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# **Health** Budget Brief 2018 Zanzibar

## Key messages and recommendations

- In FY 2017/18, the health sector has been allocated TShs 84.2 billion. This is a TShs 33.2 billion increase on the previous year, equivalent to 65 per cent increase or 62 per cent increase accounting for inflation.
- Government spending on health as a percentage of the total budget has been consistently lower than the Abuja target of 15 per cent. The sector is estimated to account for 7.7 per cent of the national budget in FY 2017/18. The Government must increase the resources available for health, if all children are to have access to essential health care.
- The FY 2017/18 budget has shown an increased commitment to preventive health and a reduction in the percentage of resources consumed by health administration. The preventive health services programme is expected to grow from 19 per cent of actual total government health spending in FY 2016/17 to 27 per cent in FY 2017/18.
- Medical treatment abroad consumes a large and increasing proportion of Ministry of Health (MoH) resources. In FY 2016/17, it consumed 13 per cent of the total spending despite efforts to reduce recourse to treatment abroad. Since FY 2013/14, this item has been consistently underestimated, with actual expenditure exceeding budget expenditure by 400 per cent in FY 2014/15 and FY 2016/17.
- Budget execution, especially the development budget, has been low but improved significantly in FY 2016/17. The procurement of drugs and medical equipment has faced in-year budget cuts with an execution rate of 53.8 per cent in FY 2016/17. This had a direct impact on stock-outs of essential medicines.
- In addition to the total shortage of health workers in Zanzibar, there are also large disparities in their deployment across the islands, with noted shortages of staff in Pemba. The Health Sector Strategic Plan III (HSSP III) has detailed indicators to monitor staffing requirements. Health worker training and retention strategies must be assessed against performance.
- Decentralization is a contested issue. Preventive health functions will be decentralized in FY 2017/18.

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- **Inadequate funding of health centres led to a decline in the quality of health care and an increase in informal health facility charges. This is thought to be responsible for declining rates of pregnant mothers giving birth at health facilities and delayed registration for antenatal care.**
- **Low public health expenditure, coupled with high household expenditure on health, make it likely that health events could result in catastrophic spending and impoverishment. Out-of-pocket spending on health accounts for 30 per cent of household expenditure in Zanzibar. Further study is warranted to better understand the issue.**

## SECTION 1: INTRODUCTION

**Almost all health services are administered by the MoH.** The MoH receives 87 per cent of all health sector funding. The Ministry is composed of eight directorates: Curative, Planning, Policy and Research, Administration and Human Resource, Preventive Services and Health Education, Chief Government Chemist, Chief Government Pharmacist, Central Medical Stores and Coordination Office in Pemba.

**Mnazi Mmoja is the only tertiary-level hospital. It was given semi-autonomous status in 2016, with its own budget and is headed by an Executive Director.** In FY 2017/18, Mnazi Mmoja will receive 12 per cent of the total health sector funding.

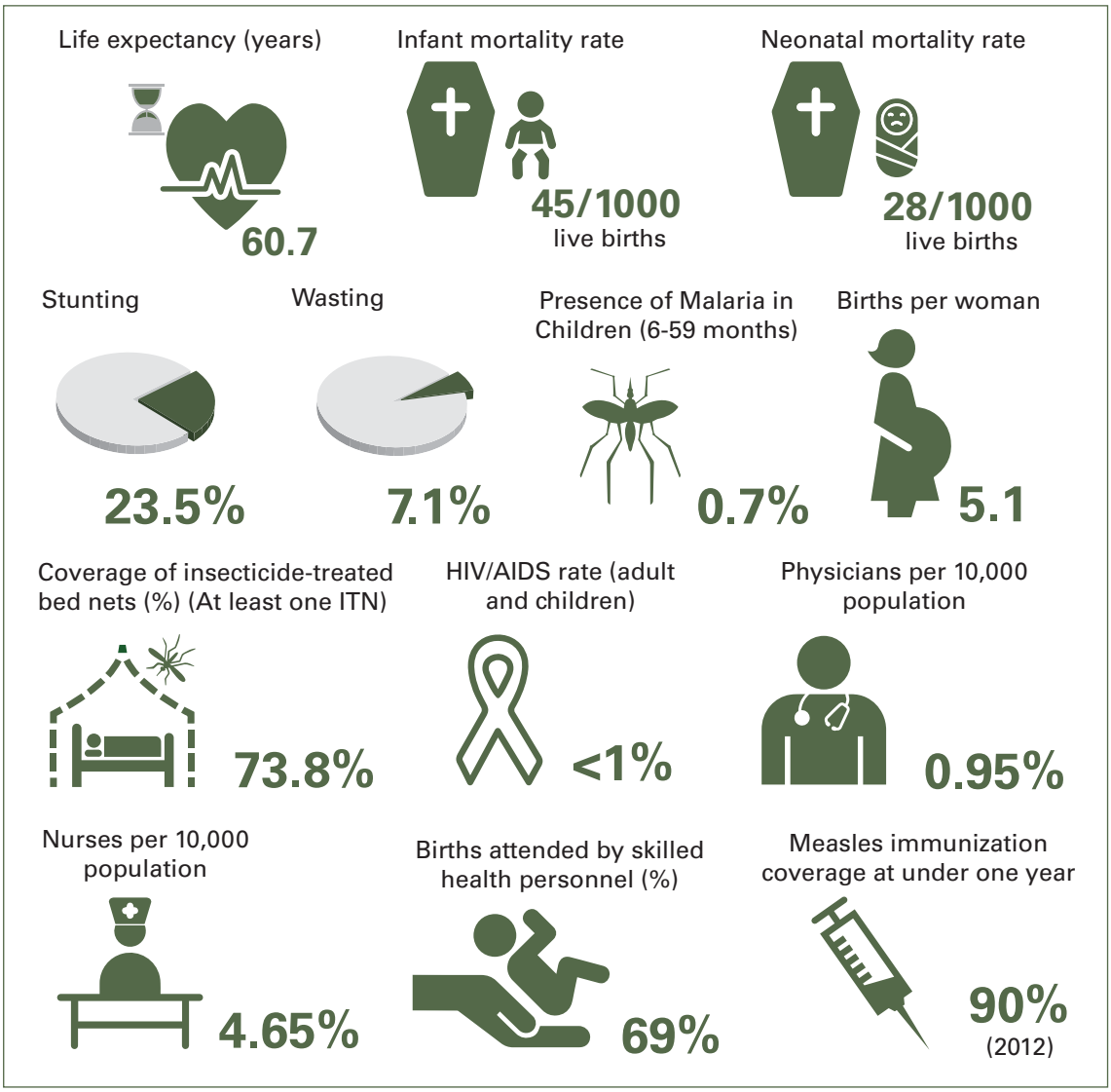
**The Zanzibar AIDS Commission (ZAC) was established in 2002 to manage the national response to HIV and AIDS.** It is a semi-autonomous body under the Second Vice-President's Office. In FY 2017/18, it is expected to receive 1 per cent of health sector funding.

**The Zanzibar Health Policy of 2011 provides overarching direction for the health sector.** The health policy was updated to be more reflective of efficiency, equity and gender issues. The health sector is guided by the Health Sector Strategic Plan, running from FY 2013/14 to FY 2018/19, which is in its third phase (HSSP III). Reporting against HSSP III targets is conducted annually and an in-depth mid-term review was completed in 2017. The national development strategy, Zanzibar Vision 2020, outlines the goal to create equal opportunity of access to basic and essential quality health care.

**Zanzibar has very low prevalence of communicable diseases of global public health significance compared to mainland Tanzania and much of sub-Saharan Africa. Malaria, HIV and AIDS and tuberculosis incidence rates are all less than 1 per cent.** There is a need for continued vigilance against these diseases. Malaria incidence in Zanzibar prior to 1960 reached as high as 74.2 per cent. An eradication campaign in the 1960s reduced the prevalence rate to 6.3 per cent. However, malaria returned to Zanzibar and in the 1990s the incidence rate reached 45 per cent.[1] Continued vigilance against malaria will be required. There are some indications of negligence and a reduction of financing for malaria programmes in HSSP reporting. Distribution of ITNs to pregnant women reduced from 80 per cent in FY 2011/12 to 47 per cent in FY 2015/16.[2] Similarly, HSSP reporting shows a reduction in the rates of HIV counselling and testing.

[1] ZAMEP, 2014.
[2] Mid-Terms Review of the Zanzibar Health Sector Strategic Plan III, 2017.

**Figure 1:** Key health indicators




**Source:** TDHS, 2015–2016; NBS Population Projections, 2017; MoH Performance Report, 2015; ZHSSP Mid-Term Review, 2017; TDHS-MIS, 2015/16.

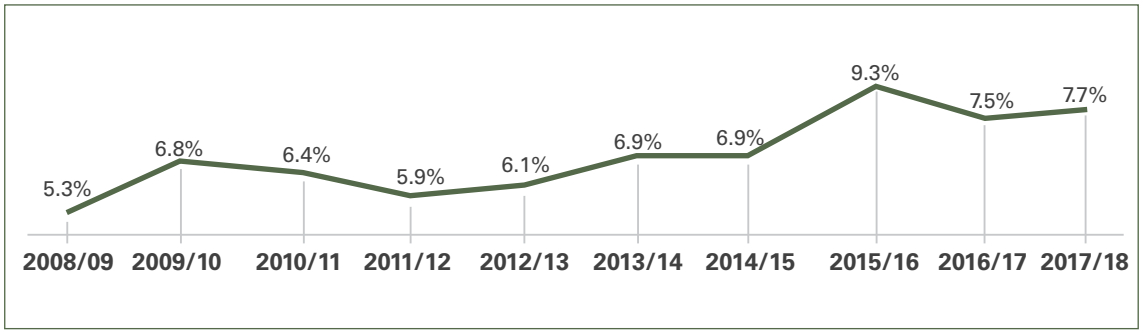
**The fertility rate in Zanzibar is high (5.1 births per woman) while the contraception prevalence rate is very low.** The latest survey findings show that contraception prevalence is only 14 per cent. This compares poorly with Kenya (58 per cent in 2014), Uganda (27 per cent in 2014) and Tanzania mainland (32.5 per cent in 2015/16).[3]

[3] Ministry of Health Draft Performance Report, 2015/16.

# SECTION 2: HEALTH SPENDING TRENDS

**The health sector has been allocated TSh 84.2 billion in FY 2017/18. This is a TSh 33.2 billion increase on the previous year, equivalent to 65 per cent increase or 62 per cent increase adjusting for inflation.** While this is a large increase, most of it is allocated to the development budget, which had a low execution rate in the previous year (40 per cent). Total recurrent spending has increased by 9 per cent in nominal terms. The MoH budget increased by 74 per cent on the FY 2016/17 outturns or 34 per cent based on the FY 2016/17 approved budget. The budget for Mnazi Mmoja increased by 16 per cent on FY 2016/17 outturns and 15 per cent on FY 2016/17 approved budget.

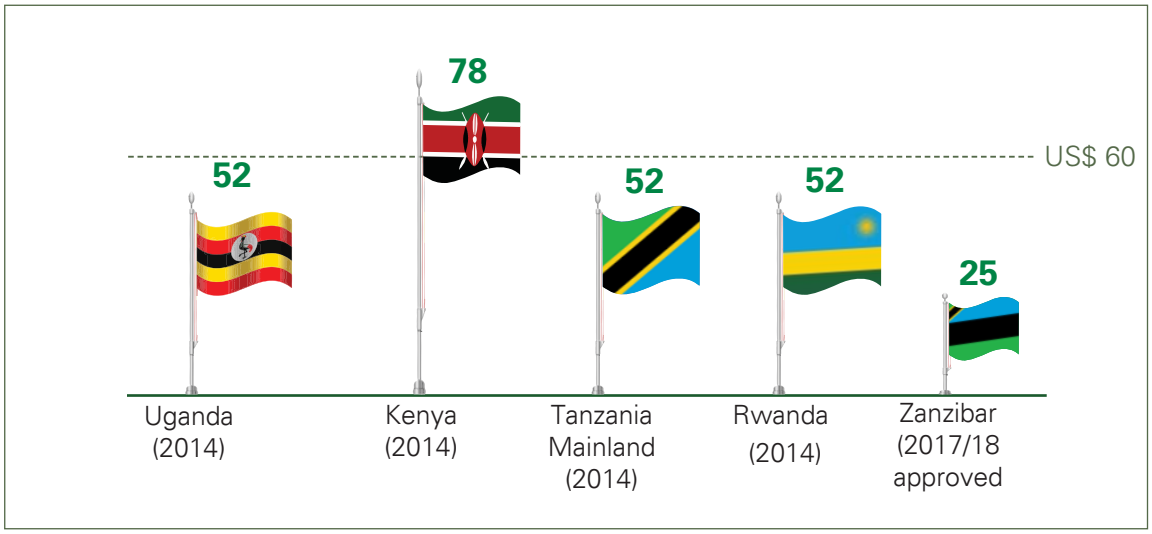
**Figure 2:** Percentage of actual health spending as a percentage of total government spending




**Source:** Ministry of Health Draft Performance Report, 2015/16; IFMIS.
*2016/17 and 2017/18 data are approved estimates

**The FY 2017/18 health budget increases the sector spend to 7.75 per cent of total government spending, well below the Abuja target of 15 per cent (*see Figure 2*).** Total health expenditure per capita is estimated to be US$ 25 per capita, below the US$ 60 (green dashed line) recommended by the World Health Organization (*see Figure 3*).

**Figure 3:** Government health expenditure per capita (current US$)




**Source:** WDI and RGoZ approved budget, 2017/18; NHA, 2011.

Considering the low expenditure on health per capita, Zanzibar enjoys relatively good health outcomes. With a life expectancy of 65 years, Zanzibar is not far behind Kenya (67) and Rwanda (67) (*see Table 1*). One of the key reasons for this is the relatively low incidence of major,high mortality diseases, endemic in other east African countries. Malaria is on the verge of elimination with incidence at less than 1 per cent. This compares very well with the sub-Saharan average of 23 per cent. HIV incidence is also low at less than 1 per cent. This compares favourably against other East African countries; Kenya 5.4 per cent, mainland Tanzania 4.7 per cent, Uganda 6.5 per cent Rwanda 3.1 per cent. Zanzibar's concentrated population may also reduce the cost of providing health services for the population.

**Table 1:** Life expectancy in 2015, comparison by countries

| Life expectancy | Years |
|---|---|
| Zanzibar | 65 |
| Sub-Saharan Africa (excluding high income) | 60 |
| Uganda | 60 |
| Rwanda | 67 |
| Kenya | 67 |
| Tanzania | 65 |

**Source:** World Bank, Tanzania Population and Housing Survey for Zanzibar, 2012.

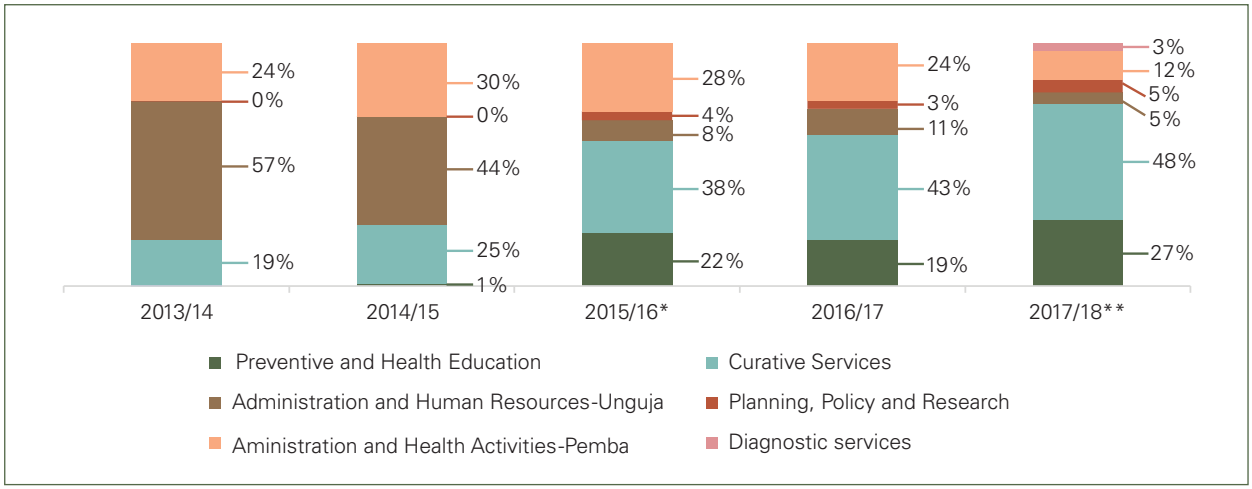
## Takeaways

- The health sector will receive a significant increase as a percentage of the budget in FY 2017/18 than in FY 2016/17. In nominal terms, the health sector will receive a 65 per cent increase or a 62 per cent increase accounting for inflation.
- The MoH budget increased by 74 per cent on the FY 2016/17 outturns or 34 per cent based on the FY 2016/17 approved budget. Mnazi Mmoja had its budget increased by 16 per cent on FY 2016/17 outturns.
- Health spending has been consistently lower than the Abuja target of 15 per cent.

# SECTION 3: COMPOSITION OF HEALTH SPENDING

Since the introduction of programme-based budgeting (PBB) in FY 2015/16, it has been possible to monitor allocation to programmes relating to the key priorities as outlined in the National Health Policy.

**Figure 4:** MoH actual expenditure (by programme and sub-programme)




**Source:** IFMIS, MoFP.
*Programmes were reclassified in FY 2015/16, **FY 2017/18 data is budget estimates

**The FY 2017/18 budget has shown an increased commitment to preventive health spending.**[4] Preventive and Health Education programme has been allocated more than three times what was actually spent in FY 2016/17. Vision 2020 listed preventive health services as the number one priority in health and explicitly called for increasing the budget dedicated to preventive services. Increasing the availability of preventive care is outlined in MoH policy objectives from 2011. This is especially welcome as such activities have been heavily reliant on donor funds.

**Spending on the Curative Services programme has been increasing.** Funding to secondary and tertiary hospital services and procurement of medicine and medical equipment are the big drivers of the increase to this programme. This

[4] Ministry of Health Accounts, 30 June 2017.

is welcome news as stock-outs of essential medicines was raised as a pressing issue in the most recent MoH performance report. Inadequate budget provisions and the withdrawal of donor support have been identified as the causes.[5]

**As resources for the Zanzibar health sector increase, the proportion of funds dedicated to management and administration should decrease.** About 27 per cent of the FY 2017/18 health sector budget is allocated to the programmes 'Coordination of Health Activities in Pemba', 'Management and Administration of Mnazi Mmoja Hospital' and 'Management and Administration'. This is consistent with the last detailed examination of health spending conducted for the FY 2012/13 and FY 2013/14 health budgets. Spending on administration in Zanzibar is high by international standards although this is a common characteristic of small countries since a small health system does not have proportionately smaller health administration requirements. The most notable trend from Figure 4 is the reduction in management and administration spending. The combined share of the 'Administration and Human Resources – Unguja' and 'Administration and Health Activities – Pemba' has reduced from 36 per cent in FY 2015/16 to 17 per cent in 2017/18. This is partly explained by the scale-up of health sector spending. As these programmes have declined in nominal terms, it is also likely that some administrative spending has been reclassified.

**The MoH reported that 51 per cent of the economic classification 'Other Charges' was spent on medical treatment abroad.[6]** This was almost four times what was budgeted in FY 2016/17 budget estimates. The increase in treatment abroad could have caused MoH to postpone several planned exercises. Many international research papers have identified government funded medical treatment abroad as expensive, inequitable and often having poor health outcomes.[7] Reporting basic information on medical treatment abroad should be included in the MoH annual performance report. Such reporting should include the number of patients treated and the total budget at a minimum.

**The poor rates of contraception coverage (14 per cent) and the percentage of married women with unmet family planning needs (28 per cent) are partly to blame for the high fertility rate (5.1 births per woman) and the high number of unwanted pregnancies.** In a welcome development, these issues are of high priority for the MoH. The Ministry recently finalized the costed family planning workplan and the process to launch this plan and conduct a national family planning campaign is underway. At the same time, the Ministry is conducting research into the underlying factors of low contraceptive use in Zanzibar.

[5] Ministry of Health Performance Report, 2015/16
[6] Ministry of Health Accounts, 30 June 2017
[7] http://journals.sagepub.com/doi/abs/10.1177/146801810379990?journalCode=gspa, https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-015-1054-2

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**The retention of skilled health professionals is a bottleneck to improving service delivery.** Trained staff can easily migrate and work in mainland Tanzania. Health professionals can receive a significantly better salary relative to Zanzibar. The MoH is currently working to improve its staff retention strategy, which will involve recipients of government-funded training committing to a fixed number of years of service within the public health sector in Zanzibar.

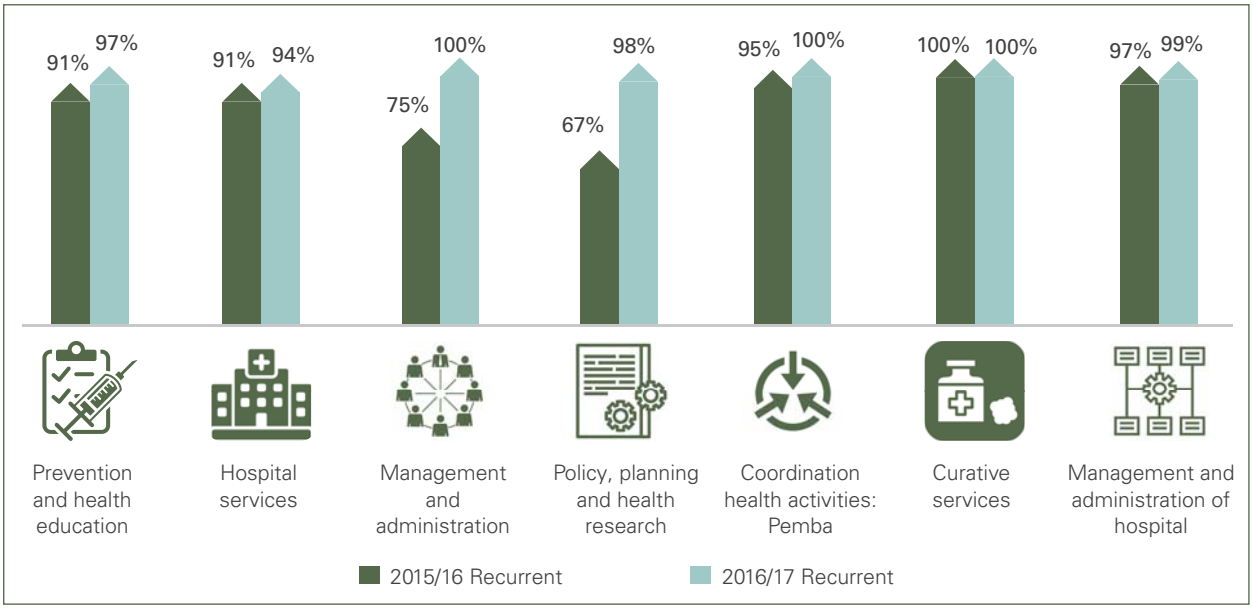
## Takeaways

- The FY 2017/18 budget has shown an increased commitment to preventive health, in line with MoH policy objectives and Vision 2020.
- Administrative spending in the Zanzibar health sector has consumed a large proportion of health sector resources. FY 2017/18 health budget increases have lowered the proportion of resources consumed by administration.
- Medical treatment abroad consumes more than half of the "Other charges", with poor health outcomes.
- Poor contraception coverage and unmet family planning needs contribute to high fertility rates. The MoH has finalized a family planning workplan which is expected to improve child survival and well-being.
- The MoH is currently working on an improved staff retention strategy. Turnover, migration, retention and lack of training of skilled health workers is an obstacle to improving health outcomes.

# SECTION 4: BUDGET CREDIBILITY AND EXECUTION

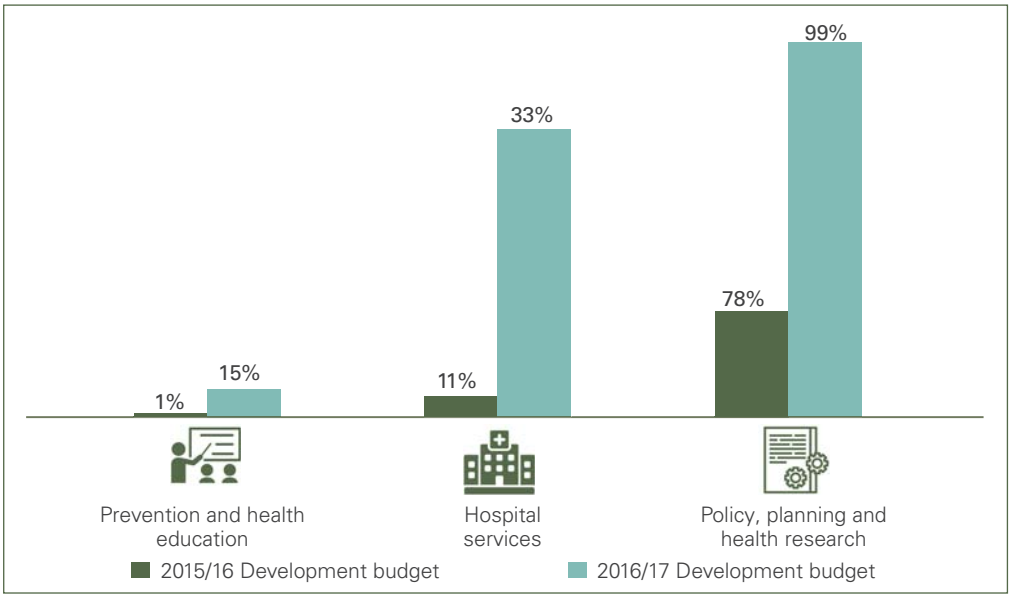
**Both donors and MoH officials reported budget credibility (budget outturn reflecting budget estimates) and the timely disbursement of funding as the greatest impediment to improving health services.** Figures 5 and 6 show a significant improvement in execution rates from FY 2015/16 to FY 2016/17. This follows a government-wide trend of improved execution, founded on revenue targets exceeding expectations and a commitment to realistic budgeting.

**Figure 5:** Execution rates of recurrent spending across MoH programmes




**Source:** IFMIS.

**Figure 6:** Execution rates of development spending across MoH programmes




**Source:** IFMIS.

**While budget execution rates by programme have been improving, virements within programmes should be monitored.** Several key activities were not funded according to the approved budget. Procurement of essential medicines attracted less spending than budgeted while medical treatment abroad overspent the approved budget.

**Health, compared to other sectors, has shown low execution rates.** Development spending has had particularly low execution rates. Only 8 per cent of planned development spending was realized in FY 2015/16, improving to 40 per cent in FY 2016/17. The programme 'Prevention and Health Education' executed 1 per cent of its development budget in FY 2015/16 and 15 per cent in FY 2016/17.

**Development spending often has poor rates of execution due to the nature of managing construction works.** The additional approval processes of donors as well as the misalignment of budgets between donors and government can complicate planning. Poor disbursement by donors is a major reason for the low execution rate in the health sector.

**Budget performance has serious impacts on service delivery, creating additional financial burdens for those with the least ability to pay.** Procurement of drugs and medical equipment has faced in-year budget cuts. The MoH estimated the minimum budget required to fulfil basic services to be a total of TSh7.2 billion for procurement of drugs and medical equipment. In FY 2015/16, TSh 4.4 billion was allocated but only TSh 2.5 billion (57 per cent) was disbursed by the Ministry of Finance and Planning (MoFP). Poor execution and underfunding of drugs and medicines has caused stock-outs of essential medicines to increase. In FY 2014/15, stock-outs of essential medicines were reported to be 37 per cent. This increased to 68 per cent in FY 2016/17. The targeted levels of stock-outs for FY 2016/17 was 23 per cent.

## Takeaways

- Budget execution by programme, especially the development budget, has been low but improved significantly in FY 2016/17.
- In-year prioritization and reallocation are key issues. Activities and items which have a history of overspending or underspending should be reported upon in the MoH annual performance report for additional scrutiny.

# SECTION 5: DECENTRALIZATION AND HEALTH SPENDING

**Health management in Zanzibar is highly centralized.** With a small concentrated population,and just over 160 health facilities, there is a compelling argument to favour a centralized approach to management.

**Table 2:** Number of health facilities and services provided

| Primary | Services offered | Number |
|---|---|---|
| Primary health care units (PHCUs) | Outpatient services (management of common diseases and injuries), inpatient (observation), maternal and child health care, family planning services, adolescent, sexual and reproductive health, integrated management of childhood illnesses, immunization and nutrition, environmental health, school health, control of communicable diseases (malaria, HIV, TB, NTD), post exposure prophylaxis (PEP), referral services, control and management of non-communicable diseases, basic diagnosis, treatment and rehabilitation of mental health and support services (referral, health promotion, quality assurance), planning and monitoring, and evaluation | 119 |
| PHCUs+ | Additional services: delivery (basic emergency obstetric care), laboratory services, dental services and dispensing services | 34 |
| Primary health care centres (PHCCs) | Additional services: inpatients, surgical, gynaecological, internal medicine, paediatric, mental health, support functions (lab general, x- ray, ultrasound, PEP services referral, blood bank and transfusions) and comprehensive emergency obstetric care | 4 |
| Secondary | | |
| District hospitals | Acute trauma and emergency conditions, fistula surgery, rehabilitation of disability, comprehensive HIV care and anti-retroviral therapy (ART) services and PEP | 2 |
| Regional hospital | Acute trauma and emergency conditions, dental and oral conditions, ear, nose and throat conditions, endocrine conditions, eye conditions, special family planning, gastro intestinal conditions, gynaecology, infections, mental illness, musculoskeletal conditions, neonatal conditions, neoplasms, nutritional and haematological conditions, obstetric conditions, orthopaedic conditions, respiratory conditions, skin diseases, surgical care | Abdalla Mzee Hospital (Pemba) |
| Tertiary | | |
| National hospital | Acute trauma and emergency conditions and cardiovascular conditions, central nervous system conditions, dental and oral conditions, ear, nose and throat conditions, endocrine conditions, eye conditions, special family planning, gastro-intestinal conditions, gynaecology, infections, mental illness, musculoskeletal conditions, neonatal conditions, neoplasms, nutritional and haematological conditions, obstetric conditions, orthopaedic conditions, respiratory conditions, skin diseases, surgical care | Mnazi Mmoja |

**Source:** Consolidated information from the Ministry of Health Draft Performance Report, 2015/16.

**Decentralization is mandated in Vision 2020 and in the HSSP.** Though decentralization is mandated in these policy documents, the MoH does not have an operational plan to decentralize and the level and method of decentralization is contested. The decentralization approach that has been adopted by the MoH has been through deconcentration. That is, MoH officers stationed in districts are given increasing responsibilities and control of health funds. MoH district offices are referred to as District Health Management Teams (DHMTs).

**DHMTs are primarily responsible for supervision of district health facilities and have recently taken on the responsibility for planning health interventions.** DHMTs are expected to manage primary health services in FY 2017/18. The final aim of decentralization efforts is to align health services management and provision with the local government decentralization efforts, which entails devolving health service delivery to district health leadership.[8]

Several obstacles remain for decentralization efforts,including noted unclarity at the national level to devolve power, the lack of qualified staff and the need for financial training of DHMTs.[9]

## Takeaways

- The health sector is highly centralized, while decentralization is mandated by Vision 2020 and the HSSP. The MoH does not have an operational plan to decentralize.
- DHMTs are set to assume responsibility for preventive health services in FY 2017/18.
- A lack of qualified staff at DHMTs is an obstacle to further decentralization.

[8] HSSP.
[9] HSSP and ZHSSP review.

# SECTION 6: EQUITY OF HEALTH SPENDING

**Health facility charges are thought to partly account for regression in some health indicators.** The percentage of pregnant mothers receiving antenatal care at least once during pregnancy fell from 97 per cent to 80 per cent from 2013/14 to 2014/15. Issues related to the quality of care, increased number of drug stock-outs and an increase in the physician-to-patient ratio are also thought to contribute.[10]

**Given the low public allocation to the health sector, lack of national health insurance and the very high household expenditure on health (30 per cent of household income), it is likely that health events could result in catastrophic spending and impoverishment.** The National Health Accounts study called for further investigation into catastrophic spending and out-of-pocket spending by socioeconomic groups.[11]

**Significant geographic equity issues exist in Zanzibar, both in terms of health outcomes and health services.** In Unguja, one medical doctor serves 7,711 people while in Pemba one medical officer serves 70,302 people. For the number of nurses and general clinicians the variations in staffing are not as severe. Pemba is also underserved by the private sector. All 38 private pharmacies are located on Unguja.

**Contraception prevalence also differs significantly between the islands (Unguja: 16.3 per cent, Pemba: 9.1 per cent).** Unsurprisingly, the total fertility rate follows the trend in contraception prevalence. In 2015 the fertility rate of Unguja was estimated at 4.4 births per women while on Pemba it was estimated to be 6.8.

## Takeaways

- There are huge disparities in the allocation of health facilities and distribution of health workers across Zanzibar, which are reflected in health outcomes.
- Informal health facility charges are thought to be responsible for declining rates of pregnant mothers receiving antenatal care.
- Low public health expenditure coupled with high household expenditure on health make it likely that health events could result in catastrophic spending and impoverishment.

[10] MoH performance report.
[11] NHA.

# SECTION 7: FINANCING THE HEALTH SECTOR

**The Zanzibar health sector must be modernized, including examining the introduction of fees for service and health insurance for those with the ability to pay.** This will increase the overall resources available for health care. If appropriate wavers and exceptions are available for those who are unable to afford health care, health outcomes will be improved in the long term. Historically, the health sector in Zanzibar was guided by the socialist principal of free health care. While this was sustainable at the time of the revolution in 1964, massive population growth and the emergence of new health care demands, without similar increases to the health budget have seen the quality of health services deteriorate. Introducing moderate health sector reforms, commonplace in most countries, is a highly political issue.

**Out-of-pocket spending on health care contributes to a large proportion of total health care spending.** Out-of-pocket spending on health accounts for 30 per cent of household expenditure in Zanzibar compared to 23 per cent in mainland Tanzania. Since Independence in 1964, the Revolutionary Government of Zanzibar has held a policy of free health care. While free health services remove barriers to accessing health, it is acknowledged by both the MoH and many donors that this strategy of health provision is not financially sustainable.

**The maintenance of an official free health care policy without the adequate funding to implement this policy has resulted in poor targeting of the scarce public resources available for health.** Rather than targeting specific basic health interventions to be fully funded, a full range of health interventions are offered but only when resources are made available. As well as targeting basic health interventions to fund, services where a health-seeking behaviour is highly sensitive to user fees should also be offered free of charge.

**Increasing pressures on the health budget have led to the practice of informal out-of-pocket payments which vary between regions and health facilities.** The 2015/16 Ministry of Health performance report showed patients were charged an average of TSh 16,000 for the delivery of a child and TSh 4,000 for an antenatal visit. Quality of health care has deteriorated under the pressures of increasing costs for health care provision, population growth and increased longevity. Cost-sharing arrangements can increase the total resources available for health and improve the quality of health

care. If cost-sharing is well targeted (choice of health interventions or coupling with national registration cards) it can recover resources from those with the ability to pay for health care services without restricting access to those who are unable to pay for services. If this measure is introduced by RGoZ, the implementation should be carefully monitored.

**The retention of user fees by health facilities will need to be accompanied by guidelines and training on how to account for these public funds.** If the government proceeds with introducing fees for some health services, the current proposal is for health facilities (district and referral hospitals) to retain user fees. The total contribution of user fees to health financing is likely to be small and the retention of fees incentivizes facilities to collect revenue. This model of financing can lead to issues with how these funds are accounted and utilized by facilities. MoF and MoH would need to provide detailed guidelines to health facilities on accounting, reporting and monitoring these funds.

**The basket fund for district health services has increased the number of contributing donors from two to five.** In the financial year 2012/13, the RGoZ created the basket fund to align donor contributions to the health sector and to better fund district health facilities. Contributions to the fund have not grown according to initial expectations, although the Ministry of Health expressed the usefulness of this financing mechanism due to the predictability and flexibility of funding.[12] With the decentralization of primary health services to districts, the RGoZ is entering into a memorandum of understanding (MoU) with basket fund donors to commit to increasing government contributions in line with the increased responsibilities of districts.

## Takeaways

- The RGoZ is considering much needed reforms to modernize health sector financing. These could help to improve the quality of health services for those most in need.
- Out-of-pocket health spending in Zanzibar accounts for 30 per cent of household expenditure as compared to 23 per cent in mainland Tanzania.
- The Health Basket Fund has been useful in improving the flexibility and predictability of donor funding.

[12] MoH Performance Report, 2015/16.

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## Acronyms

| | | |
|---|---|---|
| AIDS | – | acquired immune deficiency syndrome |
| BEmOC | – | basic emergency obstetric care |
| CEmOC | – | comprehensive emergency obstetric care |
| DHMT | – | District Health Management Team |
| FY | – | financial year |
| GDP | – | gross domestic product |
| HIV | – | human immunodeficiency virus |
| HSSP | – | Health Sector Strategic Plan |
| IFMIS | – | Integrated Financial Management Information System |
| ITN | – | insecticide-treated net |
| MoF | – | Ministry of Finance |
| MoH | – | Ministry of Health |
| MoU | – | Memorandum of Understanding |
| NTD | – | neglected tropical diseases |
| PBB | – | programme-based budgeting |
| PEP | – | post exposure prophylaxis |
| PHCC | – | primary health care centre |
| PHCU | – | primary health care unit |
| RGoZ | – | Revolutionary Government of Zanzibar |
| WDI | – | World Development Indicator |
| WHO | – | World Health Organization |
| ZAC | – | Zanzibar AIDS Commission |

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