Report of the 6th Zanzibar Annual Joint Health Sector Review

REVOLUTIONARY GOVERNMENT OF ZANZIBAR

Pemba Misali Sunset Beach Hotel

31st October – 1st November, 2011

Ministry of Health - Zanzibar
Health Sector Reform Secretariat
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Acronyms

ACT	Artemesin combination therapy
ADB	African Development Bank
AJHSR	Annual joint health sector review
ANC	Antenatal care
ARV/T	Anti-retroviral therapy
BCC	Behaviour change communication
BCG	Bacillus Calmette-Guérin
CDHP	Comprehensive district health plans
CEU/O	Continuing education unit/officer
CHAI	Clinton HIV/AIDS Initiatives
CHN	Community health nurse
CHS	College of Health Sciences
CMS	Central medical stores
CoHS	Community health strategy
cPAC	Comprehensive post-abortion care
C-S	Cost-sharing
CSO	Civil society organization
Danida	Danish international development assistance
DHMT	District health management team
DMU	Drug management unit
DPs	Development partners
DPT	Diptheria, pertussis, tetanus
EHCP	Essential health care package
EmOC	Emergency obstetric care
EPI	Expanded programme for immunization
FADB	Foods and Drugs Board
FBO	Faith-based organization
FP	Family planning
FY	Financial year
GBV	Gender-based violence
GoT	Government of Tanzania
GoZ	Government of Zanzibar
HBC	Home-based care
HCEU	Health care engineering unit
HFs	Health facilities
HIPZ	Health Improvement Project Zanzibar
HIS	Health information system
HMIS	Health management & information system
HMTs	Health / Hospital management teams
HR(H)	Human resources (for health)
HRIS	Human resource information system
HSF	Health service fund
HSR	Health sector reform
HSRS	Health sector reform secretariat
HSS	Health systems strengthening
ICT	Internet communications technology
IDSR	Integrated disease surveillance reporting
IDU	Intravenous drug user
IMCI	Integrated management of childhood illness
IPT	Intermittent preventive treatment
IRS	Insecticide residual spraying
ITNs	Insecticide treated nets
IVI	International Vaccine Institute
KAP	Knowledge attitude practice
LLINs	Long-lasting impregnated nets
MARPs	Most at-risk populations
MDA	Maternal death audit
MDGs	Millennium development goals
MEEDS	Malaria early epidemic detection system
MKUZA	Zanzibar Poverty Reduction Strategy
MMH	Mnazi Mmoja Hospital
MMR	Maternal mortality ratio
MoFEA	Ministry of Finance & Economic Affairs
MoH&SW	Ministry of Health & Social Welfare
MoU	Memorandum of understanding
MSD	Medical stores department (DSM)
MTEF	Medium term expenditure framework
MVC	Most vulnerable children
NACTE	National Council for Technical Education
NCDs	Non-communicable diseases
OC	Other charges
OCV	Oral cholera vaccine
PE	Personal emoluments
PEP	Post-exposure prophylaxis
PER	Public expenditure review
PHCC/U	Primary health care center/unit
PMTCT	Preventing mother-to-child transmission
PNC	Postnatal care
PoA	Plan of action
PS	Principal secretary
QIRI	Quality improvement & recognition initiatives
RCH	Reproductive and child health
RDT	Rapid diagnostic test
STI	Sexually transmitted infection
TAMC	Traditional & Alternative Medicine Council
TB	Tuberculosis
ToRs	Terms of reference
TWGs	Technical working groups
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary counselling & testing
WHO	World Health Organization
YFS	Youth friendly services
ZAC	Zanzibar AIDS Commission
ZACP	Zanzibar AIDS Control Programme
ZAMES	Zanzibar Medical School
ZANA	Zanzibar Nurses Association
ZAPHA+	Zanzibar Association of People with HIV/AIDS
ZDPGH	Zanzibar Development Partners' Group-Health
ZHMT	Zonal health management team
ZHSRSP	Zanzibar health sector reform strategic plan II
ZMCP	Zanzibar Malaria Control Programme
ZMO	Zonal Medical Officer
ZOP	Zanzibar Outreach Programme

Executive Summary

The 6th Zanzibar Annual Joint Health Sector Review meeting was convened in Chake Chake district, Pemba. This event marked the first occasion that this critical review process has been conducted in Pemba, signifying the Ministry of Health's core value of serving the health needs of all of Zanzibar's residents as well as minimizing disparities in access to care. This year also marked the first time that the President of Zanzibar has attended such a meeting, a reflection of the priority status that health has been accorded by the country's leadership.

The meeting, which was co-chaired by the Permanent Secretary of the Ministry of Health, Dr. Mohammed Jiddawi and Bi Amina (Executive secretary Planning commission), cantered around the pertinent theme of "change". The specific theme was: "We must change to deliver quality health care for the people of Zanzibar." This theme was reiterated throughout the presentations which called policy-makers to innovate in reshaping delivery of health services to the people of Zanzibar. The theme of change was best distilled by a quote offered by His Excellency, President Dr. Ali M. Shein, in his opening speech: "Change is inevitable in a progressive country, and change is constant." Quoting former U.K. Prime Minister Benjamin Disraeli, President Shein reinforced to the gathering, the fact that the process of change must involve a holistic approach, integrating all personnel within the health sector.

The objective of this annual meeting was to evaluate the achievements made by the Ministry of Health as well as to consider potential solutions to bottlenecks and challenges encountered. This meeting assembles all key partners of the Ministry of Health (MoH), including donors, implementing partners, and civil society, in an effort to transparently evaluate performance and to set priorities for the upcoming year. In this way, it provides a forum for partners to express their views and to cement a working relationship for better partnership and coordination.

Following two days of deliberations, the following key recommendations emerged as central priorities to be tackled by the Ministry of Health and partners, towards the goal of improving health.

1. Health Sector Basket Fund

The extent of vertical funding targeted at specific projects within the Ministry of Health, while sometimes warranted, undermines government systems and potentially exerts limitations on aid effectiveness and value for money. In order to mitigate this, the MoH is establishing a Basket Fund, to pool donor resources in the health sector, thus enabling more efficient, evidence-based planning and resource allocation. The Basket Fund, which will operate at the district level, will be targeted towards promotion and strengthening of primary health care services. In taking this step, MoH will become the first Ministry in Zanzibar to develop a form of sector-wide support. Development partners were thus called upon to change the modality of supporting the health sector by channelling support through this mechanism.

2. Long Term Financial Sustainability

During the 2011/2011 financial year, the total resource envelope of the health sector, including donors, debt relief allocation, and Zanzibar AIDS Council (ZAC), amounted to TZS 31 bn. This represents a 5.7% decline compared to the previous year. Although funding to MoH increased by 17%, the overall decline is due largely to a drop in development partner support – the Global Fund specifically. (Donor support represents 41% of the total health sector resource envelope). The share of government spending allocated to health increased this year, but there is concern that it will drop again next year as no future debt relief funds are anticipated. Zanzibar has committed to allocate a share of 15% (Abuja Declaration) and 12% (Health Sector Reform Plan) of total government spending to the health sector, but the current level of 7% falls short of these targets.

Given the current global fiscal situation and increasing unpredictability of donor financing, the participants highlighted the urgency of developing a plan for long term financial sustainability, ultimately generating domestic, autonomous sources of revenue for the health sector. In line with the theme of change, there was an emphasis on developing innovative mechanisms for financing. The group was informed that a process of evaluating various options and potential scenarios for financing the health sector has begun. This includes the introduction of cost sharing in the provision of health services, using the experience of other countries to guide the process. However, an important caution was raised to ensure that equity of access is not compromised. Various options for community health prepayment funds are also being considered, which may protect households from the poverty of impact of health expenditure.

3. Integration in Planning and Implementation

The issue of limited integration between partners was discussed at length and emerged as a recurring theme throughout the meeting. This effect plays out in two ways: integration between plans of the Ministry of Health programs and the Department of Planning, and integration between the Ministry of Health and development partners. Examples were cited of planned development grant awards and projects with donor resources, although these had not been embedded into the Ministry's annual Plan of Action or the Mid-term Expenditure Framework (MTEF). The health sector as a whole was urged to finalize planned projects in consultation with the President's Office on Finance, Economy and Development Planning (PoFEDP).

The challenge of integration projects supported by development partners into the Ministry's Plan of Action may stem partly from the fact that partners are not included in larger strategic planning exercises, where priorities are identified.

4. Quality through Strengthening Health Systems

The group considered various potential strategies for improving the quality of health service delivery. These select areas were highlighted as offering the greatest potential to improve quality in Zanzibar's health system:

- Introduce staff recruitment and retention mechanisms.

  Training plans have been developed, spanning a period of ten years, to ensure that all health facilities meet the minimum staff needs. Critical staff shortages limit quality of care in Zanzibar, as they do in many of the resource-constrained settings of the region. The resultant high workload results in responsibilities for some tasks shifting to under qualified personnel, lack of adherence to protocols and standards, and overall low productivity. In particular, an assessment of Zanzibar's workforce uncovered an aging workforce in the health sector, with 20% of personnel above the age of 55, and only 17% under the age of 34.

  Urgent reforms are needed to attract motivate young people to enrol into the medical field, and to retain staff within the health sector. Notable successes were highlighted in this regard; 205 students are enrolled in medical programs outside Zanzibar, while 9,307 are currently enrolled into the Zanzibar College of Health Sciences, and 271 new graduated were recruited into the medical field within the last year. Once recruited, staffs are not sufficiently incentivized to perform at a high level; this needs to be addressed through the introduction of staff appraisals, and improved working and living environments. Performance-based financing, which would reward staff against achievement of certain outcomes, also has potential to increase motivation, while career development plans will provide new recruits with a long term view of potential growth prospects within the health sector.

- Referral systems.
  The current medical system is not equipped to cope with the high level of medical expertise that is required. The shortage of specialists in both the private and public sectors is resulting in increasing numbers of Zanzibaris seeking medical care abroad, with significant financial implications for the health sector. The upgrading of Mnazi Moja Hospital as well as the establishment of a cancer unit is expected to control this trend somewhat; however, more investments are needed in recruiting specialists, upgrading infrastructure, and focusing on prevention of non-communicable diseases.

5. Maternal Mortality

One of the key successes noted during the review was the decline in maternal mortality, from 473 deaths per 100,000 in 2006 to 288 per 100,000 in 2010. More births are delivered in health facilities (42%) and a growing number of primary health care units are providing basic emergency obstetric care. Despite these gains, the target of the Millennium Development Goals (MDGs) is to attain a maternal mortality ratio of 130 and greater support is still needed for this goal; less than 10% of donor support supports reproductive and child health. A more thorough protocol for conducting maternal death audits begun in 2011, and it has found that deaths are mainly due to delays in seeking care, partly as a result of the financial barriers to travelling to the health facility, as well as user fees for care during delivery. It was noted that although there is a user fee of TZS 40,000 for deliveries, the Ministry's official policy insists that no deliveries should be denied due to inability to pay; some facilities are however failing to comply with this policy. Further reducing maternal mortality is a central priority and the Ministry and its partners need to further evaluate the potential negative impact of user fees for this group, with a potential waiver to cost sharing being introduced for pregnant women.

6. Community Health Strategy

Despite recommendations in the last annual review to begin to implement community health strategies, only partial progress has been achieved against this goal. The revitalization of community health is intended to increase the role and ownership of communities in health service improvement. A taskforce has been set up and preparatory activities have begun, but progress on this front has been stalled by the lack of resources to carry out this mandate. Relevant authorities from Ministry of Local Government and other central level players are being sensitized, with the aim of establishing committees at each district to oversee this process. A representative of the Taskforce highlighted that a team has been trained and is ready to begin implementing this strategy immediately if funds can be made available.

At the end of two days of discussions and field visits, a set of 7 milestones were proposed for the 2011/2012 year. These are:

1. Implement staff deployment system based on data of available staff and requirement.
2. Institute Performance Based Financing (PBF) system in 2 piloted districts of North A and Mkoani
3. Facilitate the implementation of Cost Sharing Guideline at all levels of health service delivery.
4. Establish 100 Sheahia Health Custodian Committees in selected Shehia
5. Adopt and implement Health Care Financing Strategy for Zanzibar.
6. Develop Zanzibar Health Sector Strategic Plan III (2011/2012 – 2015/16)
7. Develop long term National Nutrition Strategy
8. Review the implementation of Road map of RCH

Introduction and Opening Session

The 6th Zanzibar Annual Joint Health Sector Review meeting, organized by the Health Sector Reform Secretariat, was held in Chake Chake district, Pemba on October 31 and November 1, 2011. This occasion was the first time that this critical review process has been conducted in Pemba. This year also marked the first time that the President of Zanzibar has attended such a meeting, again reflecting the priority which health is being accorded by the country's leadership.

The meeting was attended by more than 120 participants, representing a broad spectrum of sectors. Referred to annex No. I. In addition to the Ministry of Health, partners and stakeholders from other government departments (finance, local government), development agencies, and civil society were represented. There was a significant presence of participants from Pemba.

The report summarizes presentation and discussion highlights from the two days meeting. A detailed agenda, participant list, and key speeches can be found in the attached Annex No I to No. VII. Detailed presentations and documents circulated prior to the meeting can be obtained from the HSRS.

Welcome and Introductory Remarks

Dr. Malick A Juma, Director General
J.K. Tindwa, Regional Commissioner, South Pemba

Dr. Juma welcomed the participants and thanked them for supporting the exercise of reviewing the performance of the Ministry of Health in its endeavour to provide quality services to the people of Zanzibar. The theme for this year's review meeting was announced as "We must change to deliver quality health care for the people of Zanzibar."

Commissioner Tindwa, the host of the event, also welcomed all participants to Pemba South Region and congratulated the Ministry of Health for its dedication to improving the health of residents of Zanzibar, including South Pemba. He acknowledged that the people of South region were receiving improved health services, albeit with some challenges. He assured the group that the region is working systematically and innovatively to solve health problems wherever they occur.

Opening Remarks

Hon. Juma D. Haji, Minister of Health Zanzibar

The Honourable Minister offered opening remarks, declaring that the conference was being held in Pemba as part of Ministry's culture of meeting and serving the needs of all people. The Hon. Minister outlined the objective for the day's proceedings, which was to reflect on the achievements of the Zanzibar MoH, as well as challenges encountered, and to deliberate on way forward during the coming year. He also stated that it was a key forum for partners to express views and cement working relationships towards better coordination and partnership. The Minister elaborated on the theme of "change," saying that it was intended to facilitate greater, accelerated improvements delivery of health care services.

The Hon. Minister thanked His Excellency, the President, for agreeing to officiate this event, stating that this was adequate testimony of the commitment by the President to the health sector of Zanzibar. The Minister also congratulated the Health Sector Reform Secretariat for organizing this meeting. Since its inauguration in 2005, the HSRS has convened the review meetings and has drafted laws,

policies and guidelines to facilitate health reform. The Hon. Minister reiterated the theme for this year's review: "we must change to deliver quality health care for the people of Zanzibar." This theme conveys a message to all providers with regards to the approach of providing care, and it is in line with the President's insistence on not continuing with business as. The Hon. Minister acknowledged that the support of the President is of paramount importance in efforts to deliver health care and improved health status.

The Minister outlined the following priorities which had emerged over the previous year and set them as key issues to be addressed by the Ministry officials in the review meeting.

1. The reduction of maternal mortality is commended, but deserves further attention. Less than 10 percent of donor support to the health sector is allocated to reproductive and child health. If Zanzibar is to achieve Millennium Development Goal 5, it will need more support in this area. There is a need for better coordination of funds and critical examination of factors contributing to maternal deaths. Currently, each maternal death is being examined or audited to understand reasons for delay in seeking care; hospital records are also being reviewed and recommendations given as to how each maternal death could have been avoided.

2. Non-communicable diseases – especially diabetes, cancer, and cardiovascular complications – are being diagnosed with increased frequency in Zanzibar and the MoH has conducted a survey to identify risk factors for this category of illnesses. Currently, funding for non-communicable diseases (NCDs) has been under-prioritized and it has been difficult to solicit support for these diseases locally, despite increasing global attention towards a new epidemic of NCDs in developing countries. The cost of preventing this class of illnesses is minor compared to the costs of treating them.

3. There is a need to revitalize efforts towards the community health care strategy and decentralization of health care services. A key element of this strategy is to increase the community's involvement and its role in efforts to improve their own health, thus giving them ownership.

The Hon. Minister acknowledged the presence of the development partners, in particular, the presence of the Danish delegation, including the outgoing DANIDA Advisor to the Ministry of Health, as well as the incoming DANIDA Senior Health Advisor.

The Hon. Minister invited the President to share his remarks and officially open the meeting.

Opening Speech

His Excellency, President of Zanzibar, Dr. Ali M. Shein

The Guest of Honour for this, the 6th Annual Review Meeting, was His Excellency, the President of Zanzibar, Dr. Ali M. Shein. This occasion marks the first time that a President has attended a health sector review meeting.

Prior to giving the opening speech, the President spent a significant amount of time touring the various exhibition stands that were set up around the conference venue to highlight the work and achievements of various departments in the health sector. The President toured the following stands, where he was given key information by stall attendants representing each of the various programs:

environmental health and sanitation, malnutrition, HIV counselling and testing, Zanzibar AIDS Control Programme, Zanzibar Malaria Control Programme, Zanzibar Outreach Programme, Leprosy Programme.

In his remarks, the President reminded the audience that as we approach 2015, the target year for the MDGs, all stakeholders need to take stock of the present situation of the respective targets and consider the areas which need significant work and focused attention. As a key stakeholder in health, the President said he was pleased to note the achievements made in the health sector, highlighting the expansion in both quality and quantity of health services. He also commended the fight against communicable diseases, making particular mention of the gains in malaria control which have resulted in Zanzibar almost reaching a status of malaria elimination. With regards to HIV, he noted that Zanzibar had managed to maintain a prevalence of less than 1% since the first case was identified in Zanzibar in 1986.

However, the President cautioned the participants that they needed to double their efforts in the spirit of building a new, prosperous Zanzibar. Towards this end, the President urged the health sector to maintain and expand its relationships with development partners.

H. E. Dr. Shein affirmed the theme for this year's review, saying it was well designed and sure to alert and monitor providers of care to increase their efforts. Citing a quotation by former U.K. Prime Minster, Benjamin Disraeli, - "Change is inevitable in a progressive country, and change is constant" – the President reinforced to the gathering the fact that the process of change must involve a holistic approach, integrating all personnel within the health sector. With this, he urged the MoH and its stakeholders to be innovative in bringing about change, reminding them that quality health care ought to have a holistic approach, and that the process of change must involve all personnel within the health sector.

The President commended the selection of Pemba as the venue for this year's review; as it s mostly rural, he said Pemba needs to pay greater attention to primary health care, which is the entry point to care for most people.

The President also highlighted interesting data from the displays which he had toured earlier on, in particular the results of efforts to reduce maternal mortality. He commended the declining trend between 2005/2006 (476 deaths per 100,000 births), and 2010/2011 (280 deaths per 100,000). He pointed out this success as an example of the fact that "change is inevitable, and change is possible".

The President also noted that the modality of funding for the health sector is changing as the MoH will become the first Ministry in Zanzibar to engage in the development of sector-wide budget support with the development of the Health Basket Fund. He said this is expected to strengthen government systems and increase transparency and will serve as a role model for other sectors. While he recognized efforts to address the challenges in human resources for health, the President cautioned that this the current situation remained a threat, and encouraged consideration of incentives to retain staff within this sector.

Vote of Thanks

Mohamed J., Dahoma Director Preventive Services

Dr. Dahoma thanked the President for his remarks, pronouncing that the Ministry will double its efforts of MoH to realize national and international targets. He committed to striving for innovation and ensuring quality in programmatic efforts, and that all would be held accountable in ensuring

delivery of quality services. Dr. Dahoma also reiterated that research, training, and data quality will be upheld as key priorities.

Performance Report 2010/2011

Dr. Malick A. Juma, Director General

Dr. Juma presented the annual performance report, giving an overview of the structure of the health sector, a review of milestones for the ending fiscal year 2010/2011, and an analysis of the implementation of the Plan of Action 2010/2011. (The Director General gave a caveat that while all efforts have been made to present quality data in this analysis, there was a possibility that some information may be later revised or corrected; however, the information presented would be sufficient for the purposes of discussion and drawing conclusions). He acknowledged the diligent efforts of the HSRS in presenting and preparing the Performance Report.

Prior to reviewing the 9 milestones set for the previous year, Dr. Juma reviewed the following aspects of the health sector, highlighting recent developments and changes.

- The Directorate of Social Work and Substance Abuse had shifted to other Ministries in order to allow the Ministry of Health to focus purely on the provision of health services and to avoid compromises in the intended focus on health provision
- The Directorate of Preventive Services – with 13 disease programmes and units – was considering the integration of programmes to run more efficiently and cost effectively. For example, Reproductive and Child Health (RCH) together with Management of Childhood Illnesses (MCI), or HIV and TB. However, many details are still to be clarified before these transitions occur.
- At the primary health care level, there are 137 primary health care units (PHCUs), making for an impressive network that leaves most residents of Zanzibar less than 10km away from a PHCU. The Executive Committee has resolved to equip 34 PHCUs + with additional Laboratory, delivery, dental and pharmaceutical services.
- In the private sector, there are 4 private hospitals, 74 clinics, 96 pharmacies, and 330 over-the-counter drug shops. These are mainly distributed in urban areas. Development of partnership with the private sector is underway, including collaborations with the Aga Khan Foundation as well as Health Improvement Project Zanzibar. (HIPZ)

Review of Milestones

Dr. Juma presented a summary of progress against milestones set for the year under review – 2010/2011. Out of 9 milestones, 7 were partially achieved, and 2 were not achieved.

Milestone	Description of Progress	Comments
1. Have a minimum of 2 PHCUs+ in each district providing delivery, laboratory, dental and dispensing services. PROGRESS: PARTIALLY ACHIEVED	• Review of staffing requirements conducted (358 required, 222 existing, 136 needed). • 5PHCUs+ added, making a total of 25PHCUs operational • 11PHCUs+ renovated in Unguja and Pemba • 13 PHCUs+ in Pemba and 13 in Unguja have staff houses • At least two facilities in each district provide delivery and laboratory services	Main challenge to completing expansion of services has been staffing, compounded by a lack of equipment
2. Establish an incentive scheme for health facilities based on a performance appraisal system. PROGRESS: PARTIALLY ACHIEVED	• 5 TWG members were trained on PBF concept • PBF Guidelines that suit Zanzibar context have been developed • Pilot in two districts expected to start in January 2012	Senior officials of MoH oriented on PBF. 3 trained in Zambia and 2 in Nairobi. A focal person has been appointed and the guidelines are ready. Now awaiting funding, with a plan to pilot in 2 districts next year.
3. Develop clear referral guidelines at all levels with recommendations for implementation. PROGRESS: NOT ACHIEVED	• ToR for the task was revised • Local consultants have been recruited • Exercise not undertaken due to lack of funds	It was initially felt that this could only be completed with support from external consultants. Some development partners were ready to support, but no consultants responded to the advertised consultancy. This issue should be given more serious attention during the upcoming year.
4. Define support services for EHCP implementation at primary level, refine cost estimates and develop medium-term financing plan. PROGRESS: PARTIALLY ACHIEVED	• Task has been completed, though there are comments outstanding. To be finalized soon after review meeting.	

5. Develop an appropriate health care financing strategy for Zanzibar. PROGRESS: PARTIALLY ACHIEVED	• ToR for the task developed and approved • First consultancy was hired • A financing option was explored • Three scenarios are under discussion by stakeholders; one to be selected • Cost sharing guidelines drawn up	After selection of an option, the process of implementing is expected to take significant time, and may require a change in legislation (particularly if the ZSSF option is pursued).
6. Formulate guidelines to improve synergies, coordination and cooperation between public and private sector health service providers. PROGRESS: NOT ACHIEVED	• PPP guidelines not yet developed up to now • Partnership are coordinated through the developed SOPs and MOUs with specific partners	
7. Facilitate the implementation of road map of the Community Health Strategy (CoHS) PROGRESS: PARTIALLY ACHIEVED	• Task force with ToR to facilitate the implementation formulated • The CoHS document has been revised and approved • Communication toolkit has been developed • A team of 18 trainers has been trained • Sensitization meetings conducted in both islands to local government officers, and 13 shehias in Wete district, 25 members from DHMT and MoH programs and units • Next step is piloting in 100 shehias	
8. Evaluate the implementation of NCD Strategic Plan PROGRESS: PARTIALLY ACHIEVED	• Working team appointed with its ToR • NCD Step Survey and Associated Risk factors was conducted • Survey results feed the new NCD Strategic Plan	This was a prematurely formulated milestone; the NCD document was not a fully-developed Strategic Plan and further work is needed to get it up to standard.
9. Revive and expand maternal death audits and follow-up on recommendations at all levels PROGRESS: PARTIALLY ACHIEVED	• Modalities of review revised; information also collected from the community • Findings discussed in decision-making committee • Maternal death audit restarted	There is a need to address delays in providing services in health facilities, including the attitudes of some senior doctors who maintain an attitude of unaccountability in their handling of patients.

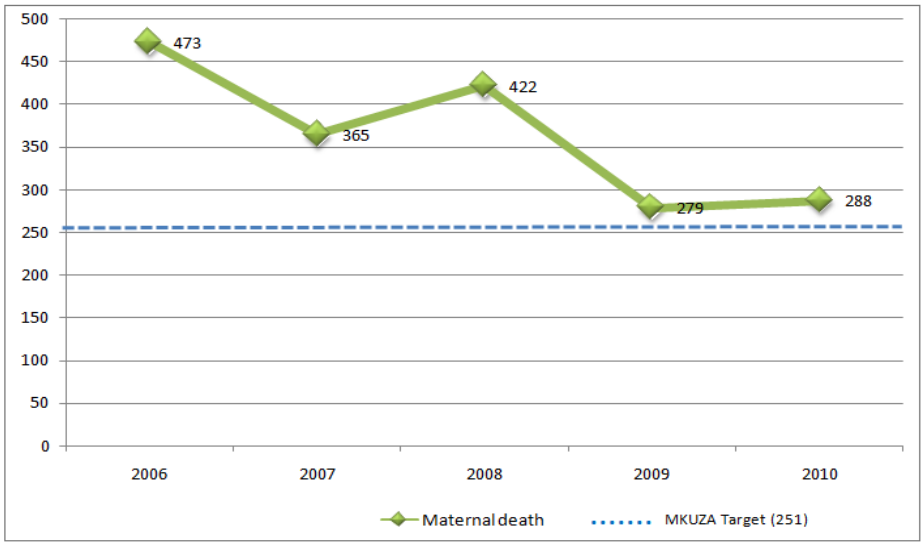
ZHSRSP Priority Interventions

The four priority health interventions according to the Zanzibar Health Sector Reform Strategic Plan (ZHSRSP) II were reviewed in turn.

1. **Reproductive and Child Health**

   There has been a decline in the institutional maternal mortality ratio (473 per 100,000 in 2006 to 279 in 2009, See *Figure 1*). However, a slight increase was observed in 2010 (288); there is a need to assess and address the reason for the recent increase, but the overall downward trend is commendable. More primary health care units (PHCUs) providing post-abortion care and providing cervical cancer screening. There is a concerning decline in the proportion of fully immunized children (91.8% in 2009 to 74.6% in 2010).

Figure 1: Trends in institutional maternal mortality, Zanzibar (2006 - 2010)



2. **Health Promotion and Disease Prevention**

   An inspection of school latrines revealed that only 35% have satisfactory latrines; trainings and demonstrations on how to build low cost latrines have been provided.

3. **Communicable and Non-communicable Diseases**

   Malaria prevalence currently stands at less than 1% (once over 10% in 2005). 34,372 free ITNs were distributed to Urban and West district households, net utilization is 65%, and a 95% coverage of indoor spraying was achieved this year (94.6%). The Affordable Medicines Facility for malaria (AMFm) was introduced and has increased the accessibility of effective anti-malarials at a cost of approximately TSh 1,000 (although smaller doses which are recommended to be sold at ~TSh 300 are also being sold at TSh 1,000). The Malaria Early Epidemic Detection System (MEEDS) has been expanded from 69 to 90 PHCUs.

   HIV prevalence remains low at 0.6%, although higher rates are found in most at risk populations (MARPs). 11 clinics are not providing care and treatment centres for PLHIV (formerly 8 clinics in 2009/10), while there has been an increase in PMTCT centres, from 29 in 2009/10, to 49 in 2010/11.

A TB proposal was submitted to the Global Fund in Round 10. There has been an increase in the proportion of HIV patients screened for TB, from 90.1% in 2009, to 98.2% in 2010. The prevalence of schistosomiasis fell from 45% to 7.6%, while that of soil-transmitted helminths remains high.

Hypertension is now the 3rd leading cause of hospitalization and the 2nd leading cause of death. A national Non-communicable Diseases Step Survey was conducted to determine the prevalence of NCDs and risk factors. There is a plan to formalize an NCD unit to reflect the priority of this issue.

4. **Psychosocial Disorders**
   There is an increase in the number of psychosocial patients in the public health system, from 574 to 790, most of which are suffering from substance abuse. School screening programmes are to be conducted to support the identification of special needs students.

The Director General highlighted aspects of the support system for quality care implemented during the previous year.

The human resource information system (HRIS) was updated; a Workload Indicators for Staffing Needs (WISN) assessment was conducted for all hospitals in Unguja and Pemba. A training plan for 2011/2012 was subsequently developed to ensure all health facilities meet their minimum staff requirements.

271 health professionals were recruited and deployed, and an effort was made to deploy 60% to Pemba. 11% of new recruits did not report to the assigned stations of work. The Zanzibar College of Health Sciences (ZCHS) has improved greatly since the change of management; business plans have been developed and a website established. The ZCHS is in the process of reviewing its curriculum. The Zanzibar Medical School has 50 students currently enrolled.
Mid-term plans for telemedicine and e-learning programmes have been developed; most hospitals in Zanzibar now have this facility and can access UK specialists for support.

An overall analysis of the Ministry's Plan of Action for 2010/2011 is summarized as follows:

The MoH planned to implement 1,688 activities; of these:

- 63% were implemented
- 51% were fully achieved
- 12% were partially achieved.

166 unplanned activities were implemented during the period under review.
Dr. Juma called on the Ministry and its partners to be cautious about spending excessive and sometimes unwarranted time and resources on the formulation of documents, while underutilizing these documents.
In closing, the following milestones were proposed for the Year 2011/2012.

- Implement staff deployment system based on data of available staff and requirement.
- Institute Performance Based Financing (PBF) system in 2 piloted districts of North A and Mkoani
- Facilitate the implementation of Cost Sharing Guideline at all levels of health service delivery.
- Establish 100 Sheahia Health Custodian Committees in selected Shehia
- Adopt and implement Health Care Financing Strategy for Zanzibar.
- Develop Zanzibar Health Sector Strategic Plan III (2011/2012 – 2015/16)
- Develop long term National Nutrition Strategy
- Review the implementation of Road map of RCH

Public Expenditure Report

Mr. Omar Ali Abdallah, Health Economic Officer, MoH Policy and Planning

Mr. Abdallah presented the Public Expenditure Report (PER); this report is designed to establish the total resource envelope for the sector, and to understand its core composition. In this analysis, spending by the health sector is also evaluated in terms of efficiency and equity.

Total Funding

The total resource envelope for the 2010/2011 period was TZS 31 billion; this includes funds made available to the Ministry of Health, as well as through the Multilateral Debt Relief Initiative (MDRI), the Zanzibar AIDS Council, and consolidated funds.

Compared to the previous year, the total resource envelope fell by 5.7%; this was mainly due to the decline in resources from development partners. (There was a 20% reduction in funding from development partners, due largely to a drastic decline in funding from the Global Fund. The U.S. Government, African Development Bank (ADB), and DANIDA make up 75% of external funding to the health sector). There has been severe fluctuation in funding by development partners, introducing a high level of unpredictability to the funding situation for the health sector (See *Figure 2*). Contributions from cost sharing and the Revolutionary Government of Zanzibar (RGoZ) have increased.

Figure 2: Unpredictable donor financing support for the health sector

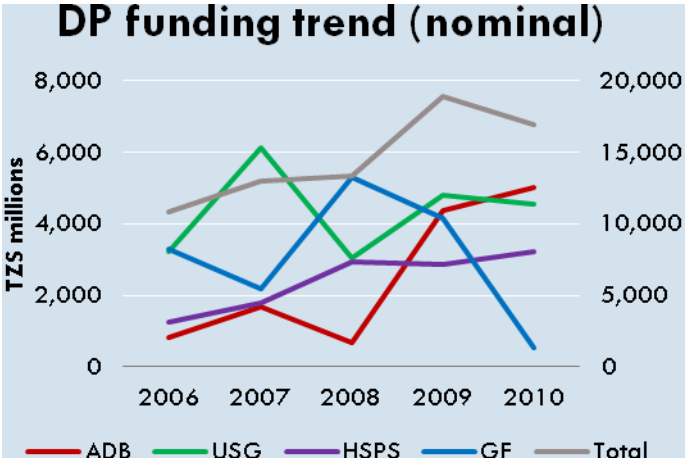


Table 1: Funding for the health sector in 2010/2011

Total funding	TZSm	Share	% change from 2009
MoHSW	11,673	37.6%	17%
Other RGoZ	1,774	5.7%	32.8%
Insurance	15	0.05%	n/a
Cost sharing	682	2.2%	153.5%
Development partners	16,896	54.4%	-20.8%
Total	31,000	100%	-5.7%

Funding from the RGoZ has displayed a promising trend since 2006; funding for the MoH increased by 17% during the last year. Despite this, the share of total government spending allocated to the health sector (7%) remains short of the 15% commitment of the Abuja Declaration, as well as the 12% minimum set in the Health Sector Strategic Plan (HSSP). Funding per capita is at its lowest since 2006; it currently stands at $18.8 per capita, which is below the WHO recommended $40 per capita. (However, it should be noted that this only includes health spending in the public sector, without the private sector contributions).

The gap in spending per capita between Pemba and Unguja has fallen to less than $1 (almost $4.50 in previous years), signalling improvements in equity.

A highlight of the expenditure pattern is the spending on medical services abroad. During the past year, almost TZS 1 billion was spent on medical expenditures abroad, plus another TZS 400 million for transfers (made available through consolidated funds). Together, TZS 1.4 billion – 12% of MoH expenditure - was spent on medical expenditures outside the country.

The resource envelope has benefited from the allocation of MDRI funds; as MDRI funds will not be available during the coming year, the total funding to the health sector is expected to decrease again in 2011/2012.

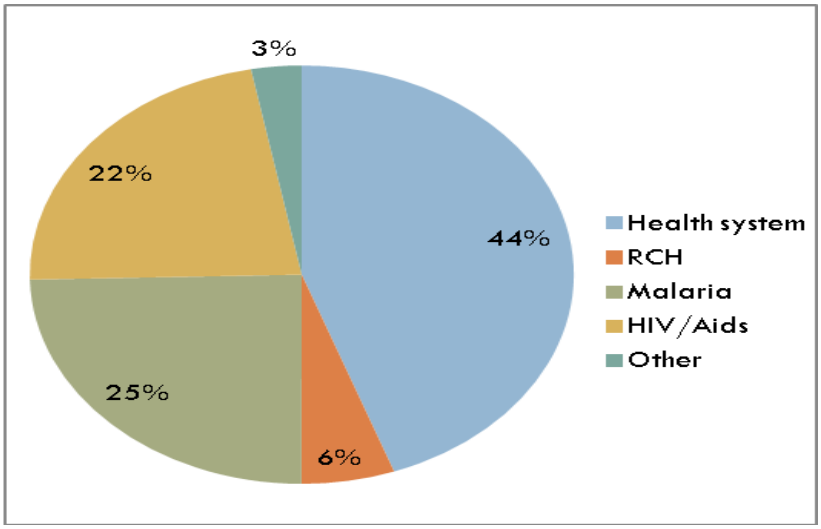
User Fee Funding

A total of TZS 677 million has been collected in user fees; user fees represent only 2% of the total resource envelope. 93% of user fees which are collected across all health facilities are collected at Mnazi Moja Hospital. User fees cover 68% of the hospital's running costs; it was highlighted that without cost sharing, the hospital's ability to continue to provide services would be seriously compromised. A discussion on the formalization of user fees is underway, and guidelines on cost sharing have been drawn up, drawing on experiences from other countries. A long term financing strategy is also being developed

Donor Support and Integration

The main development partners during the previous year were the U.S. Government, African Development Bank, and HSPS/DANIDA; together they were responsible for 75% of external funding, and 41% of the total sector resource envelope. Although there has been great fluctuation in funding from each of the development partners year-to-year, DANIDA has shown stable growth over the last five years. Over the last five years, the USG has been the main donor (15.5%), followed by the Global Fund (11.1%). Health systems strengthening (HSS) has received the greatest share of all donor support (44%), while malaria alone receives 25% of all donor support received. Reproductive and child health receives only 6% of donor support. Donor partners are however not well integrated into the MoH planning system, partly due to the lack of a sector budget support mechanism as well as the existence of multiple financial years across the MoH and partners; this has introduced significant limitations to efficiency. Partners are encouraged to use a newly developed resource tracking tool (which is internet-based) to plan and report on activities in a coordinated fashion, facilitating the efficient compilation of the annual MTEF.

Figure 3: Donor support for the health sector, by programme (last 5 years)



The Ministry is also planning to establish a **Basket Fund -** specifically targeted at the district health services - whose main aim will be to promote primary health care services. With this experience, it is hoped that a sector-wide budget support system will be developed. Donor partners were encouraged to change the modality of support for the health sector, turning towards the new Basket Fund.

Discussion Points

- In 2007 and 2010, the actual expenditure by MoH was above the initially MoF-approved estimates. This indicates that government is willing or has the capacity to allocate more than what is actually approved; the Ministry of Finance was requested to consider raising the allocation to MoH from the current 5.6% to 8 or 9%. The share of government spending to the health sector remains a concern; the health sector receives a smaller contribution of government spending compared to mainland Tanzania (12%), as well as in comparison to other countries in the region.
- 68% of the running costs of Mnazi Moja Hospital are received from cost sharing revenue, including payment for deliveries. There is a need to balance financing objectives with equitable provision of services. Charging fees for delivery can undermine maternal and child health (and thus progress towards the MDGs); a recommendation was made to the Ministry to waive fees for pregnant women.
- The establishment of the Basket Fund was commended, albeit with agreement that it would be necessary to engage different stakeholders to ensure that principles of accountability are built in, given that transparency will be one of the main concerns.
- According to the PER, 2008 – 2010 saw a four-fold increase in funds for medical evacuations or referrals abroad. The medical systems are unable to cope with the level of expertise that is needed (hence current efforts to upgrade tertiary institutions, including the development of a cancer unit). This is expected to reduce the number of international medical evacuees.
- It was established that there is a lack of clarity on the flow of general budget support (GBS) funds. 4.5% of GBS to Tanzania is allocated to Zanzibar; these funds, once in Zanzibar, are fully fungible as they are pooled with other Treasury funds and disbursed with no earmarking. However, some officials insisted that GBS funds are earmarked for different sectors. The relevant officials agreed to follow up on this issue and clarify the flow of these funds. A newly appointed Aid Coordinator is expected to work with the MoH Planning Unit and ease the process of tracking aid coming into the health sector.

Plan of Action 2011/2012

Ms. Khadija Said, Chief Planning Officer

The 2011/2012 Plan of Action (PoA) is a summary of a year of activities, mainly extracted from the MTEF 2011/2014; it is also developed by focusing on the main objectives as set out in the Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRP) II, the MDGs, and Vision 2020.

In the Plan, funds are allocated based on three main sources of funding – government (15%), development partners (77%), and cost sharing (1%). 7% of the plan is unsecured activities, i.e. those whose source of funding has not been identified or secured.

Within this Plan, 3 new departments have been introduced, while 2 departments have been shifted to other Ministries and no longer appear in the MoH PoA. The 3 new departments are: Chief Government Pharmacist, Department of Administration and Civil Service, and Department of Central Medical Stores.

Planned activities under the recurrent budget sum to a total of TZS 14.8 billion, 2.1 billion of which has been budgeted and approved by Government, 11.1 billion will be supported by development partners, while 1.5 billion worth of activities are unsecured. It was noted that all planned activities under community health promotion (recurrent) are unsecured, with no expected funds from government, or development partners.

Under the development budget, TZS 15 billion worth of activities are planned; TZS 2.5 billion from the government budget, TZS 12.2 from development partners, while approximately TZS 306,989,000 worth of activities remains unsecured. Four additional development projects are planned for the upcoming financial year; these include:

- Construction of a Central Medical Stores
- Construction of a Chief Chemistry Laboratory
- Upgrading of Mnazi Moja Hospital to a referral facility
- Strengthening PHC to become a district hospital

The key challenges to planning efforts were highlighted as follows:

- The multiple revisions of the budget ceiling from PoFEDP result in multiple revisions to the Plan of Action
- Partners do not fully integrate their activities into the Plan of Action; some activities which are budgeted by donors therefore do not match what is in the PoA. There is a need for one, integrated PoA between the Ministry and development partners
- The MTEF, a 3year plan, does not always relate well with the PoA, which is a 1-year plan and provides more granular breakdown of the timing of activities as compared to the MTEF. As a result, the lack of synchronization results in discrepancies between the plans, as well as difficulty in making cash flow predictions.

A key tool for addressing these challenges is the newly-developed resource tracking tool, a web-based application which all partners are encouraged to use for the purpose of planning and reporting using one platform, thus alleviating the challenge of coordination and integration of plans.

Discussion Points

- The gap of almost TZS 3bn in unsecured funding for next year's Plan of Action calls for greater urgency in moving ahead with cost sharing measures, including social health insurance. The government is encouraged to begin considering donor succession and plans for long term sustainability of financing.
- There was concern about the number of unplanned activities conducted, as reported in the performance analysis; this suggests a lack of coordination as a significant number of activities are occurring outside the national planning and budgeting framework. However, the discussion concluded that the proportion of unplanned to planned activities (10%) was reasonable, and that unplanned activities can be necessary and allows the programmes flexibility to respond to unforeseen challenges.
- A recurrent theme throughout the meeting was the concern about limited integration and coordination between MoH and development partners. This may be partly due to the fact that not all partners are included in the initial planning cycles, hence they plan and implement activities outside of the national framework; greater effort should be made to maintain inclusion of all partners throughout the strategic and annual planning processes as a way of embedding the development partners into the Ministry's core plans. All divisions currently developing projects outside of the main implementation plan were requested to submit their plans to the National Department of Planning; all sectors are requested to develop projects in conjunction with the Ministry of Finance, and to finalize plans with the Planning Commission. A web-based tool for use in tracking disbursements and expenditures by all partners is available and officers have been trained within the Ministry. Computers have been provided, but the Ministry staffs have cited the lack of internet connectivity as a challenge.
- The numerous iterations of budget ceilings provided to MoH from PoFEDP were cited as a challenge to developing the Plan of Action. Representatives from PoFEDP explained that this is an inevitable part of the planning process and MoH should prioritize activities within its plans in order to align subsequent iterations of the ceiling with the plans.
- The drop in immunization coverage, from 91% to 74% in 2010 is concerning, and can be attributed partly to insufficient community knowledge. Despite this, funds for planned community health promotion are not secured within next year's Plan of Action. Stakeholders need to recognize the critical role of health promotion, and MoH needs to make greater efforts to increase the uptake of services such as immunization by the community.

Strengthening Health Systems

Dr. Mohamed Dahoma, Director of Preventive Services

Dr. Mohamed Dahoma offered a framework for evaluating the performance of the health system and its ability to deliver quality services; the framework assesses the system through its composite parts, namely: access to essential commodities, health information, health financing, leadership and governance, and health workforce.

1. **Access to essential medicines.** Major achievements have been made, with the design and implementation of a new Zanzibar Integrated Logistic System (ZILS), which operates on a pull, rather than a push system (although the system is not yet operating electronically). Construction of a state of the art warehouse has been commenced, and is scheduled to be completed by February 2012. The Central Medical Stores will be moved to the new location;

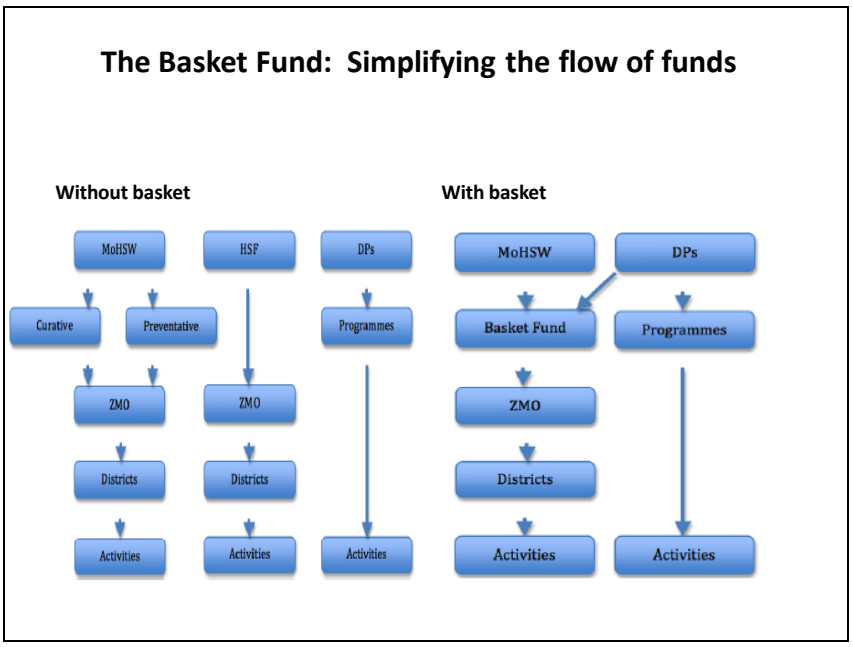
35 people have been trained in the running of a medical store, and 175 staff has been trained to facilitate ordering in health facilities.

For the first time in several years, the RGoZ will contribute to the procurement of essential drugs (through a TZS 700m commitment) for 2011/2012. However, there remains a funding gap of US$1.5 million for essential drugs alone. Challenges remain with regards to forecasting drug needs in relation to the burden of disease.

2. **Health Management Information System (HMIS).** New and innovative approaches are being strengthened and re-established to improve HMIS, including electronic medical records for cottage and district hospitals. The electronic information system will also be extended to selected health facilities.

3. **Health systems financing.** Given the fluctuation and inherent unpredictability in donor support, there is a need to consider options for a long term financing strategy that enhances sustainability. Although there has been an upward trend in the allocation from the RGoZ, the allocation as a proportion of total government spending remains low. A new health financing strategy is under consideration; Zanzibar needs to finalize plans to provide health insurance for all citizens, through the introduction of social health insurance schemes that include both the formally employed and informal sectors. Cost sharing guidelines have been developed. The District Basket Fund is expected to move the sector from project-based, to sector-wide support, while a performance-based financing model to be piloted in 2012 has the potential to enhance efficiency through alternative reward and incentive structures.

Figure 4: Flow of funds to the health sector through the proposed Basket Fund



4. **Leadership and Governance.** Several regulatory boards and councils exist to evaluate and ensure the quality of services being provided; these include the Medical and Nurses Council, the Food and Drug Board, the Medical Board etc. Support for the functions of the regulatory bodies is needed to ensure consistency and effectiveness in their appointed mandates.

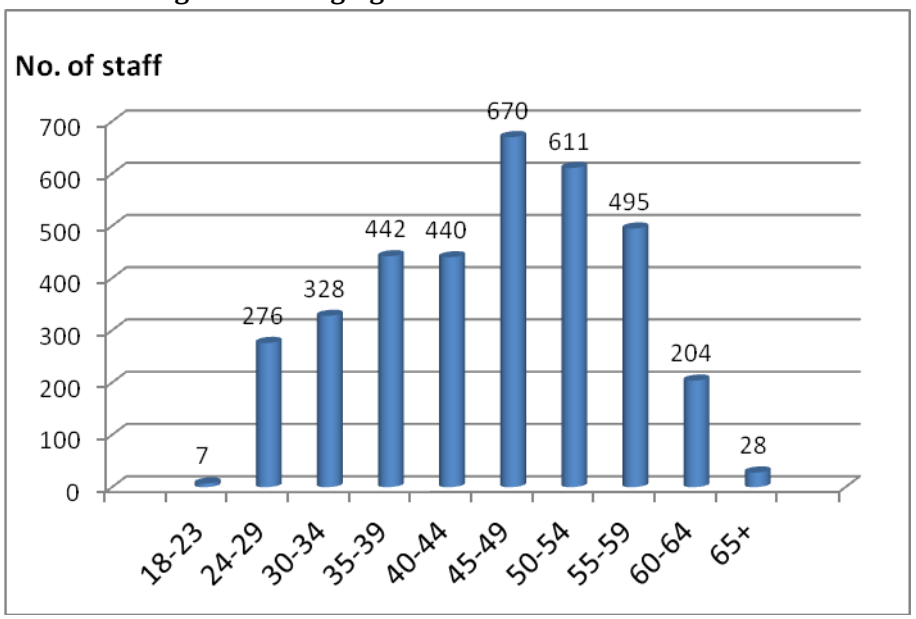
Community involvement is being enhanced through the development of the Community Health Strategy. The decentralization of health services, which begun in 1991/1992, has been a very slow process, limited by the fact that other sectors have yet to adopt the policy on decentralization.

The establishment of a Basket Fund will simplify the flow of funds as donors will place funds into a joint health account, which MoH can then access via a request through PoFEDP. It is expected that the Basket Fund will become operational, providing sector-wide budget support by 2014/2015. A cautious approach will be taken during this period to ensure a smooth transition to the new system; the Basket Fund for health will be a model in sector budget support for Zanzibar, being the first sector to undertake such an effort. The MoH is seeking Technical Assistance for 2 years to coordinate the Basket Fund's establishment and build capacity among the relevant ranks of the Ministry.

5. **Health workforce.** Critical shortages in human resources for the health sector are limiting productivity and undermining the quality of services. Critical staff shortages limit quality of care in Zanzibar, as they do in many of the resource-constrained settings of the region. The resulting high workload results in responsibilities for some tasks shifting to under qualified personnel, lack of adherence to protocols and standards, and overall low productivity. Factors contributing to the shortage include the lack of motivation (driven partly by low salaries); in the absence of career development plans, new recruits to the health sector are also not provided with clear career development prospects for the long term.

Zanzibar is also facing a unique challenge of an aging workforce. A rapid assessment was conducted and revealed a skewed distribution in the age of workers in the health force; 20% of personnel are above the age of 55, and only 17% are under the age of 34. Increasingly, health workers are joining the profession late into their twenties, and fewer numbers are entering the health workforce; more paramedics are joining compared to other professions.

Figure 5: An aging workforce in the health sector



To begin to address this problem, training plans were developed in 2010/2011, spanning a period of ten years, to ensure that all health facilities meet the minimum staff needs. Urgent reforms are needed to attract young people to enrol into the medical field, and to retain staff within the health sector. Once recruited, staffs are not sufficiently incentivized to perform at a high level; this needs to be addressed through the introduction of staff appraisals, and improved working and living environments. Performance-based financing, which would reward staff against achievement of certain outcomes, also has potential to increase motivation, while career development plans will provide new recruits with a long term view of potential growth prospects within the health sector.

Discussion Points

- The challenge of an aging workforce and attrition is fuelled by the reluctance by development partners to invest in long term training, preferring short courses instead. Currently, long term training programs are being supported primarily by African Development Bank, while the medical school is completely government-funded. ZCHS also receives most of its funding from government.
- The commitment to scale up community participation and the completion of guidelines for community involvement was one of the milestones of the previous review meeting. However, this issue has not been given sufficient attention during this review. The President's speech also highlighted this as a priority intervention. The revitalization of community health is intended to increase the role and ownership of communities in health service improvement. A taskforce has been set up and preparatory activities begun, but progress on this front has been stalled by the lack of resources to carry out this mandate. Relevant authorities from Ministry of Local Government and other central level players are being sensitized, with the aim of establishing committees at each district to oversee this process. A representative of the Taskforce highlighted that a team has been trained and is ready to begin implementing this strategy immediately if funds can be made available.
- The aid management platform is currently operating, although some development partners have not subscribed. This will enable transparency and information sharing.

Findings of Zanzibar Malaria Programme Review

Mr Mwinyi Msellem, Assistant Manager, ZMCP

Zanzibar has witnessed a dramatic decline in malaria disease trends since 2006; prevalence currently stands at 0.5% according to the latest Malaria Indicator Survey. The Zanzibar Malaria Control Programme (ZMCP) underwent an exhaustive malaria programme review, which is a periodic joint assessment for reviewing the performance of malaria country programmes. The findings of the MPR will contribute to improving performance and redefining the strategic direction of the country's malaria control efforts. The review, which was attended by local and global partners and experts from a variety of partners, recommended the following action points.

- **Programme Management.** Given the successful reduction in malaria transmission, ZMCP needs to reorient towards a malaria elimination programme, with new policies and strategies needing to be developed and implemented. In particular, surveillance and response systems need to be strengthened, while human resource capacity at shehia level needs to be built up. Increased funding from the RGoZ is needed in order to enhance financial sustainability of malaria programming.

- **Advocacy/IEC.** There is a need to update the Communications Strategy in line with the new vision of malaria elimination. An increased funding base is needed to sustain community-based activities. There is an opportunity to focus communication activities at the community level using the Community Health Strategy.

- **Case Management**. The malaria case-based surveillance system needs to be implemented rigorously, while improving the notification and investigation of parasitologically confirmed cases within 24 hours. Efforts need to be taken to improve procurement and supply management of anti-malarials and stop the sale and distribution of artemisinin monotherapies. The MPR committee recommended ZMCP to begin to introduce malaria radical treatment with primaquine in addition to the standard artemisinin-combination therapy.

- **Vector Control**. In order to ensure an adequate vector control response in an elimination phase, district vector control teams need to be equipped to implement vector control activities. At the national level, guidelines are needed to guide the phased transition from universal vector control with a combination of IRS and LLINs, towards focalized IRS, while maintaining high LLIN coverage. This process of targeting interventions needs to be guided by the stratification of malaria risk in districts in order to identify malaria foci (through epidemiological and entomological information). Maps of the distribution of vector breeding sites should also be developed to allow targeted larval source management where appropriate.

- **Surveillance & M&E.** The MPR recommended the establishment of malaria profiles at health facilities and at district level to facilitate tracking of monthly trends in access and coverage interventions, as well as disease trends and outbreaks. Weekly surveillance reports should focus on review of positive cases and transmission hotspots.

The main challenges facing the ZMCP were summarized as:

- Sustaining declining malaria prevalence: Can Zanzibar maintain the gains?
- External financing for malaria commodities is unpredictable and unsustainable.
- Key staff within the MoH are frequently redeployed
- There is no malaria response team operating at district level
- Inadequate staff remuneration

As a way forward, a critical issue to address will be the domestic financial commitment to financing for malaria control, and elimination given that donor funding is fraught with unpredictability and unsustainability issues.

Discussion Points

- The overreliance on the ZMCP on external funding presents a major threat to sustainability and places the programme at increased risk; the programme relies on 2 donors (GF and PMI) for 97% of financing, while the government contribution is less than 1%. (This does not include integrated health systems costs). Financial sustainability must be addressed if Zanzibar is to embark on an elimination effort. ZMCP is in the process of finalizing a financing plan for the next ten years to begin to address this issue.

Schistosomiasis Elimination Project

Dr. Khalfan A. Mohammed, Manager, NTDs Control Programme

As with malaria, there has been a radical decline in the prevalence of schistosomiasis, with the possibility of elimination of the disease in the near future. While all district of Pemba still have prevalence of schistosomiasis, South A, Urban A and B in Unguja no longer have schistosomiasis transmission; existing cases are mainly imported from other districts. Before 1990, prevalence in Unguja and Pemba was above 50% and 60% respectively; the latest surveys (conducted at 24 schools on each island) show a prevalence of 8% in Unguja, and 15% in Pemba.

Since 1986, preventive chemotherapy has been the main intervention against schistosomiasis; praziquantel was the most commonly-used drug, sometimes combined with albendazole. In addition to preventive chemotherapy, environmental interventions were implemented. The Zanzibar Water Authority, with funding from ADB, pans to improve piped water and sanitation in some areas (though not before 2013). Control of snails is done using Niclosamide. New behaviour changes approaches are needed as knowledge, attitude, and practice (KAP) studies suggest that improved community understanding has the potential to support interruption of transmission.

The Schistosomiasis Elimination Project, launched in August 2011, therefore has the following goals:

- Eliminate schistosomiasis as a public health problem in Unguja in 3 years, and interrupt transmission in 5 years
- Control schistosomiasis throughout Pemba (prevalence less than 10%) in 3 years, and eliminate it as a public health problem in 5 years
- Learn what is effective and what are the costs, successful strategies, and barriers associated with various interventions.

Through the Schistosomiasis Consortium for Operational Research and Evaluation (SCORE) program, a randomized control trial (3 arms) is planned to study the implementation of schistosomiasis elimination in Zanzibar. $900,000 in funding has been committed for four years, with additional drug supplies and technical assistance expected from other partners.

Non-communicable Diseases and Associated Risk Factors

Dr Faiza Kassim Suleiman, Principal Investigator

A national NCD household survey was conducted (2,639 individuals) using a multi-stage cluster sampling method; the survey conducted socioeconomic and demographic data, as well as measurements of risk behaviour, anthropometric measurements and biochemistry. The survey was the first of its kind to be conducted in Zanzibar, which, like other developing countries, is undergoing an epidemiological transition as non-communicable diseases are on the increase.

The preliminary findings of the survey are organized by risk factor.

Risk Factor	Preliminary Results
Tobacco	Overall prevalence of smoking is 7.3% (14.7% in men) Overall prevalence of current alcohol consumption is 1.7% (15.8% in men)
Diet	An average serving of 1.7 fruit and vegetables per day (no age or gender difference) There is high consumption of vegetable and coconut oil (saturated fats)

Physical Activity	51% of women and 80% men are highly physically active; physical activity is usually work related.
Overweight and Obesity	37% of the survey population has BMI over 25(overweight) – 42.6% female vs. 30.5% men Women between 45 – 64 years had highest prevalence of overweight/obesity (51%)
Hypertension	Prevalence of hypertension was higher among females (33%), compared to men (29%)3%). Females between 45 – 64 years had the highest prevalence (62%).
Diabetes	The overall prevalence is low (compared to other countries) at 2.2%, although there is increasing prevalence with age. 50 % of people diagnosed with diabetes did not know that they had the condition.

In summary, the survey found that the current risk factors exposed through the survey will lead to a larger challenge with conditions such as diabetes, heart diseases, and cancers. However, NCDs can be prevented because the risk factors mentioned are modifiable with lifestyle changes. The presented cited the high prevalence of risk factors such as obesity and hypertension points among women which suggest that "the danger of being a woman does not end after childrearing age."

In response to these findings, the MoH will focus on quality education for behaviour change and screening at community level, using the primary level as an entry point for care and early detection of selected NCDs. The NCD response also needs to be integrated within the essential health care package (EHCP), reproductive and child health (RCH), and other programmes to ensure a healthy population.

Ongoing Research and Training Opportunities at Public Health Laboratory

Mr. Said M. Ali Director Public Health Laboratory

The Public Health Laboratory (PHL) conducts a range of services, including the coordination of research studies, surveillance of epidemics, evaluation of the impact of control strategies on morbidity/mortality, drugs quality control, and training of health staff. The main laboratory in Pemba conducts regular quality control for the malaria programme, monitoring 10% of all slides conducted for malaria diagnosis. PHL is also strengthening maternal and newborn health services; as part of a 4-year study, PHL is following children from birth to 28 days with cord care services for the reduction of neonatal mortality. In collaboration with international institutions, PCR quality control facilities are being set up for quality control of TB diagnosis.

PHL is also involved in the Millennium Village Project, along with the Millennium Promise Alliance, the Earth Institute at Columbia University and United Nations Development Programme (UNDP), to facilitate progress towards the MDGs through community led actions. These include activities in health, agriculture, education, infrastructure, nutrition, and gender.

A broader range of ongoing research and training projects are occurring in the areas of HMIS and data management, cholera vaccines, typhoid fever, and monitoring of neglected tropical diseases.

The research enterprise at PHL is challenged by limited resources, which make it difficult to maintain scientific standards. As a result, PHL's activities are based towards research as a main source of funding. However, progress towards sustainability is progressing, as currently, all staff are from Zanzibar, and material bought for research projects becomes the property of PHL after conclusion of the studies. The laboratory intends to develop human resources and the capacity for grant-writing and fundraising to enhance sustainability.

Reproductive and Child Health

a) Unmet Need in Family Planning

Dr. Hanuni, RCH Programme Manager

Family planning is a cost effective intervention with the potential to impact on all the Millennium Development Goals, namely poverty reduction, school attendance, gender equality, infant mortality, maternal mortality, and slowing of HIV transmission. There is an established correlation between the use of family planning methods and reduction of maternal mortality, since women are able to space and limit the number of pregnancies. However, use of family planning in Zanzibar remains low, although a small increase in the use of family planning has been seen, from 9% to 12%.

The "unmet need" for family planning was defined as the gap among "women who are sexually active and fecund (productive), but are not using any method of contraception, and report not wanting any more children, or wanting to delay the birth of their next child." The unmet need for family planning in Zanzibar stands at 34.7% (31% In Unguja and 40% in Pemba). Contributing factors to this gap are: inadequate knowledge of family planning, misconception on family planning within the religious context, and poor accessibility of family planning services (inadequate staff with knowledge and skills to provide these services, facilities only open between 8am and 3pm). There are also socio-cultural factors that limit women's negotiation abilities, compounded by low male participation in family planning services.

In order to overcome these challenges, the MoH is conducting health education sessions focused on family planning within the communities; it is also recruiting and training male CBDs and involving religious leaders in efforts to educate communities and increase the demand for family planning. A booklet on family planning and Islam was launched to clarify prevailing misconceptions on what Islam teaches about family planning.

Support was requested to determine why the unmet need is high and which interventions would be feasible, effective, and sustainable in addressing this gap.

b) Immunization Coverage Survey

Mr. Yussuf Haji, EPI Manager

An EPI coverage survey was conducted among four districts in Pemba to determine the status of routine vaccination coverage of children and mothers (among children aged 12 – 23 months, and among women with children aged 0 – 11 months for tetanus vaccine coverage). The survey was motivated by the frequent occurrence of outbreaks of vaccine preventable diseases such as measles and neonatal tetanus. The survey found that overall crude vaccination coverage was above 90% in all districts, while valid coverage is below 80% in all antigens in all districts except for Mkoani

(suggesting a poor quality of data in most districts). Measles coverage was only above 80% in Wete and Mkoani.

Access to the immunization system is good in all districts; there is high coverage of BCG, but this is followed by a high dropout rate after BCG, particularly between BCG-Measles and DPT1-Measles.

Measles Outbreak. Zanzibar has experiences a measles outbreak since May 2011, with West District being most affected (167 cases in West district reported by September 4). A joint team from World Health Organization (WHO), UNICEF, and MoH conducted an investigation in early September; it was found that of the 167 cases in West district, 64% had not been vaccinated (includes those without vaccination card), while 29% had been vaccinated. The outbreak was reported to be over by the time of the review meeting.

Challenges facing this programme include limited resources for social mobilization and surveillance, and the failure of caretakers to follow the routine immunization schedule. There is also a low valid vaccination rate; most measles cases were reported in a district that records a very high immunization coverage. The districts also have limited capacity for outbreak investigation.

Recommendations to strengthen this programme include intensifying social mobilization to create demand, intensifying measles case based surveillance, and regularly conducting data quality assessments at health facilities. Training of health workers on data quality and immunization policies, along with tetanus vaccinations in schools will be prioritized as key next steps.

Nutrition

Ms. Asha Hassan, Head Nutrition Unit

Although Tanzania signed a commitment to the global Scaling Up Nutrition (SUN) movement, committing itself to actions to reduce malnutrition, this issue has not been given sufficient priority in the health sector. According to the Demographic and Health Survey (DHS) 2010, of children under five, 30% are stunted, 20% are underweight (compared to a target of less than 10% in MKUZA), 4.5% have severe acute malnutrition, and 69% are anaemic. 14% of women are likely to have low birth weight because of undernourishment. Between 1992 and 2004, there was a sustained decline in the prevalence of stunting, but prevalence has increased from 2004 until today.

Malnutrition is Zanzibar is attributed to inadequate caring practices, including breastfeeding and complementary feeding; the average duration of exclusive breastfeeding in Zanzibar is only 2 weeks (compared to the recommended duration of 6 months). There is also inadequate access to health services; only 39% of women take Vitamin A supplements after delivery. The programme is also made vulnerable by a high level of donor dependency. Mandatory food regulations for food fortification may help in addressing vitamin and mineral deficiencies. Only 24% of households in Pemba consume iodized salt (compared to 50% national average).

In order to scale up nutrition efforts and improve outcomes, sufficient political attention is needed to place this issue higher on the development agenda. Nutrition is a cost-effective method for tackling various pressing development challenges (mortality, school performance), and so adequate financial resources are needed. The health sector will develop a National Nutrition Strategy and costed Implementation Plan to provide a roadmap for scaling up nutrition actions; it will also advocate with the Second Vice President's Office for the establishment of multi-sectoral committee on nutrition.

Maternal Death Reviews

Dr. Khadija, Training Officer, Mnazi Moja Hospital

A new approach to conducting maternal death audits has been adopted; a total of 69 maternal death audits were conducted in the previous year (40 of them using the new approach). Currently, each maternal death is being examined or audited to understand reasons for delay in seeking care; interviews with staff and family members are conducted, and hospital records are also being reviewed and presented to a panel of decision-makers who provide recommendations on how each maternal death could have been avoided.

The main contributing factors to maternal mortality have been identified as: delay in seeking treatment (partly due to financial barriers), various issues with blood supplies, poor adherence to treatment protocols at PHCU and PHCC level, and low community awareness of the need for maternity care. Clinical causes for death also include post ceasarea complications (eclampsia and pre-eclampsia complications).

Discussion Points

- A plan for expansion of Mnazi Moja Hospital is being supported by the Netherlands, and will be implemented in about 6 months' time. This is expected to increase space for a maternity ward. Stakeholders are also called upon to support ZCHS to build capacity in programmes that will begin to more dramatically influence maternal and child mortality.
- Concern was raised over the decline in ANC attendance rates; this will no doubt impact on maternal mortality (which is still far from the MDG target of 130 deaths per 100,000. It was recommended that the Basket Fund, which will operate at district level, be used to support financing of health services for women and children. The TZS 40,000 fee for delivery, while not ideal, was defended from a financing perspective. However, no pregnant women are to be denied care and access to facilities for delivery on the basis of payment. Disciplinary actions should be taken against providers who fail to adhere to the right to fee waivers.
- The challenge of sustaining activities in reproductive and child health must be considered within the context of a long term financing plan for Zanzibar. Donor support is not guaranteed to perpetuity; there have been experiences in the past where Zanzibar sustained vaccination campaigns with no donor support.

Management of Child Violence

Dr. Marijani Msafiri, Pathologist, Mnazi Moja Hospital

Management of child violence was once organized under the Gender-based Violence unit, but now stands by itself, and seeks to address all types of malpractice against children; these include physical or mental abuse, negligent treatment, and sexual abuse. Violence against children results in fatal outcomes (homicide), physical problems, negative health behaviours (smoking, drugs), mental problems (depression, sexual dysfunction), and reproductive problems (unwanted pregnancy, unsafe abortions, infections). A 2009 national survey on violence against children found a high prevalence of physical violence, as well as emotional and sexual violence. It also revealed that boys experience greater levels of sexual violence compared to girls (6.2% vs. 9.3%). (The survey was conducted among children aged 13 – 24 years). It also found a 71% prevalence of physical violence among boys, and 62% among girls.

The One Stop Centre was launched in 2011 as a support for victims of violence (gender-based violence and violence against children). Located at Mnazi Moja Hospital, the centre provides health, legal, and psychosocial support services in one setting. Between 30 and 100 clients visit the centre per month, most of them are under the age of 18, and primarily victims of sexual violence. In addition to providing medical and psychosocial support, the centre is also able to facilitate reporting to the police as well as collection of forensic evidence.

The presentation focused on the challenges faced by the centre, which are summarized below.

- Lack of permanent health care providers specifically for the centre; most health care staff are hospital casualty staff or emergency services staff juggling this work and their regular duties. Many are often transferred to other departments, resulting in loss of skills at the centre.
- Lack of skills in forensic specimen collection among health care workers. This results in insufficiency of medical evidence presented to courts; the DNA samples to be analysed in Dar es Salaam are often incomplete (sometimes only from the victim, and not from the offender as well). Victims also delay the reporting of the crime and fail to preserve evidence by the time they seek care.
- Victims of childhood violence are not adequately rehabilitated due to the lack of permanent social workers for psychosocial counselling, and the lack of psychologists for therapy.

The following action points were recommended as the way forward:

- Another One Stop Centre is planned for Chake Chake ; this will ideally have its own permanent workers to maximize efficiency
- Police, DPP and MoH need to develop a clear procedure for specimen that is exported for DNA analysis, and ensuring that suspects are brought to facilities for specimen collection
- Health care providers within MoH need to be trained on gender based violence and violence against children.

Need Assessment for College of Health Sciences

Dr. Hakim Gh. Bilal, Principal, Zanzibar College of Health Sciences

The Zanzibar College of Health Sciences (ZCHS) was established in 1989 and has been the sole institution in Zanzibar for training of human resources for health for the past 22 years. Each year, approximately 300+ health workers graduate from ZCHS; this includes nurses, medical lab technologists, pharmacists, health and clinical officers. The need assessment sought to evaluate ZCHS's capacity to produce the required quantity and quality of human resources for health for Zanzibar, particularly to respond to the needs of maternal and newborn health. The findings are outlined below.

- **College management.** The college needs greater autonomy over recruitment, remuneration and firing decisions. Information and materials to publicize the college are also needed, as well as committees to monitor the quality of training according to the standards of the National Council for Technical Education (NACTE). (NACTE is a registered body which supervises the operations of the college). The college needs improved infrastructure, including multipurpose halls and staff houses. The study also highlighted the importance of protecting land space for the college and future expansions.

- **Training Programs.** Training, recruitment, and retention mechanisms are needed to build and maintain capacity among college staff. There is a need for supportive staff with a variety

of skills (cooks, drivers etc), as well as strategies to retain staff. The college needs to construct a mixed skills laboratory (for patient care simulation to boost skills and confidence), as well as teaching aids and supplies.

Other needs faced by the College include:

- Inadequate numbers of qualified teaching staff to run programs and train the cadres
- Need for construction of a health facility to provide health services to the community, while simultaneously providing effective practicum exposure for students
- Limited equipment and infrastructure, including periodicals, internet connectivity, lecture theatres and hostels.

The key recommendations are listed below.

- Make purposeful move to improve training of human resources for health, including:
  - Establishing selection criteria for new students
  - Maintaining student teacher ratio no greater than 1:40
  - Improving practicum teaching, by using more teaching hospitals
  - Developing higher courses for health human resources
- Allow the College a greater degree of autonomy in decision-making, expediting functions and thus increasing accountability and sustainability
- Management of teaching hospitals is encouraged to discuss how students from the college can receive supervision for practicums. More teaching hospitals should be added and logistics made available to allow students to participate.

NGO Presentation: Iodated Salt

Mr. Juma Bakari Alawi, AZASPO

AZASPO began as a small scale salt production project in 1997, designed to create employment opportunities for rural women and youth, while also contributing to the Iodine Deficiencies Disorders (IDD) control efforts. IDD-related diseases include dwarfism, and low IQ in children. After the initial project phase, ASAZPO was set up as a legal entity to carry on these activities.

The Iodine Deficiencies Disorders Control Programme, in collaboration with UNICEF, conducted a survey in 2001 to assess the status of iodine deficiency in the Islands. Prevalence of goitre was found to be 26% (32% in Pemba and 21% in Unguja); the survey also found 32.2% utilization of iodated salt in households (1% in Pemba and 64% in Unguja).

In 2003, AZASPO, with financial support from UNICEF and in collaboration with MoH, begun a comprehensive programme on promotion of salt iodation, aiming at control of IDDs. Since then, additional programmes have been implemented through this partnership (AZASPO and UNICEF) to improve iodine supplementation in Zanzibar; these include supply of KIO_3, training of salt producers, and supply of processing machines. Since the initial surveys in 2001, utilization of iodated salt in households has increased significantly to 62 % (47% in Pemba, 77% in Unguja) according to a 2006 survey. However, utilization dropped by 2009 (38% in Pemba and 45% in Unguja).

Main challenges faced by AZASPO in its efforts to counter this issue are the lack of regulation governing the salt business, and resources to procure iodine filler chemical (KIO_3). Regulations concerning the salt industry have been drafted and considered by the Attorney General's Chamber; it is expected that the new regulations will be released soon for nationwide enforcement.

NGO Presentation: Findings of Household Survey on Water, Sanitation and Hygiene Practices in Wete District

Bakari Omar Khatib, CASHAO

The NGO CASHAO, one of the sub-recipients of the Global Fund Malaria/HSS grant Round 8, assists district health medical teams (DHMTs) in the implementation of the essential health care package, especially in environmental health. As a response to frequent cholera outbreaks in Wete district, CASHAO set out to conduct a household survey to determine an adequate response to the challenge of water and faecal borne diseases in Northern Region, Pemba. The survey found that public taps are the most frequent source of drinking water (46%), and 93% of the residents surveyed use an improved source of drinking water. 42.6% of households have no sanitation facilities, while 37.5% use pit latrines. There was a significant difference in availability of improved sanitation facilities between urban and rural shehias; M/Kusini had no improved sanitation facilities. 88% of households said they allow the water to stand as a treatment practice, with only 11% either boiling of adding chlorine or bleach.

In summary, the low coverage of improved sanitation facilities in the district is alarming, hand washing is not well practiced, and drinking water is not adequately treated. A key recommendation is for the provision of technical support in the construction of low-cost, improved latrines, and conduction of school health programmes on personal hygiene in pre and primary schools.

Field Visits and 2011/2012 Milestones

On Day 2 of the review exercise, field visits were conducted throughout Pemba; these provided concrete examples of Day One's policy discussions and progress achieved since last year. Additionally, meeting participants had strong reactions to gaps and challenges witnessed during the field visit: these reactions reinforced the group's mission and the need to continually strive to serve the health needs of Zanzibaris. In particular, the field visits highlighted several key issues.

First, ssynergies between food security and nutrition efforts and the MoH must to be scaled up to increase food security and decrease malnutrition. The salt factory visit was a surprise for some participants, and served as a reminder that Zanzibar must cast a wide net when structuring the health system. Secondly, drug shortages and stock outs remain a significant problem. Furthermore, improved health management information systems may improve the quality of health commodities forecasting, especially for Pemba. Community-based interventions are also an area of opportunity in which the health sector can build on gains in health facility interventions of recent years. A field visit to Public Health Laboratory (PHL) characterized preventable community-based health risks such as education around vector control of soil-transmitted helminths among commercial fishermen.

At the end of Day 2, the following milestones were proposed for the upcoming year.

1. 1 Implement staff deployment system based on data of available staff and requirement.
2. Institute Performance Based Financing (PBF) system in 2 piloted districts of North A and Mkoani
3. Facilitate the implementation of Cost Sharing Guideline at all levels of health service delivery.
4. Establish 100 Sheahia Health Custodian Committees in selected Shehia
5. Adopt and implement Health Care Financing Strategy for Zanzibar.
6. Develop Zanzibar Health Sector Strategic Plan III (2011/2012 – 2015/16)
7. Develop long term National Nutrition Strategy
8. Review the implementation of Road map of RCH

Annex

ANNEX NO I

Ministry of Health - Zanzibar
Provisional Programme for The 6th Zanzibar Annual Joint Health Sector Review
Pemba Misali Sun - Set Beach Hotel
31ST OCT – 1ST November, 2011

Day One - Monday 31ST OCT, 2011
Meeting chair PS Ministry of Health/ PS PoFEDP/ Zanzibar Development Partner Group Convener

TIME	ACTIVITY / PRESENTATION	RESPONSIBLE
08.00 – 08.30	Registration	Health Sector Reform Secretariat- Mr. Abdallah Mohammed
08.30 – 08.40	Introduction of participants	All
08.40 - 09.10	Performance Report 2010/11	Director general Dr. Malick A. Juma
09.10 – 09.25	Public Expenditure Report	Health Economic Officer Mr. Omar Ali Abdallah
09.25 – 09.35	Ministry Plan of Action	Chief Planning Officer Ms Khadija Said
09.35 – 09.50	Building and Strengthening Health system (Sector finance/Basket Funds/District sub vote)	Director Preventive services and Health Education Dr. M. Dahoma
09.50 – 10.30	Discussion	All
10.30 – 10.55	Health Break	All
10.55 – 11.05	Review Report Zanzibar Malaria control Programme	Asst Manager Malaria Control Programme Mr Mwinyi Mselem
11.05 – 11.15	Neglected Tropical Disease Schistosomiasis elimination Project	Head NTD MoH Dr. Khalfan
11.15 – 11.30	Zanzibar NCD risk factors survey reports	Principal Investigator Dr. Faiza Kassim
11.30– 11.40	Public health Laboratory On Going Research and Training opportunities at PHL	Director Public Health Laboratory Mr. Said M. Ali
11.40 – 12.00	Discussion	**All**
12.00 – 12.10	Welcome Note and invite RC to welcome Minister of Health Zanzibar	Principal Secretary, MoH Mohammed Jiddawi MD
12.10 – 12. 15	RC to welcome Minister of Health Zanzibar	Regional commissioner South Pemba J. K Tindwa
12.15 - 12.25	Minister of Health Zanzibar Invite Guest of Honour	Minister of Health Zanzibar Hon. Juma D. Haji
12.30 - 13.00	Opening Speech	Guest of Honour, Hon. President of Zanzibar Dr. Ali M. Shein
13.00 – 13.10	Vote of Thanks	Deputy Minister of Health Zanzibar Hon. Dr. Sira U. Mamboya
13.10 – 13. 20	Official Group Photo	All
13.20 - 13.50	Gallery walks	**All**
13.40 – 14.30	Lunch Break & Prayer	**All**
14.30 – 14.40	Leaving the Guest of Honour	Guest of Honour,
14.40 – 15.10	Reproductive and child Health • Un meet need in Family Planning • EPI coverage study • Nutrition	Manager, RCH programme Dr.Hanuni Manager EPI Mr. Yussuf Haji Head Nutrition Unit Ms. Asha Hassan
15.10 – 15.20	Maternal Death Review	Training Officer MM Hosp Dr. Khadija
15.20 – 15.30	Multi-sectoral collaboration Challenges in managing child violence's	Pathologist Mnazi Mmoja Hospita Dr. Marijani Msafiri

	(One drop centre experiences)	
15.30 – 16. 00	Discussion	**All**
16.00 – 16.30	Break & Prayer	All
16.30 – 16.40	College of Health Sciences Need assessment for college of health sciences	Principal Zanzibar College of Health Sciences Dr. Hakim Gh. Bilal
16.40– 16.50	Discussion	**All**
16.50 – 17.10	NGO Presentation Iodized Salt	Juma Bakari Alawi
17.10 – 17.20	NGO Presentation – Care and Share (Wete) benefits observed in working with NGO	Bakari Omar Khatib
17.20 – 17.40	Discussion	**All**
17.40 – 18.00	High light on field visit (2nd day of the meeting)	Dr Sauda
18.00	Reception & End of Day one	**All**

Day Two: Tuesday 1st November, 2011

TIME	ACTIVITY / PRESENTATION	RESPONSIBLE
08.00 – 08.15	Registration	Health Sector Reform Secretariat
08.15 – 12.00	**Field visit. Three Groups**	**All**
12.00 – 13.30	**Lunch Break & gallery walks**	**All**
13.30 – 14.40	Group works (Field Experiences plenary presentation)	Individual Groups Secretaries
14.40 –15.00	**Discussion**	**All**
15.00 – 15.15	Main conclusions, recommendations & way-forward	Director, Preventive services and Health Education - MoH
15.15 – 15.30	Closure	Principal Secretary, MoH
15.30	**End & departure**	**All**

ANNEX NO. II LIST OF PARTICIPANTS

6TH ANNUAL JOINT HEALTH SECTOR REVIEW 2010/2011 PEMBA MISALI SUNSET BEACH 1ST NOVEMBERS, 2011

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ANNEX NO III

WELCOMMING NOTE BY THE PRINCIPAL SECRETARY, MINISTRY OF HEALTH ZANZIBAR AT THE 6th ANNUAL JOINT HEALTH SECTOR REVIEW
31st OCTOBER, 2011

- Your Excellency, the President of Zanzibar and Chairman of the Revolutionary Council – Dr Ali Moh'd Shein
- Our host, The Regional commissioner South Pemba
- The hon. Minister of Health Zanzibar
- Executive Director Zanzibar Planning Commission, Co - Chair
- Director General MOH
- Delegation from Ministry of Foreign affairs Denmark
- Representatives of government sectors,
- Development Partners, both from Zanzibar and outside Zanzibar
- Representative from Civil Society Organizations
- Our guests from the Ministry of Health Tanzania mainland,
- Other stakeholders and collaborators,
- Ladies and Gentlemen: Asalaam Alaikum.

Your Excellency and distinguished guest,
I would like at the outset to thank you Mr. President and Chairman of the Revolutionary Council for agreeing to officiate the opening of the 6th Annual Health sector Review. This is adequate testimony of your commitment to the health sector in Zanzibar.

Secondly, I would like to thank all our guests, some of whom travelled a long distance to come to Zanzibar specifically for this meeting.

Thirdly, I thank the Health sector Reform secretariat for organizing this meeting here in Pemba and for choosing such a beautiful venue.

Your Excellency and distinguished guests, it is six years now since we started to conduct Annual Health Sector Review and the 1st meeting was held in 2006 following the inauguration of Health Sector Reform Secretariat in 2005. This Secretariat is the think tank of the Ministry and has done very good job in drafting laws, policies and guidelines etc. In due course , there were numerous reforms which took place in the Health Sector especial in the area of service delivery.

Your Excellency, Our theme for this year is 'We Must Change to Deliver Quality Health Care'. This theme conveys the message to health care providers to change their attitudes towards giving care to the people.

Mr. President you have insisted on many occasion that we should not continue and urged us to change our attitudes towards work, hence it is your words of wisdom that chose the theme for us.

Mr president, Since we gathered last year at Zanzibar town, for the 5th Annual joint Health Sector Review are always the same, and we are here today to review the health sector performance for the last year and discuss the constrains and challenges so that we can together plan the future of the health sector in the next year.

Once again, let me assure you that, the ministry of health Zanzibar is very happy and encouraged by representation of our development partners and other stakeholders I'm seeing in this room. Your active participation, contributions and continued commitments are indeed of paramount importance in our efforts to deliver quality health care to this country and improve the health status of our people.

Your Excellency,
I would like to take this opportunity once again to express our gratitude for joining us here in Pemba Island despite of many national and international commitments you have.

May I therefore call upon our host Honourable Minister for Health Zanzibar to say some few words and then welcome you.

I thank you for your attention and **KARIBUNI SANA PEMBA ISLAND**

ANNEX NO IV

SPEECH BY THE HON. MINISTER OF HEALTH, JUMA DUNI HAJI
ANNUAL JOINT HEALTH SECTOR REVIEW
MISALI SUNSET BEACH - 31ST OCTOBER 2011

- Your Excellency, the President of Zanzibar
- Hon. Regional Commissioner South region Pemba.
- Principal Secretary Ministry of Health, Chairperson of this Meeting
- Executive Director Zanzibar Planning Commission, Co - Chair
- Representatives of government sectors,
- Development Partners, both from Zanzibar and outside Zanzibar
- Delegation from Ministry of Foreign affairs Denmark
- Representative from Civil Society Organizations
- Our guests from the Ministry of Health Tanzania mainland,
- Other stakeholders and collaborators,
- Ladies and Gentlemen: Asalaam Alaikum.

Your Excellency
and distinguished Guests
Allow me to begin by thanking Almighty God for enabling us to be here today.

Secondly I would like to thank you, Your Excellency for agreeing to come and officiate our meeting.
Your Excellency, today we are having this conference in Pemba as part of our ministry of health culture to meet annually. This important forum is involving different experts and officials from public and private sectors within and outside Zanzibar. The meeting aims at critically discussing what Ministry of health Zanzibar has achieved, changes we encountered and deliberate on the way forward in the coming years. It is also a forum for partners to express their views, their objectives and areas of interest which will ultimately cement working relationship with the Ministry of health underscore problems and challenges ahead.

Mr. President, the theme of this year is "**Change**". **For us, Ministry of Health, it means change to deliver quality health services in Zanzibar**.
The theme has been designed with the special intention of facilitating more changes in health care service delivery to our people
.
The Ministry of health, do take care of various health and health related activities, but I would like to point out that one of the top priorities in the list is ' Reduction of Maternal Mortality'. Over the last five years our financial records shows that 6% donors support has been channelled to reproductive and child health care activities. If we are to achieve goal number 5 of reducing maternal mortality, in Zanzibar there is a need to increase the proportion of donor support to Reproductive Health. It would be more advisable if the funds/initiatives be better coordinated and they should focus on the factors that contribute to the maternal deaths we have been experiencing.

Mr President, in our efforts to reduce Maternal Mortality, the Ministry has taken serious efforts in investigating each and every maternal death, going all the way to the families and communities from where these mothers came, trying to understand why the pregnant woman was kept longer without taking her to the neighbouring primary health care or hospital. Hospital records are frequently reviewed and key decision-makers drew up recommendations on how each and every factor could be addressed. It is our hope that, this exercise will contribute to achieving MDG 5.

Your Excellency, Another area of priority which I have to mention is Non Communicable diseases most notorious of which are Diabetes, Cancers and Cardiovascular complications which are being diagnosed with increasing frequency. We in the Ministry of Health have conducted a quick assessment of NCDs in Zanzibar. The results will enable us to have good estimates of the prevalence of selected NCDs and their risk factors in Zanzibar, and it's time to act together, using evidence based interventions to prevent the rapid spread of these mainly chronic diseases. There will be a detailed presentation on NCDs at this gathering.

Mr President funding of the NCD area does not match the prevalence of these diseases or their risk factors. It is highly under-prioritized, and thus it has been difficult to attract finance from our partners despite its current global attention on UN conferences. More 'glorious' diseases and programmes are often favoured, thus strengthening the Primary Health Care for managing NCDs is critical for combating the epidemic of NCDs. The cost of supporting interventions to prevent NCDs is very minor to what it will cost to treat the diseases.

Your Excellency, the third priority of the Ministry is currently to revitalize the community health care strategy through decentralisation of health services, aiming at more community involvement and thus giving people the responsibility for their own health, by providing them a structure in which this can be done. Thus the theme "Change" means giving the ownership of the health services delivery to the community.

With these few words, I once again thank you very much Mr President for accepting our invitation to come and officiate the 6th annual Joint Health Sector Review here in Pemba. I also thank our development partners for collaborating with us in health care delivery.

Mr President I now would like to request you to come and give us your words of wisdom to this audience and then officially open our meeting.

Thank you very much for your kind attention.

ANNEX V

SPEECH BY THE PRESIDENT OF ZANZIBAR AND CHAIRMAN OF THE REVOLUTIONARY COUNCIL, HIS EXCELLENCY DR. ALI MOHAMED SHEIN AT THE OPENING OF THE OPENING OF THE SIXTH JOINT ANNUAL HEALTH SECTOR REVIEW MEETING. WESHA - PEMBA

October 31st, 2011

The Honourable Minister for Health,
The Honourable Regional Commissioner, South Pemba,
The Principal Secretary Ministry of Health, Chairperson of this Meeting,
The Deputy Principal Secretary Ministry of Finance & Economic Affairs, and Development Planning, the Co-Chair
Participants Representatives Development Partners,
Delegation from Ministry of Foreign Affairs Denmark
Representative from Civil Society Organizations
Representative from the Ministry of Health and Social Welfare Tanzania,
Distinguished Participants ,
Ladies and Gentlemen:

Asalaam Alaikum.

I am greatly honoured to be invited to officially open this important health forum involving different stakeholders, being the Sixth Joint Annual Health Sector Review Meeting. On behalf of the Government and people of Zanzibar, I would like to take this opportunity to welcome you all the distinguished participants from outside Zanzibar.

Please enjoy the green beauty of Pemba and hospitality of its peoples

Ladies and Gentlemen,

I am informed that, this meeting involves different stakeholders who will work in the spirit of partnership to make a comprehensive review of the implementation of programme and activities of the last four years This is a gigantic task but it is an essential one in planning for the future as well as identifying challenges.

As we approach 2015, the targeted year for the implementation of the Millennium Development Goal on health, it's important for all stakeholders, including the Government, to take stock of the present situation and consider the important areas to be worked on towards the achievement of MDGs. It is well known that the ministry of Health has an important role to play in ensuring the success of the implementation of the MDG targets and linking its activities within the National Strategies for Economic Growth and Poverty Reduction (MKUZA II and VISSION 2020). I am confident that the Ministry of Health is doing well in keeping track of the MDGs target through the planned goals and indicators.

Personally as a key stakeholder in health I'm pleased to acknowledge some of the notable achievements which took place in the past few years here in Zanzibar. Health services have expanded in terms of quality as well as quantity. These positive results are verified in terms of increase of services provided as well as impact in terms of health status of the population which has improved in the recent years.

The fight against communicable diseases that caused high burden of morbidity and mortality has shown remarkable achievements. It's well known that Zanzibar has almost reached a pre elimination status of Malaria with the prevalence below 1%, and now is planning towards elimination under the campaign of "***MALIZA MALARIA ZANZIBAR"***. Regarding HIV and AIDS we managed to maintain the status of

having a prevalence of less than 1% for the general population. This has persisted for almost a decade. I wish to take this opportunity to commend the Ministry of Heath personnel for their great contribution toward the achievement we have made. In the spirit of building a Prosperous New Zanzibar, you need to double your efforts.

I also wish to congratulate you for taking the correct decision of working in partnership with health stakeholders within and outside Zanzibar to find solution to most of the health problems facing our country. I urge you to maintain and expand this partnership.

I am happy to learn that the theme for this year is "**We must change to deliver quality health care".** This slogan has been well designed since it will alert the providers of health care and will motivate them with the notion that everything should not be reflected under the concept of despair at a time of diversity. We must accept to change attitude and recognize our ability to transform life situation. The life of yesterday can never be the same as the life of today or tomorrow, Let us remember Benjamin Disraeli, a former Prime Minister of Britain, who said in a speech 1867, Changes in inevitable in a progressive country. Change is constant. Therefore I urge all health care providers and other key stakeholders to be innovative in bringing about changes for betterment of our people's health. In doing this however, I believe quality health care should have a holistic approach and great care must be taken to make the changes useful and meaningful to our people. I agree with your theme that "***We must changes to deliver quality health care***". This process must involve all the personnel in the Health Sector and each person must play his or her part. It is only then that we shall bring change and make our people see improvement in the delivery of health services

Ladies and Gentlemen,

It is my sincere hope that in these two days deliberations you will be able to share and discuss critical issues that can be used as a basis for development of strategic interventions of delivering quality health care to our people. I see from your programme that you will discuss among other Research and training opportunities. Multispectral collaboration and Review of the Zanzibar Malaria Control Programme. In addition to these, I am sure that there will be a number of issues that will emerge which you will need to consider and priorities within your activities. With proper planning you should be able to meet the rising situations. I must say I am keenly interested in the discussions at meeting and the final resolution.

Let me take this opportunity to acknowledge the contributions made by various development partners and other stakeholders in supporting various sectors in Zanzibar, Health in particular. Your contribution has enabled the ministry to fill most of the gaps including financial & technical and therefore manage to accomplish the desired activities in time. I thank you all for your contribution and for the effective and productive partnership existing among us. It is my hope that this partnership will continue and grow.

I am glad that this meeting is being held here in Pemba which is mostly rural or semi urban side. As such it needs great attention in the provision of primary health care, the corner stone of our health system and the entry point to care for most of us. We have made remarkable progress in strengthening the district health activities. In an effort to strengthen the decentralization of health services the Ministry has initiated the Health Service Fund which is used by the relevant district, on their own initiative, to invest in outreach of immunization and ambulance services directly related to the MDGs of reducing under five years mortality and maternal mortality rates.

This funding modality is changing and I am proud that the MoH is the first in Zanzibar to engage in a basket fund. This basket fund has the aspiration of developing Zanzibar's first Sector Budget Support. This will

strengthen Government systems; ensure financial sustainability and increase transparency and accountability between all stakeholders. The success of this modality is of particular importance for the Government because it should act as a role model for other sectors in the development of Sector Budget Support. I hope that you will consider supporting us in this virgin territory, which would be in line with the Paris Declaration.

Ladies and Gentlemen

Another issue that has been on the agenda for the past many years is human resource for health. I recognize and appreciate efforts done so far in improving the situation especially in addressing the crisis. However, the present situation is not very encouraging. Placing skilled staff in the right places is difficult due to many factors including, insufficient incentive to attract and retain the required staff in the districts. This is a challenge of our time in all developing countries and not just Zanzibar. We need practical support to reduce the problem. I would like to assure you that the government is dedicated to address the challenges using the available resources. My appeal to all of you today is to support us

I wish to bring to your attention that several years of increased investment in the health sector has actually provided substantial improvement, not only in term of services output, but also in terms of improved health status of our population. I am proud that we have somehow succeeded to achieve the set milestone on some of the essential health status indicators; but we should realized that accomplishment of our future targets require sustained and increased efforts and investments. In partnership with all stakeholders we should be able to meet the MDG targets and realize our vision 2020 objectives.

Ladies and Gentlemen,

In conclusion, I am pleased to learn that there will e a field trips to visit some of the facilities and community health initiatives in Pemba. I am sure this will enable you to get an opportunity to witness some of the achievement we have made and the challenges to e addressed. I urge you to critical observe the situation and on return please feel to give us your views. It will also give you the opportunity to see the attractions of Pemba.

I wish you all and our visitors a happy stay in Pemba and all the participants a successful meeting.

With these remarks I now declare the 6th Joint Annual Health Sector Review 2011officially opened.

Thank you

ANNEX NO VI

Milestones and priority areas for Technical Working Groups/Units and Programmes of the Ministry for the year 2011-12

1. Background

A detailed review of the performance of the health sector in Zanzibar over the financial year 2010-11 was followed by a two-day meeting that included all key stakeholders. During the meeting field visits were made and discussions held over many aspects of quality health service delivery. The discussions focused on the need for change.

The meeting concluded with agreement on eight milestones and twelve priority areas for the Technical Working Groups of the Ministry of Health, its programmes and units. The priority areas are intended to provide focus for planning and implementing activities to for quality health care services delivery.

2. Milestones

Eight Proposed Milestones for 2011/12

1. Implement staff deployment system based on data of available staff and requirement.
2. Institute Performance Based Financing (PBF) system in 2 piloted districts of North A and Mkoani
3. Facilitate the implementation of Cost Sharing Guideline at all levels of health service delivery.
4. Establish 100 Sheahia Health Custodian Committees in selected Shehia
5. Adopt and implement Health Care Financing Strategy for Zanzibar.
6. Develop Zanzibar Health Sector Strategic Plan III (2011/2012 – 2015/16)
7. Develop long term National Nutrition Strategy
8. Review the implementation of Road map of RCH

3. Priority areas for Technical Working Groups/Units/ Programmes

Priority areas are presented under the following twelve headings:

1. **Financial and Programming matters:**
    a. Capturing all activities undertaken within the health sector and reporting to Ministry of Finance to facilitate accurate measurement of progress against MKUZA II indicators.
    b. Preparing relevant guidelines and systems for the Basket funding mechanism to replace the Health Services Fund by July 2012.
    c. Introducing affordable safe delivery.
    d. Expanding the review of Public expenditure to capture cross-cutting expenditure in other sectors that influence health outcomes (e.g. on water supply and roads).
2. **Health promotion**:
    a. Developing budget and allocating of resources to health promotion specifically.
    b. Introducing interventions to treat effectively and avert non -Communicable diseases.
    c. Monitoring of the provision of services at each level of the health system according to their mandate (PHCU,PHCU+,PHCC and referral hospitals) with an emphasis on provision of the required resources (equipment and human resources).
    d. Creating public awareness on matters and basic right to accessing or receiving quality services (basic) in line with the Ministry of Health policy, vision and mission to enhance quality of services and client satisfaction

3. **Human resource for health**:
    a. Recruiting, deploying and retaining human resources for quality service delivery.
    b. Capturing information on human resource database (by age and place of work) to allow for the monitoring of attrition rates and for decision-making on deployment, recruitment and training.
    c. Establishing system of accountability within the health workforce including career development paths and plans.
4. **Community based interventions**:
    a. Integrating community based interventions within existing systems to minimise the introduction of parallel systems.
    b. Accelerating the decentralisation process that results in the stimulation of local government & other Ministry, Department and Agency respectively to follow suit.
    c. The Systematic monitoring of community empowerment and client satisfaction so that quality care is provided [implementing community health packages in line with strategic plans].
5. **Governance**
    a. Integrating the Integrated Management of Childhood Illnesses (IMCI), Reproductive Health and Expanded Programme of Immunization (EPI) programmes to meet the needs of clients in a holistic manner and to maximise cost effectiveness through joint planning, budgeting, implementing and monitoring of activities.
6. **Quality health information system**:
    a. Improving the quality, reliability and user-friendliness of health management information.
    b. Establishing a health system data auditing platform/taskforce.
    c. Evidence based planning.
7. **Reproductive health services**
    a. Reviewing maternal mortality and improving, decentralising and monitoring family planning services to achieve MKUZA II indicators and Millennium Development Goals.
8. R**esearch, monitoring and evaluation**
    a. Including research, monitoring and evaluation data and findings from supportive supervision to inform planning of interventions and for decision making within the Ministry of Health.
9. **Coordination platforms**:
    a. Sharing of relevant information with stakeholders periodically within and outside the Health Sector.
    b. Enhancing Development Partner participation in the Technical Working Groups etc. to allow for effective and efficient planning for emerging areas including ad hoc emergency and routine interventions.
    c. Establishing a health think tank to encompass all Development Partners
    d. Including key stakeholders (irrespective of their size) in guideline development
    e. Establishing thematic technical working groups.
10. **Referral system**
    a. Establishing a formal referral mechanism/system.
11. **Public Private partnership:**
    a. Redefining the mechanisms and modus operandi on public partnership (set standard operating and collaborating procedures).
12. **Infrastructure and maintenance issues.**
    a. Adhering to an infrastructure master plan and equipment maintenance schedule.

ANNEX VII PARTICIPANTS GROUP PHOTO