REVOLUTIONARY GOVERNMENT OF ZANZIBAR

MINISTRY OF HEALTH

HEALTH SECTOR STRATEGIC PLAN IV

2020/21 – 2024/25

NOVEMBER 2021

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Foreword

Health sector is very important in ensuring that the health status and living standards of the population is improved. After the Great Revolution of Zanzibar in 1964, the Revolutionary Government of Zanzibar embarked on improving the health of her people by providing health services free of charge and aimed at reaching universal healthcare coverage. This strategic plan gives the direction of where the sector aims to be in the next five years; it gives a pure and fresh direction of the Ministry of Health, Social Welfare, Elderly, Gender and Children in achieving universal health care coverage and admirable social services delivery to her people.

It gives comprehensive explanation of the desired outcomes needed to be attained for the next five years including: improved maternal and child health, improved quality of health services as per Essential Health Care Package (EHCP) at all levels; improved social protection schemes aimed at prompting inclusive economic growth and reducing vulnerability; attainment of gender equality and equity, social inclusion and empowerment of women, girls, widows and people with disabilities and people in vulnerable situations; increased financial resources for Zanzibar health sector used according to stated priorities; enhanced prevention of and response to violence against women and children; increased financial resources for Zanzibar; strengthened planning and budgeting system with accountability and transparency; strengthened health sector governance at all levels; improved planning and budgeting capacity at district level to address national as well as local priorities; strengthened partnership to align with RGoZ systems, policies and guidelines; strengthened referral system according to an Essential Health Care Package; sufficient coverage with well-maintained functional infrastructure equipment and transport; effective emergency preparedness system in place; ensured availability, access, safety and efficacy and rational use of essential medicine, reagents and medical products; improved human resources; and strengthened Health Information Systems and M&E at all levels.

This Health Sector Strategic Plan IV (HSSP IV) is formulated through the guidance from The Zanzibar vision 2050 and ruling party manifesto (2020 – 2025), following the new format of the Balanced Score Card system. The effort and support for health sector from all stakeholders such as national and international donors could be the main pillar for the attainment of the Strategic Plan IV.

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Acknowledgment

On behalf of the Ministry of Health, I would like to express my appreciation to all organizations and individuals who supported the review and updating of this Strategic Plan. Many Individuals and organizations devoted their time, efforts, and resources to ensure this endeavour is achieved.

I would like to thank all who provided inputs through community participation assessment convened by MoH to solicit inputs for the development of the Strategic Plan. In particular, I would like to sincerely acknowledge all technical team members for their invaluable inputs towards the development of this strategy plan.

I would like to recognize and mention a few individuals that made specific contributions to the process. Ms. Attiye J. Shaame, the former Director of Planning, Policy, and Research of the MoH who provided strong leadership and guidance to the process. Her support and encouragement at various stages were critical for the completion of the assignment, the staff of the Division for Budgeting and Planning for their active participation throughout the entire process. I would also like to thank Dr. Finn Schleimann, the Senior Health Advisor who was always available to support the team technically at all times. In the same breath, I would like to recognize and appreciate the participation and leadership of Ms. Halima M. Salum, the former Deputy Principal Secretary MoH, at the time.

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The technical and financial resources for this undertaking were provided through Basket Fund. This included the provision of a technical advisor to support the process, meetings with community members, units and programs, and other potential stakeholders.

Last but not least, I would like to acknowledge those organizations and individuals who contributed in one way or another towards the completion of the document.

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Executive summary

1.1 Achievements of the HSSP IV

At the end of this strategic plan, the Ministry of Health (MoH), Zanzibar will have moved decisively towards Universal Health Coverage (UHC), reduced poverty and increased standard of living by having:

An Essential Health Care Package (EHCP) that ensures that all Zanzibaris receive cost-effective, quality health services; curative as well as preventive and promotive care that addresses the vast majority of illness and disability.

Implemented a financing strategy that ensures sufficient financing of the EHCP, equity in health care as well as protection against catastrophic health events, enhanced economic development and social wellbeing.,

This will be made possible by ensuring substantially increased financial resources for health sector.

Motivated skilled Staff in place according to revised norms. Sufficient and well-maintained buildings, equipment, and transport. Availability of essential medicines and medical commodities.

1.2 Background

Zanzibar throughout its history had a strong commitment regarding Primary Health Care. This has resulted in good coverage with health infrastructure and well-developed support systems for example for planning and medicines and related commodities supply.

Zanzibar through the Union Government of Tanzania is a signatory to the Sustainable Development Goals (SDGs), which include the goals of good health and well-being within the health sector. The RGoZ is determined to fulfil the key health-related SDG target of Universal Health Coverage.

The health sector has had several strategic plans, with the latest being the Health Sector Strategic Plan III, therefore this plan is named the Health Sector Strategic Plan IV (HSSP IV).

The HSSP IV has been developed in a collaborative manner that included all departments and several key stakeholders.

1.3 MoH Mission and Vision

Mission

The Mission of the MoH is to ensure universal access to health and social protection services delivered in a comprehensive range of quality, equitable, and efficient to all people in Zanzibar.

Vision

Vision healthy population and social well-being. The HSSP IV is a key element in achieving the overall visions and development goals of Zanzibar's Vision 2050, the Zanzibar Development Program as well as the Zanzibar Health Sector Policy.

Achieving the results envisioned by implementing the HSSP IV is dependent on the priority given by the Revolutionary Government of Zanzibar (RGoZ) to the health sector, including budget allocation of the sector in the annual budget approved by the House of Representatives.

1.4 Key elements of MoH HSSP IV

The HSSP IV aims at achieving thirteen strategic results:

Table 1:MoH HSSP IV Strategic Results

Improved quality of health services as per EHCP at all levels
Increased financial resources for Zanzibar health sector used according to stated priorities
Strengthened planning and budgeting system; accountability and transparency
Strengthened health sector governance at all levels
Improved planning and budgeting capacity at district level to address national as well as local priorities
Strengthened referral system according to EHCP
Sufficient coverage by well-maintained functional infrastructure, equipment, and transport
Effective emergency preparedness system in place
Ensured availability, access, safety and efficacy, and rational use of essential medicine, reagents, and medical products
Improved Human Resources for Health
Strengthened Health Information Systems and M&E at all levels
Well-coordinated health and health-related research for decision-making

1.5 Key Performance Indicators

A number of performance indicators have been selected as well as targets to be achieved for each of these. In the table below are few key indicators, with base-line values and targets:

Table 2:Performance Indicators with targets

Indicator	Baseline	Target (2023/24)
Institutional Maternal death	166 per 100,000	96 per 100,000
Health Facility Delivery	66%	100%
New Family Planning adopted	7%	20%
Coverage of 8+ ANC visits	Unknown	41%
PNC visit with correct timing (48h)	78%	>90%
Children <1 year fully immunized	88%	>90%
Out-Patient Department (OPD) visits per capita	1	1
Vaccination with HPV	54%	>90%
Current Health Expenditure as % of Gross Domestic Product	3%	5%
Current health Expenditure per Capita is US $	30	50
Percentage of facilities with stock outs of essential medicine	11%	0%
Percentage of facilities meeting minimum staffing norms	-	80%

1.6 Cost of the HSSP IV

Below is the cost of achieving the Strategic Goals including reaching the set targets by implementing the HSSP IV's Strategic Initiatives: This costing is made using the WHO one health tool which is the health services oriented and does not consider the administrative costs.

Table 3:Cost of implementing HSSP IV over five years' period

Cost of MoH HSSP IV (in TZS)	
Recurrent Cost	669,068,000,000
Development Cost	166,578,000,000
Total	**835,646,000,000**

The total cost for the health sector is estimated at 360 million USD over 5 years, giving a yearly government health expenditure of around USD 50/capita, compared to the current government expenditure plus that of developments partner partners which is USD 25/capital.

Terms and Abbreviations

AJHSR	Annual Joint Health Sector Review
ANC	Ante-natal care
ART	Anti-retroviral Treatment
CGC	Chief Government Chemist
CGCLA	Chief Government Chemist Laboratory agency
CGP	Chief Government Pharmacist
CHE	Current Health Expenditure
CHV	Community Health Volunteer
CMS	Central Medical Store
CPO	Chief Pharmacist Office
CSO	Civil Society Organisation
DAHR	Director Administration & Human Resources
DCS	Director Curative Services
DHIS2	District Health Information System
DHMT	District Health Management Team
DP	Development Partner
DPG	Development Partners' Group
DPPR	Directorate of Planning, Policy & Research
DPS	Director Preventive Services
EHCP	Essential Health Care Package
eLMIS	Electronic Logistic Management System
EMONC	Emergency Obstetric & New-born Care
FY	Financial Year (July-June)
FM	Financial Management
HB	Health Bulletin
HIV	Human Immunodeficiency Virus
HIS	Health Information System
HMIS	Health Management Information System
HPU	Health Promotion Unit

HRH	Human Resources for Health
HRIS	Human Resource Information System
HSSP	Health Sector Strategic Plan
ICD	International Classification of Diseases
ICT	Information & Communication Technology
IDSR	Integrated Disease Surveillance & Response
IDWE	Infectious Disease Weekly Ending
IFMIS	Integrated Financial Management System
IMCI	Integrated Management of Childhood Illness
IRCH	Integrated Reproductive and Child Health
IRS	Indoor Residual Spraying
IT	Information Technology
LLIN	Long Lasting Impregnated Net
LMIS	Logistics Management Information System
LMU	Logistics Management Unit
M&E	Monitoring & Evaluation
MDA	Ministries, Departments & Agencies
MDR	Multi-drug resistance
MIS	Management information system
MMH	Mnazi Mmoja Hospital
MMR	Maternal Mortality Rate
MoF	Ministry of Finance
MoH	Ministry of Health
MoFP	Ministry of Finance & Planning
MoU	Memorandum of Understanding
MPDSR	Maternal & Perinatal Deaths Surveillance & Response
MTEF	Medium Term Expenditure Framework
MTR	Mid Term Review
NCD	Non-Communicable Disease
NGO	Non-Governmental Organisation
NHA	National Health Account
NIMR	National Institute of Medical Research
NPA	National Plan of Action

NTD	Neglected Tropical Diseases
OCAGZ	Office of the Controller & Accountant General of Zanzibar
OHT	One Health Tool
OHU	Occupational Health Unit
OOPS	Out of Pocket Spending
OPD	Out-Patient Department
OPRAS	Open Performance Review and Appraisal system
OSH	Occupation Safety and Health
PBB	Program Based Budgeting
PHCU	Primary Health Care Unit
PLHIV	People Living with HIV
PoA	Plan of Action
PoFP	President Office Finance and Planning
PORALG-SD	President's Office Regional Administration & Local Government & Specialised Departments
PPP	Public Private Partnership
PS	Principal Secretary
RGoZ	Revolutionary Government of Zanzibar
QA	Quality Assurance
RAS	Regional Administrative Secretary
RBF	Results-Based Financing
RMCH	Reproductive, Maternal & Child Health
RMNCAH	Reproductive, Maternal, New-born, Child& Adolescent Health
SDG	Sustainable Development Goal
SHCC	Shehia Health Custodian Committee
SME	Standard Medical Equipment
STI	Sexually Transmitted Diseases
SOP	Standard Operating Procedure
HSSP	Health Sector Strategic Plan
SUZA	State University of Zanzibar
SWOC	Strengths, Weaknesses, Opportunities & Challenges analysis
SWOT	Strengths, Weaknesses, Opportunities & Threats analysis
TB	Tuberculosis

TBD	To Be Determined
TDHS	Tanzania Demographic & Health Survey
THE	Total Health Expenditure
THIS	Tanzania HIV Infection Survey
TMIS	Tanzania Malaria Infection Survey
TMU	Traditional Medicine Unit
U5Y	Under 5 Years
UHC	Universal Health Coverage
UN	United Nations
UNDAP	United Nations Development Assistance Plan
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
WCF	Workers' Compensation Fund
WHO	World Health Organisation
ZADES	Zanzibar Development Strategy
ZAHREC	Zanzibar Health Research Ethical Committee
ZAHRI	Zanzibar Health Research Institute
ZAMEP	Zanzibar Malaria Elimination Program
ZBS	Zanzibar Bureau of Standards
ZCHS	Zanzibar College of Health Sciences
ZFDA	Zanzibar Food and Drug Agency
ZHBF	Zanzibar Health Basket Fund
ZIHTLP	Zanzibar Integrated HIV, TB & Leprosy Program
ZILS	Zanzibar Integrated Logistics System
ZNMC	Zanzibar Nurses & Midwives Council
ZPC	Zanzibar Planning Commission
ZSGRP	Zanzibar Strategy for Growth & Reduction of Poverty

SECTION ONE: INTRODUCTION AND BACKGROUND INFORMATION

1.7 Introduction

1.7.1 Development of Health Sector Strategic Plan IV

The HSSP is focused on the goal of moving towards achieving Universal Health Coverage, full participation and making the decision, which will ensure delivery of quality, equitable and affordable health to improve health status, financial protection and client satisfaction. These are targets set by the international community as part of the Sustainable Development Goals (SDGs) and endorsed by the Revolutionary Government of Zanzibar (RGoZ).

The Health Sector Strategic Plan IV (2020/2021 – 2024/2025) was developed in a participatory process under the leadership of the Ministry of Health (MOH), with the inputs from Governmental, Non-Governmental and Private Sector Partners, with contributions from Ministries, Departments and Agencies (MDAs and from Development Partners (DPs). Interventions were prioritised based on available resources and defined realistic targets for Health.

HSSP IV used a Balance Score Card approach, which is a strategic planning and management system that is used to align and communicate prioritized projects, products, and services. The system also measures and monitors progress towards strategic targets. The developed HSSP IV will be cascaded down through the organization, objectives to become more operational and tactical, as do the performance measures.

In March 2018, the Zanzibar Planning Commission developed a "Guideline for Developing Strategic Plans for Ministries, Departments and Agencies in Zanzibar" to guide all MDAs in Zanzibar in developing/reviewing their strategic plans. This HSSP IV developed used a format provided by the above-mentioned guideline.

Importance of Developing a Sector Strategic Plan

Health sector is a complex sector and therefore it need a clear strategic direction and priorities to steer many different elements of the sector towards achieving the overall mission and vision for the Ministry. The Strategic Plan is fundamental to provide guidance on global and national multi-sectoral strategies as well as providing broad direction in emerging and re-emerging health conditions.

Similarly, this strategic plan will help all staff to be accountable and working together towards the ministry's goals.

1.8 Zanzibar's Development Agenda

The HSSP IV is defined and aligned with the Key National and International documents such as Zanzibar Development Vision 2020 - 2050 (Vision 2020/2050), Zanzibar Health Policy 2011.

The Zanzibar Development Vision 2020 - 2050 (Vision 2020/2050) is a document that provides direction for long-term development. The Government Health Policy focuses on improving health and sustaining the well-being of the people of Zanzibar.

1.8.1 Zanzibar Development Vision 2020 – 2050

The Vision 2050 emphasizes on the provision of basic health services for all people without discrimination, combating epidemics, maternal and childcare services and the dissemination of health education for all so as to create the opportunity for all Zanzibaris to live a decent, safe and secure life. To attain the above, vision 2050 provides direction under the priority area defined as "**HUMAN CAPITAL AND SOCIAL DEVELOPMENT"** of which, the health sector is among the components of social services.

The following are aspirations stated in **vision 2050.**

- Universal health coverage with emergency medical care and referral services across Zanzibar to improve access to health care in underrepresented areas.
- A highly reliable and accessible primary health care sector that incorporates strong health promotion and community health programs targeting the prevention and management of non-communicable and communicable diseases, including HIV/AIDS.
- A modern health care delivery system supported through an effective investment plan and related interventions with a focus on human capital development, health research, infrastructure, medical technology, digital health system, quality control as well as specialised medical and health practitioners and services.
- Inclusive, high-quality services for the elderly and people with disabilities as well as in reproductive, maternal, neonatal, child, and adolescent health to reduce mortality and malnutrition as well as to manage population growth.
- A multi-sectoral approach to health care at the forefront of social services by strengthening linkages to education through training, to water, sanitation, and hygiene through disease prevention, and to tourism through medical tourism where appropriate.
- A resilient health care system with adequate contingency plans to maintain the high coverage of essential services in crises.

- Diverse and sustainable health care financing for quality service provision to all.

1.8.2 Zanzibar Development Strategy

Overall development in Zanzibar is governed by the Zanzibar Development Strategy covering the period 2021-2026. The strategy put more emphasis in the provision of basic health services for all and health education towards achieving Universal Health Coverage.

1.8.3 Zanzibar Policies on Health Sector

The health sector is guided by:

1) **Zanzibar Health Policy** from 2011, with the vision of "a healthy population with reliable and accessible preventive and curative health services" and a mission to "ensure that all Zanzibaris secure their right to quality and equitable health services rendered through Primary Health Care approach".

1.8.4 Sustainable Development Goals and Other International Guidance

Zanzibar agrees with the global Sustainable Development Goals (SDGs)1, including the key cross-cutting indicator for health namely UHC. The SDGs, as well as the One-Health approach, emphasize on the crucial importance of multi-sectoral action for improving the health and social well-being of the population.

The HSSP IV is aligned with and contributing to the national goals in provision as described below.

[1]The United Republic of Tanzania is a signature to the Sustainable Development Agenda

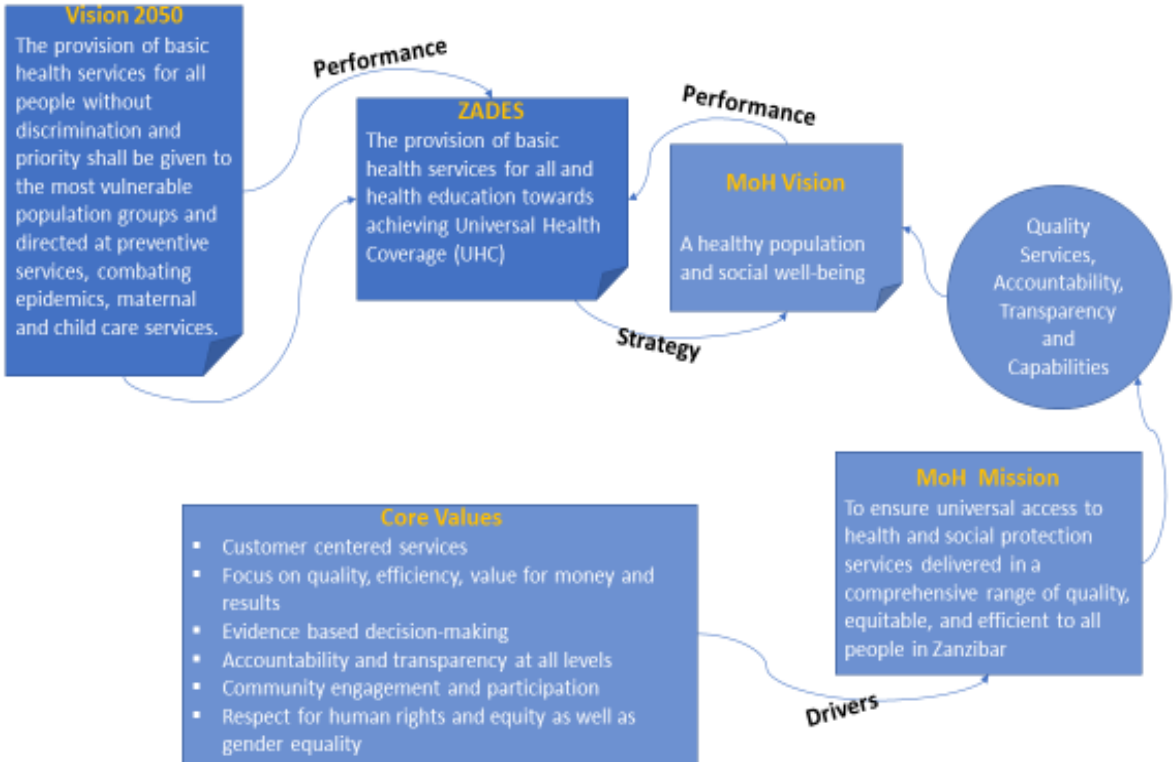


Figure 00-1:Alignment of National Goals in the provision of Health & Social Services Delivery

1.9 Organisation Description

MoH is overall responsible for the strategic direction of the sector. Primary level services are run by District Health Management Teams and their associated facilities. Secondary health care services are rendered by district and regional hospitals, while tertiary health services are provided by Mnazi Mmoja Hospital (MMH) - a semi-autonomous institution. Apart from the mentioned public health sector, there is a large number of private sector institutions providing a different level of health care to the community, within the framework of the relevant laws and regulations as well as oversight by government institutions, and in some cases as specific public private partnerships (PPP).

There are various Health Professional Boards and Councils under the MoH which are responsible for the promotion of transparency, professionalism, and accountability within the professions. The Boards and Councils also have a mandate on the provision of technical advice to improve health service delivery at all levels including assuring technical standards of staff and ethics.

There is also a Private Hospital Advisory Board that ensures private facilities provide quality health services by qualified and skilled health personnel.

The execution of the HSSP IV will depend on the active participation of different actors. The coordination among the implementers at all levels is crucial for this endeavour.

1.9.1 Public Private Partnership

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

Roles of different stakeholders in service delivery are:

1) **Ministry of Health:**

- Responsible for setting norms and guidelines for the health sector.
- Overall responsible for District and Regional Hospitals
- Facilitating preparation of sector work plan
- Conducting Supportive Supervision for Councils as well as District and Regional Hospitals

2) **Mnazi Mmoja Hospital:**

- National referral hospital that is a semi-autonomous institution under MoH.

- Providing tertiary health care services
- Teaching hospital for SUZA and other training institutions in and out of Zanzibar
- Conducting health related research

3) Regional and District Hospitals:

- Administratively under Director Curative Services.
- Provision of secondary health care services

4) District Health Management Teams:

- Responsible for health care service delivery at the Primary Level. Administratively under Director Preventive Services & Health Education

5) Private health sector providers:

- Private hospitals, clinics, laboratories and pharmacies. Supervised and governed by RGoZ regulations and institutions, including the Private Hospital Board.

1.10 Objectives and Desired Strategic Results of Sector Strategic Plan IV

1.10.1 Strategic Objectives

The following are the **Objectives of this Strategy:**

1) Establish and supervise the implementation of the health Policy and guidelines.
2) Facilitate and sensitize research for decision making and evidence-based planning.
3) Ensure availability of skilled Human Resources for Health (HRH) at all levels.
4) Ensure equitable, affordable, and accessible quality health services to the community.
5) Improved social services and wellbeing aimed at succeeding a healthy and educated population.
6) Ensure availability of quality essential medicine and medical supplies.
7) Promote sensitive health education to the community on communicable and non-communicable diseases.

8) Ensure access to quality and safe food and food products, pharmaceutical and cosmetics products.

9) Improve leadership and governance (particularly setting direction and regulations) across the health sector and at all levels of the systems.

10) Improve the quality information and make it accessible to all intended users for evidence–based decision making through standardized and harmonised tools across all programs.

1.10.2 Strategic Results

The above objectives are aimed at providing a strategic framework for reaching the following Strategic Results:

1) Improved quality of health services as per EHCP at all levels

2) Increased financial resources for Zanzibar Health Sector used according to stated priorities.

3) Strengthened planning and budgeting system with accountability and transparency.

4) Strengthened health sector governance at all levels.

5) Improved planning and budgeting capacity at district level to address national as well as local priorities.

6) Strengthened partnership to align with RGoZ systems, policies, and guidelines.

7) Strengthened referral system according to EHCP.

8) Sufficient coverage by well-maintained infrastructure, equipment, and transport

9) Effective emergency preparedness system in place

10) Ensured availability, access, safety and efficacy, and rational use of essential medicines reagents, vaccines, and medical products.

11) Improved human resources for health.

12) Strengthened health information system and M&E at all levels.

13) Well-coordinated health – and health-related – research for decision making.

1.10.3 The Desired Success of the Strategic Plan

At the end of the HSSP IV, Zanzibar will have moved decisively towards UHC, reduced poverty, and increased standard of living by having:

1) A revised Essential Health Care Package that ensures that all Zanzibaris receive cost-effective, quality health services, curative as well as preventive and promotive, that addresses the vast majority of causes of illnesses and disabilities.
2) A well-developed financing strategy that will be implemented ensuring sufficient financing, equitable consumption of health services as well as protection against disastrous health events.

This will be supported by achieving the following **essential targets:**

1) Substantially increased financial resources for health sector
2) Implementation of the revised Essential Health Care Package (EHCP)
3) Filling of the majority of staff posts according to revised norms for staffing at all facilities.
4) Well maintained buildings, equipment, and transport, equipped according to guidelines.
5) Availability of all essential medicines and related commodities with minimal stock-outs.

SECTION TWO: ORGANIZATION PERFORMANCE REVIEW

2.1 Health Sector Performance Review

During the implementation of the HSSP III appreciable achievement were noted. Table 1 below shows the core targets and achievements reported.

Table 4:Core targets and achievements reported.

INDICATOR	HSSP III Baseline	HSSP III Target (2018/19)	Achievements 2016/17	Achievements 2018 (HB 2018)
Institutional MMR	310	111	119	155
Facility deliveries	59.4%	80%	62,2%	67%
Skilled personnel deliveries	53.7% (2010)	90%	63.3%	-
1st ANC visit	99.4% (2010)	100%	81,4%	85.5%

INDICATOR	HSSP III Baseline	HSSP III Target (2018/19)	Achievements 2016/17	Achievements 2018 (HB 2018)
4th ANC visit	30.9% (2013)	60%	28%	30.3%
PHCUs+ providing BEMONC	19 (2013)	34	34	49
PHCUs w. Comprehensive Post Abortion Care	21 (2013)	83	34	7
Facilities w. 80% staff trained IMCI	38% [2013]	80%	82%	-
< 1 year immunization rate	84.1% (2013)	>90%	67,5%	78%
<1 year Penta 3 rate	81.2% (2013)	>90%	83,9%	86%
<1 year Measles immunisation rate	89.3% (2013)	>90%	68,4%	92.8%

A situational analysis of the sector is found in Annex 2.1

The following are the key challenges to moving towards UHC identified:

1) HRH

- Inadequate number of skilled staff at all levels
- Inadequate specialists in number and mix at secondary and tertiary levels of care.

2) Financing

- The escalating cost of health care,
- High out of pocket spending on health

3) Health problems/Service delivery

- High maternal mortality
- Change in disease pattern from communicable to non-communicable diseases.
- Inadequate medicine and medical supplies
- Lack of defined essential benefits package according to population need.

SECTION THREE: ORGANIZATION STRATEGIC ASSESSMENT

3.1 SWOC.

The SWOT table below outlines the strengths and weaknesses of the MoH as well as the broader health and social sectors and the opportunities and threats faced.

Table 5: SWOC

	STRENGTHS What do we have?	**WEAKNESSES** What are our shortcomings?
INTERNAL	- Good policy framework in place - Strategies, Laws, Regulations, and Guidelines in place in many areas - Long tradition of comprehensive planning and budgeting modalities (e.g., MTEF, PoA) - Availability of reporting tools: PoA Reporting Tool, Bango Kitita, etc. - Proper Public Financial Management (PFM) rules & regulations in place - Regular Program and operations reviews such as AJHSR and MTR Extensive health infrastructure (high tech	- Grossly insufficient health financing funds for given the ambition of providing free health services to all. - Delays in fund disbursement, due to long bureaucratic government administrative procedures - Inadequate quality and quantity coupled with insufficient human resources in number and skills mix. - Inadequate HRH development, management, and retention measures Inadequate technical and managerial capacity in some many areas and at all levels
	- and state of the art medical equipment, modern health facilities) - Some well-functioning disease-specific programs - Well-structured coordination platforms such as SWAp Committee, AJHSR, DP Health Group, Technical Working Groups, technical and political leadership	- Inefficient fragmented planning, budgeting, reporting, and accounting systems - Insufficient Public Financial Management (PFM) capacity and no value for money audit - Inadequate implementation of policies and particularly

	STRENGTHS What do we have?	**WEAKNESSES** What are our shortcomings?
	- In-depth, participatory revision of EHCP - Availability of Digital Health Strategy - Existence of national and international policies and guidelines as well as networks	enforcement of regulations and guidelines - Missing strategies, regulations, and/or guidelines in some areas - Inadequate commodity forecasting capacity leading to frequent stock-outs of medicine and other supplies. - Inadequate diagnostic facilities - Lack of preventive maintenance plans leading to inadequate preventive maintenance of facilities and equipment - Shortage of transport for prompt referral and other services - Inadequate information sharing and use due to limited capacity on HMIS. - Limited information sharing - Limited use of information for decision making - Fragmented supportive supervision to vertical programs and lack of national integrated supportive supervision guidelines. - Weak collaboration with the private sector as well as insufficient enforcement of regulation of the private sector. - Inadequate multi-sectoral platform - Lack of Emergency Response Unit and plan

	STRENGTHS What do we have?	**WEAKNESSES** What are our shortcomings?
		- Poorly functioning IDSR system - Low uptake of family planning - Decline in immunization coverage. - Not all Technical Working Groups functioning well. - Low capacity on additional resource mobilization - Inadequate capacity in fundraising advocacy
EXTERNAL	- The political focus on health could be increased in the context of UHC. - The on-going development of a Health Financing Strategy can improve the mobilisation, channelling, and targeting of resources. - Work in progress on health financing options - The Basket Fund provides a harmonised and efficient donor funding modality that could be scaled up. - Improving and building on the PoA system - Community Health Workers/Volunteers system could improve both preventive services, demand side, and accountability. - Building on the HMIS systems and capacity already in place and improving it to make data and anorsis available at all levels for decision making. - Making the new SWAP committee functioning thereby improving	- Maintain strong involvement of Councils in health issues following the re-centralisation. - High population growth - Financial sustainability, including that DANIDA, a major donor and technical partner is phasing out. - Investments in tertiary care may compete with securing adequate financing for PHC. - No strong incentive to improve PFM. - High level of travel/migration into Zanzibar - Competition for HR from the private sector and NGO/CSO sector, as well as from job opportunities abroad - Partner/DP preference for a vertical approach - Political dynamics - The unpredictability of donor funding - Limited multi-sectoral coordination

	STRENGTHS What do we have?	**WEAKNESSES** What are our shortcomings?
	strategic discussions and decisions as well as partner coordination and alignment. - Improving the AJHSR to focus more on the most important strategic issues and bottlenecks to performance. - Collaboration and synergy with otheremployees. e.g. education - Working with and support from external organisations (DPs, research, clinical; UN organisations, etc.) and regional initiatives as well as NGOs/CSOs - Existence of DPG-Health platform for improving and harmonizing donor support - The work on quality assurance recently started with assistance from external partners could be given high priority, and result in improved health services. - Innovative use of IT - Use traditional media and social media. - Enforcing national and international policy guidelines and strategies including Vision 2050, UNDAP 2018-2022, and MKUZA III	

3.2 Stakeholder's Analysis.

The table below outlines the key stakeholders, core services of the MoH as well as the health sector and the expected benefits.

Table 6:Stakeholder Analysis

STAKEHOLDER	CORE SERVICES	EXPECTED BENEFITS	MOH EXPECTED BENEFITS
Community	Health promotion and prevention. Curative. Home base care; and Rehabilitation services, Social Services delivery.	Availability of quality services. Accessibility; and Affordability. Equality and Equity; Access to informunits. and Participation.	Community
Development Partners	Technical. Financial; and Capacity-building support	Proper utilization of support (technical and financial). Ministry collaboration in accelerating progress towards international agenda recognition. Availability of reliable and timely report. Good governance; Sharing of good experiences and best practise.	Development Partners
Non-State Actors (NGOs, FBOs, CSO	Provision of health services;	Full support to provide health services. Collaboration and integration. Guidance through policies, plans, and international conventions.	Non-State Actors (NGOs, FBOs, CSO

STAKEHOLDER	CORE SERVICES	EXPECTED BENEFITS	MOH EXPECTED BENEFITS
		Financial assistance and capacity building. Availability of reliable, relevant information. Monitoring and evaluation.	
Health Private sectors	Provision of health services. Apply SOPs to deliver quality health services. Record service data. Abide with Private Hospital Act and Regulation. Work closely with the Private hospital Advisory Board.	Follow up and supervision. Data collection tools, Guidelines and SOPs. Support provision of RMNCAH services.	Health Private sectors
Local Government	Support District level health services delivery Support community-based health campaigns	Financial and logistical support	Local Government
Other MDAs		Operationalize health interventions according to the MOH demands (WASH, food security, and nutrition). Enforcement of law and regulation. Provision of national guidelines (budget guideline).	Other MDAs

STAKEHOLDER	CORE SERVICES	EXPECTED BENEFITS	MOH EXPECTED BENEFITS
		Good coordination and cooperation. Monitoring and Evaluation.	
Companies (e.g., ZAT, ZANTEL, TRCA)	Information sharing. Health promotion and education.	Cooperation and support.	Companies (e.g., ZAT, ZANTEL, TRCA)
Media-printed, TVs, Radio, social media	Information sharing. Health promotion and education.	Reaching wider population targets. Uniform messages and Collaboration and cooperation. Reliable and relevant information.	Media-printed, TVs, Radio, social media
Community	Health promotion and prevention. Curative. Home base care; and Rehabilitation services, Social Services delivery.	Availability of quality services. Accessibility; and Affordability. Equality and Equity. Access to information and Participation.	Community

SECTION FOUR: INTERNAL STRATEGY IMPLEMENTATION PROCESS

This section graphically highlights the strategy implementation process for the successful execution of the HSSP IV (2020 – 2025). The implementation will require a coordinated and integrated approach by various stakeholders at different levels including central government, financial institutions, Planning Commission, development partners, communities, and other potential stakeholders. Furthermore, the implementation also calls for a costed plan with a clearly defined monitoring and evaluation system.

The figure below outlines the most significant institutional relationships and activities that will ensure the effective implementation of the HSSP IV.

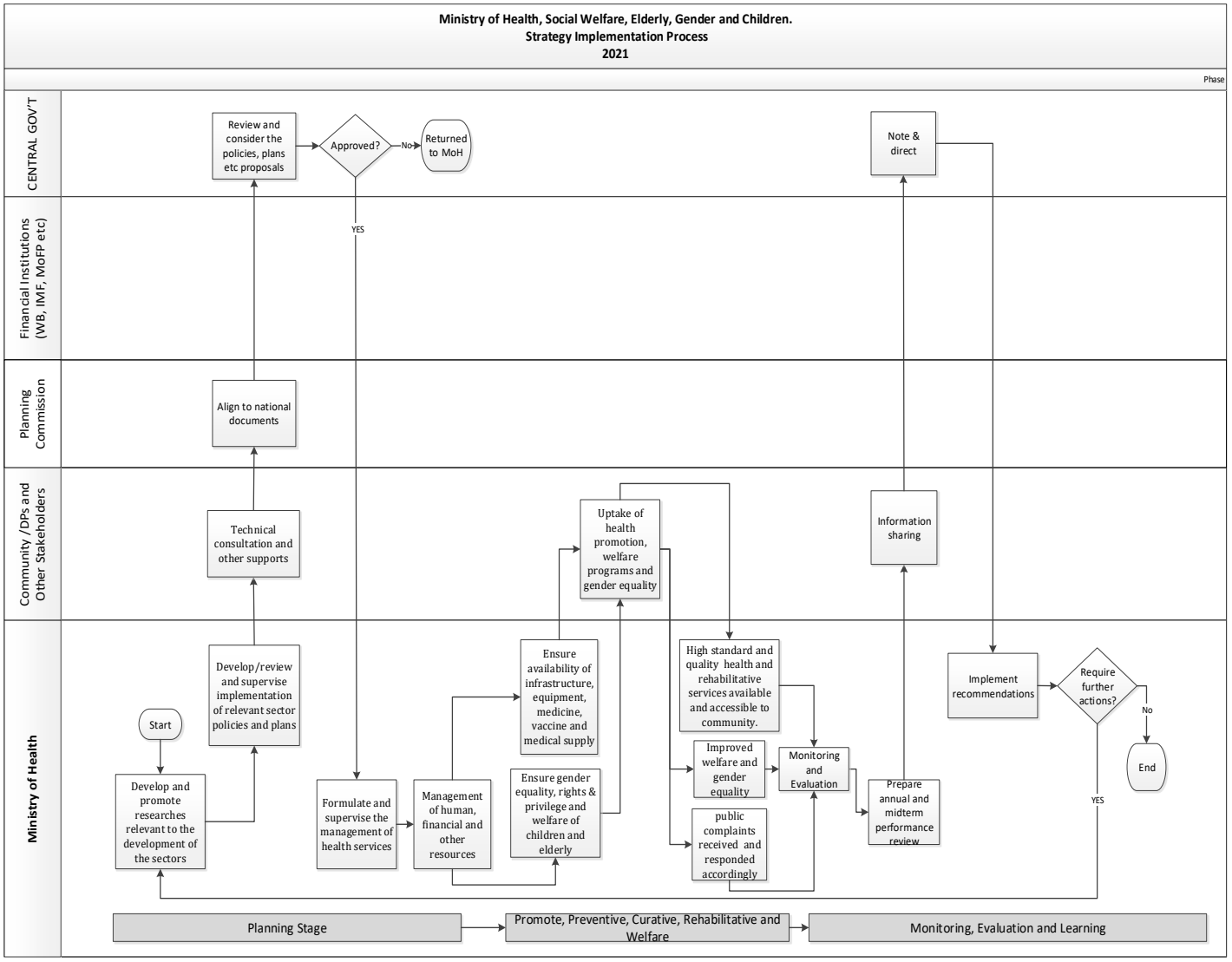
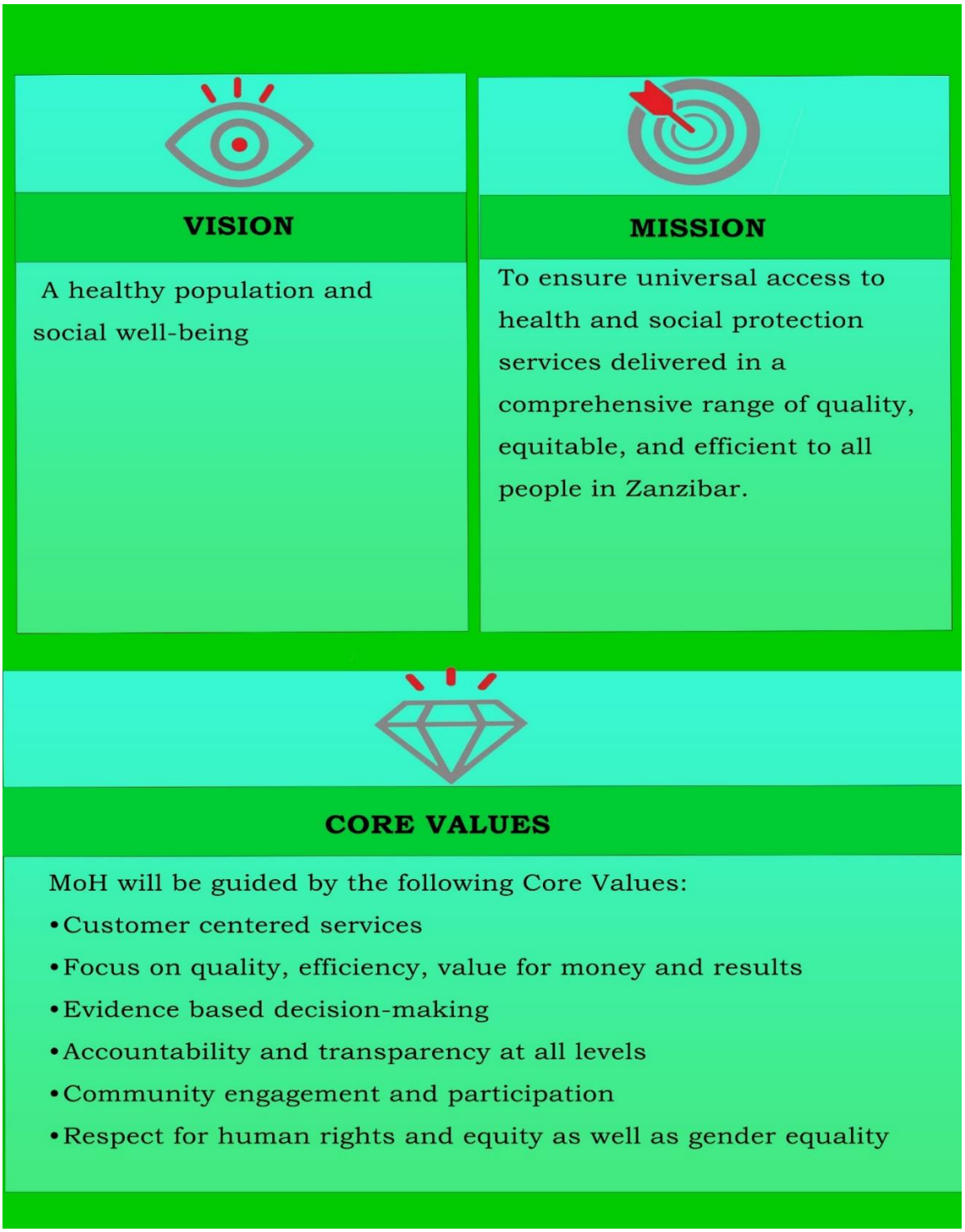


Figure 0-1 Strategy Implementation Process

4.1 Strategic Plan Framework

4.1.1 The vision, mission, and core values



SECTION FIVE: DESCRIPTION OF MEASURABLE STRATEGIC RESULTS

The Health Sector is some of the most, if not the most, complicated of all sectors. Apart from the narrow medical issues it also includes very crucial economic, social, cultural, ethical, and even political concerns.

There is a need for MoH to have the capacity to manage multi-disciplinary sector and complex systems in order to produce the intended results.

Furthermore, health services are dependent on many other sectors, such as education, agriculture, social development well as on the overall economy.

Mentioned below are the key features of the Health Sector Strategic Plan IV under each of the four perspectives, and a list of the Strategic Results, the Strategic Initiatives, and the concrete goals in terms of Measures and Targets.

5.1 Explanation of Result under each perspective

5.1.1 Learning and Institution Capacity

The cornerstone of the health and social sectors is the staff, therefore a key focus of the HSSP IV will be to improve the workforce in terms of the training, numbers and distribution, motivation, and the management of human resources focusing on performance and achieving results.

One of the key elements of health services is the availability of medicines and other medical supplies. Therefore, HSSP IV will improve the management of medicines and related commodities, strengthen quality assurance for medicines, and ensuring the availability of essential medicines and other related medical supplies at all facilities.

Availability of proper buildings, equipment, and means of transport is fundamental for delivering quality health and services. The HSSP IV aims at ensuring the infrastructure development, availability of needed equipment, proper maintenance of buildings, equipment and transport. It will also facilitate the construction of new facilities to ensure equitable access. The construction of Binguni Teaching and Referral Hospital will improve the availability and quality of specialized tertiary health services in Zanzibar.

The finalization of the EHCP will ensure that a prioritized package of Health services will underpin the above-mentioned key elements of HR, medicines, equipment, buildings, and other infrastructures. A specific area that will be given attention in the light of recent epidemics and pandemics is to put an effective emergency preparedness system in place.

Finally, the sector needs good systems for collecting and analysing information including research to make right decisions based on evidence. Therefore, a concerted effort to improve data collection, data quality, and analytical capacity as well as conducting priority research will be an important part of HSSP IV.

5.1.2 Internal Business and Governance Processes

Governance, systems, and management are crucial for delivering high-quality services to all citizens. The health and social sectors sector are governed by MoH, as well as some associated health governing bodies.

In general, governance will be strengthened at all levels i.e., MoH, District Hospitals, Districts, Clinics, and Shehia levels. Specific strategic initiatives will be developed and implemented including more autonomy for tertiary hospitals, improved regulations of the private sector as well as Public Private Partnerships (PPP), and implementation of the Community Health Strategy.

Planning and budgeting will be strengthened with a focus on quality, value for money, targeting priority interventions, equity, and transparency. In Addition to that effective referral system mechanism for health service delivery will be strengthened.

The government will also improve its working relationship with Development Partners by strengthening coordination and better alignment to the government priorities and systems.

Financial Stewardship

The HSSP IV desires to move towards Universal Health Coverage and admirable social service delivery, hence stable and sustainable health, and social services financing is an essential component.

Effective financial governance will ensure that the overall Zanzibar Health Policy Mission Statement; "To ensure universal access to health and social protection services delivered in a comprehensive range of quality, equitable, and efficient to all people in Zanzibar" is achieved. The health financing strategies of HSSP IV are guided by objectives subscribed to efficiency in resource mobilisation, financial risk protection, efficiency in service delivery and quality of service, and fairness and social inclusion.

Two of the main strategic initiatives will be to:

a) Develop costing scenarios for the Essential Health Care Package, i.e., making clear what resources are needed for different scenarios in terms of which services will be offered to the public by the government.
b) Develop a financing strategy which will ensure that resources are mobilised, distributed, and prioritised in a way that optimises moving towards UHC.

Efficiency gains from effective procurements and strategic initiatives mentioned under the three other Perspectives would help in utilising existing funding more efficiently.

5.1.3 Stakeholders

The ultimate stakeholders for the MoH are the population of Zanzibar that is highly dependent on the health services provided by the government and private sectors.

Under this Perspective and its Strategic Result of "Improved quality of health services as per EHCP at all levels" a vast number of Strategic Initiatives will be carried out to strengthen the quality of services, particularly in priority areas such as Reproductive, Maternal, New-born, Child & Adolescent Health (RMNCAH), Immunisation, Nutrition, TB, HIV/AIDS, NCDs (including mental illness), NTDs, Eye Care, Occupational Health and tertiary care. Supplementing the more focused interventions will be an effort to improve quality and quality assurance, and to improve diagnostic services.

5.2 Test Cause-effect linkage through Strategy Map

This section shows how the strategy map helps to give direction towards achieving the desired strategic results. The perspectives are linked to successfully attaining the health sector' vision, mission, and ZADES goal. The connection between cause

and effect amongst perspectives (i.e., Stakeholders, Financial, Governance, and Institutional Capacity) is crucial in health sector system strengthening. The description aligned under each perspective has been clearly defined in figure 3 below2.

[2] Strategic results etc. have been slightly shortened to fit in the figure.

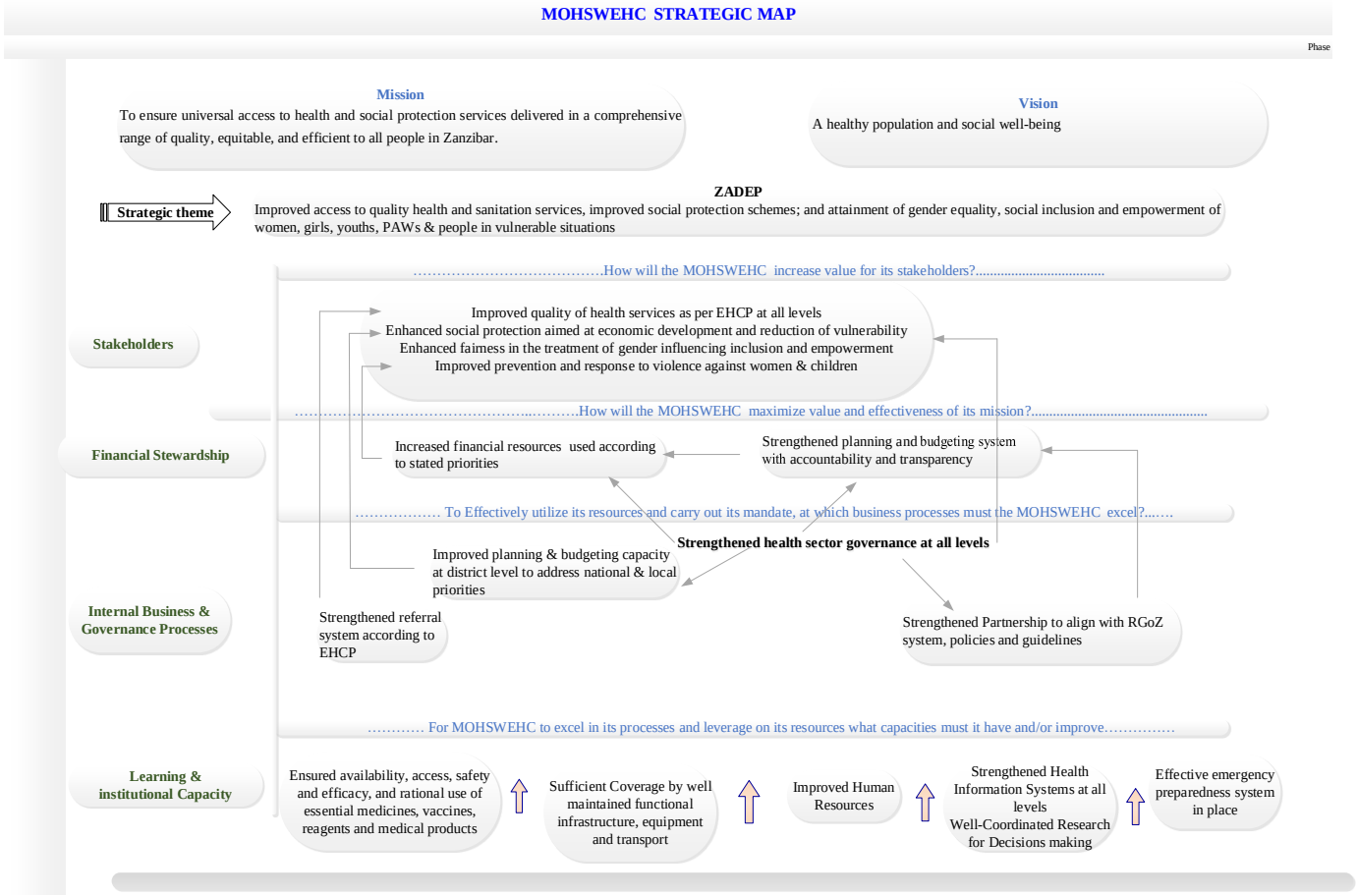


Figure 0-1:MOHSWEHC STRATEGIC MAP

SECTION SIX: MEASURING PERFORMANCE

The health sector has a comprehensive monitoring and data collection system, both in terms of routine data collection, particularly through District Health Information System (DHIS2) and regular population-based surveys, for example, Tanzania Demographic & Health Survey (TDHS).

In the Table below, Measures (indicators) and Targets including Baseline have been selected to reflect the progress of implementing the Strategic Initiatives, as well as achieving the Strategic Results.

The Table is structured using a combination of the ZPC Guidelines Four Perspectives – Stakeholders, Financial Stewardship, Internal Business Processes, and Learning & Institutional Capacity - and the WHO's health system Building Blocks – Leadership & Governance, Service Delivery, Health System Financing, Health Workforce, Medical Products, Vaccines & Technologies, and Health Information Systems. The setting measurement could be used as a monitoring tool for the HSSP IV progress implementation for the next five years.

The data source and frequency concerning the Measures and Targets have been listed in Annex 3.

Table 7:The Balanced Score Card: Targets linked to perspectives, strategic results, and initiatives.

Perspectives	**Building Blocks**	**Strategic Result**	**Measure (indicator)**	**Baseline**	**Target (2023/24)**	**Source**	**Strategic Initiatives**	**Initiative owner**
Stakeholders	Services Delivery	Improved quality of health services as per EHCP at all levels	% of clients expressing satisfaction with outpatient services	97.9% (2019)	100%	Client satisfaction survey	Scaling up institutionalization of the client satisfaction survey	DPPR
			% of clients expressing satisfaction with ANC services	99.2% (2019)	100%	Client Satisfaction Survey		
			% of clients expressing satisfaction with delivery services	99.5% (2019)	100%	Client Satisfaction Survey		
			% of health facilities performing according to standards	0% (2019)	80%	Quality Improvement assessment	Ensure availability of harmonized quality improvement tools Conduct periodic quality improvement assessment	DPPR
							Develop a digital platform on DHIS2 for continuous tracking and visibility or a similar system	DPPR

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Stakeholders	Services Delivery	Improved quality of health services as per EHCP at all levels					Implement the new community health strategy including strengthening the roles of CHVs Prioritized behavioral change interventions, including developing a health promotion strategic plan and increased capacity for health promotion. Institute comprehensive school health program, including screening	DPS
			Improved maternal and child health					
			Maternal mortality ratio	307 (2012)		TPHC		DPS
			Institutional Maternal Mortality Ratio	166/100,000 live birth (2019)	130/100,000 live birth	Health Bulletin	Establish a functional National MPDSR committee. Develop MPDSR dashboard on DHIS2 and integrate MPDSR into IDSR system.	

							Strengthen RMNACH services, including strengthening EMONC services in all health facilities	
			Perinatal mortality rate	49/1,000pregnancy (2016 TDHS-MIS)	38/1,000 Pregnancies	Demographic and Health Survey (national surveys)	Strengthen management & implementation of IMCI Guidelines	

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Stakeholders	Services Delivery	Improved quality of health services as per EHCP at all levels	Neonatal mortality rate	28/1,000 live births (2016 TDHS- MIS)	25/1,000 Live births	Demographic and Health Survey (national surveys)		
			Infant mortality rate	45/1000 live births (2016 TDHS- MIS)	15/1,000 Live births	Demographic and Health Survey (national surveys)		
			Under-five mortality rate	56/1,000 live birth (2015-2016 TDHS-MIS)	19/1,000 live birth	National Survey		
			% of births attended by skilled health personnel	63.3% (2017)	85%	Health Bulletin	Deploy skilled health personnel as per Minimum staffing requirement. Advocate for appropriate deployment and retention of skilled birth attendants	DAHR
			% of births delivered at a health facility	65.8% (2019)	100%	Health Bulletin	Prioritized behavioural change interventions to strengthen RMNCAH services at all levels	DPS
			Coverage of 8+ ANC visits	1.7%	20%	Health Bulletin		

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Stakeholders	Services Delivery	Improved quality of health services as per EHCP at all levels	Modern Contraceptive prevalence rate	14% (2015/16)	34.6%	TDHS	Improve integration of family planning in RMNCAH services Ensure universal access to sexual and reproductive health- care services, including family planning	DPS
			Family planning new client's acceptance rate	6.8% (2019)	16%	TDHS		
			Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group	47 per 1,000 live births	32 per 1,000 live births	Census		
							Revive immunization Inter-Agency Coordination Committee (ICC) Strengthen Reach Every Child (REC) intervention. Introduce Hepatitis B vaccine birth dose	DPS
			% of Children<1 year immunized for Penta 3 (immunization coverage)	88.2%	>95%	Health Bulletin		
			% of adolescents 9-14 years received 2nd dose of HPV vaccine	54% (2018)	>95%	Health bulletin		

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Stakeholders	Services Delivery	Improved quality of health services as per EHCP at all levels	% of children Under-five Years who are underweight	14% (2016 TDHS)	9.8%	National Survey	Increase the proportion of women of reproductive age, pregnant women, mothers & caregivers of children under 5 who practice optimal nutritional behavior. Improved prevention and management of malnutrition for under-five children	DPS
			% of children Under-five Years who are stunted.	21.5% (2018 TNNS)	15%	National Survey		
			Percentage of children under five years who are wasted (SAM	7.1% (2018 TNNS)	<5%	National Survey		
			% of under Five who are supplemented with Vitamin A	>90 % (2019)	100%	Annual Performance Report	Conduct community mobilization to send under-five children to a health facility for routine Vitamin A supplementation and deworming. Strengthen multi-sectoral collaboration to implement Zanzibar multi-sectoral nutrition	
			% of under-five children who are dewormed					
			Communicable and non-Communicable disease					

			Number and percentage of PLHIV who are currently on ART	6,519 (93.2%)	95	CTC2 Database	Improve the quality of HIV/AIDS interventions, curative, health promotion, and support	

Perspectives	**Building Blocks**	**Strategic Result**	**Measure (indicator)**	**Baseline**	**Target (2023/24)**	**Source**	**Strategic Initiatives**	**Initiative owner**
Stakeholders	Services Delivery	Improved quality of health services as per EHCP at all levels	Number and proportion of people who were tested for HIV and received their results within the past 12 months	271,123 (16.9)	24%	ZIHHTLP Annual report		DPS
			Percentage of pregnant women with known HIV status	64,286/73,152 (87.8%)	100	ZIHHTLP Annual report		
			Percentage of infants born to HIV positive mothers who receive HIV antigen test (DNA PCR) within 2 months of birth	343/393 (87.2%)	95	DHIS2		
			Number of all new registered Leprosy cases	163	172	ZIHHTLP Annual report	Improve diagnosing and treatment of TB	
			Number of notified cases all form of TB – Bacteriological confirmed plus clinical diagnosed new and relapse cases	967(2019)	1966	ZIHHTLP Annual report		

			Number of notifications of new Leprosy cases contributed by Active Case Finding and other interventions	163(2019)	172	ZIHHTLP Annual report	Conduct active and passive Leprosy case finding and provide proper management	

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Stakeholders	Services Delivery	Improved quality of health services as per EHCP at all levels	Number of HBV patients currently on antiviral treatment	46	450	ZIHHTLP Annual report	Community sensitization on testing Hepatitis Capacity Building for Health Care Providers on HIV, Hepatitis, TNB & Leprosy Conduct of Supportive Supervision	DPS
			Number of HCV patients currently on antiviral treatment	0	34	ZIHHTLP Annual report		
			Number of men and women diagnosed with and treated for STIs/RTI	17,115	10,610	DHIS 2		
			Percentage of people who inject drugs receiving Opiate Substitution Therapy (OST)	22	40	ZIHHTLP Annual report		
			Malaria prevalence rate	<1	0	TMIS	Continue effort for malaria elimination. Perform IRS campaign in all targeted areas. Improve staff capacity on Malaria surveillance and response at all levels	
			Malaria incidence per 1,000 population	0.2	0	TMIS	Access to universal coverage of LLINs	

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Stakeholders	Services Delivery	Improved quality of health services as per EHCP at all levels	Age standardized prevalence of insufficiently physical active among persons aged 18+ years (%)	17.6 (2002)	7.6	NCD step survey report	Conduct systematic analysis to identify the barriers to implementing physical activity in Zanzibar. Develop national guidelines for physical activity in Zanzibar To promote physical activities at all levels Review NCD strategic plan	DPS
			Age standardized prevalence of diabetes among persons aged 18+ years (%)	3.7 (2011)	3.7	NCD step survey report	Strengthen early detection of diabetes in children and pregnant mothers Conduct NCD step survey	
			Age-standardized prevalence of raised blood pressure among persons aged 18+ years	33	19	NCD step survey report		

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Stakeholders	Services Delivery	Improved quality of health services as per EHCP at all levels	Age standardized prevalence of Tobacco use among persons aged 18+ years	7.3 (2002)	6.5	National GATS Report	Strengthening Cervical Cancer Screening at all levels	DPS
			Age standardized prevalence of obesity among persons aged 18+ years	14.3 (2011)	14.3	NCD Survey	Implement tobacco control regulations	
			Death rate due to road traffic injuries	1.6(2018)	0	Health Bulletin	Revive NCD multi-sectoral committee	
			44 Mortality rate (%) attributed to common NCDs (cardiovascular disease, cancer, diabetes, or chronic respiratory disease	Cardiovascular = 38.5 Diabetes = 25 Chronic respiratory diseases = 36.5	Cardiovascular = Diabetes = Chronic respiratory diseases =	Performance Report	Improve health workers' ability to manage mental disorders, incl. substance abuse Improved primary eye care including prevention and treatment of early childhood blindness	
			Percentage of households with access to basic sanitation facilities (improved toilets)	80.7	100	HBS	Enhance promotion of sanitation and clean water	
			% Percentage of households using improved water	91.1 (2019-2020)	100	HBS		

			source for drinking					

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Stakeholders	Services Delivery	Improved quality of health services as per EHCP at all levels	Percentage of health facilities comply with standards for Infection Prevention and Control (IPC)	Unknown	80	IPC Assessment Report		
			% of health facilities offering access and services to special needs groups	TBD		TDHS	Provide appropriate and accessible services to groups of special need sat all level of care Support the introduction of identity document that will enable a poor older person to have access to health and other social services	DPPR
			Prevalence of schistosomiasis in the general population	1.4% (2020)	0%	Annual parasitology survey	Mass drug administration in relation to NTDs Snail control	DPS
			Prevalence of lymphatic filariasis	3.6% (2018)	0%	Pre-Transmission Assessment Survey		

			Number of people requiring interventions against neglected tropical diseases	1,671,598(2020)	1,821,285	Annual Performance Report	Behaviour change activities	

Perspectives	**Building Blocks**	**Strategic Result**	**Measure (indicator)**	**Baseline**	**Target (2023/24)**	**Source**	**Strategic Initiatives**	**Initiative owner**
Stakeholders	Services Delivery	Improved quality of health services as per EHCP at all levels					Strengthen occupational health services. Strengthen accessibility to an occupational health and safety program that meet applicable legislation and/or regulation requirements. Promote awareness creation on occupational health issues Carry out regular workplace risk assessment. Strengthen human resource capacity to inspect occupational services and medical examination of all employees (public and non-public) align with OSH laws and guidelines.	DPS

							Strengthen rehabilitation and resettlement of workers who are unable to work due to long term illness and accident	

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Stakeholders	Service delivery		Number of extremely poor households receiving cash transfer	96 (2020)	150	DESW and TASAF	Provide social transfers and assistance to extremely poor Zanzibaris for minimum income security	DESW
			Number of older people receiving universal pension	28,685 (2020)	30,000	DESW annual performance report		
			Proportion of vulnerable (poor) households served by social protection schemes	41.7	50	TASAF Progress Report	Provide adequate protection against life course shocks and livelihood risks by installing effective safety nets and extending social security coverage. Extend access to basic social services such as education, health, care, social welfare, and child and other protection services	

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Financial stewardship	Health System Financing	Increased financial resources for Zanzibar health sector used according to stated priorities	Total health expenditure (THE) as a percentage of GDP	3.4% (2017/18)	4%	National Health Account	Lobbying with Ministry of Finance to increase Health Budget each year. Enhance resource tracking system. Align Donor Funding with MOH strategies plans and priorities. Strengthen coordination of donor funding for health Conduct National Health Account Survey and other types of comprehensive financial flow and expenditure tracking survey Costing of EHCP	DPPR
			Per capita expenditure on health (current + capital expenditure)	30 USD/cap (2017/18)	47USD/cap (EHCP 2020)	National Health Account		
			Percentage of total government expenditure on health	48% (2017/18)		National Health Account		

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Financial stewardship	Health System Financing	Increased financial resources for Zanzibar health sector used according to stated priorities	Out of Pocket (OOP) as percentage of the Total Health Expenditure	18.7% (2017/18)	10%	National Health Account	Strengthen coordination mechanism to conduct fund mobilization and solicit support from DPs	DPPR
							Develop and agree on Health Financing Strategy Conduct Out of Pocket Survey	
							Prioritize which health services the public system will finance, including revision of the EHCP	
							Develop investment plan for equipment, transport, supplies, and construction	DAHR
							Develop and operationalize an annual and medium-term procurement plan	

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Financial stewardship	Leadership & Governance	Strengthened planning and budgeting system with accountability and transparency	Percentage of MoH units and programs using planning and reporting system	0	100		Improve process of planning and budgeting at all levels to ensure the budget and account structure are matching Improve governance, leadership, planning, and budget capacity at all levels. Develop platforms and capacity for harmonized annual plans at all levels. Establish web-based planning instrument Strengthening monitoring of district's health plans Develop a system to track recommendation	

							from supportive supervision. Strengthening supportive supervision at all level	
Perspectives	**Building Blocks**	**Strategic Result**	**Measure (indicator)**	**Baseline**	**Target (2023/24)**	**Source**	**Strategic Initiatives**	**Initiative owner**
Internal Business Processes		Strengthened health sector governance at all levels	Percentage of professional malpractices cases reported	1	0	Performance Report	Operationalize Zanzibar Medical Laboratory Develop Zanzibar Medical Radiology & Imaging Practitioners Act Practitioners Act Establish Private Hospital & Health Facilities Regulatory Agency	DCS
							Develop and implement regulation, standard guidelines and by-laws for private hospitals Review Chief Government Chemist Laboratory Act of 2011	

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Internal business process	Leadership & Governance	Strengthened health sector governance at all levels					Increased institutional capacity of professional boards and councils to provide quality services and monitor codes of conduct and professional ethics. Ensure adherence to EHCP. Improve regulation, supervision, and incentives for private health providers obtaining an optimal public-private mix (e.g. PPPs) and improved quality Decide on organizational structure and possible integration of tertiary hospital services	DCS DCS
			Number of Shehias with a functional Health	72 (2017/18)	388	Performance Report	Implement the revised Community Health Strategy, including	DPS

			Custodian Committee				strengthening the roles of CHVs	
							Establish MoH Contract Management Committee	DAHR
							Assess Health sector-related Laws and address lacks and insufficiencies identified	
							Propose and develop new health-related laws	

Perspectives	**Building Blocks**	**Strategic Result**	**Measure (indicator)**	**Baseline**	**Target (2023/24)**	**Source**	**Strategic Initiatives**	**Initiative owner**
Internal business process	Leadership & Governance	Improved planning and budgeting capacity at district level to address national as well as local priorities	Updated service delivery specification for each level	0	6	Documents available	Specify the responsibilities for each level/entity within the health sector, including which services to be delivered at each level	DPPR, DCS & DPS
							Improved Planning & Budgeting Guidelines for DHMs and District Hospitals	
			Revised regulation document	TBD	TBD	Documents available	Revise regulations of the public health system needed to make the health services function optimally	
							Strengthen coordination between MoH and PORALGSD	DPPR & PORALG-SD

							MoH to provide technical advice to DHMTs, including on planning & budgeting	DPPR w DCS &DPS

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Internal Business Processes	Leadership and Governance	Strengthened Partnership to align with RGoZ systems, policies, and guidelines	Number of SWAp Steering Committee Conducted	0	20	Performance Report	Established procedures related to Code of Conduct & SWAP Committee, ZHBF, and AJHSR made effective	DPPR
			Percentage of SWAp recommendation provided by Steering Committee implemented	0%	100%	Performance Report	Enhance partnerships with other sectors Lever age technical capacity of DPs and NGOs in resource mobilization, strategy development, technical working groups, and advocacy	

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Internal Business Processes	Service Delivery	Strengthened referral system according to EHCP	Revised policy and guidelines for referrals	Not available	In place and Functional		Develop or revise policies and guidelines related to referral, incl. establishing clear roles and responsibilities and a well-functioning referral and counter- referral system Establish referral system for samples & diagnostic investigations	DPPR DCS
Learning and Institutional Capacity	Service Delivery	Sufficient Coverage by well-maintained functional infrastructure, equipment and transport					Construct, equip and deploy all National Referral Hospitals	
							Develop and implement preventive maintenance policy guidelines for buildings, equipment, and transport at all levels	

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Learning and Institutional Capacity	Service Delivery	Sufficient Coverage by well-maintained functional infrastructure, equipment and transport	% Of facilities with functioning equipment (non-medical) according to the standard list	Unknown	80	Asset Register Report	Improve coverage of health facilities with a focus on equity	
							Transform Mnazi Mmoja into a fully autonomous institution Develop and implement appropriate hospital reform program that will include review and strengthen hospital referral health services, horizontal and vertically Strengthen mobile health services, including mobile health services, digital health services, and routine and ad hoc outreach health services at all levels Promote private sector participation in the provision of specialized health services, e.g. PPP Provide and contain appropriate infrastructure for disposable of medical waste	

							Strengthen capacity of the tertiary hospital to be a base of medical training institute with capabilities of managing advanced medical conditions aiming at minimizing medical tourism	

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Learning and Institutional Capacity	Service Delivery	Effective emergency preparedness system in place	Proportion of health facilities submitting IDSR report on time	79	100	DHIS2, eIDSR	Training and supportive supervision on effective emergency preparedness	DPS
			proportion of outbreaks or any public health event responded in a particular time period	100%	100%	Alert register	Conduct investigation, and respond to events Support effective coordination of response activities at all level	
Learning and Institutional Capacity	Medical Product Vaccines & Technologies	Ensured availability, access, safety and efficacy, and rational use of essential medicines, vaccines, reagents and medical products	% Of facilities reporting stock-outs for Essential Medicine	11.3% (2019)	0%	eLMIS	Improve supply chain management and drug storage regulations at all levels Roll out eLMIS	CMS CGP
			% Of facilities reporting stock-outs for Standard Medical Equipment	Unknown	80	eLMIS		

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Learning and Institutional Capacity	Medical Product Vaccines & Technologies	Ensured availability, access, safety and efficacy, and rational use of essential medicines, vaccines, reagents and medical products	% Of facilities reporting stock-outs for Laboratory Supplies	16%	0%	eLMIS		
							Strengthen implementation of Zanzibar Food, Drugs & Cosmetics Act 2/2006 Strengthening and maintain harmonized operational between CGLA, ZFDA, and ZBS Established coordination and experience sharing platforms between professional boards. Establish coordination platforms between boards and private institutions. Assess status of the rational use of medicine in Zanzibar Capacitate local ICT personnel in the maintenance of logistic system software. Revive Compounding unit at MOH/CPO **Capacitate CPO with biomedical engineering and labour scientist align logistic management**	

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Learning and Institutional Capacity	Medical Product Vaccines & Technologies	Ensured availability, access, safety and efficacy, and rational use of essential medicines, vaccines, reagents and medical products	% of facilities with appropriate standard storage condition	78% (2018/19)	100%	eLMIS	Proper application of standard treatment guidelines and other SOPs Develop National Standard Storage Guidelines and standards for pharmaceuticals at different facilities	
							Ensure Pharmacy Council is in place and well-functioning	CGP
							Liaise with food safety institutions to develop a national food safety policy	ZFDA
			Percentage of blood unit collected	91.1% (2019/20)	100%	Blood Establishment Computerized System (BECs)	Mobilization of blood donation, collection, testing, and separating	DCS
			Percentage of blood units separated into Components	100%	100%	Blood Establishment Computerized System (BECs		
			Percentage of blood component distributed to the Hospital Transfusion facilities	76%	100%	Blood Establishment Computerized System (BECs)	Sensitize community to donate more blood Strengthen blood collection information system	

							Establish Chief Government Chemist Laboratory Agency eMIS and database	
							Develop National Standard Storage Guidelines for drugs	

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Learning and Institutional Capacity	Medical Product Vaccines & Technologies	Ensured availability, access, safety and efficacy, and rational use of essential medicines, vaccines, reagents and medical products					Review blood safety strategic plan, training plan, and quality manual, and implement recommendations	DCS
							Review and update Zanzibar Traditional Medicines Act	
							Promote scientific pharmacovigilance monitoring of prescribed herbal medicine	
Learning and Institutional Capacity	Health workforce	Improved Human Resources for Health	Doctor: population ratio	1: 4,445 (218/19)	1: 4,000	Performance Report	Deploy sufficient number of doctors and nurses according to revised staffing norms Increase number of skilled health personnel through long term and short-term training, on-the-job orientation, and induction Provide mechanism, guidance, and technical support to provide medical health training institutions established in Zanzibar	DAHR
			Nurse: population ratio	1: 1,314 (2018/19)	TBD	Performance Report		

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Learning and Institutional Capacity	Health workforce	Improved Human Resources for Health	% Of health facilities meet minimum staffing requirements	Unknown	80%	Health worker's registry Health facility registry	Deploy/allocate sufficient number of staff required to ensure implementation of EHCP Strengthen the utilization of HRIS for planning and management (Including deployment) Establishment of health worker registry Establishment of health facility registry	DAHR
			Percentage of health staff meeting performance according to their job description	Unknown	100%		Implement Open Performance Review and Appraisal System (OPRAS) Finalize scheme of service Promote the rights and safety of all health personnel in the workplace in line with OSHA	
			Attrition rate	5.3% (2016/17)	TBD			

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Learning and Institutional Capacity	Health workforce	Improved Human Resources for Health					Finalize and implement staff retention strategy Improve staff remuneration Prepare succession plans for all MoH units Develop proper non-monetary incentive structure	DAHR
			Number of staff trained as per HRH development plan	223 (2019)	775	HRH report	Seek Scholarship from different organizations Lobbying to increase the training budget Update HRIS to become a better tool for HRH planning and management Promote adherence to ethical practice and code of conduct among doctors, nurses, and other health professionals	

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Learning and Institutional Capacity	Health information systems	Strengthened Health Information Systems and M&E at all levels					Develop and implement new HMIS/HIS Strategy and M&E Guidelines Develop Health Statistical Compendium	DPPR
							Strengthen implementation of DHIS2, including data review and audit process	
				68% (2017)	100%	Health bulletin	Strengthen data use for decision making at all levels	
							Conduct HSSP IV Midterm Review and end-term evaluation	
			% Percentage of units MoH receiving supportive supervision	TBD	TBD	Performance Report	Improve usefulness and timeliness of Annual Health Bulletin and Annual Performance Report	

Perspectives	Building Blocks	Strategic Result	Measure (indicator)	Baseline	Target (2023/24)	Source	Strategic Initiatives	Initiative owner
Learning and Institutional Capacity	Health information systems	Strengthened Health Information Systems and M&E at all levels					Develop Digital Strategy and ICT Policy Guidelines Conduct midterm review Mapping area of digital application	DAHR
		Well-Coordinated Health and Health-Related Research for Decisions making	Number of research proposals meet health ethics standards	120 (2019/20)	TBD	Performance Report	Develop and implement a Health Research Strategy for Zanzibar, including areas of cross-disciplinary & multi-focus research	ZAHRI
							Conduct annual scientific conference to disseminate research and survey findings	

SECTION SEVEN: FINANCING: LINKING RESOURCE ALLOCATION TO STRATEGY

The achievement of the Strategic Results of the HSSP IV; particularly taking a significant step towards UHC and commendable social service delivery during the coming five years, assumes a significant increase in Total Health Expenditure – public and private - for the health sector of roughly 50%. Most of this increase will come from a substantial rise in government funding for health that will come from increasing the share of health expenditure out of the total government spending from 8% to 12%3, albeit this would still be short of the Abuja Target4.

During the planning period, the Ministry will develop strategies/guidelines that will facilitate the realignment of resources that will contribute moving towards UHC and decent provision of social services. In this regard, efforts will be made to generate additional resources by advocating for higher budgetary allocation. In addition, mechanisms that ensure development partners' support is aligned with the sector goals and objectives will be enhanced. Finally, financial risk pooling mechanisms will be promoted.

7.1 Costing

For the health sector, the majority (around 95%) of the costing is derived from the costed Essential Health Care Packages prepared according to the Zanzibar context using the One Health Tool (OHT). Other supporting services, which could not be costed using the OHT, are costed using projected cost derived from the assumed cost of the relevant Strategic Initiatives using historic unit costs for inputs. Table 8A below show the list of the projected cost for health sector required to attain each of the Strategic Results.

3 As was the target for HSSP III

4 See analysis in Annex 2.1, Section on Health Financing

Table 8A: Cost of HSSP IV – Health Sector (Million TZS)

STRATEGIC RESULT	**COST**						
	TYPE	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	**TOTAL**
*Improved quality of health services as per **EHCP** at all levels*	*Recurrent*[a]	1,531	1,493	1,339	1,267	1,247	6,878
	Development[a]	184	184	184	184	173	909
	TOTAL	**1,715**	**1,677**	**1,523**	**1,451**	**1,420**	**7,787**
*Increased **financial resources** for Zanzibar health sector used according to stated priorities*	*Recurrent*	*118*	*176*	*176*	*118*	*60*	650
	Development	*118*	*176*	*176*	*118*	*60*	650
	TOTAL	**237**	**353**	**353**	**237**	**121**	**1,299**
*Strengthened **planning and budgeting** system with accountability and transparency*[c]	*Recurrent*	*104*	*249*	*220*	*110*	*122*	806
	Development	*104*	*249*	*220*	*110*	*122*	806
	TOTAL	***209***	***499***	***441***	***220***	***244***	**1,612**
*Strengthened health sector **governance** at all levels*	*Recurrent*[b]	*1,854*	*1,909*	*1,964*	*2,018*	*2,072*	9,816
	Development[b]	*4,326*	*4,454*	*4,582*	*4,709*	*4,834*	22,905
	TOTAL[a]	**6,180**	**6,363**	**6,546**	**6,727**	**6,906**	**32,721**

*Improved **planning and budgeting capacity** at district level to address national as well as local priorities*[c]	*Recurrent*	*32*	*154*	*195*	*32*	*32*	447
	Development	*14*	*66*	*84*	*14*	*14*	191
	TOTAL	**46**	**220**	**278**	**46**	**46**	**638**
*Strengthened **Partnership** to align with RGoZ systems, policies, and guidelines*[c]	*Recurrent*	*49*	*97*	*7*	*28*	*7*	188
	Development	*32*	*65*	*5*	*19*	*5*	125
	TOTAL	**81**	**162**	**12**	**46**	**12**	**313**
*Strengthened **referral system** according to EHCP*[c]	*Recurrent*	*0*	*58*	*70*	*12*	*12*	151
	Development	*0*	*58*	*70*	*12*	*12*	151
	TOTAL	**0**	**116**	**139**	**23**	**23**	**302**
*Sufficient coverage by well-maintained functional **infrastructure, equipment, and transport***	*Recurrent*[a]	9,566	12,288	14,804	14,932	15,060	66,649
	Development[a]	22,697	5,201	3,923	1,767	1,781	35,369
	TOTAL	**32,263**	**17,489**	**18,727**	**16,699**	**16,841**	**102,019**

Effective ***emergency preparedness*** *system in place*[c]	*Recurrent*	*49*	*292*	*227*	*65*	*65*	698
	Development	*21*	*125*	*97*	*28*	*28*	299
	TOTAL	**70**	**418**	**325**	**93**	**93**	**998**
Ensured availability, access, safety and efficacy, and rational use of essential ***medicine, vaccines, reagents, and medical products***	*Recurrent*[a]	38,286	43,837	48,919	55,169	63,397	249,607
	Development[a]	6,909	7,538	7,911	8,349	8,818	39,525
	TOTAL	**45,195**	**51,375**	**56,830**	**63,517**	**72,215**	**289,132**
Improved ***Human Resources*** *for Health*	*Recurrent*[a]	49,457	57,022	61,815	66,916	72,022	307,233
	Development[a]	11,369	6,637	7,059	7,262	7,374	39,703
	TOTAL	**60,826**	**63,659**	**68,875**	**74,179**	**79,396**	**346,935**
Strengthened ***Health Information Systems*** *and M&E at all levels*	*Recurrent*[b]	*2,273*	*6,943*	*6,334*	*2,913*	*2,787*	21,250
	Development[b]	*2,273*	*6,943*	*6,334*	*2,913*	*2,787*	21,250
	TOTAL[a]	**4,546**	**13,886**	**12,667**	**5,826**	**5,575**	**42,501**

*Well-coordinated health and health-related **research** for decision making*	*Recurrent[e]*	*939*	*939*	*939*	*939*	*939*	4,695
	Development[e]	*939*	*939*	*939*	*939*	*939*	4,695
	TOTAL[d]	**1,878**	**1,878**	**1,878**	**1,878**	**1,878**	**9,390**
TOTAL Recurrent		*104,258*	*125,458*	*137,009*	*144,520*	*157,823*	669,068
TOTAL Development		*48,986*	*32,637*	*31,584*	*26,423*	*26,948*	166,578
TOTAL All		***153,244***	***158,095***	***168,593***	***170,943***	***184,771***	***835,646***

a) **Costing using One Health Tool**

***b*: Assumptions regarding proportional distribution on recurrent and development, while total costing is done by One Health Tool**

***c:* Calculated based on assumed cost of Strategic Initiatives, as well as assumptions on distribution between recurrent and development cost.**

***d:* Based on cost of ZAHRI draft Strategy Plan 2018-22 plus 20%**

e: Assumptions regarding proportional distribution on recurrent and development, while total costing is done as indicated in d.

SECTION EIGHT: MONITORING, PERFORMANCE REPORTING, AND ACCOUNTABILITY

The Ministry of Health has several systems in place for data collection and generating regular reports thereby monitoring progress of implementation of the Strategic Plan.

8.1 Information System

The Zanzibar health sector uses.

1) District Health Information System (DHIS2) platform for the collection of diseases, deaths, and service delivery data at the health facility level.
2) Electronic Logistic Management Information System (eLMIS) for management of medicines and related supplies data.
3) Integrated Human Resource Information System (iHRIS) for capturing human resource data.
4) Blood collection Information system used for monitoring blood transfusion services.
5) Community Health Volunteer monitoring system for monitoring the customers' perspective on service delivery particularly on the quality aspect.
6) Integrated Financial Management Information System (IFMIS) for accounts and financial tracking and
7) Integrated Weekly Ending System (IDWE) which has been current renamed as Integrated Disease Surveillance and Response (IDSR).

8.2 Main Routine Reports

From the above-mentioned systems, a number of reports are produced and presented on different platforms. Among the reports produced are the Annual Health Sector Performance Report which provides progress in the execution of the Plan of Action, and the Annual Health Bulletin which provides detailed information on service delivery such as reproductive and child health services, morbidity, and mortality information. These reports are normally shared in the Annual Joint Health Sector Review (AJHSR) meeting. Others are quarterly reports - Bango Kitita, which are presented to the President of Zanzibar and the Chairman of the Revolutionary Council, and the Permanent Social Welfare Committee of the House of Representatives. The budget speech is presented annually to the House of Representatives for budget approval. There is also the monthly external financial report which is submitted to the President Office, Planning and Finance Other Reports generated include Public Expenditure Review (PER) and Quarterly Progress Reports for development projects.

Moreover, Health Information System (HIS) Strategic Plan was revised to guide the collection of health information to meet stakeholders' needs.

The M&E data from the above-mentioned systems that generate routine reports are supplemented by regular surveys such as:

- Tanzania Demographic & Health Survey (TDHS)
- Non-Communicable Diseases Survey
- National Nutrition Survey
- National Health Accounts (NHA)
- Client Satisfaction Survey (CSS)

In addition, many disease-specific surveys are carried out including:

- Tanzania Malaria Indicator Survey (TMIS)
- Tanzania HIV Indicator Survey THIS
- NTD Survey

Research plays a major role in providing evidence that inform interventions and approaches to be developed. HSSP IV will priorities research that will inform which strategies and interventions will best address major systems and disease issues. Enough resources should be set aside for quality research.

The reports are also used to share information in various meetings, and engaging facility managers during regular supportive supervision visits.

Main monitoring and review meetings are:

- Annual Joint Health Sector Review (AJHSR) – involving all stakeholders within the sector.
- Quarterly Performance Assessment – done by Public-Private Performance Teams
- SWAp Committee – involving major stakeholders within the sector.
- Zanzibar Health Basket Steering Committee – MoH and Basket Funders quarterly meeting,
- Bango Kitita - Meeting with the Presidents of Zanzibar and Chairman of the Revolutionary Council
- Quarterly Meetings with Social Welfare Committee of the House of Representatives
- MoH quarterly Leadership Committee Meeting
- MoH quarterly Executive Committee meeting

The implementation of recently developed Digital Health Strategy will improve coordination and harmonisation of reporting, and thus improving the ability of the sector to assess its performance and take action for improvement.

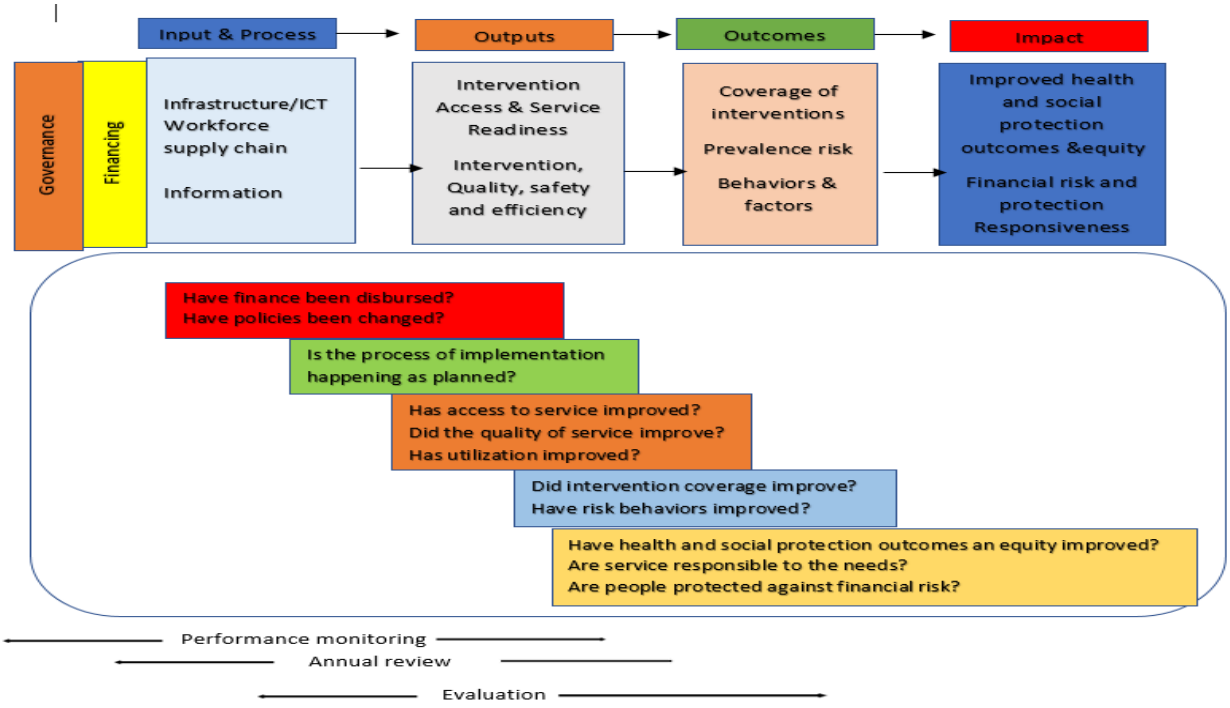


Figure 0-1:Overview of principles of monitoring the HSSP IV

8.3 Strategic Plan Risks and its Mitigation Plan

The Health Sector Strategic Plan IV summarises the possible risks that may affect MoH's ability to achieve its overall Strategic Results and targets. There is a variety of risks that can arise and directly affect health and social sectors. For each individually recognized risk, its potential level of occurrence has been identified and its mitigation plan has been developed to reduce the threat of the risk.

Table 9:Risks and Mitigations

Risks	**Description**	**Risk type**	**Likelihood of Risk**	**Impact of the Risk**	**Mitigation Plan**
Insufficient funding for the health sector	Funding does not match the strategic interventions and targets	Financial Risk	High	Underfunding leading to unavailability and low quality of services	Documenting financing needs, including through conducting NHA Lobbying for fully funding EHCP and other services Improving Basket funding modality to attract more donors

Risks	Description	Risk type	Likelihood of Risk	Impact of the Risk	Mitigation Plan
Unpredictability of Donor Funding Delay of Disbursement	Uncertain about how much exactly will the Development Partners finance	Financial Risk	High	Operational activities are not implemented or delayed Inability to plan effectively due to unknown commitment of some Development Partners	Strengthen coordination mechanism to conduct fund mobilization and solicit support from DPs Establish the Health Insurance Scheme Improve the effectiveness of Basket management
Decline in political support for UHC	Reduced support for RGoZ resources to the sector	Political Risk	Low	Under-resourced services	Dialogue with House of Representatives, MoF, and others on the importance of health not only for wellbeing but also for the economy
Emergency unpreparedness	Unprepared in the event of natural or	Emerging Risk	Medium	Overwhelmed at treatment centres, doctors and nurses	Conduct supportive supervision, training, and investigation on effective emergency preparedness to effectively respond to uncertain events.

Risks	Description	Risk type	Likelihood of Risk	Impact of the Risk	Mitigation Plan
	human disasters			Death	Develop emergency contingency plans
Insufficient Human Resources for Health	Shortage in numbers, capacity, and specialization of Health Care Workers	Operational Risk	High	Poor provision of health care services, including: - Lack of Doctors, nurses, and midwives	Deploy more skilled health personnel Ensure long- and short-term training to ensure effective implementation of EHCP Implement Quality Assurance Strategy
Stock-outs for essential medicine, medical equipment and laboratory supplies	Unavailability of specific items and products	Operational Risk	High	The inability for public health facilities to function optimally thus hinders UHC	Improve supply chain management and drug storage regulations at all levels Appropriate funding according to needs
Ineffective Referral structure in place	Poor Management of patients to		High	Overcrowded at Mnazi Mmoja Hospital	Develop or revise policies and guidelines related to referral, incl. establishing clear roles and responsibilities and a well-functioning

Risks	Description	Risk type	Likelihood of Risk	Impact of the Risk	Mitigation Plan
	other physicians for a specific problem				referral and counter- referral system

SECTION NINE: ANNUAL PLANNING CYCLE

9.1 Overview of Planning Cycle

The table 10 below shows the overview of the annual planning cycle used by the MoH:

Table 10:Overview of the planning cycle

	Activity	**Time frame**	**Responsible person**
1	Develop an action plan and budget (review documents and plans)	December	DHMTs, Hospitals, Departments, units, and Programs
2	Consultation planning meeting with Development Partners • Joint planning meeting	February	DPs and MOH stakeholders
3	Submission and scrutinizing of MOH plans: • CDHP by DHMTs • Units and Programs plans by responsible Directors	February	All Directors
4	Submission and scrutinizing of plans including CDHP by the technical team under DPPR	March	DPPR
5	Compilation of POA and MTEF	March	DPPR
6	MTEF approval by MOH Executive Committee: MTEF (PBB) sent to the President Office, Finance & Planning for inter-ministerial compilation	April	PS MOH PS President Office Finance & Planning
7	Preparation of Budget Speech	April	DPPR

8	Approval of speech by the Leadership Committee of the MOH	May	Minister for Health,
9	The budget speech is sent to the Social Welfare Committee of the House of Representative for approval	May	PS MOH
10	Final approval of the budget to House of Representative	May/June	Minister for Health
11	Implementation of approved activities	July/June	All Stakeholders
12.	On-going monitoring, evaluation, and reporting	Monthly, quarterly, semi-annual and annual reports	All implementers

9.2 Description of key stages in the Planning cycle

Below are the steps of the planning cycle.

1) Develop an action plan and budget.

- MoH annual plan and budget preparation will be guided by priorities outlined in HSSP IV and sector priorities developed by the central government in every fiscal year. Under the guidance of the planning department (DPPR), each unit and program update its action plan using the planning template and is compiled at the central level resulting in a MOH plan.
- MoH issues Comprehensive District Health Planning Guidelines for DHMTs following the priorities outlined in the HSSP IV.
- Regional & District Hospitals develop their Plans that are approved by MOH.
- Based on the Planning Guidelines, Districts and Hospitals develop District Health Plans according to the POA format, which is approved by MoH.
- Mnazi Mmoja Hospital, a semi-autonomous institution, develops an independent annual budget in line with HSSP IV which approved by MMH Advisory Board.

1) Periodic Reporting

- DHMTs deliver monthly accounts reports and quarterly progress reports to MoH.
- All programs, projects and Units receiving fund from Development partners have to submit monthly external financial report to Department of external Finance via MoH. They also submit quarterly and annual progress reports in the Bango Kitita format to the MoH.
- MoH delivers the quarterly progress report to the Office of the President and the House of Representatives.
- For the Basket funding, MoH submits quarterly progress reports regarding the hospital and District Health Plans to the ZHBF Steering Committee.

1) Review of Strategic Direction

- MoH's leadership discusses and takes action on the progress reports, and also receives feedback from the President's Office and House of Representatives on the Bango Kitita reporting.
- The SWAp Committee chaired by the Principal Secretary has representatives from all potential stakeholders. This committee discusses general progress as well as specific issues of relevance to health sector performance.
- The ZHBF Steering Committee discusses progress reports on a quarterly basis.

2) Consultation & Feedback

Health Sector Performance Report for the Financial Year (FY) and the Zanzibar Health Bulletin calendar year are discussed at the AJHSR; and recommendations are made for implementation.

ANNEXES

Annex 1: Strategic Plan Implementation Matrix

The overall implementation of the HSSP IV will be done using the following formats:

Table 11:Strategic Results Implementation Status

VISION: A healthy population and social well-being
MISSION: To ensure universal access to health and social protection services delivered in a comprehensive range of quality, equitable, and efficient to all people in Zanzibar.
ZADES INSPIRATION: : Provision of basic services for all and health education toward achieving Universal Health Coverage
OUTCOME: At the end of the HSSP IV Zanzibar should have moved decisively towards UHC, by having: • Availability of a revised Essential Health Care Package that ensures that all Zanzibaris receive cost-effective, quality health services, curative as well as preventive, that address the vast majority of causes of illness and disability. • A well-developed financing strategy that is implemented ensuring sufficient financing of the package, equitable consumption of health services as well as protection against catastrophic health events. This will be supported by achieving the following essential targets: • Filling of the majority of staff posts according to revised norms for staffing at all facilities. • Well maintained buildings, equipment, and transport, equipped according to norms. • Availability of all essential medicines and medical commodities with minimal stock-outs. Zanzibar at the end of HSSP IV should have increased equity and equality between men and women, improving the well-being of children and good opportunities for all Zanzibaris to enjoy a decent and dignified life.

Table 12: Strategic Results Cost & Disbursement Status

STRATEGIC RESULT	COST (Million TZS)					DISBURSEMENT STATUS	REMARKS
	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5		
Improved quality of health services as per EHCP at all levels	**1,715**	**1,677**	**1,523**	**1,451**	**1,420**		
Increased financial resources for Zanzibar health sector used according to stated priorities	**237**	**353**	**353**	**237**	**121**		
Strengthened planning and budgeting system; accountability and transparency	**209**	**499**	**441**	**220**	**244**		
Strengthened health sector governance at all levels	**6,180**	**6,363**	**6,546**	**6,727**	**6,906**		
Improved planning and budgeting capacity at district level to address national as well as local priorities	**46**	**220**	**278**	**46**	**46**		
Strengthened Partnership to align with RGoZ systems, policies, and guidelines	**81**	**162**	**12**	**46**	**12**		
Strengthened referral system according to EHCP	**0**	**116**	**139**	**23**	**23**		
Sufficient coverage by well-maintained functional infrastructure, equipment, and transport	**32,263**	**17,489**	**18,727**	**16,699**	**16,841**		
Effective emergency preparedness system in place	**70**	**418**	**325**	**93**	**93**		
Ensured availability, access, safety and efficacy, and rational use of essential medicine, reagents, and medical products	**45,195**	**51,375**	**56,830**	**63,517**	**72,215**		

Improved Human Resources for Health	**60,826**	**63,659**	**68,875**	**74,179**	**79,396**		
Strengthened Health Information Systems and M&E at all levels	**4,546**	**13,886**	**12,667**	**5,826**	**5,575**		
Well-coordinated health and health-related research for decision making	**1,878**	**1,878**	**1,878**	**1,878**	**1,878**		

Annex 2 Situation Analysis

Annex 2.1 Health sector situation analysis

Overall context

Zanzibar consists of two major islands, Unguja and Pemba, as well as several small islands, and is part of the United Republic of Tanzania. Together, the two islands have a total of five regions and eleven districts covering a total area of 2,654 square kilometres. Zanzibar has a young, rapidly growing, and increasingly urbanized population. The population of Zanzibar is estimated to be about 1.4 million, of which, approximately 46 % reside in the urban areas. Furthermore, an estimated 33 % of the population is young — between the ages of 10 to 24 years old — the majority of whom are adolescents below the age of 19 years.5

Zanzibar's population has grown by 33 % over 10 years since 2002. The population is currently estimated to be growing at a rate of 2.8 % per year and is expected to double by 2036. The population density is high at 530 people per square kilometres.

The rapid population growth is not matched by the pace of economic growth, presenting challenges in achieving Zanzibar's Vision 2020 of achieving middle-income status. Moreover, achievement of the desired socio-economic goals (such as attaining a high and sustainable economic growth averaging 9-10 per cent per annum, a high level of employment in the modern sector, high education standards, universal education, and improved quality of life), will continue to be highly constrained by the demands of high population pressures on resources.6

Zanzibar is fighting a double burden of diseases: despite the elimination of malaria Zanzibar still has a high burden of infectious diseases, and non-communicable diseases are rising.

5 Section derived from Zanzibar Family Planning Costed Implementation Plan 2017-22

6 Ibid

Finally, climate change poses substantial threats to the population of Zanzibar, including regarding health.

Policies and context

The Vision 2020 emphasizes the provision of basic health services for all people without discrimination. Priority shall be directed at preventive services, combating epidemics, special maternal and child care services, and the dissemination of health education for all. To attain the above, the following shall be accorded priority:

To raise the health and nutritional standard of the Zanzibar Community generally and specifically for women and children.

To enhance the efficient provision of health services together with careful utilization of the meagre resources available.

To provide standard basic health services for all within community vicinities.

To promote a safe delivery system, planned motherhood, and child survival.

To give priority to the provision of child immunization.

To channel more resources for preventive services to cut down the cost of curative services.

To establish reliable epidemic control measures, to have a well-trained working forcefully equipped and financed while emphasizing public education.

To create good and safe procedures for the involvement of traditional healers as well as providing them with the necessary knowledge base befitting their working environment.

To institute a preventive mechanism for dealing with the ill effects of environmental degradation and hazardous materials.

To encourage the involvement of private capital in the health sector (e.g. as PPPs).

To raise the level of community health awareness in both urban and rural areas.

To provide special emphasis on the war against the spread of HIV/AIDS through a popular mass education programme that will lead the people to change their unsafe sexual behaviours.

Overall development in Zanzibar is governed by the Zanzibar Development Strategy covering the period 2021-2026, which among its vision inspiration has “Universal health coverage with emergency medical care and referral services across Zanzibar to improve access to healthcare in underrepresented areas”.

The health sector is guided by the Zanzibar Health Policy 2011, with the vision of "A healthy population and social well-being"

Responsibility. of the sector includes:

Quality assurance Access to health services also in gender and human rights perspective

Coordination across all units and harmonization of off-budget transactions Equitable resource allocation for all levels of care Improved supply and management of health professionals.

Improved public health practices including public health promotion, emergency preparedness, and response Prevention, management, and rehabilitation of disability Strengthen blood safety services Strengthen pharmaceutical sector. The Health Policy is currently being reviewed and revised. Like all sectors in Zanzibar, the health sector has a multi-year strategic plan, currently the Health Sector Strategic Plan IV, covering the period 2020/21 to 2024/25. Importantly, the Revolutionary Government of Zanzibar (RGoZ) has decided that all government health services are to be free of charge. Zanzibar endorses the global Sustainable Development Goals (SDGs)7, including the key cross-cutting indicator for health namely UHC. The SDG, as well as the One-Health, the approach emphasizes the crucial importance of multi-sectoral action for improving the health of the population.

Health Systems Governance and Implementation arrangements8

Administratively, Zanzibar is divided into 5 Regions, 11 Districts, 2 Sub-districts, and 388 Shehias. At the District the District Health Management Team is in charge of health services. Being a small country with only 1.4 million inhabitants, Zanzibar's health ministry is quite small, but its health sector is not at all proportionally less complicated than that of countries with much larger populations. This results in a lack of sufficient capacity in terms of the number of ministry staff, a well-known problem for small countries. In several areas, this lack of capacity is further aggravated by insufficient skills among staff. Unfortunately, this lack of capacity is not sufficiently taken into consideration by other actors, within Zanzibar as well as external Development Partners, when they interact with the MoH.

7 The United Republic of Tanzania is a signature to the Sustainable Development Agenda

8 Includes Governance and management & Coordination, leadership and reforms.

Fig.5: MoH Organogram:

ORGANIZATION STRUCTURE OF MINISTRY OF HEALTH

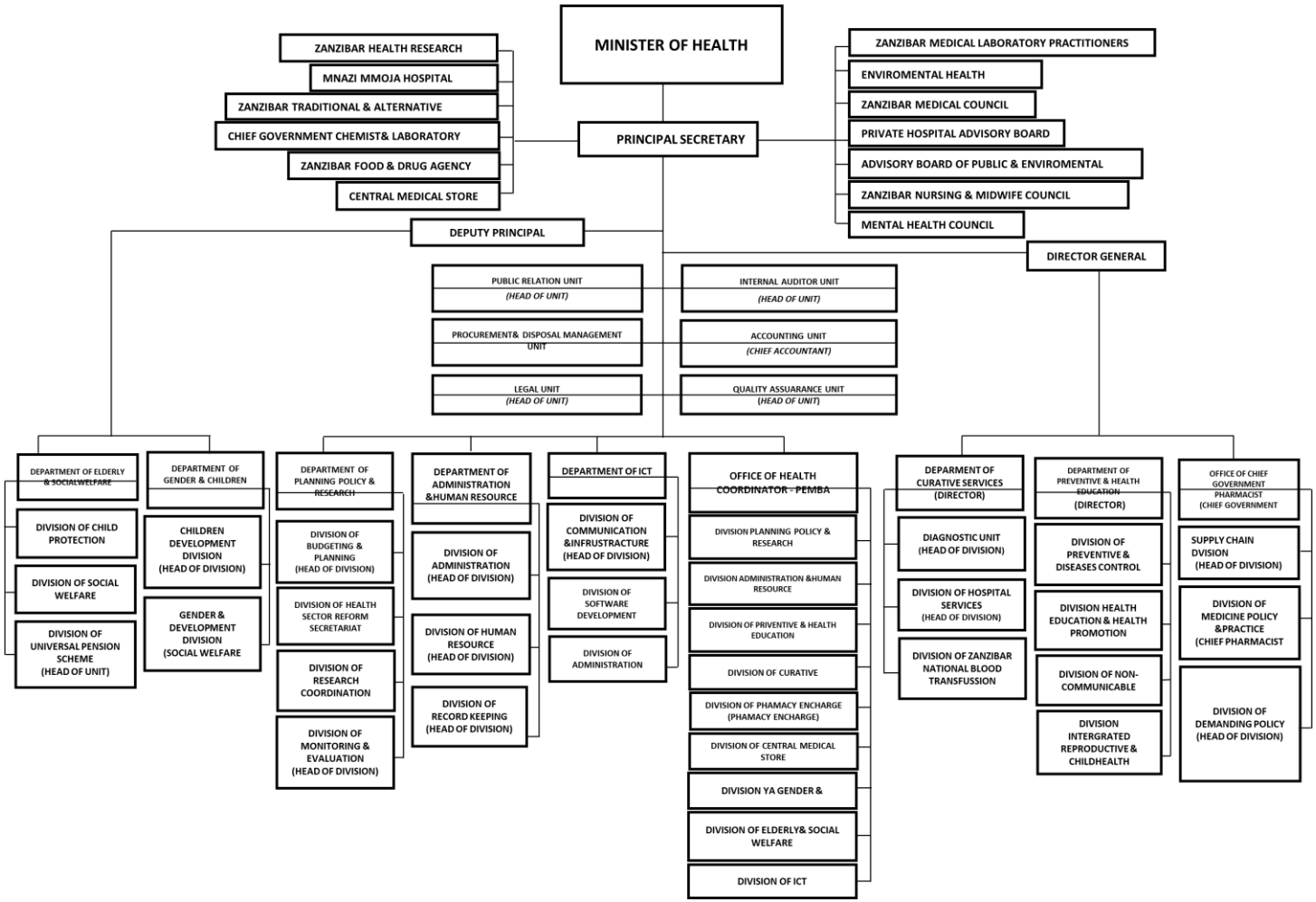


Figure 0-1:MOH ORGANOGRAM

MoH has developed a new organogram to better align with emerging disease patterns and the focus of the SDGs (Sustainable Development Goals). It is currently with the Minister responsible for civil servants and is expected to be implemented soon.

The Health Sector at the National level is guided by the following structures:

1) Permanent Social welfare committee of the House of Representatives which meet quarterly, its role to monitor implementation of the health sector
2) Leadership committee
3) Executive committee
4) Audit committee
5) Tender board committee
6) Technical working groups guided by Health Sector Reform Secretariat (RMNCAH, Community Health, Health Care Financing, Quality Assurance, Sector Performance & Monitoring, and Human Resources for Health and others). These are to meet quarterly.
7) Annual Joint Health Sector Review (AJHSR)

All of the above fora oversee performance within their respective areas. Moreover, the Ministry has other joint technical meetings with stakeholders, on the overall level in the form of the SWAp Committee.

Health Boards and Professional Councils are expected to play a stronger role including assisting in ensuring quality and compliance with Code of Conduct for medical practitioners.

MoH is linked to the Disaster Management Commission under the Second Vice-Presidents Office on health and health-related disaster interventions. Regarding emergency preparedness and response within the health sector, although there is no emergency preparedness & response unit in place, the Ministry has established Public Health Emergency Operation Centre which is responsible for coordinating emergency issues. An Emergency Preparedness and Response plan has not been developed yet. However, the Ministry of Health has developed Zanzibar Cholera Elimination Plan 2018-2027, Public Health Emergency Plan for airport and seaport, Ebola Contingency Plan, and National Action Plan for Health Security

The sector still uses the Program Based Budget (PBB) and the Plan of Action (PoA) format for annual planning and Medium-Term Expenditure Framework (MTEF) which is three years planning tool.

MTEF and PoA have different sets of expenditure categories. The MTR pointed out that the planning process of PoA is not fully participatory, had weaknesses, and had gaps in monitoring activity implementation. The mid-term planning review meeting is held to identify gaps for improvement of the coming year's plan.

The sector has established sufficient coordination mechanisms with:

- SWAp Steering Committee9, chaired by MoH and co-chaired by PORALG-SD & the DPG Chair.
- Annual Joint Health Sector Reviews (AJHSR).
- Development Partner Group (DPG).
- Basket funding mechanism: Zanzibar Health Basket Fun (ZHBF) is governed by a Basket Steering Committee chaired by MoH.

While the systems are in place, the ability of the partners, MoH and Development Partners (DPs), to ensure timely and well-prepared meetings and AJHSR has not been sufficient.

Likewise, MoH leadership has not always been as explicit as proper country ownership would require.

Last, but not least, more than half of DP funding is ear-marked leaving little flexibility for MoH to pursue its HSSP priorities and most DPs exhibit a surprising lack of coordination with other partners, which is damaging to the efficiency of the sector.

In general, overall management is not sufficient, as exemplified by the considerable delays in preparing the PoA and complying with Basket procedures. Fortunately, several of the disease-specific programmes are better resourced and exhibit more robust management.

Zanzibar has a large private sector spanning from hospital services, over clinics to allopathic and traditional providers as well as many private laboratories and other diagnostic services and pharmacies. There are some regulations in place, but the Private Hospital Act is not yet finalized, and enforcement is rather weak, e.g. inspections of private facilities are taking place, but not to the desired degree, and the Private Hospital Advisory Board is under-resourced.

Furthermore, harnessing the private sector to achieve better access and quality for all citizens by improving synergies between the public and private sector is not done to any significant degree, with the two-way public-private referral of patients between Mnazi Mmoja Hospital and Global Hospital (MoU established) as the exception.

Human Resources for Health

9 Agreed in principle and expected to be fully operational during the last half of 2019

A recent study10 found the following issues and challenges regarding human resources for health (HRH) in Zanzibar:

- Shortage as a result of imbalances between supply and demand
- Misdistribution of staff, with higher shortages of staff in remote and rural areas
- Poor staff performance including low/declining productivity and quality.
- Fragmented approaches to HR planning, management, and development
- Inadequate HRH financing

With a doctor to population ratio of 0.9511 per 10,000 and the similar rate for nurses being 4.6512, Zanzibar has a severe shortage of Human Resources for Health (HRH). The density of RMNCAH HR is 6, 313 per 10,000 population, far below the WHO recommended 23 needed to achieve 80% births attended by skilled personnel. In 2015 an analysis of gaps showed a substantial shortage of staff of all cadres at the Primary Health Care Unit (PHCU) level14.

However, considerable improvements of HRH in terms of numbers and professions have been realized in 2018/19. The total number of Health Workers increased by 16% in 2018 /2019 as compared to the year before.

10The Situational Analysis on Human Resources for Health in Zanzibar, NIMR & UNFPA, 2017.

11UNICEF Health Budget Brief 2017/18. NOTE: The Health Sector Performance Report 2018/19 indicates much higher figures 1.5 per 10,000 for doctors and 7.6 per 10,000 for nurses.

12Ibid

13The Situational Analysis on Human Resources for Health in Zanzibar, NIMR & UNFPA, 2017

14HSS Gap Analysis, Danida 2015

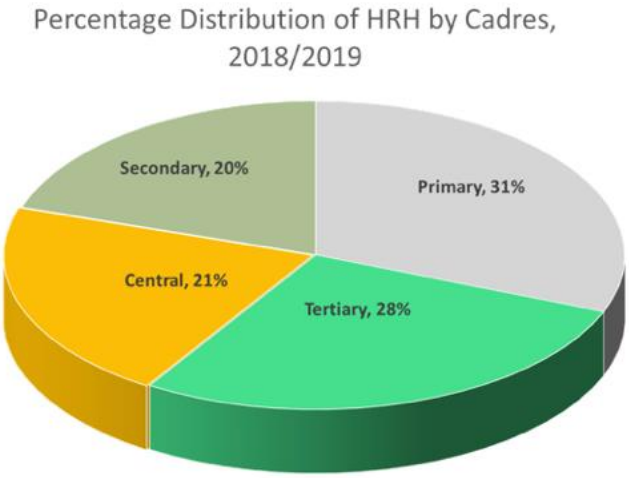


Figure 0-2:Distribution of HRH across the levels of the health systems

Distribution is geographically skewed with 60% of health workers in the urban district of Unguja which accounts for 18% of the population, resulting in a health worker density of 20 compared to only 1 in Pemba's West District15.

Production is being addressed by Zanzibar College of Health Sciences (ZCHS) – part of the State University of Zanzibar (SUZA) maintaining an enrolment of 30016 per year, although this is below the HSSP III target of 500, and the planned MoU between SUZA and MoH to ensure production of lower cadres has not yet been established. A few years back the first batch (48)17 of medical doctors graduated from Zanzibar Medical School, which has been accredited by Tanzanian Commission for Universities. A medical engineering program has been started at ZCHS a few years back.

Zanzibar Nurses & Midwives Council (ZNMC) in collaboration with Tanzania Nursing & Midwifery Council is planning to establish licensing examinations for all four nursing training institutions.

The perceived inefficiency18 of professional boards and councils are being addressed through strengthening these as part of HSSP III.

15The Situational Analysis on Human Resources for Health in Zanzibar, NIMR & UNFPA, 2017

16MTR

17 MTR

18The Situational Analysis on Human Resources for Health in Zanzibar, NIMR & UNFPA, 2017

Work is ongoing to establish manning levels in terms of numbers and types of staff required at all the different levels of the health system. This is supposed to be followed by developing schemes of service and starting the revision of wages to increase them. The intention is to establish a five-year recruitment plan.

A Human Resource Information System (HRIS) has recently been established and is functioning fairly well, although it still faces challenges such as delays in inputting data and too little usage for decision making. In addition, it needs further customization. The HRIS is technical updated by the University of Dar Es Salaam.

There are unclear roles and divisions of responsibilities between MoH's HR Unit and institutions' HR units. Job descriptions for staff at MoH and tertiary institutions are in place. The Open Performance Review and Appraisal System (OPRAS) is planned to be initiated.

In addition, quality is being addressed by increasing teachers' qualifications, e-learning and revitalizing districts' resource centres. A Human Resources & Staff Retention Strategy has been finalized and is awaiting implementation.

Furthermore, also in the area of HRH, there is a need to further develop the rules and regulations governing the new decentralized system as relations and interactions, including supervision, are not clear.

In recent years, Community Health Volunteers (CHV) have attracted much attention as an important resource both to improve health prevention and promotion as well as data collection and monitoring of quality. The two existing schemes (UNICEF and D-Tree) and other smaller CHV programs are to be merged into a national CHV program and expanded under the MoH and PORALG-SD. Specifically, the CHVs will do Health promotion and education through individual and group coaching; screening for danger signs, risks, missed routine visits/services, and unhealthy behaviours facility referrals including follow up; monitoring of concerns, referrals, facility discharge/counter referral to the community; distribution of health commodities; and community data collection

Currently, the package of services for CHV has been developed with the focus on RMNCAH and nutrition services and the other services are planned to be gradually included within the coming five years.

Health Service Delivery

Zanzibar has good coverage of public health facilities: One tertiary hospital with a maternity wing and a mental health wing located in Zanzibar City (MMH), one hospital in Pemba, five district hospitals (Kivunge and Makunduchi in Unguja and Micheweni, Wete and Chake Chake located in Pemba), one Primary Health Care Centre (PHCC also called Cottage Hospital), Vitongoji in Pemba, 34 PHCU+s (13 in Pemba and 21 in Unguja) and 119 PHCUs (51 in Unguja and 68 in

Pemba)19On average more than 90% of the population in Zanzibar are within a 5 km radius of the nearest health facility and there is a facility for every 5,000 population which is within the RGoZ target20, however, there are huge differences in the facility per population across districts.

The total number of OPD visits has increased by 40% from 2016 to 2018. The highest increase has been in the public facilities namely 63% increase while the increase in private facilities was 38% and there was a decrease in parastatal and faith-based facilities21. The increase has been higher in Pemba compared to Unguja.

OPD utilization rate is 1.1 per person per year, and 2 for U5Y almost unchanged over the last couple of years. The OPD rate varies hugely across districts (from 1.7 in Chake Chake and Kati to 0.6 in Magharibi B)22.

The private sector is significant at all levels of the health sector and presumably expanding, however many figures/data are not available. There are 91 registered private health facilities in Zanzibar (21 in Pemba and 70 in Unguja), of these 8 are faith Based, 11 are NGO based and 70 are private for-profit23. The number of OPD patients seen in private facilities (including FBOs) constituted a fifth of all OPD patients24.

A key element of the service delivery is the main referral hospital, Mnazi Mmoja Hospital (MMH):

- MMH is the only tertiary hospital for Zanzibar.
- It is a semi-autonomous public hospital established bytof 2016.
- It has a bed capacity of 678 spread over three campuses.
    - The main campus, MMH has 541 beds.
    - Mwembeladu Maternity Home has 37 beds and
    - Kidongo Chekundu Mental Hospital 100 beds.
- MMH is a tertiary institution, but it also manages outpatient cases that are mainly self-referrals and makes MMH a busy hospital.

192017 HMIS bulletin + update from UNICEF

20MTR

21 Based on OPD figures in Zanzibar Health Bulletin 2018

22Ibid

23 HMIS bulletin 2017

24Zanzibar Health Bulletin 2018

MMH is being congested with patients seeking healthcare services for uncomplicated conditions that could be treated at lower levels, due to a dysfunctional referral and gate-keeping system. This hampers the delivery of quality tertiary care at MMH.

The facility-based staff is being supplemented by Community Health Volunteers (CHV). The new Community Health Strategy was launched during the AJHSR (Feb. 2020) and addresses policy and strategic issue which were observed during the implementation of the previous. To ensure implementation of the revised strategy which includes the issue of CHV supplementing the facility-based staff at the community level, the MoH is going to request the funding from World Bank. At present MoH together with D-Tree International and UNICEF secured funding for setting up the National Digital Community Health Volunteers who will provide the RMNCAH and nutrition services.

Since 2011 only 8025 Shehia Health Custodian Committees (SHCC) out of 338 Shehias have been established, and the functionality of the already established committees was not satisfactory. The establishment and functioning of SHCC has been stagnant due to many reasons including, insufficient financing, slow pace of the strategy implementation, and the decentralization process. There has been a lack of proper definition for coordination and supervision mechanisms. Similarly, there has been weak monitoring and evaluation and lack of a strong community data component, insufficient involvement, and engagement of key stakeholders during strategy26.

Like most other countries there are considerable inequities across several parameters in Zanzibar. Most important, inequity is observed in human resource allocation, service utilization, and health outcomes between Unguja and Pemba.

While there is no Quality Assurance Unit in MoH, a Quality Assurance (QA) Technical Working Group with diverse members is functional and oversees quality improvement initiatives including the development of the QA strategic plan and framework. Staff from MoH Mainland are giving technical support.

Laboratory services are well developed with qualified personnel at all levels, and a reasonable supply of reagents, although stock-outs are frequently experienced. For lower levels, specimen referrals are not clearly defined. A comprehensive quality assurance system is lacking, although some elements are in place.

25Health Sector Performance Report 2018/19

26Draft Community Health Strategy (2019)

Sub-sector strategies and plans are not aligned to the HSSP IV timeframe, which means that there could be discrepancies between them and HSSP IV.

Maternal & Child Health and Reproductive Health

Under-5 mortality and infant mortality are declining, while neonatal mortality is almost constant.

The under-5 mortality reduced from 73 deaths per 1000 live births in 2010 to 56 in 2015 and infant mortality has reduced from 54 deaths per 1000 live births in 2010 to 45 in 2015. Unfortunately, neonatal mortality has not declined with 29 neonatal deaths per 1000 live births in 2010 as compared to 28 in 2015/2016. There are concerns that without concrete actions the neonatal death rate may rise.

High fertility rates that drive rapid population growth also contribute to a persistently high maternal mortality ratio in Zanzibar, estimated at 307 per 100,000 live births in 201227

The number of deliveries in health facilities as well as skilled deliveries overall have been increasing and was in 2015 (TDHS) 66% and 69% respectively, and deliveries at health facilities were 67% in 201828.

A focused approach to reducing institutional maternal and neonatal mortality is yet to be established, particularly with a view to the high maternal and neonatal mortality within health facilities, including at MMH and Chake Chake Hospitals. Nevertheless, Institutional Maternal Mortality Rate has been declining, from 277 in 2016 to 155 in 2018 (per 100,000 live births)29.

Community Health Volunteers have been capacitated to educate and mobilize on utilising reproductive health services, also to increase deliveries at health facilities.

ANC coverage30 is 86% attending at least one visit, but only 30% completes four, and only 26% attends ANC before 16 weeks of pregnancy and the ANC coverage,

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27 2012 Census data

28 Health Bulletin 2018

29 Ibid

30 Figures from Health Bulletin 2018

therefore, could be improved. Also, the proportion of women and new-born who receive postnatal care within 2 days could be better.

Tanzania's rate of population growth is among the highest in the world. Zanzibar continues to have a very low level of use of modern contraceptives (14% in 2015), with considerable disparities across geographical areas (Kusini Unguja 27%, Kusini Pemba 7%)31, slightly increasing since 2009/10. Many factors influence this state of affairs related to health systems and resources, community perceptions but also "lack of commitment of high-profile leaders and implementers to fulfil their expected roles"32. Couple Years Protection Rate (CYP) has however improved with almost a doubling from 2016 to 2018 to 281 (per 1000 women of reproductive age)33.

Despite efforts such as the costed FP implementation plan (2017-2022 - finalized in 2018), sensitization meetings with political and religious leaders, support for male involvement, and FP outreach services, the unmet need for family planning is still high, 28% in 2015/16. It is however encouraging that FP New Clients Acceptance Rate has increased from 6.3 in 2016 to 7.3 in 201834, with a much bigger increase on Pemba than Unguja (19% over the two years vs. 9%), so this indicator is now the same on the two islands.

Immunization coverage for 2018 of 78%35did not meet the HSSP III target, but 86% of children had received their third dose of pentavalent vaccine.

Shortage of Transport in some districts delayed timely vaccine distribution and supervision.

The issue of Gender-Based Violence (GBV) is increasingly being addressed through SOPs, seven One-Stop Centers, increasing services at health facilities, and awareness creation.

Malaria Elimination

Malaria is almost eliminated with a prevalence of less than 1% since 2008. This positive situation may change if the sustained mechanisms are not in place

31 Family Planning Quality Study – Exploring Factors Influencing Utilization of Family Planning Services in Zanzibar – UNFPA Tanzania January 2017

32Ibid

33 Based on figures from Health Bulletin 2018

34 Health Bulletin 2018

35 Health Bulletin 2018

before funding from external aid is terminated. Local transmission in a few places exists which requires intensive efforts to realize the set target.

The use of impregnated bed nets is still low. The introduction of new long-lasting mosquito nets (PBO Nets) is a new milestone in malaria elimination. Indoor residual house spraying is on-going as a targeted approach.

HIV/AIDS and TB

Zanzibar has one of the lowest HIV prevalence rates in the Africa region, <1%. Unguja Island has a higher HIV prevalence than Pemba (1.2% and 0.3% respectively), with HIV prevalence highest in Urban West Region at 1.4%. However, Zanzibar has a concentrated HIV epidemic with high HIV prevalence among Key Populations.

HIV counseling and testing are increasing consistently over the past 3 years whereby 94,507 individuals were tested in 2016, thereafter 161,002 were tested in 2017, and 261,404 were tested in 2018, a yearly increase of 60-70%.

The population living with HIV had been relatively steady between 2000 and 2008 but a slight increase was noted from 2008 through 2015, this can be explained by the establishment of care and treatment services in 2005 and access to anti-viral treatment that reduced mortality among PLHIV.

The number of new HIV infections from 2005 shows a downward trend across all age groups indicating that HIV prevention and treatment interventions are bearing fruits.

Moreover, the number of deaths among PLHIV has decreased over the last 10 years. The decline is remarkable from 2005 which reflects the period when a care and treatment programme with access to anti-viral treatment was established.36

The burden of TB is high with a prevalence of 124/100,000 population37. MDR (multi-drug resistant) TB case detection is low. However, MDR case detection is improving: 3cases were detected in 2016, 3 cases were detected in 2017 and 7 cases were detected in 2018.

36This section is derived from Zanzibar Health Sector HIV & AIDS Strategic Plan 2017-2022 – November 2017

37 2013 TB prevalence survey

The treatment success rate of bacteriologically confirmed TB cases (alternatively termed cure rate) is also increasing from 91% in 2016, to 93% in 2017 to 95% in 2018.

Nutrition

The latest TDHS (2015/16) shows declining levels of malnutrition, however not reaching the targets of the HSSP III. There is, unfortunately, a decline in children under 5 receiving Vitamin A, it is currently 79%38. Significant inequality was demonstrated by a rate of stunting and underweight of 39% and 18% in Pemba and 26% and 16% in Unguja.39

Key issues identified:

- Under nutrition rates are declining, but overweight (especially among adults) and anaemia (especially among pregnant women) are rising or remain high.
- Adolescent girls are not reached with interventions to prevent anaemia.
- Multisectoral coordination is still a challenge; synergies between nutrition-specific and sensitive interventions need to be clear.

Non-Communicable Diseases (NCD)

The three chronic NCDs which contribute the most to overall mortality in Zanzibar are cardiovascular diseases, cancer, and diabetes. In addition, other NCDs have been recognised as priorities to be addressed including oral health, mental health, and road traffic injuries. The treatment of complicated NCDs already costs Zanzibar TSH 1.5 billion annually in paying for treatment abroad.40

The burden of NCDs in Zanzibar is high, with over-weight and obesity approaching epidemic proportions particularly among women41. A third of the 25-64-year-old population has raised blood pressure42. And in 2011 4% had raised blood sugar43. Tobacco use is significant albeit lower than in many

38Health Bulletin 2018

39 MTR

40 Section based on Integrated Non-Communicable Diseases Strategy and Action Plan for Zanzibar 2014-19

41 2011 STEPS survey & MTR

42 Ibid

43 Ibid

industrialised countries (6% in 2011)44, while alcohol consumption is low (>90% lifetime abstainers).

This substantial burden of NCDs is being addressed by having an NCD Strategic Plan, an NCD Unit in MoH, training facility staff in addressing NCDs, ensuring continuous supply of diabetes and hypertensive medicines at health facilities, conducting health promotion campaigns.

Mental health services have been expanded to the PHCU+ level.

Neglected Tropical Diseases (NTD)

Training and drugs for helminthiasis and schistosomiasis are available at facilities.

Prevalence for Filariasis and Schistomiasis is 3.4% and 0.9% respectively. The number of cases of schistosomiasis and intestinal worms has both been increasing slightly from 2017 to 2018, while filariasis has reduced. Mass drug administration against schistosomiasis and filariasis for 2018/19 reached 98%.45

Medical Products and Equipment46

The MoH, in collaboration with various stakeholders, continues to improve the availability of health commodities at service delivery points through strong and vibrant supply chain management systems. Over the years the Ministry has implemented many initiatives for this purpose which include: integrating most health commodities into one supply chain logistics system - The Zanzibar Integrated Logistics System (ZILS), developing and implementing the Zanzibar Supply Chain Costed Action Plan (SCCAP) 2017-2020, implementing the electronic systems that facilitate business processes and communications between health facilities and Central Medical Store (CMS), including the electronic logistics management information system (eLMIS), and advocating with the government to increase the overall budget for health commodities. A complimentary software known as eLMIS Facility Edition has recently been introduced to improve inventory management at the facility level to improve data quality and availability of real-time data.

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44 Ibid

45 All figures in this section are from Health Sector Performance Report 2018/19

46 Includes: Pharmaceutical and medical supplies & Equipment and infrastructure

Zanzibar has a good system of essential medicines supply with facilities experience stock outs of only about 10% of tracer drugs. A new warehouse in Pemba is in the final planning stages, and a process for expanding the warehouse in Zanzibar City is underway.

Major supply chain stakeholders in MOH are CMS and Chief Pharmacist Office. The core function of CMS is to store and distribute all commodities to health facilities at different levels.

The Chief Pharmacist Office through Logistic Management Unit (LMU) oversees all logistic systems. Currently, four working logistic systems use the electronic logistic management information system. There are:

1. The Zanzibar Integrated Logistics System (ZILS)
2. The Tuberculosis (TB) and Leprosy Logistics System
3. The Laboratory Supplies Logistics System (ZLLS)
4. Standard Medical Equipment (SME)

There is a considerable lack of systematic preventive maintenance of buildings as well as equipment, and the Health Care Engineering Unit as well as Medical Equipment Workshop, and other engineering units are generally under-resourced and under-staffed.

There is no systematic stock of spare parts; procurement is done ad hoc according to needs. Outsourcing is not done in any systematic way.

The issues of erratic supply of fuel for transporting referred patients have at least temporarily been alleviated by the Afya Bora project.

The present Information & Communication Technology (ICT) system, suffers from some shortcomings, these include47:

- The current ICT unit is not designed nor equipped to provide proper coordination to support all the departments and units of the health system.
- There are no structural or recognized linkages between the ICT unit and other units from different programs and departments with ICT staff scattered across units.
- Units, programs, and departments develop ICT solutions without involving the ICT Unit.
- One important example of the lack of coordination is that there are five different patient registration systems, that use different criteria and IT

47 From TOR for the Development of ICT Strategic Plan 2019/20 – 2024/25 for MoH Zanzibar, May 2019

platforms, and cannot communicate/interface with each other, resulting in disjointed information on service delivery within the health sector, impeding planning and management.

The health sector in Zanzibar has a fairly well-developed high-speed fibre network that connects many facilities, as well as MoH. MoH, however, cannot fully benefit from the fibre-net due to inadequate IT infrastructure within the ministry.

Health Financing

As per National Health Accounts (NHA)48, the Total Health Expenditure (THE) was found to be TZS 105,682.53 billion, representing appr. 3% of GDP. This represents average spending of TZS 68,121.50 (or the US $ 30) per person, an improvement from 2014 where it was 25$/cap. The biggest share of THE is provided by Government, 49.5%, followed by Donors49 31.1%, and Households50, 18.5%, with the least share provided by Corporations, 0.9%. Regarding Current Health Expenditures (CHE), which constitutes 2/3 of THE, the proportions are: Government, 42%, Donors 36%, Households51, 21%, and the Corporations, 0%. For Capital Expenditure (one-third of THE) Government is providing by far the largest proportion with 73%, followed by foreign Donors with 24%.

The government uses almost 8% of its total expenditures on health, 7.7% in FY 2017/18.

The primary level and hospital levels received a roughly equal proportion of CHE funding, followed by an administration that received a substantial amount namely almost a quarter of all funding. Treatment abroad accounted for a little more than 5%.

Out of these expenditures, almost half is used for curative services nearly equally distributed between in- and out-patient care. The other half of CHE is more or less equally divided between preventive services and administration.

48The Zanzibar National Health Accounts (NHA) was undertaken to track the flow of funds in the health sector for the fiscal year (FY) 2017/18.

49Including NGOs

50Household expenditures build on health service consumption data from the 2014/15 Household Budget Survey but using a more recent cost based on the Consumer Price Index for health products for 2017/18.

51 Ibid

In terms of the type of inputs used in health care, the findings revealed that compensation of employees (mainly salaries) took the largest share of CHE, namely 38%, followed by healthcare goods (incl. pharmaceuticals) with 21%.

The spending by conditions/diseases52 was the following: Infectious and parasitic diseases accounted for the largest share at 52%, followed by non-communicable diseases at 22% while injuries and reproductive health accounted for 9% each.

Main Conclusions arising from NHA.

The following are the main conclusions based on the NHA, combined with other available information:

- While there has been an improvement in per capita spending, 30$/cap is far below the WHO minimum of 86$/cap53 needed to achieve Universal Health Coverage (UHC).
- Similarly, the government uses only around 8% of its total expenditures on health, far below the Abuja target of 15% and also below the proportion used by most countries that have been successful in achieving UHC.
- And the total spending on health is only 3% of GDP, falling below the WHO estimate that at least 5% is needed to achieve UHC.
- The MTR stated that "the ZHSSP III has been underfunded during every year it has been in existence".
- The Out Of Pocket (OOP) expenditure of over 18% is substantially more than the threshold of 10% above which the World Bank considers there is a substantial risk that households are impoverished due to health reasons.
- The above findings demonstrate that the present resources available – government and donor funding – are too little to run a health system that provides UHC and that in reality free quality health services cannot be assumed to be fully provided.
- Administration cost is high. This may partly be due to the fact that small countries' health systems do not require proportionally fewer resources to run, and therefore tend to be proportionally more expensive to manage.

52Across the International Classification of Diseases (ICD) spectrum

53Matt Jowett: "Spending Target for Health: no magic number", WHO 2015, where it is pointed out, that progress towards UHC can be made with very low levels of spending, i.e.<PPP40$/cap, although in terms of financial protection, significant improvement is observed only once public spending is greater than PPP$ 200/cap.

Overall Recommendations arising from the NHA findings.

The NHA's findings give rise to the following overall recommendations:

- Increase substantially government allocation to the health sector.
- Seek additional donor resources for health, mainly resources that are well aligned to the implementation of the country priorities i.e. HSSP IV.
- Implement alternative financing options. This would include developing a financing strategy that includes considerations regarding health insurance as well as establishing a health fund that could efficiently channel funding towards government priorities, including UHC and PHC.
- Consider ways of making the administration of the health sector more efficient and less costly.

Budget Implementation

Budget implementation is quite good for recurrent spending, >94% for all cost categories, but not good for development spending (including capital investments) within the categories "prevention and health education" (15%) and "hospital services" (33%), however, "policy, planning and health research" achieved 99%. It should be noted that in Zanzibar the category Development Spending includes most donor support for recurrent expenditures54.

Zanzibar has no comprehensive health financing strategy, only a few principles mentioned in the Health Policy and HSSP III, the current government's principle of free health care, as well as some political intentions regarding health insurance. Some groundwork was done in 2011 with the assistance of external consultants to outline the options in terms of health financing for Zanzibar55, and recent work has started on developing a Health Financing Strategy.

Public Financial Management

54UNICEF Health Budget Brief 2017/18 – but this information has to be checked, as some in MoH claim it is not the case.

55 U Enemark & A Bjerrum: "Sustainable financing of health services in Zanzibar – which way to go?"; Undated (2011)

An Internal Audit Department has been established in MoH, improving financial management. Regarding budgeting, accounting and auditing see the section above under Health Systems Governance and Implementation arrangements. Currently, departments are not preparing timely cash flow, there are no assets and contract registers. The recent review by DPPR of PoAs for FY 2017/18 showed considerable shortcomings, e.g. wrong use of cost categories and unexplainable differences across districts.

Health Information and Research

The cornerstone of health information in Zanzibar is the District Health Information System (DHIS2). The information from DHIS2 (District Health Information System) bears the morbidity, mortality, and services provisions at facility levels. The Management of this information is done through Health Management Information System (HMIS). Also, within the MoH, there are other systems for capturing information such as Electronic Logistics Management Information System (eLMIS) and Human Resource Information System (HRIS) providing information on reporting and requesting of health commodities and human resources availability and capacity respectively, as well as Financial Management Systems that governed by the President Office Finance and Planning (PoFP). Even though some health programs have mini data collection systems purposively for their program M&E systems. In addition, some hospitals established electronic medical records. Ideally, these systems are required to be included in HIS including other systems that have health-related components such as Birth and Death registration.

M&E Organizational Structure

Within MoH seems to be more diverse with separate units such as HIS Coordinating Office, M&E Division, HMIS Unit, as well as program-specific M&E units dealing with daily data monitoring. There are also Health Information System Core Team and a HIS Steering Committee.

Data collection process

Health Management Information System

The morbidity, mortality, and service delivery information collected from health facilities (for Hospitals: clinics, and wards) by using registers. The patients or clients registered in the registers on basis of services demanded by such client/patient. While at the end of the month the monthly summarized report is prepared in the respective area of service delivery. This process is required to be done within five days of the coming month. Then the summary reports are entered within DHIS2 by trained health providers under the supervision of the

District Data Manager (DDM). From there the data are accessed by DHIS users under the HMIS monitoring.

Logistic Management Unit

This unit accomplished its objectives by collecting all information regarding reporting and requesting health commodities. Data collected as follow:

- Collect its information by using paper R&R at facility level by each quarter.
- Paper R&R received by DP at district level for approval and entering in the eLMIS
- Currently, some facilities use eLMIS directly for R&R while the DP used to approve within Elmis

Human Resource Information System - iHRIS

Normally, it collects information about workers. This process helps the sector to estimate the workers' demand and to know the number of workers available. The process is done:

- Allow districts data managers to enter new workers and upgrade the existing ones
- Head office that controls iHRIS used to register new workers once they employed and also use OPF to upgrade the information of the existing employees

Electronic Medical Records - EMR

Electronic Medical records are used to capture real health data from the site. Since August 2018 the implementation was in place at MMH. Currently, it operated at one department (general OPD) and pharmacy for only OPD patient; unfortunately, do not expand further in other departments.

The process is done as follows:

- New patients registered in the system in the registration rooms and given a unique number.
- For returning patient required to enter its reg. number to update their information

Data Analysis and interpretation

The analysis is done automatically in all systems for direct indicators and the systems allow manual analysis by downloading the data file in excel.

Health Data Quality

The quality of data management has been addressed either by training data managers at hospital and district levels. Nowadays also there are trained health staff at the facility level as data clerks (among the health providers). This facilitates the timeliness of report submission to the DHIS2. For doing this District Data Managers used most of their time to review the data entered within DHIS2 and correct the errors committed during the data entry (by health provider) under the supervision of HMIS staff. This condition enables HMIS to get completed data sets, and correct and consistent data from the health facility. To obtain correct data from the health facilities, the semiannual data audits, supportive supervision at facility levels, and data cleaning are employed under specific guiding tools. Also, some programs conduct their data audits by using existing systems.

Also, data quality is enhanced during annual data use workshops, District Quarterly Review Meetings, and vertical programs quarterly and annual review meetings.

The overall submission rate of completed forms was ranging 80% to 99%56 and timeliness in 2017 was 68.2%.

In building the data consistency and trustworthiness, HMIS makes different efforts to strengthening the DHIS2 while at the same time invited health programs to use integrated national DHIS2 as their reporting tools.

Integration of some program systems such as a Disease Surveillance & Response (IDSR) that has been integrated to DHIS2 since 2018 together with some supervision checklist initiated by ZAMEP and expectation of some other to be integrated soon.

Challenges encountered by health information and research.

Overall, the functioning of the health information system is affected by inadequate resources (financial, human, and equipment)57. Also, the actual use of data in decision making is weak at all levels 58. The following are some specific challenges:

56Zanzibar Health Bulletin 2018

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i. Shortage of experienced staffs with the capacity of complex analysis and ICT/IT staffs based on database management.
ii. Existence of multiple systems that collect the same data collected in DHIS2
iii. Inadequate supply of internet bandwidths at all levels of data collection sites.
iv. Lack of updated HMIS guidelines and SOPs on data collection procedure and sector direction on data which translate the HSSP into action.

Data Dissemination and Use

Every year HMIS provides the Annual Health Bulletin while M&E division disseminates information through the Annual Performance Report which includes some indicators from data collected by HMIS. Also, health programs provide annual reports of respective programs.

The human resources department is also required to provide a bulletin yearly but unfortunately do not produce it since the last one in 2013.

Research

Research activities are not strong due to a lack of research legal framework, skilled researchers, and infrastructure59, and often are driven by the priorities of foreign research institutions. The Zanzibar Health Research Ethical Committee (ZaHREC) has been reconstituted with new leadership and strengthened staffing, and standard operating procedures (SOPs) are being developed.

There is no national health research priorities and policy from MoH guiding the health research in Zanzibar, but there are research frameworks at programs and unit level.

Recently, the Zanzibar Health Research Institute (ZAHRI) is being set up, headed by a Director General60. The level of resources for ZAHRI is not clear, neither how much it will contribute to improving the situation, but its vision is to "be an

59MTR

60 Draft Legal Notice for ZHRI (2017?)

institution of excellence for the advancement of health research and development in Zanzibar and beyond"61.

Achievement of HSSP III Targets

Table 13:Achievement of HSSP III Targets

Indicator	Baseline (data source, year) 2013/14	End term target (2018/19)	Achievement (data source, year) (2015/16)	2016/17	2018	Remarks
HEALTH STATUS						
Institutional maternal mortality ratio/ per 100,000 deliveries	310/100,000	111/100,000	237/100,000	119/100,000	155/100.000	
Malaria prevalence rate	< 1% (THMIS)	0% (2018/19)	< 1% (TDHS-MIS 2015/16)	Survey data	Survey data – not available yet	Increase in Malaria incidence of 0.8% from 2017/18 to 2018/19
Neonatal Mortality Rate/1,000 live births	29 (TDHS)	TBD	28 (TDHS, 2015/16)	Survey data	Survey data – not available yet	
Infant Mortality	54 (TDHS 2010)	23	45 (TDHS, 2015/16)	Survey data	Survey data – not	

61 Draft ZAHRI Strategic Plan July 2018-June 2022

Rate/1,000 live births					available yet	
Under 5 Mortality Rate/1,000 live births	73 (TDHS)	34	56 (TDHS)	Survey data	Survey data – not available yet	
HIV prevalence among the general population	< 1% THMIS	< 1%	1,20% (AHB 2015, Proxy indicator)	Survey data	Survey data – not available yet	1.2% is a health facility average
COVERAGE						
Proportion of pregnant women delivered at health facility	59.4% (2013 (DHIS 2, 2010) 49.2% (TDHS-MIS)	80%	51.5 (DHIS2, 2015); 66% (TDHS - MIS 2015/16)	62.2%	67.0% (HB2018)	
Proportion of pregnant women delivered by skilled birth attendant/personnel	53.7 (TDHS, 2010)	90%	68.8 (TDHS, 2015/16)	63.3% (HB 2017)	-	
Contraceptive prevalence rate (modern method)	12.4 TDHS (2010)	25	14 (TDHS - MIS, 2015/16)		Survey data – not available yet	No new survey figure, but CYP increased by around 90% from 2016 to 2018

1st ANC visit	99.4 (TDHS 2010)	100	99.7 (TDHS-MIS 2015/2016)	81,4	85,6 (HB 2018)	
4th Visit ANC coverage	30.9 (DHIS2 2013) 48.9 (TDHS 2010)	60 (DHIS 2)	22.6 (DHIS 2 2015) 52.9 (TDHS-MIS,2015/16)	28	30.3 (HB 2018)	
No. of PHCUs+ providing BEMONC services	19 (Health Bulletin, 2013)	34	22 (Health Bulletin, 2015)	34	49 (HB 2018)	
No. of PHCUs providing Comprehensive Post Abortion Care services	21 [DHIS2 2013]	83	34 (DHIS2, 2015)	34 (PR 2017)	7 (HB 2018)	DHIS2 not suitable to monitor this indicator.
% of delivered women going to clinics for postnatal care (within 2 days)	32.4 (TDHS, 2010)	50	40.1 (TDHS - MIS, 2015/16)		-	
Percentage of health facilities with 80% staff trained IMCI	38% [APR 2013]	80%	66.7 (APR 2015)	82%	-	
Coverage of fully immunized children under 1 year	84.1% (DHIS2 2013); 77%(TDHS 2010)	>90%	82.7%(DHIS 2, 2015) 80.8% TDHS 2015/16)	67.5%	78% (HB 2018)	

Vaccination coverage of Penta 3 for under 1 year (%)	81.2% (DHIS 2, 2013); 95% TDHS 2010	>90%	76.3% (DHIS2) 93.4% (TDHS 2015/16)	83,90%	86% (HB 2018)	
Measles Coverage of children under one year	89.3% (DHIS, 2013)	>90%	88.2% (DHIS, 2015) 89.4% TDHS 2015)	68,4%	92.8% (HB 2018)	MCV1
Non Polio AFP case detection rate to ≥ 2/100,000 population under 15 years	2.6 (EPI report: 2014)	Greater than or equal 4.5/ 100,000	2.6 (EPI report: 2014)		-	
% districts report at least 1 suspected measles case with a blood specimen per year (target > = 80% at yearend)	10 (EPI report 2013)	10	10 (EPI report 2015)		-	
Reduce number of NNT cases to < 1 NT / 1,000 live births/ year /district	0.6/1,000 live birth per year per district [DHIS2 2013]	<1 NT /1,000 live births per year per district	0.66 per1,000 live births in Zanzibar and ranges from 0 to 2.14/1000 live births in the districts		-	

			[DHIS 2 2015]			

HB 2018: Health Bulletin 2018

Annex 3 Monitoring, data sources, and frequency

Table 14:Some of few selected Indicators for the health and social sectors with Sources & Frequency

Measure(Indicator)	Source	Frequency	Remarks
%of clients expressing satisfaction with outpatient, inpatient, ANC, and delivery services	Client Satisfaction Survey	After every 4 years	
Number of OPD visits per capita in public facilities	Health Bulletin	Annually	
% of health facilities performing according to standards	Quality Improvement assessment	Annually	
Food Safety Policy in place and Functional	Annual Performance report	Annually	
Institutional MMR	Health Bulletin	Annually	
Perinatal mortality rate	TDHS	After every 5 years	
Neonatal mortality rate	TDHS	After every 5 years	
% of births attended by skilled health personnel	Health Bulletin	Annually	
% of births delivered at the health facility	Health Bulletin	Annually	
% delivered women attending PNC	Health Bulletin	Annually	
Contraceptive prevalence rate	TDHS	After every 5 years	
<5 mortality rate	TDHS	After every 5 years	
% of Children <1 year fully immunized	Health Bulletin	Annually	

% of adolescents 9-14 years received 2nd dose HPV vaccine	Health Bulletin	Annually	
% of U5Ys:			
- underweight	TDHS	After every 5 years	
- stunted	TNNS	After every 5 years	
- severe acute malnutrition	TNNS	After every 5 years	
Prevalence of HIV	THIS	After every 5 years	
% of people with HIV who know their status are on treatment	ZIHHTLP report	Annually	
TB Incidence	ZIHHTLP report	Annually	
TB case notification rate	ZIHHTLP report	Annually	
TB treatment success rate	ZIHHTLP report	Annually	
Malaria incidence rate	ZAMEP report	Annually	
% <5 sleeping under LLIN	TDHS	After every 5 years	
Prevalence of schistosomiasis	Annual parasitology survey	Annually	
Prevalence of lymphatic filariasis	Pre-Transmission Assessment Survey	Annually	
Number of extremely poor households receiving cash transfer	DESW performance report and TASAF	Annually	
% people sleeping under LLIN	TDHS	After every 5 years	
Age standardised prevalence among persons aged 18+ years of:			
−Insufficiently physical active	NCD step survey	After every 5 years	
− Tobacco use	National GATS report	After every 5 years	

−Raised blood pressure	NCD step survey	After every 5 years	
−Overweight & obesity	NCD step survey	After every 5 years	
Percentage of blood unit collected	Blood Establishment Computerized System (BECs)	Quarterly	
Percentage of women in decision making bodies at all levels	Annual CSW report	Annually	
Number of women and children benefited from legal aid services	Annual performance report	Annually	
- Proportion of women 30-49 years screened for cervical cancer at least once	Cervical Cancer Screening report	Annually	
Death rate due to road traffic injuries	Health Bulletin	Annually	
Coverage of services for mental disorders (measure TBD)	Performance report	Annually	
% of households w. access to basic sanitation	TDHS	After every 5 years	
% of households w. safe drinking water	TDHS	After every 5 years	
% of health facilities offering access and services to special needs groups	TDHS	After every 5 years	
% of premises inspected	Performance Report	Annually	
# of workers screened	Performance Report	Annually	
% of patients transferred out of Zanzibar for medical treatment	Performance Report	Annually	
% Of GDP spent on Health	National Health Account	Every 1 to 2 years	Improved planning and budgeting

Per Capita Health Spending			capacity at district level to address national as well as local priorities
Total Expenditure on Health as a % total Government Expenditure			
Out of Pocket (OOP) as % of THE			
% of Donor contribution to Total Health Expenditure			
% of private health facilities licensed	Performance report	Annually	
% of private health facilities inspected			
% of Shehias with a Health Custodian Committee			
% of Planning Officers trained on planning at different levels within MoH	Performance report	Annually	
% of resolved audit queries	Annual Audit report	Annually	
proportion of outbreaks or any public health event responded in any time period	Alert register		
		Annually	
% of health facilities receiving supportive supervision	Joint Supervision Report	Annually	
Revised policy and guidelines for referrals			
Number of National Referral Hospitals functioning	Performance Report	Annually	
Preventive maintenance guidelines for:			
Buildings	Asset Register Report		

Equipment and Transport			
% of facilities reporting stock-outs for the following:	Elmis	Annually	
- Essentials			
- Malaria			
- IRCH			
- ARV			
- TB			
- SME			
- Nutrition			
- Laboratory supplies			
National Standard Storage Guidelines for drugs			
% of facilities with appropriate storage			
Doctor: population ratio	Performance Report	Annually	
Nurse: population ratio	Performance Report	Annually	
% of health facilities meeting minimum staffing requirements	Health Workers Registry	Annually	
Number of staff trained as per HRH	HRH report	Annually	
development plan			
% of HSSP IV implementation status	Midterm and evaluation report		
Performance appraisal institutionalized	Performance Report	Annually	
% staff that have their job description	Performance Report	Annually	

Attrition rate	Performance Report	Annually	
% of staff retained annually	Performance Report	Annually	
HMIS/HIS Strategy	Health Bulletin	Annually	
% of health facilities submitting monthly report timely			
% of units & programs submitting monthly/quarterly reports timely			
% of facilities receiving supportive supervision and data audit visits			