

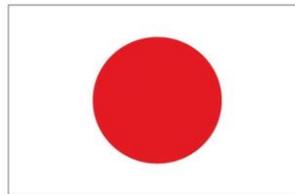
THE UNITED REPUBLIC OF TANZANIA



MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND
CHILDREN
&
PRESIDENT'S OFFICE REGIONAL ADMINISTRATION AND LOCAL GOVERNMENT

CCHP - 5TH EDITION, DISSEMINATION TRAINING MARCH, 2020

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Participant expectations

- What do you hope to learn from this training?

Overall Objective

Dissemination of 5th Edition CCHP Guideline and 2nd HF Planning Guide to RHMT and CHMT members

Specific Objectives

- To **orient Regional and Council teams** on the revised CCHP Guideline and HF Planning Guide for successful implementation of the guidelines
- To build skills on how to use **web-based planning, budgeting and reporting** systems based on revised Guidelines
- To improve **understanding of the Regional and Council teams'** roles in data production/ extraction from relevant sources of data
- To **create culture of data use** through building skills on how to interpret and use data in planning, budgeting and performance monitoring
- To share experience and challenges in implementing the evidence-based planning

Evolution of CCHPs

- First CCHP guidelines were developed in 1999 and revised over the years to support councils' CCHP preparation and ensure that health facilities within councils use allocated funds effectively
- Health facilities' appropriate use of CCHP funds has become a particularly important issue, as the government shifted in the past few years to funding facilities directly instead of sending funds to the council levels.
- While CCHP guidelines are comprehensive, there have been challenges effectively applying them at operational level because of inadequate knowledge.

Evolution of CCHPs

- In order to assure the coordinated delivery of health services at the local level, the DMO and CHMT are required to prepare a Comprehensive Council Health Plan (CCHP) that guides the delivery and development of health and social welfare services.
- Furthermore, a system of committees (at the district level, but also facility-level) has been set up to assure public participation, oversight and accountability over local health and social welfare services.
- In Tanzania, CCHPs are developed through an annual process where councils (an administrative-level equivalent to districts in other countries) plan and budget for the coming year's essential health and social welfare programs.

Overview of CCHP Guidelines-Fifth Edition

Overview: CCHP Guidelines Chapters

- The guideline has five chapters:

Chapter one: Introduction

Chapter two: Preparation of Comprehensive Council Health Plan

Chapter three: Contents of Comprehensive Council Health Plan

Chapter four: Guiding principles on the disbursement and expenditure of funds from different sources

Chapter five: Monitoring of CCHP implementation and reporting the progress

Chapter One: Introduction

The chapter defines CCHP, provides the rationale of the review, and outlines the framework guiding the council health planning process.

What is CCHP?

- CCHP is an annual Council health plan which entails a consolidation of Council Health Management Team and health facility plans.
- Aim of CCHP is to maintain and improve the health provision through the provision of Promotive, Preventive, Curative and Rehabilitative health and social welfare services and make it accessible, affordable, effective, equitable and of good quality.
- A comprehensive Council Health Plan has the following features:

Main Features of CCHP

Technical aspect

- Evidence based aspect which includes four components (Curative, Preventive, Rehabilitative and Promotive services) derived from National Essential Health Care Interventions Package (NEHCIP)

Financial aspect

- This aspect includes all financial and non-financial contributions of all actors

Main Features of CCHP cont'd

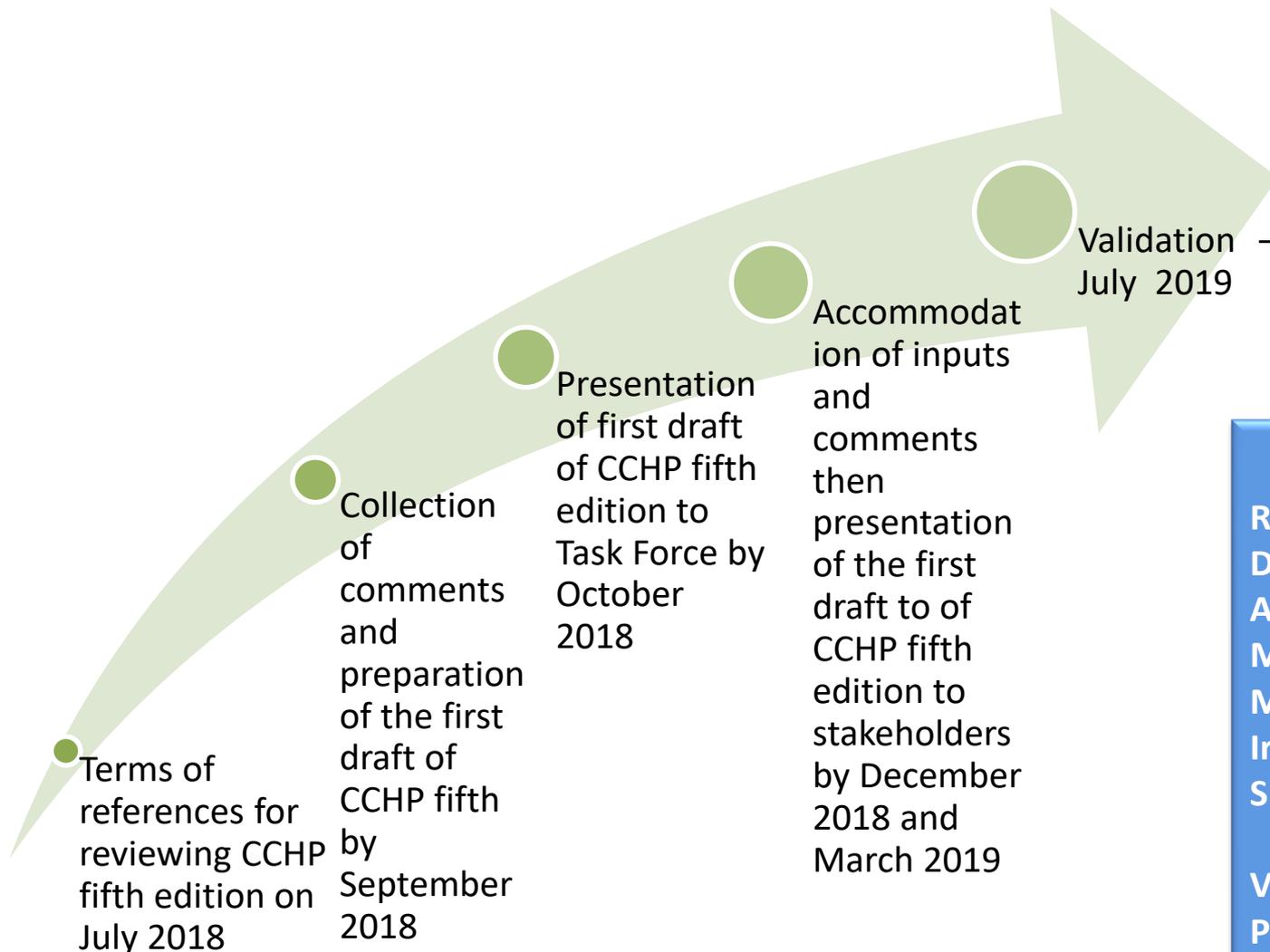
Structural aspect

- This aspect includes the mode of health and social welfare services delivery from household, Community to Council level as delivered by Public, Private and Faith Based Organizations.
- Evolution of CCHP since introduced and achievements including partners and first round assessment)
- Guiding documents during planning process (mention)

Rationale for Reviewing CCHP

- To align health sector planning at Council level with new developments in the sector.
- International and National Policies, Strategies, Guidelines and new initiatives since 2011 include;
 - SDGs 2030,
 - Astana Declaration on Primary Health Care (2018),
 - Tanzania Development Vision 2025,
 - DHFF
 - Improved CHF
 - Prime Vendor System for Commodities Procurement
 - HSSP IV 2015-2020
 - Disease and Intervention specific guidelines and plans.
 - New arrangement of the HSBF which requires CCHPs to be funded based on performance

Process of Reviewing the Guidelines



Stakeholders involved

RHMT and CHMT:
Dodoma, Singida, DSM,
Arusha, Kilimanjaro,
Morogoro, Mbeya,
Mwanza, Kigoma, Kagera,
Iringa, Manyara,
Shinyanga

**Vertical Programs, FBOs,
PMSC-HBF**

What's New in CCHP Fifth Edition

1. Health priorities Areas
2. Cost Center
3. Ceiling allocation in Health Priorities Areas
4. Assessment Criteria
5. Ceiling allocation to the Cost Center
6. Ceiling allocation to the health Commodities
7. Planning Team
8. Amendment of Tables
9. Schedules

Frameworks guiding CCHP

- CCHP translates the overall Health Policy and the Health Sector Strategic Plan into annual plans.
- CCHP has to align its focus, targets and interventions with;
 - i. National health policy implementation strategy**
 - ii. Health Sector Strategic Plan**
 - iii. Departmental or Program specific strategies and guidelines**
 - iv. Specific initiatives implemented in the health sector**

Frameworks guiding CCHP

- i. It is important that Council and Health Facility Planning Teams adhere to the mentioned Strategies, Policy documents and Guidelines and use them as reference documents.
- ii. CHMTs need to consider and consult relevant acts/laws for various operations such as the Mental Health Act (2008) and Public Health Act (2009), Persons with Disability Act (9/2010) and Child Act (21/2009).
- iii. CHMTs need to consider Acts for the purpose of promoting adherence or as the regulators of actions that violate curative or preventive services or social welfare aspects.

Selected Strategies, Policy documents and guidelines that are to be used as references during planning

<ul style="list-style-type: none"> The Sustainable Development Goals (SDGs) 2030 	<ul style="list-style-type: none"> Annual Health Sector Policy Commitments Annual Budget Guidelines for Social Welfare (FY2020/2021)
<ul style="list-style-type: none"> Astana Declaration 2018 on Primary Health Care 	<ul style="list-style-type: none"> The National Essential Health Care Interventions Package of Tanzania
<ul style="list-style-type: none"> The Tanzania Development Vision 2025 	<ul style="list-style-type: none"> Specific disease/program/initiatives strategies and guidelines
<ul style="list-style-type: none"> The National Five-Year Development Plan 	<ul style="list-style-type: none"> Council Strategic Plan
<ul style="list-style-type: none"> Ruling party Manifesto 	<ul style="list-style-type: none"> Additional guiding documents
<ul style="list-style-type: none"> The National Health Policy 	<ul style="list-style-type: none"> Regulatory Frameworks
<ul style="list-style-type: none"> The Health Sector Strategic Plan 	<ul style="list-style-type: none"> Annual budget Guidelines

Chapter Two : Preparation of Comprehensive Council Health Plan

This chapter provide guidance on how to
prepare CCHP

Preparation of Comprehensive Council Health Plan

- The Comprehensive Council Health planning process is conducted at two levels;
 - ✓ Health Facility level
 - ✓ CHMT level
- Plans are then consolidated to form a CCHP.
- The figure below presents stages of the council health planning process.

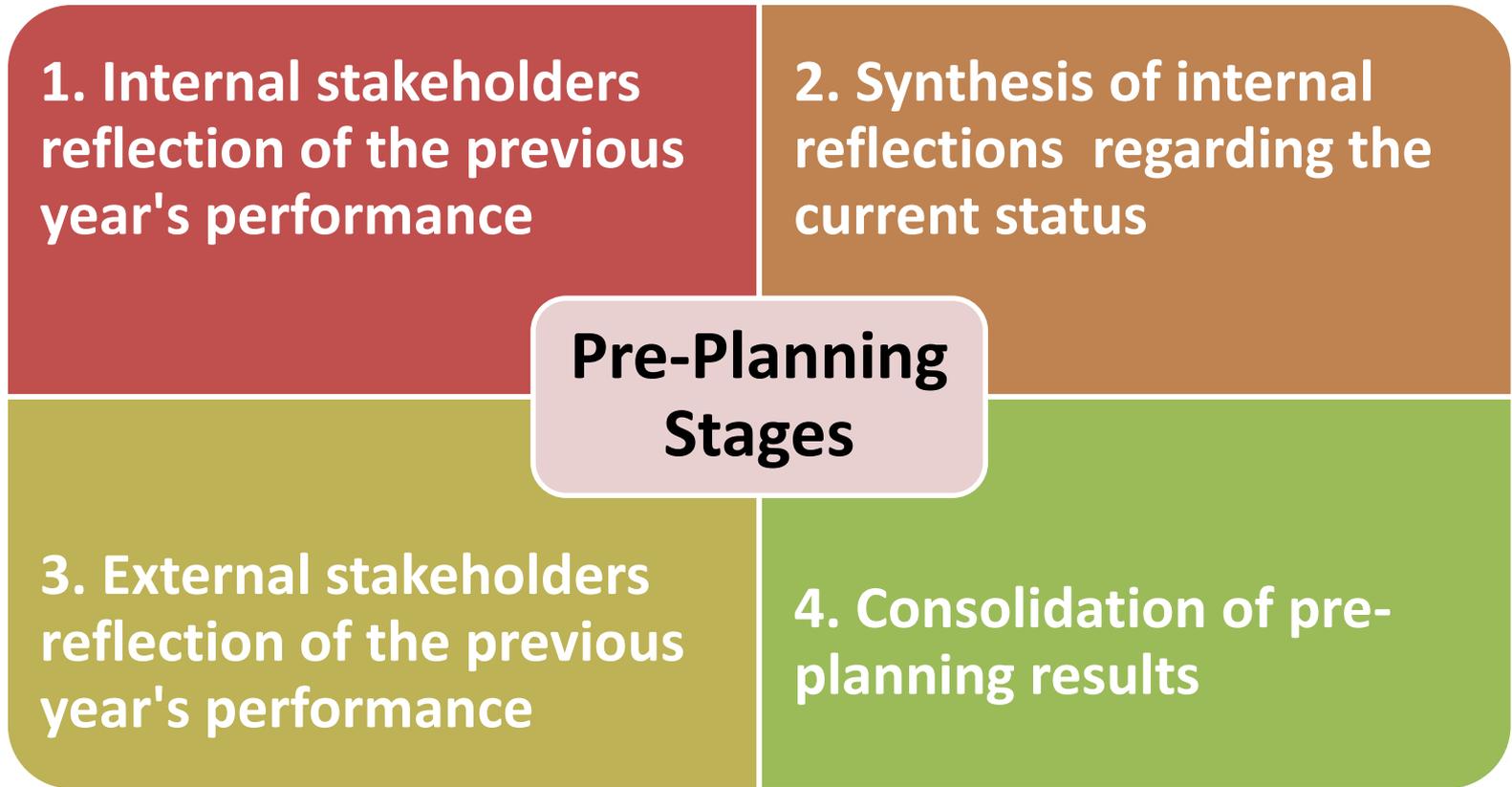
The Comprehensive Council Health Planning Process



Pre-Planning

- The purpose of this stage is to ensure that CHMT and health facilities staff get prepared and organized for planning sessions while spelling out the key priority interventions for the forthcoming financial year.
- Pre-planning is coordinated and conducted by CHMTs and health facility teams.

Pre-planning stages



NB: CHMTs should ensure that this stage is well guided and organized so that all relevant information is collected including guidelines and circulars

Stage 1: Internal stakeholders' reflection

- 1) Review of previous plan implementation
 - establish whether what was planned (CHMT and health facilities) was achieved
 - what did not work and what worked
 - establish the reasons for success or failures from the internal perspective
- 2) Review of resources availability
 - establish the status of resources availability and their influence in the achievement of previous plan
 - establish the reasons for success or failures from the internal perspective

Stage 1: Internal stakeholders' reflection.....

3) Review of partners contribution

- establish the contribution of partners in the achievement of the previous plans
- establish the reasons for success or failures from the internal perspective

4) Review of functionality of governing structures (CHSB and HFGC)

- establish how community structures function to support health service delivery
- establish issues related to meetings conducted, roles played by HFGCs and CHSB
- establishes the reasons for success or failures from the internal perspective

Stage 2 : Synthesis of internal reflections regarding the current status

- CHMTs and health facility teams will reflect on the products of stage 1, interpret and identify areas needing further assessment during situation analysis stage.
- This stage will provide an in-depth understanding of which health facilities perform well and which ones have limitations.
- The main output of this session is indication of focus areas needing further in-depth analysis during facility and CHMT planning

Stage 3: External stakeholders' reflection of the previous year's performance

- Stakeholders meeting will be held to provide feedback on how Council health services is faring with regards to previous years CCHP implementation.
- This will gather stakeholders' perspectives on the achievements and challenges of the previous year's CCHP implementation and priorities from other stakeholders.
- Actors to be involved include Community representatives, FBO health facilities, CBOs, NGOs, Private for profit health facilities, Bilateral and Multi-lateral partners. The output of this step is focus areas agreed by all stakeholders.

Stage 4: Consolidation of pre-planning results

- During this stage CHMTs are supposed to consolidate all reviews and prepare pre-planning report.
- CHMTs should utilize the report to support Health Facility planning teams during health facility planning and also use the report to guide them when developing CHMT plan.
- At this step CHMT should also develop a plan on how they will support development of health facilities plans.

The Role of data in Pre-planning and Planning Process

In pre planning the preparation of data is very important for use during planning. Therefore skills for data compilation, quality checks, analysis, interpretation and use are highly needed for evidence-based planning.

In this section the planning team will learn:

- **how data are produced/generated**
- **importance of quality**
- **what data can be used for (in this case, to formulate evidence-based council/facility plans)**

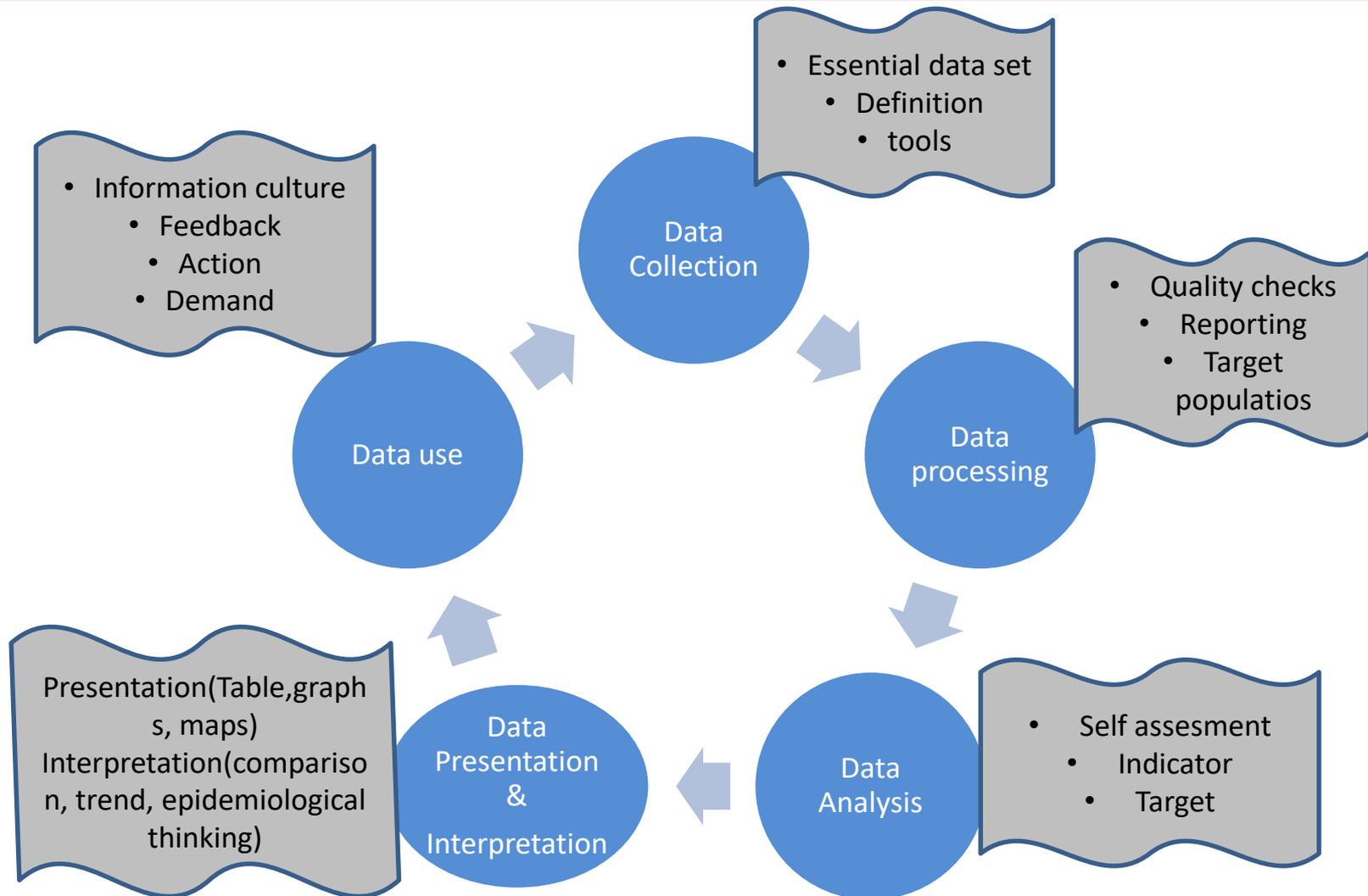
Data production, Quality and Use

What is Data?

- Any specific information that is meant to provide and fulfill the role for which it was collected/generated
- Data may be numerical or non-numerical

Registration and personal information								
Visit date	Unique ID No.	Patient clinic ID	Name Surname Given name	Sex	Age	Weight	Clinical Malaria	TB
07/01/2007	KS0031	1852	Michelle	F	44	44	Y	N
07/02/2007	KS0014	1824	Mary	F	31	52	N	N
07/12/2007	KS0088	1864	Andrew	M	26	41	N	N
14/07/2007	KS0013	1754	Charles	M	71	39	N	N

Life cycle of data



Why is data important?



First: on your own, spend 2 minutes thinking about why data is important in your work



Then: get together with 3 other people and spend 5 minutes talking about why you all think data is important



Finally: have a member of your group summarize and write on the wall why you all think data is important



Why is data important?

At the **facility level**, data are needed to:



Plan and
develop
interventions

Identify clients in
need of services
and/or referrals

Inventory
resources to
determine what
to order and
when

To improve data
quality

Monitor and
evaluate quality
of care

Improve
efficiency
through
administrative
organisation

Why is data important?

At the **council and regional levels**, data are needed to:



Inform acquisition and distribution of resources

Demonstrate trends in key indicators

Assist the C/RHMT to plan and monitor interventions

To improve data quality and supervisions

Understand human resource capabilities and challenges at the facility level

Plan for construction or expansion of facilities and services

Common sources of data for planning

Data can come from both routine and non routine health information reporting systems such as

- ✓ Health Management Information System
- ✓ Supportive Supervision
- ✓ Community monitoring systems
- ✓ Financial Reports
- ✓ Facility/councils assessments and survey reports
- ✓ Other reports



What is data analysis?



- Turning raw data into useful information
- Purpose is to provide answers to questions being asked at a program site or research questions
- Even the greatest amount and best quality data mean nothing if not properly analyzed—or if not analyzed at all
- Analysis does *not* mean using computer software package
- Analysis is looking at the data in light of the questions you need to answer:

How would you analyze data to determine: “Is my program meeting its objectives?”

Routine Analyses



- **Program Coverage** - Extent to which a program reaches its intended target population, institution, or geographic area
 - ✓ Compare current performance to prior year/quarter
 - ✓ Compare performance between sites
- **Utilization:**
 - Is the target population utilizing services, accessing commodities, being reached with services?
- **Availability:**
 - Are the services available where there is a need?
 - What are some examples of ways you could analyze the data you just reviewed and why is this important?

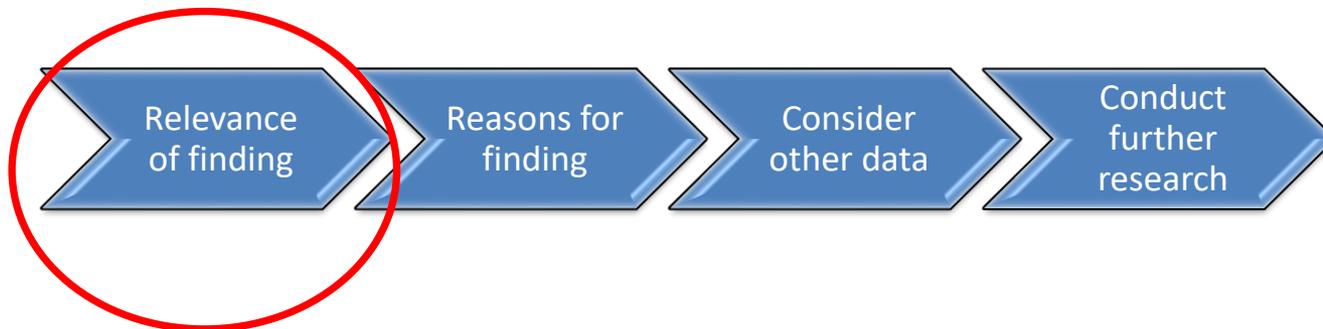
How to interpret data

Data interpretation is adding meaning to information by making connections and comparisons and exploring causes and consequences



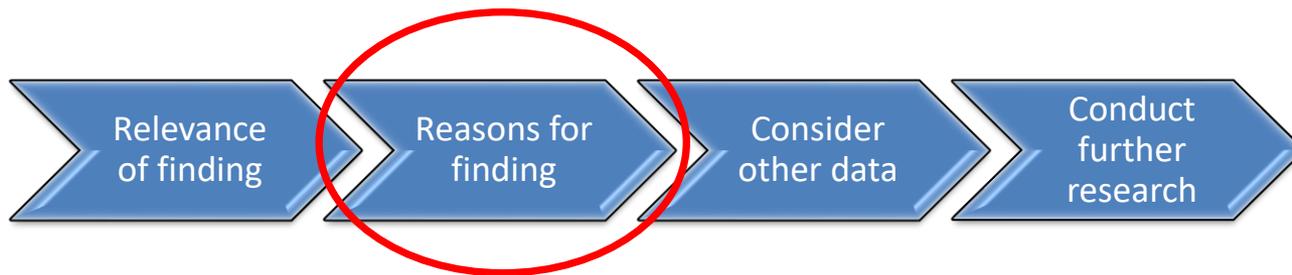
Interpretation- Relevance of findings

- Does the indicator meet the target?
- How far from the target is it?
- How does it compare (to other time periods, other facilities)?
- Are there any extreme highs and lows in the data?



Interpretation- Reasons for finding

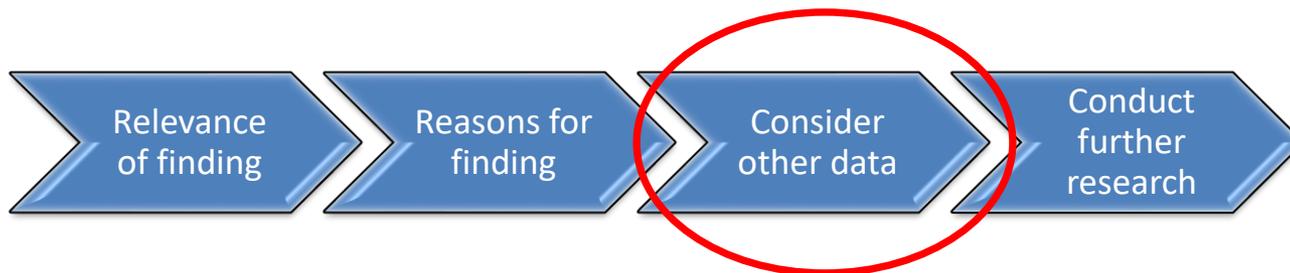
Supplement data with expert an opinion (others with knowledge of the program or target population) to generate a better context for the finding.



Interpretation- Consider other data

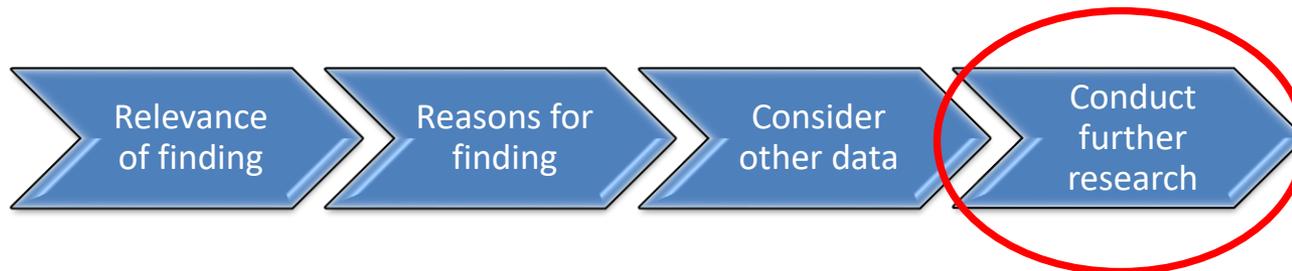
Use routine service data to clarify questions

- Calculate nurse-to-client ratio, review commodities data against client load, etc.
- **What other data sources can you use?**



Interpretation- Conduct further research

- When there's a data gap, conduct further research
- The methodology depends on questions being asked and resources available



Group work 1: Data Interpretation



- **First:** Review the data set you have been given
- **Next:** - Look at the nutrition indicators for vitamin A and Iron folic for pregnant women in your catchment area. What are the % of pregnant women who have received recommended doses of Iron and folate tablets during ANC visits? Are receiving vitamin A? Do the coverage rates make sense? Why or why not?
- **Work through:** the 4 steps in the data interpretation process and develop a conclusion based on the process.
- **Be sure to note:** what additional information you need, where you would get the information and how available that information is to you.
- **Then:** find a partner and discuss the process
- **Finally:** share your results with the full group

Actual Planning:

Actual Planning

This stage involves development of CHMT and health facility plans. The actual planning includes the following activities;

- i. Description of the current situation and review of resource availability
- ii. Problem identification and prioritization
- iii. Problem analysis and identification of solutions
- iv. Setting of Objectives, Service outputs, Targets, Interventions and Activities
- v. Budgeting
- vi. Developing plan of action
- vii. Identification of assumptions and risks and
- viii. Developing a monitoring plan of the activities implementation.

i. Description of the current situation

- Is a process of analyzing and interpreting health system information, to assess the current status of the council performance on nationally agreed health performance indicators.
- The aim is to establish what works, what does not work and identify where bottlenecks are.
- The analysis is done from various perspectives in terms of needs and priorities linked with:
 - promotive,
 - preventive,
 - curative, and
 - rehabilitative health challenges.
- The situational analysis needs to involve the study of all areas that will normally affect the performance of the council's health plans and programs.

Important information for description of current situation

- Distribution of the population by sex and age group: Table 1
- Maternal and neonatal deaths: Table 2
- Status of implementation of previous year plan: Table 3
- Council progress on performance indicator target: Table 4
- Main OPD Diagnoses (list the top 10 diseases): Table 5
- In Patient Admissions(list the top 10 admission): Table 8
- Top ten causes of deaths in the council: Table 9
- Notifiable diseases: Table 10
- Community based initiative/ data: Table 20
- Technical and governing committees: Table 21
- Coverage of partner's program/project across the council: Table 22

Review of Resources Availability

Review current and future situations in the council by checking the state of human resource for health, materials, transport, equipment, information, time and finance:

- HR requirement, material/equipment/medicines and supplies, Transport availability and Sources of funds

Review of resources availability involves checking both the current as well as the future situations in the Council with respect to the above resources including Time, Information and Finance

ii. Problem identification and prioritization

- After extraction of information presented under current situation the plan team needs to identify and list the health problem affecting the council.
- It is unlikely that the council will be able to solve all the identified problems in a one year timeframe.
- Therefore after the planning team has identified a problem, the next logical step is to rank the problems in order of importance.
- This is called problem prioritization and is done based on the following criteria.

Criteria for problem prioritization

Criteria	Definition
Magnitude	Proportion of people affected by a problem
Severity/danger	This refers to how serious the condition is. Does it cause major suffering? Is it life threatening?
Existence of high impact intervention	If a problem is not vulnerable to intervention, it makes no sense to include it in the list of those targeted for action.
Cost of intervention	This criterion should answer the question whether the problem, if addressed, is worth the financial cost involved.
Political will	Even if a problem fulfils all of the above criteria, if addressing it is not a priority politically, it makes no sense to include it among the high priority list.

iii: Problem analysis

- Problem identification and prioritization is followed by thorough analysis of the prioritized problems to determine the causes and effects related to the problem.
- Problem analysis is a systematic process with special arrangement/steps of identifying the cause and effect of a particular problem and match/harmonize the relations of those causes and their consequences.
- This level of analysis is important to make sure your solutions address the actual causes of the problem instead of the symptoms of the problem.

Problem analysis - Approaches

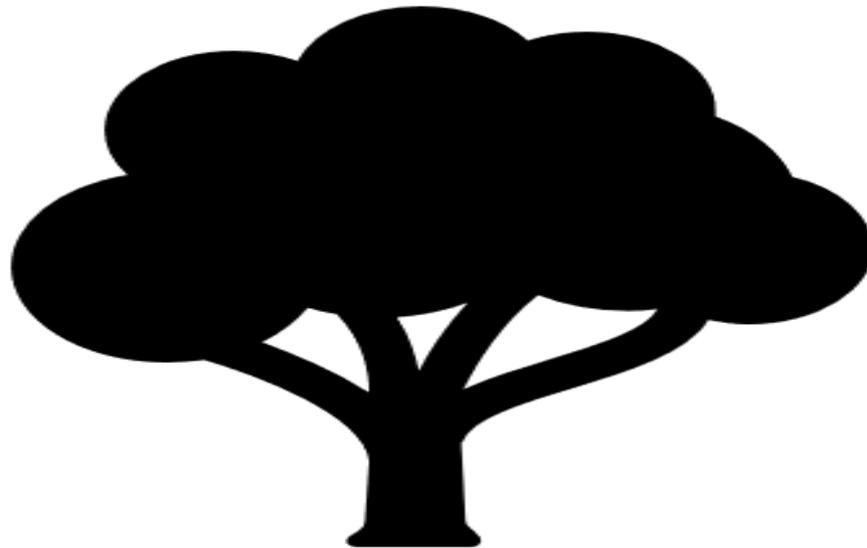
There are several techniques used in identifying the overriding problem and its causes. These include; -

- **Problem Tree and Objective Tree**
- Force-Field Analysis
- **SWOC Analysis**
- Bottleneck Analysis

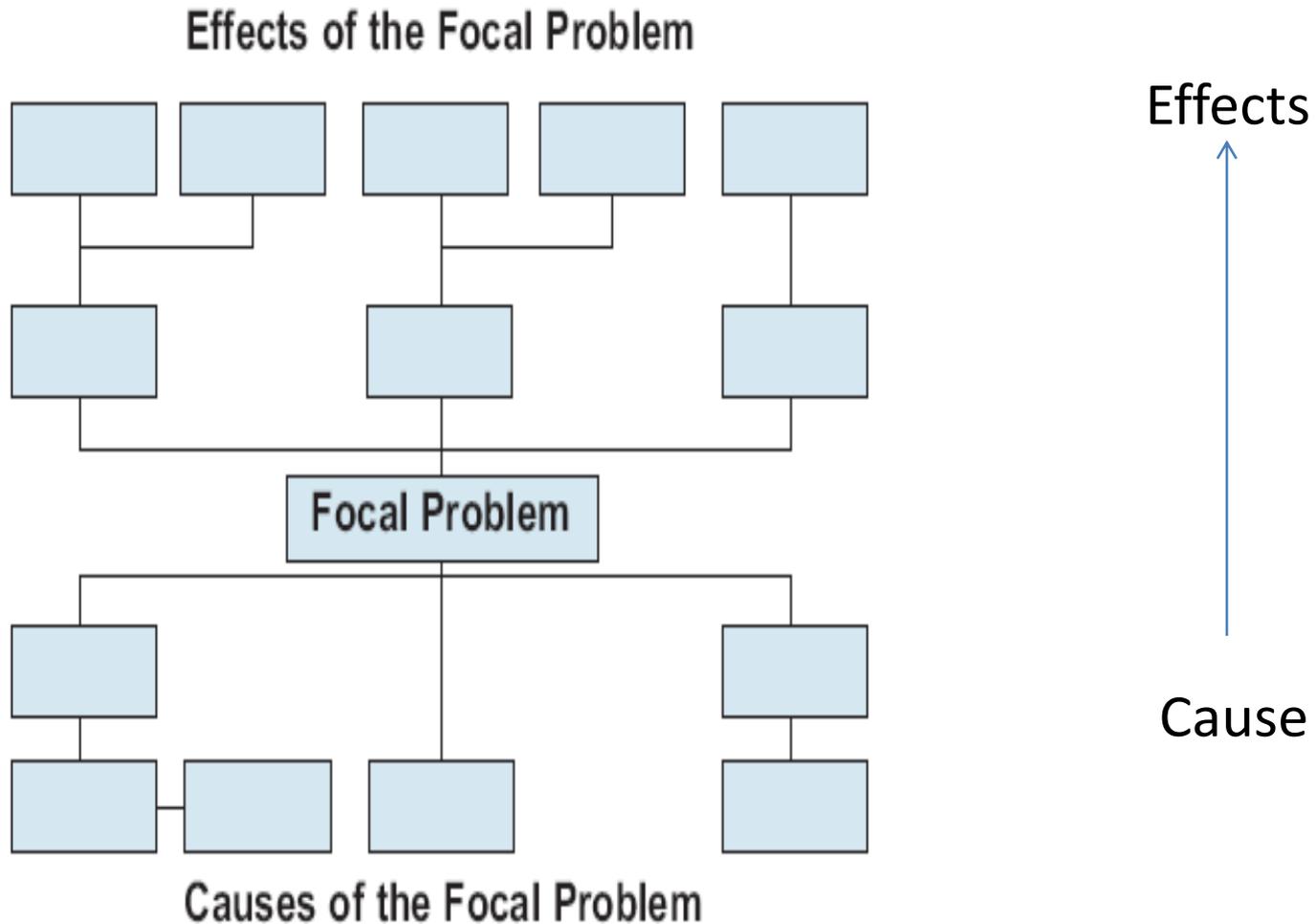
For this training, the focus is on “Problem Tree” and “SWOC analysis”

Problem analysis – Problem tree

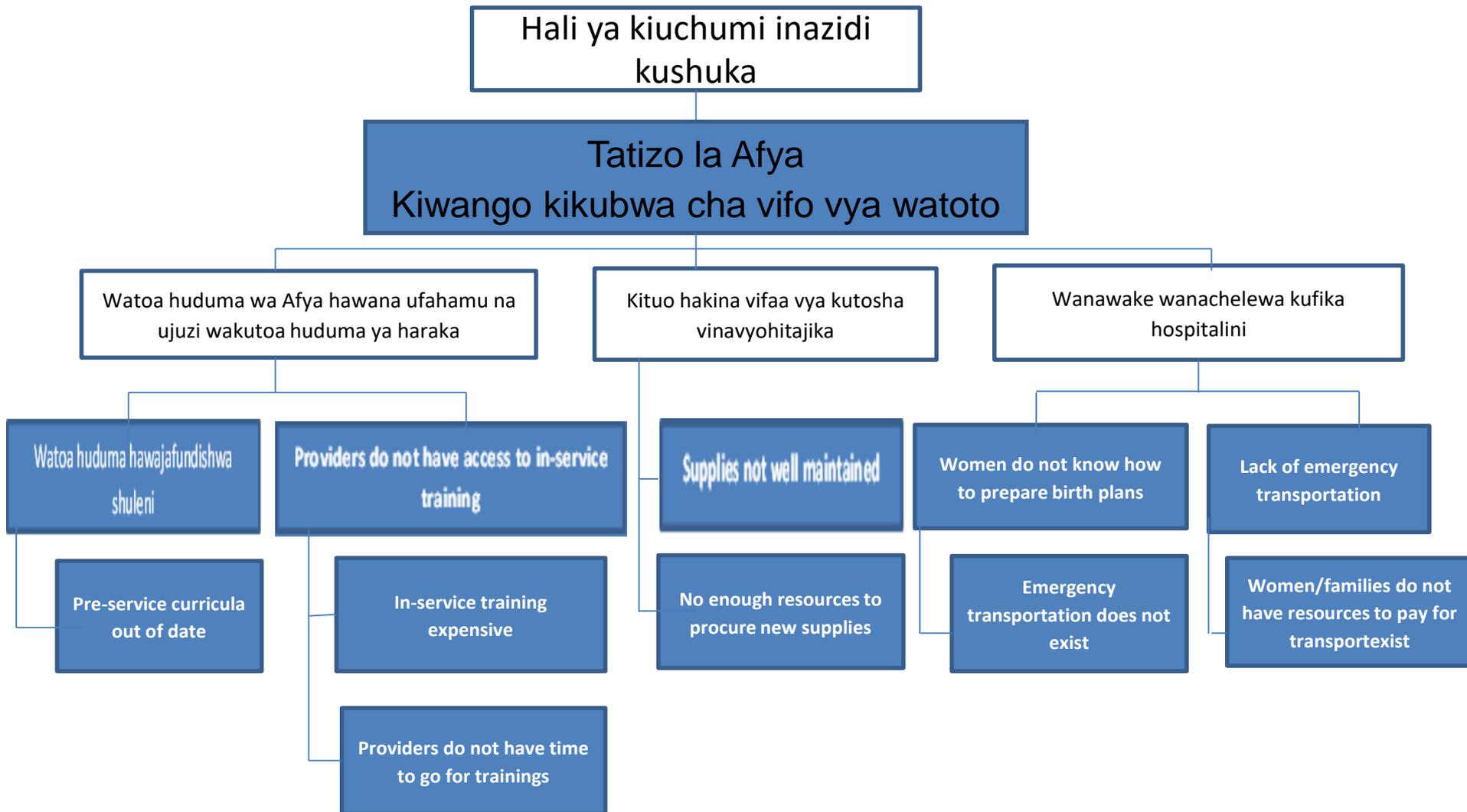
- By using the Problem Tree, you will be able to identify and analyze the cause and effect of the problem, and thus achieve productive solutions.



How to analyze a health problem using the problem tree



How to analyze a health problem using problem tree



Steps for analyzing problem using problem tree

- ❑ **Start** by writing a problem statement.
- ❑ **Then:** Identify factors you think are causing health problem in your area to which you placed a high priority, for whatever reason,
- ❑ **And:** Keep asking yourself the question "WHY?"
- ❑ **Finally:** For each of the reasons you identified, ask yourself . "Is it something your service center can do change it / fix it? ". What can be done?

Problem Analysis Using SWOC

- ***Strengths***: characteristics that improve performance.
- ***Weaknesses***: characteristics that affect performance negatively.
- ***Opportunities***: elements in the environment that the sector could exploit to its advantage.
- ***Challenges***: elements in the environment that could cause trouble for the sector.

SWOC MATRIX

UNDERSTANDING SWOC

	Positive Factors	Negative Factors
Internal Factors	<p><u>Strengths</u> Good Now</p> <p>Maintain Build Leverage</p>	<p><u>Weaknesses</u> Bad Now</p> <p>Remedy Stop Improve</p>
External Factors	<p><u>Opportunities</u> Good Future</p> <p>Prioritize Optimize</p>	<p><u>Challenges</u> Bad Future</p> <p>Counter Get it Right</p>

Diagram annotations:

- A blue arrow labeled "Convert" points from Weaknesses to Strengths.
- A blue arrow labeled "Convert" points from Challenges to Opportunities.
- A blue arrow labeled "Match" points from Opportunities to Strengths.

SWOC of the Health Sector

- Everything pertaining to the health sector is **internal**
- Strengths and Weaknesses
- Everything outside the health sector is **external**
- Opportunities and Challenges

Identification of solutions to problems

- When evaluating solutions it is important to remember that health systems solutions are often very context specific
- It's important to consider the wider socio-political context, norms and power relations that exist in the Council.
- Through the solution **brainstorming** process, the planning team may come up with multiple solutions which should be prioritized in the

Criteria for evaluating solutions

- **Feasibility:** The solution could be implemented in a reasonable timeframe with reasonable levels of effort.
- **Affordability:** The solution could be implemented with existing resources or additional resources we are likely to raise.
- **Equity focused:** The solution will help improve healthcare for the most vulnerable.
- **Acceptability:** The solution is considered appropriate by both; the healthcare providers and the clients/ community.

Prioritization matrix for possible solutions

Identified solutions	Feasibility (Policy, capacity)		Affordability (Cost effectiveness and availability of funding)		Acceptability		Equity: Does it benefit the poor?	Score	Recommendations
	Approved supportive policy	Does the Council have the capacity to implement	Is the solution cost effective	Is funding available	Is it acceptable to the community	Is it acceptable to the partners			
Solution 1	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3		
Solution 2	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3		
Solution 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3	1 2 3		

Group Work 2

Problem identification analysis using SWOC



Based on extracted council information on performance indicators;

- First:** Analyze and interpret the current situation of the council performance,
- Next:** Identify and list the health problem affecting the Council,
- Then:** Rank the problems in order of importance based on criteria for problem prioritization,
- Then:** Conduct thorough analysis of the prioritized problems to determine the causes and effects related to the problem using SWOC/ problem tree analysis,
- Then:** Brainstorm solutions to identify causes of the problems,
- And:** Prioritize solutions and select the solution that will have high score for implementation.
- Finally:** Summarize your finding in table below and report out to the larger group

Group Work 2

Summary for problem identification, prioritization, analysis and identification of solutions

No.	Problem identification and prioritization			Problem Analysis		Identification of solutions	
	Method used	List of prioritized problems per priority area		Method used	List of root causes of prioritized problems	Method used	List identified prioritized solutions
		Priority area	Problems				
1							
2							
3							
4							
5							

iv. Defining Objectives, Service Outputs, Targets, Interventions, and Activities

Terms	Definitions
Objective	<p><i>Ultimate achievements one wishes to obtain with a given input and process.</i></p> <p><i>They are broad statement of what is to be achieved, they describe an intended outcome or impact and summarizes why a series of actions have been undertaken</i></p>
Service Outputs	<p><i>An output of the service provided</i></p>
Targets	<p><i>A target is a desired amount of progress towards an objective through a number and quality of specified activities that have to be carried out before the objective can be reached.</i></p> <p><i>Targets must be SMART</i></p>
Interventions	<p><i>Actions to be taken over a period of time to address priority health problems.</i></p> <p><i>An intervention comprises a set of several activities</i></p>
Activities	<p><i>Is the action taken or work performed in order to produce a given target.</i></p> <p><i>They describe how a target is to be produced</i></p>

Setting of Objectives, Service Outputs, Targets, Interventions, and Activities

- Planning team is required to select Objectives from a list of National Objectives, set service outputs, targets and articulate Interventions and activities in a logical way.
- There should be direct relationship between the objectives set, service outputs and activities with the problems and their causes
- Targets are developed in a consultative manner, by reviewing objectives, considering relevant findings from the situation analysis and defining a series of strategies.
- It is important for the planning team to set activities that will enable them to achieve set performance targets.

v. Budgeting

- Budgeting is a process of estimating cost of each input for every activity.
- Inputs are resources identified to enable the execution of planned activities.
- Example of inputs include; per diem, extra duty allowance, diesel, medicine, and salary.
- Inputs are normally measured in terms of financial costs.
- In order to budget, one requires knowledge of quantity of inputs required, frequencies in which the inputs are required and the unit price of inputs.
- Inputs are denoted by GFS codes; e.g. Per diem 22010105, extra duty allowance 21113103, diesel 22003102, medicines 22004102, and Salary 21111101.

vi. Plan of Action

- Plan of action/work plans describes when activities will take place and who is responsible for implementing them and cost of each activity
- There must be a clear correlation between the descriptions, the activity plan and the budget

vii. Identification of Assumption and Risks

- Planning team is required to list anticipated facilitators and barriers to implementation of the CCHP.
- The assumptions and risk that should be mentioned are those that might affect the CHMTs and health facilities ability to meet their targets.
- Assumptions are things that we believe to be true but not 100% certain.
- There are some risks that the assumption will not come true.
- Because of this uncertainty, assumptions are very much related to risk, and in fact are simply low-level risks.
- They have the same characteristics as a risk – probability of occurrence and impact to your implementation.
- There are two key characteristics of risks and assumptions.
 - i) Must be some uncertainty to the event.*
 - ii) Assumptions and risks are both outside the total control of the planning team.*

Assumptions and Risks

Assumptions	Risks
All activities planned will be implemented to achieve desired service coverage	Some of the planned activities may not be implemented if: <ul style="list-style-type: none">•Some activities in the budget proposal are not approved.•The budgeted amount is decreased by inflation.•The approved budget is not disbursed on time or not disbursed at all.•There is occurrence of Outbreaks making the implementation difficult.•There is changes in government position about the interventions.
All planned coverage will be achieved	Planned coverage may not be achieved if: <ul style="list-style-type: none">•Clients do not use services because of cultural beliefs and taboos.•Clients can't afford to pay for services.

viii. Developing a Monitoring plan of the activities implementation

- CHMTs are required to prepare a plan to monitor the implementation of the CCHP.
- Planning team is expected to describe how the government and the partners will monitor activities planned and how this function will be coordinated.
- Levels of monitoring of the implementation of CCHP; Facility, Council, Regional and National level.
- If the Monitoring plan is clearly articulated, it will be a tool for other levels to align their plans with council Monitoring plan.

Developing a Monitoring plan of the activities implementation

Council Health Planning Team should indicate the following:

- Outcomes envisaged by implementing the planned activities which align with the indicators of interest set for measuring performance.
- Align the outcomes with relevant activities.
- Identify set of performance indicators at output level.
- Identify mechanism in which the performance will be tracked.
- Indicate kinds of information relevant for tracking progress.
- Indicate sources of information.

Chapter Three: Contents of the CCHP

This Chapter describes the CCHP format and contents.

The CCHP Format

Cover page

Table of contents

List of Council Health Planning Team

Acknowledgement

Acronyms

Executive Summary

Chapter 1: Introduction

Chapter 2: Disease Burden Status

Chapter 3: Resource Availability

Chapter 4: Problem identification, Prioritization, Analysis and Identification of solutions

Chapter 5: Objectives, Service outputs, Targets, Interventions, Activities and Budgeting

Chapter 6: Plan of Action

Chapter 7: Assumptions and risks

Chapter 8: Monitoring plan

Contents of the CCHP sections- Preliminary pages

- **Cover page:** It has the title of the document, plan time frame, Name of the Council, Address of the Council, and date of completion of CCHP development.
- **Table of Contents:** shows major topics and subtopics with respective page numbers to help readers to trace and find relevant information easily.
- **List of Council Health Planning Team:** This shows full names, titles and organizations of all members of the Council Health Planning Team to evidence participation of all eligible members in the preparation of the CCHP
- **Acknowledgement:** This is a section where appreciation of the persons/institutions involved in the preparation of the CCHP and those who provided inputs in the planning process is written by the CHMT members and compulsory signed by the Council Medical Officer.
- **Acronyms:** These are words which are formed from the first letters of other words and which are pronounced as full words. Example; AIDS is an acronym for Acquired Immune Deficiency Syndrome
 - All Acronyms used in the CCHP document should be listed and defined.

Contents of the CCHP sections-

Preliminary pages

Executive Summary

- The Executive Summary should be prepared and signed by the Council Director
- It should be written clearly to enable the reader to pick up essential information
- It is expected to be brief, not exceeding 3 pages and divided into three parts
- It should also present the special initiatives or activities conducted within the year and also if there are special initiatives planned to be implemented in the coming year

Contents of the CCHP sections

3.2.1. Preliminary pages

Executive Summary- part 1

- Contains information reflecting a summary review of the previous year's CCHP implementation status
- This should include interventions achieved and activities implemented in-terms of percentage and summary of targets met
- It should also provide reasons for not achieving set targets and report any issues that are of importance e.g. status of human resources, immunization coverage, status of facilities e. t. c (both positive and negative)

Contents of the CCHP sections

3.2.1 Preliminary pages

Executive Summary- part 2

- Contains a brief summary of the new plan
- It is expected to answer the following questions:
 - ✓ What are the major interventions in the year?
 - ✓ Have last year's unachieved interventions been addressed in the current plan?
 - ✓ What are the available resources and sources of funding?
 - ✓ Who are the key collaborators in the Council?

Contents of the CCHP sections

3.2.1 Preliminary pages

Executive Summary- part 3

- Contains Budget Summaries: Budget summary tables showing the expected funding of the CCHP should be filled and presented as part of the executive summary
- These Budget summary tables are: -
 - ✓ Main Budget Summary reflecting all sources of funds by Cost Centre - (Annex 6.1).
 - ✓ Specific Budget Summary for Health Basket Funds by Cost Centre - (Annex 6.2).
 - ✓ Specific Budget Summary for Health Block Grant by Cost Centre - (Annex 6.3).
 - ✓ Specific Budget summary for Cost Sharing funds by Cost Centre - (Annex 6.4).

CCHP Chapter 1: Introduction

The Training of this chapter will include how CCHP data can be populated from DHIS2. The participants will learn on how CCHP data can be populated from DHIS2.

The introduction includes information on;

- Section 1.1: The Council profile,
- Section 1.2: Achievements and challenges encountered in the previous year implementation and
- Section 1.3: Current CCHP presented

CCHP Introduction:

1.1 The Council Health Profile Showing

- Map of the Council with operating health facilities (Public and Private).
- Geography: nature, climate, season
- Administration: borders, structures (list of division etc.).
- Socio-economical information with gender perspective: ethnic groups, main economic activities, employment situation, literacy rate and poverty rate.
- Transport and communication: roads, roads condition and communication facilities (phone, fax, e-mail and website).
- Provide facts and narration regarding water supply, toilets availability, refuse collection and disposal of medical waste
- Provide information regarding health promotion initiatives and campaigns including their achievements and challenges
- Population characteristics: total population, population growth, urban-rural distribution of the population, population groups, Total Fertility Rate, Birth rate, and Mortality rates
- Community involvement in health related activities.

CCHP Introduction:

1.2 Achievement and Challenges encountered in the previous year of implementation

- Presents the performance of implementation against what was planned and approved in the previous financial year.
- Reasons for good and poor performance have to be teased out to generate lessons for the current plan.
- CHMTs are also expected to provide progress across health facilities and reasons for variation if any.

CCHP Introduction:

1.3 Current CCHP

- Purpose of the CCHP (main Objectives and Targets).
- How the needs were identified and prioritized.
- Inclusion of the annual hospital, health center and dispensary plans.
- Available resources and sources.

CCHP Chapter 2: Disease Burden Status

This chapter comprises of Council's Morbidity and Mortality Trends.

Main OPD Diagnoses (top 10 diseases) in the Council

Top 10 causes of admission in the Council

Top 10 causes of death in the council

Notifiable diseases

CCHP Chapter 3: Resource Availability

Chapter three of CCHP describes the status of resource availability. The chapter comprises of the following sections;

- Availability of health Commodities
- Availability of human resources for Health
- Health facilities availability and health facility infrastructure development
- Transport Availability
- Community Based initiatives in the council
- Technical and Governing committees
- Coverage of partners' programs/projects across the Council
- Financial resources

Details on Review of Resources Available

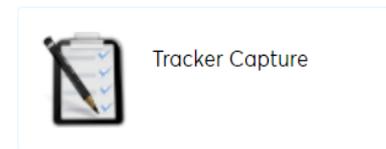
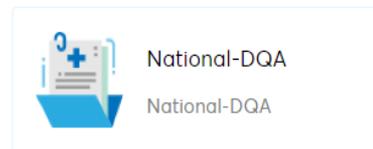
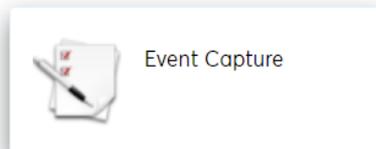
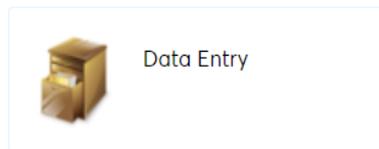
- **Human Resource Requirement:**
 - Human Resource for Health requested, funded, recruited and current status of HRH availability in the council- table 12
 - Attrition status by cadre- table 13
 - CHMT (Managerial and technical members)- table 14
 - HRH initiatives implemented in the council- table 15
- **Material / Equipment/ Medicines/ Supplies:**
 - Overview on the availabilities and conditions of essential Medical Equipment and Apparatus – table 11
- **Health facility availability and Infrastructure :**
 - Operational health facility available in the council- table 16
 - Health facilities providing CEmONC services available in the council – table 17
 - Health facilities under construction and major rehabilitation- table 18
- **Transport:**
 - Vehicles and their use – table 19
- **Sources of Funds:**
 - The different Sources of Financing – table 23

Other Tables : Community based initiatives, technical and govern committees and partners support distribution by geographical location and focus areas

DHIS2 and Data Extraction

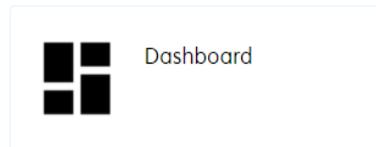
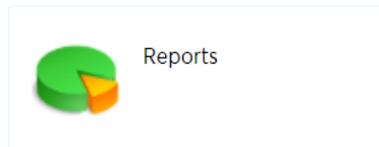
Data entry modules

These apps/modules are used for data entry



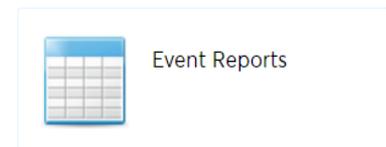
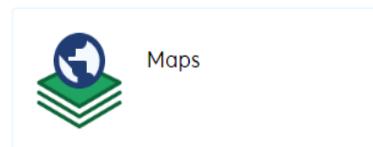
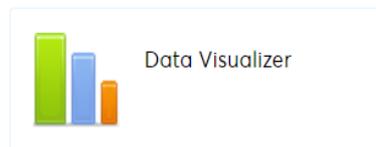
Reports modules

These are apps/modules used for accessing/generating reports



Analysis tools

These are analysis tools. You can generate reports in table, charts, maps etc formats and be able to download into excel for further analysis and use



Group work 3: Data Extraction

Extract data from DHIS2 and fills the tables below:



Table 1: Distribution of the population by sex and age group

Table 2: Maternal and Neonatal Deaths

Table 3: Status of implementation of previous year plan

Table 4: Council progress on performance indicators targets

Group work 3: Data Extraction Cont.

Table 5: Council performance in leveraging local resources



Table 6: Cost of exemptions/ waivers provided at Health facilities

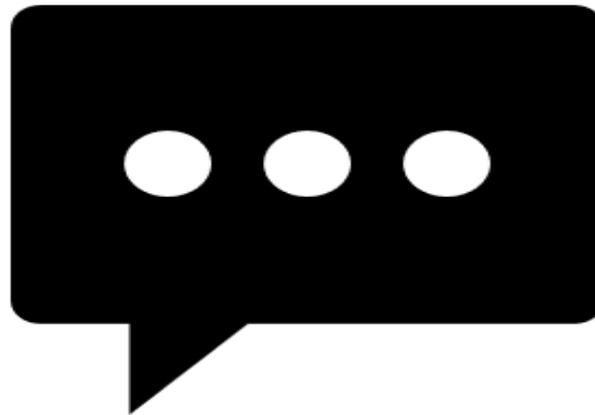
Table 7: Main OPD Diagnoses (top 10 diseases) in the Council

Table 8: Top 10 causes of admission in the Council

Table 9: Top 10 causes of death in the council

Table 10: Notifiable diseases

Discussion: Group Work 3



CCHP Chapter 4: Problem Identification, Prioritization, Analysis, Identification of Solution

This section provides a brief description on how CHMTs conducted;

- Problem identification,
- Prioritized the problems,
- Analyzed the prioritized problems, and
- Identified solutions for action

CCHP Chapter 5: Priority areas, Objectives, Service outputs, Targets, Intervention, Activities and Budgeting

This chapter contains two sections;

- Objectives, Service outputs, Targets, Intervention and Activities
- Budgeting

It must be noted that the inputs (description) in budget breakdown must be assigned to appropriate GFS Code and the costs assigned **MUST** be realistic

Table 25: Objectives, Service outputs, Targets, Interventions and Activities



Priority Area	Intervention	Problem	Underlying cause	Objective	Service output	Target	Activity
RMNC AH	New born care	High perinatal mortality rate by 20%	HCW lack new born resuscitation skills	C: Improve access, quality and equitable social services delivery	C05: Reproductive and child health care improved	O3S: Perinatal mortality rate reduced from 20% to 10% by June, 2022	C0503S01: To Conduct orientation on Care of high risk neonates premature birth asphyxia to 10 Health Centre workers for 5 days by June 2019.

Priority Areas

Priority Area

Priority area is the main focus area chosen by the country in addressing health problems. CCHP is developed on thirteen priority areas:-

1. Health commodities (Medicines, medical equipment, medical and diagnostic supplies and management system)
2. Reproductive, Maternal, Newborn, Child and Adolescent health
3. Communicable Diseases and Priority Neglected Tropical Diseases and Zoonoses
4. Control Non-Communicable Diseases Control
5. Nutrition
6. Environmental Health and Sanitation
7. Social Welfare and Social Protection
8. Strengthen Human Resources for Health Management capacity for improved health services delivery

Priority Areas cont'd

9. Strengthen Organizational Structures and institutional capacities for improved Health Services Management
10. Emergency Preparedness and Response
11. Traditional and Alternative Medicine
12. Construction, Rehabilitation and Planned Preventive Maintenance of physical Infrastructures of Health facilities
13. Community Health systems

Intervention

Intervention

- An intervention is a set of activities that can be implemented to solve an identified health problem.
- Some interventions in their respective priority areas are listed below as examples:
- **Priority area 5: Nutrition (Some interventions):**
 - ✓ Exclusive Breast-feeding for first six months
 - ✓ Management of severe, moderate and acute malnutrition
 - ✓ Nutritional Supplementation for mother, neonates and children
 - ✓ Promotion of food & dietary diversification and food fortification
 - ✓ Prevention and management of diet related NCDs
 - ✓ Rehabilitative support
 - ✓ Growth monitoring

Intervention

- Priority area 13: Community Health systems
- ✓ Council Health Service Boards (CHSBs), Health Facilities Governing Committees (HFGC) function
- ✓ Community Sexual Reproductive Health Services sensitization for BCC
- ✓ Community Owned Resource Persons (CORPs)
- ✓ Community Based Health Care Services for Maternal Newborn and Child Health (Community Health care workers, Community Based Distributors for FP, etc).
- ✓ Community based HIV/AIDS services (CBHS)
- ✓ Community based health promotion

Problem

Problem

- These are priority health problems identified during the problem identification and prioritization session.
- They are the results of situational analysis (data analysis and interpretation)
- This is to say that the problems must be evidence – based and they must be quantified

Underlying Cause

Underlying cause

- These are factors that lead to existing problem
- The underlying cause in this guideline actually means the root cause
- It is the result of an in depth situational analysis to identify the root causes of the problem
- These must be addressed by the activity (ies)
- In practice and basing on the district health services provision, a problem may have more than one root cause

Chapter 5

Objectives

Objectives

The objective part of table 25 is filled by selecting appropriate objective from the list of National Objectives listed below:

- Objective A: Improve services and reduce HIV/AIDS infection
- Objective B: Enhance, Sustain and effective implementation of the National Anti-Corruption Strategy
- Objective C: Improve access, quality and equitable social services delivery
- Objective D: Increase Quantity and Quality of social services and infrastructure
- Objective E: Good governance and Administrative services enhanced
- Objective F: Social welfare, gender and community empowerment improved
- Objective G: Management of natural resources and environment enhanced and sustained
- Objective H: Local economic development coordination enhanced
- Objective I: Improve Emergency and Disaster Management
- Objective Y: Multi Sectoral Nutritional Services Improved

Service Output

Service Output

- Service Output are **final goods and services** that are produced as core business of specific sector. For health sector the core business is to provide health services and example of service outputs for the sector include children immunization, OPD care, maternal services, reproductive and child health care
- ✓ Service Output: [C05] Reproductive and Child Health care improved
- ✓ Service Output: [Y02] Improved maternal, infant, young child and adolescent nutrition practices and behaviours
- It should be distinguished from outcome in that, it is the immediate result obtained after implementing the activity where as the latter is the long time effect

Targets

Target

- When setting targets ensure they are Specific, Measurable, Achievable, Realistic and Time bound (SMART).
- Should be developed based on their baseline and what can be achieved within a year
- Targets must be SMART (See example in table 25)
- You can have several targets to achieve an objective



Targets

- What happens if your targets aren't SMART?
 - You might not really know the actual coverage rates in your catchment area.
 - For example, commodities may run out early, vaccine supplies may be low, leading to disease outbreaks.
 - What other implications are there of targets that are set incorrectly?

Activities

Activities

- These are tasks to be executed to eliminate the causes of bottlenecks identified/ root causes and monitor the implementation of plan
- A matrix of possible activities that can be planned in CCHP is attached as annex 7 of the guideline
- The activities must also be SMART (see the example above)

Cost Centre

- Cost center refers to levels of service provision within a Council.
- For example; in the health sector, there is one cost centre which includes all health centers in the LGA, and one for all dispensaries.
- Below is a list of five Cost centres under CCHP and their codes.

SN	Cost Centre	Code
1	CHMT	508A
2	Council Hospital	508B
3	Voluntary Agency Hospital	508C
4	Health Center	508D
5	Dispensary	508E

Hands-On Exercise 2

With your planning team: fill out the two tables (25&26)



in the web-based PlanRep, adhering to the following points:

Appropriate priority area must be selected and it must relate to the objective and target

- ✓ The target should address the problem
- ✓ The intervention should correspond to the activity
- ✓ The activity should address the underlying/ root cause
- ✓ The activity must be SMART

Note: the majority of the information to populate table 26 has been generated in table 25

Table 26: Budgeting



Cost center : 508B: Council Hospital											
Priority area: RMNCAH											
Intervention	S/N	Activity	Output indicators	GFS Code	Description	Unit Cost				Total cost	S o u r c e o f f u n d s
						Unit of measure	Quantity	frequency	Price		
New born Care	1	C01S02: To conduct orientation on care of high risk neonates, premature birth asphyxia to 10 Health centre workers for 5 days by June 2019	Number of participants trained	22007109	Conference facility	Days	1	5	50000	250,000	H B F
				22003102	Diesel	Litres	50	1	2300	115,000	
				22014104	Food and refreshment	Person	20	5	10000	1,000,000	
				22001101	stationery	Person	1	1	50000	50,000	
				22010105	Perdiem participants	Person	20	6	80000	9,600,000	
				22010105	Perdiem facilitators	Person	4	6	120000	2,880,000	
				22010105	Perdiem drivers	Person	2	6	80000	960,000	
Sub Total									14,605,000		

CCHP Chapter 6: Plan of Action table 27

Cost Center: Code and Description e.g. E03- Dispensary											
Intervention	S/N	Activity (code & description)	Output Indicator	*Time Frame	Sources of Funding/ amount						**Responsible person
					BG	HBF	Council Own source	Cost Sharing	Receipt in Kind	Other Funding	

G3: Chapter 7: Assumptions and Risks

- The planning team is required to list anticipated facilitators and barriers to implementation of the CCHP.
- The assumptions and risks that should be mentioned are those that might affect the CHMTs and health facilities ability to meet their targets.

Chapter 8:

Table 28: CCHP Monitoring Plan

Cost centre: CHMT							
Target	Activities	Output			Means of verification	Frequency of reporting	Responsible
		Output Indicator	Output number	Achievement			
	C01S02: To conduct orientation on care of high risk neonates, premature birth asphyxia to 10 Health centre workers for 5 days by June, 2019	Number of Health care workers trained	10	10	Activity report	Annually	DNO

Hands-on Exercise 3: Plan of Action & Monitoring Plan



- **First:** On your own, go to Plan Rep
- **Then:** complete the Plan of Action and Monitoring Plan
- **Finally:** discuss your results with the full group

Chapter Four (Guideline): Guiding Principles on the Disbursement and Expenditure from Different Sources

This chapter describes how funding is allocated to CHMTs and facilities and provides guidance on things to consider when spending the allocated funds.

Guiding principles on the disbursement and expenditure of funds from different sources

- This chapter describes how funding is allocated to CHMTs and Health facilities and provides guidance on things to consider when spending the allocated funds.
- The CCHP is developed based on available financial resources because activities need to be matched with funds.

Sources of funds for CCHP include;

- i. Health Block grant (Personnel Emoluments, Other charges and Development grants)
- ii. Health Sector Basket Fund
- iii. Cost sharing money (Out of pocket, Insurance schemes)
- iv. Council Own sources
- v. Global fund
- vi. Block grant from MoHCDGEC to Council Designated Hospitals
- vii. Bed and staff grant to Voluntary Agency Hospitals
- viii. Fund for medicine, equipment and supplies through MSD
- ix. National programs (NMCP, NACP, IVD, NTLF, FP)
- x. NGOs
- xi. Bilateral and Multilateral development partners
- xii. Donations
- xiii. Community contributions
- xiv. Other sources

Resource allocation formula

A. Basis for resource allocation to councils

- **Population (60%):** Health Block Grant and Health Basket Fund is distributed in proportion to the population of each council by 60%.
- **Poverty (10%):** Councils receive additional resources for the special needs of a poor population (10% of the grant resources).

Resource allocation formula

Councils



- **Capped land factor (20%):** The formula recognizes the higher expenditure needs of rural areas. As such, the formula takes into account the higher operational cost of delivering health services to a rural population and to sparsely populated areas; including higher costs faced in immunization and supervision.
- **Under-five mortality (10%):** The formula also aims at directing 10% of resources to places with high burden of diseases; here the under-five mortality (U5M) is considered as an appropriate proxy for burden of diseases.

Resource allocation formula

Health Facilities



B. Basis for resource allocation to health facilities

- **Catchment Population (40%):** Takes into account the population expected to be served by the Health facility.
- **Distance of the individual Dispensary/Health Centre to the Council's headquarter (10%):** It is important in budgeting funds to be used for referral, and logistics requiring health facility staff to travel to headquarters.

Resource allocation formula

Health Facilities - continued



- **Actual utilization (40%):** Measured by a composite indicator, the “Care unit” . Combined estimate of service output, weighted by cost;
 - Outpatient attendances
 - Antenatal attendances
 - Institutional deliveries

Plus at HC level;

- Admissions
- C-sections

NB: 30% for Dispensaries and 25% for Health Centres have been combined to provide a pool for lower level health facilities

Resource allocation formula

Health Facilities - continued



- **Performance(10%):** To reflect facility contribution towards LGAs performance. Taken from current LGA scorecard;
 - % WRA using modern methods of family planning
 - HF with constant availability of tracer medicines

Prerequisites for health facilities to receive funds



- At least one qualified health staff
- Availability of an annual health facility plan
- Availability of HMIS data
- An active health facility bank account as per MoFP guidelines
- Availability of a health revenue accounting person
- Availability of a functional communication channel
- Functional Health Facility Governing Committee (HFGC)

Health Basket Fund (HBF) (performance-based financing)

- Disbursement of HBF in the health sector is aligned to performance in the sector and includes two components which are base tranche and performance tranche
 - The disbursement of the **base tranche** depends on the achievement of targets for five indicators measuring institutional strengthening. Allocation of Base Tranche follows LGAs resource allocation formula.
 - Disbursement of the **performance tranche** depends on the achievement of targets for a set of agreed indicators at LGAs (twelve indicators), RHMTs (three indicators), and Central level (four indicators).

Base Indicators

1. Percentage of councils whose annual CCHPs pass in the first round of assessments.
2. Percentage of completion of “Star rating” assessments/reassessments of Primary Health Care facilities.
3. Percentage of annual employment permits for Primary Health Care Human Resource for Health given to nine critical regions.
4. Percentage of Primary Health Care facilities with bank accounts opened according to guidelines from Ministry of Finance and Planning.
5. Action plans of audits of recipients of Health Basket Fund received

Indicators (LGA level)

1. % of pregnant women attending 4 or more ANC visits.
2. % of ANC attendees receiving IPT2.
3. % of pregnant women who receive adequate quantity of Iron and Folate tablets during their current ANC visit (enough supplies to next visit).
4. % of institutional deliveries
5. % of women of reproductive age (15-49 years) using modern family planning methods.
6. % of children (12-59 months) receiving at least one dose of Vitamin A supplementation during past 12 months.
7. % of PHC facilities with 3 stars rating or higher.

Indicators (LGA level cont'd)

8. % of PHC facilities with at least one skilled Human Resource for Health (clinician or nurse).
9. % of PHC facilities with continuous availability of 10 tracer medicines in past year.
10. Existence of a Functional Council Health Service Board and percentage of functional Health Facility Governing Committees.
11. % of completeness of a quarterly DHIS2 entry by LGA (by day 30 after quarter's end).
12. % of LGAs with unqualified opinion in the external audit report previous year.

Indicators (Regional level)

1. RHMTs conduct required biannual data quality audits (DQAs) for LGAs that meet national DQA standards
2. RHMTs conduct required annual supportive supervision visits for LGAs that meet national supervision standards
3. % of LGAs submitting requests for CHF matching funds.

Indicators (Central level)

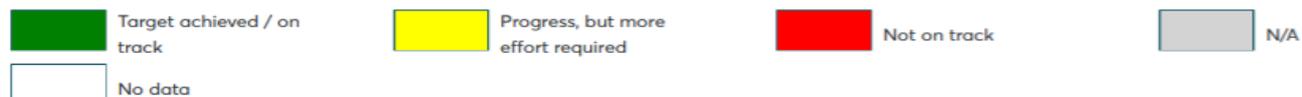
1. Average and variance of LGA performance scores
2. Average of Regional performance scores
3. % of unsupported expenditures in MoHCDGEC and PORALG annual audits
4. 4. % of LGAs receiving CHF matching funds

Performance criteria - Definition

- The level of progress towards set targets for each indicator determines the disbursements.
- This is also referred to as the 'sliding scale' principle. For LGAs targets are set as progress against an LGA-specific baseline, thus rewarding equally those who improve from a lower and a higher baseline level.
- Performance is monitored using a balanced scorecard with agreed upon indicators.

Scorecards

Basket Fund Indicators



▲ Increase from last period ▼ Decrease from last period

	ANC 4th visits Coverage	ANC IPT 2 coverage	% institutional deliveries	Contraceptive Coverage - Modern Methods	ANC Iron supplementation rate	Vitamin A Supplementation on 1 - 5 Years Coverage	Tracer Medicine entire package	Data completeness / Data timeliness
MOH - Tanzania	▲ 83.1	88.2	▲ 86.4	45.3	84.4	▼ 84.1	96.7	99.2 / 98.4
Arusha Region	▲ 87.8	94.7	73.1	45.7	82.1	▼ 84.9	97.9	100 / 99.8
Dar Es Salaam Region	91.3	102.8	▼ 61.3	25.2	84.2	▼ 103.6	97.4	96.9 / 95.4
Dodoma Region	▲ 84.2	▲ 100.6	79.8	58.1	86.4	▼ 166.7	96.4	98.7 / 96.9
Geita Region	▲ 82.4	81.4	▲ 113.6	▲ 34.6	88.8	▼ 53.5	97.5	99.1 / 99.1
Iringa Region	▲ 86.6	92.2	80.7	▲ 86.2	86.1	▼ 72.3	97.1	98.9 / 98.4
Kagera Region	74.2	81.6	84.5	▲ 42	90.7	▼ 66.2	98.1	99.6 / 99.5
Katavi Region	▲ 99	▼ 85.7	▲ 108.3	▼ 59.8	▼ 87.5	▼ 165.2	97.1	100 / 99.6
Kigoma Region	▲ 98.1	86.2	▲ 105.8	42.1	92.2	▼ 63.9	97.6	100 / 100
Kilimanjaro Region	85.6	109.2	57.1	46.4	99.4	▼ 71.7	97.6	100 / 100
Lindi Region	▲ 90.2	87.1	68.5	87.5	84	▼ 78.6	95.4	95 / 90.5

RMNCAH Scorecard

RMNCAH SCORE CARD



Region	Pre-pregnancy		Pregnancy				Labor & Delivery			Postnatal Care		Child Health				Health Systems		Human Resources	Health, Financ						
	% women 15-49 on contraceptives / Proportion of long-term FP methods	% of Male spouses involved in RMNCAH services / % Adolescents pregnancy	ANC 1st Visit Before 12 weeks rate / ANC 4th visits Coverage	ANC IPT 2 coverage / Proportion of pregnant women received Fefal (Iron Folic) supplementatio n	% institutional deliveries / % deliveries w skilled attendant	% mothers given uterotonic interventions (Oxytocin, Ergometrine) after delivery	PNC Mothers (within 48 hours) / PNC (2 days) baby	% infants receiving ARV prophylaxis	% infants receiving PCR test	% children receiving Penta3	% Children (1 to 5years) received vitamin A supplements	children receiving MR2	% HF with RCHs tracer drugs package	Data completeness / Data timeliness	Nurse Midwives per 10,000 Population	% of household enrolled CHF/TIKU									
MOH - Tanzania	42.2	40.9	74.7	25.7	32.1	77.7	87.9	83.1	80.8	77.5	94.4	70.3	69.1	98.5	98.7	105.7	▲	176.5	▲	92.4	88.8	98.9	98.4	0	20.6
Arusha Region	48.7	40.3	55.8	18.5	29.2	78.6	90.6	80.2	73.4	71.3	87.8	63.3	61.2	106.2	102.5	122.6	▲	264.9	▲	110	89.2	99.9	99.4	0	22.6
Dar Es Salaam Region	25.5	63.3	61.8	13.4	16.1	92.9	105.9	83.3	89.9	68.3	101.2	58.4	57.9	95.2	95.4	99.2	▲	177.9	▲	96.4	90	95.9	94.3	0	0.3
Dodoma Region	56.5	42.3	60.8	26.9	29.2	71.4	93.3	88.1	78.5	74.6	89.3	55.4	55.4	86	87.5	109.4	▲	248.1	▲	91.1	88.5	98.5	97.8	0	4.8
Geita Region	29.7	58.3	78.8	34.2	45.4	76.5	80.5	86.1	95.5	95.4	100.6	95	94.2	86.5	96.8	96.6	▲	172.7	▲	81.1	86.9	98.8	98.6	0	3.4
Ininga Region	77.1	47.3	63.9	14.9	38.8	71.3	87.5	88.8	76.3	71.5	96.6	75.2	72.6	98.9	96.9	105.5	▲	246.6	▲	110.5	90.1	98.6	97.5	0	31.1
Kagera Region	37.5	29.4	81.8	22	49.9	70.7	78.2	91.9	80.2	76.8	98	77.9	77.9	86.7	101.2	89.8	▲	76.1	▲	74.2	90.9	99.6	99.6	0	6.7
Katavi Region	6	61.7	85.5	50	31.2	93.4	91.7	93.4	99.4	83.1	86.8	83.3	74.2	85.9	99.2	125.4	▲	273.9	▲	97.9	90.1	100	97	0	25
Kigoma Region	41.3	43.5	85.1	25.8	52.5	91	89.8	90.9	95.7	94.6	97.3	82.8	77.8	95.8	100	94.8	▲	94.3	▲	77.1	90.1	100	100	0	31.2
Kilimanjaro Region	46.4	36.7	57.8	10	23.9	85.3	73	99	58.4	58.1	99.2	50.2	49.8	100.3	100.7	82	▲	177.8	▲	84.4	91.8	100	99.9	0	22.7
Lindi Region	88.7	19.7	80.8	21.9	20.8	83.6	91	88.9	65	61.2	97.8	62.2	62.2	96.9	83.2	109	▲	214.7	▲	105.4	88.5	96.7	93.9	0	40.1
Manyara Region	38.4	43	67.2	18.1	13.1	60.6	88.5	78.4	59.9	57.2	85.3	55.3	49.9	90.2	100.7	100.9	▲	207.6	▲	87.7	88.6	98.9	98.4	0	25.3
Mara Region	40.4	48.9	70	27.9	35.7	77.7	81.6	77.9	85	78.3	94.7	84.7	84.6	92.8	95.9	98.6	▲	200.2	▲	81.9	84.6	99.6	99.6	0	33.3

Allocation ceilings for Cost Centres at Council Level (HBF & OC)

SN	Cost centre	Allocation
1	CHMT	15 %
2	Council Hospital /Council Designated Hospital	20 %
3	Voluntary Agency Hospitals (VAH)	10 %
4	Health Centre	25 %
5	Dispensary	30 %

Ceilings for expenditure items for CHosp, HC and Disp (HBF, HBG and Cost Sharing)

Type of expenditure	Allocation Ceilings	Example of expenditures
Priority area 1: Health commodities	35%	<ul style="list-style-type: none"> • Procurement of medicine • Procurement of Medical equipment and medical supplies • Procurement of laboratory reagents and dental supplies
Priority area 8: Strengthen Human Resources for Health Management Capacity for improved health services delivery	15%	<ul style="list-style-type: none"> • Uniform allowance • Leave allowance • Staff incentives
Priority area 2, 3, 4, 5, 6, 7, 9, 10, 11, 12	45%	<ul style="list-style-type: none"> • Reproductive, Maternal, Newborn, Child and Adolescent health. • Communicable Disease and Priority Neglected Tropical Disease and Zoonosis Control. • Non-Communicable Disease Control. • Nutrition. • Environmental Health and Sanitation. • Social Welfare and Social Protection. • Emergency Preparedness and Response. • Strengthen Organizational structures and institutional capacities for improved Health Services Management. • Traditional and Alternative Medicine. • Construction, Rehabilitation and Planned Preventive Maintenance of physical Infrastructures of Health facilities.
Priority area 13: Community Health systems	5%	<ul style="list-style-type: none"> • HFGC functions. • Incentives to Community Owned Resource Persons (CORPs). • Community Health Promotion activities.

Expenditure ceilings cont'd

- a) Allowances for training activities allocated to respective interventions is not part of the 15% ceiling.
- b) The 35% earmarked for Health commodities should be allocated to procurement of Medicines, Hospital supplies, Medical/diagnostic equipment, Laboratory reagents, and Dental supplies as follows:

Medicine	50%
Hospital Supplies	10%
Medical equipment's	15%
Dental equipment and supplies	10%
Laboratory Reagent	10%
PPM of Medical and dental equipment	05%

Reallocation procedure highlights

Reallocation of Funds

- 41 – (1) An Accounting Officer may, upon approval by the Minister, reallocate funds from the authorized expenditure,
- (2) Notwithstanding the provisions of subsection (1) an accounting **officer shall not** reallocate funds where;-
- (a) funds are appropriated for expenditure prescribed as ring fenced;
 - (b) funds are appropriated for transfer to another government entity or person;
 - (c) Funds are appropriated for capital expenditure except to defray other capital expenditure; or

Reallocation highlights cont'd

- The Council Director will review and submit to Council Standing Committee for approval.
- After the approval by Council Standing Committee, the changes will be communicated to the RAS who will consolidated all reallocations and submit to Paymaster General/Permanent Secretary- Treasury through PORALG

Reallocation of expenditures is not recommended unless there is a strong need to do so, and there must be solid reasons for making reallocation of funds and the application forms must be signed by Accounting Officers.

What 's new in CCHP Chapter 4

Area	COMMENT
Health Basket Fund performance based financing (<i>Base tranche and Performance tranche + Performance criteria</i>)	New entry
Basis for resource allocation to councils	Change of %ge
Basis for resource allocation to health facilities	New entry

What 's New in CCHP Chapter 4 cont'd

Area	COMMENT
Allocation ceilings for Cost Centres at Council Level	Change of %ge
Allowable ceilings for expenditure items for Health Basket Fund, Health Block Grant and Cost sharing funds	Change of %ge
Ceilings for selected expenditure items for Council Hospital, Health centre and Dispensary Cost centres	Change of %ge

What 's New in CCHP Chapter 4 cont'd

Area	COMMENT
Basis for resource allocation of health commodities receipt in kind from MSD	Criteria for budget calculation has been improved.
Procedure for re-allocation of approved budget	Procedures have changed
Flow of funds and disbursement mechanism	New entry

Hands on Exercise 4

Procedures for reallocation of approved budget and online reallocation

- **First:** On your own, go to Plan Rep
- **Then:** complete the Plan of Action and Monitoring Plan
- **Finally:** discuss your results with the full group



**Guidelines Chapter Five:
Monitoring of CCHP implementation and
reporting the progress**

Monitoring

Monitoring is the systematic process of collecting, analyzing and using information to track progress toward reaching the set objectives in order to guide management decisions.

Usually focuses on processes, such as when and where activities occur and who delivers them based on the set outputs. In addition; it tracks how resources are used and whether there is compliance to principles of resource management and utilization.

Why monitoring is important in CCHP

- Track implementation and outputs systematically to establish the effectiveness of the implementation.
- Determine whether Councils are on track and if interventions are needed to improve implementation.
- Identify challenges impeding performance and provide corrective measures.

Monitoring Key Areas

Technical Aspects

Financial Resources

Human Resource

Health Commodities and other supplies

Health Infrastructure

Monitoring and management of Public Private Partnership (PPP)

Data Sources

Both Financial and non-financial data sources are use to monitor the implementation of CCHPs; The sources are:

- Health Management Information System
- Supportive Supervision
- Community monitoring systems
- Financial Reports
- Facility/councils assessments and survey reports

Types and frequency of reporting

There are two types of reports, technical and financial progress reports; the frequency of reporting is Quarterly and annually.

- **Quarterly reports** shall reflect the implementation status of each quarter (i.e. the three months period).
- **Annual Reports** shall reflect the implementation status of the whole financial year.

Content of the quarterly progress report

- Preliminary pages
 - Cover page
 - Table of contents
 - Acknowledgement
 - Acronyms
 - Executive summary
- Quarterly financial position
- Combined Technical and financial performance
- Report on selected performance indicators
- Report on the status of tracer health commodities
- Report on the status of special projects implemented by the Council
- Constraints /challenges encountered during implementation
- Way forward how to address the constraints/ challenges reported

Quarterly financial position

Cost centre:

Cost centre:							
Sources of funds	Source sub-category	Approved Budget current quarter	Opening balance	Amount received current quarter	Total Funds available	Amount spent per quarter	Closing balance end of quarter

Summary of receipts and expenditure by cost centre

SN	Cost centre	Opening Balance	Amount received	Available funds	Expenditure	Closing balance
1	CHMT					
2	Council Hospital / CDH					
3	VA Hospital					
4	Health Centre					
5	Dispensary					
	Total					

Technical and financial performance

Cost centre: continued

Priority Area	Activity code	Approved annual budget	Planned Activities per Quarter (according to Priority areas)			Actual Implementation this Quarter			Cumulative Implementation (according to Priority areas)					
			Activities	Source of Funds	Budget (TZS)	Implementation status (Technical)	Amount received (TZS)	Amount spent (TZS)	Implementation status (Technical)	Achievement (%)	Amount spent (TZS)	Amount spent (%)	Balance end of Quarter	Remarks

Report on selected performance indicators

Priority Area	Performance indicators	Total planned (Quarter)	Total number implemented (Quarter)	Total number implemented (Cumulative)
Reproductive, Maternal, New born, Child and Adolescent Health	Percentage of ANC first visit before 12 weeks of gestation			
	Antenatal care coverage : 4 th visits and above			
	Pregnant women receiving TT2 + (%)			
	Pregnant women receiving IPT2 (%)			
	Women of Reproductive age using Modern Family planning methods (%)			
	Pregnant women who receive recommended doses of Iron and Folate tablets during ANC visits (%)			

Tracer health commodities (medicines/medical supplies and laboratory reagents) Status Report

S/N	Description	Number of Health Facilities providing Health commodity	Number of HFs with availability of commodity throughout the Quarter	Number of Facilities with stock out for the whole month	Facilities with stock out (%)
1	DPT + HepB/HiB vaccine for immunization				
2	Vitamin A				
3	Artemether / Lumefantrine (ALu) oral				
4	Amoxicillin TD/ tablets				
5	Cotrimoxazole syrup/ tablets				
6	Albendazole or Mebendazole oral				
7	Ergometrine or Oxytocin injectable, or Misoprostol oral				

Report on the status of special projects implemented by the Council

Project name	Objectives	Target	Project Budget	Budget received	Expenditure	Balance	Implementation status

Constraints /Challenges encountered during implementation

Constraints	Level affected [Tick Appropriate]		Corrective measures taken
	Health facility	CHMT	

Reporting periods

Activity	Responsible for Action	Timing of Action
<p>Councils produce and submit Progress reports to RS / RHMT</p> <p>Quarterly reports</p> <ul style="list-style-type: none"> •July to September report •October to December report •January to March report •April to June report <p>Annual report</p> <ul style="list-style-type: none"> •July – June Report 	<p>Council Director / CHMT</p>	<p>Quarterly reports</p> <p>By 20th day of the following month after the end of the quarter. E.g. January – March Quarter report by 20th of April</p> <p>Annual report</p> <p>July-June report by 31st July</p>
<p>RS / RHMT assess and approve the quarterly and annual reports and submits to PORALG (Assessment criteria attached as annex 9)</p>	<p>RS / RHMT</p>	<p>By 30th day of the following month after the end of the reporting quarter.</p> <p>July-June report by the 10th day of August</p>
<p>Assessment of quarterly and annual reports by Central level (Assessment criteria attached as annex 9)</p>	<p>MoHCDGEC and PO RALG</p>	<p>Quarterly</p> <p>By 30th day of the following month after the end of the quarter.</p> <p>Annual</p> <p>By 10th day of September</p>
<p>Central level produces final summary and analysis of annual progress reports</p>	<p>MoHCDGEC and PO- RALG</p>	<p>By 31st October</p>

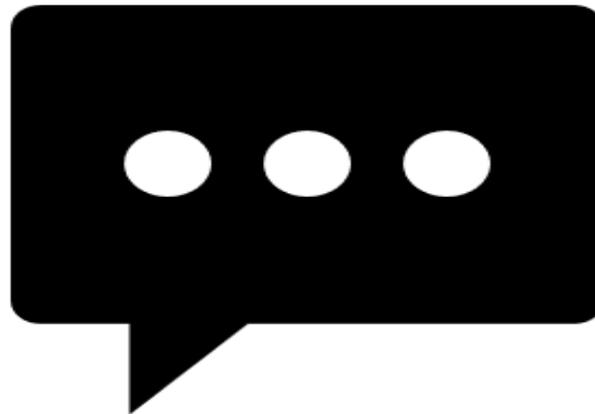
Hands- on exercise 5:

Preparing progress report(Web based plan Rep)

- **First:** On your own, go to Plan Rep
- **Then:** Prepare quarterly progress report
- **Finally:** discuss your results with the full group



Discussion: Hands on Exercise 5



HEALTH FACILITY PLAN AND DATA USE

Data use at facility-level

- Health facilities teams are responsible for the following:
 - Conduct thorough assessment of previous year's implementation of the health facility (Hospital, Dispensaries and health center) plans to guide discussions of the next year's plan.
 - Gather community opinions regarding priorities and challenges in accessing health care services to inform planning process.
 - Conduct a robust situation analysis about the morbidity and mortality trends, underlying causes and health systems bottlenecks hampering the delivery and uptake of interventions.
 - Prepare plans in accordance to existing framework.
 - Provide feedback of approved facility plan to Health Facility Governing Committee, Village Development Committee and Ward Development Committee.
 - Ensure that the plans are responsive to local needs (facility and population).

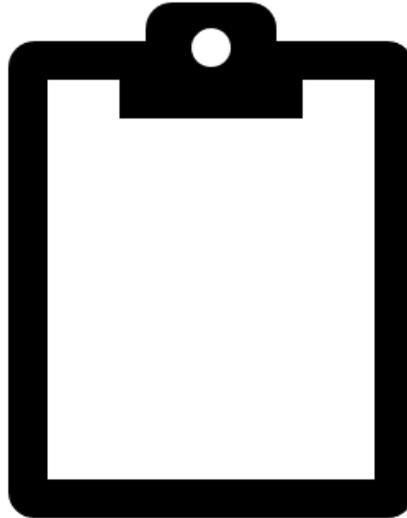
Data use in relation to plan and budgeting at facility-level

- ✓ During planning and Budget sessions
- ✓ To improve service delivery.
- ✓ Monitoring and evaluation of the progress

Framework for connecting data to planning and budgeting

- Decision makers and stakeholders with potential interest in your data
- Decisions / actions that the stakeholder makes (possible uses of data)
- Questions to which the stakeholder requires answers
- When the decision will be made
- Indicators and/or data of interest (to respond to stakeholder need)
- Source of data
- How will data be presented (what types of analyses, graphs, formats)?

Post ToT Evaluation



Thank you!