joint Assistance Strategy Tanzania
JMIP	Joint Ministry Internet Project
JPO	Junior Professional Officer (Danida)
LLITN	Long-lasting insecticide-treated mosquito net
MDG	Millennium development goals
MKUZA	Kiswahili acronym for ZSGRP
MMH	Mnazi Mmoja Hospital
MMR	Maternal mortality rate
MOFEA	Ministry of Finance and Economic Affairs

MOH&SW	Ministry of Health and Social Welfare
MOU	Memorandum of understanding
MRALGSD	Ministry of State Regional Administration and Local Government and Special Departments
MSD	Medical Stores Department (Tanzania mainland)
MTEF	Medium Term Expenditure Framework
NHA	National Health Accounts
NGO	Non-governmental organisation
OC	Other charges (GOZ budget line)
PBF	Performance-based financing
PE	Personal emoluments (GOZ budget line)
PER	Public Expenditure Review
PFM	Public finance management
PHC	Primary health care
PHCC	Primary health care centre
PHCU	Primary health care unit
PHL	Public Health Laboratory (Pemba)
PMU	Procurement Management Unit (MOH&SW)
POA	(annual) Plan of Action
PPP	Public-private partnership
PSM	Procurement and supply management
QA	Quality assurance
QIRI	Quality Improvement and Recognition Initiative
RALG	Regional Administration and Local Government
RCH	Reproductive and child health
RDE	Royal Danish Embassy
SC	Steering committee (HSPS)
SHA	Senior Health Adviser (Danida)
STI	Sexually transmitted infections
SWAp	Sector wide approach
TA	Technical assistance/assistant
TACAIDS	Tanzania Aids Commission
TB	Tuberculosis
TOR	Terms of reference
TSh	Tanzania shilling
TWG	Technical working group
U5MR	Under five mortality rate
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
US$	US dollar
VCT	Voluntary counselling and testing
WHO	World Health Organization
ZAC	Zanzibar Aids Commission
ZACP	Zanzibar Aids Control Programme (MOH&SW)
ZANA	Zanzibar Nurses Association
ZANGOC	Zanzibar NGO Cluster for HIV/AIDS prevention
ZHOA	Zanzibar Health Officers Association
ZHSRSP	Zanzibar Health Sector Reform Strategic Plan
ZMCP	Zanzibar Malaria Control Programme
ZSGRP	Zanzibar Strategy for Growth and the Reduction of Poverty

ii. Executive summary for HSPS IV

Introduction

Denmark has supported the health sector in Tanzania for decades. The fourth phase of Danish support to the Tanzanian health sector 2009-2014 comprises a budget of DKK 910 million in support to the health sector in Mainland, the health sector in Zanzibar and the multi-sectoral response to HIV/AIDS.

HSPS IV (2009-14) is in line with the Third Health Sector Strategic Plan (Mainland) 2009-2014, the Second Zanzibar Health Sector Reform Strategic Plan 2006-2010 and the National Multi-sectoral Strategic Framework for HIV/AIDS 2008-2012, the Joint Assistance Strategy for Tanzania..

Objectives

The overall aim for the Danish development assistance to Tanzania is to contribute to poverty reduction and to the achievements of the MDGs. The objectives of the Danish assistance through HSPS IV correspond to three inter-related and complementing objectives for the three sectors:

a) To provide basic health services in accordance to geographical conditions, which are of acceptable standards, affordable and sustainable and with focus on those most at risk an responsive to the needs of citizens in order to increased the life span;
b) To ensure equitable access to quality health services in Zanzibar, in particular at the district level and below and to encourage the health system to be more responsive to people's needs and demands; and
c) To support the multi-sectoral response to HIV and AIDS in Tanzania through support to the implementation of the NMSF.

Strategic approach

The capacity of the health systems in Mainland and Zanzibar and the multi-sectoral response to HIV/AIDS will be strengthened using a mix of modalities. The majority of the funding will be provided through joint financing arrangements to the implementation of national or organisational strategic plans, supplemented by more targeted capacity strengthening through earmarked financing in specific intervention areas as well as by technical assistance.

A minor share of the total budget is earmarked for specific areas of support, but provided as flexible funding to be detailed in the annual work plans and budgets as appropriate in response to needs at the time. Thus, funds are primarily committed to broad areas of work rather than to specific activities. The areas selected for earmarked funding are based on expressed GOT & RGOZ needs and priorities and are areas where Danida has a comparative advantage, e.g. prior experience or considered preferred donor by government, or where such support is deemed more appropriate in terms of allowing innovation and experimentation.

The focus is on ensuring quality service delivery at district level and below and the strengthening of necessary central support and referral systems to support the lower levels. The program recognises the need to consider the health sector in its entirety and the need for strengthening the involvement of the non-government sector in public health and HIV/AIDS activities. Each component therefore contains three sub-components focusing around three types of intervention: a) Un-earmarked support through (and development of) joint funding arrangements; b) Earmarked support for capacity strengthening of central level support to systems development, management and strategic initiatives; and c) Support to PPP and private sector involvement.

Component 1: Support to the health sector in Tanzania Mainland
The health sector in Tanzania Mainland will be supported by a total grant amounting to DKK 528 million (including contingencies). Firstly, general support to the implementation of the HSSP III will be provided through the HBF and the LGCDG Health Window (for infrastructure) and may introduce an element of pay for performance. The majority of this support will be channelled through the HBF mechanism, which as of 2008 corresponds to sector budget support. Secondly, earmarked support will be provided for health systems and capacity strengthening including strategic initiatives with focus on supporting the implementation of hospital reforms and strengthening of the drug chain from policy level to end user. Finally, earmarked support will be provided for strengthening the non-governmental health sector and public private partnership with a view to provision of public health services.

Component 2: Support to the health sector in Zanzibar
The health sector in Zanzibar will be supported with a grant amounting to DKK 120 million (including contingencies). Firstly, unearmarked support to the implementation of district health services against district health plans will be provided through the HSF. The allocation to HSF may grow if RGOZ starts making its own contribution and if other DPs join the HSF. The HSF will include a performance based element in the district allocation formula. Secondly, earmarked support will be provided for selected central level for systems development, management and strategic interventions. The majority of the support will be provided in the area of Procurement and supply management of pharmaceutical products, maintenance and ICT. The other selected intervention areas are Human resource management and development, Quality assurance, Health promotion, HMIS, Health financing and sector performance monitoring, Strategic Initiatives. Finally, earmarked support will be provided to support NGOs, in particular professional associations, and public private partnerships.

Component 3: Support to the multi-sectoral response to HIV/AIDS
The multi-sectoral response to HIV and AIDS will be supported with a grant amounting to DKK 220 million (including contingencies). Firstly, unearmarked support to the implementation of the NMSF will be provided through the HIV Fund for a harmonised support to the HIV/AIDS response provided that certain pre-conditions are met. Secondly, earmarked support will be provided for institutional capacity building of TACAIDS, including support to the development of a capacity building unit in TACAIDS, support to capacity building of TACAIDS regional offices and support for infrastructure development in the form of a new or rehabilitated office for TACAIDS. Finally, support will be provided to support non-government sector capacity for NMSF implementation in the form of continued support to some of the NGOs previously supported by Danida and in the form of support to strategic initiatives.

Capacity development support
The implementation of the HSSPs will require long term technical assistance for institutional capacity building as well as short term targeted technical support through short term TA or consultancies. The unearmarked and earmarked support for activities will therefore be supplemented by technical assistance to capacity building in key areas for implementation of the sector strategic plans.

HSPS IV includes funding for a total of 8 long-term advisers and a Junior Professional Officer (JPO):

- Five advisers (Hospital Reforms, Pharmaceutical Services, PPP, Health Policy, Planning & Management, Public Financial Management) will be provided to assist the MOHSW, Mainland. The latter may after agreement be lent out for limited technical support to TACAIDS.
- Two advisers (Health, Human Resources) and a JPO will be provided to assist MOHSW, Zanzibar
- One adviser (Organisational Development) will be provided to assist TACAIDS

Funding for a total of 120 person months will be available for short term TA.

All advisers will work within MOHSWs and TACAIDS with designated counterparts. They will report to their head of department. The Health Adviser in Zanzibar will head the HSPS Office.

Implementation arrangements

The programme will, wherever possible, be implemented using joint procedures as agreed in MOUs with government and development partners or between non-government institutions and development partners. For oversight and decision-making of the earmarked support a Steering Committee will be set up in Component 1 and 2, while it is envisaged to use the Joint Thematic Working Group for Component 3. The activities of the Steering Committees will be kept to a minimum.

There will be no HSPS management structure per se in Component 1 and 3. The HSPS Office in Zanzibar will be maintained with the Senior Health Adviser as team leader. The management capacity in the MOHSW is presently limited. The Zanzibar Component will technically operate as a decentralised accounting project as regards earmarked funding. Integration into government systems will be pursued. The responsibility regarding the HSF is expected to be handed over to RGOZ as it develops into a basket fund arrangement.

Budget Overview over indicative budget distribution

	Amounts	**Percentage distribution**	
	Millions of DKK	**within components**	**between components**
Component 1: Support to the health sector Mainland			
1.1 Support to the health basket funds	416.5	80%	
1.2 Support to Capacity strengthening	50.0	9%	
1.3 Support to PPP	25.0	5%	
Technical assistance (short and long term)	28.5	5%	
Administration	4.0	1%	
Contingencies	4.0	-	
Total - Component 1	528.0	100%	58%
Component 2: Support to the health sector Zanzibar			
2.1 Support to the Health Services Fund	32.2	28%	
2.2 Support to central level support systems	55.2	48%	
2.3 Support to NGOs and PPP	2.6	2%	
Technical assistance (short and long term)	18.5	16%	
Administration	5.5	5%	
Contingencies	6.0	-	
Total - Component 2	120.0	100%	13%
Component 3: Support to the HIV/AIDS multi-sectoral response			
3.1 Support to the health basket funds	100.0	48%	
3.2 Support to Capacity strengthening of TACAIDS	50.0	24%	
3.3 Support to non-government sector	50.0	24%	
Technical assistance (short and long term)	8.5	4%	
Administration	1.5	1%	
Contingencies	10.0	-	
Total - Component 3	220.0	100%	23%
Reviews, studies, etc.	10.0		1%
Unallocated funds	32.0		4%
GRAND TOTAL	910.0		100%

iii. Cover page

Country	:	United Republic of Tanzania
Sector	:	Health
Title	:	Health Sector Programme Support, Phase IV
National Agency	:	Ministry of Health and Social Welfare, Zanzibar
Duration	:	5 years
Starting Date	:	July 2009 – June 2014
Overall Budget	:	910 million DKK.
Component Budget	:	120 million DKK (excluding unallocated funds, but including contingencies)

Signatures:

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Ministry of Health and Social Welfare - Zanzibar
Revolutionary Government of Zanzibar

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Royal Danish Embassy
Government of Denmark

1. Introduction

The HSPS IV consists of three components that are to be implemented in three sectors independently of each other. The main responsibility for implementation of each component rests with three different institutions and it has therefore been decided to develop separate component descriptions that can be used for reference by implementers in each of the three sectors. The present Annex 2 describes Component 2: Support to the health sector in Zanzibar.

2. Brief situation analysis: Sector context

2.1. National context

Zanzibar has recorded annual economic growth rates of 6 to 8% in recent years. In June 2008, the Minister of State for Finance posted a growth rate of 6.5% for 2007, projecting a slightly higher rate of 6.8% for 2008. The real per capita income in 2005 stood at € 269 or US$ 340 per year (increased from US$ 276 in 2002 and US$ 303 in 2004), and the inflation rate has been contained at a single digit, although not below the target of 5%. As part of the United Republic of Tanzania, yet with its own president, cabinet and parliament, Zanzibar focuses on the improvement of spice plantation and tourism, the two pillar industries of the economy. Zanzibar is the world's major exporter of cloves accounting for 80 percent of the world export total, while tourism, under the auspices of investment from both overseas and the government coffer, has improved rapidly to account for more than a fifth or 22 percent of the Zanzibar gross national product.

It is generally agreed among development experts that with political commitment, good policies and increased financial and human resources, economies of small islands like Zanzibar could achieve national and internationally agreed development goals, including the MDGs. However, Zanzibar is still facing several challenges, including population growth, a high age-related dependency rate, youth unemployment, low land and labour productivity, weaknesses in marketing of agricultural produce, an underdeveloped industrial infrastructure that is unfavourable to attract foreign investments, limited credit facilities and high interest rates (up to 30%). There is a potential to further develop the tourism sector, which however is quite vulnerable to global economic development.

Fundamental among the key national policies are the Constitution of Zanzibar and the Zanzibar Poverty Reduction Plan 2002 for implementation of 'Vision 2020'. Zanzibar's medium-term development and poverty reduction goals are articulated in the second Strategy for Growth and Reduction of Poverty (ZSGRP), popularly dubbed after its Kiswahili acronym MKUZA (January 2007). Covering the period 2006 to 2010, MKUZA provides a reference framework for national development policy and lays the foundation for sector policies, such as in the domain of social services and wellbeing. MKUZA explicitly addresses health, water and sanitation in the context of social services as critical elements for the development of the nation, and includes some operational targets for 2010. It also recognizes specific sector reform programmes and emphasizes local stakeholder partnerships, harmonized assistance and interventions that will reduce inequalities and improve well-being among the poor. Cluster 2 of MKUZA covers health, nutrition, water & sanitation and HIV/AIDS, as part of social services and well-being, and it addresses broad issues of human capability. The cluster comprises four overall goals that are relevant to the health sector.

Box 1: MKUZA Cluster 2 goals related to the health sector

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

From each of these goals, a set of operational targets has been derived, some of which relate to service output (and population coverage by specific services) and others to health outcomes (in terms of improved health status).

A study on local government reforms, conducted in December 2004 with support from UNDP, found that local governments in Zanzibar are neither resourced properly nor managed as autonomous institutions. Local levels of administrations are marginally involved in service delivery and there is a general lack of coordination among sectors. The reasons for this are partly political (lack of clarity on what form of decentralisation is pursued), but also constitutional and legal (e.g. lack of provision for local government institutions at grassroots level, duplication of roles and functions between agencies of governance) and institutional (particularly lack of coordination among sectors). The Government of Zanzibar was yet to start decentralising some of its powers and authority to district councils, as is being done in Tanzania mainland. For the health sector, the Ministry of State Regional Administration, Local Government and Special Departments (MRALGSD) hence does not play the key role which its counterpart ministry in Tanzania mainland (PMO-RALG) has assumed over recent years. Decentralisation within the health sector is thus constrained by the lack of a clear GOZ policy, legal and institutional framework, with is further compounded by the general resource constraints.

Zanzibar has a Good Governance Strategic Plan in place, which in principle provides a suitable framework for public sector reform and a successful local government reform. The 2004 UNDP study identified Civil Service reforms as an area which would need particular emphasis. The Civil Service Commission is responsible for the recruitment of government staff and it performs this function on behalf of all ministries. It is claimed however, that many of the recruited staff do not meet the required qualifications and that their selection is based more on political interest than professional competence and/or experience. Few of those currently employed have formal job descriptions and there is no staff performance appraisal system in place in any of the ministries. This would affect the motivation of government employees, which is further compounded by low salaries, uncertain retirement benefits, unclear promotion criteria and a lack of equilibrium in remuneration packages (including allowances). The UNDP study made some clear recommendations to address these weaknesses, but progress has so far been limited.

2.2. Significance of the sector

Over the past 4-5 years, significant progress has been observed in some key health indicators. The prevalence of malaria has been reduced very significantly, with a reduction of 94% in clinically confirmed malaria cases among children under five years of age between 2002 and 2007; a reduction in hospital admissions for malaria (a proxy for severe malaria) from two-thirds of the total number of admissions in 2002 to one in six admissions in 2007; and a three-fold reduction in deaths attributable to malaria over the same period. This has been achieved through a combination of measures, including prevention campaigns (promotion of ITN), early diagnosis (including the introduction of rapid tests)

and prompt treatment, control of malaria in pregnancy, and a strong emphasis on surveillance and operational research.

Successes are also reported in relation to HIV/AIDS (of which the prevalence has so far been contained to 0.7%), sexually transmitted diseases, tuberculosis and child immunisation coverage. The availability of essential drugs and the financing of primary health care services have significantly improved, mainly through the ongoing Danida-funded HSPS programme.

Zanzibar does not yet have a well established routine of reviewing the performance of its health sector. The first annual health sector performance report appeared in 2007, reviewing the first year of implementation of the five-years strategic plan (July 2006-June 2007). HSPS has helped the Health Sector Reforms Secretariat of the MOH&SW to institute quarterly review meetings at the district level and at the zonal level (Unguja and Pemba) to assess progress against annual plans. National health programmes and central level departments do have a routine of providing broad reviews of their activities at the time of preparation of the annual budget speech of the Minister of Health to the House of Representatives (in April/May). However, these reviews only cover the first three quarters of the financial year. The MOH&SW with support of HSPS has set out to conduct Annual Joint Health Sector Reviews in September each year, to assess achievements against annual plans (POA). These reviews are meant to be comprehensive, i.e. involving all parties (not just government) and all resources (including donor funding).

The Annual Health Sector Performance Report 2006/07 reviewed the extent to which 14 milestones were achieved. These milestones had been adopted and incorporated into the Minister's annual budget speech for financial year 2006/07. Among the five milestones that were achieved:

- Road map for accreditation of the College of Health Sciences by the Tanzanian National Council for Technical Education (NACTE)
- Review of cost-sharing practices in public health facilities, as a step towards a policy on health financing
- Situation analysis of human resource and management needs of Mnazi Mmoja Hospital
- Guidelines and manuals for data collection, data analysis and data use
- Health information bulletin produced and Annual Sector Performance Report prepared.

Some of the milestones were only partly achieved:

- At least one PHCU in each rural district offering quality delivery services
- EHCP reviewed and guidelines developed for efficient patient referral
- Comprehensive district health plans developed
- Donor coordination meetings held twice a year
- Preparation of MTEF in line with sector planning cycle.

Milestones not achieved are:

- HRH policy developed and approved; HRH division established in MOH&SW
- Modalities developed for involvement of private sector in health service provision
- Government financing for the health sector increased from 8% to 10% by 2007/08
- Creation of a health sub-vote for districts, in conjunction with MOFEA

The 2006/07 Health Sector Performance Report further assessed progress in relation to health service delivery, including reproductive health, child health, infectious disease control and non-communicable disease control. In recognition of Zanzibar's achievement in reducing malaria prevalence, in part through support by the US Government, the Principal Secretary was invited to the White House Summit on malaria where he met President Bush in December 2006.

2.3. Institutional set-up of the sector

The health sector in Zanzibar is governed by the Ministry of Health and Social Welfare (MOH&SW), which is entirely independent of its counterpart ministry in Tanzania mainland. The MOH&SW is responsible for overall policy formulation, technical monitoring and supervision.

Zanzibar's health service infrastructure in the public sector relies on:

- A fairly dense network of Primary Health Care Units (PHCUs), providing basic PHC services in principle for a population of 3,000 to 5,000;
- Primary Health Care Centres (PHCC), commonly known as *cottage hospitals*, providing inpatient care (30 beds) and medical investigations (laboratory, X-ray), with a higher staff profile and located in places that have somewhat larger populations than those with a PHCU;
- District hospitals: providing second-line referral services, including surgery, with 80 to 120 beds;
- One general referral hospital (Mnazi Mmoja hospital, MMH), a large maternity hospital (Mwembeladu) and one hospital specialised in mental health (Kidongo Chekundu, KCH), all in Stone Town in Unguja.

In total there are four PHCCs in Zanzibar (two in Unguja and two in Pemba) and three district hospitals (all in Pemba). Unguja does not have a district hospital and this has several important implications. Kivunge PHCC in North Unguja serves a role that comes close to that of a district hospital, while Makunduchi PHCC (located in a relatively sparsely populated area in the most southern part of the island) also provides some hospital type services, although for a small population, resulting in low service utilisation levels. As a result, Mnazi Mmoja Hospital serves not only as the country's sole tertiary general referral institution, providing specialist services for patients with complicated conditions, but also as a secondary referral institution for the entire population of Unguja.

The private sector in Zanzibar comprises four registered hospitals, 80 private dispensaries providing outpatient consultation and a number of private pharmacies and drug outlets. A study sponsored by the ADB in 2004 found that, particularly in the urban area, the service demand from private providers is greater than that from public institutions. Zanzibar municipality (the capital city) is served by 38 private health facilities (including four hospitals) with an estimated attendance of 1,000 out-patients per day compared to 270 patients per day that are seen at Mnazi Mmoja Hospital. For maternity services, though, the private sector was found to play a much more limited role, with just 7% of all assisted deliveries in Zanzibar town. Inpatient care facilities at the few private hospitals were found to be underutilised, with bed occupancy rates of less than 20%, while at times some of the public hospital wards are overcrowded. There is no umbrella organisation specifically for health NGOs, which could be compared to CSSC in Tanzania mainland.

The Zanzibar AIDS Commission (ZAC) is responsible for the coordination and monitoring of the multi-sectoral response to HIV/AIDS. Other national stakeholders in the fight against HIV/AIDS are the Zanzibar AIDS Control Programme in MOH&SW (ZACP), district councils and a number of NGOs, which are grouped under the Zanzibar NGO Cluster (ZANGOC).

2.4. Key sector policies, legislation and programmes

Health sector development in Zanzibar is guided by the National Health Policy and the 2nd Zanzibar Health Sector Reform Strategic Plan (ZHSRSP), which covers the five-year period from 2006/07 to 2010/11. This means that a new national strategic plan is due by the time that the new phase of HSPS is one year underway.

Prior to MKUZA, Zanzibar formulated its health policy, of which the overall goal is to "improve and sustain health status of all Zanzibar people" (GOZ 1999, updated in 2002). The policy comprises 11 areas of reform, of which the driving force is to increase the efficiency of the health system and to maximise the utilisation of budget resources. Among the main strategies in relation to health care delivery, the policy gives emphasis to:

- Use of integrated primary health care approaches to prevent, control and manage all diseases (communicable and non-communicable);
- Use of varieties of health educational strategies that involve the community in health promotion and the prevention of diseases; and
- Establishment of an integrated decentralised health care system with defined intervention packages for each level (i.e. primary, secondary and tertiary levels).

The second strategic plan that is based on the above policy and that guides health sector development over a five-year period – the ZHSRSP II, covering 2006/07 to 2010/11 – emphasises five core strategies/themes:

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

The ZHSRSP II further distinguishes five categories of "priority health interventions" around which the health system is built and which the ongoing health sector reforms try to strengthen. These five priority health interventions constitute *the core business* of the health sector. It is important to point out that they provide the intervention framework for the sector as a whole, and therefore not just for the public sector. Private parties and development partners (donor agencies) are expected to support this intervention framework and indicate how their contributions are aligned with it.

The five priority health interventions are subdivided into several components, each with a set of concrete targets for the year 2010/11, and a set of core interventions that need to be implemented:

1. Reproductive and Child Health	1.1 Reproductive health
	1.2 Adolescent sexual & reproductive health
	1.3 IMCI
	1.4 EPI
	1.5 Nutrition
2. Health promotion & disease prevention	2.1 Health education and promotion
	2.2 Environmental health
	2.3 School health
	2.4 Occupational health
3. Communicable diseases	3.1 Malaria
	3.2 STI, including HIV/AIDS
	3.3 TB
	3.4 Lymphatic filariasis
	3.5 Schistosomiasis and soil-transmitted helminths
	3.6 Leprosy
4. Non-communicable diseases	4.1 Diabetes

	4.2 Hypertension
	4.3 Injuries and disabilities
	4.4 Oral health
	4.5 Eye care
5. Mental health, social welfare and substance abuse	5.1 Mental health
	5.2 Social welfare
	5.3 Substance abuse

The core interventions that are derived from the above list are obviously delivered by various actors (public providers, NGOs/private not-for-profit, private for-profit, the community itself), but the level at which they are delivered (household, shehia/village, 1st level of care, 2nd level of care, 3rd level of care) varies, depending on the availability of resources and the priorities of funding agencies. While this is disturbing, the MOH&SW with support from Danida (through the current HSPS) has tried to address this by developing an essential health care package (EHCP), which stipulates a uniform package of services for each level of care.

Among the national health programmes that have considerable external funding, most of them from multiple sources, are the Zanzibar Aids Control Programme (ZACP), the Zanzibar Malaria Control Programme (ZMP), the Zanzibar TB and Leprosy Programme (ZTLP) and the Reproductive and Child Health Programme (RCH).

The Zanzibar National HIV Strategic Plan (ZNSP), which was launched in June 2005 and which covers the period July 2005 to June 2009, guides the multi-sectoral response to HIV/AIDS. It sets out to prevent HIV transmission in the general population and at work places; and to increase access to care and promote positive sexual behavioural change, targeting various vulnerable groups. Despite the fact that there is this consolidated strategy, HIV/AIDS activities are highly dispersed and fragmented, and there is a general lack of focus.

2.5. Sector financing

The 2007 health sector Public Expenditure Review (PER) – the second of its kind in Zanzibar – found that the overall resource envelope for the public health sector in the financial year 2005/06 was TSh 17.0 billion, which is equivalent to US$ 14.3 million. This translates to around US$ 13.06 per capita. Of this amount, 63% was contributed by external sources, while the share of the Government of Zanzibar was 36%. Cost-sharing revenues added the remaining 1%. In real terms per capita, these shares are equivalent to US$4.65 for GOZ spending, US$ 8.32 for external financing, and US$0.08 for cost-sharing.

Comparison with FY2004/05 indicated that there was a modest growth in the total resource envelope in nominal terms (8.3%). In real terms this increase was more modest: 0.9%. Because of population growth, however, the real per capita expenditure fell slightly (from US$ 13.35 to 13.06).

As a share of overall government spending, the FY2006/07 budget for the health sector was lower according to most definitions: from 8.5% to 8.1% of discretionary recurrent budget (i.e. excluding Consolidated Fund Services); from 8.0% to 7.6% of the GOZ domestic total (excluding CFS); from 6.4% to 5.6% of the GOZ domestic total (including CFS); and from 6.1% to 3.6% of the GOZ total (including CFS and external on-budget funding). These figures signify a reduced commitment to the sector, with all indicators falling short of the Abuja declaration target of 15%.

Budget performance improved substantially in FY2005/06, with expenditure reaching 96% of the budget, compared with 77% in FY2004/05. This was largely driven by the PE component (personal emoluments; staff salaries and allowances) which exceeded the budget by 4%, while OC expenditure (other charges) was 59% of budget. PE dominate the MOH&SW budget, at 78% in FY2006/07. In terms of actual spending, this is even more marked, with PE accounting for 87% of actual expenditure in FY2005/06.

Analysis of expenditure by zone indicated that OC budget performance is consistently lower for Pemba compared with Unguja. Further analysis is required to determine the extent to which expenditure through Unguja sub-votes ultimately benefits beneficiaries on Pemba, e.g. for the procurement of drugs and/or for medical referrals outside Zanzibar.

Analysis of the PE allocation by administrative level of the health system indicated that 60% of the allocation is for district level, 18% for zonal level, with the balance of 22% going to national level. Hospitals account for 46% of the overall wage bill, primary level services for 26%, administration and management for 13% and technical support for 10%. (The balance of 5% could not be allocated.) The operational costs of health facilities continue to absorb only a small proportion of the total budget, at around 15% of the total OC budget. Much of this goes to purchasing hospital food, leaving very little for primary level facilities.

Medical expenses abroad were highly overspent in FY2005/06 at 158% of the budget allocation. This amounts to 14% of total OC spending, which is similar to the total allocation for running health facilities (including Mnazi Mmoja Hospital).

External financing in FY2005/06 was estimated at TSh 10.86 billion or US$ 9.1 million. Of this, Danida (through HSPS) contributed around one quarter (DKK 12 million or US$ 2.3 million), making it the largest external donor agency in the health sector (at least for on-budget external funding).

It is noted that the PER found some mismatch between the information on external financing included in the official budget, the monthly information collated by the MOH&SW Donor Coordination Unit of the MOH&SW (and submitted to the Ministry of Finance and Economic Affairs), and data compiled for the PER. This is a matter of some concern, as fragmentation of financing prevents a full and systematic analysis of external financing as such, and of the overall allocation of funds within the sector. The GOZ and the DP community is aware of the role of PERs in informing priority-setting within the sector through the regular budgetary processes. WHO and Danida (through HSPS) have so far been the main supporters of PERs.

Analysis of spending by programme area or by category of expenditure was not possible due to information constraints. There is a need to introduce more detailed and standardised reporting to improve analysis in this area.

The Health Service Fund, which has been instituted through HSPS (see section 3.1.1), provides essential support to districts, hospitals and zonal offices. The absolute level of funding has risen from TSh 306m in FY2004/05 to TSh 700m in FY2007/08. Overall absorption capacity rose from 75% in the first year (FY2004/05) to 86% in FY2006/07, with Pemba performing slightly better than Unguja. By level of the health system, districts have been able to spend 92% of available funds over the three years, compared with 94% by hospitals. The zonal level has overspent by 31% over the same period, reflecting in part the low level of initial funding for the zonal offices.

An assessment of cost-sharing in public health facilities, which was conducted parallel to the PER, enabled calculation of the financial contribution from patients/clients. User fee charges are in place in all PHCCs and hospitals, although they have not been formally introduced. There is very little information on exemptions and waivers. Estimated revenues were TSh 42.7m in FY2004/05, TSh 107.3m in FY2005/06 and TSh 82.2m for the subsequent six months to December 2006. While contributing less than 1% to the overall resource envelope, and only US$ 0.08 per capita in FY2005/06, such revenues accounted for not less than 17% of operational funding of district hospitals and 28% of that of Mnazi Mmoja Hospital.

The GOZ health budget for FY2007/08 has increased significantly in nominal terms, from TSh 6.6bn in FY2006/07 to TSh 9.1bn for FY2007/08, representing an increase of 37%. This reverses the recent downward trend in the real value of the budget, although it still has not yet regained its 2003/04 real value. Despite the increase, the sector share of overall government spending has still fallen further, from 8.1% to 7.9% of the GOZ discretionary recurrent budget, and from 7.6% to 7.5% of the GOZ discretionary total budget. The increase in the health budget has been largely driven by the PE component, which rose by 38% compared, with the OC allocation increasing by 6%.

External financing estimates for FY2007/08 remain incomplete, but are expected to exceed TSh 7.5bn, equivalent to US$4.47 per capita.

The PER resulted in several key recommendations:

- MOH&SW should use the PER data to keep pressure on MoFEA for an increased share of the budget, in line with the Abuja declaration and the recognition in the MKUZA of the inter-relationship between a healthy and productive population.
- The small but important component of the OC budget which benefits health facilities should be released in full, should be allocated according to the same formula as HSF funding, and should be channelled directly to the accounts at zonal level in order both to ensure that they are received and used by the districts and hospitals, and to demonstrate government commitment to the concept of a district basket for health services. This will strengthen the case for investment in such a basket by other partners.
- Urgent steps should be taken to design and implement standardised reporting formats for external funding, from all programmes and partners. Such reporting should include all data required by MoFEA, but should also be elaborated to enable better analysis at the sectoral level, and should be enforced at the programme level. As an interim step, the Donor Coordination Unit should obtain copies of all programme documents, and technical and financial reports.
- The Technical Working Group on Health Financing should review proposals for categorising expenditure, both geographically and by expenditure category, in order to facilitate future PER analysis.
- Urgent steps should be taken to implement the recommendations of the assessment of cost-sharing in public health facilities, in order to improve transparency and accountability both to Parliament and to the users and beneficiaries of the public health system.
- Work should continue on the development of an overall health financing strategy for Zanzibar, to guide future developments in the area of complementary financing.
- The next PER should include a complete and detailed inventory of external support, thereby facilitating a more complete analysis of overall sector funding. This should be timed to feed into

the planning cycle for FY2008/09, with reporting to the March/April partners coordinating meeting.

A National Health Accounts study (NHA) has not been conducted in Zanzibar as yet. The WHO Country office in Tanzania mainland intends conducting one, but funding has not been secured for the time being.

2.6. Donor coordination

To support the implementation of the growth and poverty reduction strategies of both Tanzania mainland (MKUKUTA) and Zanzibar (MKUZA), a joint assistance strategy has been developed between the government and development partners. The Joint Assistance Strategy for Tanzania (JAST) includes, among other issues, commitments on alignment and division of labour in order to reduce the number of actors in the sectors. In the division of labour, Denmark continues to support the health sector, but it is not listed as a donor in HIV/AIDS. Most of the key development partners in Tanzania mainland are not active in Zanzibar.

Zanzibar has started to develop a coordination mechanism in the health sector. Biannual partner coordination meetings were introduced in 2005: the meeting in March/April serves to exchange plans for the upcoming budget year (starting 1st July), while the September meeting services to review the financial year that has just ended. The first Annual Health Sector Performance Report was presented and discussed at the AJHSR meeting in September 2007. Development partners also have an opportunity to provide technical inputs through the Technical Working Groups that have been instituted (with the support of HSPS) in four different domains that are considered of strategic importance: Health Finance, Sector Monitoring, Quality Assurance and Human Resources. The TWG's operate under the stewardship of the Health Sector Reforms Secretariat, which comes under the Director General of Health Services of MOH&SW.

For the joint response to HIV/AIDS in Zanzibar, the first review was conducted in 2007 (April 2007; covering 2004-2007). This was a very comprehensive review, focussing on the drivers of the HIV epidemic, HIV service delivery (prevention in the community and at health facilities, care and treatment, impact mitigation), the enabling environment (political commitment, legal and policy framework, management and coordination, resource mobilisation, advocacy, capacity building) and monitoring and evaluation of the response to HIV/AIDS. The main outcome of the review was an overwhelming realization that actors in Zanzibar need to focus and target the HIV response. 'Scale up' in the context of Zanzibar's HIV response does not mean 'more of the same', especially in such a resource constrained environment. Scale-up in the context of Zanzibar's HIV response means 'deepening' the response by targeting those areas needing it the most.

2.7. Cross-cutting issues and priority themes

Gender

With some of the health indicators stagnating, awareness of gender issues in relation to health is emerging among health service providers, programme managers and policy makers. For instance, ZMCP staff has noted that the targeting of pregnant women through such activities as LLITN distribution, while extremely important, may limit greater male or family involvement in malaria control. Gender dimensions based upon biological, normative roles and activity differences are being considered in activity implementation so that the programme reaches, involves and benefits men and women of all ages. A positive lesson in relation to gender from the indoor residual spraying campaigns (IRS; against the malaria vector) has been the recruitment of female supervisors and sprayers for the IRS teams, roles not conventionally held by women in an otherwise very conservative society. These

unconventional roles have been a critical factor in the success of the IRS programme, as female sprayers have been able to gain access to female-attended households, where male sprayers would likely not have made it across the threshold.[1]

In the MOH&SW, three focal persons have been appointed for gender issues (in the Health Sector Reforms Secretariat and the Policy and Planning Department). With support form HSPS, a plan of action has been developed to build capacity and promote gender mainstreaming in the various departments of the ministry and in the various national priority programmes. Also, efforts are underway to disaggregate health information according to gender, where appropriate, so as to detect and act upon gender imbalances.

Environment

The health aspects of water, sanitation and environmental issues are the prerogative of the Department of Public Health of the MOH&SW. Environmental health officers posted at health facilities have the task to oversee the health dimensions of the environment. Hospitals have a special responsibility to ensure that their clients find themselves in a clean and safe environment. In 2007, HSPS supported a study to assess the environmental impact of the planned disposal of expired and unwanted pharmaceutical products in Zanzibar. The results and recommendation of this study feed into the policy of the Pharmacy Department and in particular the Central Medical Stores to dispose of such products in a safe manner.

The three Danida priority themes – HIV/AIDS, Children & youth, and Sexual & reproductive health and rights – are part and parcel of the proposed HSPS. HSPS Component 3 will address the multi-sectoral response to HIV/AIDS.

2.8. Key Challenges

Health

The population of Zanzibar is around 1.2 million, which is three percent of the total population in the United Republic of Tanzania (mainland and Zanzibar combined). Health sector performance suffered from the withdrawal of donors in 1995, who disputed the legitimacy of the elections in Zanzibar. Over the years, external support to the health sector has gradually been reintroduced, resulting in financial and technical assistance to a seriously under-funded national health system.

A review of the Essential Health Care Package in Zanzibar, which was conducted in 2007, found some important gaps in service delivery with regard to maternal and obstetric care, newborn care, prevention and treatment of non-communicable diseases (diabetes, cardio-vascular disease), mental illness and rehabilitation of people with disabilities. In addition, there was no proper patient referral system, based on established protocols.

Along with the increase in external funding, the sector has witnessed emerging systemic problems, mainly caused by the fragmentation due to programmes with little or no integration at the service delivery level; poor planning and coordination of physical infrastructure and human resources, limited use of data and lack of accountability to the populations served.

Human resource capacity is insufficient at all levels, in particular at the primary health care facilities which many health workers consider unattractive to work at. The College of Health Sciences (CHS) plays a crucial role in training medical and paramedical workers and has the ambition of making Zanzibar self-sufficient for at least a few cadres. In the absence of a medical school in Zanzibar, most

[1] Source: Malaria proposal to obtain funding from the Global Fund Round 8 (June 2008).

of the medical doctors and clinical officers are being trained in Tanzania mainland. Since 2007, some medical doctors are being trained locally through a collaboration between the MoH&SW and the University of Matanzas Cuba, using the Cuban training model.

While primary health care is seriously under funded, Danida is for the time being the sole agency that is providing 'core' funding to district health services, through the Health Service Fund (HSF). HSPS also plays a key role in the procurement and distribution of essential pharmaceutical products. Other external financing to the sector is mainly being channelled towards communicable disease control (malaria, TB, HIV/AIDS) through national priority programmes that are administered in a rather vertical manner. This has resulted in fragmentation and inefficiencies, which the MOH&SW in Zanzibar has not been able to counteract sufficiently.

The above weaknesses are common to the delivery of national priority programmes, such as malaria, TB and HIV/AIDS, and they affect health outcomes in a negative way. This presents a number of key challenges.

- *Sustaining the quality of case management and diagnosis at peripheral facility level where services are under-resourced and under-staffed*

Several programmes have focused on appropriate case management in public health facilities at all levels through the introduction and dissemination of treatment guidelines and the delivery of training programmes. After introduction of ACT's in 2002, for instance, the ZMCP conducted training for health workers nationwide. Recent data show that 94% of the health facilities have at least one staff member trained on malaria case management and IMCI. However, within these same facilities, clinical assessment for malaria is found to be weak, implying that follow up of training through effective supportive supervision by the DHMTs is inadequate. In addition, while confirmatory diagnosis of malaria has increased, surveys have shown that such diagnosis is not always requested by clinicians (76% of inpatients under five years of age received confirmed diagnosis). District level capacity, both of the DHMTs to effectively support and supervise peripheral facilities and of the facilities to deliver quality services, remains a challenge due to under-resourcing and under-staffing at these functional levels.

- *Creating effective linkages between peripheral health facilities and the communities they serve, through a joint community health strategy*

At the level of local communities, activities are often conducted in an *ad hoc* and uncoordinated manner without the active participation of the peripheral facilities tasked to serve these same communities. This results in inadequate promotive and preventive activities, a lack of ownership in the health services by the communities, and a lack of local schemes for effectively dealing with referrals to these facilities. Currently, priority programmes are employing multiple community health strategies which respond to programmatic needs, but not necessarily to the needs of communities or individuals within those communities. Zanzibar had a relatively successful Community Based Health Care programme in the early 1990s which subsequently disintegrated into a 'plethora of activities at the interface level between communities and health care suppliers'. In early 2008, a Community Health Strategy has been articulated which envisages that communities and the peripheral level health services that support them are able to better demand and drive promotive, preventive, curative and palliative services and activities at the community level. The strategy aims to empower communities to take responsibility for their own health and the way that peripheral health services are organized and financed. It is the intention of the MoH&SW that all stakeholders 'buy into' this strategy, including the national priority programmes.

- *Strengthening health sector support systems and common (join) intervention strategies for national priority programmes; implementation of the Essential Health Care Package*

The development of the Essential Health Care Package (EHCP) in 2007 highlighted the 'excessive fragmentation' in support systems and intervention strategies employed by the various priority programmes. This has been exemplified by an overreliance of these programmes (malaria, TB, HIV/AIDS, RCH) on parallel monitoring systems instead of information availed through the routine Health Management Information System (HMIS). Other supportive systems and strategies which tend to be driven programmatically include communication/IEC, quality assurance, planning and procurement. Fragmentation results in efficiency losses and (possibly) reduced health outcomes. Recent efforts to resolve these health system weaknesses and gaps are multiple and the challenge is now to implement and sustain these efforts.

The EHCP not only defines an agreed package of essential health care services but has also defined the support systems and strategies required to deliver the EHCP in order to address current fragmentation in these systems and strategies. These are outlined below:

Support Systems	***Support Strategies***
Communication, IEC, health promotion	Special youth friendly clinics
Quality assurance, adherence to standards, continuity of care, referrals	Outreach services into communities, follow-up of defaulters
Comprehensive planning	Mass campaigns
Monitoring and evaluation, reporting	School health: health promotion and screening
Management of HRH and time	Occupational health: health promotion, addressing health hazards and screening
Management of infrastructure, space, equipment, logistics including maintenance	Support to community based activities
Management of drugs and supplies	Collaboration with traditional medicine sector
Pre-service training, continuing education, in-service training	Collaboration with the private sector, public-private partnerships
	Intersectoral collaboration

The EHCP proposes to assign tasks to specific departments or units within the MoH&SW to elaborate comprehensive intervention strategies taking into account the requirements of all priority programmes and develop appropriate support systems to benefit these same programmes. In this way, a priority programme such as for instance the Malaria Control Programme, may be tasked to develop a support system such as comprehensive planning or elaborating a strategy for community-based activities, which then all departments and programmes would utilise and follow.

- *Strengthening the institutional capacity of the MOH&SW*

The organisation of the Ministry of Health and Social Welfare does not have a clearly defined structure at the moment, and there is some overlap in mandates and responsibilities of certain departments with a lack of clarity about reporting lines. Human resource management leaves room for improvement, challenging staff recruitment, deployment and retention and adding to the much criticised low level of financial remuneration in the public sector.

- *Further development of modalities to strengthen district health services*

The MoH&SW with support from Danida (through HSPS) has instituted a Health Service Fund to address inadequacies in health service provision at the level of zones, districts and individual health facilities. These range from chronic shortages of service providers, inadequate supervision, poor availability of essential drugs, equipment and supplies, the lack of privacy and confidentiality observed by service providers to poor client-provider interaction in general. The fund has been in place since

2004 and is in line with the GOZ policy of decentralizing decision-making authority and resources, along with comprehensive planning, prioritization and integration of services. To ensure quality of care, a quality improvement and recognition initiative (QIRI) has been introduced, as well as a tool for integrated supervision. Facility and staff quarter renovations have been supported through HSPS and the ADB to retain and attract health workers to the district facilities.

- *Disease surveillance and HMIS*

With support of HSPS/Danida, a considerable effort has been made to strengthen the national HMIS/IDSR for data collection, processing, analysis, presentation and interpretation of health information. To this end, an integrated HMIS data collection tool has been developed and district surveillance officers have been trained and equiped to produce monthly reports for consolidation at central level. Feedback and dissemination mechanisms have been developed including the production of an annual health bulletin. The 2007 Health Bulletin was the first of its kind and efforts are underway to make it more comprehensive. Complementing these initiatives, the Italian Cooperation is planning to provide support for higher level training opportunities in epidemiology and health information systems.

HIV/AIDS

The recent joint Review of the National HIV Response in Zanzibar (December 2007) presents the available data on HIV prevalence from various sources. HIV prevalence among women attending ANC clinics has risen since 2002, but with 0.87% in 2005 it is well below the rate found in other countries in Sub-Saharan Africa. Among the general population, young adults (25 to 34 years) are most affected (15 per thousand), and the infection rates among women are four to six times higher than among men. HIV prevalence rates among different sub-populations range from less than 1% among blood donors, to 3.8% among female domestic workers, 4.1% among STI patients, 2% to 11% among VCT clients (depending on the district), 12.9% among substance abusers, 28.4% among injecting drug users and 33% among TB patients.

The main outcome of the review was an overwhelming realization that actors in Zanzibar need to focus and target the HIV response. 'Scale up' in the context of Zanzibar's HIV response does not mean 'more of the same', especially in such a resource constrained environment. Scale-up in the context of Zanzibar's HIV response means 'deepening' the response by targeting those areas needing it the most.

3. Strategy

3.1. Summary of past experience & achievements

This section highlights the experience so far and the main achievements in strengthening the health sector in Zanzibar, with respect to various functions: support to district-level health services, procurement of pharmaceutical products, development and maintenance of infrastructure, human resource development and management (HRD, HRM), quality assurance, evidence-based decision making and community health.

3.1.1. District health services

One of the major sources of recurrent funding for district level routine activities within the Zanzibar health system is the Health Service Fund (HSF). The HSF was established in 2004 with Danida support (through HSPS) with the aim of providing funds to districts and their health facilities, so as to cover some of their recurrent expenditure. The fund is in accordance with the GOZ policy of decentralising decision-making powers to districts.[2]

From its introduction in FY2004/05, the intention has been throughout that other development partners would contribute some of their funding to the HSF, enabling its evolution into a basket for district level activities, as happens in Tanzania mainland and other countries in the region. Unfortunately this has not happened so far, although the prospects of other development partners joining the HSF look promising.

In FY2007/08 and FY2008/09, HSF funding was based on a per capita contribution of US$ 0.50 (up from US$ 0.40 in FY2006/07) and allocated to districts using a weighted capitation formula which takes into account four distinct criteria: population (50%), land area (10%), poverty level (25%) and the under-five mortality rate (15%).

Absorption capacity of HSF budget allocations at both district and hospital level has been very good, after a rather modest start in the first year (FY 2004/05) when 75% of the total allocation was used (72% in Unguja, 81% in Pemba; see Figure 1). Over the four years, up to FY 2007/08 (inclusive), the total budget execution has been 99%, although it should be noted that some unspent balances have been carried forward from one year to the other.

A typical feature of the HSF is that a certain key guides the use of funds by DHMTs: around 5% of the funds are meant for administration, 10% for minor maintenance, 20% for transport, 10% for equipment and clinical supplies, 15% for training, 10% for meetings, 10% for community interventions and activities, 10% for specific priority interventions and 10% for monitoring and evaluation. This is after deduction of 3% from the total capita-based allocation to each district as a contribution to the recurrent costs of the Zonal Health Management Teams (in Unguja and Pemba) and 7% for maintenance services and repairs, provided by the HCEU. In addition, a certain percentage is deducted from the allocation to each district as a contribution to the delivery of primary health care services by nearby hospital (20% to cottage hospitals; 30% each to district hospitals and MMH). This leaves the DHMT with annual allocations ranging from TSh 21 million (around DKK 100,000 or US$ 20,000; South district) to TSh 66 million (around DKK 310,000 or US$ 61,000; Urban district) in 2008/09.

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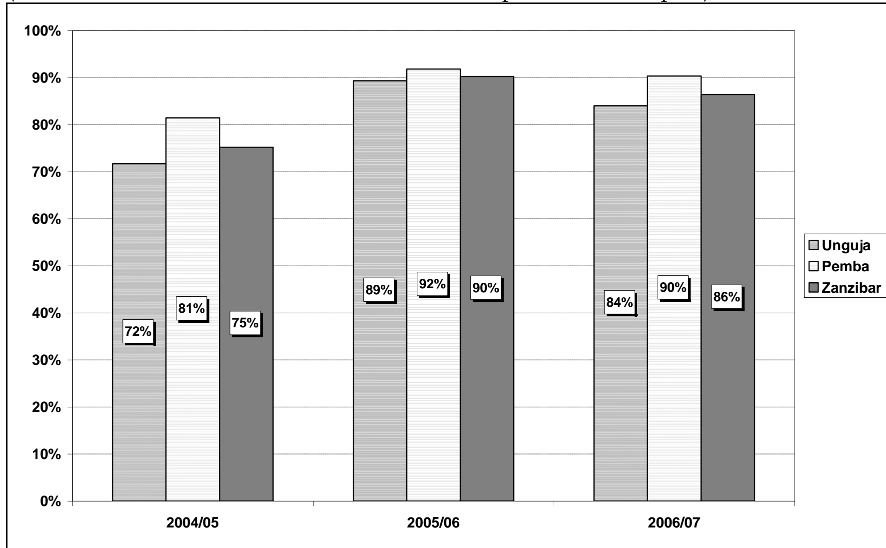
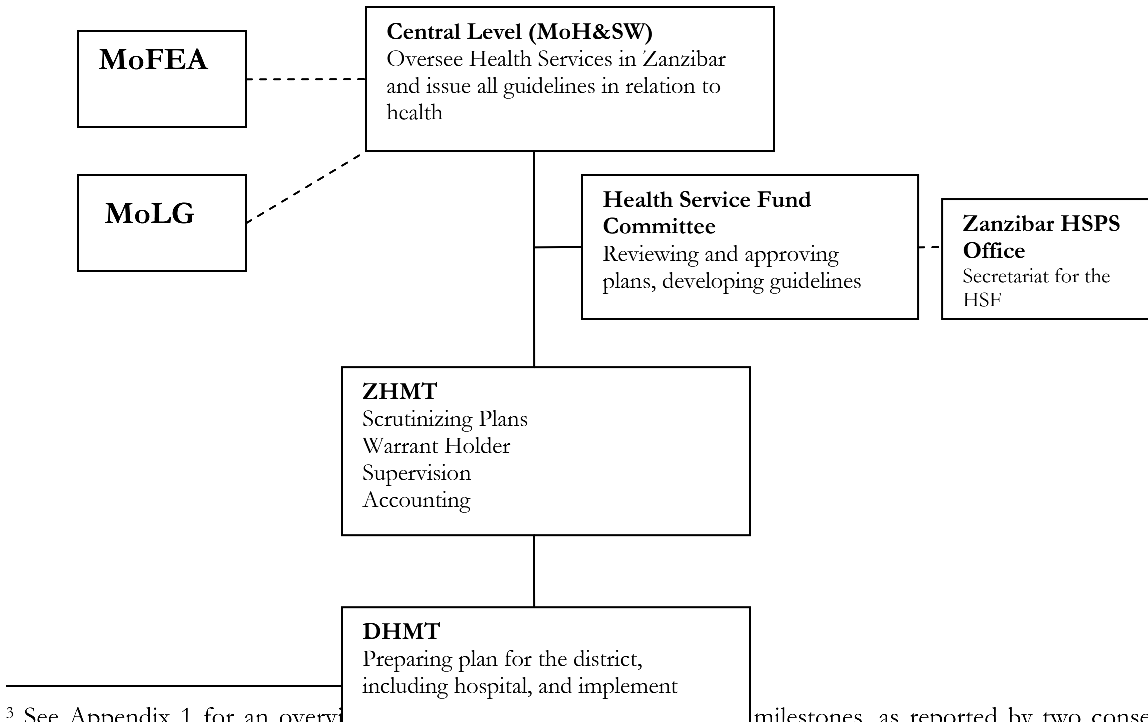
[2] See: Zanzibar Health Service Fund Guidelines, MOH&SW, June 2004.

Figure 1: Improvements in HSF absorption, FY2004/05 – FY2006/07
(source: MOH&SW 2007, Annual health sector performance report)



The HSF plays a crucial role in enabling DHMTs to implement their annual district health plans. These plans are becoming increasingly comprehensive, including more and more the various types of support received through national health priority programmes. The health sector performance review for FY 2006/07 found that Milestone #5 was partly achieved:[3] comprehensive district health plans (CDHP), including all programme support budgets (vertical as well as government funding). Hence, the HSF has proven instrumental in supporting a programme-based approach at the district level, with DHMTs in the role of coordinators who see to it that services are delivered in an integrated manner.

Figure 2: Institutional set-up of the Health Service Fund (source: GOZ 2008, Proposal for Global Fund Round 8)



[3] See Appendix 1 for an overvi[...] milestones, as reported by two consecutive annual health performance reports (2007 and 2008, respectively).

Figure 2 shows the responsibilities of district, zonal and national level health authorities and the current roles of the Health Service Fund Committee and the HSPS office in HSF management. Presently, funding for the HSF is transferred twice a year to bank accounts opened for the ZHMT. Funds are released to DHMTs in cash monthly (as no banks are available at district level) and receipts are returned to an accountant with the ZHMT - likewise on monthly basis. The accountant will do the bookkeeping before onwards submission of the compiled accounts to the accountant in the Zanzibar HSPS Office. No GOZ funds are presently decentralised to Zonal or district level, see also Ch. 3.2.1.

It is hoped that other development partners will join the HSF, including the GOZ itself through its medium-term expenditure framework (MTEF). Recent funding proposals submitted to the Global Alliance for Vaccines and Immunisations (GAVI) and the Global Fund for Aids, TB and Malaria (GFTAM, Round 8; June 2008) have included elements of funding to be channelled through the HSF. The Global Fund proposal was recently approved, including financial support to districts through the HSF. The modalities for how to implement this new support is presently being prepared. Most likely this will speed up the transition of HSF from a bilateral arrangement into a district basket arrangement. In general, there is an increased recognition on the side of some of the national priority programmes that the HSF is an appropriate mechanism to harmonise external support to the health sector and seek alignment with national priorities and management procedures.

3.1.2. Procurement of pharmaceutical products, management of infrastructure

The MOH&SW recognizes the importance of sound procedures and operational guidelines when it comes to the procurement, management and distribution of pharmaceutical products (drugs, medical supplies) and equipment. During the first five years of Danida assistance to the health sector in Zanzibar (through HSPS III, component 3; from July 2004 onwards), much has been invested in building the institutional and human resource capacity to develop policy and guidelines, improve storage, ensure rational distribution of drugs and medical supplies and introduce preventive maintenance and timely repairs of medical and non-medical equipment.

Prior to Danida's involvement in the health sector in Zanzibar, a National Drugs Policy was adopted (1999), along with a National Essential Drugs List, Hospital Formulary, Standard Treatment Guidelines and a master plan for action for the pharmaceutical sector. A National Drugs and Therapeutic Committee was installed and training on the rational use of drugs was being provided through a continuing education programme. However, there were serious flaws in the procurement, storage, inventory control, distribution and use of pharmaceutical products. In addition, the GOZ budget allocation for drugs and medical supplies was far below the WHO norm of US$ 1.0 to 1.5 per capita per year. At hospitals and health centres there was a quasi-permanent crisis in drug availability. To help solve the crisis, Danida started funding the procurement of pharmaceutical products in the form of drug kits for PHCU and PHCC through the MSD (Medical Stores Department in Tanzania mainland). In addition, HSPS assisted the MOH&SW in providing training opportunities for pharmaceutical staff to upgrade their competence and in rehabilitating and equipping the Central Medical Stores (CMS), which falls under the Chief Pharmacist.

At present (2008), Zanzibar has a newly developed National Medicine Policy, a five years strategic plan for the pharmaceutical sector (covering 2007/08 to 2011/12) and a revised Procurement Act (#9/2005). Since mid-2007, the MOH&SW has a functional Procurement Management Unit (PMU), which works hand in hand with the Drugs Management Unit (DMU) headed by the Chief Pharmacist. A Ministerial Tender Board, comprising all directors, the Chief Accountant and the head of the PMU, oversees all tender procedures, whether they concern goods or services. Depending on the nature of

each tender, Evaluation Committees are formed that evaluate all offers and make their proposals to the Ministerial Tender Board. This process works well, although at times it is lengthy. Whenever shortages of particular drugs emerge (e.g. following disease outbreaks), there is a need for fast-tracking procurement. HSPS has been instrumental in this regard by facilitating direct procurement as the capacity for procurement of drugs through CMS remains rather limited. As a result, drug shortages at the district level and below have become less frequent and it is now claimed that at least 85% of the essential drugs are available at all times throughout the year.[4]

Health care engineering

Maintenance and repairs is another domain in which the MOH&SW has been able to improve its capacity through HSPS support. There is now a functional Health Care Engineering Unit (HCEU; previous called the Maintenance Unit), with a total staff complement of 54 and headed by a qualified Chief Engineer. The HCEU ensures five different types of maintenance: civil engineering (buildings), electrical maintenance, mechanical, biomedical and electronic maintenance. The unit comprises technicians with various types of expertise: electricians, plumbers, mason, carpenters, painters, motor vehicle mechanics and electrical engineers. Operating under the responsibility of the Directorate of Policy and Planning, and housed in Mnazi Mmoja hospital, the HCEU serves the whole country, with clients coming not only from Government health institutions (hospitals, health centres, the College of Health Sciences, the ministry itself), but also other clients (e.g. NGO/faith-based health institutions, Danida, WHO). For obvious reasons, the island of Pemba has its own workshop, which is formally part of the HCEU (with 20 staff, against 34 in Unguja).

The HCEU keeps track of its performance through a relatively simple computerised data base of all completed repairs and preventive maintenance works. Repairs still constitute the bulk of the work. An increase has been noted of 588 breakdowns that were reported and followed up in 2005/06, to 969 in 2006/07 and 1094 in 2007/08. This represents an increase of 86% over two years. The Chief Engineer assessed client satisfaction as part of the fulfilment of his master's thesis (HSPS funded). This provides an opportunity to incorporate client satisfaction assessment as part of the HCEU's routine monitoring of its performance.

Having benefited from a long-term technical adviser through HSPS for almost four years, who has brought in and shared a great deal of his expertise in engineering and preventive maintenance, the HCEU can now operate without a long-term adviser. The unit has developed a five-year strategic plan which sets out its ambitions and guides its future operations (2008-2012). Ultimately, its ambition is to concentrate more on preventive maintenance (e.g. fumigation to fight termites and bats that undermine buildings), which should bring down the number of breakdowns and reduce government expense on repairs and replacement of equipment.

Information Technology

Access to the vast potential of the internet is a critical means of improving both individual knowledge and skills, and more general communication within the Ministry and between partners. During FY2006/07, all DHMTs and hospitals were connected to internet through the US Government funded Joint Ministry Internet Project (JMIP), involving the MOH&SW, the Ministry of Education and the Ministry of Local Government. This project has provided an advanced communications infrastructure, computer hardware, software and technical support to district councils, district education offices, and the district health offices.

Capitalising on these achievements, the e-Collaboration Project is an ongoing initiative that establishes new partnerships and capacity to accelerate development of health human resources and the health

[4] Information from Pharmacy Department.

system through application of a web-based virtual learning and collaboration platform. This project involves several ministerial departments, Zanzibar Nurses Association (ZANA) and various organisations already active in Zanzibar: Aga Khan University (East Africa), African eDevelopment Resource Centre, E-luminate and Zanlink. The project utilizes appropriate technologies for the East African context and provides technical support in the critical areas of project management, IT infrastructure development and maintenance, and collaboration applications. The project works towards the establishment of a secure intranet (using the existing communications infrastructure) between MOH&SW sites, which minimizes reliance on the internet for locally-driven content and applications. It further implements locally-hosted applications to enable mixed mode (asynchronous and live interactive) distance learning between three sites (Dar es Salaam, Zanzibar Stone Town, Kivunge); and a so-called 'e-Grainery', that will be accessible from all 47 sites in Zanzibar that were created by the JMIP. Two technical IT staff of the MOH&SW are being trained on infrastructure maintenance (hardware and software) and support.

The distance learning component of the e-Collaboration project is described elsewhere (under HRH; section 3.1.3). Its management and organisation comes under the Continuing Health Education unit of the MOH&SW.

Transport

In 2006, the MOH&SW had a survey done of the transport situation in the ministry and a projection of the transport needs with the cost of vehicle operation in the next three years from 2006/07 to 2008/09. The study revealed that, at that time, a total fleet size of 48 vehicles was serving the ministry. Two-thirds of all the vehicles had been in use for more than five years. Some vehicles were as old as 21 years. Operating and maintenance costs for such vehicles were found to be very high, and it may be more cost-effective to replace them. Future transport needs for the coming three years were calculated at 66 vehicles (of which 43 in Unguja and 23 in Pemba) and this would imply that the MOH&SW would have to acquire 49 new vehicles. In addition, there was a need for 25 new motorcycles bringing the total to 46. Vehicle operating costs per vehicle and per annum were also calculated.

HSPS has invested in transport facilities during the previous phase, by procuring second-hand vehicles for the HSRS, the HCEU, CMS (Pemba), the two zonal offices and several of the district health offices. The above transport needs assessment recommended to strengthen vehicle management and control, to ensure that vehicles would be used solely for their intended purpose with a view to increasing their lifetime and reducing the operational cost of transport. A comprehensive transport policy would be required for this (see the Aide Mémoire of the HSPS Bilateral Review of September 2007), but this has not materialised as yet.

3.1.3. Human resources for health

Human resources for health have received significant attention in the health care delivery system in Zanzibar in almost all post-independence health policy papers. The Vision 2020 and the 1st Zanzibar Poverty Reduction Plan have both highlighted the need to improve human resources. The Health Sector Reform Strategic Plan stresses the need for a sound HRH system for efficient and effective delivery of health services in Zanzibar.

Cognisant of the importance of a skilled workforce as the most important resource in the health sector, the MOH&SW has identified eight priority areas for the Government to work on (Human Resource for Health 5-year Development Plan 2004/05-2008/09). Among these are human resource development (HRD), strengthening the capacity of the College of Health Sciences and staff retention. The Zanzibar Health Workforce Profile, which was a joint effort of the MOH&SW and WHO (May 2007), provides some insight (albeit a snap shot picture) into the availability and deployment pattern of the different health cadres.

As the primary health training institution in Zanzibar, the College of Health Sciences (CHS) bears the responsibility for the training of seven different medical and paramedical cadres, through two or three-year training courses. Among these courses are: general nursing, environmental health science, pharmaceutical science, medical laboratory science and dental therapy. A new curriculum has been designed for nursing anaesthesia, but training has not been started as yet for lack of trainers and equipment. With assistance from HSPS the College has developed its own five-year strategic plan (2005-2010). Based on the annual action plans that are derived from this, it has been receiving assistance from the African Development Bank (ADB) for the expansion of its physical infrastructure and to strengthen the capacity of its trainers and from HSPS to review training curricula, purchasing audio-visual and other teaching aids (including some pharmaceutical products and laboratory reagents). In 2008/09, support will be provided, amongst others, for printing training modules and some incentive package for trainers. With a staff establishment of 22 permanent staff (of which 9 are currently away for long-term training) and 16 part-timers, and some 500 students at any given moment, the CHS has a semi-autonomous status. It receives Government support for salaries and some of its recurrent expenditure. Since this is insufficient to run the institution in a proper manner, some form of cost sharing has been introduced (in 2005), which implies that MOH&SW sponsored students (almost 90% of all students[5]) contribute 50-60% of the tuition fees themselves. Despite this obvious financial barrier, the CHS has no difficulty in recruiting enough students to fill all its courses. With its Governing Board/Council recently dissolved and elections due soon, the CHS has the ambition to become fully autonomous and ensure that Zanzibar is self-sufficient for the production of newly trained medical and paramedical cadres. The ambition to create a CHS branch on the island of Pemba has been shelved for the time being, as the present institutional capacity of the CHS is considered insufficient for this and it would dilute its weak resource base.

In addition to the success of the CHS, several development partners have supported long-term training courses for MOH&SW staff. Among them is HSPS, which has so far supported 11 health professionals to participate in diploma courses in Tanzania mainland, with another 18 trainees who will soon start their training (1st year covered under the current HSPS phase), giving a total of 29. Four senior staff members have obtained a Master's degree in International Health in Denmark.

Among the milestones that were agreed upon for the FY 2006/07 for the sector as a whole, and that were reviewed at the Annual Joint Health Sector Review meeting in September 2007, the first two relate to HRH exclusively, while several others have some relation to HRH. Milestone #1 was that new HRH policy guidelines were to be developed and the HRH Division to be established in the MOH&SW. This milestone was found not achieved at the time of the Annual Sector Performance Meeting in September 2007. Meanwhile, the policy guidelines have been circulated and are now awaiting formal approval by the MOH&SW executive committee. Similarly, the formal establishment of the division is awaiting follow-up action by the MOH&SW Director General.

Milestone #2 was to prepare a roadmap leading to the accreditation of the CHS by the Tanzanian National Council for Technical Education (NACTE). This has been achieved: the CHS has received NACTE recognition and registration; accreditation has been obtained for courses in general nursing and environmental health sciences. Efforts will continue to be made to obtain accreditation for the other courses.

The achievement of other milestones depends to some extent on advancements in HRH deployment. Milestone #3, for instance, which stipulates that at least one PHCU in each rural district offers quality delivery services, depends first and foremost on the presence of qualified midwives. The skewed deployment of midwives is widely considered an Achilles heel, and it illustrates the importance of firm

[5] 10-15% of the students are sponsored by private organizations or come from Tanzania mainland or other countries: they pay 80% of the tuition fees.

measures in the deployment and retention of staff if Zanzibar wishes to make any advancement in reducing maternal and peri-natal morbidity and mortality. Milestone #12 involved a situation analysis of management needs and human resource requirements at Mnazi Mmoja Hospital. This analysis has been undertaken as part of the development of a five-year strategic plan for the hospital, which has been approved by the MOH&SW.

The Capacity Project (USAID funded) has provided support to introduce a Human Resource Information System (HRIS), as part of an inter-ministerial undertaking that involves the ministries of Finance, Local Government, Education and Health. This has so far involved programming and customisation of the HRIS data base structure, provision of ICT equipment to the HRH division and training of ICT staff. It is not known as yet when the HRIS is expected to be functional. ADB has come in with external support for the construction of staff houses so as to make it more attractive for health workers to work in rural areas.

Through the e-Collaboration Project, the Continuing Education Unit of MOH&SW is working towards the establishment of two CE resource centres (in Stone Town and Kivunge) capable of supporting nursing education needs. A two-year programme is currently in operation, upgrading nurses from a certificate to a diploma level, accredited by the Aga Khan University. The programme is in its second year of operation in Zanzibar and to date, 22 students have been enrolled over two years. The third cohort is being recruited to begin in January 2009. Direct supervision is provided by clinical preceptors at two sites (Stone Town and Kivunge). Lecturers travel from Dar es Salaam to Stone Town twice a month for face-to-face sessions with the students. Educational materials are paper-based. The time and expense of travelling to Stone Town for these sessions (currently incurred by the students) has been identified as a significant barrier to recruitment of students and scaling-out the programme beyond the main urban area. The e-Collaboration project offers possibilities to extend distance learning to other professions by making course content available on-line through a secure course website and by enabling virtual interactive sessions between instructors in Dar es Salaam (or Stone Town) and students in the field.

3.1.4. Quality assurance

Quality of care is of critical concern in the sector and is widely considered one of the main reasons for the prevailing low service utilisation rates (e.g. less than 50% of all deliveries in Zanzibar take place outside health institutions) and partly also for poor health outcomes (maternal mortality, neonatal mortality, malaria case fatality rate in hospitals, hospital infections).

A number of efforts are underway to improve quality in a structural manner, for instance, through the renovation and expansion of infrastructure, the procurement and regular maintenance of key equipment and the procurement and management of essential drugs and medical supplies. All these efforts are geared towards creating a conducive environment for health professionals to deliver quality services as per protocol. It is recognised, though, that the human factor cannot be ignored. In late 2006, a Technical Working Group for Quality Assurance (QA) was created with the aim to initiate and coordinate QA in the health sector. The group operates under the auspices of the Health Sector Reform Secretariat and draws it members from various departments. As of yet, a comprehensive national framework for Quality Assurance does not exist but a variety of interventions has been carried out, such as the review of the Essential Health Care Package, adoption and extension of the Quality Improvement and Recognition Initiative (QIRI), the development of an essential procedures manual for primary health care services and the development of integrated supervision guidelines.

Supportive supervision

In recognition of the fragmented nature of technical supervision currently undertaken in Zanzibar, whether by national priority programmes, by hospitals or by DHMTs, and as a step towards greater

coordination and efficiency within the sector, the MOH&SW has develop a set of integrated supervision guidelines. Drawing from international experience and best practices, these guidelines take account of the specific context in Zanzibar. The draft guidelines were circulated and tested in the field, before they were finalised and disseminated in November 2007. Training of district-level health staff in the implementation of these guidelines is currently going on, with support from the 'One UN' initiative (through UNFPA), the Capacity Project (funded by USAID) and HSPS.

Quality Improvement and Recognition Initiative

The Quality Improvement and Recognition Initiative (QIRI) started as a pilot project that was undertaken by the Reproductive and Child Health programme, with support from European Commission/UNFPA, in three districts (Chake Chake, North A and North B districts). This pilot came to an end in December 2006. Building on this experience, and in response to requests from the districts themselves, work has continued in 2007 and 2008 to extend the use of the QIRI tools to other districts so as to strengthen health care delivery more generally, i.e. beyond RCH. Following modification of the tools, all DHMTs received training in May 2007.

A baseline assessment of service provision in each district was completed in 2007. The intention is that such assessments will take place periodically to monitor progress, in addition to the (monthly) supportive supervisory visits by DHMTs. Results will be entered into the routine HMIS data base. Districts are being trained in the use of both HMIS and QIRI data, and it is envisaged that this will facilitate the use of information throughout the planning and reporting cycle, as well as a comparison of districts among each other, which would feed into the annual health sector performance review. Any future initiative to introduce a performance-based incentive system would need to consider linking up with QIRI.

Public Health Laboratory "Ivo de Carneri"

PHL is a research centre in Pemba that comes under the Directorate of General Health Services of the MOH&SW. Apart from research, the centre has a role in training and quality assurance of laboratory investigations, as well as in monitoring disease control and surveillance of outbreaks. At present, the centre is amongst others engaged in quality control of malaria blood slides in conjunction with the Malaria Control Programme, and it is planning to extend such activities to other tests, especially the 'rapid' ones (rapid diagnostic tests), which are increasingly being used for malaria, HIV, cholera and other infections.

Among the recent achievements of the PHL are the creation of a TB section which provides cultures of Mycobacteria and conducts drug sensitivity tests; and the ongoing installation of the Polymerase chain reaction technique, which will allow molecular analysis for advanced epidemiological and clinical investigations of several infectious and parasitic diseases.

Review of maternal mortality and institution of maternal death audits

Reduction of maternal mortality is one of the prime concerns of the MOH&SW leadership. Following reports of disturbing rates of maternal deaths within health institutions, and the finding of the EHCP review team that emergency obstetric care facilities are grossly deficient, the MOH&SW initiated a series of activities to address the situation. Led by the RCH department, in close conjunction with Mnazi Mmoja Hospital, the HMIS unit and the HSRS, and with support from HSPS (including technical assistance), the following achievements can be recorded:

- A study of the facility-based maternal mortality over three years (2005 to 2007). This study has served as a baseline and a catalyst for genuine discussions and initiatives to improve maternal health. The study showed an increase in institutional maternal mortality ratio from 377 per 100,000 live-births in 1998, to 533 per 100,000 live-births in 2006. The two major causes of

death were found to be haemorrhage and eclampsia, with 26% each. The case fatality rate for deliveries over the three years was 3.9%, which is significantly above the internationally accepted maximum of 1%. There was a serious underreporting of maternal deaths with only 43% of the cases at the tertiary referral hospital being reported to HMIS.

- Establishment of a maternal death audit system at Mnazi Mmoja Hospital: weekly maternal death audit meetings are being conducted since March 2008, involving all departments relevant to providing optimal quality of care to maternity patients. Two external consultants from Tanzania mainland provide technical support through HSPS. Preliminary figures for maternal death in May-June 2008 show a decline compared to the same period in previous years.
- Maternal death review forms have been developed, tested and introduced at Mnazi Mmoja Hospital to address the problem of underreporting; the forms have been formally adopted as part of the routine HMIS and data are being entered in the HMIS DHIS software. Monthly feedback sheets on maternal health are being developed. Similar will be introduced shortly in other hospitals.
- One focal person has been designated who is now responsible for the collection and analysis of reported cases of maternal death in Unguja. This person participates in the weekly maternal death audits.
- Other activities include support by a management expert, resident in Zanzibar, to improve the organisation and management of maternity services through local action plans that involve all hospital staff from department heads down to the level of cleaners.
- Health providers have been trained in active management of 3rd stage labour and the use of *misoprostol* for the treatment of post-partum haemorrhage. This training was provided by Venture Strategies for Health and Development. HSPS now ensures the procurement of this essential drug through CMS.
- Job aids and treatment guidelines are being developed with the support of UNFPA.

3.1.5. Community health

Zanzibar has known a relatively successful community-based health care programme in the early 1990's. For various reasons, though, the sector has not been able to sustain this programme and this has evolved into a plethora of activities at the interface between communities and health care providers.

One of the central-level support functions of the MOH&SW which the 2007 review of the Essential Health Care Package found to have a weak resource base is health promotion. It is widely acknowledged that prevention and health promotion is important in the control of all diseases, whether communicable or non-communicable. Almost all national priority programmes have a behavioural change component, but only to a limited extent are they pooling their resources to support activities at the community and primary health care level to promote health and healthy behaviour.

While the Health Sector Reform Strategic Plan refers only cursory to community involvement, the 2007 EHCP review recommended the development of a community health strategy which would be geared towards people taking responsibilities for their own health and for the way health services are organised and financed. This is very much in line with current international thinking. The World Development Report of 2004, for instance, points at evidence that the involvement of communities in the governance of the first line health delivery system does increase effective utilisation of these services.

Following the EHCP review, the MOH&SW commissioned a consultancy to formulate a community health strategy specifically for the Zanzibar context. It has resulted in a comprehensive strategy which

has been discussed and reviewed at various levels and which is expected to be formally adopted very soon by the ministry's leadership.

The community health strategy was formulated based on a number of premises:

- The establishment of demand driven forces within the health service delivery system so as to counterbalance the hitherto supply driven system, on the understanding that services that are asked for will be consumed more effectively.
- Ensuring quality demand, facilitated by the creation of informed consumers through the development of a community health information system, and by putting consumers in the 'driving seat'.
- The distinction between management and steering of service delivery, whereby management is vested in professionals, but where consumers are empowered to make decisions on priorities and allocation of resources towards health service delivery. This guides the approach towards cost sharing under the community health strategy.
- The enforcement of the district level as the health service delivery 'entity' that is able and flexible to respond to a community formulated demand for services, including promotional, preventive, curative and palliative services.

Based on these considerations, the following vision and mission for the community health strategy were derived.

Vision: Empowering recipients as a right to be involved in the governance of first line health care delivery, when rooted in a sound understanding of their health situation, will improve the quality of demand for, and therefore increase the responsiveness, equitability, effectiveness and efficiency of services rendered.

Mission: To describe the implementation modalities necessary to create a well informed consumer of health services, who has the capacity and communication channels to act as an equal partner at the primary health care level. Committees representing the community set out strategic directions for service delivery, and sensitize their constituent communities to share the responsibilities to improve health status with the formal Zanzibar health delivery apparatus.

The community health strategy has to be seen within and fitting with the various initiatives undertaken in Zanzibar under the National Health Sector Reform Strategy. While the Essential Health Care Package aims to bring delivered services in line with health needs, the community health strategy will attempt to bring demand closer to these same needs. It proposes that the existing structures concerned with health planning at the community level be replaced with one Health Custodian Committee at the shehia level, while leaving existing delivery mechanisms intact. The sole purpose of this committee will be the formulation of a quality demand, to be responded to by the professionally managed health service delivery apparatus. This community demand will form the basis of the district health plans, which will eventually fulfil the important function of linking supply to demand. To enact such a construction the strategy describes how the necessary conditions can be met:

- The demand formulated by the shehia Health Custodian Committees reflects the real community demand. Therefore committees are established following democratic representation principles with respect for minority groupings within the community. Reporting and accountability channels concur with the existing administrative hierarchy, bearing in mind that - honouring demand - suppliers are accountable to their customers.
- The quality of the demand depends on a sound understanding of the committee of the health situation and contributing factors within their communities. For this, a comprehensive

community health information system is necessary to complement (health) facility based data with community based information. This community health information system will be an extension of the existing Health Management Information System.

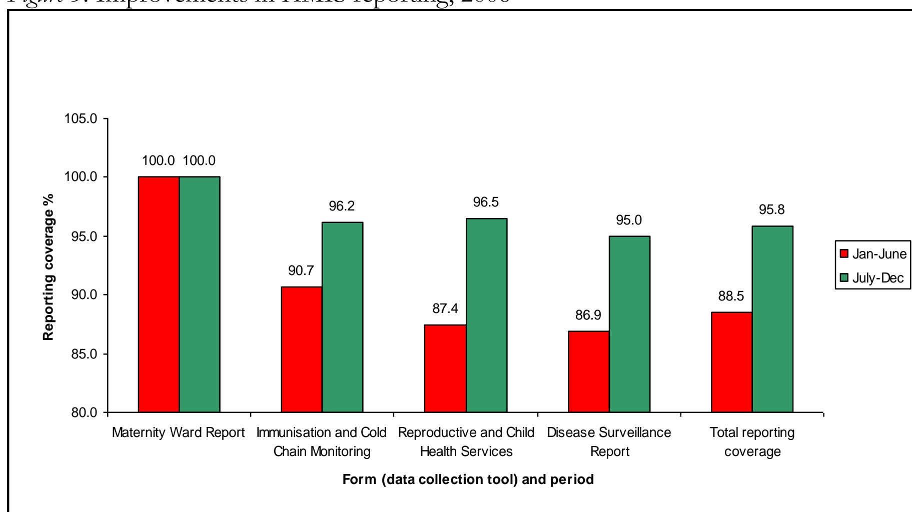
- The annual comprehensive district health plan needs to be formally accepted by all stakeholders (service providers) as the platform where demand meets supply and as the planning axis for all delivered health services in Zanzibar.
- The sustainability of the community health strategy is vested in incentives provided through competition rather than financial rewards. This competition is conducted through a peer review mechanism with the dual purpose of (a) increasing the quality of community health demand over time and (b) assessing the relative performance of shehia Health Custodian Committees.

Another crucial strategy to promote health and healthy behaviour, apart from community health, is school health. Although several national priority programmes engage in school health activities (ZACP, RCH, there is at present not a consolidated strategy to incorporate health into the curricula of primary and secondary schools.

3.1.6. Evidence-based decision making

The Health Management Information System in Zanzibar has made some remarkable progress over the past few years. After a long period during which very little reliable information was available, policy makers and health managers are now in a better position to make informed decisions. There is an established health management information unit, with a full-time head and a total staff complement of 18 staff (four of which are based in Pemba), out of which only a few have computer knowledge. Six staff members have completed a six-month training course in HMIS at the University of Dar es Salaam. An integrated HMIS system has been developed and progressively introduced in the past few years with financial support from Danida and WHO and technical support from HISP. This is now showing some positive results. An annual Health Information Bulletin is being produced which summarises key information collected by districts and referral hospitals (MMH and district hospitals) on health service utilisation (including some service coverage indicators) and some key morbidity and mortality indicators. The 2007 Health Information Bulletin, which summarises the information for the calendar year 2007, is more comprehensive than its predecessor. Unlike the 2006 bulletin, it includes data on caesarean sections and availability of emergency obstetric services. Although problems remain, there have been improvements in the timeliness and completeness of data reporting by the districts and hospitals, as shown by Figure 3 below.

Figure 3: Improvements in HMIS reporting, 2006



Milestones #13 and 14 of the FY 2007/08, which relate to HMIS, have thus been achieved: guidelines and manuals for data collection, analysis and use have been developed, and the 2006 Health Information Bulletin has been completed, printed and distributed. The latter has served as an important input to the Health Sector Performance Report, of which a draft was circulated to stakeholders for discussion, prior to the September 2007 Joint Review Meeting.

National guidelines have been developed for Integrated Disease Surveillance reporting, in line with WHO guidelines. These are intended to improve notification by health workers of thirteen priority conditions, namely cholera, yellow fever, measles, dysentery, rabies, acute flaccid paralysis (polio), neonatal tetanus, pneumonia, diarrhoea, malaria, pulmonary tuberculosis, road traffic accidents and meningococcal meningitis.

The Medical Research Task Force of the MOH&SW meets periodically (six times during the year, in principle) to review study proposals. With support from WHO and the National Institute of Medical Research of Tanzania mainland (NIMR), this task force has completed a situation analysis on medical research ethics. A research agenda has not yet been established, though. Also, the HMIS is not yet represented in the task force.

3.1.7. Private sector activities and public-private collaboration

An ADB-supported study conducted in 2004 on the private sector found there was scope to engage the private sector in pursuing public health goals. While policies and regulation to monitor and streamline private practice are in place, implementation of these policies is problematic. The Private Hospital Board (semi-autonomous) is a regulatory body, which lacks the resources to reinforce positive practices and the power to take disciplinary action, if required.

Besides the private institutions enumerated in the ADB study (see section 2.3), several new private parties have recently engaged in the delivery of health services in conjunction with the public sector. The best-known and best documented example is Rahaleo, a government owned clinic in the urban district offering comprehensive 2nd line health services (including laboratory and VCT). This clinic started a community health programme in early 2004 with the support of the Aga Khan Foundation (AKF). It comprises, amongst others, a youth and school outreach programme, and the clinic has piloted cost-sharing, as a financing strategy to complement its core funding from the Government and grants from AKF and the Global Fund.

In 2007, a UK-based charity organisation by the name of HIPZ (Health Improvement Project Zanzibar) engaged in a partnership agreement with the MOH&SW concerning the development and management of Makunduchi cottage hospital located in the southern tip of Unguja island. The agreement involves a 10-year lease of the hospital to HIPZ, which is currently in the process of upgrading the existing physical infrastructure with a view to turning the hospital into "a centre of excellence for the delivery of sustainable and accessible healthcare in keeping with policies of the Revolution Government of Zanzibar on Health Sector reform". In addition to providing a salary top-up to the health staff employed by the Government at the hospital, HIPZ also envisages attracting Zanzibari senior professionals to provide specialist clinical services and ensure sound hospital management.

Other more recent initiatives involve various overseas private parties wishing to support the cottage hospitals in Kivunge and Micheweni and Paje PHCU (1st line) in strengthening their respective service packages on a structural basis.

A number of local NGOs engage in health activities, primarily at the community and primary levels of care. Earlier (section 3.1.5), the multitude of committees have already been mentioned which have been formed at the shehia level to work with national priority health programmes. There is a great deal of

confusion and overlap in roles and responsibilities, which the new community health strategy hopes to address. At the national level there are two 'umbrella' organisations that try to coordinate NGO activities. The Association for NGOs in Zanzibar (ANGOZA) oversees the activities of all NGOs, not just for health. The Zanzibar NGO cluster for HIV/AIDS prevention (ZANGOC) was established in 1996 (formally registered in 1998) and has currently a membership of 29 community-based organisations, of which 25 in Unguja and 4 in Pemba. ZANGOC is a sub-recipient of funds made available by the Global Fund (Rounds 3 and 6), through the Zanzibar Aids Commission (ZAC). Other sub-recipients include TUISHI, the Zanzibar Association for Children's Advancement (ZACA), the Zanzibar Association of Farmers and Fishermen for Development (ZAFFIDE), the Zanzibar Association of People Living with HIV/Aids (ZAPHA+) and the Zanzibar Association for Medical Laboratory Scientific Officers (ZAMELSA). Some of these organisations have received funding from UNDP, UNICEF, FAO, the Finnish Embassy, the Swedish Embassy, the Bill and Melinda Gates Foundation, Africare, African Youth Alliance and Medicos del Mundo.

Two associations of health professionals are active in Zanzibar: the Zanzibar Nurses Associations (ZANA) and the Zanzibar Health Officers Association (ZHOA). Established in 1992, ZANA has its own office, a few designated support staff and a membership of 450 nurses. This is out of around 1000 nurses formally registered with the Council for Nurses and Midwives, of which around 800 are civil servants and around 200 purely in private practice. ZANA forms a platform for nurses and its vision is to enhance professional standards and quality of care. In the absence of any core funding, ZANA engages in project implementation. At present ZANA is involved in home-based care programmes in eight out of 10 districts (two districts in Pemba are not involved) and training workshops on AIDS-related workplace violence through the Southern Africa Network of AIDS (SANA) and the Norwegian Nurses Association. In early 2008, at the occasion of Nurses' Day, ZANA received some funding through HSPS for nurse training workshops. A promising initiative is the e-Collaboration Project (described in section 3.1.3), which provides on-the-job distance training for nurses and which foresees the establishment of a learning centre at the ZANA office.

3.1.8. Resource mobilisation, health financing

Resource mobilisation and developing long-term health financing strategies are among the most important roles of the government. The Ministry of Health and Social Welfare in Zanzibar has vested this role in the HSRS, which works in close conjunction with the Policy and Planning Department. In recent years, some important work has been undertaken by the HSRS to analyse health financing and health sector performance, two domains each overseen by a Technical Working Group that draws its membership from various ministerial departments and development partners.

In relation to financing, the TWG for health care financing has coordinated public expenditure reviews in 2006 and 2007 and pilot studies plus follow-up work on cost-sharing. A draft position paper on cost-sharing policies has been produced with various policy options for decision making by the senior management team. Meanwhile, work has been going on to improve the Medium Term Expenditure Framework (MTEF) which consolidates the budget proposals for capital and recurrent expenditure from all MOH&SW directorates into one overall budget with a three-year horizon. Progress is being made in clarifying the levels of funding being made available by various external sources (development partners), which will give a more complete picture of the resource envelope available for the delivery of health services in the public sector.

The production of the first health sector performance report in September 20007 (covering FY 2006/07) was a major achievement, which helped the Ministry monitor and improve sector performance. The report built on existing reports and the previous year's plan of action (POA). The second health sector performance, presented and discussed during the 3rd Annual Joint Health Sector Review meeting held on 22-23 September 2008, was more comprehensive than its predecessor.

3.2. Challenges & opportunities

3.2.1. District health services

One of the greatest challenges for the MOH&SW is to secure adequate Government funding for the operational cost of district health services. The MOH&SW has partly decentralized its activities, in line with the decentralization policy of the GOZ (e.g. MKUZA Cluster 3, Goal 1, point 1), the MOH&SW (Health Policy, Target 4.2.2) and the ZHSRSP II (section 3.2.2). The activity planning for the primary care level has been decentralized to the District Health Management Teams (DHMTs) that prepare comprehensive district health plans (CDHPs). This allows matching service provision and local needs. The DHMTs are thus responsible for the running of the PHCUs and PHCCs in their respective districts.

The funding for these activities, however, is not yet decentralized. Funds are not allocated to the districts, but are currently going through the budgets/subvotes of two different departments. Personal Emoluments (PE) are included in the subvote/budget for the Department of Planning (as for all employees of the MOH&SW), while 'other charges' (OC) go through the budget of the Department of Preventive Services. The ZHSRSP II specifically mentions that "budgetary restructuring will be pursued in order both to harmonize HSF and government funding modalities for district health services" (p.22) and that "it is hoped that [the increase in district planning capacity] will also extend to the devolution of GOZ budgetary resources for district health services during the plan period" (p.26). This would make the funding for primary care more predictable and flexible, improve the quality of services and also have an impact on the implementation of the Essential Health Care Package. The sub-vote for District Health Services (DHSS) is therefore the logical next step in the decentralization of service provision in the MOH&SW. A proposal to this effect has been prepared by the Department of Policy and Planning. The next steps are:

- For the MOH&SW and the Ministry of Finance and Economic Affairs to agree on the creation of a sub-vote for DHMTs, and then allocate funds accordingly in MTEF (Milestone #9);
- Ensure that national health priority programmes and global initiatives/funding mechanisms channel some of their financial resources to the HSF so as to enable districts to implement their planned activities (as per CDHPs);
- Concurrently, there is a challenge for districts (DHMTs) to 'deliver' and show evidence that they are building up their capacity to implement planned activities and reach their targets; this would then convince external partners to provide districts with non-earmarked financial support through the HSF;
- There is also a challenge for DHMTs to involve officers from their respective District Commissioner's offices in the health sector planning cycle; this would enable the DC planning officers to incorporate health in their overall (multi-sectoral) strategic planning.

One of the constraints is that local government legislation has so far not articulated a role for shehias (the lowest level of local administration) in health matters. On the other hand, this also constitutes an opportunity for HSPS to demonstrate what that role can be (see also the section on health promotion and implementation of the community health strategy).

With DHMTs building up their capacities and national priority programmes realising that the performance of their programmes depend to a large extent on the functionality of districts, there are thus opportunities for the HSF as a modality to attract funding from other sources.

In line with HSPS greater emphasis on productivity and performance in the next phase it is proposed that the annual entitlements for each district will in the future not only be based on input indicators (population, area, poverty level) but also on performance against a set of agreed key indicators, such as

for instance immunisation coverage, antenatal coverage or institutional deliveries under safe conditions. Districts that show clear improvement would get a higher allocation the next year. It is presumed that such a performance dimension would serve as an incentive for DHMTs and health service providers to do a good job, as they would be rewarded for their good performance.

There is also an opportunity to involve local communities in performance appraisal, in line with the new community health strategy.

3.2.2. Procurement of pharmaceutical products and maintenance of infrastructure

One of the greatest challenges in relation to procurement and maintenance issues is the retention of qualified staff. With the low salaries of civil servants and more attractive conditions in the private sector or in Tanzania mainland – for some of the technical cadres such as pharmacists and engineers – there is a continuous danger that senior staff will resign from their posts sooner or later. Recruitment is another challenge, which is all the more acute, since the Government announced a freeze in the recruitment of 'support staff' (some 2-3 years ago). This freeze does not only affect medical and paramedical staff, but engineers as well, which poses a threat to the HCEU.

Challenges and opportunities that are specific to the various intervention areas are listed here.

Procurement

The newly developed procurement and supply management system is still quite fragile. Procedures, although developed in theory, need to prove that they are effective and efficient. One of the main challenges is to strengthen the procurement process and shorten the cycle.

Another challenge is to ensure that procurement procedures are adhered to so as to avoid purchase of equipment items with specifications that preclude local maintenance and the acquisition of spare parts.

Pharmaceutical products

The procurement and supply management (PSM) system for pharmaceutical products involves many stages, each of which requires a certain expertise and agreed procedures:

- Selection of products
- Quantification of the requirements
- Procurement
- Storage
- Distribution
- Use of the products.

The main challenge is to capitalise on the available expertise and operationalise the process. Technically, the MOH&SW has built up quite some expertise. Yet, drug stock-outs do still occur because of flaws in the system. Some form of technical assistance will continue to be required.

A second challenge is to ensure that national priority programmes follow the existing PMU regulations and utilise existing structures, where appropriate. A good example is the Malaria Control Programme (ZMCP), which, unlike some other externally funded programmes, involves the PMU and CMS in the procurement, storage and distribution of drugs and supplies. Alignment of all national priority programmes and restraint on the side of development partners to do their own procurement would go a long way to strengthen local capacity and reduce transaction costs. On the other hand, it will remain necessary to procure certain commodities through parallel processes, since MSD is not able to deliver all requested items. At present, an estimated 20-25% of the total value of pharmaceutical products is being procured through private suppliers (i.e. outside MSD). HSPS itself has the ambition to identify a prime vendor that could also be engaged in strengthen the capacity of CMS.

Thirdly, the Government budget allocation to drugs and medical supplies is exceptionally inadequate, such that almost 100% of the cost of pharmaceutical products in public facilities is funded from external sources. From a sustainability point of view this is clearly an undesirable situation. The 2007 Public Expenditure Review convincingly demonstrated the huge relative weight of the wage bill in GOZ health expenditure: personal emoluments (PE) accounted for 78% of the budget in FY 2006/07; in terms of actual spending, PE accounted for 87% of expenditure in FY 2005/06. This leaves very little for the expenditure category Medical Supplies and Services (MSS; see table 1 below), which captures some of the most important operating costs of health facilities in the sector, namely running costs for hospitals, PHCCs and PHCUs, and the procurement of drugs.

Table 1: GOZ allocations to Medical supplies and services, FY2003/04 – FY2006/07

	FY2003/04		FY2004/05		FY2005/06		FY2006/07
	Budget	Expd	Budget	Expd	Budget	Expd	Budget
Total MSS (TSh m)	**788.73**	**344.57**	**496.72**	**143.05**	**299.15**	**278.80**	**327.80**
As % OC	*37%*	*41%*	*30%*	*26%*	*23%*	*37%*	*24%*
As % Recurrent	*12%*	*7%*	*8%*	*3%*	*5%*	*5%*	*5%*
Expd as % of budget		44%		29%		93%	

It is promising, though, that the GOZ budget for the financial year 2008/09 shows for the first time an allocation to Central Medical Stores. Previously their financial requirements had to be covered by the budget allocations to other departments, such as the Department of Curative Services and Mnazi Mmoja hospital.

Health care engineering and maintenance

The HCEU faces similar challenges as the Drug Management Unit, and the Pharmacy Department as a whole: (a) available expertise and established procedures need to be consolidated and improved upon; (b) support is required from other Government departments, in particular the national health priority programmes, and where possible private actors, to use/purchase the services of the HCEU; and (c) a sound financial basis is required for the HCEU to sustain its services.

With regard to (a), the HCEU wishes to further its technical competence to provide 1st line maintenance and repairs of biomedical equipment. Unlike some of the mechanic and electrical equipment items, biomedical machines require an increasing level of skill, which technicians have to keep updated with. Thus, training is required.

With regard to (c), it is not realistic to have high expectations from core GOZ funding for the HCEU. Apart from financing staff salaries, the health MTEF indicated a recurrent budget allocation of TSh 14 million for maintenance works for the year 2007/08. None of this money has been spent. It appears more realistic for the HCEU to try and raise its own income so as to cover part of its operational costs. The unit already has its own bank account, and the fact that part of the HSPS allocation to the HSF is earmarked for maintenance and repairs (7%) constitutes an opportunity for the HCEU to achieve some degree of financial autonomy.

Another opportunity for the HCEU relates to cooperation with private sector parties. At present the unit makes limited use of private contractors (e.g. a contract has been established with a company that services elevators in the hospital). More outsourcing could be done to procure services for which the HCEU does not have the technical competence, but also to involve local artisans in maintenance work and minor repairs at rural clinics, which may be more cost-effective than sending somebody down from the HCEU workshop.

ICT

At present there are two ICT specialists in the MOH&SW, one who provides general support to the Ministry, while the other provides services to departments and units that are dependent on ICT equipment and software, such as HMIS, the HR division (including CEU and Personnel unit), CMS, HCEU, CHS. There is a challenge to strengthen ICT support and institute a mechanism from which all departments and units in the Ministry will benefit.

3.2.3. Human resource management and development

The Zanzibar Health Workforce Profile, which was published in May 2007, demonstrates a disproportionate large number of non-skilled staff employed in the health sector (many health orderlies), and an acute shortage of some key professional cadres, such as clinical officers (a deficit of 49 on a total requirement of 140; 35%), community health nurses (a deficit of 110 on a total requirement of 130; 85%) and public health nurses-B (a deficit of 168 on a total requirement of 279; 60%). The large number of health orderlies is an historical legacy that will slowly fade out, since this cadre is no longer being recruited. The shortage of the above key cadres, however, requires an accelerated effort to train, recruit and deploy new professionals and to redeploy and retain those already in service.

Pre-service and in-service training

The College of Health Sciences is Zanzibar's most important institution for pre-service training and presents opportunities for development partners to help strengthen its institutional base, so that it is in a better position to fulfil its mandate. One of the greatest challenges at the CHS is to strengthen the capacity of trainers, make the environment more conducive for teaching and learning, and to introduce an incentive scheme that helps to retain trainers.

In addition, there is a challenge for the MOH&SW to offer its current staff appropriate opportunities to stay abreast with new developments and upgrade their knowledge and skills. The e-Collaboration project, implemented through the Continuing Education Unit, among others, offers possibilities to extend distance learning to all professions by making course content available on-line through a secure course website and by enabling virtual interactive sessions between instructors in Dar es Salaam (or Stone Town) and students in the field.

Another challenge is for the national priority programmes to coordinate their training activities, especially workshops and seminars that are directed at health workers at the district level and below. Competition for staff-to-be-trained should be avoided at all times, and the best way to achieve this is to acknowledge that it is the prerogative of DHMTs to coordinate all district health activities (including training). DHMTs would then ensure that all training then gets incorporated into the comprehensive annual plans for their respective districts.

Recruitment and deployment

The recent review of the Essential Health Care Package offers an opportunity for the Government to redress the urban bias in staff deployment. Minimum numbers of workers that would be required to deliver the EHCP at the level of PHCUs, PHCCs and district hospital have been proposed, whereby a distinction is made between low-density, medium-density and high-density PHCUs. It is now a matter of adhering to these staffing norms and (re-)deploying staff accordingly.

Retention

There are no reliable data about health staff resigning from civil service and taking up jobs in the private sector or outside Zanzibar. Several senior government staff have left in recent years to take up positions with international development agencies. While some of them are on secondment and may still return to their old positions, others will not.

Staff productivity

A study conducted by the USAID-funded Capacity Project in 2006, pointed out that staff productivity leaves a lot of room for improvement. Despite frequent calls that staffing levels are low, the study provided evidence that during their working hours medical and paramedical staff get engaged in various activities that do not carry a benefit to their clients. Productivity levels varied substantially between cadres, types of facilities and districts. The reasons for low productivity were not explored in depth, but were believed to be multiple. While the study has generated a lively debate in the sector, it has so far not resulted in very concrete steps to improve staff productivity. Hence, this constitutes an opportunity for HSPS to complement its support to pre- and in-service training with a future focus on increased staff productivity and performance, so as to obtain more value for investments made. There are also obvious linkages with the Quality Improvement and Recognition Initiative (QIRI), which the MOH&SW has introduced on a pilot basis (with support from UNFPA and HSPS) and which HSPS continues to support as part of the efforts to enhance adherence to norms and standards and quality assistance in general (see section 3.1.4).

3.2.4. Quality assurance

The recent attention for maternal mortality and the multiple interventions being undertaken to reduce maternal death demonstrate that it is possible to mobilise the sector behind a common purpose. More such concrete initiatives are required to combat neglect and create a 'culture' of caring for the wellbeing of patients. It is probably too early to speak of a success and it is yet to be seen whether the various activities and procedures (such as maternal death audits) will get firmly institutionalised. Yet, the example clearly shows that action is required at various levels and there is no single intervention that will lead to improvement if undertaken in isolation from others.

Challenges are multiple, since all professional cadres and the entire health system is involved from the community right up to the central hospital:

- Improving the referral system, by discouraging the use of referral institutions as primary centres of care
- Introducing standard treatment protocols and professional standards of care
- Ensuring strict adherence to standard treatment protocols, reinforcing professionalism
- Instituting performance-based incentives and sanctions.

Opportunities are also multiple, since there is commitment among the leadership at the ministry and among various development partners that are willing to support quality improvements (WHO, UNFPA and others). Apart from maternal health, there is also a need for concrete action within health institutions to reduce neonatal and infant mortality. While cognisant of the fact that some of the underlying factors are at the community level (late reporting to a health institution in case of problems during pregnancy, labour) or at the level of primary health care facilities (wrong or late diagnosis, late referral), there is much to be gained by improving the quality of services within hospitals. Professionalism and adherence to standard treatment and protocols are prerequisites to the enhancement of the quality of any type of hospital care.

Apart from quality improvements in the public sector, there is obviously also scope for initiatives in the private sector. Initiatives have so far focussed on particular issues, such as compliance to treatment regimens (malaria, TB), driven by some of the national health priority programmes. However, so far no comprehensive efforts have been made to assure quality of services in the private sector through professional associations or boards. The establishment of a Standard Service Charter for the private sector (including NGOs), which was one of the agreed milestones in the sector for the year 2007/08, has so far not been achieved. Such a charter could form the basis of a future accreditation system. At

present, individual private institutions (clinics, pharmacies, drug stores) obtain their licenses on a periodic basis from the Private Hospital Board (under the MOH&SW). Individual doctors and nurses renew their licences to practice from the Registrar in the MOH&SW (every two years), but *de facto* there is no inspection and control system and sanctions are rarely applied.

3.2.5. Health promotion, including community health and school health

The multitude of activities at the interface between communities and health care suppliers is to a large extent due to the multitude of programmes and projects, and the fragmentation of the delivery of services described earlier. On the positive side, this means that a number of skilled and experienced people and structures are already present at this level. On the downside it means that coordination of activities has become increasingly complex, resulting in inherent duplications and inefficiency of delivery.

Another challenge is posed by the current utilisation and referral practices in Zanzibar. Although in most cases clear catchment areas can be attributed to first line health service facilities, customers tend to bypass these facilities to get primary care from second and third line facilities. This is especially so in urban areas and areas close to 'cottage hospitals' which *de facto* fulfil the role of district hospitals.

Cost sharing as a strategy to complement financing of health services is high on the agenda of the MOH&SW. Till date, however, it is being implemented in a fragmented and uncoordinated way. It is difficult at this stage to foresee what the role of community involvement could be in the different aspects of cost sharing. Ability and willingness to pay, and the approach towards waivers and exemptions, has obviously wider implications than and stretches beyond the health sector alone. In terms of the community health strategy it is rather a general shehia concern. The current capacity for managing the revenues from cost sharing appears quite acceptable at the district level, but very limited at the community level.

With regard to school health, as stated before, there is not as yet a consolidated strategy for the incorporation of health issues into school curricula. Yet, there is broad consensus within the sector that there is scope to direct health promotion activities much more directly to youth and adolescents who form the future generation of Zanzibar.

3.2.6. Evidence-based decision making, HMIS

While some progress has been made (see section 3.1.6), the Health Management Information Unit has the ambition to further improve the comprehensiveness and quality of its data sets and to promote the actual use of information for decision-making at all levels, from the primary health care level right up to policy level. Some major challenges remain. The most important ones are:

- Improving the quality and completeness of the HMIS data, and instituting an appropriate mechanism to monitor quality;
- Incorporation of data from the private sector, i.e. both the not-for-profit NGOs and faith-based organisations as well as the commercial (for-profit) health institutions: especially data on service outputs (clinic attendance), but also new cases of infectious and non-communicable diseases and certain types of mortality;
- Incorporation of community-based data into the HMIS; for instance inclusion of vital statistics and the service outputs of environmental health officers, community-based distributors (for family planning commodities), traditional birth attendants and other community-based health workers.
- Incorporation of data on resource availability and resource use at public health facilities (human resources, selected essential drugs); and linking this with the information systems of the relevant departments (e.g. the human resource information system of the Human Resource division);

- Promoting the actual use of data for informed decision-making; this requires amongst others a certain capacity to analyse and display trends over time (e.g. graphs);
- Introducing and maintaining medical records systems at hospitals (Mnazi Mmoja hospital and district hospitals);
- Introducing a geographic information system (GIS) for the display of available health resources (e.g. health infrastructure, distribution of various types of professional staff) so as to analyse resource gaps; and for epidemiological analysis of the spread of communicable and non-communicable diseases and conditions in relation to resources and resource gaps.

The above challenges and ambitions are yet to be consolidated into a comprehensive HMIS strategy and a master plan, indicating how this will be achieved and what resources are required.

Several opportunities arise to address the above challenges and realise the ambitions. First and foremost, several of the national priority health programmes already have systems in place and a certain routine of collecting data from hospitals and peripheral health centres. There is a need to harmonise the existing information systems and consolidate them into one uniform strategy.

The malaria proposal for Global Fund Round 8 (submitted end of June 2008) includes an intervention to strengthen the HMIS: Intervention #1 of the Health Systems Strengthening component, which has three cross-cutting interventions (see p. 46 of the proposal). This clearly illustrates the preparedness of one of the larger national programmes to allocate some of its resources to systems strengthening.

3.2.7. Public-private collaboration

There is obviously a role for professional associations to promote professionalism and engage in improving the quality of care, as discussed earlier (see section 3.1.4). There is scope for organisations such as ZANA and ZHOA to play their part in the design of a national framework for QA for their respective professional cadres. This will require institutional strengthening so as to enable these organisations to work towards the fulfilment of their mandates.

The interest of external parties (NGOs, foundations) who have medical expertise and funds to support the health sector in Zanzibar provides new opportunities but also some challenges. The number of parties seems to be on the increase and this may be related to the attractive tourist facilities that Zanzibar has to offer. There is scope for the sector to capitalise on what these parties have to offer so as to strengthen the health care delivery system.

There is no policy framework to guide public-private partnerships in the health sector. This is not surprising, since the public and the private sector have been operating in a quasi parallel manner and formalised partnerships between parties from the two sectors are a new phenomenon in Zanzibar. The policy framework will need to be developed gradually, based on practical experience with concrete forms of public-private collaboration. The challenge for the MOH&SW is to ensure that external parties wishing to support individual health facilities in Zanzibar operate within a policy framework. This would ensure, amongst others, that the infrastructure and service packages offered are in line with national priorities (no 'white elephants'), that the quality of care provided is up to standard, that health staff is duly rewarded without undermining a rational staff distribution, that there is a sound financial strategy without creating barriers for patients unable to pay.

Apart from a policy framework, there is a need for concrete written agreements (contracts) that define the modalities work public and private parties to work together. Such agreements would define (a) the types of services that one party provides to the other, and vice versa, (b) the volume and quality standards of these services, (c) their costs, and (d) how they will be financed.

While PPP is quite new for Zanzibar, there are obviously experiences elsewhere, to capitalise upon. Reference is made to Tanzania mainland, where one of the church-related hospitals (Bumbuli hospital) recently entered into a service agreement with the local district council (Lushoto district, in Tanga region). CSSC has a policy to promote service agreements for all its members as a strategy to strengthen and sustain health service provision by faith-based organisations.

3.2.8. Health financing and monitoring sector performance

The main challenge for the HSRS is to improve the quality and comprehensiveness of the analytical work that is being done with a view to identifying appropriate measures to increase sector performance and curb health outcomes in the right direction. Strengthening local capacities to conduct studies and reviews is a priority for the MOH&SW and HSPS provides opportunities to source national and international expertise and link it with government staff.

Another challenge is to strengthen and harmonise the planning cycle. The Department of Policy and Planning has designed a planning schedule which will henceforth need to be strictly adhered to by all departments, programmes and districts in preparation of future annual plans and budgets.

Monitoring of progress towards the annual plan (POA) is largely done separately by programmes and individual units, and it is the tasks of the HSRS (through the TWG Health Sector Performance Monitoring) to consolidate this into one comprehensive report. It was envisaged to produce periodic quarterly updates on overall progress at HSR review meetings but this may have been too ambitious. Nevertheless, periodic assessments and reports remain necessary as part of monitoring of progress in implementing the POA. The ministry has designed various tools (forms) to ensure availability of adequate information from all departments and programme implementers.

The preparation of POA as part of the ongoing reform process is expected to reduce inefficiencies and address various weaknesses in programme implementation:

- A uniform planning cycle, which enables harmonised activities and improves the link between MTEF and POA;
- Comprehensiveness of POA that includes all relevant information from all MOH&SW departments, national health priority programmes and development partners;
- Integration of programme activities into district plans;
- Involvement of departments heads, programmes, zones and districts in the preparation of cash flow and expenditure reports;
- Transparency of all programmes in their plans, budgets and the extent of actual implementation.

The latter issue remains a challenge, since as it affects the predictability of funding for the sector. This is further complicated by the use of different planning horizons by various partners (varying from less than a year to three years, sometimes five years), and also financial years (calendar years, GOZ financial years, or other 12-month periods).

3.3. Strategic approach

Similar to the approach taken during the first five years of HSPS support to the health sector in Zanzibar (Phase III), the strategy will continue to be to strengthen district health services, by supporting decentralisation and improving the resource base (human, financial, material) in rural areas. This will be combined with strategic support to central level support systems that are key to the smooth functioning of the sector. Such support systems are easily overlooked since they do involve a service to patients/clients and hence result only *indirectly* in better health outcomes of the population. The approach of HSPS is to <u>help create a conducive environment and strengthen local capacity</u> for central

level support systems to function properly, so that, eventually, health institutions and individual health workers are able to provide quality services.

Creating a conducive environment means not only that the necessary infrastructure and supplies are in place (hardware), but also appropriate policies and operational guidelines and procedures (software). This involves a continued 'engagement' of HSPS in policy development and strategic planning of the sector itself, while keeping in touch with the realities of the field (i.e. the actual provision of health services) so as to experience how national policies work out in practice.

Although much of the external support to the health sector in Zanzibar is greatly appreciated by the national authorities, there is also an increasing recognition that, as a whole, the various initiatives are fragmented and that many initiatives are rather vertical in nature. While externally funded programmes may provide some very concrete outputs and may have a positive influence on health outcomes, they do tend to create parallel sub-systems and hence they fail to support the health system as a whole. In some cases one could argue that they even undermine the existing system.

The approach that HSPS will use is to work in close conjunction with national policy makers and planners, and to try and convince the national health programme managers and their donor agencies to 'buy into' the HSPS efforts to strengthen district health services and central level support systems.

While the first two elements of the HSPS approach (creating a conducive environment and the 'buy-in approach') are a continuation of the ongoing phase, there are two elements that are rather new in the next phase: demand creation and an emphasis on quality and performance. So far, HSPS has provided its support based on perceived needs and requests from specific departments and units in the MOH&SW. In a way, the support has been very much based on inputs (commodities, finance, TA), as identified in annual action plans and associated budgets. The next phase will put much more emphasis on service outputs (productivity) and performance against predefined targets and quality standards. Efforts will be made to make funding levels, at least partially, dependent on performance. One of the readily available possibilities to introduce the principle of performance-based financing is the HSF: allocation of funds will be based, as in the past, on population, land areas and poverty level, along with under-five mortality. In addition, there will be a provision for additional funding, depending on concrete improvements in service output (e.g. increase in immunisation coverage rate, in antenatal coverage or in institutional deliveries). This would imply recognition for districts that have done well in the previous year. Mechanisms to involve local communities in the appraisal of 'performance' will be pursued in line with the recently developed community health strategy.

Demand creation is a manner to get away from the conventional input-based planning and budgeting. There is scope for ministerial departments and units to generate demand for the services they provide to communities/shehias, districts and even to other Government departments. In principle this means a transition from a 'push' to a 'pull' system, whether it involves commodities (such as drugs) or services (maintenance, IT support, IEC support).

3.4. Brief narrative summary of component

All in all, HSPS will comprise clusters of interventions that are grouped in three sub-components:

Sub-component 1: Support to the HSF, as a precursor to harmonised sector budget support

Support for annual planning (through comprehensive district health plans and POA) and the HSF are two complementary strategies to work towards an integrated way of service delivery and channelling central level support in a coordinated manner. As a funding modality, the Health Service Fund is a mechanism to increase the level of funding for primary health care services, which is a prerequisite for the improvement and expansion of quality care and the attainment of national indicators.

While supporting the HSF, care will be taken to ensure that all funds are properly accounted for and that all accounts are audited on a regular basis. In the expectation that other development partners will start channelling funds to the HSF, the current central level management and accounting system, which is ensured by the HSPS programme implementation unit, will at a certain stage be transferred and integrated into the Government financial and accounting system. HSPS will build the necessary capacity towards this end through training and technical support, and a stepwise approach towards integration will be taken. Presently, accounts are prepared manually by zonal accountants and handed over to the HSPS accountant. It is planned to introduce computerised accounting for the HSF at the zonal level. The computerised system will be compatible with the government system, which will facilitate integration as and when the GOZ system is decentalised to the Zonal level. The next step might be that MOH&SW takes over the accounting responsibility for HSF funds from the HSPS accountant until sub-votes have been created for districts and zones and full integration can be completed. The level of integration and way forward will be an item for discussion during annual reviews. This will then turn the HSF into a modality for harmonised budget support for district health services. With the very recent approval of the Global Fund support to health Systems Strengthening through the HSF, this process may be implemented with more speed than originally anticipated.

Sub-component 2: Earmarked central sector support to systems development and strategic interventions

Two types of interventions fall under this sub-component::

I. Procurement and supply management of pharmaceuticals and other products

A combination of strategies will be used to improve pProcurement and supply management of pharmaceuticals, equipment and other products. Focus will be on procurement of pharmaceuticals, including procurement of right types and qualities in a timely manner, storage and distribution of pharmaceuticals and other supplies, rational prescription, system for maintenance of equipment and facilities, supported by a functioning ICT unit and adequate transport., a transport policy and a transport management information system

II. Capacity strengthening

Capacity strengthening covers a broad range of activities:

With regard to human resources for health, HSPS will employ a combination of strategies and modalities to support pre-service training, recruitment, rational staff deployment, in-service training, retention and modern human resource management for improved staff productivity and performance.

	Responsible GOZ department	*HSPS strategy*	*Modality of support*
Pre-service training	College of Health Sciences	Support curricula; strengthen capacity of trainers	Institutional support to CHS based on new/revised strategic plan and subsequent POAs
Recruitment	MOH&SW with Civil Service Department	Assist in calculation of staff requirements	Reviews and studies
Deployment and redeployment	MOH&SW: HR division, Personnel unit	Assist in reviewing staff deployment patterns	Institutional support to the HR division; reviews and studies
In-service training	MOH&SW: HR division, Training unit and CE unit	Assist in offering training opportunities in all districts	Support to the e-Collaboration project, coordinated by the CE unit
Retention	MOH&SW: various	Reviewing retention	Reviews and studies

	departments	schemes	
HRM for increased productivity and performance	MOH&SW: HR division	Assist with HRIS; Assist in reviewing job descriptions and introducing performance appraisal	Technical assistance, reviews and studies

With regard to health promotion, HSPS proposes a three-pronged approach: (a) Support to implementation of the community health strategy, (b) Support to the design and implementation of a school health strategy with inputs from various national health programmes, and (c) Establish a health promotion common fund ('basket') with inputs from various national health programmes and development partners.

The approach of HSPS in support of informed decision-making in the health sector will consist of technical and financial assistance to the HMIS unit. This will be done firstly by further strengthening the capacity of designated HMIS officers, programme managers and service providers at all levels, mainly through training and by offering external technical expertise to strengthen the HMIS system itself. The latter will involve not so much the information technology aspects of HMIS, but rather a combination of epidemiological and didactical expertise that is required to select (and design, where appropriate) appropriate indicators, tools/instruments and guidelines that will allow to utilise information for informed decision making. Secondly, the HSPS approach will be to encourage national health priority programme staff to participate in the periodic review of core indicators, instruments, guidelines and health information reports/bulletins; and to avoid any undue parallel data collection and reporting.

With regard to quality assurance, HSPS proposes a two-pronged approach to improve the quality of care: (a) support to focused initiatives to improve health outcomes in referral institutions; and (b) support to professional associations to promote and enforce quality of care, in both the public and the private sector.

For the first approach, resources will be made available and technical support will be mobilised to address medical conditions and problem situations in a comprehensive manner. The ongoing effort to reduce maternal mortality (described in section 3.1.4) serves as an example. As successes will not be achieved overnight, this initiative will require sustained external support. Other conditions that require focussed initiatives will be identified in the course of programme implementation. One of the priorities of the MOH&SW and senior hospital staff is the reduction of neonatal and infant deaths. The second approach will be addressed in sub-component 3, see below.

The new HSPS will further have a provision to undertake and support strategic initiatives for strengthening health sector performance. The 'strategic' aspect of such initiatives lies in the nature of the intervention (innovation, new technologies, new approaches), as well as in their potential to raise interest among new partners (knowledge centres, funding agencies) and form new partnerships. Such initiatives will obviously build on local needs and opportunities, and take into account international experience and evidence obtained elsewhere in the world that may be relevant to Zanzibar.

Sub-component 3: Support to NGOs and public-private partnerships.

For the second approach to quality assurance to be successful, firstly the roles and responsibilities of various actors need to be clarified. On the side of the Government, the mandates and resource base of the various Boards and Councils need to be clarified and reinforced (Private Hospitals Board, Food and Drugs Board; Medical Council, Nursing Council). On the side of NGOs, there is scope to reinforce the Zanzibar Nurses Association (ZANA), the Zanzibar Health Officers Association (ZHOA) and others,

to fulfil their roles as protectors of professionalism. In view of the recent interest of external private parties in engaging in health service delivery (see section 3.2.6), there is also a need for close monitoring and periodic critical-supportive reviews of the various innovations and unfolding public-private partnerships, with a view to informing national policy and exploring a possible scale-up of such initiatives.

The malaria component of the proposal that was recently submitted to the Global Fund (Round 8) includes three 'cross-cutting' interventions for health systems strengthening in general (i.e. not particularly in relation to malaria, or HIV/AIDS). One of these interventions comprises a set of measures to institute Quality Assurance and Control mechanisms in the health sector, specifically geared to strengthening drug quality assurance, pharmaco-vigilance and diagnostics in private health facilities. If funds are granted, this set of measures will complement the HSPS support.

HSPS will continue to support and work in very close conjunction with the Health Sector Reform Secretariat (HSRS), including its various technical working groups (TWG's).

3.5. Capacity development support

Several of the intervention areas that form part of sub-component 2 (Earmarked central sector support to systems development, management and strategic interventions) are not robust enough to absorb financial support if this is not complemented by technical assistance.

Past experience (in HSPS Phase III; the first five-year period of Danida support to the health sector in Zanzibar) has shown that the procurement and supply management system, in particular for pharmaceutical products (drugs, medical supplies) requires continued technical support. While the Danish Embassy in Dar es Salaam has been instrumental in procuring medicines that CMS Zanzibar cannot obtain from the Government Medical Stores Department in Tanzania mainland, this arrangement cannot be sustained. It needs to be replaced by a system whereby the Pharmacy Department of the MOH&SW itself, in conjunction with the Procurement Management Unit, ensures the procurement of all pharmaceutical products. Technical support is required to get the systems in place for quantification, procurement and distribution in a timely and efficient manner.

Human resource management, quality assurance and health promotion are three intervention areas that are new to HSPS, even though some important work has been done during the previous phase (Phase III), for instance in improving the quality of delivery services. Current capacities are not strong enough to make the necessary advancements in human resource management, so as to increase staff productivity and performance; neither are they strong enough to engage successfully in quality assurance trajectories or in establishing a comprehensive health promotion programme. Long-term technical assistance that draws from international best practices in these domains (especially in resource-constrained environments) appears a prerequisite for success. Apart from bringing in fresh knowledge and expertise, the role of the TA (technical assistant) is to coach and groom national department heads and programme managers for the tasks they are responsible for. For this reason, two of the three proposed technical assistants will be based in designated MOH&SW departments, away from the HSPS office.

The three proposed positions are:

1. Senior health adviser
2. Health adviser HRH and QA
3. Junior professional officer (JPO), to support Health Promotion.

The senior health adviser (SHA) is the component manager of HSPS support to the health sector in Zanzibar and works under the direction of the Steering Committee for this HSPS component

(Component 2 of HSPS IV) to provide overall guidance for the implementation of the HSPS. In this capacity the SHA is also the head of the HSPS office, together with the HSPS programme coordinator (nominated by MOH&SW). The SHA further assists the MOH&SW in instituting a coherent and comprehensive programme-based approach in the health sector, ensuring that all external support (not only Danida support through HSPS) is fully aligned with GOZ policies and strategies. He/she also assists the MOH&SW in strengthening its procurement, management, reporting and accounting systems, in particular in the domain of pharmaceutical procurement and supply management, which absorbs a significant of the HSPS funding (around 25%). And finally, the SHA is responsible for the overall coordination of the technical inputs of the HSPS funded long-term technical assistance to MOH&SW, as well as for the coordination of short-term technical assistance and consultancies. The job description of the SHA is attached as Appendix 2.

The health adviser HRH & QA has two main responsibilities: (a) support the Human Resource division in implementing the HSPS programme intervention area that deals with human resource management and human resource development; and (b) undertake concrete initiatives to improve the quality of care at all levels of the national health system. The health adviser will be a member of the two Technical Working Groups operating under the Health Sector Reforms Secretariat (TWG for HRH and TWG for QA) and work in conjunction with their respective members. The job description for the health adviser HRH & QA is attached as Appendix 3.

The JPO will support the Health Promotion unit of the MOH&SW in implementing the HSPS programme intervention area that deals with community health and school health. The job description is attached as Appendix 4.

Short-term technical assistance and consultancy will be made available through HSPS for for example in health care engineering (maintenance), transport management systems, HMIS and public-private partnerships.

3.6. Strategy for integrating HSPS support into government systems

The success of capacity development hinges on the extent to which HSPS support can successfully be integrated into government systems. Building on the experience gained in the previous Phase, such integration will be explicitly pursued in at least three areas as follows.

a. Financial systems

   Accounting for HSPS financial support to the district level through the HSF will be delegated from the HSPS office[6] to the zonal level, and in the future possibly to the district level. In the next Phase, all HSF expenditure will be administered through the GOZ financial accounting system, which will be automated (computerised) and operated by GOZ employees. The financial systems for the earmarked support will be adjusted with a view to facilitate integration into the MOH&SW systems, once sufficient capacity is in place.

b. Procurement systems

   Direct procurement of pharmaceutical products by the RDE in the next Phase will be phased out and this responsibility will be transferred to the Central Medical Stores department in consultation with the Procurement Management Unit and the Drugs Management Unit of the MOH&SW.

c. Sector performance monitoring and review

[6] At present, HSPS already uses a GOZ accountant, made available by the Ministry of Finance and Economic Affairs.

Already during the previous phase of HSPS, programme reviews have been combined with the periodic sector review meetings, once these started to be organised (by the Health Sector reforms Secretariat, with support from HSPS). HSPS will continue to strengthen local capacities to institutionalise sector-wide planning, budgeting and performance reviews, through its earmarked support to certain central sector support systems (HSRS, HMIS).

If successful, other types of external support (by other development partners) may also be aligned to government systems, which could strengthen national ownership, increase transparency and enhance local accountability for resources used and results obtained.

4. Objectives, outputs and main activities

The overall development objective of the Danida funded Health Sector Programme Support to the health sector in Zanzibar is

to improve the health status and well-being of the people of Zanzibar with a focus on those most at risk.

Specific objectives are:

- *to ensure equitable access to quality health services, in particular at the district level and below, and*
- *to encourage the health system to be more responsive to people's needs and demands.*

These objectives are in line with the national health policy (1999), which aims to "improve and sustain the health status of all Zanzibar people", as well as with the Zanzibar Strategy for Growth and the Reduction of Poverty (MKUZA) and the five-year strategic plan for health sector reform. Those who are considered vulnerable and most 'at risk' are: the poor, women of child-bearing age, children, the disabled and elderly people.

The previous chapter presented the three sub-components of HSPS support to the health sector in Zanzibar through which the assistance will be provided:

1. Support to the HSF, as a form of harmonised sector budget support, primarily for districts
2. Earmarked central sector support to systems development, management and strategic interventions
3. Support to NGOs and public-private partnerships.

Each of these sub-components has its own immediate objective, expected outputs and set of activities, as presented below.

4.1. Sub-component 1: Support to the Health Service Fund

As pointed out in section 3.4, the Health Service Fund is a mechanism to increase the level of funding for primary health care services. It goes together with support for annual planning through comprehensive district health plans and POA.

The immediate objective of support to the HSF is

to create a sustainable financing mechanism that enables DHMTs and district level health facilities to perform their duties and provide quality health services.

Four concrete outputs are expected from HSPS support to the HSF:

- Financing for district-level health services ensured in line with the (annual) comprehensive district health plans;
- Satisfactory budget execution rates (>95%);
- Transformation of the HSF into the routine GOZ budget and accounting system;
- Budget allocations to district health services by GOZ and other development partners.

The HSPS allocation to the HSF during the last two years of the previous phase (HSPS Phase III) was US$ 0.50 per capita (2007/08 and 2008/09). In the expectation that budget execution will continue to be nearly 100% until the end of the previous phase, the allocation will be increased by 20% to US$ 0.60 per capita with effect from the start of the new HSPS programme (Phase IV, July 2009/10).

The HSPS allocation to the HSF may grow further depending on progress in the policy dialogue and in GOZ financial performance as monitored through PER and other instruments (disbursement rates and auditing results). Key considerations for the Steering Committee to decide whether or not the HSF allocation should effectively be increased are:

(1) Whether GOZ is making its own financial contribution directly to the districts; and

(2) Whether other development partners will have joined the HSF.

The latter condition is not unlikely, since several DP's have indicated they are considering channelling some of their support through the HSF.

The indicative budget foresees an increase from US$ 0.60 per capita during the first two years (2009/10 and 2010/11) to US$ 0.75 in Years 3 and 4 (2011/2012 and 2012/13) and US$ 1.00 per capita in the final year. This would represent a 100% increase over five years (i.e. the allocation in the final year of the new phase compared to the allocation in the final year of the previous phase).

The new five-year programme will see the introduction of an extra allocation to the HSF, based on performance. The exact modalities will need to be worked out during the first year of the programme. Especially when supplemented with funding from other sources (Government, other DPs), this will substantially increase the financial capacity of districts. It will put them in position to start procuring services from various central level departments for which they are able to pay as a genuine client upon expression of their demand (rather than as a recipient). The example of the HCEU presently receiving 7% of the HSF allocation to districts refers. In the future there would then not be a standard allocation, but payment against satisfactory completion of services obtained. The exact modalities will need to be worked out during the first year of the programme. The budget foresees in an allocation of 20% of the standard (per capita based) HSF allocation in Year 2, increasing to 30% in Year 3, and further to 40% in Year 4 and 50% in Year 5.

This will bring the total allocation (from HSPS) to HSF to US$ 1.5 per capita (of which half is performance-based) in Year 5. Especially when supplemented with funding from other sources (Government, other DPs), this will substantially increase the financial capacity of districts. It will put them in position to start procuring services from various central level departments for which they are able to pay as a genuine client upon expression of their demand (rather than as a recipient). The example of the HCEU presently receiving 7% of the HSF allocation to districts refers. In the future there would then not be a standard allocation, but payment against satisfactory completion of services obtained.

Activities that HSPS will support comprise the following:

- Support to CDHP development and annual budgeting; this will include the use of HMIS data in annual planning;
- Quarterly review of progress in CDHP implementation (and budget execution), linking up with data obtained through HMIS;
- Introduce the use of GOZ systems for routine accounting and auditing of HSF ;
- Involve officers from the respective District Commissioner's offices in the health sector planning cycle, so as to enable the DC planning officers to incorporate health in their overall (multi-sectoral) strategic planning;
- Transfer of HSF management responsibilities to appropriate GOZ structures in the Ministry of Finance and Economic Affairs;
- Capacity building (training, both off and on-the-job) to realize this transfer;
- Advocacy towards national health priority programmes and global initiatives/funding mechanisms for channelling financial resources to the HSF so as to enable districts to implement their planned activities (as per CDHPs);

- Develop a mechanism to introduce a performance-based component of HSF (from Year 2 onwards); and as part of this, a mechanism to appraise performance, with a distinct role for local communities, in line with the new Community Health Strategy.

4.2. Sub-component 2: Earmarked central sector support to systems development, management and strategic interventions

Chapter 3 has described the past experience and achievements in strengthening central level health sector support systems that are crucial to the delivery of district health services and the achievement of national objectives and targets. Based on the challenges and opportunities analysed in section 3.2, the immediate objective of the earmarked HSPS support to the central level is

> *to ensure that central sector support systems in the Ministry of Health and Social Welfare are functional and supportive to the delivery of quality health services in both the public and the private sector.*

HSPS support as part of this sub-component is directed to selected central level support systems, which have been grouped into seven intervention areas under this sub-component. For each of these, the expected outputs and broad activities are outlined below.

Intervention area 2.1: Procurement and supply management of pharmaceutical products, maintenance and ICT

The expected outputs are as follows.

2.1.1 Procurement

- Medicines, medical supplies and equipment are procured of the right type, in the right quantities and in a timely manner;
- No national stock-outs of essential commodities;
- Reduction in the number of equipment items (donated or not) that are not standardised or that come without spare parts and/or maintenance contracts;
- All MOH&SW priority programmes follow PMU regulations and procedures.

2.1.2 Pharmaceutical products

- Apart from procurement (in conjunction with the national priority programmes), the DMU fulfils its role in relation to selection, quantification of the requirements, storage and distribution of pharmaceutical products (drugs and medical supplies);
- Hospital departments and district health management teams are adequately equipped (in terms of technical knowledge and skills; resource materials) to ensure rational drug prescription and use;
- 'Charging mechanism' firmly institutionalised: all national health priority programmes and donor agencies making use of CMS paying a certain percentage (e.g. 6%) as handling charge for storage and distribution of medicines;
- In the medium-term: drug kit system to be replaced by an indent system, based on actual drug requirements ('pull' in stead of 'push' system).

2.1.3 Health care engineering and maintenance

- Institution of a demand driven (rather than supply driven) system of preventive maintenance and repairs at all levels of the health system (public sector), with a financial contribution from the user/client
- Inventory kept up-to-date of the physical state of buildings and all major types of equipment (medical and non-medical) in public institutions
- Institution of a transparent system of outsourcing technical services which the HCEU is unable to provide itself
- A reduction in the rate of breakdowns of medical and non-medical equipment at all levels.

2.1.4 ICT

- A functional ICT unit, that operates in a demand driven manner and provides quality technical support to the MOH&SW (all departments) for the installation and maintenance of servers, computers, networking equipment, conferencing equipment and software packages (including protection against viruses).

2.1.5 Transport

- A transport policy in place and implemented throughout the MOH&SW;
- A transport management information system in place;
- A reasonable fleet of transport available for use in the health sector.

The activities that will be undertaken to realise the above inputs will be derived from the strategic plans (as far as these are available)[7] of the MOH&SW departments and units concerned or their annual plans (POA).[8]

Intervention area 2.2: Human resource management and development

With regard to pre-service training, in-service training (including continuing education) and HRM, the expected outputs are as outlined below.

2.2.1 Pre-service training

- Training of various medical and paramedical cadres supported by appropriate ICT facilities at the College of Health Sciences, in line with the HRD master plan;
- Introduction of a Bachelor course in nursing at the CHS.

2.2.2 In-service training

- A functional central Continuing Education resource centre in place at MOH&SW headquarters;
- Functional satellite CE centres in place in selected (remote) districts;
- DHMTs de facto in charge of the planning and coordination of training opportunities offered by the national level.

2.2.3 HRM for increased productivity and performance

- Mandates and terms of reference of MOH&SW departments/units reviewed and formally approved;
- MOH&SW organogram reviewed and formally approved;
- Job descriptions of all cadres reviewed and formally endorsed;
- Human Resource Information System installed and kept up-to-date;
- Staff performance appraisal system in place and well functioning; performance contracts introduced, where appropriate;
- Performance-based financing schemes introduced, where appropriate.

The main activities will grossly comprise, amongst others:

- Capacity strengthening of CHS trainers; incentive/retention scheme for trainers;
- Assisting all departments/units of the MOH&SW in increasing their performance, by instituting departmental meetings (for coordination purposes; e.g. once every fortnight), ensuring adequate delegation of tasks, scheduling of activities and keeping diaries, optimising the use of space, adequate filing, etc.
- Linking performance appraisal with the Quality Improvement and Recognition Initiative (QIRI, initiated by UNFPA, so far in three pilot districts only);
- Linking HRD and HRM with the Capacity project (USAID): need to clarify the future support through this project (beyond installation of HRIS and support to two pilot districts);

[7] Five-year strategic plans have been elaborated by the Pharmacy Department and the Health Care Engineering Unit.
[8] All MOH&SW departments have an annual plan.

- Linking HRD with the e-Collaboration project (described in section 3.1.2);
- Exploration of PBF and community involvement in assessing performance, linking up with cost-sharing;
- Linking HRM with Quality Assurance trajectories (see below).

Intervention area 2.3: Quality assurance

Expected outputs of this intervention area:

- A national framework in place to assure quality of care;
- Health facilities (public and private) inspected routinely for QA;
- Improved compliance to standard treatment guidelines, protocols and professional standards (with evidence from routine supervision and surveys);
- Concrete examples of follow-up actions taken by health policy makers and managers, upon evidence of sub-standard care or misconduct.

As a result of the focussed initiatives within hospitals, one may expect improvements in specific health outcomes, such as reduced (hospital-based) maternal mortality, neonatal mortality and infant mortality.

The activities will grossly comprise:

- Concrete QA initiatives, similar to the one that was started in early 2008 to reduce maternal mortality (see section 3.1.4);
- Broad consultation (across departments, across levels of health care) to consolidate the experience with QA into a national framework, that specifies the roles and responsibilities of various stakeholders;
- Elaboration of standard treatment guidelines and protocols, where required, drawing from international best practices;
- Capacity building to improve compliance.

Intervention area 2.4: Health promotion

Expected outputs:

- Shehia health custodian committees in place and engaged in local priority setting and health planning;
- Community health information system developed and function (as an extension of the HMIS);
- Peer review mechanism in place for shehia health custodian committees;
- A school health strategy, developed jointly by the MOH&SW and the Ministry of Education;
- School health programme implemented with technical inputs from various national health priority programmes;
- A health promotion common fund with financial input from various priority programmes and development partners.

HSPS will provide technical and financial support to the Health Promotion unit of the MOH&SW to realise the above. Coordination of ongoing and new health promotion activities will play a key role.

Intervention area 2.5: HMIS

Evidence-based decision making being the overall aim, the expected outputs of this intervention area are:

- DHMTs using evidence in their strategic decisions and in the compilation of their comprehensive district health plans; hospital management teams using evidence in their strategic decisions;
- Annual Health Bulletins produced and disseminated;
- HMIS contribution to the annual health sector performance report (especially in relation to MKUZA, MDG and health sector strategic plan indicators);

- Medical record systems established in all hospitals;
- Community health information sub-system developed (in conjunction with Health Promotion unit) and linked to HMIS, in line with the community health strategy;
- Weekly and monthly integrated disease surveillance reports routinely produced and submitted to WHO;
- Research agenda established, indicating national research priorities.

Activities will comprise:

- Periodic review of indicators, tools and reports with national departments and programmes;
- Quarterly feedback meetings with DHMTs on quarterly HMIS reports (by zone);
- Feedback meetings with hospital management teams;
- Design of community health information system;
- Capacity building at all levels, especially to encourage the use of health information for decision making.

Intervention area 2.6: Health financing and sector performance monitoring

HSPS will continue to support the MOH&SW, through its technical working groups, in exploring new strategic orientations and possibilities to generate additional resources for the sector; and in monitoring progress in the implementation of health sector reforms and in health sector performance.

Expected outputs:

- Periodic reviews of public expenditure (PER);
- Annual revisions of MTEF, based on annual plans;
- Strategies to increase the resource envelope for the health sector in a sustainable and equitable manner;
- Annual health sector performance reports of high quality, highlighting achievements and shortcomings, and providing recommendations to increase performance;
- Biannual stakeholder meetings, reviewing past performance and exploring opportunities for increased effectiveness and harmonisation of external assistance.

The activities that will be supported follow from the annual plan of the HSRS and its respective TWGs. The terms of reference, the composition and the operational procedures of the TWGs will be reviewed so as to increase their functionality and make them less dependant on external assistance provided through HSPS.

Intervention area 2.7: Strategic initiatives

As mentioned earlier (section 3.4), HSPS will have a provision to undertake and support strategic initiatives. This may involve innovations, piloting new technologies and new approaches, with a view to a possible scale-up nationwide. Strategic initiatives will be undertaken on the basis of agreed terms of reference, which may be adjusted 'en route' as the experience is gained. They will aim at raising interest among new partners (knowledge centres, funding agencies) and forming new partnerships that have the potential to increase access to quality health services.

4.3. Sub-component 3: Support to NGOs and public-private partnerships

The immediate objective of this type of support, which is new for HSPS, is

> *to encourage non-governmental parties to link supply and demand for quality health services, in particular at the level of local communities.*

The expected outputs are:

- Stronger involvement of NGOs, in particular professional associations such as the Zanzibar Nurses Association (ZANA) and the Zanzibar Health Officers Association (ZHOA); other NGOs that promote and protect professionalism may be considered as well;
- Policy guidelines for public-private partnership in the health sector, with an implementation framework and concrete instruments (e.g. standard service agreements).

HSPS activities comprise of institutional support to the above NGOs (ZANA, ZHOA and possibly others) based on their respective vision, mission and strategic plans. Also, reviews of the experience with public-private partnership will be conducted, with a view to developing concrete recommendations for PPP, and eventually policy guidelines.

5. Budget

Under Component 2 Danida will support the health sector in Zanzibar for the five-year period July 2009 to June 2014 through a grant of up to 120 million DKK (including contingencies). Table 2 presents the breakdown of the budget. Financial support to the sub-components has been allocated over the five years, but the breakdown across years is based on assumptions on pace of implementation and is indicative only. Each year detailed work plans and budgets will be developed.

Table 2. Indicative budget for Component 2: Support to the health sector in Zanzibar. In million DKK.

Sub-component	2009/10	2010/11	2011/12	2012/13	2013/14	TOTAL
1.1 HSF						
Objective: to create a sustainable financing mechanism that enables DHMTs and district level health facilities to perform their duties and provide quality health services.						
2.1.1 HSF	4.00	4.00	5.00	5.00	6.60	**24.60**
2.1.2 Performance-based allocation to HSF	-	0.80	1.50	2.00	3.30	**7.60**
Sub-total	**4.00**	**4.80**	**6.50**	**7.00**	**9.90**	**32.20**
2.2: Earmarked support to central level support systems						
Objective: to ensure that central sector support systems in the MOH&SW are functional and supportive to the delivery of quality health services in both the public and the private sector.						
2.2.1 Pharmaceutical supplies, maintenance, IT, transport	5.00	7.00	8.00	9.00	8.00	**37.00**
2.2.2 Capacity strengthening (HRH, QA, health promotion, HMIS, health financing & sector performance monitoring, strategic initiatives)	3.30	3.60	3.60	3.60	3.60	**18.25**
Sub-total	**8.80**	**10.60**	**11.60**	**12.60**	**11.60**	**55.20**
2.3: Support to NGOs and PPP						
Objective: to encourage non-governmental parties to link supply and demand for quality health services, in particular at the level of local communities.						
Institutional support to professional associations/NGOs and public/private partnerships	0.30	0.50	0.60	0.60	0.60	**2.60**
Sub-total	**0.30**	**0.50**	**0.60**	**0.60**	**0.60**	**2.60**
Technical assistance (short- and long-term)	3.50	4.00	4.00	3.50	3.50	**18.50**
Sub total Direct support	**16.60**	**19.90**	**22.70**	**23.70**	**25.60**	**108.50**
Administration	1.20	1.00	1.30	1.00	1.00	**5.50**
Contingencies	0.00	1.00	1.00	2.00	2.00	**6.00**
Grand total incl administration	**17.80**	**21.90**	**25.00**	**26.70**	**28.60**	**120.00**

Almost half of the total funding (48%) is allocated to earmarked support (sub-component 2); 28% is allocated to the HSF (sub-component 1), with 16% of total funding going towards TA and 2% towards Support to NGOs and PPP (sub-component 3).

Reallocation between budget lines within the sub-components is possible, subject to approval by the Steering Committee (see Ch. 7.1). The budget line for Administration can, if need be, be used for necessary start up cost for office equipment for the technical advisers, as well as for ad hoc support to financial systems development, possibly through a company contract.

Appendix 6 contains a more detailed budget, with an indicative breakdown of support to capacity strengthening as part of the earmarked support to central level support systems (sub-component 2.2.2)

and that of support to professional associations/NGOs and public/private partnerships (sub-component 2.3).

Unallocated funds to the tune of 32 million DKK is available under the overall programme budget. The unallocated funds may be used for activities across components or to unforeseen major initiatives of strategic importance within the components. Such initiatives and activities should be within the development objective of the overall programme and such that cannot easily be accommodated within the existing component budgets.

The Steering Committee under each Component may propose activities for funding and forward these to the RDE. The decision to approve or reject the proposal will be made by letter of exchange between the signatories to the overall programme, i.e. the Danish Ambassador and the PS of MOFEA after the signatories to the Components, i.e. the PSs of MOHSW Mainland, PMO-RALG Mainland, MOH&SW Zanzibar and the Executive Director of TACAIDS, have had the opportunity to comment[9]. Depending on the magnitude of the proposed funding, the proposal will have to go to Danida Copenhagen (Bilateral Chief) for final approval.

[9] I.e. the RDE will send the proposals for comments within a specified period. No comments before the deadline will be taken for no objection.

6. Sustainability and replicability issues

Danida cannot commit itself beyond a five years period of HSPS support. It is therefore important that there is a prospect that all forms of assistance – whether technical, financial or material – will either become redundant after some time or that they be taken over by the government or other partners.

Capacity strengthening has been and will continue to be the main strategy to ensure that sound policies and operational procedures get rooted into the routine operations of the sector. Apart from offering training opportunities for individual staff, to enable them to upgrade their competence, the new phase of HSPS will envisage further institutional strengthening, in particular of the departments and units that are concerned with procurement (the PMU), pharmaceutical products (DMU, including CMS), engineering and maintenance (HCEU), information & communication technology (ICT) and transport.

Financial sustainability is an issue that will receive particular attention, as the dependency of the MOH&SW on donor agencies is worrisome. Since the GOZ has many priorities and is not likely to be able to include financial allocations for all support systems into its budget, there is a need to raise other forms of income. One of the tracks that will be pursued is to continue raising funds among clients that benefit from the services of the HCEU. The current system of allocating 7% of the HSF for maintenance works, which in fact is earmarked money to support the HCEU, will be continued. When the government itself and other development partners come on board and start supporting the HSF, this would automatically boost the income position of the HCEU. A similar strategy will be pursued for other types of central level support services, such as ICT assistance and vehicle repair.

The experience with the ongoing focussed support to the reduction of maternal mortality at Mnazi Mmoja Hospital and the recent introduction of such initiatives (e.g. maternal death audits) at district hospitals warrants documentation of the process, highlighting the factors that have facilitated and hindered change. Institutionalisation of improved practices being a great challenge, the external technical support will be utilised to identify those factors and bring them to the attention of hospital managers and policy makers for possible scale-up and replication elsewhere.

HSPS ambition to introduce a staff performance appraisal system, in conjunction with the Human Resource division of the MOH&SW, may raise the interest of the Civil Service Commission for possible replication in other sectors, if found appropriate. This is something that needs exploration and follow-up by the senior management of the MOH&SW at the start of HSPS Phase IV.

7. Implementation arrangements

7.1. Management and Organisation

Oversight and decision-making structures

The Steering Committee (SC) which has been in place to guide the direction of the HSPS component that deals with support to the health sector in Zanzibar as part of the previous Phase III (expiring in June 2009), will continue to play this role for Component 2 of HSPS Phase IV. The SC is responsible for the overall strategic direction of the programme and has the mandate to reorient the programme if this is judged appropriate. The mandate of the SC includes the formal approval of annual plans and budgets, the formal approval of (annual) progress reports, the approval of audit reports and major decisions concerning procurement, long-term technical assistance (advisers), and the need for reviews/ studies and short-term technical assistance (consultancy). The terms of reference of the SC are attached as Appendix 5.

The Steering Committee comprises three core members: the Principal Secretary of the MOH&SW (chairperson of the SC), the Director General Health Services of the MOH&SW and the Counsellor Health of the Royal Danish Embassy (RDE) in Dar es Salaam.

The following may attend the SC meetings as resource persons:

- The departmental directors of Policy and Planning, Curative Services, Preventive Services, Administration and Finance in the MOH&SW;
- Core members of the Health Sector Reform Secretariat (HSRS);
- The two zonal health coordinators (for Unguja and Pemba);
- Representative from the Ministry of Finance and Economic Affairs (MOFEA);
- Representative from the Ministry of State Regional Administration and Local Government and Special Departments (MRALGSD).

As observers may attend:

- Danida Health Advisers;
- Representatives from other development partners that support the health sector in Zanzibar;
- Members from the SC for HSPS Component 3 that deals with support to the multi-sectoral response to HIV/AIDS (for Tanzania and Zanzibar combined).

The Senior Health Adviser (Danida) and the HSPS Programme Coordinator (MOH&SW) assume the secretariat of the Steering Committee. Formally they are not members of the SC.

In principle, the SC meets twice a year to review progress against the objectives and expected outputs outlined in the present programme document; and to guide, and readjust, if appropriate, the future orientation of the programme. Additional SC meetings may be called by any of the core members whenever the need arises.

The need for separate HSPS SC meetings will be reviewed two or three years into the programme. It is expected that such meetings will no longer be appropriate in the medium-term, depending on the progress towards a truly sector-wide approach. Joint annual or bi-annual sector review meetings, based amongst others on comprehensive strategic planning and annual joint sector performance reviews, would then come in place of the HSPS SC meetings. The process of conducting annual sector reviews in Zanzibar would need to mature further before HSPS SC meetings can be broadened to the entire health sector.

Programme Management Team

The Senior Health Adviser (SHA) will serve as the component manager (for Component 2 of HSPS Phase IV). He/she is responsible for providing overall guidance to the implementation of HSPS and to assist the MOH&SW in instituting a coherent and comprehensive programme-based approach in the health sector, ensuring that all external support (including Danida support through HSPS) is fully aligned with GOZ policies, strategies and operational procedures. This implies that one of his/her duties is to work towards a future scenario in which HSPS Component 2 transforms from a project with decentralised accounting to a programme that is integrated into local GOZ reporting and control mechanisms, see also Chapter 3.6.

The Senior Health Adviser is accountable to both the Director of Policy and Planning of the MOH&SW and the Head of the Health Sector Reforms Secretariat[10]. Together they form the programme management team, which is responsible for all expenditures made under the Zanzibar component of HSPS IV. The Director of Policy and Planning may delegate some of his operational tasks as member of the HSPS management team to a qualified senior officer from his department, to work along with the SHA as HSPS programme coordinator. If this will be the case then the HSPS programme coordinator will also be a member of the HSPS programme management team.

While the HSPS programme coordinator remains answerable to the MOH&SW, the SHA is answerable to the Counsellor Health of the RDE in Dar es Salaam and reports to him/her for all administrative issues (see job description in Appendix 2).

As part of the strategy to integrate HSPS support into government systems, the HSPS Programme Coordinator and the SHA will shift their offices to the MOH&SW headquarters at some stage during HSPS IV. The HSPS office, which is currently housed in an MOH&SW building (previously a clinic) at about 100 m from the ministry's headquarters, will then be phased out. Once every year the Steering Committee will review the capacity of the MOH&SW to absorb and integrate HSPS support into government systems and, depending on progress made, decide whether it is opportune to relocate the HSPS office. While the HSPS office is still in place, though, a local support team comprising of a qualified financial manager and a senior secretary will continue to be employed by the HSPS programme to assist the project management. The MOH&SW will make available some designated support staff (driver, office supervisor, cleaner, watchmen).

For clarity purposes: the other long-term technical adviser and the JPO are not part of the management team, nor of the SC. They report to the heads/directors of the departments they work with: in the case of the Health Adviser HRH/QA this is the Director of Policy and Planning (under whom the Human Resource Division falls); and in the case of the JPO it is the Director of Preventive Health Services (under whom the Health Promotion unit falls).[11] The Adviser and the JPO will have their offices in the departments/units implementing the HSPS supported interventions to which they provide their technical advice.

Integration of HSPS support into government systems

As stated earlier (section 3.6), the success of capacity development hinges on the extent to which HSPS support can successfully be integrated into government systems. Such integration will be explicitly pursued in at least three areas: financial systems, procurement systems and sector performance monitoring and review. If successful, other types of external support (by other development partners)

[10] This may be changed as soon as there is more clarity about the functional organization of the MOH&SW. The HSRS coordinator currently reports to the Director General Health Services, who is formally the head of the HSRS. Especially the relation between the HSRS and the Department of Policy and Planning will need to be clarified.

[11] This also may change once the MOH&SW has settled for a clear organisational structure and a single organigramme.

may also be aligned to government systems, which could strengthen national ownership, increase transparency and enhance local accountability for resources used and results obtained.

7.2. Financial management and procurement

A Procedures Manual for the implementation of HSPS IV Component 2 programme activities will be developed prior to the start of the programme and approved by the SC at their first meeting. The Procedures Manual will describe details of the financial management and procurement of goods and services and be in accordance with Danida guidelines. It will be supplemented with an Accounting Manual for the financial administration, describing the specific accounting procedures of HSPS IV Component 2. The Accounting Manual will be updated/revised based on the version that was used in HSPS Phase III.

Planning and Budgeting

Since the Government of Zanzibar has begun to institute MTEF it has recently become possible for HSPS support to be reflected in the 'total' resource envelope for public sector activities in the health sector. The annual planning and budgeting process, which involves all MOH&SW departments, results in an annual Plan of Action (POA), that includes HSPS support to the Health Service Fund and some of the other types of support to the central level (not all). At district level, annual comprehensive district health plans are prepared, which include district and cottage hospitals and a separate plan for Mnazi Mmoja hospital.

The MOH&SW (and its agencies) is responsible for proposing annual work plans and budget for the earmarked funds based on the ZHSSP as part of the annual MTEF planning exercise. Planning and budgeting for the HSPS funds should follow the normal government procedures and time lines for development of work plans and budgets. The work plan and budget will be discussed and approved by the SC.

The component work plans and budget for the first year of HSPS IV will be developed in the present phase of support.

Disbursements

HSPS funds, like all other external financial support to the health sector in Zanzibar, do not enter the general treasury account as the systems are not mature enough as yet. While one of the intervention areas of HSPS is precisely the strengthening of the planning and budgeting process and of financial management, most of the HSPS funds will thus for the time being be administered by the HSPS office itself.

The funds covered under sub-component 1 (HSF; which constitutes around 30% of the total envelope) can be considered *de facto* a precursor to local budget support. For the time being the disbursement of HSF allocations to districts and hospitals will continue to be made to separate accounts (at the two zonal levels: Unguja and Pemba), rather than to a single account in the Ministry of Finance and Economic Affairs (MOFEA) from where the money would find its way to the districts. However, as stated earlier, it is expected that in the course of HSPS programme implementation districts will start receiving their own financial allocations from the Government. Once that is the case, Danida and other development partners could then start disbursing allocations for district health services through MOFEA. A precondition will obviously be that there is a common understanding and trust that disbursed funds will be properly accounted for. This will still require some capacity strengthening before sector budget support can be implemented.

Procurement
The procurement will follow the procedures stipulated in the Procedures Manual.

For international consultants contracted through RDE/Danida Copenhagen, Danida's procedures and regulations will apply. Payment will be made directly by Danida in Copenhagen to the consultant according to a contract between these two parties. Goods and services paid for directly by Danida are considered to be grant-in-kind assistance.

Accounting and auditing

The existing GOZ financial reporting system and accountability mechanisms are presently not considered adequate for ensuring satisfactory use of external aid and proper accounting. The fiduciary risks are considered too great for the time being. HSPS Component 2 will thus be run as a project with decentralised accounting, similar to the set-up in the previous phase (HSPS Phase III, expiring in June 2009). As before, the programme management will therefore be directly accountable to RDE.

The accounting will follow the Accounting Manual. The accounting system will be in line with Danida guidelines and organised in such a way that it allows proper insight into programme expenditure to the Steering Committee, the project management, the project's account staff, auditors and the RDE/Danida. The Chart of Accounts will be compatible with the MOH&SW accounts to facilitate integration into MOH&SW financial reporting and future integration of accounting responsibilities with the MOH&SW.

Annual financial expenditure reports, specifying expenditure against the various main budget lines, will be made available to the SC, together with the annual performance reports. Monthly expenditure reports will be submitted to the RDE in Dar es Salaam. All accounts vouchers and other supporting documents remain with the programme implementation unit. An independent external auditor shall audit the project accounts and make unannounced checks of cash holdings and other assets. The RDE appoints the auditor, in consultation with the Steering Committee.

7.3. Monitoring, reporting, reviews and evaluations

Monitoring of sector performance is one of the key functions of the HSRS, for which it receives technical and financial support from HSPS. Health sector performance reviews will be conducted on an annual basis, and the reports that result from these reviews will be presented and discussed in the annual health sector performance review meeting (usually in September), which involves representatives from all stakeholders in the sector. In addition, HSPS will support review meetings at the district level, which will amongst others assess progress in performance against objectives and targets set in the annual comprehensive district health plans.

The above two types of reviews, which the previous phase of HSPS support to the health sector in Zanzibar has helped to institutionalise, will form the basis for annual performance reports that the HSPS management team will submit to the SC for its appraisal and formal endorsement. The annual performance report will elucidate to what extent the outputs that are expected from each of the HSPS sub-components and intervention areas (outlined in the present programme document; chapter 4) have been realised; and it will analyse the reasons for delays, if any, or lower performance than expected, if that were the case.

Once a year, Danida will conduct a bilateral review of HSPS, resulting in an *aide mémoire* with recommendations for the MOH&SW and the RDE to consider and follow up. This review will preferably be held back-to-back with the health sector performance review meeting (in September). The bilateral reviews serve to validate the finding and recommendations of the annual performance reports. With time, as the overall health sector performance gain in comprehensiveness and quality, the specific annual HSPS performance reports and the bilateral reviews will be phased out.

An external mid-term review of the HSPS support to the health sector in Zanzibar, or of one or more of its sub-components, may be considered in case specific problems arise or if progress falls behind

expectation. It is the SC's prerogative to decide whether such a review is required. A final evaluation of HSPS support to the health sector in Zanzibar is not foreseen, as it is expected that by that time (2014) a sector-wide approach will be in place and joint reviews will be organised on a periodic basis.

8. Assessment of key assumptions and risks

Political leadership and demonstrable commitments to the goals and strategies outlined in the ZHSRSP are key requirements for successful implementation of the health sector reforms. Such leadership and commitments are required from the MOH&SW and the Government at large, including the Ministry of Finance and Economic Affairs (MOFEA) and the Ministry of State Regional Administration and Local Government (MRALGSD). One way of demonstrating such commitment is through budget allocations and budget performance, in particular fiscal discipline. The share of government budget allocation to health has not improved in recent years (see section 2.5) and there has little progress in creating a dedicated budget vote for district health services. Public expenditure reviews will allow monitoring of actual health expenditure and provide an insight as to whether stated priorities have been supported by the necessary financial resources. Such information will be made available as part of the sector performance reviews that will be presented at annual stakeholders meetings.

Support to district health services being one of the key priorities of HSPS, the HSF makes up around 30% of the total HSPS Zanzibar component budget over five years. Section 4.1 explicitly states that any growth in the contribution of HSPS to the HSF is subject to progress in the policy dialogue and in GOZ financial performance as monitored through PER and other instruments. Key considerations for the Steering Committee to decide whether or not the HSF allocation should effectively be increased are: (1) Whether GOZ is making its own financial contribution directly to the districts; and (2) Whether other development partners (or programmes that obtained funding through global financing mechanisms) will have joined the HSF. There are signs that the latter will happen once the first condition has been fulfilled. The chances of GOZ making available dedicated funding for district health services are good, but require a concerted effort by the MOH&SW, MOFEA and MRALGSD. In the unlikely case that the HSF is not broadened to become the new modality for sector budget support, it is not opportune at this point in time to increase the earmarked support to central level support systems (Sub-component B) at the expense of the budget allocation to the HSF (Sub-component A). The HSPS budget would then potentially remain underutilised and the balance of Sub-component A would revert to Danida or the other HSPS components.

Human resources being the most important resource for the health sector, there is a need to put more emphasis on productivity and the performance of health workers and programme managers, as argued before (e.g. section 3.3). This requires commitments, both from the Government's side as well as from development partners. The Government leadership is expected to guide and support efforts to appraise performance and provide appropriate incentives and disincentives (including sanctions, if necessary). Donor agencies on the other hand are expected to harmonise their approaches amongst each other, align to Government rules and regulations (for instance with regard to the payment of allowances and/or per diems) and refrain from 'pushing' their individual priorities. It is suggested that the annual sector performance reviews (and subsequent stakeholder meetings) review this issue on a periodic basis and discuss it in a critical and frank manner. This would go a long way improving accountability at all levels.

Apart from the above assumptions and risks, it is obvious that macro-economic conditions and political developments will determine to a certain extent the success of HSPS. The programme cannot influence those, but the HSPS Steering Committee will monitor the developments closely and make adjustments, if considered appropriate. In case the political situation deteriorates and HSPS would need to be discontinued, careful consideration will be given to the possibility of continuing certain key supplies (essential drugs and pharmaceutical commodities) on a humanitarian basis.

9. Implementation plan

The three sub-components 1, 2 and 3 will be implemented concurrently.

Three of the intervention areas, or parts of them, will start later on during programme implementation:

- The introduction of a performance-based allocation to the HSF (intervention area 1.2): from Year 2 onwards, pending the elaboration of the modalities for this during the first year;
- The procurement of vehicles to strengthen the transport capacity of the MOH&SW (part of intervention area 2.1): from Year 2 onwards, subject to adoption and implementation of a transport policy and transport management system;
- The development of a school health strategy (part of intervention area 2.4): from Year 2 or 3 onwards, since priority will be given to implementation of the community health strategy.

Physical rehabilitation of infrastructure will be undertaken in Year 1: rehabilitation of the MOH&SW building that houses the Health Promotion unit, among others (included in the budget under 2.4: Health promotion); and in Year 1 or 2: rehabilitation of the MOH&SW building that houses the HMIS unit, the HSRS and the Personnel unit (included in the budget under 2.1 Maintenance/HCEU).

Appendices

Appendix 1: Progress towards health sector milestones

A. Progress towards health sector milestones as reported in the Health Sector Performance Report 2007 (covering July 2006-June 2007)

No	Area	Milestone description	Progress	Comments
Human resources / College of Health Sciences				
1	HRH	By April 2007 HRH policy approved by government and HRH Division established within MoH&SW.	**Not achieved**	Policy circulated, but approval not yet obtained at MOHSW Executive Committee level so cannot be forwarded to higher bodies. Proposal to DG on creation of Division not yet submitted, due to other commitments on time of relevant staff
2	CHS	Road-map leading to accreditation with NACTE prepared by CHS including steps to be taken (by whom and when).	**Fully achieved**	NACTE accreditation obtained for some courses.
Provision of quality health services / services for the vulnerable				
3	RCH	At least 1 PHCU in each rural district offering quality delivery services by September 2007.	**Partially achieved**	x PHCUs now offering delivery (ie x%): Fuoni, Jambiani, Muyuni, Bumbwini, Pujini,
4	Referral	Essential Health Package for the different service delivery levels reviewed (including materials, equipment, drugs and human resources) and guidelines developed for efficient referral of patients from primary to secondary and tertiary level.	**Partially achieved**	Review undertaken, report submitted and awaiting approval by MOHSW
Integration / Coordination / Decentralization / PPPartnership				
5	Decentralisation	Comprehensive district health plans include all programme support budgets (vertical as well as government funding).	**Partially achieved**	District health plans prepared, but still do not include all sources of funding, particularly MTEF.
6	Coordination	Conduct donor coordination meetings twice a year.	**Partially achieved**	Partners Coordination Meeting held in October 2006
7	PPP	Modalities developed by MoH&SW to involve private sector and NGOs that serve the vulnerable, in service provision (Standard Service Charter).	**Not achieved**	Time constraints due to competing priorities. No central level person responsible for quality assurance, hence issue not well taken up.

No	Area	Milestone description	Progress	Comments
Health Financing and Transparency / Accountability				
8	Health financing	Government to increase financing of the health sector from 8% to 10% by 2007/08	**Not achieved**	MOHSW share fell. Not within control of the MOHSW. Lobbying to continue.
9	Health financing	Proposal prepared by MoH&SW for budgetary restructuring for the sector (Sub-vote for District).	**Not achieved**	Written proposal not yet prepared, but proces initiated through discussion with MOFEA.
10	Health financing	Concrete steps will be taken to bring the process of preparing the next MTEF in line with the revised strategy for the sector/the annual plan of action, in a consultative, participatory and transparent way.	**Partially achieved**	Process improved but still has some way to go in terms of synchronisation, and consultation.
11	Health financing	Present informal cost-sharing practices (including exemption/waivers) reviewed as contribution towards developing a policy on health financing	**Fully achieved**	Review undertaken and report circulated
Mnazi Mmoja Hospital				
12	Hospital services	Situation analysis done of management needs and human resources needs at Mnazi Mmoja Hospital.	**Fully achieved**	Undertaken as part of the process of developing the MMH Strategic Plan which has been approved by MOHSW
HMIS / Monitoring and evaluation / Health sector performance				
13	HMIS	Guidelines & manuals for data collection, data analysis and data use, in place.	**Partially achieved**	All ready, awaiting translation and printing
14	M&E	Health Information Bulletin and Annual Sector Performance Report produced and disseminated to all stakeholders	**Fully achieved**	Documents produced and circulated

B. Progress with milestones as reported in the Health Sector Performance Report 2008 (covering July 2007-June 2008)

No	Area	Milestone description	Progress	Comments
Human resources for health				
1	HRH & EHCP	Develop 5-year training master plan based on the staffing needs identified in the essential health care package.	**In process**	ToR for short-term consultancy prepared. Consultant identified. Funding difficulties, but new source secured. On track for consultant to complete by end of 2008.
2	HRH	Have HRH guidelines in place to implement Zanzibar Health Policy.	**Partially achieved**	Awaiting guideline approval. Approval establishing HRH division pending.
Health sector performance / Monitoring and evaluation / HMIS				
3	M & E	Operationalize a standardized reporting system for technical and financial data for all programs, departments, councils and task forces by March 2008.	**Partially achieved**	Standard form for technical and financial reports developed and in place. Additional part on financial data to be finalized. Templates to be circulated to stakeholders for comments.
4	Health sector performance	Include presentation and discussion of draft MTEF and PoA for 2008/09 in partner coordination meeting in March/April 2008.	**Partially achieved**	Presented at the April 2008 Partner Coordination Meeting. MTEF is still in its infancy. Merging MTEF with PoA and comprehensive district health plans (CDHPs) not 100% for some programs.
Provision of quality health services / Services for the vulnerable				
5	EHCP	Develop a comprehensive community health strategy for implementation in FY 2008/09.	Achieved	Consultancy done. Community Health Strategy document available. Stakeholders to be sensitized on its use.
6	Regulatory	Make the Health Research Council operational.	**Partially achieved**	Proposal for formulation of Health Research Council prepared. Formally submitted to the MoH&SW. Minister to appoint members.
7	Referral	Develop clear and efficient referral guidelines including emergency obstetric care by March 2008.	**Not achieved**	ToRs formulated for consultancy.
8	RCH	Quality delivery services offered in at least one PHCU in rural districts by June 2008.	Achieved	8 of 10 districts with at least 1 PHCU providing delivery services. Urban and Wete districts soon. Supporting services provided.

Appendix 2: Draft Job description for Senior Health Adviser

Senior Health Adviser
Ministry of Health and Social Welfare Zanzibar / Danida

1. Background

Danida strives to integrate its support to the health sector in Zanzibar into the planning and budgeting cycle of the Government of Zanzibar, by aligning the Health Sector Programme Support 2009-2015 (HSPS IV) with the five-year strategic planning process for the health sector, the medium-term expenditure framework of the MOH&SW, the annual Plan of Action (POA) and related budget of the MOH&SW, and the Comprehensive District Health Plans and related budgets.

At the same time, HSPS IV provides support to strengthening these national planning and budgeting processes themselves, and work towards a comprehensive (sector-wide) programme-based approach to which all development partners can align their support for the health sector.

The HSPS office in Zanzibar is an administrative set-up to facilitate HSPS IV implementation, for which the justification is given in the HSPS IV Programme Document. On the one hand it operates as a programme implementation unit, but at the same time it provides technical support to the MOH&SW, in particular to the Health Policy and Planning Department and the Health Sector Reforms Secretariat. As the latter departments gain in strength and the Government of Zanzibar (GOZ) reporting and accounting procedures become more solid, the need for a separate HSPS office will diminish. Its functions are therefore expected to be taken over in due course by the MOH&SW itself.

2. Responsibilities and scope of work

The Senior Health Adviser (SHA) has four distinct responsibilities.

1. The SHA is the component manager of HSPS support to the health sector in Zanzibar and works under the direction of the Steering Committee (SC) for this HSPS component (Component 2 of HSPS IV) to provide overall guidance for the implementation of the HSPS. In this capacity the SHA is also the head of the HSPS office, together with the HSPS programme coordinator (nominated by MOH&SW).

2. The SHA assists the MOH&SW in instituting a coherent and comprehensive programme-based approach in the health sector, ensuring that all external support (not only Danida support through HSPS) is fully aligned with GOZ policies and strategies.

3. The SHA assists the MOH&SW in strengthening its procurement, management, reporting and accounting systems, in particular in the domain of pharmaceutical procurement and supply management, which absorbs a significant of the HSPS funding (around 25%).

4. The SHA is further responsible for the overall coordination of the long-term technical assistance to HSPS, provided through the team of Danida advisers (one adviser, one junior professional officer; each have their own terms of reference), as well as for the coordination of short-term technical assistance and consultancies.

In order to fulfil the first two of the above three responsibilities, the SHA reports to the Director General Health Services, and works in close collaboration with the Director Policy and Planning of the MOH&SW and the coordinator of the Health Sector Reform Secretariat (HSRS). In order to avoid that the latter two officials are taken up almost entirely by the management of HSPS, the MOH&SW nominates a senior officer to work along with the SHA as HSPS programme coordinator, on behalf of

the Director Policy and Planning. The HSPS programme coordinator, nominated by the MOH&SW, is charged with the day-to-day management of HSPS (separate terms of reference to be developed). The SHA has technical, managerial and administrative duties, which include, but are not necessarily limited to the following.

Technical duties:

- Provide assistance to the implementation and further development of HSPS components, where appropriate, and propose solutions in case problems arise;
- Assist the Department of Policy and Planning Department of the MOH&SW in organizing support to District Health Management Teams for the preparation of their respective comprehensive district annual work plans and budgets;
- Assist the Department of Policy and Planning in ensuring that district plans get integrated into the Government planning and budgeting cycle;
- Assist the MOH&SW in developing an appropriate organisational structure, integrated management guidelines and operational procedures for a joint sector programme;
- Assist in the preparation of annual joint health sector reviews and other meetings that involve donor coordination;
- Assist the Health Sector Reform Secretariat, and its various technical working groups, in pursuing the reform agenda;
- Prepare and participate in the HSPS Steering Committee meetings.

Managerial and administrative duties:

- Provide coaching to the HSPS Programme Coordinator, in the day-to-day management of the HSPS;
- Identify possible needs for medium/short-term consultancy services in support of HSPS, elaborate terms of reference and facilitate implementation of the consultancy services;
- Monitor progress in implementation of HSPS components in relation to plans and budgets and in overall programme performance;
- Provide financial reports in line with Danida regulations and report deviations, if any, to the MOH&SW and the Royal Danish Embassy (RDE) in Dar es Salaam;
- Facilitate communication between the Zanzibar and Danish authorities.

The SHA will not represent Danida or the RDE unless explicitly requested to do so in specific instances.

The SHA will support the Director of Policy and Planning in coordinating the support by the two long-term technical assistants under the HSPS. The SHA will serve as the technical supervisor of the Junior Professional Officer (JPO), but not of the other Health Adviser. His/her role in relation to the Human Resources for Health and Quality Assurance Adviser will be to ensure that job plans and reports are presented timely and to act as a liaison between the advisers and the MOH&SW on issues not covered under normal job descriptions and reporting procedures.

3. Reporting and lines of accountability

The Senior Health Adviser is a resident consultant to the Department of Policy and Planning / Health Sector Reform Secretariat of the Ministry of Health and Social Welfare, Zanzibar. He/she reports to the Director General of Health Services MOH&SW.

The SHA is accountable to the Counsellor Health of the RDE in Dar es Salaam, and will have annual performance appraisals with him/her.

4. Qualifications

The SHA should hold a university degree in medicine, health science or a related discipline, and a master's degree in public health. He/she has proven ability to manage complex programmes in the health sector in low- or middle-income countries, and a minimum of five years of practical experience in public health. Experience in programme-based approaches (SWAp) and knowledge of Danida's development policy and guidelines is desired.

Appendix 3: Draft Job description for Adviser Human Resources for Health and Quality Assurance

Adviser Human Resources for Health and Quality Assurance
Ministry of Health and Social Welfare Zanzibar / Danida

1. Background

One of the sub-components of Danida support to the health sector in Zanzibar as part of HSPS Phase IV (July 2009 – June 2014) involves earmarked support to some selected central level support systems at the Ministry of Health and Social Welfare (MOH&SW). Among these support systems are Human Resources for Health and Quality Assurance, which are closely connected.

2. Responsibilities and scope of work

The Health Adviser HRH & QA has two main responsibilities.

1. The Adviser will support the Human Resource division of the MOH&SW in implementing the HSPS programme intervention area that deals with human resource management and human resource development; and

2. He/she will undertake concrete initiatives to improve the quality of care at all levels of the national health system.

The Health Adviser will be a member of the two Technical Working Groups operating under the Health Sector Reforms Secretariat (TWG for HRH and TWG for QA) and work in conjunction with their respective members.

The technical, managerial and administrative duties include, but are not necessarily limited to the following.

Technical duties in relation to HRH:

- Provide institutional support to the Human Resource division of the MOH&SW and its four units (Policy, planning & legislation; Training; Continuing education; Personnel): support organisation of work and distribution of responsibilities, planning and target setting, priority setting, delegation of tasks, monitoring of performance, reporting, archiving, etc.
- Activate the computerised human resource information system and train staff in the use of this system;
- Review mandates of departments/units and job descriptions;
- Develop and institute a staff performance appraisal system throughout the MOH&SW;
- Provide advice, where appropriate, to other institutions and departments involved in human resource development (College of Health Sciences, national health priority programmes, etc.)

Technical duties in relation to QA:

- Sustain the ongoing efforts and measures that have been taken to reduce maternal death in hospitals;
- Initiate similar trajectories to improve other health indicators: neonatal and infant mortality, hospital infections, etcetera;

- Based on these and other initiatives, develop and institute a quality assurance framework in the health sector;

Managerial and administrative duties:

- Provide coaching to the head of the Human Resource division and the unit heads, in day-to-day management of their units and manpower;
- Provide coaching to heads of other MOH&SW and/or hospital departments and wards, where appropriate;
- Prepare and participate in meetings of the TWGs HRH and QA;
- Monitor progress and report on performance against objectives and targets in relation to HRH and QA;
- Ensure that HRH and QA activities are adequately included in routine plans of action at all levels.

3. Reporting and lines of accountability

The Health Adviser HRH & QA is a resident consultant to the Human Resource Division of the Ministry of Health and Social Welfare, Zanzibar. He/she reports to the Director of Policy and Planning, under whom this division falls, for all content matters.

The Health Adviser HRH & QA is accountable to the Counsellor Health of the RDE in Dar es Salaam and will have annual performance appraisals with him/her. For the latter, the Counsellor Health may solicit input from the SHA, in view of his/her role as component manager of HSPS support to the health sector in Zanzibar and, more in particular, his/her responsibility to ensure that all external support (including technical support) is fully aligned with GOZ policies and strategies and that it goes towards a coherent and comprehensive programme-based approach in the health sector.

4. Qualifications

The Health Adviser should hold a university degree in medicine, health science or a related discipline, and a master's degree in public health or public health administration. He/she has a minimum of five years of health sector experience in low- or middle-income countries, and a minimum of three years of practical experience in human resource management. Knowledge of Danida's development policy and guidelines is desired, experience of working in a policy and planning environment will be an advantage. A working knowledge of English is essential and working knowledge of Kiswahili an advantage.

Appendix 4: Draft Job description for Junior Professional Officer Health Promotion

Bilateral Junior Professional Officer (JPO) Health Promotion
Health Sector Programme Support (HSPS), Zanzibar

1. Background

The HSPS support to the health sector in Zanzibar offers the possibility for a Junior Professional Officer (JPO) to work under the guidance of the Danida Senior Health Adviser (SHA) and gain professional experience in health systems strengthening.

Prior experience with postings of JPOs on Tanzania mainland and Zanzibar has been very positive and justifies the continuation of such posts. While in principle JPO posts have an educational purpose, the Ministry of Health and Social Welfare (MOH&SW) in Zanzibar regards them as a much needed and welcome way of increasing the technical and administrative capacity to implement the Health Sector Programme Support.

In Zanzibar the speed of developments and achievement during the first five years of Danida support has been impressive, in particular taking into consideration the human resource constraints throughout the health system. Much of the reform process is carried forward by a small but dynamic team of members of the Health Sector Reform Secretariat (HSRS). In this set-up the JPO has a unique opportunity to gain experience in the strategic choices of the reform process and in health sector management at all levels, from the community right up to the policy-making level in the Ministry.

2. Responsibilities and scope of work

In the context of the Danida-supported HSPS, the JPO will be part of the Health Sector Reform Secretariat (HSRS) of the Ministry of Health and Social Welfare in Zanzibar. As a member of the HSRS, the JPO will assist with the implementation of the HSRS work plan.

The work of the JPO will include but is not necessarily limited to the following:

- Participate in and assist with all routine activities of the HSRS, including the Technical Working Groups and the overall health sector reform process;
- Attend meetings, both within as well as outside the MOH&SW, as far as these are relevant to the ongoing health sector reforms;
- Participate in field visits by MOH&SW and/or Embassy staff in the context of HSPS, for the purpose of supervision, monitoring and technical assistance;
- Assist the Senior Health Adviser and the HSPS Programme Coordinator in the smooth implementation of HSPS;
- Assist the MOH&SW in the further development and implementation of the community health strategy, in close conjunction with the Health Promotion unit of the Ministry;
- Assist the MOH&SW in the development of a school health strategy, in close conjunction with the Health Promotion unit of the Ministry;
- Assist district health management teams in the preparation of comprehensive district health plans and associated budgets, where appropriate.

3. Reporting and lines of accountability

The JPO will report to the head of the Health Sector Reform Secretariat through the Senior Health Adviser of HSPS Zanzibar. The JPO will be based in the Ministry of Health and Social Welfare.

The JPO is accountable to the Counsellor Health of the RDE in Dar es Salaam and will have annual performance appraisals with him/her.

4. Qualifications

The JPO should hold a university degree in medicine, health science or a related discipline (e.g. medical sociology/anthropology), and take a special interest in community health, health education and/or health promotion. Prior working experience in a low-income country is an advantage.

Appendix 5: Terms of reference for Steering Committee

The Steering Committee (SC) for Component 2 of HSPS Phase IV will guide the direction of the agreed support to the health sector in Zanzibar, in line with the programme document. The SC is responsible for the overall strategic direction of the programme and has the mandate to reorient the programme if this is judged appropriate. The mandate of the SC further includes:

- the formal approval of annual plans and budgets;
- the formal approval of (annual) progress reports;
- the approval of audit reports; and
- major decisions concerning procurement, long-term technical assistance (advisers), and the need for reviews/studies and short-term technical assistance (consultancy).

The SC comprises three core members:

- the Principal Secretary of the MOH&SW, who is the chairperson;
- the Director General Health Services of the MOH&SW; and
- the Counsellor Health of the Royal Danish Embassy in Dar es Salaam.

The following may attend the SC meetings as resource persons:

- The departmental directors of Policy and Planning, Curative Services, Preventive Services, Administration and Finance in the MOH&SW;
- Core members of the Health Sector Reform Secretariat (HSRS);
- The two zonal health coordinators (for Unguja and Pemba);
- Representative from the Ministry of Finance and Economic Affairs (MOFEA);
- Representative from the Ministry of State Regional Administration and Local Government and Special Departments (MRALGSD).

As observers may attend:

- Danida Health Advisers;
- Representatives from other development partners that support the health sector in Zanzibar;
- Members from the Steering Committee for HSPS Component 3 that deals with support to the multi-sectoral response to HIV/AIDS (for Tanzania and Zanzibar combined).

The Senior Health Adviser (Danida) and the HSPS programme coordinator (MOH&SW) assure the secretariat of the Steering Committee. Formally they are not members of the SC.

In principle, the SC meets twice a year to review progress against the objectives and expected outputs outlined in the present programme document; and to guide, and readjust if appropriate, the future orientation of the programme. Additional SC meetings may be called by any of the core members whenever the need arises.

The need for separate SC meetings will be reviewed two or three years into the programme. It is expected that such meetings will no longer be appropriate in the medium-term, depending on the progress towards a truly sector-wide approach. Joint annual or bi-annual sector review meetings, based amongst others on comprehensive strategic planning and annual joint sector performance reviews, would then come in place of the HSPS SC meetings. The process of conducting annual sector reviews in Zanzibar would need to mature further before HSPS SC meetings can be broadened to the entire health sector.

Appendix 6: Detailed budget (tentative)

Note: the breakdown provided below of HSPS support to capacity strengthening as part of the earmarked support to central level support systems (sub-component 2.2.2) and that of support to professional associations/NGOs and public/private partnerships (sub-component 2.3) is tentative.

Indicative budget for Component 2: Support to the health sector in Zanzibar. In million DKK.

Sub-component	2009/10	2010/11	2011/12	2012/13	2013/14	TOTAL
1.1 HSF						
Objective: to create a sustainable financing mechanism that enables DHMTs and district level health facilities to perform their duties and provide quality health services.						
2.1.1 HSF	4.00	4.00	5.00	5.00	6.60	**24.60**
2.1.2 Performance-based allocation to HSF	-	0.80	1.50	2.00	3.30	**7.60**
Sub-total	**4.00**	**4.80**	**6.50**	**7.00**	**9.90**	**32.20**
2.2: Earmarked support to central level support systems						
Objective: to ensure that central sector support systems in the MOHSW are functional and supportive to the delivery of quality health services in both the public and the private sector.						
2.2.1 Pharmaceutical supplies, maintenance, IT, transport	5.00	7.00	8.00	9.00	8.00	**37.00**
2.2.2 HRH	2.00	2.00	2.00	2.00	2.00	**10.00**
2.2.3 QA	0.15	0.15	0.20	0.20	0.20	**0.90**
2.2.4 Health promotion	0.30	0.20	0.20	0.20	0.20	**1.10**
2.2.5 HMIS	0.30	0.20	0.15	0.15	0.15	**0.95**
2.2.6 Health financing and sector performance monitoring	0.55	0.55	0.55	0.55	0.55	**2.75**
2.2.7 Strategic initiatives	0.50	0.50	0.50	0.50	0.50	**2.50**
Sub-total	**8.80**	**10.60**	**11.60**	**12.60**	**11.60**	**55.20**
2.3: Support to NGOs and PPP						
Objective: to encourage non-governmental parties to link supply and demand for quality health services, in particular at the level of local communities.						
2.3.1 Institutional support to professional associations	0.10	0.10	0.20	0.20	0.20	**0.80**
2.3.2 Support to public/private partnerships	0.20	0.40	0.40	0.40	0.40	**1.80**
Sub-total	**0.30**	**0.50**	**0.60**	**0.60**	**0.60**	**2.60**
Technical assistance (short- and long-term)	3.50	4.00	4.00	3.50	3.50	**18.50**
Sub total Direct support	**16.60**	**19.90**	**22.70**	**23.70**	**25.60**	**108.50**
Administration	1.20	1.00	1.30	1.00	1.00	**5.50**
Contingencies	0.00	1.00	1.00	2.00	2.00	**6.00**
Grand total incl administration	**17.80**	**21.90**	**25.00**	**26.70**	**28.60**	**120.00**

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