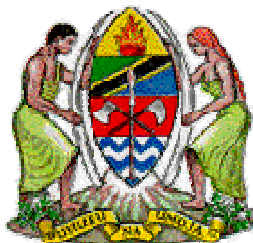


THE UNITED REPUBLIC OF TANZANIA



**SUMMARY OF THE ANALYSIS OF ANNUAL COMPREHENSIVE COUNCIL
HEALTH PLANs (CCHPs) 2011/2012**

PRELIMINARY REPORT

**Ministry of Health
and Social Welfare
P.O .Box 9083,
DAR-ES SALAAM**

**Prime Minister's Office Regional
Administration and Local Government
P.O. Box 1923
DODOMA**

27th July 2011

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Abbreviation and Acronyms

AIDS	-	Acquired Immune Deficiency Syndrome
CC	-	City Council
CCHP	-	Comprehensive Council Health Plans
CHF	-	Community Health Funds
DC	-	District Council
DPs	-	Development Partners
EPI	-	Expanded Programme for Immunization
FP	-	Family Planning
IMCI	-	Integrated Management of Childhood Illnesses
LGAs	-	Local Government Authorities
MC	-	Municipal Council
MDGs	-	Millennium Development Goals
MMAM	-	Mpango wa Maendeleo wa Afya wa Msingi
MOSHW	-	Ministry of Health and Social Welfare
MSD	-	Medical Stores Department
MTUHA	-	Mfumo wa Utoaji Taarifa za Afya
NHIF	-	National Health Insurance Funds
NTDs	-	Neglected Tropical Diseases
PE	-	Personal Emoluments
PMORALG	-	Prime Minister's Office Regional Administration and Local Government
PPM	-	Planned Preventive Maintenance
RCHS	-	Reproductive and Child Health Services
RHMT	-	Regional Health Management Teams
RS/RHMT	-	Regional Secretariat/ Regional Health Management Team
TC	-	Town Council

SUMMARY AND ANALYSIS OF CCHPs 2011-2012 REPORT

1.0 Introduction:

The MOHSW in collaboration with PMO-RALG are responsible for assessing and prepare the consolidated summary analysis of the CCH plans and progress reports for the purpose of presenting at the Health Basket Financing Committee for approving the Health Basket Funds for the implementation of the annual LGAs health plans (CCHPs) and Supportive supervision plans of the RS/RHMT, MOHSW and PMORALG for ensuring that quality health services are delivered at the LGAs level. This is in line with the requirement of MoU reached between DPs and Government. To fulfill the aforementioned requirement the team from these two Ministries have conducted the assessment of CCH plans for the financial year 2011/12 from 11th – 17th 2011.

1.1 Broad objective

The main objective of the CCHP analysis by the central level (PMO-RALG and MOHSW) and RS/RHMTs is to check for compliance with the national guidelines and where possible provide necessary support to Local Government Authorities to improve the quality of their annual health plans linked with proper allocation of fund to priority areas and financial management so as to improve the quality of health service delivery at the district level. Secondly is to recommend the LGAs' CCHP to BFC for approval of funding.

1.2 Specific objectives

- To assess the annual Comprehensive Council Health Plans for the year 2011/2012
- To impart the insight learning and understanding on the context of the developed CCHPs to the MoHSW Assistant Directors by involving them in the process of reviewing and assessing the CCHPs if it is in line with and address Health policy, MDGs, MKUKUTA, HSSP III 2009-2015, National Program Strategic Plans eg. NACP, Malaria, L/TB, MNCH-One Plan, HRH Strategic Plan, NTDs, NCD, etc.
- To find out if the plans have been developed in line with the revised 2011 CCH Planning Guideline. Since the draft revised CCHP guideline have been used by CHMTs and RHMTs

for developing the FY 2011/2012 plans for the purpose of testing the applicability and obtains necessary comments and additional inputs which have been included and refined guideline.

- To identify weak RS/RHMTs and LGAs (Councils) those are in need of further technical assistance and support to improve their plans.
- To assess for compliance to the criterion and other aspects of completeness, consistency, accuracy, relevance of the CCHPs in measuring the desired results of addressing identified priority health problems linking with the set indicators, objectives, interventions, targets and planned activities.
- To get an overview status of the application of the PlanRep in view of the revised CCHP guideline pretested together.
- To find out if health centres and dispensaries plans were included in the CCHPs as part of the plan,
- To find out if the required members of the Planning team for CCHP were involved
- To assess the budget allocated for delivery kits and Council Health Services Board and Health Facility Governing Committees for its function
- To assess and review the technical and financial progress reports for the third quarter (January to March 2011) specifically to come up with an Income and Expenditure for January – March 2011.
- To analyse data from CCHP on performance of MDGs.
- To analyse the data on status of health facilities and human resources in the country
- To consolidate the budget allocated to priority areas and summarize all sources of funds for implementation of the CCHP for 2011/2012.

2.0 Methodology

i) An evaluation of Comprehensive Council Health Plans 2011/2012 was conducted by a team of technical staff from Ministry of Health and Social Welfare and PMO-RALG in collaboration with heads of Zonal Health Resource Centres from eight zones (Eastern zone, Central zone, Lake Zone, Southern Highland zone, Southern zone, Northern zone, Southern West Highland and Western zone).

ii) The task was preceded by the presentations done by the Coordinators of the District Health Services (MOHSW and PMORALG). The first presentation was on an overview of the CCHP revised guideline and preparation of the CCHP. The facilitator introduced the concept of CCH-Plans and the CCHP guideline. The aim was to assist assessors understand the concepts, contents and format of CCHP document and be able to use the gained knowledge/skills to assess the Comprehensive Council Health Plans and progress reports.

iii) Important areas emphasized in the presentation were;- The concept of CCHP; Guiding tools for the preparation of CCHP; three aspects of CCHP which are the financial, technical and structural; Stakeholders to the CCHP or Members of the Planning team; CCHP format and the guiding principles for planning and implementation of the CCHP;

iv) The second presentation was on the application of assessment criteria for CCHP plans. Participants were given the assessment checklist tool comprising of a list of criteria to assess the CCHP. The aim was to equip the assessors with the criteria for assessing CCHP. The main areas focused in the Assessment criteria were:

- The importance of presenting informative executive summary in the plan and its contents; summary of implementation status of last year's plan and New Year's plan, important data and statements summarizing the contents of all tables available in the plan.
- Identification of targets set in the plan if they are SMART
- Presentation of the Main budget summary reflecting all main sources of funding and all other funds for which activities are planned and budgeted for in the Plan.
- Presentation of specific budget summary for Health Basket Funds and its allocation to cost centers, and the focus to the National Package of Essential Health Interventions and the Planning Guideline.
- Presentation of the Health Basket Fund budget summary for allowance and fuel for management team, supervision and distribution and adherence to the given ceilings.
- Appropriateness of target and activities to the stated health problems – Burden of diseases, their feasibility, and relevance to outputs and targets, where is appropriate and how is to be achieved.

- Presentation of all sources of funding targeted at priority interventions stipulated in the Planning Guideline relating to burden of diseases as referred in the situation analysis tables. These interventions among others are:-
 - Integrated Management of childhood illnesses (IMCI);
 - Budget for delivery kits ;
 - Safe Mother hood initiatives (FANC),
 - STI Syndromic;
 - Integrated Management for Emergency & Essential Surgical Care (IMEESC);
 - Immunization (EPI);
 - HIV/AIDS related activities;
 - TB-DOTS / TB/HIV activities;
 - Case management and prevention for acute febrile illnesses (AFI) including malaria/ Insecticide treated Nets (ITN) for prevention of Malaria;
 - Oral Health, Mental health,
 - Injuries and other non- communicable disease interventions;
 - Environmental Health and Sanitation interventions;
 - Social Welfare and social Protection interventions;
 - Nutrition interventions;
 - Traditional medicine interventions;
 - Human resources for Health interventions;
 - Treatment and care of other diseases of local priority including NTDs;
 - Health promotion interventions;
 - Emergency preparedness and response;

- Presentation of the updated performance indicators and new targets using processed HMIS data (check availability of indicators set based on last year achievement and what have been set for the current year plan and if realistically will be achieved.)

- Presentation of other pre-requisites of a plan of high quality such as :
 - Inclusion of map and catchment area of all facilities in the District using the filled health status tables for linking with implementation of the Primary Health Sector Development Program requiring each village/ Mtaa to have a dispensary and ward have a health centre with staff houses and inclusion of Health facility budget for maintenance of equipment and buildings

- Checking the correctness of the calculations by selecting random samples of 20 areas in the plan and test check the arithmetical accuracy of financial and other data presented in the table of cost analysis and others alike.
- Consistency of activity numbers reflected in different tables such as the cost analysis and plan of operation tables which should be identical for easy of reference and tracking.
- Issues concerning GFS and cost centers codes if are correctly filled for the purpose of tracking of expenditure when entered in the Epicor and PlanRep;
- Composition of the planning team and the importance of involving other members from the private providers, FBO and NGOs;
- Community Cost centre that have to show Community initiatives budget;
- Reflecting in the plan the budget for medicine and supplies through MSD as receipts in kind; diagnostic equipment, and related supplies budgeted from Basket Fund, and complementary schemes (NHIF, CHF and Cost sharing/ user fees); orientation activities planned for improving MNCH services through P4P services for health facility providers and bonus award after they have achieved the set indicators;
- Institutional arrangements whereby Councils have to budget for CHSB and FGC activities to make them functional;

v) After the presentation, the facilitators divided the participants into eight zonal groups, i.e. Eastern zone, Southern West zone, Western zone, Lake Zone, Central zone, Southern Highlands zone, Northern zone and Southern zone. Zonal groups were assigned to assess the CCHP 2011/2012; each group assessed the CCHPs of the LGAs under the relevant zone, using assessment criteria score forms, and other forms for reporting other important information from the CCHP including budget allocated for delivery kits and CHBS and HFGC, determining Councils applied PlanRep tool, members of the planning team and verifying inclusion of Health facility Plans.

Other groups were assigned specific tasks to extract data from CCHP as follows:

- Assessment of Financial progress report
- Assessment of Regional Health Management Teams assessment of CCHP reports.
- Income and expenditure analysis January – March 2011
- Status of Human resource for Health and Social Welfare
- MDGs related data /Disease, water and sanitation from the CCHP
- Status of Health facilities in the country from the CCHPs
- Extraction of data for all sources of fund funding the CCHP and allocation to priority areas

2.1 Outcome of the task

i) Preliminary report

Preliminary report (as per agreement at 28th BFC meeting to be ready by 31st July 2011)

- Summary and analysis of the CCHP 2011/2012 report to be presented before 31st July 2011 based on the assessment criteria - adherence to CCHP guideline; including data on budget allocated for delivery kits and Council Health service Board/ Health Facility Governing Committees; composition of members of Planning team for CCHP and applications of PlanRep for the purpose of approval and release of funding for implementation of the CCHP 2011/2012.
- Income and expenditure for January- March 2011

ii) Final report

- Summary and analysis of the CCHP 2011/2012 to be presented at the JAHSR in September / October 2011
- This will be a detailed report including other important information that was agreed in the TWG such as:-
 - Performance related to MDGs 4, 5 and 6
 - All sources of funds funding the CCHP
 - Status of Health facilities in the country
 - Status of Human Resources in the country
 - Status of safe water, and sanitation (Toilets)
 - OPD and IPD data
 - Analysis of RHMT assessment of CCHP reports 2011-2012

The assessment covered 2011/2012 CCHP plans and January- March 2011 progress reports from all 132 Councils and RHMT reports from 21 regions of Tanzania Mainland. Table 1 comprised the list of regions with its subsequent number of councils involved in this study.

Table 1: Number of Councils assessed in each region

Region	Council	Region	Council
Tanga	9	Manyara	6
Iringa	8	Manyara	6
Kagera	8	Morogoro	6
Mbeya	8	Mtwara	6
Shinyanga	8	Tabora	6
Arusha	7	Rukwa	5
Coast	7	Ruvuma	5
Kilimanjaro	7	Kigoma	4
Mwanza	7	Singida	4
Dodoma	6	Dar es Salaam	3
Lindi	6	Total LGAs - CCHP	132

The data obtained from the Council Plans were thoroughly combined to form the national level report.

The gathered data was initially entered into the Microsoft Excel 2007 for editing and cleaning, and later was exported to the Statistical Package for Social Scientists version 11 (SPSS 11) for further analysis to produce percentages and cross tabulation. Graphing was prepared using Microsoft Excel 2007 and afterward Microsoft Word 2007 was used to prepare the final report.

3.0 FINDINGS:

A total of 132 Councils from Tanzania mainland Health plans were assessed whereby 126 councils are recommended for funding while six (6) councils are not recommended.

3.1 General observations:

Generally plans in all councils were found to be of good quality however the following shortfalls were observed in some of the councils:

1. There were no community initiative budgets in some of the councils.

2. There were no sources of funding targeted for IMCI, STI syndromic management, Integrated Management for Emergency and essential surgical care, Case management and prevention for acute febrile illnesses activities, Social Welfare, Health Promotion interventions and Emergency preparedness activities.
3. The problem of formulating SMART Targets and activities
4. In identification of the real health problems, since most of the identified problems was not the root cause of the problems. Activities planned most were not addressing the identified problems.
5. The objectives in many cases were not taken from the Council Strategic Plans, thus planning teams interchanged the objectives and targets.
6. Some Council could not understand the revised CCHPs guideline hence failed to interpret, specifically how to incorporate basic information in the executive summary.
7. Computer skills were also noted to be the challenge in most of the councils particularly in the following areas: - application of PlanRep software, formatting and spreadsheets calculations.
8. Poor editing of the plans by councils and RHMTs prior to submission to the centre (MoHSW and PMORALG).

3.2 Detailed findings

3.2.1 Outcome of the assessment criteria

The Comprehensive Council Health Plans (CCHP) has produced a raw data which clearly indicated the score for each Council and the information was then analysed. There were both quantitative and qualitative data. At the initial stage the data was analysed at the council level in order to identify areas which need further action. Afterward, the information was summarized per regions for further analysis so as to enable one to clearly trace the performance of CCHP at regions level; the regions with pass mark below 70 were probed to find which councils caused such negative result.

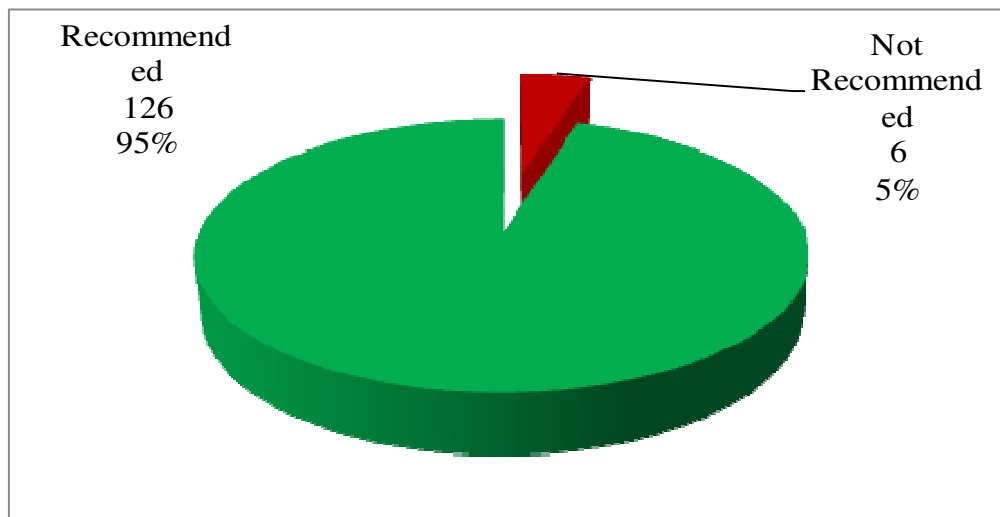
The comparison between Central and RHMT scores has indicated that the two set of data have indicated a very slight relationship ($p = 0.3$) which was statistically significant. These slight

dissimilarities has proved by the wide differences between minimum scores of both set of data, RHMT (62) while Central 48 and the differences in mean (RHMT = 87.02 while central =74.8), table 2 below has summarized these descriptive statistics.

Table 2: Descriptive Statistics

Centers	Range	Minimum	Maximum	Mean	Std. Dev	Correlation
RHMT	35	64	99	87.02	8.597	0.279
CENTRAL	32	48	80	74.80	4.269	

Figure 1: Number of Councils Recommended and not recommended

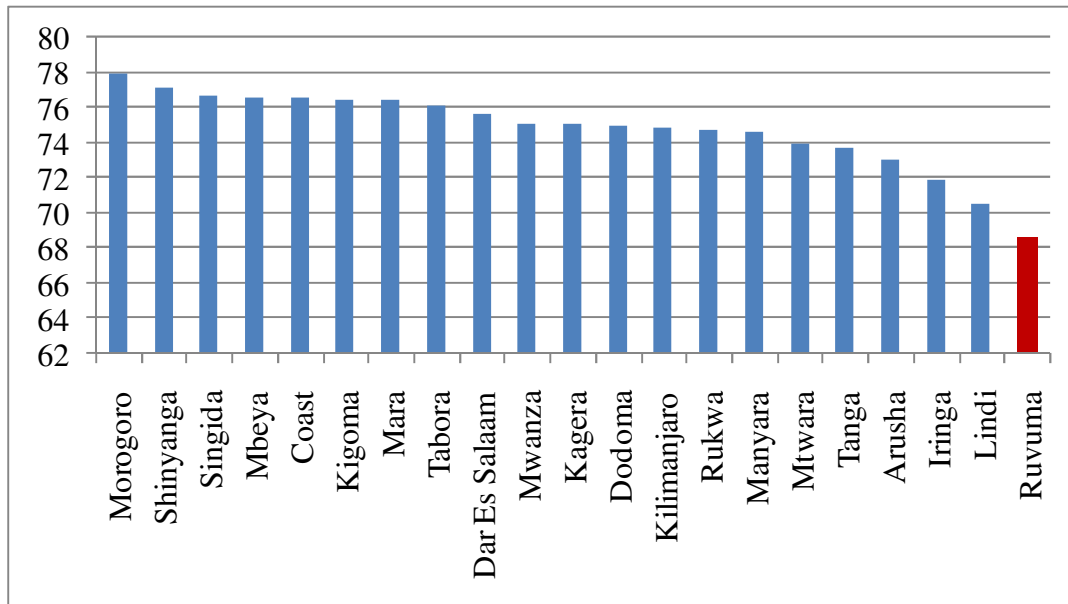


Among 132 councils, 6 councils were not recommended by the time of preparation of this report as indicated in the figure 1 above, these councils were Namtumbo DC, Liwale DC, Kilolo DC, Arusha MC, Mufindi DC and Siha DC (see table 3 for details) . In contrast, the previous result (2010 – 2011) has indicated that there were 19 councils not recommended. Liwale DC was the only council not recommended in both periods. To assist the council the central level will visit the council for mentoring and coaching.

Table 3: List of councils not recommended showing scores

Councils	Scores
Namtumbo DC	48
Liwale DC	57
Kilolo DC	58
Arusha MC	62
Mufindi DC	65
Siha DC	66

Figure 2: CCHP 2011/12 performance per region



The result has revealed that Ruvuma region has performed below the minimum pass point (70), no region score 80 and above, Morogoro region score 78 while the rest of regions score between 77 and 70 points as clearly indicated in the figure 2.

Further analysis has revealed that, in comparison to last year results, Rukwa region which scored below pass mark has significantly raised to 75 score and Arusha region which scored above 90 has drop down to 73 average score.

It has been observed that some plans have lack linkage between Problems, Objective, Target, Activity, Priority Area and Area of intervention. Hence it has resulted into formulating activities that will not assist councils to achieve the planned targets. It is recommended that more training on strategic planning is required.

3.2.2 Health facility plans, members of the planning team and application of PlanRep

Apart from CCHP scores, other information were collected from various councils, these include number of councils' included the plans of health facilities in their CCHP, composition of planning team members and whether the council has applied PlanRep software during planning.

LGAs are required to prepare the CCHPs under the guidance of the CCHP guidelines and the PlanRep2 software. The CCHP Guidelines and PlanRep3 are to ensure linkage of the CCHP targets to the National Strategy for Growth and Reduction of Poverty (NSGRP), the MDGs (specifically goal number 4, 5 and 6), and the Government Vision 2025, the National Health and Social Welfare Protection Policies, the Law of the Child Act (2009), Primary Health Services Development Program and Health Sector Strategic Plan (HSSP III), HRH Strategic Plan and Council Strategic Plan.

Health centres and dispensaries under the guidance of the CHMTs have to prepare their plans in collaboration with the Health Facility Governing Committees; these plans are submitted to the Council to be consolidated by the Council Health Planning teams into the CCHP.

The review of the CCHP has indicated that, among 132 councils about 93 (70.5%) have included health centres and dispensaries plans in the CCHP.

Table 4: Health facility plans, members of the planning team and application of Plan rep

Collated/ included health facility plans	Councils	Percent
Included	93	70.5
Not included	39	29.5
FBOs/NGOs Participation		
Participated	105	79.5
Not Participated	18	13.6
At least one FBOs or NGOs participated	9	6.8
Members of the planning team		

Substantive Positions	55	41.7
Both substantive and acting	15	11.4
Very few acting members	57	43.2
Majority were acting	2	1.5
Not indicated, no data	3	2.3
PlanRep was applied		
Applied PlanRep	55	41.7
Not Applied	77	58.3

On the other hand it was important to know the composition of the planning team members in the councils, particularly to find out if FBOs and NGOs participated in the team during CCHP planning and further to find out the status of the planning team if they are filled with staff with substantive post or in acting positions.

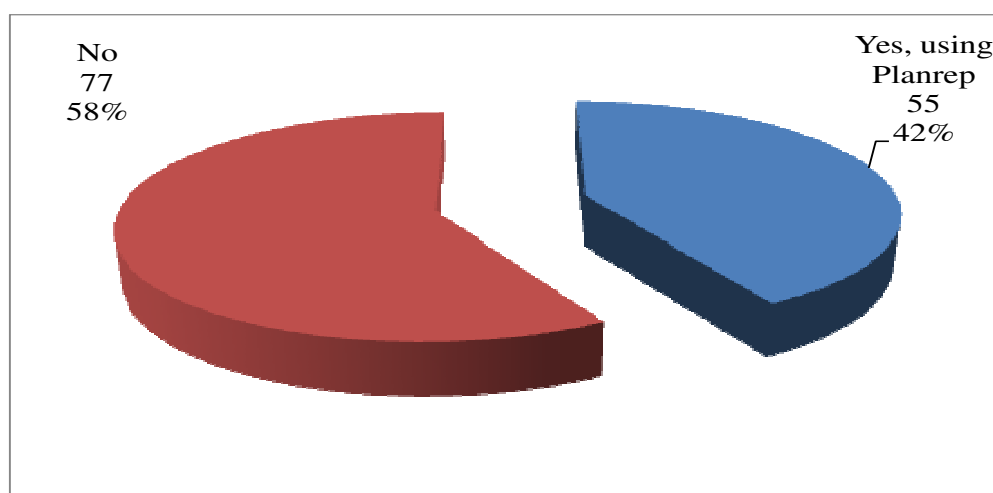
Majority (79.5%) of the councils were found to have involved both FBOs and NGOs in the council planning team, however about 18 councils which is equivalent to 13.6%, were neither involved FBOs nor NGOs representative in the planning team . The names of these councils are listed in the table below:

Table 5: List of Councils which did not involve FBOs and NGOs representative in the planning team

Name of Council	Name of Council
1. Kinondoni MC	10. Kilwa DC
2. Temeke MC	11. Liwale DC
3. Kibaha TC	12. Ruangwa DC
4. Bagamoyo DC	13. Babati TC
5. Mafia DC	14. Hanang DC
6. Kisarawe DC	15. Morogoro MC
7. Kibaha DC	16. Sumbawanga MC
8. Mkuranga DC	17. Nkasi DC
9. Nachingwea DC	18. Uyui/Tabora DC

Majority of members of planning team for CCHP are CHMTs, are supposed to have substantive positions and not acting position. In this assessment it has revealed that only 41.7% of the councils had members with substantive positions in planning team. In comparing this result with that of status performance of the councils (CCHP scores), there is a statistically significant relationship between the two data, whereby most of those Councils not recommended have either most or some of its planning team members were in the acting position, not substantive post.

Figure 3: Number and Percent of Councils used PlanRep



It has further observed that the PlanRep tool was only used by 55 (41.7%) of the Councils. Some of the councils commented to have used Microsoft Excel after realizing some shortfall in the revised PlanRep tool. Examples of these shortfalls are as follows:-

- 1) PE has been noted to be shown under the intervention of Hazardous in the priority area of Environmental Health instead of Human Resource development.
- 2) The budget for CHF, user-fees, NHIF sources does not appear in the printout
- 3) MMAM is not reflected in the main budget summary, the budgets have been found to be reflected under Development funds – this affects the total in the main budget summary not tallying with executive summary.
- 4) Burden of Disease graphs reflect burden of diseases only with funds allocated to it

- 5) Receipts in kind from MSD for medicines and medical supplies not reflected in the main budget summary but it appears in the cost analysis/table- this affects executive summary, budget summary and specific budget summary etc.

Some of the Councils did not apply PlanRep tool since they are not conversant and lacked operating skills on computer and the software. In this regard, Councils need to be trained on computer and application of the PlanRep.

3.2.3 Budget allocated for delivery kits 2010/2011 and 2011/2012

The budget for health sector has been increasing from year to year. Part of this budget has been set aside for delivery kits, the Tanzania Government through Ministry of Health and Social Welfare has been taking positive actions to make sure that the delivery kits are available in all health facilities.

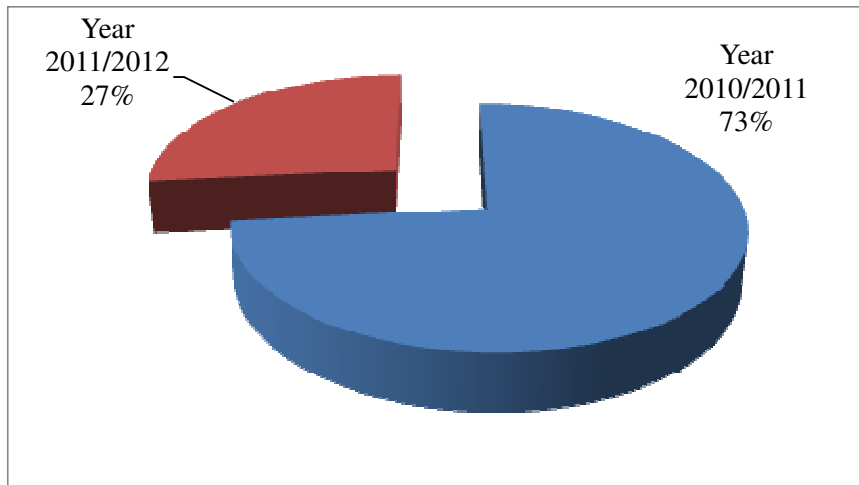
The budgets of Delivery Kits differ from Council to Council depending on the needs and availability of last financial year stock. Delivery Kits are provided free in all government health facilities.

Table 6: Budget allocation for Delivery Kits

Delivery Kits	2010/2011		2011/2012	
	Councils	Percent	Councils	Percent
Budgeted	102	77.3	73	55.3
Not Budgeted	30	22.7	59	44.7

On the other hand, the budgets of this item differ from year to year. According to the data gathered during CCHP assessment July 2011, it has observed that the previous financial year 2010/2011 budget was three times the current financial year 2011/2012 (Tshs 1, 074,659,716 in 2010/11 and Tshs 390,351,793 in the current financial year). If combined together, the current budget is only 27% of both (see the figure below).

Figure 4: Total Allocation of Delivery Kits in percents in two consecutive years



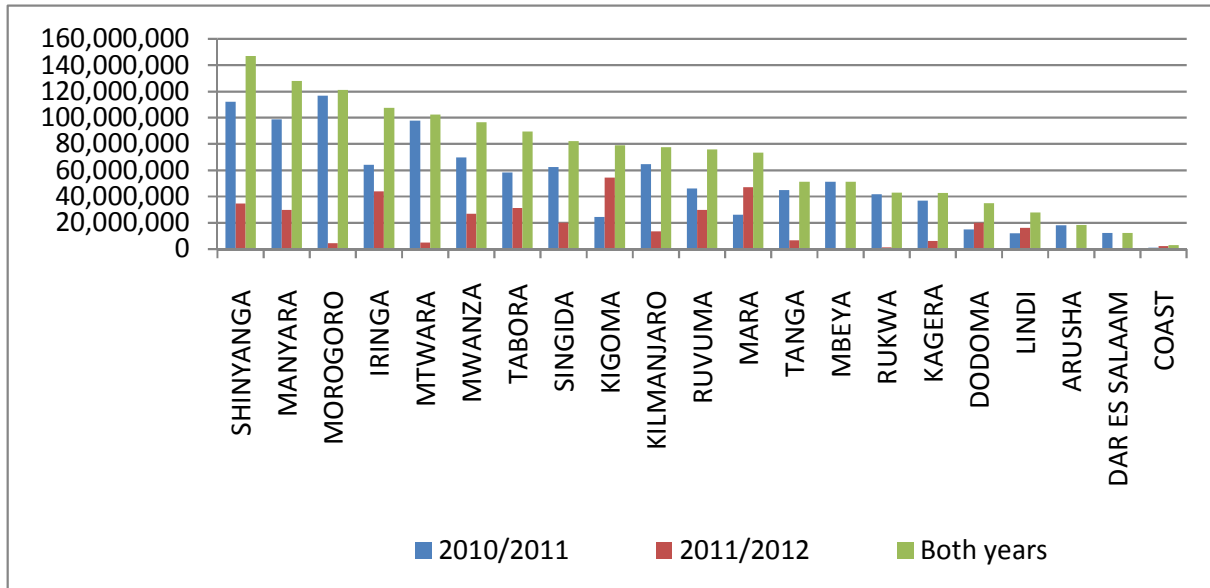
Most (44.7%) of the Councils in this financial year did not budget for Delivery Kits compared to previous financial year whereby only 22.7% of councils did not budget.

The Councils which had budgeted at least a reasonable amount compared to others are, Mbulu DC (Tshs 32,800,000), Muleba DC (Tshs 20,224,000) and Mtwara DC Tshs 20, 000, 000), the rest of councils have either budgeted below Tshs 20,000,000 or not budgeted at all.

Delivery can be made safer by preventing infection through the use of a clean delivery kits, it's believed that these items can reduce the maternal and child mortality; therefore, reducing of budget in this area is a big challenge to the health sectors. Tanzania as among the developing countries, most births in rural areas take place at home without medical assistance.

Further analysis resulted from combining two financial years (2010/11 and 2011/12), has indicated that, Coast, Dar es Salaam and Arusha regions have very low budget (below Tshs 20,000,000) in both years in such a way even the combined total of these regions is also below Tshs 20,000,000, while Shinyanga, Manyara, Morogoro and Iringa regions their total budget is above Tshs 100,000,000 compared to rest of the regions. These regions have been allocating a reasonable amount for Delivery Kits in both years.

Figure 4: Allocation of Delivery Kits per regions



3.2.4 Activities budgeted for Council Health Service Boards and other Health committees

These are the boards and committees which supervise and coordinate the health services in the council level as directed in the Health Council Board guidelines. These boards include Council Health Service Boards (CHSB), Health Facility Committees (HFC), Hospital Boards and Hospital Governing Committees.

In this regard, each council is required to allocate budget for facilitating the operation and functioning of these boards and committees so that the planned activities of health boards and committees are implemented accordingly. In financial year 2011/2012, all Councils have allocated the total budget of Tshs 2,015,420,923 for boards and committee activities.

All councils budgeted for Health Boards and Committee activities except Nkasi DC. On the other hand, it has been observed that majority of the councils (98%) budgeted below Tshs 50,000,000, except two councils Kinondoni MC and Iringa DC have allocated Tshs 112,492,000 and Tshs 58,235,000 respectively.

The least councils which budgeted below Tshs 1,000,000 were Ileje DC and Tabora DC has allocated Tshs 580,000 and Tshs 600,000 respectively. Generally, all Councils have allocated for Health Boards and Committee activities.

3.2.5 Budget allocated to priority areas and summary of all sources of funds.

Findings from the analysis of the CCHP from 132 councils reveal the following facts:-

The CCHP from 39 out 132 Councils were convincing in the sense that they have used MS Excel, acceptable font size and chapters in the plans were well organized leading the analysis task easy and had their total funds from all sources tally from the total funds allocated in the priority areas.

The CCHPs from 93 councils reveal to have some common calculation errors which led the difference between total fund from all sources expected to implement CCHP and the total funds allocated to priority areas not tallying.

Allocation of funds to priority areas in 65 Councils understated when compared with the available funding level. Whereas 28 of the CCHP allocation in the priority exceeds the total funds expected to implement the CCHP).

3.2.6 Council not filled tables of the HMIS data of 2010

- Rorya DC did not report data of 2010; instead it has reported data of 2008 and 2009 only.
- Bariadi DC and Muleba DC don't have summary table of HMIS Indicators
- Kondoa DC, Newala DC, Mpanda TC , Nanyumbu DC, Kongwa, DC Ludewa DC, Iringa MC did not report data on OPD, PLHIV, PLHIV on ARVs, TB cases cure rate and Polio.
- Ngorongoro DC has incomplete HMIS indicator data table.

1. Inconsistency in reporting data in the current year's plans

- In most of the councils, data reported in the current plan is not the same compared to previous years reported data.
- Mixing format of reporting same data, some councils have reported in percentages, ratios and others in numbers.

2. Data of Safe water coverage and Permanent sanitary Toilet Coverage

- In all councils, they have failed to separate data on safe water coverage and Permanent Sanitary. The information reported has been combined or missing completely.

3.2.7 Health staff availability trend

- The following Councils have reported only staff available in the current year: Karatu DC, Arusha DC, Bagamoyo DC, Rufiji DC, Mafia DC, Kisarawe DC, Ilala MC, Kondo DC, Kongwa DC, Mpwapwa DC, Kibondo DC, Kigoma DC, Babati TC, Simanjiro DC, Bunda DC, Serengeti DC, Rorya DC, Magu DC, Mwanza CC, Mtwara /Mikindani MC , Sumbawanga DC, Nkasi DC, Songea MC, Bukombe DC, Bariadi DC, Igunga DC, Tanga CC, Pangani DC and Lushoto DC.
- Kasulu DC, Kibondo DC, Mpanda DC, Mpanda DC, Lindi TC, Lindi DC and Kilindini DC have severe shortage of technical staff in some council according to the reported data.
- Musoma MC data for availability of staff trends are constant in each cadre for three years. Practically changes of staff availability is unavoidable, changes might have occurred which are not reported.

4.0 Challenges

- i. Council failed to link problems, objectives, targets, interventions and activities situation that may lead to difficulties in counteracting health related problems in the district. Most of the stated objectives are not specific to the identified problems. Similarly problems are not well stated most of them seem to be an outcome of the problem. This means activities planned will only solve an outcome of the problem and not the real problem.
- ii. Inadequate skills in Computer and PlanRep among the CHMTs and RHMTs
- iii. Councils have failed to interpret the CCHP guideline and allocate resources to the priority areas.

- iv. Inconsistency, incomplete and incorrect data presentation in different tables of the CCHPs
 - Some council has reported in percentages instead of numbers and vice versa.
 - Mixing data of safe water coverage and permanent sanitary toilet coverage, information reported has been combined or missing completely.

5.0 Recommendations

- i. Councils to use the additional Health Basket Funds to budget for delivery kits and other priority areas which were under budgeted or had no budget allocation at all.
- ii. Intensive training on how to develop targets, objective and indicators should be conducted to all planning team members of the district.
- iii. Capacity building for the revised CCHP plan guidelines and Computer skills should be enhanced to CHMTs and RHMTs with immediate effect.
- iv. The shortcoming from the PlanRep to be addressed and the revised PlanRep tool to be trained to all the teams at each level and should be fully implemented by LGAs.
- v. LGAs should prepare the Comprehensive Council Health Plans (CCHPs) under the guidance of the CCHP guidelines and the PlanRep3 software. The CCHP Guidelines and PlanRep3 will ensure linkage of the CCHP targets to the National Strategy for Growth and Reduction of Poverty (NSGRP) herein referred to as MKUKUTA II, the MDGs (specifically goal number 4, 5 and 6), and the Government Vision 2025, the National Health and Social Welfare Protection Policies, the Law of the Child Act (2009) and the roles and responsibilities defined for Social Welfare Officers, National Costed Plan of Action for Most Vulnerable Children (2011 – 2015), Primary Health Services Development Program (Popularly known as MMAM), Health Sector Strategic Plan (HSSP III), HRH Strategic Plan and Council Strategic Plan.
- vi. Councils should be educated on importance of good reporting of data for decision making.

6.0 Initiative taken

- 1. LGAs were consulted through mobile phone to clarify some of the areas especially on income and expenditure data and Burden of Diseases

2. Findings per each council were compiled and sent to LGAs for correction/redo the plans addressing the observed anomalies and were also instructed to allocate the additional Health Basket Fund budget on the areas identified having weaknesses/shortfall such as increase budget to delivery kit, commodities, outreach services, vitamin A supplementation and other priority areas which did not have enough budget.
3. Councils were instructed to forward the revised CCHP to PMORALG, MoHSW and Regions and keep their own corrected copy for implementation and reference.

7.0 Outcome of the Assessment of the CCHP 2011/2012

The assessment outcome of the summary and analysis of CCHP 2011/2012 undertaken by MoHSW, PMO-RALG and Eight Heads of Zonal Health Resource Centers resulted into Comprehensive Council Health Plans from 126 out of 132 Councils recommended for funding and Plans from 6 Councils not recommended for immediate funding subject to correction of the same. **See annex 1 and 2.**

8.0 Recommendation for Approval by BFC:

Following the results from the assessment of the annual CCHP 2011/2012 and income and Expenditure January – March 2011, PMO-RALG and MoHSW recommend for approval and release of Tshs. **80,990,000,000.00** for financing the implementation of the CCHP of 132 Councils for year 2011/2012 and first and second Quarters July – Dec 2011. **See Annex 3.**

Out of the total amount requested for approval of release Tshs. **20,247,500,000** are for the period of July – September 2011 and Tshs. **20,247,500,000** for the period of October to December 2011. However, the disbursement of funds to **126** councils will be made unconditionally whereas the release of fund to **6** councils not recommended will be disbursed subject to the receipt of revised and acceptable CCHP.

8.0 Way forward

Finalization of this preliminary summary and analysis of CCHP report:

1. Taking into account the inclusion of MDGs performance data trend, status of health facilities, human resources and budget allocation to priority areas and all sources of fund.
2. Assessment of RHMTs summary analysis of their LGAs CCHP plans 2011/2012
3. The final report will be presented at JAHR in Sept/October 2011

Annexes

Annex: 1.....List of recommended CCHPs 2011/2012, and their scores

Annex: 2.....List of disqualified / not recommended plans

Annex: 3..... Health Basket Fund Allocation to LGAs for 2011/2012