THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH AND SOCIAL WELFARE AND PRIME MINISTER'S OFFICE
REGIONAL ADMINISTRATION AND LOCAL GOVERNMENT

SUMMARY AND ANALYSIS OF THE COMPREHENSIVE COUNCIL HEALTH PLANS 2013/2014

September 2013

Tables and Figures

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Abbreviations

AD	-	Assistant Director
AIDS	-	Acquired Immune Deficiency Syndrome
CC	-	City Council
CCHP	-	Comprehensive Council Health Plans
CDC	-	Centre for Disease Control
CHF	-	Community Health Funds
CSA	-	
DC	-	District Council
DPs	-	Development Partners
EPI	-	Expanded Programme for Immunization
FMO	-	Financial Management Officer
FP	-	Family Planning
GIZ	-	German Agency for International Cooperation (GIZ GmbH)
ICT	-	Information Communication Technology
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
PHS	-	Principal Health Secretary
PMORALG	-	Prime Minister's Office Regional Administration and Local Government
PSU	-	Pharmaceutical Unit
PPM	-	Planned Preventive Maintenance
PPP	-	Public Private Participation
RCHS	-	Reproductive and Child Health Services
RHMT	-	Regional Health Management Teams
RS/RHMT	-	Regional Secretariat/ Regional Health Management Team
SDC	-	Swiss Development Cooperation
ST	-	Senior Technician
TC	-	Town Council
UCC	-	University Computing Centre
ZHRC	-	Zonal Health Resource Centre
WHO	-	World Health Organization

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Executive Summary

This report summaries assessment, challenges and recommendations of the summary and analysis from Comprehensive Council Health Plans (CCHPs) for 2013/2014 (July2013 – June 2014) from 161 Local Government Authorities. It is an annual plan for a council collates the health and social welfare plans at all levels and involve all stakeholders. Comprising yearly budget, activities, essential health interventions monitored by 20 indicator sets and three year targets funded through various sources. The MOHSW in collaboration with the PMO-RALG assesses for quality assurance of the plan and budget for compliance with national guidelines on planning and reporting for LGAs health services and prepares a consolidated summary analysis of the CCHPs on an annual basis. The results of this analysis are used by the Management (MOHSW& PMORALG) and other stakeholders for decision making and actions.

In addition, the report is a trigger output for the disbursement of Health Basket Funds. This is in line with the requirement of the MOU reached between Donor Partners and the Government of Tanzania.

The current assessment comprises the analysis of CCH plans for the Financial Year (FY) 2013/14. The assessment aims at presenting an overview of key routine collected indicators, trends of health status and health service delivery across the country, it also provided an overview of funding sources and budget distributions across Councils and Regions as well as insights into fund allocation according to priority areas, Burden of Disease, governance and oversight as well as key areas such as medicines allocation, Family Planning, which demand follow-up.

The assessment procedure was done electronically using the Health PlanRep3 MACRO by a team of experts drawn from Zonal Health Resource Centres, University Computing Centre, Ministry of Health and Social Welfare, PMO-RALG (ICT departments), Ministry of Finance, selected Development Partners and stakeholders from Civil Society (GIZ, Wajibika). The Team members were oriented on the Health PlanRep3 Macro assessment criteria forms embedded in the system which, generated assessment results as to whether the CCHP was recommended or not recommended.

Councils submitted their CCHPs PlanRep data files and other information in Word documents, included table of contents, Executive summary, and Health facilities map through e- mail. After assessment of the council plans, the assessed LGAs CCHPs file data was imported into the Health PlanRep3 Macro for consolidation and analysis. In addition the CCHP data files with the plans and budget was scrutinized and imported into the Epicor 9.05 system. The work of importing the plans and budget into the Epicor 9.05 was done by PMO-RALG in Dodoma. The assessment was done up to 4 rounds. First round 161 CCHPs were assessed 50 (31) % were recommended, the 2nd assessment, 111 councils were reassessed and 87 (78%) of them were recommended. In third round 24 councils were reassessed 20 (83%) passed and the last round all the remaining 4 was recommended.

Mainly identified issues which made the plans fail to be recommended included inadequately health data filled in situational analysis tables in the PlanRep3 micro that is used for analysis in the Health PlanRep3 Macro reports. Inadequate resources allocated to interventions addressing the Burden of disease, Planned Preventive maintenance of medical equipments, medical waste care, and sanitation in health facilities, including essential activities such as outreach, supportive supervision. However, more resources were directed to procure more fuel compared to the available cars, rehabilitation of health facilities and staff houses contrary to minor repair supported by Health Basket Funds. In addition funds outside the Council account were not well understood by the CHMTs. The assessment results were forwarded to each council for rectification according to the provided assessment results through phones, emails, team viewer and some on-site coaching and mentoring. Other causes of the poor results were due to lack of training on the revised CCHP Planning guidelines and PlanRep3 for the 29 new Councils, the PlanRep3 database integrated new regions, councils, wards & villages was released in mid-April 2013.

The analysis was done for all sources of funding for all LGAs; the data is comprehensive and originated from the Planrep3 data base. It has been noted that overall total funds available at Council level for health service delivery has been increasing every year at an increase of almost 32% of the budget captured in the CCHP. The highest increase was noted in the Budget captured outside the Council Account under Others and Global Funds sources from 10% and 1% to 15.37 % and 11.43% respectively. Health Basket Funding however, decreased slightly of about 1.6% compared to last year in FY 2012-13.

More funds for the local level is through Central Government Grants (46.62%), followed by Others (15.37%), Global Funds (11.43%), Council Health Basket Funds (10.84%), Receipt in kind (MSD) (5.47%), LDGD (3.64%), Cost sharing and Insurance Funds 3.56%), HSDG/MMAM (2.06%), Council Own Resources (0.94) and Community Contribution (0.07%). About 90% of the Central Government Grants are utilized for Human Resources (PE) and only 10% for Other Charges (OC). Further, analysis shows that PE 42.4% and OC 4.2%. Overall, PE and OC shares are split in 42.4% and 57.6% respectively, demonstrating that a large amount of funds are utilized for activities implemented using other charges and also indicating the limited flexible budget available for Councils in general.

In addition the analysis was done on the budget allocated to the thirteen priority areas. The area receiving the biggest chunk of funds is the area of Maternal, Newborn and Child health (57.86%). The main contribution in this area is commodities, especially EPI vaccines and Family Planning commodities provided as in-kind contributions. The second was allocated for medicines, medical supplies, medical equipment, and reagents (11.22%), Communicable Diseases control (10.49% included the in Kind commodities of ARVs, Condoms, ACT/ IRS/ ITNs/ MRDT and TB DOTS), construction, rehabilitation and planned preventive maintenance of physical infrastructure of health facilities (7.21%), Organizational Structures and institutional management (6.30%), Strengthening of Human Resources for Health Management capacity for improved service delivery (3.45%), The histogram describes the budget allocated to the existing Burden of Disease (BOD) interventions, and therefore gives an indication about the cost effectiveness of planned

interventions. In addition, it gives an idea about off-budget funds that are not included at this point of time in the CCHPs or not available for the Councils for holistic planning.

The analysis summarized the fund share into three categories of interventions as follows: essential health interventions 83.58%, non-specific delivery support intervention 5.69% and Interventions not addressing BoD 10.73%. Further, analysis of the essential health interventions, indicated that majority of funds are allocated to maternal conditions (58.46%), integrated logistics system ILS include medicines, medical equipment and supplies, and Laboratory reagents (13.51%), childhood illnesses and childhood immunizable diseases (9.57%) and then malaria (5.71%), childhood illnesses (2.99%), provision of ARVs (2.90%), STI, HIV/AID 1.82%, TB Diseases (1.59%), Newborn conditions (1.11%), Injury care (0.69%), Neglected Tropical Diseases (0.68%), Others Non Communicable Diseases (0.63%) and Provision of essential TB drugs (0.35%).

The analysis compared for two years total numbers of health facilities 5,052, of which 3,505 are owned by the Government and 1,547 by non-Government 2011 (2012/2013) and the total 6,270 the share of Government facilities 4,739 and non-government facilities 1,531 (2013/14) data for 2012, Health facilities by ownership numbers, health facilities by type as shown dispensaries 88% of all facilities, health centers 9%, and hospitals 3%. Also health facilities has been analysed per region including the budget allocated for construction and rehabilitation. The budget allocated was 27,810,301,865, distributed as follows: 61% for construction, 12% rehabilitation, 4% Equipment and 24% for staff houses.

The analysis included the population living within 5 km from Health facilities was 71.9% by June 2013. In June 2010, it was discovered that at least half (50.6%) of the population was living within 5 km, compared with 48% in June 2009. This is an increase in comparison to previous years. The data presented include the catchment areas between the health facilities. It is a clear indication that equity in provision of health facilities is being addressed if MMAM is implemented as planned.

Data for Human resources for health was analysed as follows; health care workers deficit of (49%) as a whole. The skilled health care workers the deficit is 55%. There is serious shortage of both number and qualified health workers of different cadres in most of the councils.

The budgets allocated for medicines, medical supplies, equipment and laboratory reagents, as funded by different sources and allocated according to the resource allocation formula was analysed, indicated that Medicines 70.91%, Hospital supplies 10.51%, Medical equipment 8.64%, 7.7 % for laboratory supplies and dental supplies is 5.1%. This depicted that the Council Health Planning teams adhered to the guidelines. More analysis for the budget allocated for medicines, medical supplies, equipment and Laboratory reagents per sources was done as follows; cost sharing 10% out of these CHF/TIKA 4%, NHIF 3%, user fees 3%and DRF 1 %), Health basket funds 19%, and MSD/In-kind/Central 27%. The rest of the budget is presented in kind for commodities provided to Councils from Global funds and Others, such as Bilateral Partners, LGDG, NGO Partners, Council Own Sources, Local Council Borrowing, Local Government Block Grants, Private and Parastatal Partners, Community Contributions, MOHSW, HSDG/MMAM, and Multi Partners,

The analysis included the status and trends of key health indicators. These included the top ten OPD diagnoses which showed that Malaria, acute respiratory infections (ARI) and diarrhea diseases were on the top for both under five and above five year old. The ten top inpatient admissions and deaths per diagnosis whereby, malaria listed the main cause for admissions and deaths, followed by pneumonia/ARI for both children under five and above five years old. According to the analysis clinical AIDS had high case fatality rate (CFR) of 9%, followed by anaemia 5.15%, severe Malaria 3.04% and Pneumonia 2.84%. Also showed rabies in children had a high rate of CFR at 18.06%, meningitis in ages over 5 years at 17.57% and there are still some cases of Acute Flaccid Paralysis. Other analysed data is on the trend of TB cases from 2008- 2012, the trend of TB treatment completion rates from 2008-2012, the trend of birth attendance at health facility and community delivery for four years, the trend of family planning acceptance rates for the past four years, the status of severe malnutrition in 2012, low birth weight tendency of around 6%, with a small increase registered in 2010 (6.29%), followed by a continuous decline to 5.6% in 2012

Furthermore, the CCHP analysis indicated that, the proportion of low birth weight were very higher (15%) in Pwani region compared to other regions while its lower (below 2%) in Dar es Salaam, Simiyu , Singida Shinyanga and Geita regions. There are direct relationships between malnutrition and low birth weights as depicted in the preceding figures above. More analysis on the immunization and Vitamin A supplementation coverage for 2008 – 2012, the reports showed a slight increase in immunization rates for most vaccines noted for 2012, except for OPV 0, which had a slightly higher coverage in 2010. BCG, Measles and DTP-HB-HIB3 vaccines and vitamin A supplement reach 90% and above coverage, while OPVO vaccination is recorded just below 70%.

The analysis presents the trend on outpatients' visits for three years, the different funders supporting Family Planning services in the councils through the CCHP both through cash and in-kind contributions. P4P reports was also analysed in 2012 in all regions and districts. Further, analysis of fund allocation towards health support shares was done; Human Resources for Health Management (56.97%), Supportive Supervision (12.35%) , Planned Preventive Maintenance (8.11%), governance - Council Health Service Boards (7.76%), Other support (6.01%) and Public Private Partnership (3.15%). ILS as among the support system has been integrated into the essential health interventions in this case.

There are challenges encountered such as poor data entered in the PlanRep database. New Councils plans were entered into the old council categories and new Councils had no training on the revised CCHP Planning guidelines and PlanRep3. Funds for 2012/2013 were disbursed very late to councils affected CHMT teams. The knowledge gap within the RHMTs on CCHPs and PlanRep3 tools resulted in poor quality of initial plans submitted by LGAs. RHMTs were not trained on CCHP guidelines and micro Health PlanRep to support CHMTs, neither, assessing and analyzing CCHPs using the Planrep3 tool. Inadequate knowledge on planning e.g. activities were not addressing essential interventions, targets were not addressing council identified health priority problems, priority problems were not formulated based on the data available on the situational analysis tables and as not indicating the magnitude of the problem, target were not addressing the objectives, some had no measurable parameters, activities were linked to wrong activity inputs (GFS Codes).

This appears to be a shortcoming in the planning process. In some of the plans objectives were not linked to Performance Indicators available in the system. Shortage of skilled health workers in both the management teams and health services provision this is made worse by frequent changes; transfers of Health Managers, suspension, new staff employed who have never been exposed or trained on the planning skills specifically on developing the Comprehensive Councils Health plans. Most of the staff with skills to plan are over worked and are working for long hours to produce the results which we see today. Other sources outside the Council health accounts still a challenge to some council. Some council failed to allocate resources addressing patient safety, environmental health and sanitation services in the health facilities. Most of the interventions were addressing environmental health and sanitation in the community, while their health facilities are dirt thus, becomes difficult to address the environmental health, hygiene and sanitation at the health facility level. The PlanRep3 database System not well developed. It does not capture and reflect some of the reports/data differ and also the reporting part is not well covered.

It is recommended to develop Health PlanRep3 MESO for RHMT and conduct training for RHMT on PlanRep3 Health Meso and PlanRep3 Micro (Health) in order for the central teams to reduce the timing and workload. The Ministry in collaboration with PMORALG and UCC continue provide technical support as required on CCHP development. Ceilings should be provided early to LGAs and any other information or instruction during or before starting planning period. Operationalize the planning template for the HCs and Dispensaries to involve Lower health facilities plans which captures community contribution that have to be included in their CCHP, to reflect community participation, involvement and ownership of the implementation of health services at their respective area. DMOs/CHMTs to make sure the resources provided at Council level be included in the CCHPs as receipts in kinds from all sources including NGOs so that they do not destruct the plan. NGOs to provide tentative budget estimates or activities / areas to be supported for a particular year, as this distort the Councils already planned budget during the pre-planning meeting of the stakeholders.

1. Introduction

The Comprehensive Council Health Plan (CCHP) is the principal prerequisite for any well functioning district health system. It includes objectives; strategies, interventions, activities to address health priorities and indicators to measure progress/performance (based on Health Management Information System (HMIS) indicators). The CCHP is an annual health and social welfare plan for a Council to strengthen local health service planning, budgeting, implementation and reporting, the health plan collates the health and social welfare plans at primary health care level and involve all stakeholders.

LGAs therefore need to prepare the CCHPs on an annual basis using the guidance of the CCHP Guidelines and the Planning and Reporting (PlanRep) Database system which has been developed specifically for this purpose. The Guidelines and software will ensure linkage of the CCHP targets to the relevant strategies and plans. In this context the third Health Sector Strategic Plan (HSSP III) July 2009 – June 2015 focuses on provision of equitable quality health and social welfare services and client satisfaction has been translated into CCHP planning and Reporting guideline at the implementation level. In order to promote coordinated planning and implementation of services within the health sector, the Ministry of Health and Social Welfare (MOHSW) has adopted a Sector Wide Approach (SWAp), which is concerned with the provision of accessible quality health and social welfare services in the LGAs, which are well supported, cost effective and gender sensitive with priorities developed according to the National Essential Health Care Interventions Package of Tanzania (NEHCIP – TZ).

The MOHSW in collaboration with the Prime Minister's Office Regional Administration and Local Government (PMO-RALG) assesses and prepares a consolidated summary analysis of the Comprehensive Council Health Plans (CCHPs) on an annual basis. During the analysis, continuous support to Local Government Authorities is provided to improve the quality of their annual health plans. The results are then used for internal follow-up and quality assurance of Council budgets.

The analysis further serves as a tool for comparing performance between Councils and Regions and provides advice for Councils on areas to improve, especially to reach national targets and for future CCHP planning, data recording and entry. Proper allocations of funds to priority areas will consequently improve the quality of health service delivery at the district level. Results of this analysis are also to be used by Management (MOHSW& PMORALG) and other stakeholders for decision making and actions.

In addition, the preparation of the yearly CCHP summary analysis report is presented to the Health Basket Fund Committee (BFC) to trigger the disbursement of Health Basket Funds. Health Basket Funds comprise an important part of the line budget that is channeled to Local Governments for service delivery and it is often the major part of the "flexible budget" that Councils can use in order to set their priorities according to local needs and national goals. Other analysis and reports prepared for the Health Basket Fund Committee include supportive supervision plans of the RS/RHMT, MOHSW and PMORALG who are in charge of ensuring that quality health services are

delivered at the LGAs level. This is in line with the requirement of the MOU reached between Donor Partners and the Government of Tanzania.

The current assessment comprises the analysis of CCH plans for the Financial Year (FY) 2013/14. The assessment aims at presenting an overview of key routine collected indicators, trends of health status and health service delivery across the country, it also provided an overview of funding sources and budget distributions across Councils and Regions as well as insights into fund allocation according to priority areas, Burden of Disease, governance and oversight as well as key areas such as medicines allocation, family Planning, which demand follow-up.

2. Objectives

The main objective of the CCHP analysis by the central level (PMO-RALG and MOHSW) and RS/RHMTs is to check for compliance with national guidelines on planning and reporting for LGAs health services.

Specific objectives of the analysis are as follows:

- Verify that planned activities address the councils' identified priority health problems in line with the national priorities (MDGs, MKUKUTA, HSSP III, National Health Policy etc.)
- Generate the results to be used by the Management (MOHSW& PMORALG) and other stakeholders for decision making and actions
- Identify weak LGAs and RHMTs for further technical assistance to improve their CCHPs
- Trigger the approval and funding for annual CCHPs by BFC members

3. Methodology

3.1 Assessment process and methodology

This summary report is the output from the assessment of the Comprehensive Council Health Plans (CCHPs) for 2013/2014 from 161 Local Government Authorities. The basis for this report is data that was analysed by the Health PlanRep3 MACRO.

The assessment procedure was done electronically using the Health PlanRep3 MACRO by a team of experts /assessors drawn from Zonal Health Resource Centres (ZHRC), University Computing Centre (UCC), Ministry of Health and Social Welfare (MoHSW), PMO-RALG (ICT departments), Ministry of Finance (MOF), selected Development Partners and stakeholders from Civil Society (GIZ, Wajibika). Team members were oriented on the Health PlanRep3 Macro assessment criteria embedded in the system. This was important to ensure the quality of assessment reports produced.

The assessment criteria embedded in the Health Planrep3- Macro produced the assessment results of the Plans, automatically generating assessments as to whether the CCHPs were recommended or not recommended.

Councils were requested to submit their CCHPs 2013/2014 in electronic format by mail to the central level since PlanRep3 is not yet a web-based system and does not capture certain text information that is usually submitted in Word documents, such us Table of contents, Executive summary, and Health facilities map. After receiving soft copies from the 161 LGA's the electronic assessment was carried out by a team of assessors drawn from the Zonal Health Resource Centres, University Computing Centre, Ministry of Health and Social Welfare and PMO-RALG.

The next stage followed was to scrutinize the plans and budgets ready to be entered into the Epicor system. The work of entering the plans and budget into the Epicor 9.05 was done by PMO-RALG in Dodoma. The following assessment data are based on data captured after the 4th round of assessment (n=161).

3.1 Outcome of the assessment:

Only 31% of Councils were recommended for funding in the first assessment round, substantial follow-up with Councils was needed in order to improve the other 69% plans and budgets to an extent that it could pass the relevant score. Table 1 below shows the performance of councils in the different assessment rounds:

Table1: Assessment Results showing the status of the council performance in all four rounds

Assessment	Number of councils assessed	Recommended for funding	% recommended for funding	Not recommended for funding
1st Assessment round	161	50	31%	111
2nd Assessment round	111	87	78%	24
3rd Assessment round	24	20	83%	4
4th Assessment round	4	4	100%	0

The gaps that were identified by the assessment team during the different rounds of assessment were communicated to the respective Councils for rectification before final submission for the purpose of improving the quality of their developed plans. In the 2nd assessment, 111 councils were reassessed and 87 (78%) of them were recommended for funding. In third round 24 councils were assessed and 20 of them passed. The remaining 4 that did not pass were subjected to a fourth round of assessment of which all passed. These were Rorya DC, Ilala MC, Tunduru DC and Babati TC.

Other issues included inadequately filled situational analysis tables in the PlanRep3 micro that is used for analysis in the Health PlanRep3 Macro reports. Analysis of the data was also inadequate. In some council, resource allocation and Burden of disease do not match, because more resources were allocated to interventions that did not address the BoD with appropriate supportive interventions. Some activities did not address the interventions and health problems defined in the PlanRep3 and were therefore linked to inappropriate priority areas.

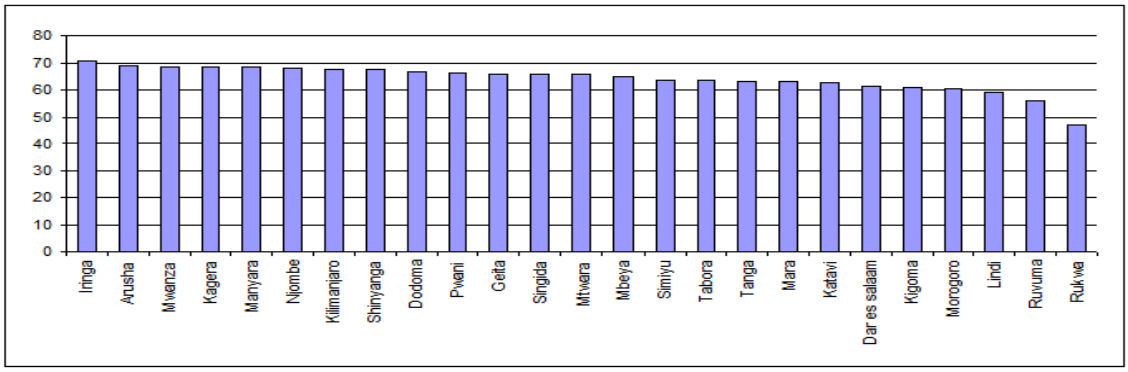
It was also observed that HBF and HBG allocation were not in line with the ceilings and the concept of community initiatives activities were not adequately understood by CHMT's. Most of them interpreted Community initiatives as activities planned to be implemented at community level by CHMTs while the community are not aware hence no community participation/involvement.

Planned Preventive maintenance of medical equipments, medical waste care, and sanitation in health facilities, essential activities such as outreach, supportive supervision were also not adequately addressed in the CCHPs. However, more resources were directed to procure more fuel compared to the available cars, rehabilitation of health facilities and staff houses contrary to minor repair.

The assessment also observed that budgeted funds outside of the Council account were not well understood by the CHMTs, e.g., activities funded from external sources were linked to the wrong funders in the PlanRep3 software (*i.e.*, Central Government via Medical Store Department/medicines, multilateral UNICEF, Global Fund and NGOs etc.). These funds were either put on the OC or DEV budget categories, instead of using the correct "receipts in kind" designation. These mistakes need to be prevented in the future through targeted training and subsequent follow

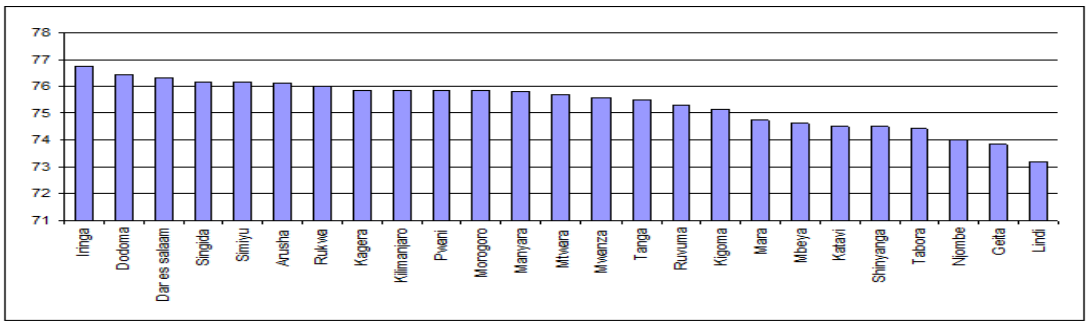
However, during the assessment period, a lot of initiatives to rectify the CCHP plans were taken: the first assessment results were availed and sent to all councils for correction and adjustment, councils were contacted through phones, emails, team viewer and some on-site coaching and mentoring. This continued with the second, third and fourth assessments until all were recommended for approval. To complete the task in a timely manner, the MOHSW, PMO-RALG, and Regions continued to instruct councils to work on all the CCHPs based on the corrections given.

Figure 1 (a): First Assessment Planning Performance per region



This is the results of the first assessment of the plans, whereby Iringa, Arusha and Mwanza scored high.

Figure 1 (b): CCHP 2013/14 planning performance per region (last assessment)



The performance of recommended plans per region by the use of the assessment criteria process is shown in Figure 1(a) and (b). The performance assessment results changed during the assessment time from the regional perspective. Iringa, Dodoma, and Dar es Salaam scored highest in the last assessment. In the first assessment, Iringa Arusha, and Mwanza had scored highest. However, none of the Regions scored more than 77% in total. Njombe, Geita, and Lindi were the least planning-related performing Regions in the fourth assessment. Lindi, Ruvuma and Rukwa had been the least performing during the first assessment. This was due to improvement made after corrections had been provided to the councils. The capacity to plan by the Councils in specific Regions varies annually. Change in management teams changes performance both positively and

negatively. While some Regions comprise quite a few well performing Councils, there might be also some less well performing Districts in the same Region (see Ilala MC as a bad performing Council, but Dar es Salaam is overall a Region that scored reasonably high). The number of councils per region also changes the regional impact of a single council's performance. (See Results *annex 1*)

Figure 2: CCHP 2013/14 planning performance by region showing the trend over the past 3 years

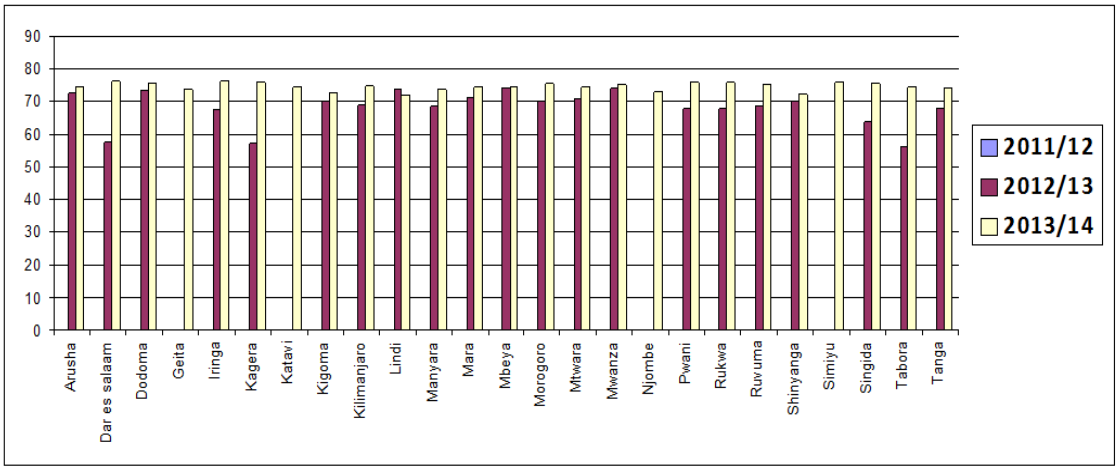


Figure 2 above, shows the trends in Regional performance, with the biggest improvements seen in the Dar es Salaam and Kagera Regions. In the year 2011/2012, only 41% of the Councils managed to use PlanRep2. PlanRep3 Health Macro had not yet been developed. Therefore it was not possible to produce an analysis of tables and graphs from that year using the Macro.

4. Findings

4.1 The Assessment Results

Similar to the previous year, all 161 Councils (100%) had entered their plans and budgets into the Micro PlanRep3 (in comparison: in 2011/12 only 41% of CCHPs that were developed using PlanRep2). This was because the Ministry of Health and Social Welfare, PMO-RALG, University Computing Centre (UCC) in collaboration with the LGAs conducted training to build capacity of CHMTs/CHPTs in February 2012, the training was in understanding the revised CCHP guidelines and Planning tool (PlanRep3) linked with Epicor in improving quality of the annual CCHPs (plans & Budgets) that aim to improve quality of health service delivery by allocating resources to priority areas that addresses most of the Burden of Diseases (BoD). The PlanRep3 is used for entering the CCHPs and producing required analysis through tables and graphs for plans, budget and reports for policy makers, implementers and other stakeholders.

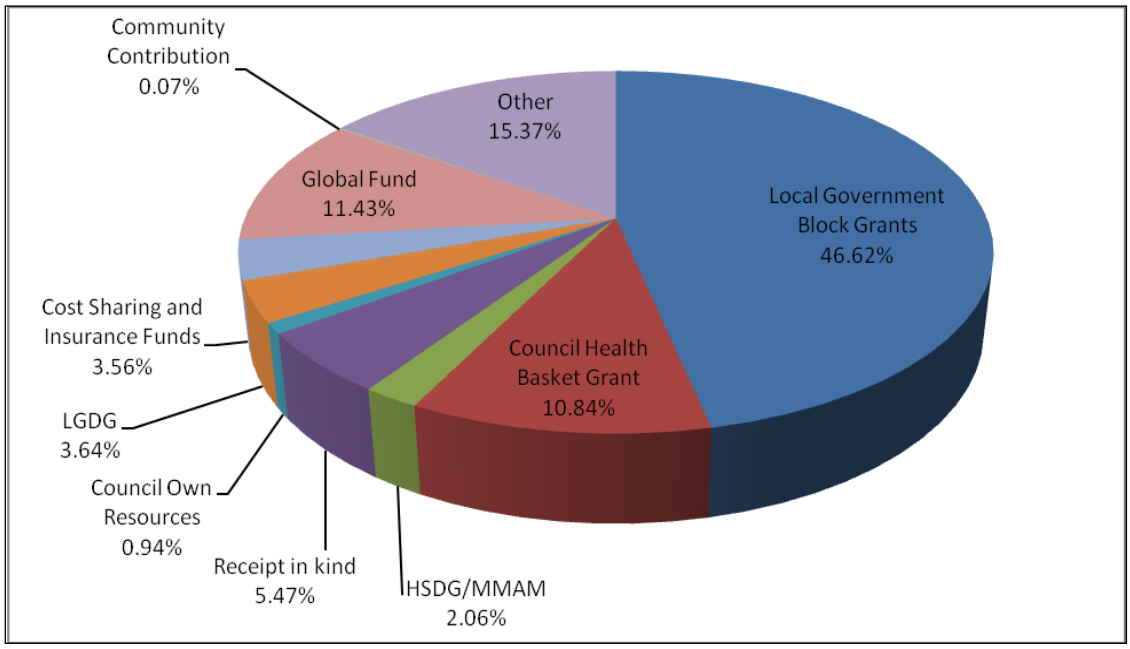
During the assessment it was found that other causes of the poor results was due to lack of training on the revised CCHP Planning guidelines and PlanRep3 for the 29 new Councils. As a result they faced difficulties in using the tools. Also integration of PlanRep3 that incorporated new structures

(New Regions, Councils, Wards & Villages) was released in mid-April 2013. This caused new councils to enter CCHPs using the old Planrep3 Codes. As a result, councils had to re-enter the CCHPs into the new PlanRep3. The CHMT members for New Councils were not in place. Therefore, the Old Councils were required to prepare two CCHP plans, one for the old and one for the new council. These challenges necessitated a great deal of capacity development, intense follow-up, and mentoring. This resulted in delays in the availability and analysis of data. Most council either under budgeted or over budgeted on the ceiling provided.

4.2 Funding Sources 2013-2014

The Figure below depicts the financial analysis for sources of funding for all LGAs. It is comprehensive and originates from the Planrep3 data base. It is important to note that overall total funds available at Council level for health service delivery has been increasing every year at an increase of almost 32% of the budget captured in the CCHP. The highest increase can be noted in the Budget captured outside the Council Account budgeted under Others and Global Funds from 10% and 1% to 15.37 % and 11.43% respectively. Health Basket Funding however, decreased slightly of about 1.6% compared to last year in FY 2012-13.

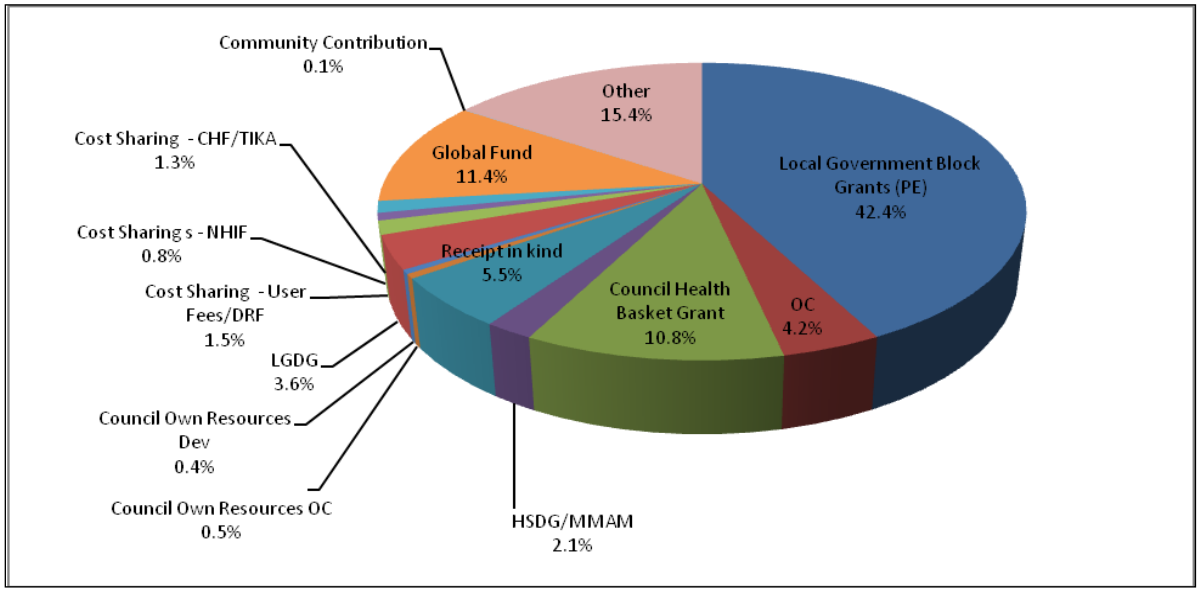
Figure 3: Sources of Health Funding at Council level for 2013-14



As in previous years, the major share of funds for health service delivery at Council level in FY 2013-14 is channeled to the local level through Central Government Grants (46.62%), followed by Others (15.37%), Global Funds (11.43%), Council Health Basket Funds (10.84%), Receipt in kind (MSD) (5.47%), LDGD (3.64%), Cost sharing and Insurance Funds 3.56%), HSDG/MMAM (2.06%), Council Own Resources (0.94) and Community Contribution (0.07%). Here, it is important to note

that 90% of these Central Government Grants are utilized for Human Resources (PE) and only 10% for Other Charges (OC).

Figure 4: Overview of funding sources (combined for all Councils) in FY 2013-14



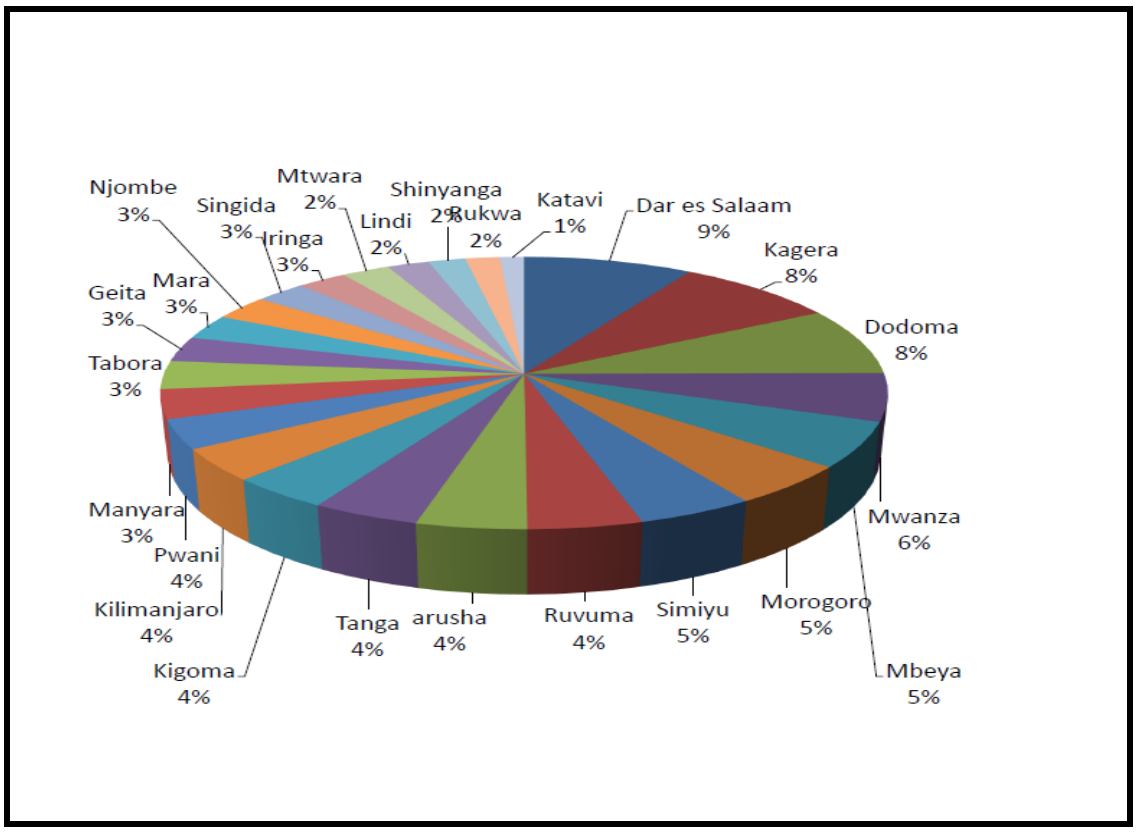
The figure above shows the major share of funds for health service delivery at Council level allocated in the CCHP in FY 2013-14 is channeled to the local level through Central Government Grants utilized as follows Human Resources (PE) 42.4% and Other Charges (OC) 4.2%. Overall, PE and OC shares are split in 42.4% and 57.6% respectively, demonstrating that a large amount of funds are utilized for activities implemented using other charges and also indicating the limited flexible budget available for Councils in general. Global Fund (GFATM) in-kind donations are increasingly captured in the CCHPs; while in FY 2012-13 only 1% of GFATM funds were captured, in FY 2013-14 this has risen to 11.4%. This year, many councils managed to capture and include the budgets from outside the council, as in-kind or commodities. With regards to incomes from Cost sharing funds, this can be divided into funds from insurances such as NHIF (0.8%), CHF/TIKA (1.3%) and User Fees (1.5%). Current numbers demonstrate the low uptake of cost sharing funds in the overall provision of funds that are provided to the local level. However, it is worth noting that these funds are usually not utilized for Human Resource payments. Rather, these funds are used for the procurement of medicines or other emergency issues at health facility level and are therefore usually seen – similar to the Health Basket Funds – as an important contribution to the decentralized management of funds. (See *Annex 2*)

4.2.1 Funds distribution to Regions and Councils

As mentioned previously, the total availability of funds has increased in FY 2013-14, compared to 2012-13. As in the previous year, the highest amounts of funds (9%) were allocated to the Dar es Salaam followed by Kagera and Dodoma Regions (both 8%). Here, a notable development occurred.

Even though Mwanza and Mbeya, similar to last year, received higher direct cash allocations than Dodoma and Kagera, the latter are ranked second and third respectively, due to higher amounts of in-kind contributions, which have elevated their overall budgets for FY 2013-14. Likewise, Shinyanga Region is currently facing an extreme drop in overall budget allocations received at regional level. While receiving 8% of CCHP funds in FY 2012-13 (putting them on the 2nd place in the funding shares received), they are now among the last 3 Regions with only 2% funds channeled to Shinyanga anymore. However, this is easily explained with the fact that Shinyanga has participated majorly in recent Council reforms, and several Councils were moved to other regions, *e.g.*, Maswa DC, Bariadi DC, Meatu DC now belong to the new region of Simiyu. Kahama DC split into 3 new Councils, (*i.e.,* Ushetu DC, Kahama TC, and Msalala DC); Bukombe DC split into two new Districts (*i.e.*, Bukombe DC and Mbogwe DC). Bukombe DC now belongs to the new region of Geita.

Figure 5: Total budget share per Region and across Councils



In FY 2013-14, the following 3 Regions are the least funded in the CCHPs: Katavi, Rukwa and Shinyanga Regions. The reasons are that Rukwa region has been divided into the two regions of Rukwa and Katavi. Katavi region, Mpanda District Council has been divided into three: Mpanda , Nsimbo and Mlele DCs, with the same size of Mpanda original square kms and area and population. Mpanda DC has now become Mpanda TC. The Rukwa region has remained with Nkasi, Sumbawanga MC and Sumbawanga DC, which itself also has been divided into two, now Sumbawanga DC and Kalambo DC.

In the Shinyanga region, three of Shinyanga's Councils have been moved to form another new region (Bariadi, Meatu and Maswa DC joined Simiyu region). Bukombe has moved to the Geita region. Therefore, the original funding resources have been spread thinly. A region that has increased its budget for Council Health Service delivery more than 7-times is Tabora. Ranked in the least position in 2012-13 with only 2,750 bn Tshs allocated, Councils in Tabora Region are now receiving 28,876 bn Tsh. This can also be again explained with an increase in Councils (from 6 to 7), as well as with population changes after the new census data. Also Manyara Region faced an upgrade in terms of funds allocated to the respective councils, and almost tripled its budget to now 28,900 bn Tshs (*see Annex 3 &4*) for a more detailed overview of funds allocated to the specific Regions. It is important to note that some of these changes can appear also in cases were previous budgets were hidden. CCHPs are now capturing more health-related funds than in previous years. The resources in-kind provided by Global Funds (ARVs/ART/Condoms, ALU, IRS, mRDT, ITNs, TB DOTS, EPI Vaccines and Family Planning methods/commodities) also include support from NGOs which participate in pre-planning meetings at the Council level.

Table 2: Top and Bottom 5 of Health Fund Allocations by Region including in kind

Dar es Salaam	=	71,781,290,134
Kagera	=	69,097,876,444
Dodoma	=	66,896,076,921
Mwanza	=	47,216,762,588
Mbeya	=	45,094,586,408

Mtwara	=	20,373,104,765
Lindi	=	17,841,682,563
Shinyanga	=	15,848,373,706
Rukwa	=	14,611,834,364
Katavi	=	10,298,160,29

There are huge differences among Councils in fund allocation, due to differences in population, poverty estimates, mortality data and infrastructure (which are the criteria for fund allocation). However, there are some few Councils that are capturing and recording substantial funds from in-kind contributions, (In kind commodities - ARVs, Condoms, TB DOTs, ACT/ ITNs/ MRDT, IRS/, EPI Vaccines, Family Planning Commodities, Medicines, medical equipment and supplies from MSD etc) and are, even though they are not receiving as much cash as others, are among the leading Councils in terms of available budgets from all sources. These Councils are specifically Kongwa DC (having budgeted more than 26 bn from in-kind), Bukoba DC (22 bn in-kind) and Bukoba MC (more than 9bn in-kind). Some CHMTs have understood the meaning of capturing resources from outside the council in the PlanRep3.

Others are barely budgeting from sources other than Block Grants and Health Basket Funds. Since it is very difficult to assess the correctness of these budgeting estimates during the planning phase,

this might either mean that the respective Councils are indeed receiving many more funds from other sources and in-kind than others, or that there are differences in estimation due to over-or underestimations in some Councils.

Table 3: Top and Bottom 5 of Health Fund Allocations (Cash) by Council, FY2013-14

Kinondoni MC=	22,110,883,572.00
Temeke MC=	17,986,290,813.00
Ilala MC=	15,980,119,567.00
Mbinga DC=	9,719,751,000.00
Nyasa DC =	8,583,816,680.00

Top 5 Councils receiving most health fund allocations

Nsimbo DC =	747,391,700.00
Bumbuli DC=	735,420,000.00
Momba DC=	710,178,263.00
Mpanda TC=	670,711,000.00
Lindi MC=	456,376,762.00

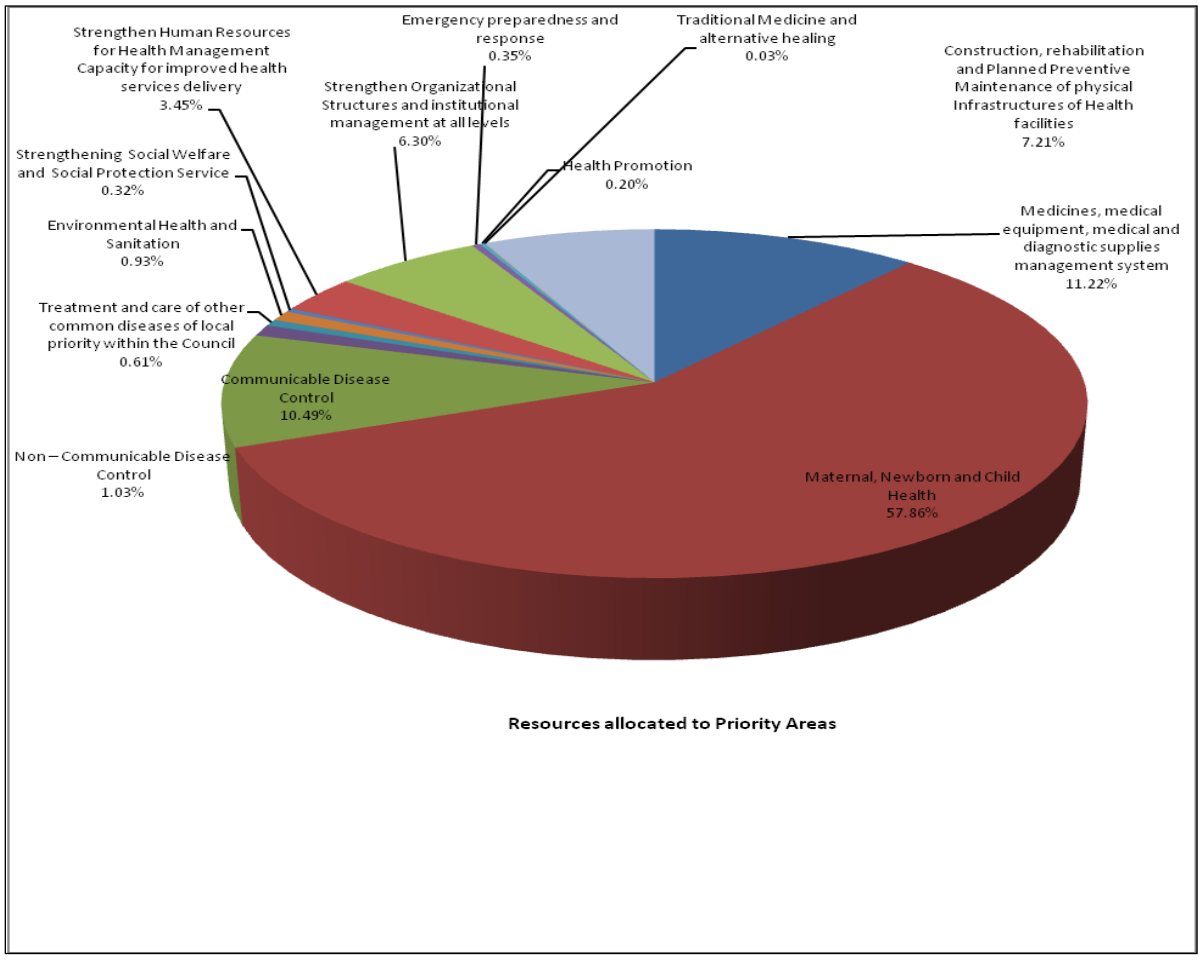
Bottom 5 Councils receiving least health fund allocations

Table 3 above indicates seemingly the unequal distribution of health-related funds at the District level results from taking various equity related variables into consideration such as the population size (accounting for 70%), estimated burden of disease (10%), poverty (10%) and the length of the mileage route for the DMO to visit the health facilities (10%). Hence the amount of funds a Council receives depends on the amount of people it is serving, under five mortality rates for the region, the number of estimated poor people in the Council as well as the size of the Council's land area. The recent population census and other studies will allow for an updated allocation formula. The population size, which determines 70% of the allocations, is hence the most significant factor to ensure equity.

4.3 Fund allocation

4.3.1 By priority areas

Figure 6: Summary of Council Health Budget allocated to priority areas 2013/2014



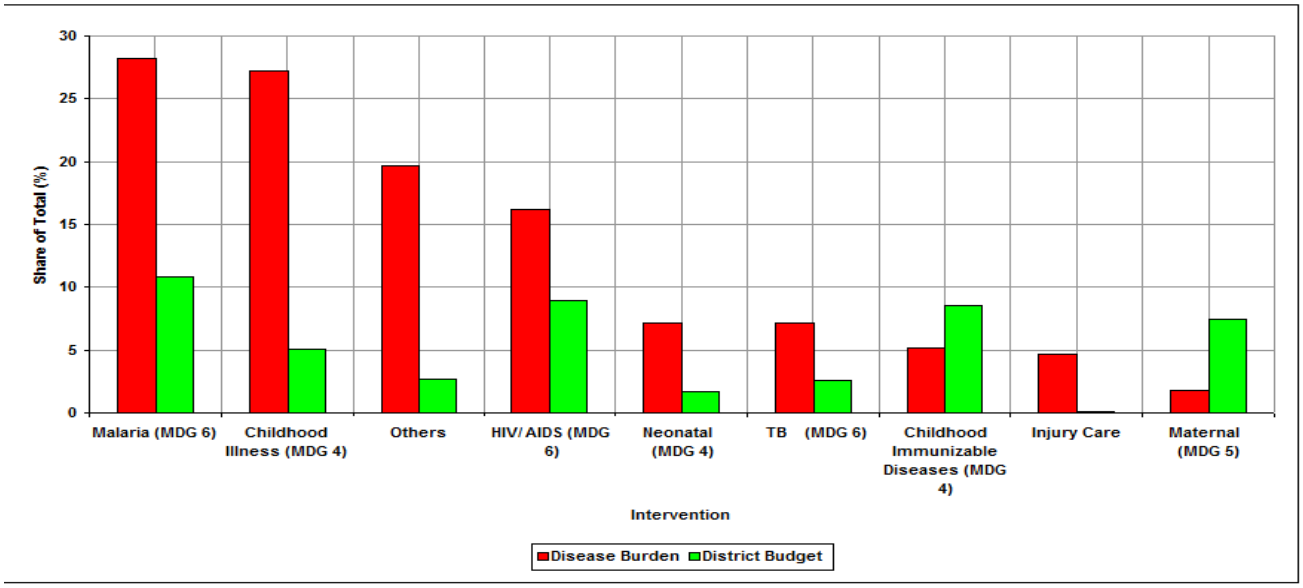
The figure above describes how resources have been distributed according to the thirteen priority areas. The area receiving the biggest chunk of funds is the area of Maternal, Newborn and Child health (57.86%). The main contribution in this area is commodities, especially EPI vaccines and Family Planning provided as in-kind contributions. The second largest amount of funds (11.22%) is going to the area of medicines, medical supplies, medical equipment, and reagents. The Next is Communicable Diseases control (10.49% also includes the in Kind commodities of ARVs, Condoms, ACT/ IRS/ ITNs/ MRDT and TB DOTS), construction, rehabilitation and planned preventive maintenance of physical infrastructure of health facilities (7.21%), Organizational Structures and institutional management (6.30%) are supported, Strengthening of Human Resources for Health Management capacity for improved service delivery (3.45%), Non-communicable disease control receives (1.03%) of the Council Health Budget, while all other areas including Environmental Health and Sanitation, treatment and care of common diseases of local priority within the Council, Social Welfare and Social Protection Services, Emergency preparedness and response, health

promotion and finally traditional medicines and alternative healing all receive less than 1% for each area. When compared to the previous year, Strengthening Human Resources for Health Management capacity for improved service delivery used to capture the lion's share, because it used to combine budgets for medicines, medical supplies, medical equipment, reagents, and construction, rehabilitation and planned preventive maintenance of physical infrastructure of health facilities. This year these categories have been separated according to the CCHP Planning Guidelines into three areas. However, budgets for medicines, medical supplies, medical equipment, reagents and health promotion is cross cutting to most of the priority areas.

4.3.2 Funds budgeted according to Burden of Disease, Essential Health Interventions and Non-Specific Delivery Support

The histogram below Figure 5 describes the budget allocated to the existing Burden of Disease (BOD), and therefore gives an indication about the cost effectiveness of planned interventions. In addition, it gives an idea about off-budget funds that are not included at this point of time in the CCHPs or not available for the Councils for holistic planning. For example, most of the data from AVRs, Malaria intervention (IRS/ ITNS etc, TB DOTs, EPI vaccines, Family Planning Commodities and GAVI are still missing. However, Global Funds are increasingly reflected in the Council budgets, though not reflected completely in the allocations.

Figure 7: Intervention Burden and Expenditure Shares 2013/14



The current CCHPs do capture a lot of activities that are planned in order to improve maternal health. However, this is mainly due to the fact that maternal health interventions are mainly on-budget, while others (e.g. Malaria, Childhood Illness-related interventions and HIV/AIDS) are off-budget or budgets are not transparent. The funds that districts are able to use according to their own priorities are skewed towards maternal and child health (MDG 4 & 5), while there are fewer allocations to malaria, HIV and AIDS. The underlying assumption is that there is a linear

relationship between funds and priorities. However, given the fact that the systemic issues (*e.g.*, Human resources, infrastructure, and other inputs to service provision) also cut across disease categories, it may not be realistic to conclude that there is underfunding of the BOD. In addition, the Burden of Disease Profile, based on the District Health Profile from the Sentinel Demographic Surveillance System, covers specific regions such as Kigoma, Rukwa, Tabora Regions for the Kigoma DSS, Lindi, Mtwara, Pwani and Tanga Regions for the Rufiji DSS and Ulanga and Kilombero Districts for Morogoro DSS, which does not seem to match with observations of the extent of the problem of maternal mortality in Tanzania as reported from other data and reports. An analysis and inclusion of on- and off-budget funds allocated to certain areas (*e.g.*, match with the NHA 2009/2010 of December 2011) is still needed in order to compile a comprehensive picture in relation to the burden of disease patterns and fund allocations.

Figure 8: Budget Shares according to Essential Health Interventions 2013/14

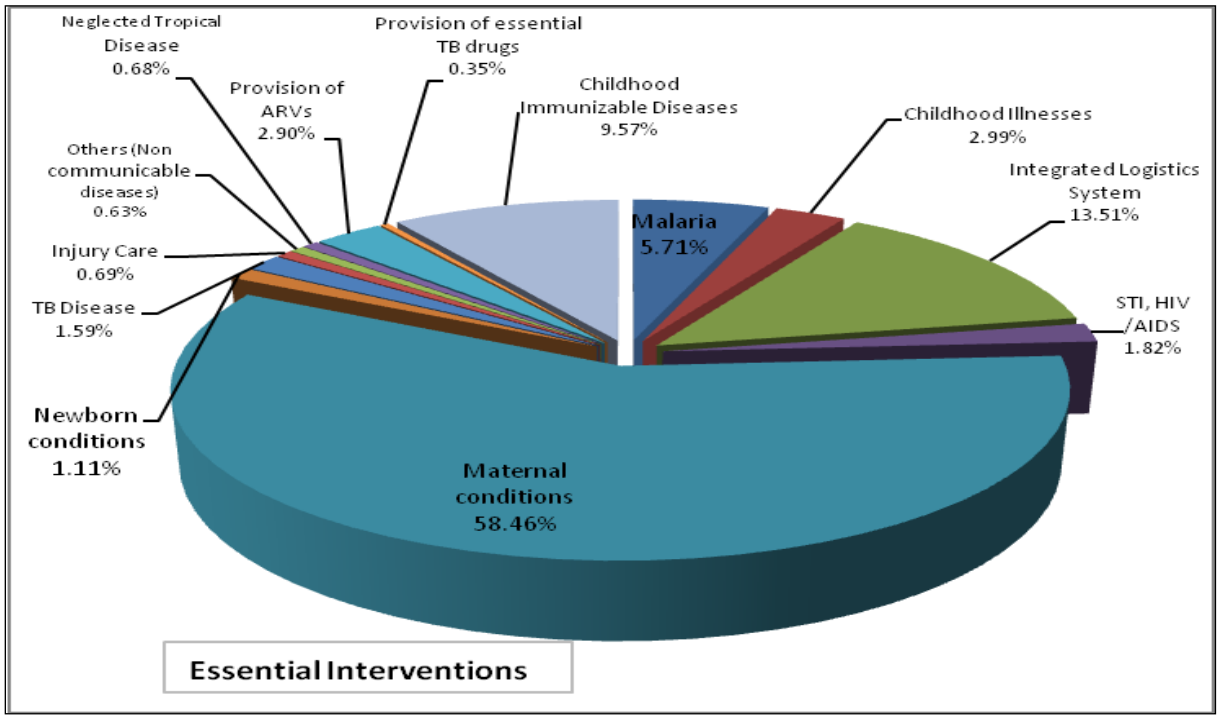
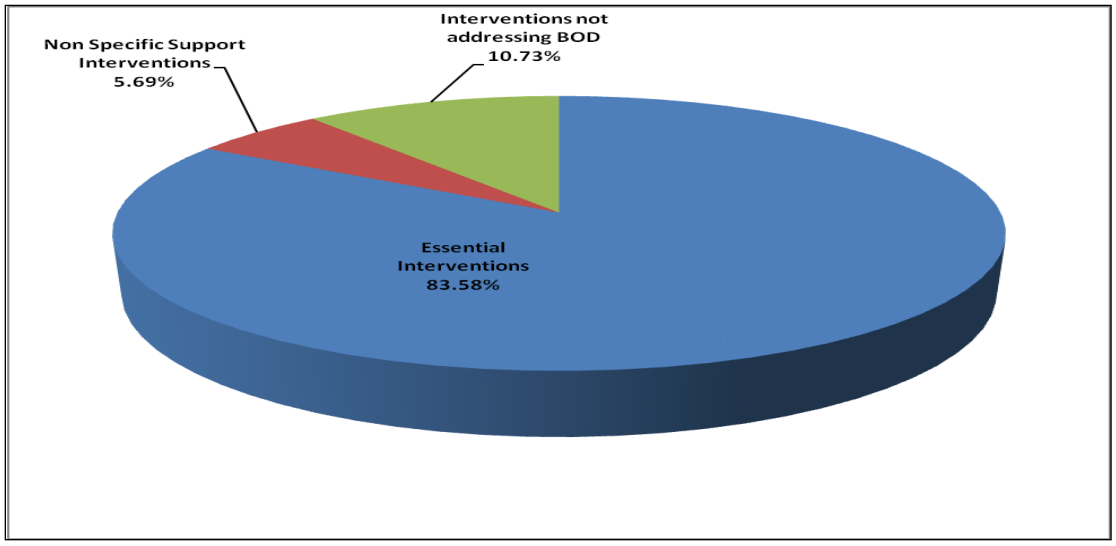


Figure 8 above shows the share among the most essential interventions. It is important to note that the majority of funds are allocated to maternal conditions (58.46%), integrated logistics system ILS include medicines, medical equipment and supplies, and Laboratory reagents (13.51%), childhood illnesses and childhood immunizable diseases (9.57%) and then malaria (5.71%), childhood illnesses (2.99%), provision of ARVs (2.90%), STI, HIV/AID 1.82%, TB Diseases (1.59%), Newborn conditions (1.11%), Injury care (0.69%), Neglected Tropical Diseases (0.68%), Others Non Communicable Diseases (0.63%), Provision of essential TB drugs (0.35%).

Figure 9: Shares of budget according to essential health interventions, non specific delivery support and interventions not addressing BOD



The figure 9 above shows internally, the fund share between these three categories is essential health interventions 83.58%, - non-specific delivery support 5.69% and Interventions not addressing BoD 10.73%. The sources of funds for interventions not addressing BOD is shown below in figure 12

Figure 10: Funding flows financing mainly essential health interventions

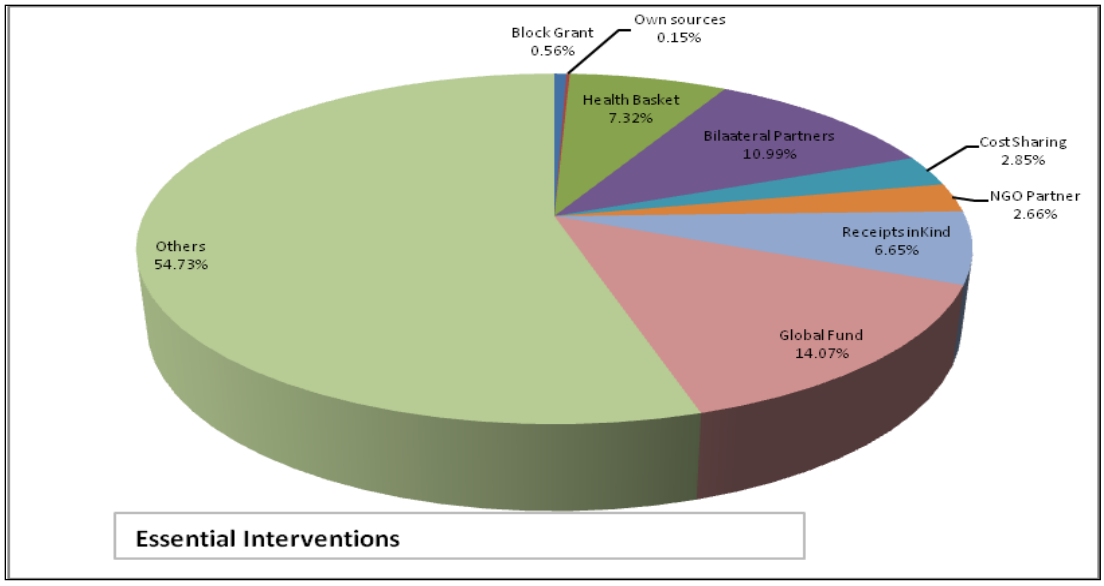
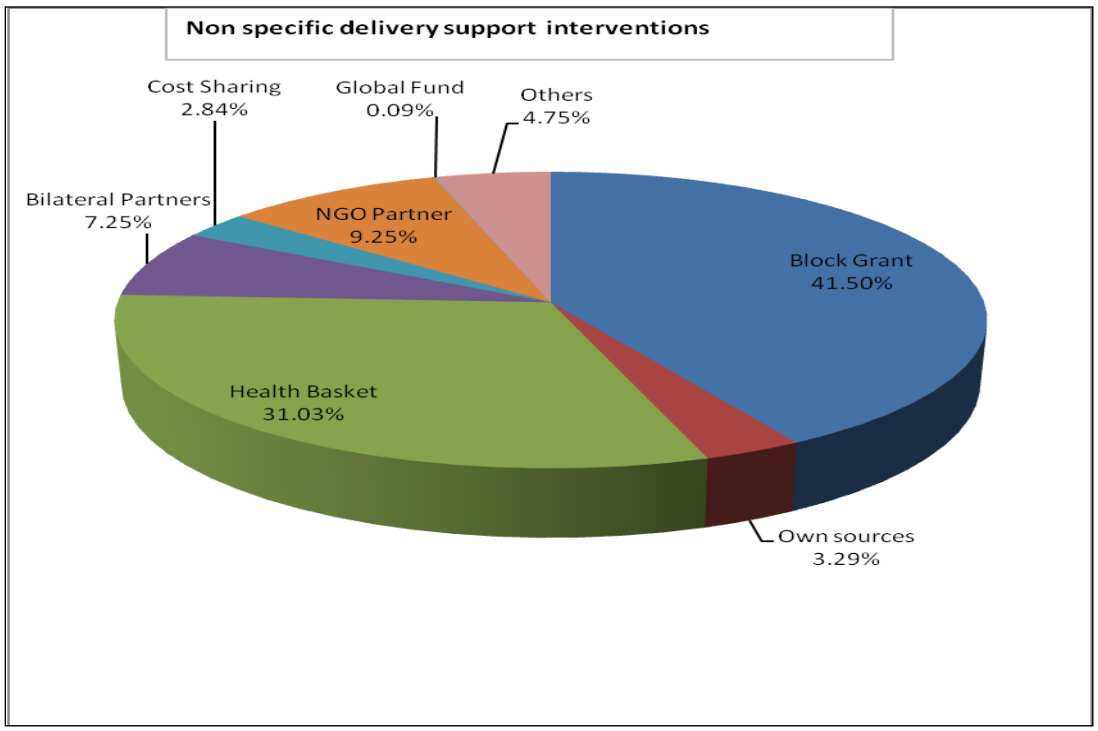


Figure 10 above shows the funding flows financing the essential health interventions 83.58%. The shares are: Others (54.73%, Global Fund contributions (14.07%), Bilateral Partners (10.99%),

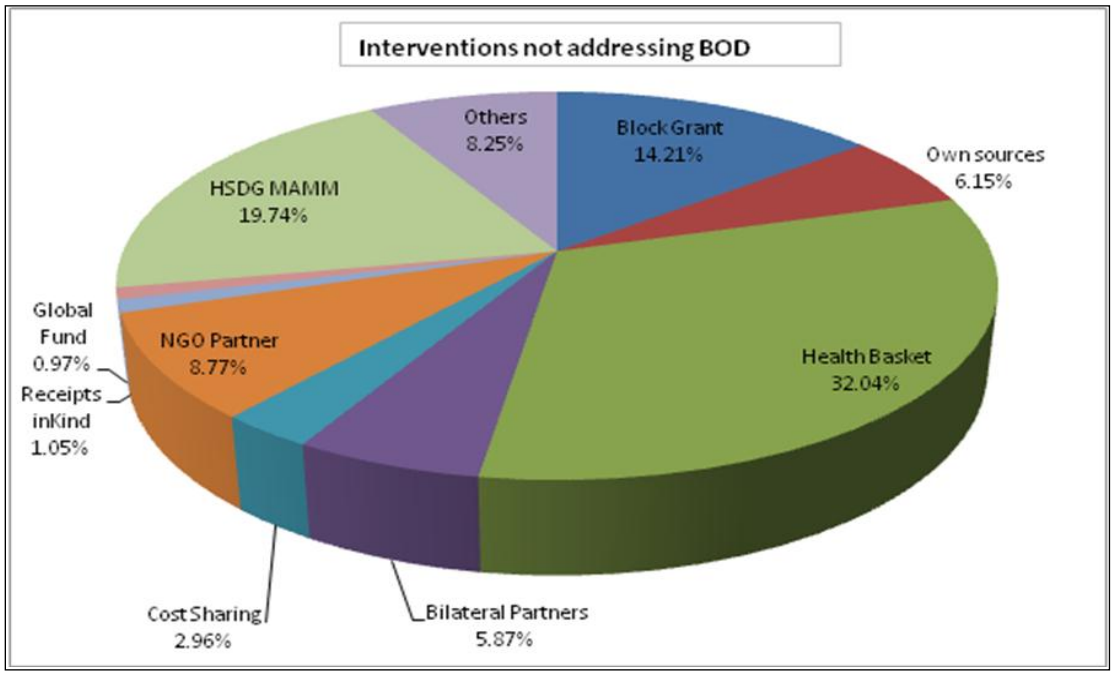
Council Health Basket Funds (7.32%), Receipts in-kind 6.65%), Cost sharing funds (2.85%), NGOs Partners (2.66%), and very little contribution from Block grant and Own Sources below (1%).

Figure 11: Funding flows financing Non Specific delivery support interventions



The figure above 11, indicates funding flows financing the non-specific delivery support interventions as follows: Block Grant (41.50), Health Basket Funds (31.03%), NGO Partner 9.25%), Bilateral Partners (7.25%, Others (4.75%), Own source (3.29%), Cost sharing (2.84%) and Global Funds (0.09. These address the Non Specific delivery support interventions (5.69%) as shown in figure 9 above. The non specific support includes Supportive supervision, Council Health Services Board and Health Facility Governing Committees, Strengthening Human resources for health capacity.

Figure12: The sources of funds for interventions not addressing BOD



The figure above shows sources of funds for interventions not directly addressing BOD (10.73%) figure 9 above. The shares is contributed as: Health Basket Funds (32.04%), HSDG/MMAM (19.74%), Block Grant (14.21%), Cost Sharing (9.06%), NGO Partners (8.77%), Others (8.25), Own Sources (6.15%), Bilateral Partners (5.87), Receipts in Kind 1.05%) and Global Funds (0.97%).

4.3. MMAM implementation status: Number of facilities, types, ownership, population/ distance.

The MMAM continued as the major strategy for improving access and expansion of health services in underserved areas planning one dispensary per village and one health centre per ward. The objective of the MMAM programme is to accelerate the provision of primary health care services and furthermore, MMAM aims at improving the referral system. However, according to the HSSP III MTR, it is unlikely that this strategy will be realized due to limited available budget within the HSSP III.

Table 4: Trend Summary of Health Facilities by ownership

Owner	Non-Government					Government					Total Number of health facilities					Lastest Change
Type of facility	Year					Year					2013/14	2012/13	2011/12	2010/11	2009/10	
	2013/14	2012/13	2011/12	2010/11	2009/10	2013/14	2012/13	2011/12	2010/11	2009/10						
Health Centres	158	126				416	336				574	462				112
Dispensaries	1,259	1,312				4,219	3,099				5,478	4,411				1,067
Hospitals	114	109				104	70				218	179				39
Total	1,531	1,547				4,739	3,505				6,270	5,052				1,218

Table 4 above shows a trend summary of Health facilities by ownership and the total numbers of health facilities extracted from PlanRep3 for year 2011 (2012/2013). Those which were entered into PlanRep 3 show total numbers of health facilities (5,052), of which 3,505 are owned by the Government and 1,547 by non-Government actors (Some Councils have data missing). For FY 2013/14 (data for 2012) the total is 6,270; the share of Government facilities (4,739) increases significantly with slightly decreases in non-government facilities (1,531) for those councils which managed to fill their data in the PlanRep3. This tendency congruent with findings of the HSSP III MTR however the number of facilities differ. According to the HSSP III MTR Analytical Report, by December 2012 there were 6,700 health facilities, based on the number of health facilities submitting HMIS data. Capacity of the Councils to fill all the tables in the PlanRep3 with quality data is required to be strengthened.

Figure 13: Percentage of Health Facility by Type FY 2013/14

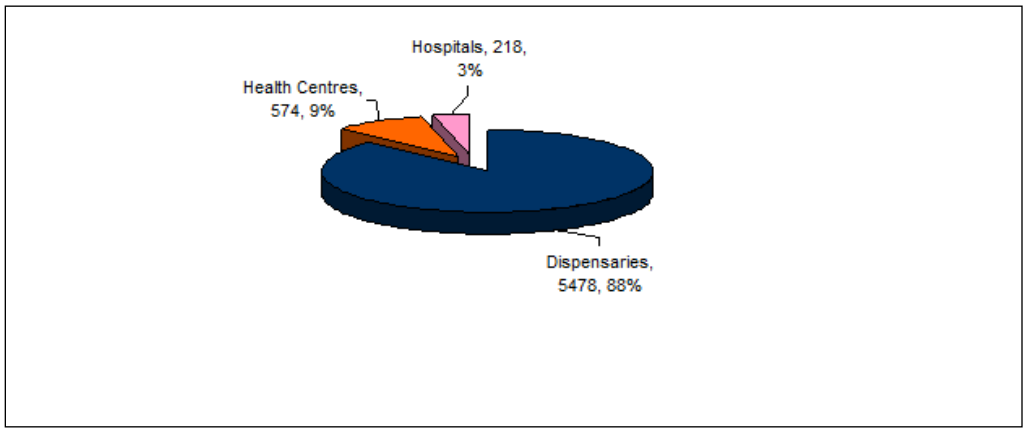


Figure 13 above illustrates the percentage of health facilities by type. Dispensaries total 88% of all facilities, followed by health centers accounting for 9%, and hospitals for 3%.

Figure 14: Number of Health facilities by Region

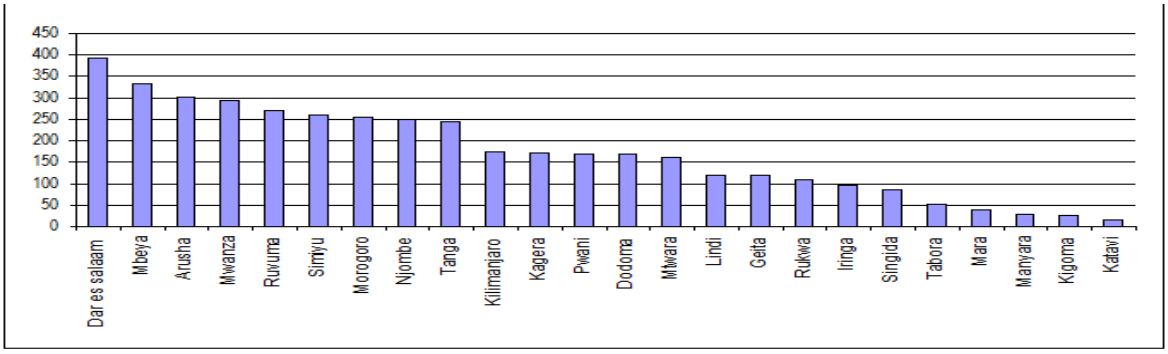


Figure 14 above shows the number of health facilities by region. Taking a look at the number of facilities per region and comparing with the 2012 population census, it is evident that health facilities are not distributed according to population numbers. While Kagera ranks fourth in population, it only ranks eleventh in terms of number of facilities. Kigoma, which nearly has the same population as Morogoro, only has a tenth of the number of health facilities as the latter. The Manyara region, which has doubled the number of people as Njombe, only shows a fraction of the number of health facilities. When it comes to funds allocations, large discrepancies can also be noted in relation to the number of health facilities. While Rukwa region only receives 30% more funds than Katavi, it comprises more than four times the amount of health facilities. Mbeya Region only receives 65% of the funds that Kagera receives, however it has nearly doubled the amount of facilities. It has to be assumed that equity variables play a large role in the distribution of facilities over the regions.

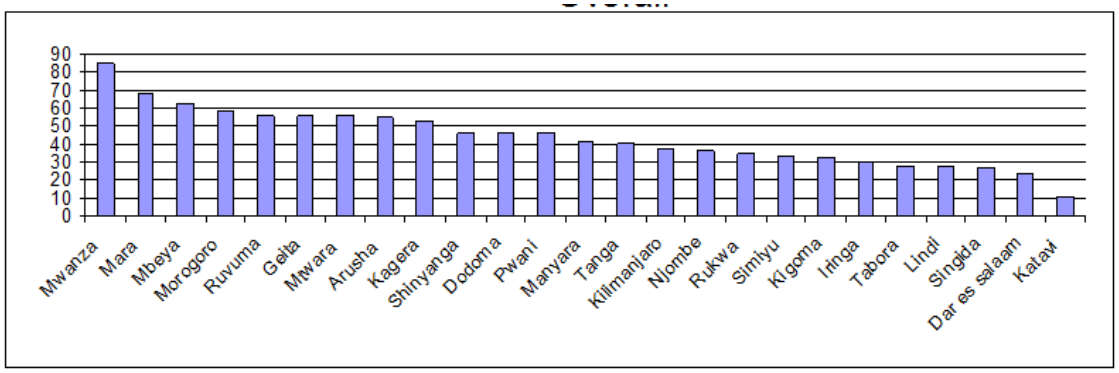
The HSSP III MTR states that the distribution of facilities between regions is fair with an average of 1.5 health facilities per 10,000 population, the lowest density of 1.1 is found in Kagera, Mwanza and Shinyanga, and the highest density of 2 is found in Kilimanjaro, Iringa and Lindi. However, these ratios give facility numbers per region which do not match with the suggested facilities per region as shown in figure10 above. Unfortunately the HSSP III MTR Capacity Development Report shows the numbers of health facilities per zone, so a direct comparison of regional numbers is not possible.

Table 5: Planned Budget for rehabilitation and construction under MMAM, by type of health facility

HFType	NoOfHFs	Construction	Rehabilitation	Equipment	Staff House	Budget_Total
Dispensary	856	11,390,665,586	2,016,794,806	525,933,280	5,395,176,080	19,328,569,752
Health Centre	194	4,430,091,606	740,313,000	286,974,104	1,083,860,048	6,541,238,758
Hospital	34	1,185,044,000	512,565,761	167,871,094	75,012,500	1,940,493,355
Total	**1084**	**17,005,801,192**	**3,269,673,567**	**980,778,478**	**6,554,048,628**	**27,810,301,865**

Table 5 above shows the planned budget for rehabilitation and construction under MMAM, by type of health facility. The budget allocated is 27,810,301,865, distributed as follows: 61% for construction, 12% rehabilitation, 4% Equipment and 24% for staff houses (See annex 5). However, for this year 2013/2014 the Ministry of Finance did not issue a separate ceiling for MMAM. In YF 2008/2009 32.0 bn, 2009/2010 23.0 bn, 2010/2011 20.0 bn, 2011/2012 20.0 bn, 2012/2013 20.0 bn. was allocated for MMAM activities. Instead the ceiling issued was a global figure included with other sectors in the Council; this included DADPS, CDG and MMAM. Then the Council was required to allocate for MMAM, CDG and consider the remaining as allocated for DADPS and CDG. Again, this depends on how the council treats MMAM as a priority compared with DADPS. The allocated resources were left to the Council to decide the basis of allocation. To finalize the CCHP plans, Councils used the previous years' ceiling provided by MoF for MMAM activities in respective councils. While the original MMAM financial outlay (MoHSW 2007) suggests a budget of 2.7 trillion for year 5-6, the budget indicated in the table shows that only a small fraction of this amount was budgeted for FY 2013/14. This confirms provisional HSSP III MTR findings that the MMAM objectives are unlikely to be realized due to limited budgets.

Figure 15 : Number of Health facilities planned for construction per region



The figure above shows the total number of health facilities to be constructed in this year 2013/2014. Mwanza region has planned more facilities to be constructed compared to Katavi, Dar es Salaam, Singida na Lindi.

Table 6: Population living within 5km from health facilities 2012

S/N	Region	Total Population	Population < 5 KM	% Pupulation < 5 KM
1	Dar es salaam	2,865,045	3,409,329	119
2	Kigoma	1,746,640	1,644,755	94.2
3	Kilimanjaro	1,575,370	1,418,139	90
4	Tanga	2,051,273	1,802,451	87.9
5	Geita	1,155,261	984,096	85.2
6	Mbeya	2,647,993	2,190,622	82.7
7	Manyara	1,321,295	1,056,938	80
8	Lindi	979,391	778,486	79.5
9	Njombe	827,342	655,606	79.2
10	Pwani	1,276,297	940,247	73.7
11	Iringa	893,549	651,103	72.9
12	Rukwa	1,193,230	866,701	72.6
13	Morogoro	2,468,595	1,766,187	71.5
14	Tabora	2,235,184	1,504,559	67.3
15	Dodoma	2,360,031	1,578,718	66.9
16	Mwanza	3,053,707	2,027,157	66.4
17	Arusha	1,261,876	831,168	65.9
18	Ruvuma	1,313,233	864,360	65.8
19	Simiyu	1,790,707	1,147,585	64.1
20	Shinyanga	1,495,758	887,976	59.4
21	Singida	1,761,541	1,043,379	59.2
22	Mtwara	1,568,905	829,695	52.9
23	Kagera	2,634,183	1,372,598	52.1
24	Mara	2,400,468	973,245	40.5
25	Katavi	845,642	207,794	24.6
	Total	***43,722,516***	***31,432,894***	***71.9***

Table 6 above, shows the population living within 5 km from Health facilities was 71.9% by June 2013. In June 2010, it was discovered that at least half (50.6%) of the population was living within 5 km, compared with 48% in June 2009 according to the data from the CCHPs. This is an increase in comparison to previous years. The data presented include the catchment areas between the health facilities. It is a clear indication that equity in provision of health facilities is being addressed if MMAM is implemented as planned.

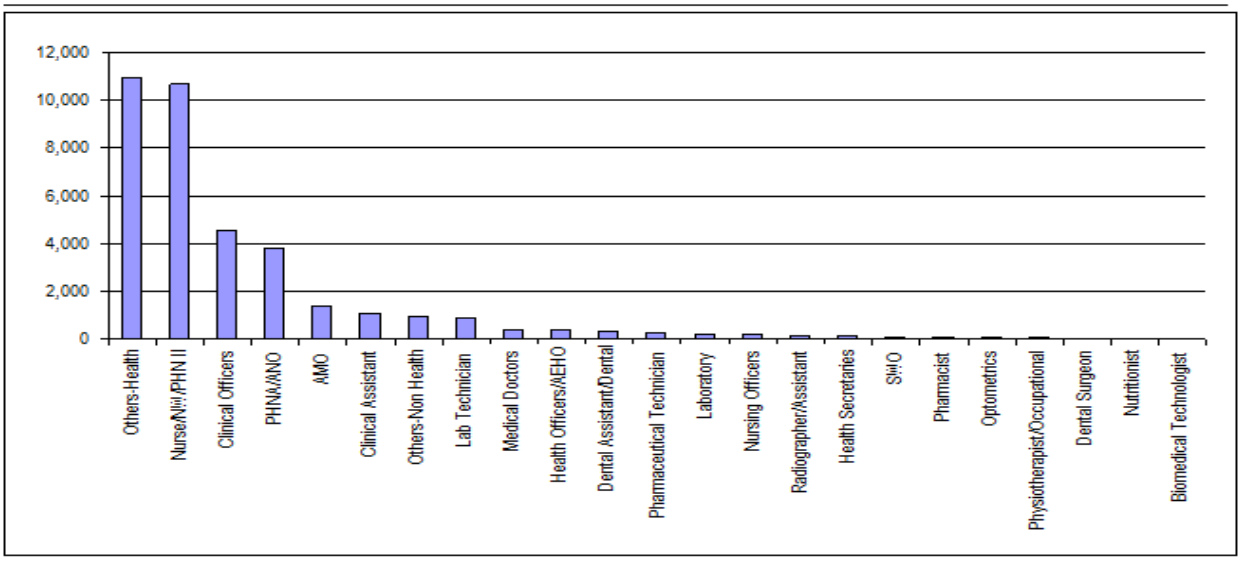
4.4 Human resource trends

Table 7: Human Resources – Overall (including deficit)

Personnel Type Group	Establishment	Available	Deficit	%Age Deficit
AMO	2,908	1,512	1,435	49%
Biomedical Technologist	99	2	98	99%
Clinical Assistant	4,183	1,232	3,067	73%
Clinical Officers	10,265	5,193	5,282	51%
Dental Assistant/Dental Therapist	1,080	348	748	69%
Dental Surgeon	206	60	153	74%
EHO	33	10	23	70%
Health Officers/AEHO	2,897	1,300	1,611	56%
Health Secretaries	264	228	75	28%
Lab Technician	3,358	1,264	2,128	63%
Laboratory Technologist/Schientist	692	338	369	53%
Medical Doctors	897	541	391	44%
Nurse/NW/PHN II	17,465	9,373	8,566	49%
Nursing Officers	1,441	579	930	65%
Nutritionist	226	63	166	73%
Optometrics	161	56	113	70%
Others-Health	15,896	13,020	4,136	26%
Others-Non Health	3,530	1,453	2,178	62%
Pharmaceutical Technician	2,375	441	1,949	82%
Pharmacist	348	191	168	48%
PHNA/ANO	6,284	3,798	2,600	41%
Physiotherapist/Occupational Therapist/Orthopaedic	338	50	289	86%
Radiographer/Assistant Radiographer	567	199	381	67%
SWO	1,031	175	875	85%
Total	**76,544**	**41,426**	**37,731**	**49%**
Total-Skilled	**57,118**	**26,953**	**31,417**	**55%**

In the above table 10 there is health care workers deficit of (49%) as a whole. For the skilled health care workers the deficit is 55%. This is as per CCHPs analysis for the *fewer* council which filled data in the tables. The report shows that the most affected cadre is of Biomedical Technologists. According to HRH profile for 2012 recorded a total of 64,449 health workers in the health sector with 52% availability using 1999 staffing norms or 36% availability based on new staffing norms (HSSP III MTR HRH draft Report 2013). Without further analysis it is however not possible to know the reasons for discrepancies in the number of health workers in the two data sets however it is evident from both records the deficit in human recourses is significant (problem with data recording).

Figure16: Numbers of Health Workers by different cadres, by June 2012

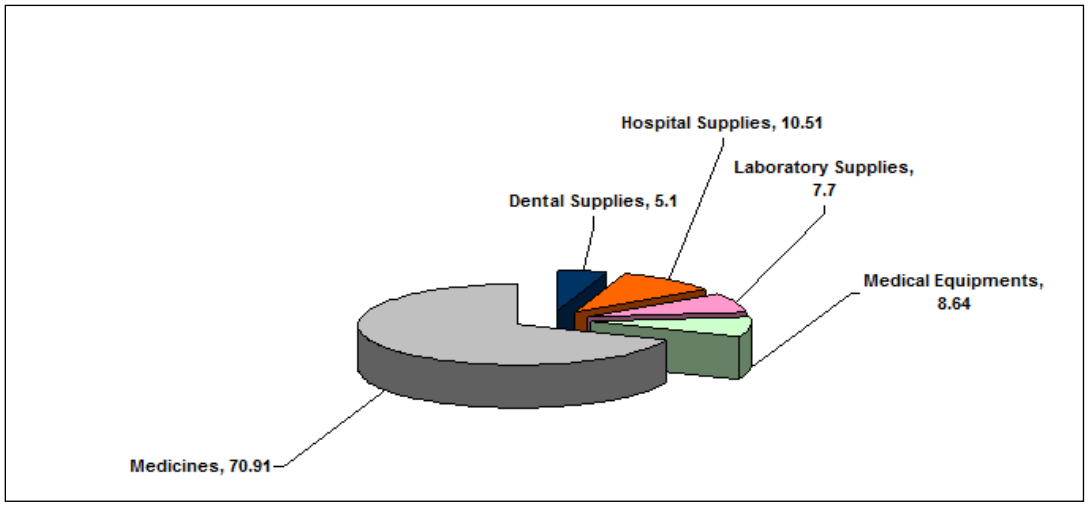


The figure 16 above presents the number of health care workers by different cadres, by June 2012. The result from this assessment has revealed that, there is serious shortage of both number and qualified health workers of different cadres in most of the councils. As explained earlier, this is however not new.

4.5 Medicines availability

4.5.1 Medicines (MSD/Other sources)

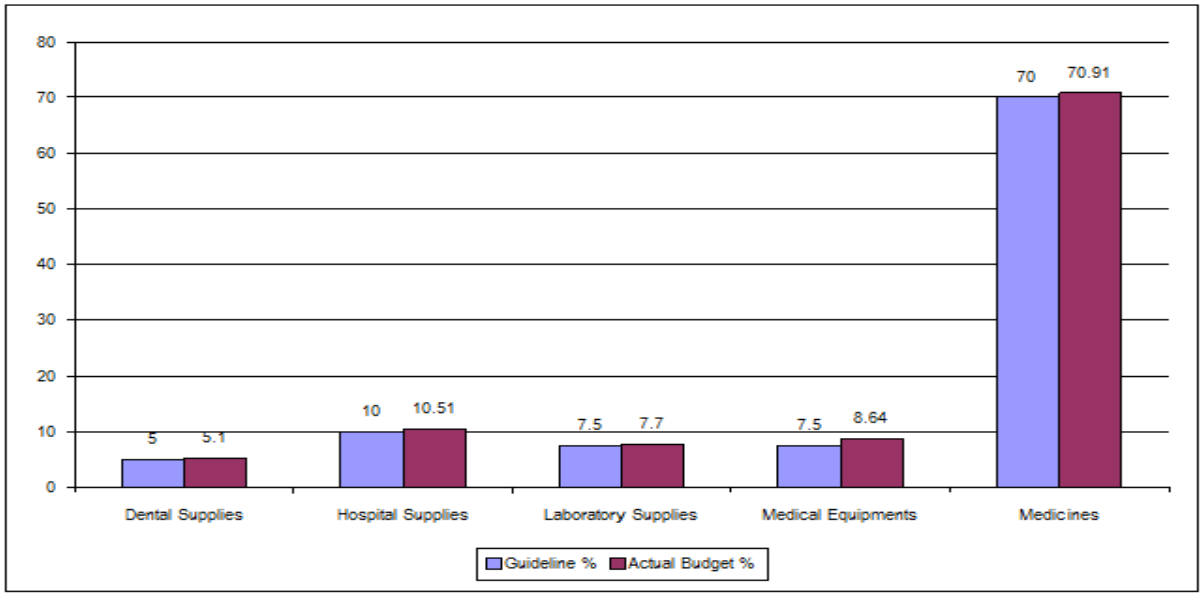
Figure 17: Budget allocated for Medicines, medical supplies and medical equipment and reagents (Both Health Basket Grant and MSD)



The figure above presents the budgets allocated for medicines, medical supplies, equipment and laboratory reagents, as funded by different sources and allocated according to the resource allocation formula for this item (Medicines 70%, Medical/ hospital/supplies 10% Medical equipment 10% Laboratory supplies 5% and dental supplies 5%). However, analysis from the figure above has indicated that Medicines bears 70.91%, Hospital supplies is 10.51%, Medical equipment is 8.64%, 7.7 % for laboratory supplies and dental supplies is 5.1%.

Furthermore, the funds from Health Basket Funds that are utilized for medicines at the Council level can be further analyzed according to several categories: 70% is spent for medicines, 10.61% for hospital supplies, 7.7% for medical equipment, 7.7 % for laboratory supplies, and 5% for dental supplies. Utilization allocated from MSD is as follows: 69.90% is spent for medicines, 10.02% for hospital supplies, 7.49% for medical equipment, 7.54 % for laboratory supplies and 4.96% for dental supplies.

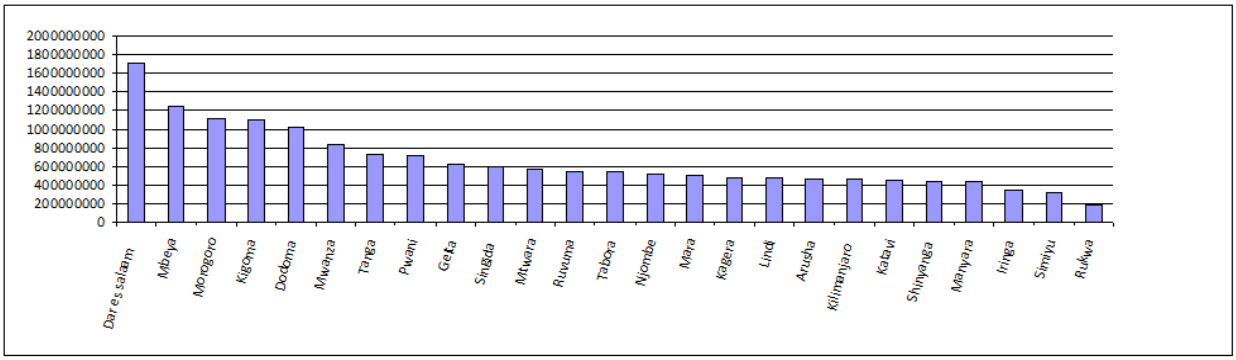
Figure 18: Guidelines shares vs. actual planned shares for medicines, medical supplies, equipment and laboratory reagents in 2013/14



The figure above compares the allocation to the guidelines, shares vs. actual planned shares, by the Councils for medicines, medical supplies, equipment and laboratory reagents. The Council health Planning teams have adhered to the guidelines; in fact most have gone a little bit beyond the guidelines, due to the importance of availability of medicines, medical supplies, equipment and laboratory reagents for health services delivery. The allocation is spread to the three primary cost centres: Hospital, health centres and dispensary levels.

Figure 19: Summary of budget for medicines, medical supplies, and equipment and laboratory reagents per region

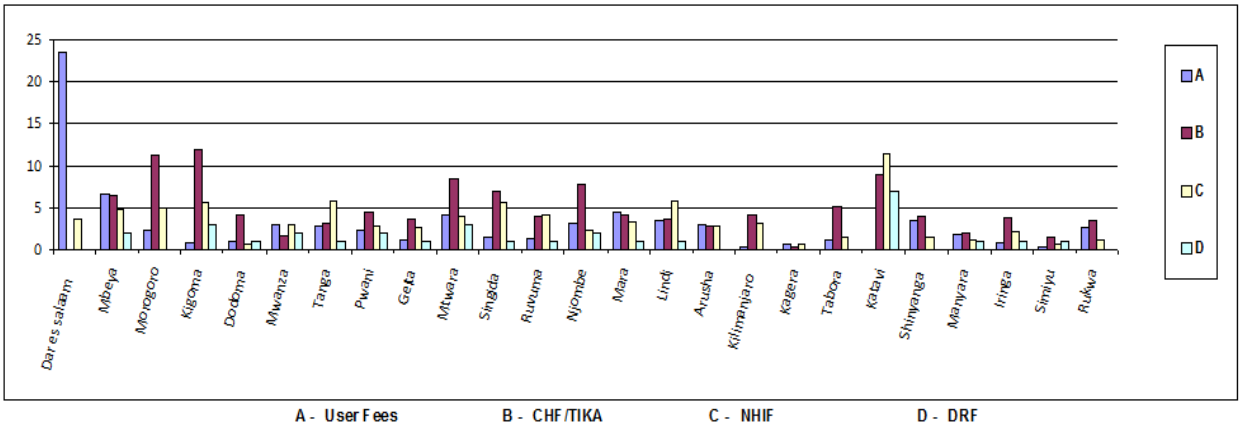
Council	Total Medical Budget	Cost Sharing Funds										Council Health Basket Fund	% of total	Receipt in kind	% of total	C Me
		User Fees	% of total	CHF/TIKA	% of total	NHIF	% of total	DRF	% of total	Total	% of total					
Total	165,113,612,239	4,377,411,112	3	6,232,949,118	4	4,276,771,054	3	1,553,627,600	1	16,440,758,884	10	30,630,003,667	19	44,690,448,701	27	7



In figure 19 above shows that Dar es Salaam region followed by Mbeya in ranking the budget allocated for medicines, medical equipment and supplies, and laboratory reagents is more. The lowest allocations are found in the regions of Rukwa, Simiyu, and Iringa.

Figure 20: Contribution of cost sharing funds to the total budget allocated for medicines, medical equipment and supplies and laboratory reagents

Council	Total Medical Budget	Cost Sharing Funds										Council Health Basket Fund	% of total	Receipt in kind	% of total	Other Funds Medical Budget
		User Fees	% of total	CHF/TIKA	% of total	NHIF	% of total	DRF	% of total	Total	% of total					
Total	164,237,923,572	4,369,171,112	3	6,188,875,125	4	4,263,911,054	3	1,554,627,600	1	16,376,584,891	10	30,643,705,107	19	44,281,541,658	27	72,936,091,916



The figure above shows the Contribution of cost sharing budget for medicines, medical supplies, equipment and Laboratory reagents. 10% of the total budget allocated for medicines is from cost sharing, (out of these 4% CHF/TIKA, 3% NHIF, 3% user fees and 1% DRF), 19% is from the health basket funds, and 27% MSD/In-kind/Central. The rest is provided as in-kind mainly in the form of

health commodities (ARVs, EPI Vaccines, ALU/ITNs/ IRS/ mRDT, TB DOTS, Family Planning methods).

Figure 21: The total budget allocated for medicines, medical supplies, and equipment and laboratory reagents

Funds	Planned Annual Cost	Percentage of Total Med Budget
Other	72,936,091,915.67	44.41
Receipt in kind	44,281,541,657.69	26.96
Council Health Basket Fund	30,643,705,107.11	18.66
CHF/TIKA	6,188,875,125.00	3.77
User Fees	4,369,171,112.45	2.66
NHIF	4,263,911,053.72	2.60
DRF	1,554,627,599.94	0.95
Total	**164,237,923,571.58**	**100.00**

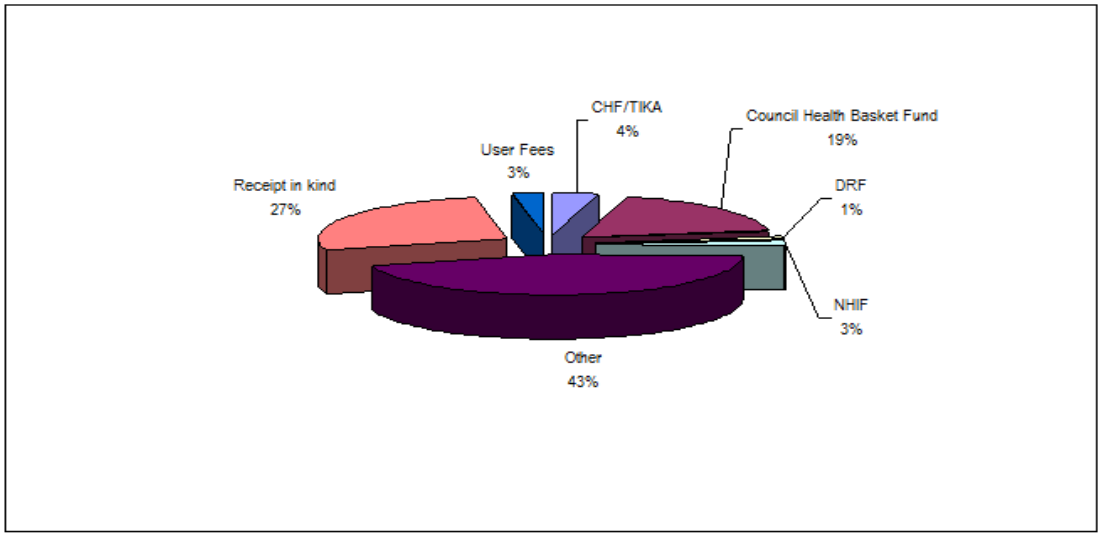


Figure 21 above presents the total budget allocated for medicines, medical supplies, equipment and laboratory reagents from all sources of funds per year. The budget from MSD represents about 27% and Others sources[1] approximately 43 %(Others - provided as in kind or in form of commodities). More resources include user fees 3%, CHF/TIKA 4%, NHIF 3% and DRF 1%, which also depends on revenue collection. Only the budget from Council Health Basket Funds 19% includes cash within the council account. These funds are used depending upon MSD's stock-status. If requested supplies are out of stock, then CHMTs have to follow procurement procedures of purchasing locally. However, the budget under MSD 27% is not only for procurement of medicines. It also includes funds used for storage and distribution of medicines. Under the current programme of Direct delivery (DD) to the health facility, each delivery per primary health facility per quarter costs a flat rate of Tshs. 130.000/=. In addition, there is a cost from the MSD warehouse to District hospitals of about 600,000/=. However, this price also varies depending upon the distances

[1] Others – includes many funders Multilateral, Bilateral (Global Funds, UNICEF, UNFPA, USAID, NGOs etc)

between districts from Zonal MSD Warehouse. An additional charge from MSD occurs when the Council receives vertical programme commodities such as ARVs, condoms, etc.; this charge is from the budget allocated for medicines under the cost centre by the DMO for district hospitals. From these transactions, the budget allocated for MSD is minimal. Councils have to intensify supervision to make sure that this small budget amount remains for medicines, that the funds be used strictly and effectively to sustain the availability of medicines in health facilities.

Figure 22: Contribution share to the total medical budget by Funders

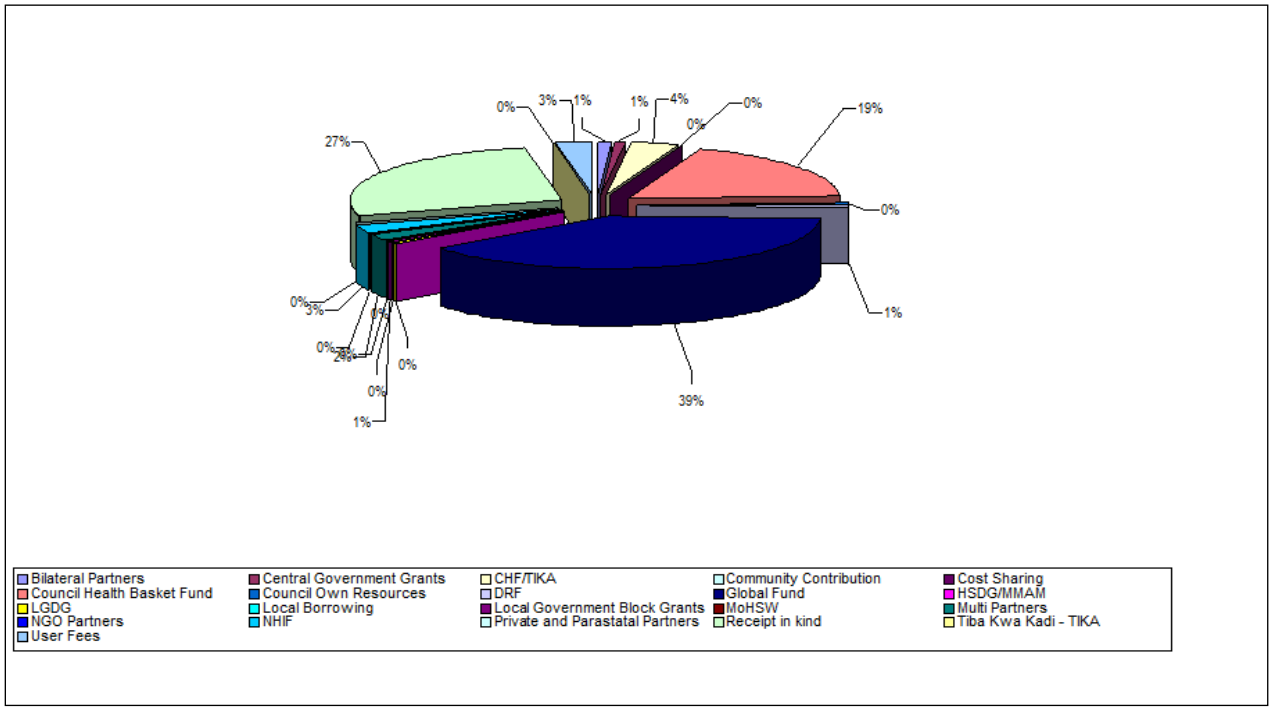


Figure 22 above shows different funders who contribute to the total medical budget. This includes contributions, both in the form of commodities (In kind) and cash. The contributors include Global funds (39%), Central Government – MSD (27%), Council Health Basket Funds (19%), CHF/TIKA (4%), User fees (3%), NHIF (3%), DRF (1%), and Others, such as Bilateral Partners, LGDG, NGO Partners, Council Own Sources, Local Council Borrowing, Local Government Block Grants, Private and Parastatal Partners, Community Contributions, MOHSW, HSDG/MMAM, and Multi Partners, which all contribute less than 1%. Their contributions seem perhaps negligible, but are nevertheless worthwhile in supporting the Tanzanian Community.

4.6 Status and trends of key health indicators

This section shows the status and trends of key health indicators. The aggregated data derives from the data which Councils have entered into PlanRep3 in 2012 (HMIS data Council level) and previous years and shows different numbers compared to data derived from HMIS and in some cases makes little sense which suggests that the capacity of data management at council level is still very weak

and need to be addressed. Nevertheless, the aggregated data are listed here as this document aims to provide Councils feedback on their performance and areas to improve. The variance in the data collected indicate the urgency for Councils to build their capacity of data management internally, as their data entry is not accurate. Much reference below has been made to the ongoing HSSP III Mid-term Review (MTR) as it collates and interprets most recent data from various surveys. N.B. all the HSSP III MTR reports are conducted in 2013 (data reported HMIS 2012 central level) and are used here to compare and validate data were still in draft form while this report was done.

4.6.1 Trends in health status and disease pattern

4.6.1.1 Top disease pattern and distribution (OPD and IP)

Table 8 shows the top ten OPD diagnoses. Malaria, acute respiratory infections (ARI) and diarrhea diseases are on the top for both under five and above five year olds. This is comparable with HMIS data aggregated in the Analytical Report HSSP III MTR which shows a similar trend for under five year olds. For ages five and above the HMIS data lists malaria and ARI ranking first and second OPD diagnoses however third most common OPD diagnosis according to HMIS are sexually transmitted infections and urinary tract infections and diagnoses associated with ear, eye and skin infections equally. Most significant however is the difference in number of recorded OPD visits. While the aggregated data from CCHPs from 161 LGAs lists a total of 3.6 million OPD visits in 2012 for ages five and above, the HMIS data reveals a staggering 16.3 million OPD visits. The data in CCHPs from 161 LGAs is only for the ten Top OPD Diagnosis, while the data reported in the HMIS is for all OPD visits per year, HMIS data is almost equal to Figure 27 OPD utilization. This variation is an indicator of the need to build capacity at different levels of health services provision and decision making to be able to use PlanRep for planning and reporting.

Table 8: Main OPD Diagnoses (top 10)

.	Diagnosis	< 5 years				5+ years			
		M	F	Total	% of total OPD Cases	M	F	Total	% of total OPD Cases
1	Malaria	798,092	830,828	1,628,920	39.7	642,175	772,952	1,415,127	39.6
2	ARI	450,663	473,795	924,458	22.6	363,516	399,694	763,210	21.4
3	Diarrhea disease	217,397	233,610	451,007	11.0	130,728	163,496	294,224	8.2
4	Pneumonia	182,022	196,028	378,050	9.2	138,683	144,745	283,428	7.9
5	Intestinal worms	97,448	117,565	215,013	5.2	117,505	114,176	231,681	6.5
6	Other diagnosis	47,047	69,465	116,512	2.8	113,257	110,051	223,308	6.3
7	Skin diseases	71,721	75,187	146,908	3.6	64,911	70,576	135,487	3.8
8	Eye conditions	54,232	58,324	112,556	2.7	52,904	55,038	107,942	3.0
9	Ear condition	32,191	33,621	65,812	1.6	36,846	39,602	76,448	2.1
10	Anemia	27,668	32,203	59,871	1.5	15,275	24,613	39,888	1.1
.	*Total*	**1,978,481**	**2,120,626**	**4,099,107**		**1,978,481**	**2,120,626**	**3,570,743**	

4.6.1. 2 Inpatient Admissions and Deaths per Diagnoses

Table 9 below presents figures for the ten top inpatient admissions and deaths per diagnosis. Even though the data are clearly faulty (*e.g.*, males having normal deliveries, low maternal death rates compared to other national surveys), some trends on admissions and deaths are in line with HMIS data. In particular, malaria is listed as the main cause for admissions and deaths, followed by

pneumonia/ARI for both children under five and above five years old. Due to the poor quality of the aggregated data on impatient admissions and deaths per diagnosis, further analysis of these data has not been considered. Moreover, future interventions should focus on improvement of data quality and completeness and on the use of PlanRep tool.

Table 9: Inpatient Admissions and Deaths per Diagnosis

Diagnosis	< 5 years				5+ years				Total				CFR in %.
	Adminissions		Deaths		Adminissions		Deaths		Adminissions		Deaths		.
	M	F	M	F	M	F	M	F	M	F	M	F	
Clinical AIDS	456	573	76	80	6,450	9,052	610	722	6,906	9,625	686	802	9.00
Anemia	12,693	12,703	553	652	6,158	7,608	367	443	18,851	20,311	920	1,095	5.15
Other diagnosis	10,467	10,931	221	217	18,070	19,008	678	783	28,537	29,939	899	1,000	3.25
Malaria severe	40,421	44,308	1,256	1,346	30,452	34,916	966	1,000	70,873	79,224	2,222	2,346	3.04
Pneumonia	21,453	23,452	632	661	11,925	12,232	315	350	33,378	35,684	947	1,011	2.84
Diarrhea diseases	11,054	11,633	166	175	6,004	6,161	93	107	17,058	17,794	259	282	1.55
Fractures	984	840	5	6	3,918	3,107	49	25	4,902	3,947	54	31	0.96
ARI	35,413	41,227	220	203	13,574	14,708	117	118	48,987	55,935	337	321	0.63
Malaria uncomplicated	25,951	27,304	95	108	19,470	21,403	93	105	45,421	48,707	188	213	0.43
Normal Deliveries	1	0	0	0	24	176,165	0	227	25	176,165	0	227	0.13

However, according to the table above clinical AIDS has high case fatality rate (CFR) of 9%, followed by anaemia 5.15%, severe Malaria is 3.04%, Pneumonia 2.84%.

4.6.1.3 Notifiable diseases

Table 10: Notifiable Diseases

S/N	Diagnosis	< 5 years				Total	5+ years				Total
		M	F	Death	CFR	Total	M	F	Death	CFR	.
1	Malaria	1304807	1394604	5515	0.2	2699411	1340924	1375085	6387	0.24	2716009
2	Dysentery	265383	294069	757	0.14	559452	159947	256001	842	0.2	415948
3	Others	25382	25714	174	0.34	51096	12506	13610	171	0.65	26116
4	Cholera	1860	1400	5	0.15	3260	56405	1859	12	0.02	58264
5	Typhoid	3049	3312	35	0.55	6361	15561	23090	613	1.59	38651
6	Rabid Animal Bite	6106	5881	6	0.05	11987	11179	9964	133	0.63	21143
7	Measles	1929	1687	31	0.86	3616	1441	1201	63	2.38	2642
8	Rabies	50	22	13	18.06	72	2795	150	50	1.7	2945
9	Meningitis	307	267	79	13.76	574	362	304	117	17.57	666
10	Acute Flaccid Paralysis	80	69	1	0.67	149	951	130	10	0.93	1081

The table 10 above presents data on notifiable diseases for 2012. The data show that rabies in children has a high rate of CFR at 18.06% and meningitis in ages over 5 years at 17.57%. Also there are still some cases of Acute Flaccid Paralysis. These data show much higher rates than those recorded by HMIS.

4.6.2 Trend of TB cases 2008-2012

Figure 23: Trend of TB cases 2008-2012

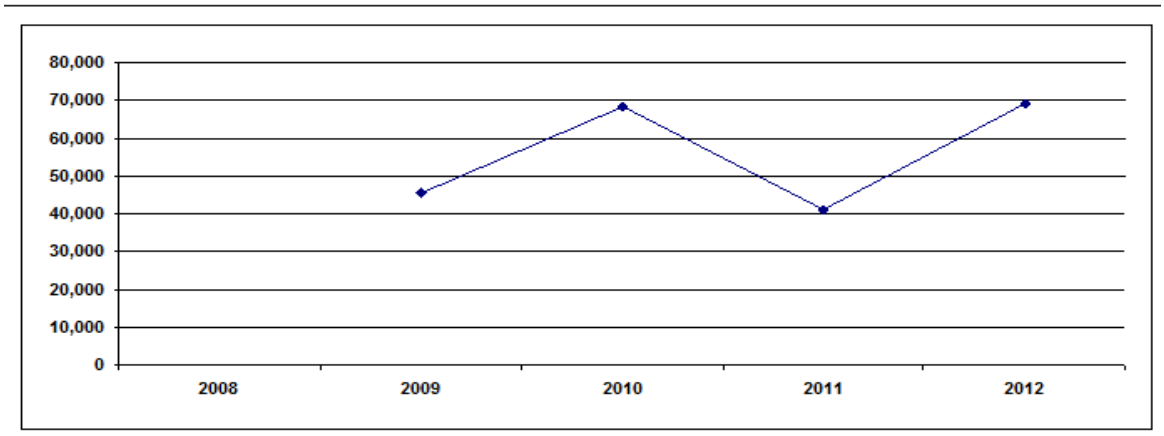


Figure 18 above shows the trend of TB cases from 2008- 2012, indicating an increase. For 2012, 70,000 TB cases were registered, which is close to previous years' estimates from WHO. TB case notifications have been fairly stable at around 60,000 new cases per year (see Analytical Report HSSP III MTR). In 2012, a TB prevalence survey was conducted in a nationally representative sample of over 50,000 adults (older than 15 years). The prevalence of bacteriologically confirmed TB in the adult population was 300 for the mainland. The 2012 TB prevalence survey shows much higher TB prevalence rates, which imply that many people with TB are not accessing health services (Analytical report HSSP III MTR).

Figure 24: Trend of TB treatment completion rates 2008-2012

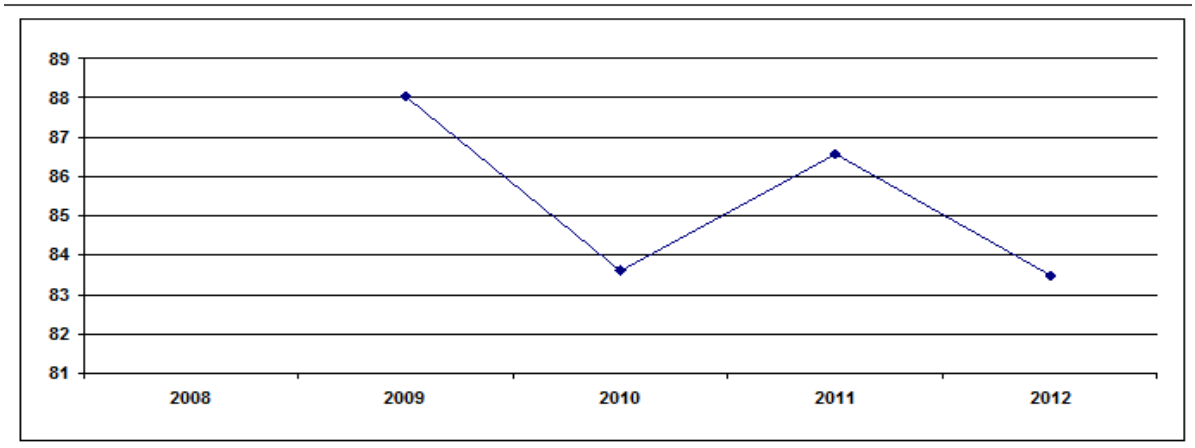
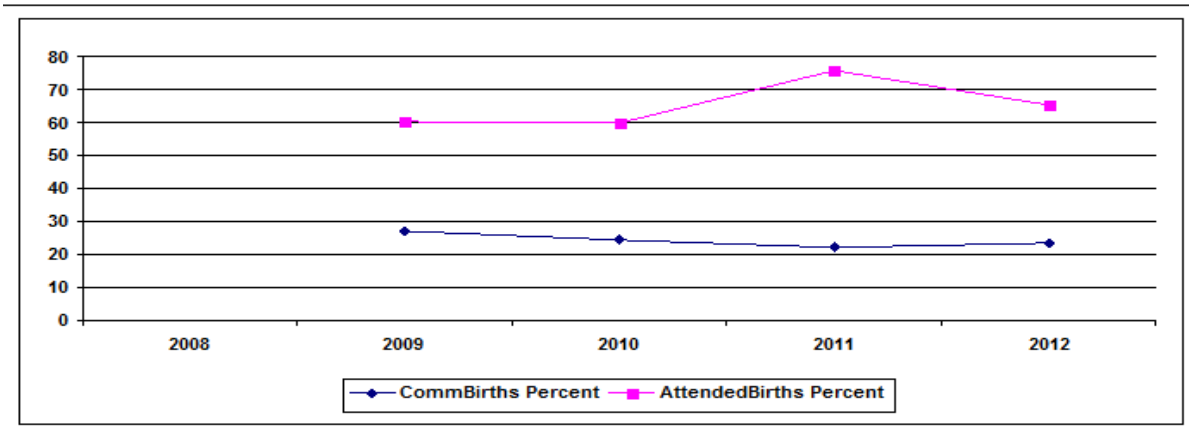


Figure 24 above presents the trend of TB treatment completion rates from 2008-2012. According to CCHPs from 161 LGAs, TB treatment success rates over the past few years have been between 83% and 88%. This is close to the HSSP III and WHO targets of 85% for 2015. HMIS data however differ here and show a 90% TB treatment success rate. The HSSP III MTR confirms that TB management services are available at all the levels of health facilities. 78.7% of TB cases reported

in 2011 were seen in government health facilities. Preliminary results of the national tuberculosis prevalence survey show that the prevalence of tuberculosis in the country is 295/100,000. This indicates that TB is still a major burden in the country (HSSP III MTR Analytical Report September 2013). Of particular concern is the TB treatment success rate in 2012, which is below the HSSP/WHO targets of 85% success rate for 2015. Whereas TB treatment success rates according to HSSP III MTR show an increasing tendency between 2009 and 2010, the above figure 19 indicates the opposite. This is may be due to poor data posting and collection, however, it gives the assignment to CHMT on importance of the data management.

4.6.5 Health services and MDG 5

Figure 25: Trend of births attendance at health facilities and community delivery from 2008-2012



The figure above the analysis from the councils which filled the data in the tables available the PlanRep3 shows the trend of birth attendance at health facility and community delivery for four years. The data is presented in numbers. The result has indicated that, the births attended at health facilities has been constantly increasing since 2007 to 2011 but slightly there is a decrease in 2012, while its rival, community delivery has been decreasing variably since 2008 to 2012.

There is generally a relationship between births at health facilities and births at home, while percent of later is decreasing, the other one tend to raise as indicated in the figure 25 above.

Figure 26: Trend of Family Planning acceptance rates, 2008-2012

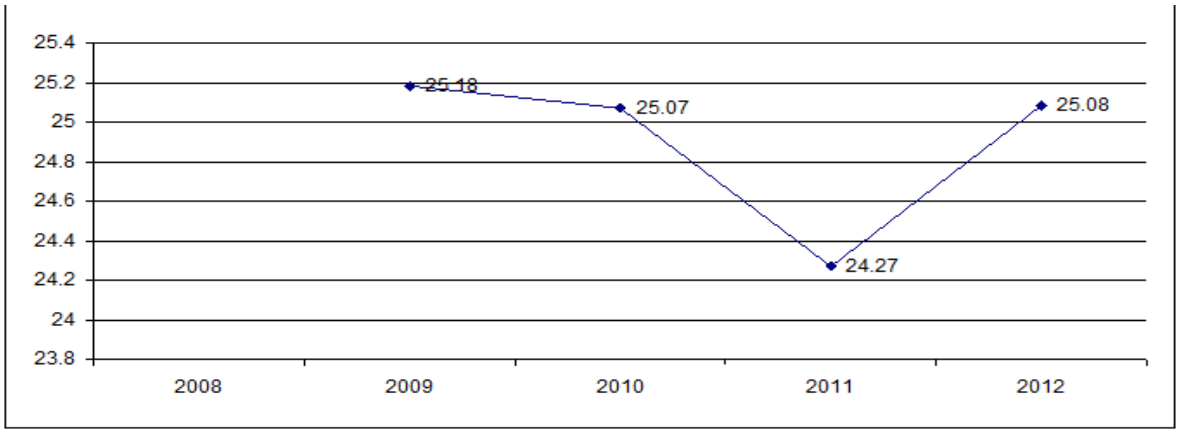


Figure 26 above shows the trend of family planning acceptance rates for the past four years. This is congruent with TDHS 2010 data which indicates a contraceptive prevalence rate of 27% in 2010. HSSP III (2009 – 2015) suggests 20% as a baseline for 2008 and 30% as a target for 2015. The HSSP III target is likely to be met. Complications of unsafe abortions contribute to 19 percent of maternal deaths in Tanzania (HSSP III MTR MNCH Draft Report). Avoiding unwanted pregnancies will likely contribute to a decrease in maternal mortality.

4.6.6 Health services and MDG 4

Figure 27: Severe malnutrition by region, FY 2013/14

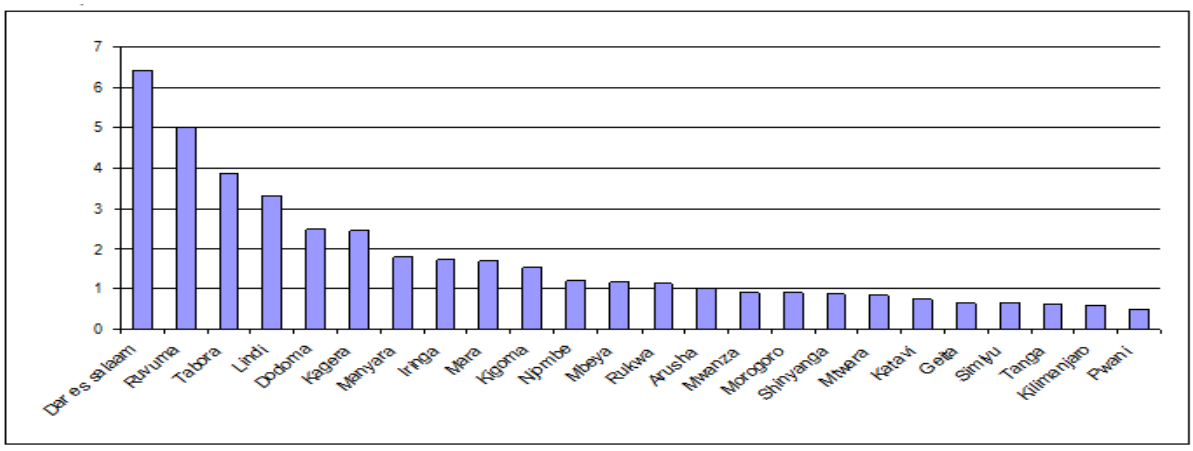


Figure 27 above presents the status of severe malnutrition in 2012. Tanzania is one of the 10 worst affected countries in the world with 42%of children aged less than five years being stunted. There are no country wide rehabilitation services for severe malnutrition. Programs focus on preventing malnutrition rather than treating it (HSSP III MTR Draft MNCH Report). Figure 22 above however, indicates a much lower malnutrition rate in general but Dar es Salaam has the highest rate of malnutrition. low rates in other regions could be the result of low detection and reporting of malnutrition cases in most of them. However, the poor families in urban areas are poorer than

their rural counterparts. No access to land and other assets. Compared to the last year analysis report, confirms that, severe malnutrition rate was high in Da er Salaam, Mara, Lindi, Dodoma and Arusha regions in 2010 while in Pwani, Singida Ruvuma, Tanga, Kagera, Kilimanjaro, Rukwa, and Mwanza regions the malnutrition is less than 1%. For this report there is a mixed picture.

Figure 28: Proportion of low birth weight tendency, 2008-2012

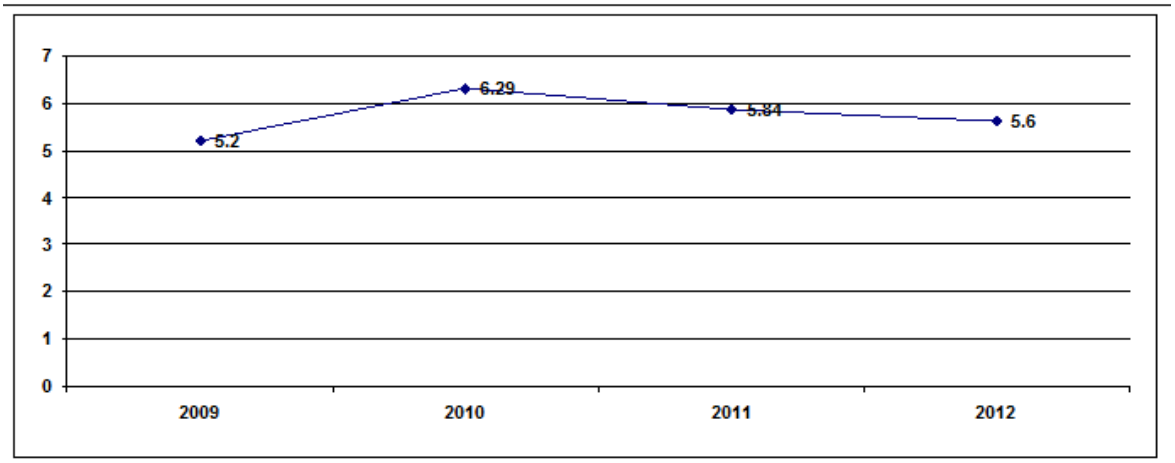
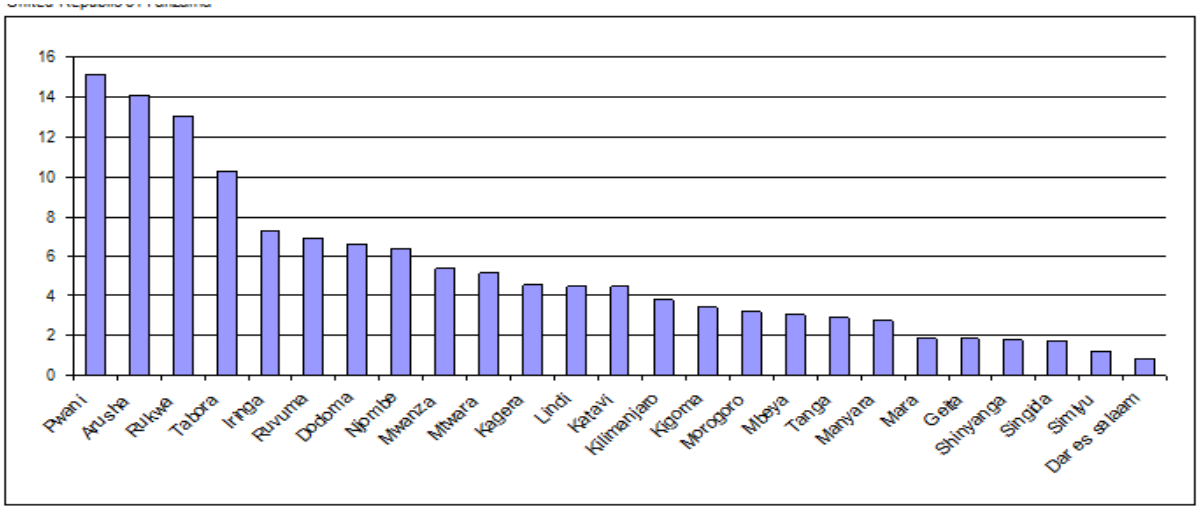


Figure 28 shows a low birth weight tendency of around 6%, with a small increase registered in 2010 (6.29%), followed by a continuous decline to 5.6% in 2012. The distribution of low birth weight recordings per region can be seen in figure 24 according to CCHPs data. However, caution is to be taken in the reliability of data in both figures. According to the National Panel Survey (2011), the prevalence of underweight children is 14%.

Figure 29: Proportion of low birth weight, by region, FY 2013/14



Furthermore, the CCHP analysis figure 29 above has indicated that, the proportion of low birth weight were very higher (15%) in Pwani region compared to other regions while its lower (below 2%) in Dar es Salaam, Simiyu , Singida Shinyanga nad Geita regions. There are direct relationships between malnutrition and low birth weights as depicted in the proceeding figures above.

Figure 30: Trend of immunization and Vitamin A Supplementations from 2008-2012

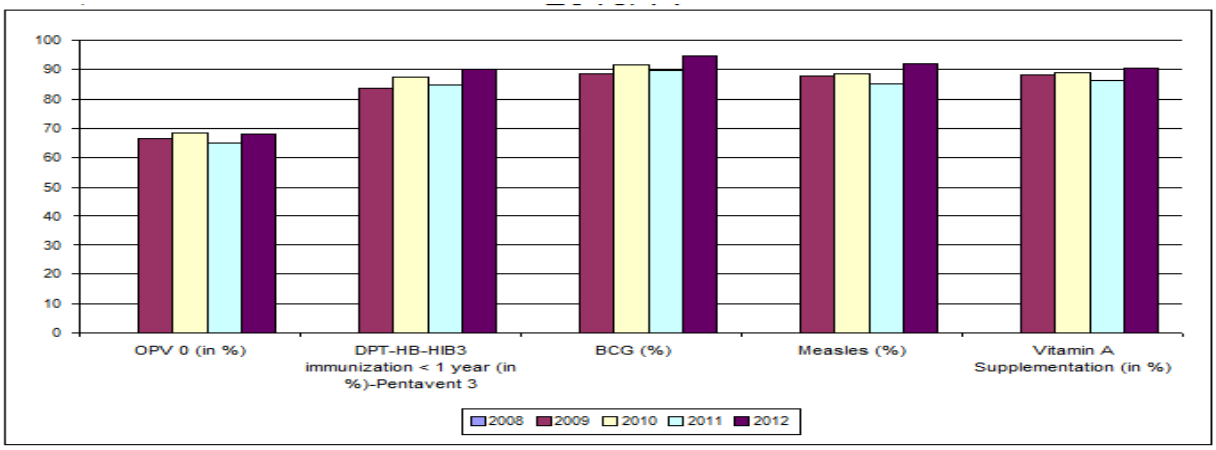
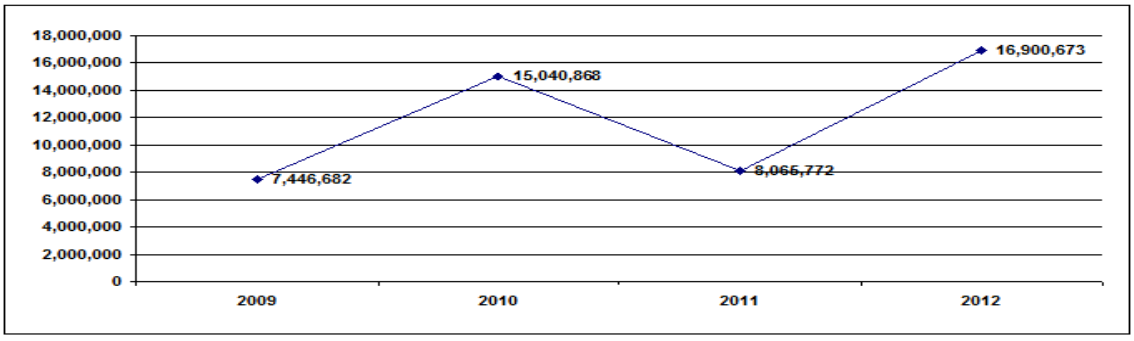


Figure 30 above, reports on the immunization and Vitamin A supplementation coverage for 2008 – 2012. A slight increase in immunization rates for most vaccines noted for 2012, except for OPV 0, which had a slightly higher coverage in 2010. BCG, Measles and DTP-HB-HIB3 vaccines and vitamin A supplement reach 90% and above coverage, while OPV O vaccination is recorded just below 70%. The HSSP III MTR confirms high immunization coverage with 100% coverage for measles and DTP-Hb 3 immunization coverage of 95% (facility report data), which are both over the HSSP III target of 85% for 2015. The HSSP III Analytical report states that for both DTP3 vaccination coverage Tanzania is performing well above the sub- regional group of nine countries since 2010. This is encouraging news.

4.6.2 Facility utilization

Figure 31: Trend of outpatients from 2008-2012



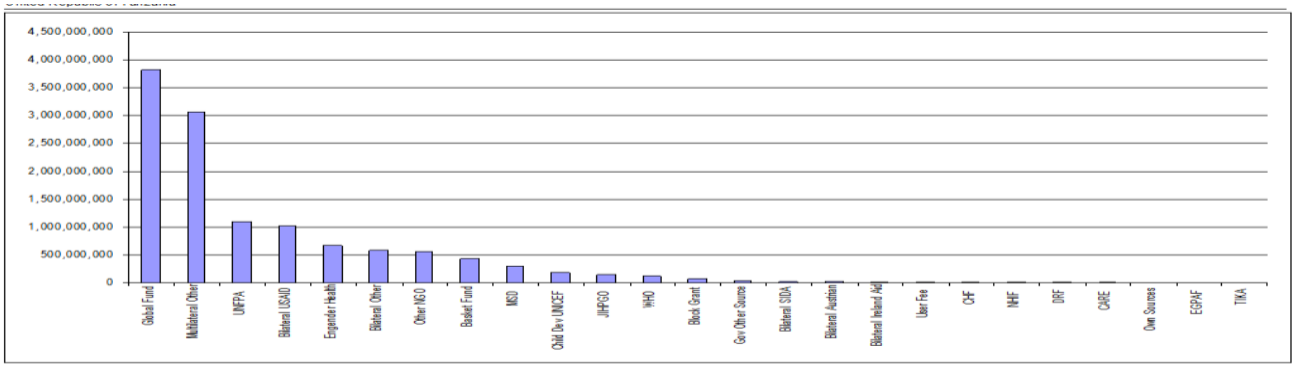
The figure above presents the trend on outpatients' visits for three years. In 2011/2013 most of the Councils did not manage to fill the tables available in the PlanRep3 database. However many District Councils have no capacity to fill the required data in the PlanRep database for their

Districts. At least this year 2013/2014 we demanded to see their CCHP to make sure the data has been filled. As a result the report of about 16,900,673 is approximately in-line with the data presented in the MTR report. This calls for the ministries to urgently address the issue of data management at District Council level and build up the capacity of the teams to be able to deliver reliable reports.

4.6.7 Selected areas of interest

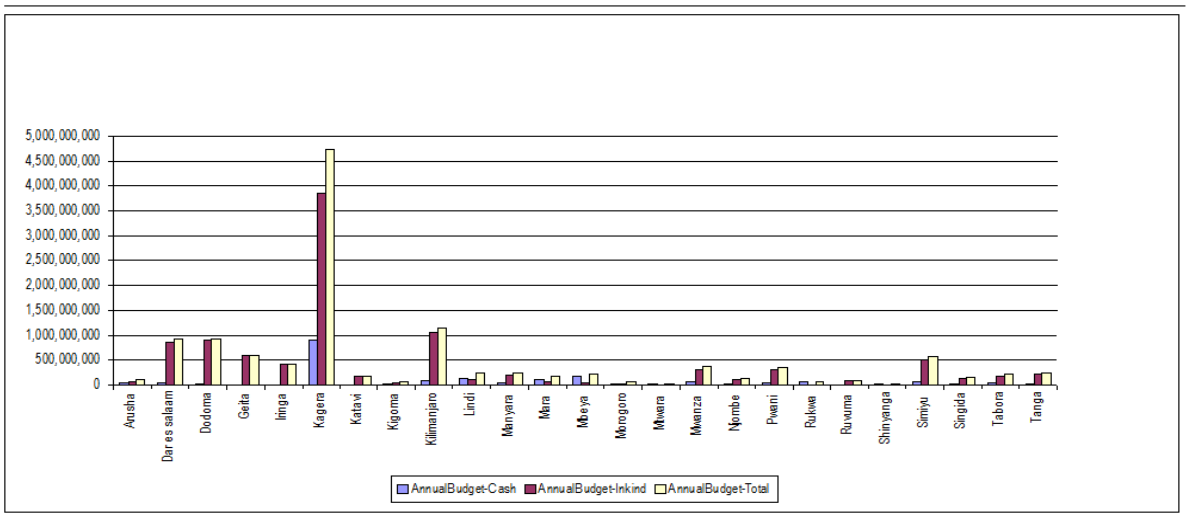
4.6.7.1. E.g. Family Planning

Figure 32: Family Planning Budget by source of fund, FY 2013-14



The figure above shows different funders supporting Family Planning services in the councils through the CCHP. The largest funder, according to this analysis, is Global funds followed by other multilaterals, and then UNFPA, USAID, Engenderhealth, Other NGOs, and Basket Funds. The resources under the Health Basket budget, Block Grant, User fees, NHIF include cash that is budgeted under the councils' account. Meanwhile, resources under Global Funds, UNFPA, USAID, multilateral others, and Engenderhealth are provided in terms of Family Planning Methods; these are accounted as in-kind and recorded outside of the Council accounts. Others, including Other NGOs and JHPIEGO include support in the form of sensitization/orientation workshops to health providers and community members. Also, the resources to the councils are provided as receipts in-kind, as they remain with the funders. Global funds, in most cases, are not supporting Family Planning Methods directly. This is due to Council Planning Teams not being familiar with what Global funds support. Therefore, when selecting funders outside the council budgets, Family Planning interventions were mistakenly linked to the Global Fund.

Figure 33 Family Planning Budget by region, FY 2013-14



The figure above indicates that all regions do consider Family Planning as one of the interventions in reducing maternal death and improving maternal health. What differs is how much they plan for this type of intervention. In addition, most of the Councils think that Family Planning support is only providing commodities for family Planning methods. For the figure above it shows that some councils have inadequate budget allocated for FP services. The activities for addressing family planning need to be unpacked and clearly indicated.

The budget/resources allocated are of two types: cash and in-kind contributions. Budgets in cash are directly under the council budget and the activities performed use cash for either sensitization or Family Planning methods, when not provided through in-kind contributions. The other budget allocated is through in-kind contributions, which are purely Family Planning methods/ commodities provided to the respective councils. In this case, also there is a problem with the Councils in selecting the appropriate funder for the relevant service support. Some have mixed those services supported by Global funds and Family planning through Others/multilateral/ bilateral funders.

4.6.7.2 P4P indicators

Figure 34 (i): P4P Indicator status by Region

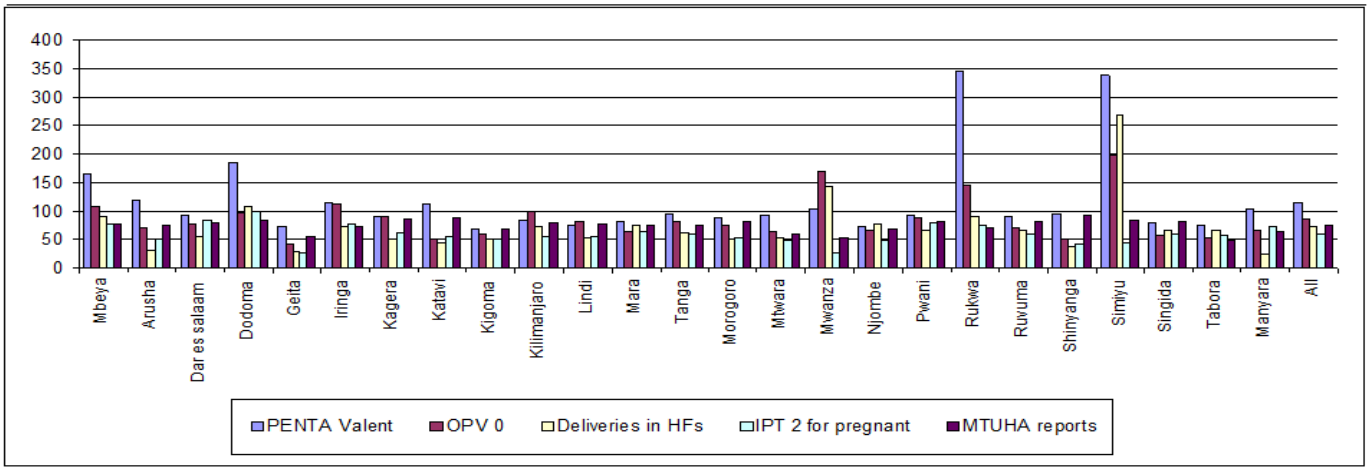


Figure 34 (ii): P4P Indicator status by Region

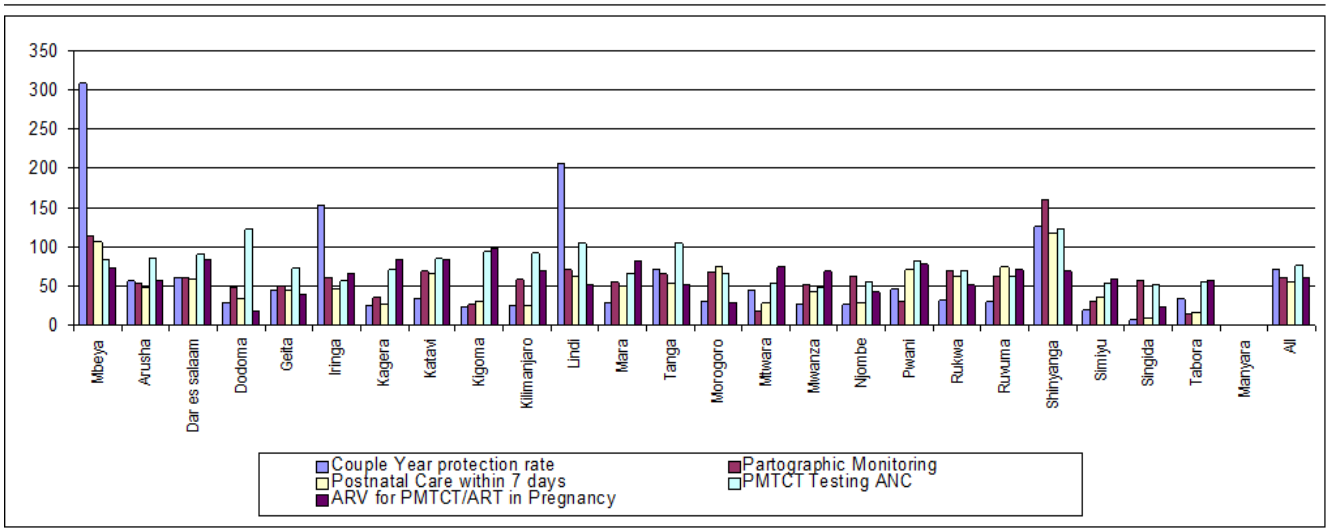
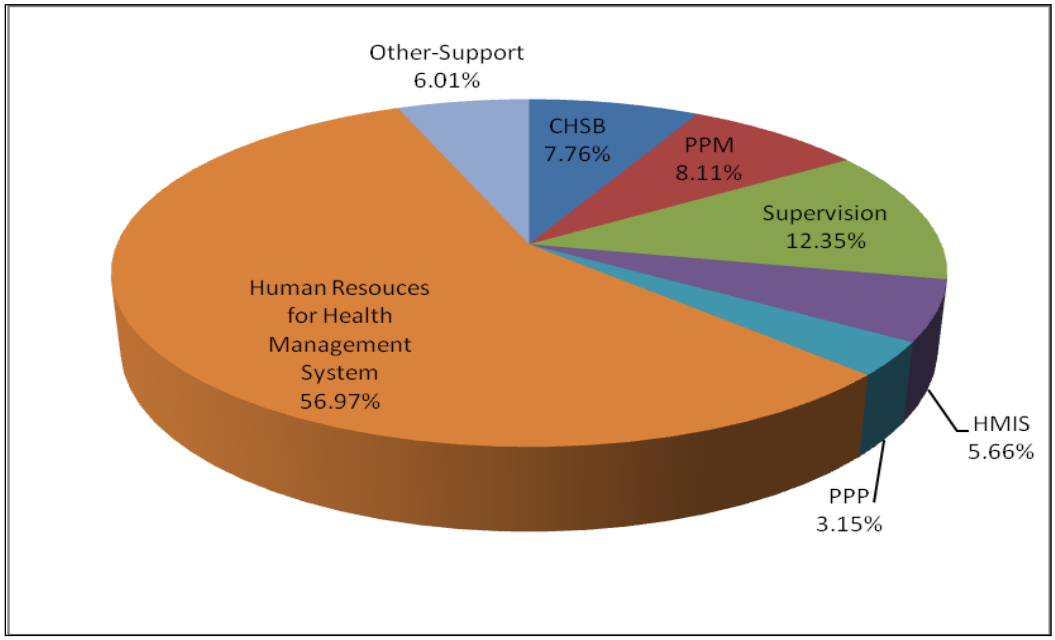


Figure 34 (i & ii) above shows the data for P4P in 2012 for the all regions. This shows that P4P is being implemented in all regions/ districts. P4P data are routinely being implemented by all Councils in the country, but lack principles for implementing P4P. The exception is the Pwani region, which has been used as a pilot,, in which data verification, monitoring and bonus awards and sensitization/training to health providers have been effected. There are nine indicators that are being implemented in the Pwani Region. However, all councils managed to fill the data in the tables that are available in PlanRep3, since these data are available in all councils for all health facilities that provide MNCH services. The problem is the accuracy and completeness of the data as long as there is no one who works on data verification and there is no incentive for data management within the councils.

4.6.7.3 Budgets for Governance (CHSB/HFGCs), supervision, PPM, HMIS oversight

Figure 35: Total Health Support Shares FY 2013-14



The figure above presents further analysis of fund allocation towards health support shares as indicated above; Human Resources for Health Management (56.97%), Supportive Supervision (12.35%) , Planned Preventive Maintenance (8.11%), governance - Council Health Service Boards (7.76%), Other support (6.01%) and Public Private Partnership (3.15%). ILS as among the support system has been integrated into the essential health interventions in this case.

5. Challenges

1) The planning exercise was very tasking to the Council planning teams as the PlanRep3 Micro was still under development. And the capacity of the Planning teams was not adequate in terms of planning skills.

2) New Councils plans were entered into the old council categories, which led the Councils to redo and use the new PlanRep3 update. CHMT/DMOs appointed to New Councils had no training on the revised CCHP Planning guidelines. As a result, they faced difficulties in using the tool.

3) Integration of PlanRep3 that incorporated new structure (New Regions, Councils, Wards & Villages) was released mid April 2013 that caused New council to enter CCHPs using the old councils Planrep3 Codes as the result councils re-entered the CCHPs in new PlanRep3.

4) The Old Councils had to prepare two CCHP plans for the old and new councils, resulting in new council plans that were replicas of the old ones. This led to a lot of capacity building and follow-up through communication by Emails/ phones etc.

5) Funds for 2012/2013 were disbursed very late to councils. This contributed to the CHMT teams being away for supervision and delays in responding to the comments that were forward to DMOs/DHS.

6) The knowledge gap within the RHMTs on CCHPs and PlanRep3 tools has resulted in poor quality of initial plans submitted by LGAs. RHMTs were not trained on micro Health PlanRep to support CHMTs, assessing and analyzing CCHPs using the Planrep3 tool. As a result, CCHPs were not analysed well. Therefore, they kept resending the plans after corrections with the same mistakes/ rejected activities. It is important for teams to be trained and able to plan and advise their managers appropriately

7) Most of the resources from National Programs have not been captured in the Planrep3 because data are not available to CHPT to be included in their plans (Malaria, NACP - ARVs, TB, EPI, FP commodities under GF). The result is that allocations measured against the BODs appear to be small.

8) Some other challenges were in the planning process included; activities were not addressing essential interventions, Targets were not addressing council identified health priority problems, priority problems were not formulated based on the data available on the situational analysis tables and as not indicating the magnitude of the problem, target were not addressing the objectives and not SMART and some had no measurable parameters, activities were linked to wrong activity inputs (GFS Codes). This appears to be a shortcoming in the planning process. This is because planning is a specialized skill especially when we are using electronic tools to generate the planning

and reporting function. We also need to have indicators of success and how best to show value for the money spent on the health service provision.

9) In some council, resource allocation and Burden of disease does not match and some activities were not addressing the interventions and health problems defined in the PlanRep3 as the result activities were linked to the wrong priority areas. It was also observed that HBF and HBG allocation were not in line with the ceilings and the concept of community initiatives activities is not adequately understood by CHMT's.

10) In some of the plans objectives were not linked to Performance Indicators available in the system and there were duplications of targets and activities within the same cost Centre under the same objective. Some of the targets were having more than 20 activities in the same cost Centre that cannot be implemented in one year. Also most council didn't allocate funds for MSD, medicines, equipment and supplies as per guidelines provided by the Ministry through PSU section.

11) There is shortage of skilled health workers in both the management teams and health services provision this is made worse by frequent changes; transfers of Health Managers, suspension, new staff employed who have never been exposed or trained on the planning skills specifically on developing the Comprehensive Councils Health plans. Most of the staff with skills to plan are over worked and are working for long hours to produce the results which we see today.

12) Other challenges included the unequal allocation of funds across Councils and Regions. However, also other sources outside the health basket fund need to be considered in order to improve allocation and service delivery especially in rural District Councils.

13) Some council failed to allocate resources addressing patient safety, environmental health and sanitation services in the health facilities. Most of the interventions were addressing environmental health and sanitation in the community, while their health facilities are dirt thus, becomes difficult to address the environmental health, hygiene and sanitation at the health facility level.

14) Inadequate capacity of the teams who prepares the plans even those of experience, Example, Ilala MC receives one of the highest shares of funds for health service implementation, making an insufficient plans much more of a critical concern than for those Councils which are new or receive smaller share. Also some council lacked DMOs, or had DMOs that were transferred during the scrutinization process. In these cases, most of the DMOs and District Health Secretaries were newly employed in the Councils.

15) The PlanRep3 System there is some problems that need to be rectified. It does not capture and reflect some of the reports/data differ and also the reporting part is not well covered.

6. Recommendations

- Develop Health PlanRep3 MESO for RHMT and conduct training for RHMT on PlanRep3 Health Meso and PlanRep3 Micro (Health) in order for the central level to receive more consolidated plans from RMHT/RS and reduce the timing and workload.

- Provide Capacity building for Central level (MOHSW and PMO-RALG) so that they are able to support RHMTs as well as CHMT during planning and report compilation.

- The Ministry in collaboration with PMORALG and UCC continue provide technical support as required on CCHP planning and Reporting (Physical & Financial) processes at District and Regional level.

- Continue Capacity building to the CHMT/CHPT on the use of the PlanRep3 Database for Planning and reporting and have short term training from the UCC to refresh their knowledge,

- PMO-RALG and MOF should make sure that Epicor 9.05 export expenditure back to PlanRep3 in order to capture the expenditure. This will enable the councils and central level to generate quarterly and annual physical and financial reports through PlanRep3 (PlanRep3 and EPICOR9.05 compliant).

- MOF and other Stakeholders should provide ceiling to LGAs early and any other information or instruction during or before starting planning period.

- The Ministry of Health and Social Welfare considers developing a web based PlanRep3 Health Meso and Macro to be used at RHMT and Ministry level. Including Export Expenditure from EPICOR to Planrep3 be ensured (mutual export and import of data).

- PlanRep3 is a planning and reporting tool, it uses information and data from HMIS/DHS, HRHIS and Lawson for developing their quality plan. For data quality and saving time it is recommended that these data base systems be linked together (PlanRep3, HMIS/DHS, HRHIS and Lawson and finally Epicor) for effective planning and reporting.

- Operationalize the planning template for the HCs and Dispensaries to involve Lower health facilities plans which captures community contribution that have to be included in their CCHP, to reflect community participation, involvement and ownership of the implementation of health services at their respective area.

- Councils to be directed to contribute a percentage of the budget from their collected Council Own sources revenues to support health services in their jurisdiction.

- DMOs/CHMTs to make sure the resources provided at Council level be included in the CCHPs as receipts in kinds from all sources including NGOs so that they do not destruct the plan.

- NGOs to provide tentative budget estimates or intervention/activities/ areas to be supported for a particular year, this distort the Councils already planned budget, when they present their support at the time when the CCHP is already completed/ approved. This should happen at the pre-planning meeting of the stakeholders.

- MOHSW in collaboration with PMORALG to compile on the suggestions for systems improvement from the LGAs and incorporate proposed suggestions to update PlanRep Micro (Health Sector), PlanRep Health Meso and PlanRep Health Macro.

Annexes

Annex 1

Summary of Assessment results for 2013-2014 CCHP

S/N	Council Name	Score Value v1	Round 1 Recommendation	Score Value v2	Round 2 Recommendation	Cumulative Status	Score Value v3	Round 3 Recommendation	Cumulative Status	Score Value v4	Round 4 Recommendation	Cumulative Status	Overall Score value	Overall Status
1	Iramba DC	77	Recommended	82	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	82	Recommended
2	Mafia DC	78	Recommended	82	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	82	Recommended
3	Magu DC	75	Recommended	81	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	81	Recommended
4	Bahi DC	65	Not Recommended	66	Not Recommended	Not Recommended	80	Recommended	Recommended		Not Assessed	Recommended	80	Recommended
5	Chamwino DC	68	Not Recommended	80	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	80	Recommended
6	Karatu DC	65	Not Recommended	80	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	80	Recommended
7	Meru DC	75	Recommended	80	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	80	Recommended
8	Mufindi DC	77	Recommended	80	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	80	Recommended
9	Bukoba DC	69	Not Recommended	79	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	79	Recommended
10	Busega DC	68	Not Recommended	79	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	79	Recommended
11	Igunga DC	60	Not Recommended	79	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	79	Recommended
12	Iringa MC	74	Recommended	79	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	79	Recommended
13	Mbulu DC	63	Not Recommended	79	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	79	Recommended
14	Meatu DC	65	Not Recommended	79	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	79	Recommended
15	Morogoro DC	58	Not Recommended	79	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	79	Recommended
16	Muleba DC	67	Not Recommended	79	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	79	Recommended
17	Tandahimba DC	60	Not Recommended	79	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	79	Recommended
18	Babati DC	72	Recommended	78	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	78	Recommended
19	Butiama DC	68	Not Recommended	78	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	78	Recommended
20	Chunya DC	59	Not Recommended	78	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	78	Recommended
21	Handeni DC	70	Recommended	71	Recommended	Recommended	78	Recommended	Recommended		Not Assessed	Recommended	78	Recommended
22	Manyoni DC	65	Not Recommended	78	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	78	Recommended
23	Misenyi DC	67	Not Recommended	78	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	78	Recommended
24	Mpanda DC	76	Recommended	78	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	78	Recommended
25	Newala DC	69	Not Recommended	78	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	78	Recommended
26	Rombo DC	68	Not Recommended	78	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	78	Recommended
27	Siha DC	75	Recommended	78	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	78	Recommended
28	Songea DC	54	Not Recommended	78	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	78	Recommended
29	Arusha CC	70	Recommended	73	Recommended	Recommended	77	Recommended	Recommended		Not Assessed	Recommended	77	Recommended
30	Bariadi DC	62	Not Recommended	77	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	77	Recommended

Summary of Assessment results for 2013-2014 CCHP

S/N	Council Name	Score Value v1	Round 1 Recommendation	Score Value v2	Round 2 Recommendation	Cumulative Status	Score Value v3	Round 3 Recommendation	Cumulative Status	Score Value v4	Round 4 Recommendation	Cumulative Status	Overall Score value	Overall Status
31	Bukoba MC	62	Not Recommended	77	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	77	Recommended
32	Gairo DC	44	Not Recommended	68	Not Recommended	Not Recommended	77	Recommended	Recommended		Not Assessed	Recommended	77	Recommended
33	Hai DC	68	Not Recommended	77	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	77	Recommended
34	Ileje DC	70	Recommended	77	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	77	Recommended
35	Kakonko DC	47	Not Recommended	70	Recommended	Recommended	77	Recommended	Recommended		Not Assessed	Recommended	77	Recommended
36	Kasulu DC	72	Recommended	77	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	77	Recommended
37	Korogwe DC	73	Recommended	77	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	77	Recommended
38	Ludewa DC	73	Recommended	77	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	77	Recommended
39	Maswa DC	63	Not Recommended	77	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	77	Recommended
40	Mkuranga DC	71	Recommended	76	Recommended	Recommended	77	Recommended	Recommended		Not Assessed	Recommended	77	Recommended
41	Mpwapwa DC	67	Not Recommended	77	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	77	Recommended
42	Musoma DC	69	Not Recommended	77	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	77	Recommended
43	Rorya DC	59	Not Recommended	64	Not Recommended	Not Recommended	69	Not Recommended	Not Recommended	77	Recommended	Recommended	77	Recommended
44	Sengerema DC	72	Recommended	77	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	77	Recommended
45	Singida MC	67	Not Recommended	69	Not Recommended	Not Recommended	77	Recommended	Recommended		Not Assessed	Recommended	77	Recommended
46	Songea MC	58	Not Recommended	60	Not Recommended	Not Recommended	77	Recommended	Recommended		Not Assessed	Recommended	77	Recommended
47	Sumbawanga MC	46	Not Recommended	67	Not Recommended	Not Recommended	70	Recommended	Recommended	77	Recommended	Recommended	77	Recommended
48	Tanga CC	65	Not Recommended	77	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	77	Recommended
49	Temeke MC	68	Not Recommended	77	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	77	Recommended
50	Ulanga DC	63	Not Recommended	77	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	77	Recommended
51	Arusha DC	71	Recommended	76	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	76	Recommended
52	Bukombe DC	74	Recommended	76	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	76	Recommended
53	Hanang DC	72	Recommended	76	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	76	Recommended
54	Ilala MC	55	Not Recommended	55	Not Recommended	Not Recommended	61	Not Recommended	Not Recommended	76	Recommended	Recommended	76	Recommended
55	Iringa DC	67	Not Recommended	76	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	76	Recommended
56	Kigoma DC	65	Not Recommended	70	Recommended	Recommended	76	Recommended	Recommended		Not Assessed	Recommended	76	Recommended
57	Kigoma/Ujiji MC	66	Not Recommended	70	Recommended	Recommended	76	Recommended	Recommended		Not Assessed	Recommended	76	Recommended
58	Kilombero DC	72	Recommended	76	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	76	Recommended
59	Kinondoni MC	61	Not Recommended	76	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	76	Recommended
60	Kisarawe DC	71	Recommended	76	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	76	Recommended
61	Kishapu DC	73	Recommended	76	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	76	Recommended
62	Kiteto DC	70	Recommended	76	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	76	Recommended
63	Kondoa DC	70	Recommended	70	Recommended	Recommended	76	Recommended	Recommended		Not Assessed	Recommended	76	Recommended
64	Kongwa	70	Recommended	70	Recommended	Recommend-	76	Recom-	Recommend-		Not Assessed	Recommend-	76	Recom-

Summary of Assessment results for 2013-2014 CCHP

S/N	Council Name	Score Value v1	Round 1 Recommendation	Score Value v2	Round 2 Recommendation	Cumulative Status	Score Value v3	Round 3 Recommendation	Cumulative Status	Score Value v4	Round 4 Recommendation	Cumulative Status	Overall Score value	Overall Status
	DC					ed		mended	ed			ed		mended
65	Kwimba DC	70	Recommended	76	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	76	Recommended
66	Kyela DC	68	Not Recommended	68	Not Recommended	Not Recommended	76	Recommended	Recommended		Not Assessed	Recommended	76	Recommended
67	Masasi DC	70	Recommended	70	Recommended	Recommended	76	Recommended	Recommended		Not Assessed	Recommended	76	Recommended
68	Mkinga DC	64	Not Recommended	64	Not Recommended	Not Recommended	76	Recommended	Recommended		Not Assessed	Recommended	76	Recommended
69	Monduli DC	68	Not Recommended	70	Recommended	Recommended	76	Recommended	Recommended		Not Assessed	Recommended	76	Recommended
70	Msalala DC	73	Recommended	76	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	76	Recommended
71	Musoma MC	56	Not Recommended	70	Recommended	Recommended	76	Recommended	Recommended		Not Assessed	Recommended	76	Recommended
72	Nanyumbu DC	71	Recommended	70	Recommended	Recommended	76	Recommended	Recommended		Not Assessed	Recommended	76	Recommended
73	Nkasi DC	48	Not Recommended	58	Not Recommended	Not Recommended	76	Recommended	Recommended		Not Assessed	Recommended	76	Recommended
74	Nyasa DC	48	Not Recommended	63	Not Recommended	Not Recommended	76	Recommended	Recommended		Not Assessed	Recommended	76	Recommended
75	Rungwe DC	70	Recommended	61	Not Recommended	Not Recommended	76	Recommended	Recommended		Not Assessed	Recommended	76	Recommended
76	Same DC	70	Recommended	76	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	76	Recommended
77	Sikonge DC	57	Not Recommended	64	Not Recommended	Not Recommended	76	Recommended	Recommended		Not Assessed	Recommended	76	Recommended
78	Simanjiro DC	71	Recommended	76	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	76	Recommended
79	Sumbawanga DC	48	Not Recommended	76	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	76	Recommended
80	Tabora MC	59	Not Recommended	76	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	76	Recommended
81	Tunduru DC	63	Not Recommended	63	Not Recommended	Not Recommended	63	Not Recommended	Not Recommended	76	Recommended	Recommended	76	Recommended
82	Uvinza DC	66	Not Recommended	76	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	76	Recommended
83	Dodoma MC	65	Not Recommended	75	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	75	Recommended
84	Geita TC	70	Recommended	70	Recommended	Recommended	75	Recommended	Recommended		Not Assessed	Recommended	75	Recommended
85	Kalambo DC	46	Not Recommended	53	Not Recommended	Not Recommended	75	Recommended	Recommended		Not Assessed	Recommended	75	Recommended
86	Kibaha TC	58	Not Recommended	75	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	75	Recommended
87	Kilindi DC	59	Not Recommended	75	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	75	Recommended
88	Kilosa DC	57	Not Recommended	59	Not Recommended	Not Recommended	75	Recommended	Recommended		Not Assessed	Recommended	75	Recommended
89	Kilwa DC	60	Not Recommended	75	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	75	Recommended
90	Korogwe TC	38	Not Recommended	46	Not Recommended	Not Recommended	75	Recommended	Recommended		Not Assessed	Recommended	75	Recommended
91	Masasi TC	57	Not Recommended	75	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	75	Recommended
92	Mbarali DC	65	Not Recommended	71	Recommended	Recommended	75	Recommended	Recommended		Not Assessed	Recommended	75	Recommended
93	Mbeya CC	73	Recommended	75	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	75	Recommended
94	Mlele DC	52	Not Recommended	75	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	75	Recommended
95	Moshi MC	67	Not Recommended	70	Recommended	Recommended	75	Recommended	Recommended		Not Assessed	Recommended	75	Recommended
96	Mtwara DC	73	Recommended	75	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	75	Recommended
97	Muheza DC	66	Not Recommended	71	Recommended	Recommended	75	Recommended	Recommended		Not Assessed	Recommended	75	Recommended

Summary of Assessment results for 2013-2014 CCHP

S/N	Council Name	Score Value v1	Round 1 Recommendation	Score Value v2	Round 2 Recommendation	Cumulative Status	Score Value v3	Round 3 Recommendation	Cumulative Status	Score Value v4	Round 4 Recommendation	Cumulative Status	Overall Score value	Overall Status
98	Mwanga DC	71	Recommended	75	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	75	Recommended
99	Mwanza CC	71	Recommended	75	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	75	Recommended
100	Nachingwea DC	63	Not Recommended	70	Recommended	Recommended	75	Recommended	Recommended		Not Assessed	Recommended	75	Recommended
101	Njombe DC	68	Not Recommended	75	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	75	Recommended
102	Serengeti DC	70	Recommended	75	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	75	Recommended
103	Ushetu DC	71	Recommended	75	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	75	Recommended
104	Bagamoyo DC	64	Not Recommended	74	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	74	Recommended
105	Bumbuli DC	68	Not Recommended	74	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	74	Recommended
106	Busokelo DC	62	Not Recommended	62	Not Recommended	Not Recommended	74	Recommended	Recommended		Not Assessed	Recommended	74	Recommended
107	Chato DC	74	Recommended	74	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	74	Recommended
108	Ilemela MC	63	Not Recommended	72	Recommended	Recommended	74	Recommended	Recommended		Not Assessed	Recommended	74	Recommended
109	Kahama TC	65	Not Recommended	71	Recommended	Recommended	74	Recommended	Recommended		Not Assessed	Recommended	74	Recommended
110	Kaliua DC	58	Not Recommended	74	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	74	Recommended
111	Karagwe DC	68	Not Recommended	74	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	74	Recommended
112	Kibaha DC	49	Not Recommended	70	Recommended	Recommended	74	Recommended	Recommended		Not Assessed	Recommended	74	Recommended
113	Kyerwa DC	69	Not Recommended	74	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	74	Recommended
114	Liwale DC	64	Not Recommended	74	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	74	Recommended
115	Mbogwe DC	72	Recommended	74	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	74	Recommended
116	Misungwi DC	63	Not Recommended	67	Not Recommended	Not Recommended	71	Recommended	Recommended	74	Recommended	Recommended	74	Recommended
117	Mkalama DC	60	Not Recommended	74	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	74	Recommended
118	Mpanda TC	67	Not Recommended	74	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	74	Recommended
119	Mvomero DC	69	Not Recommended	74	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	74	Recommended
120	Ngara DC	74	Recommended	74	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	74	Recommended
121	Njombe TC	72	Recommended	74	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	74	Recommended
122	Nzega DC	70	Recommended	74	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	74	Recommended
123	Singida DC	61	Not Recommended	70	Recommended	Recommended	74	Recommended	Recommended		Not Assessed	Recommended	74	Recommended
124	Bariadi TC	64	Not Recommended	73	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	73	Recommended
125	Geita DC	51	Not Recommended	73	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	73	Recommended
126	Kibondo DC	53	Not Recommended	63	Not Recommended	Not Recommended	73	Recommended	Recommended		Not Assessed	Recommended	73	Recommended
127	Lushoto DC	68	Not Recommended	73	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	73	Recommended
128	Mbinga DC	48	Not Recommended	63	Not Recommended	Not Recommended	73	Recommended	Recommended		Not Assessed	Recommended	73	Recommended
129	Momba DC	56	Not Recommended	73	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	73	Recommended
130	Morogoro MC	60	Not Recommended	73	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	73	Recommended
131	Ngorongor	70	Recommended	73	Recommended	Recommend-		Not As-	Recommend-		Not Assessed	Recommend-	73	Recom-

Summary of Assessment results for 2013-2014 CCHP

S/N	Council Name	Score Value v1	Round 1 Recommendation	Score Value v2	Round 2 Recommendation	Cumulative Status	Score Value v3	Round 3 Recommendation	Cumulative Status	Score Value v4	Round 4 Recommendation	Cumulative Status	Overall Score value	Overall Status
	o DC					ed		sessed	ed			ed		mended
132	Rufiji DC	72	Recommended	73	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	73	Recommended
133	Shinyanga DC	56	Not Recommended	73	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	73	Recommended
134	Shinyanga MC	67	Not Recommended	73	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	73	Recommended
135	Biharamulo DC	71	Recommended	72	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	72	Recommended
136	Ikungi DC	65	Not Recommended	72	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	72	Recommended
137	Itilima DC	59	Not Recommended	72	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	72	Recommended
138	Kilolo DC	65	Not Recommended	72	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	72	Recommended
139	Lindi MC	49	Not Recommended	70	Recommended	Recommended	72	Recommended	Recommended		Not Assessed	Recommended	72	Recommended
140	Makambako TC	60	Not Recommended	72	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	72	Recommended
141	Makete DC	66	Not Recommended	72	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	72	Recommended
142	Moshi DC	54	Not Recommended	72	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	72	Recommended
143	Namtumbo DC	65	Not Recommended	58	Not Recommended	Not Recommended	72	Recommended	Recommended		Not Assessed	Recommended	72	Recommended
144	Ruangwa DC	59	Not Recommended	67	Not Recommended	Not Recommended	72	Recommended	Recommended		Not Assessed	Recommended	72	Recommended
145	Tarime DC	65	Not Recommended	72	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	72	Recommended
146	Tarime TC	50	Not Recommended	72	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	72	Recommended
147	Ukerewe DC	66	Not Recommended	72	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	72	Recommended
148	Buhigwe DC	56	Not Recommended	71	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	71	Recommended
149	Bunda DC	67	Not Recommended	71	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	71	Recommended
150	Chemba DC	63	Not Recommended	71	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	71	Recommended
151	Lindi DC	60	Not Recommended	71	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	71	Recommended
152	Longido DC	63	Not Recommended	71	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	71	Recommended
153	Mbeya DC	70	Recommended	71	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	71	Recommended
154	Mbozi DC	58	Not Recommended	71	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	71	Recommended
155	Mtwara MC	60	Not Recommended	71	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	71	Recommended
156	Nsimbo DC	55	Not Recommended	70	Recommended	Recommended	71	Recommended	Recommended		Not Assessed	Recommended	71	Recommended
157	Nyang'hwale DC	55	Not Recommended	71	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	71	Recommended
158	Tabora DC	72	Recommended	71	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	71	Recommended
159	Urambo DC	68	Not Recommended	71	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended	71	Recommended
160	Babati TC	62	Not Recommended	64	Not Recommended	Not Recommended	66	Not Recommended	Not Recommended	70	Recommended	Recommended	70	Recommended
161	Pangani DC	62	Not Recommended	75	Recommended	Recommended		Not Assessed	Recommended		Not Assessed	Recommended		Recommended

Annex 2

SOURCES OF FUNDS FOR FUNDING CCHP FOR THE FINANCIAL YEAR 2013/14

S/N	Group Name	Source Sub Category	Amount	Percentage share
1	Local Government Block Grants	PE	343,922,956,028.00	42.4
		OC	33,984,277,749.00	4.2
2	Council Health Basket Grant		87,854,000,000.00	10.8
3	HSDG/MMAM		16,712,569,609.00	2.1
4	Receipt in kind		44,316,541,658.00	5.5
5	Council Own Resources	PE	0.00	0
		OC	3,993,530,160.00	0.5
		Dev	3,617,618,910.00	0.4
6	LGDG		29,479,230,242.00	3.6
7	Cost Sharing and Insurance Funds	User Fees/DRF	11,948,434,523.00	1.5
		NHIF	6,597,313,382.00	0.8
		CHF/TIKA	10,305,419,756.00	1.3
8	Global Fund		92,671,058,511.00	11.4
9	Community Contribution		571,655,477.00	0.1
10	Other		124,561,552,285.00	15.4
	Total		**810,536,158,290.00**	

Annex 3

Annual budget per council cash and in kind 2013/14

Annual budget per council cash and in kind 2013/14				
S/N	**Council Name**	**Annual Budget Cash**	**Annual Budget In Kind**	**Annual Budget**
1	Kongwa DC	4,309,581,176.00	26,327,545,857.00	30,637,127,033.00
2	Kinondoni MC	22,110,883,572.00	7,175,800,000.00	29,286,683,572.00
3	Bukoba DC	3,568,194,049.00	22,184,027,598.00	25,752,221,647.00
4	Temeke MC	17,986,290,813.00	7,145,083,692.00	25,131,374,505.00
5	Ilala MC	15,980,119,567.00	1,383,112,490.00	17,363,232,057.00
6	Bukoba MC	2,060,711,762.00	9,697,505,082.00	11,758,216,844.00
7	Maswa DC	8,656,744,921.00	425,867,408.00	9,082,612,329.00
8	Kilombero DC	5,498,616,101.00	3,449,379,000.00	8,947,995,101.00
9	Muleba DC	8,557,560,186.00	350,000,000.00	8,907,560,186.00
10	Magu DC	6,471,606,451.00	1,990,356,811.00	8,461,963,262.00
11	Sengerema DC	7,964,304,265.00	490,600,000.00	8,454,904,265.00
12	Karagwe DC	3,787,812,766.00	4,434,444,717.00	8,222,257,483.00
13	Tanga CC	5,288,157,700.00	2,784,111,415.00	8,072,269,115.00
14	Chato DC	3,180,250,700.00	4,646,039,882.00	7,826,290,582.00
15	Mbinga DC	6,535,661,000.00	1,240,969,556.00	7,776,630,556.00
16	Igunga DC	6,915,355,092.00	854,242,292.00	7,769,597,384.00
17	Iringa DC	4,370,612,629.00	3,328,435,041.00	7,699,047,670.00

Annual budget per council cash and in kind 2013/14				
S/N	**Council Name**	**Annual Budget Cash**	**Annual Budget In Kind**	**Annual Budget**
18	Meru DC	4,829,453,791.00	2,813,796,747.00	7,643,250,538.00
19	Bariadi DC	6,771,390,067.00	230,781,348.00	7,002,171,415.00
20	Dodoma MC	5,968,527,263.00	866,211,712.00	6,834,738,975.00
21	Mbozi DC	6,234,325,393.00	539,706,727.00	6,774,032,120.00
22	Bagamoyo DC	6,186,368,180.00	581,575,070.00	6,767,943,250.00
23	Kilosa DC	6,236,160,238.00	512,406,176.00	6,748,566,414.00
24	Kasulu DC	6,052,789,101.00	627,394,544.00	6,680,183,645.00
25	Ulanga DC	4,385,069,303.00	2,210,256,303.00	6,595,325,606.00
26	Kwimba DC	4,937,226,700.00	1,591,409,371.00	6,528,636,071.00
27	Geita DC	5,427,772,554.00	1,015,890,123.00	6,443,662,677.00
28	Nyasa DC	5,524,816,680.00	901,904,173.00	6,426,720,853.00
29	Arusha CC	5,925,076,949.00	481,882,708.00	6,406,959,657.00
30	Meatu DC	3,677,511,712.00	2,652,616,221.00	6,330,127,933.00
31	Mvomero DC	5,466,474,095.00	637,564,209.00	6,104,038,304.00
32	Tunduru DC	4,389,254,464.00	1,643,265,904.00	6,032,520,368.00
33	Ilemela MC	5,997,829,837.00	0.00	5,997,829,837.00
34	Moshi DC	5,068,717,300.00	926,200,569.00	5,994,917,869.00
35	Kibaha DC	3,616,359,850.00	2,373,971,520.00	5,990,331,370.00
36	Mbeya DC	5,659,958,553.00	210,251,447.00	5,870,210,000.00
37	Mufindi DC	5,503,968,471.00	354,490,613.00	5,858,459,084.00
38	Ngara DC	4,845,774,800.00	969,178,465.00	5,814,953,265.00
39	Babati DC	4,481,255,659.00	1,322,687,914.00	5,803,943,573.00
40	Busega DC	3,820,608,677.00	1,972,721,568.00	5,793,330,245.00
41	Misungwi DC	5,205,007,520.00	554,487,064.00	5,759,494,584.00
42	Chamwino DC	4,168,308,600.00	1,499,290,350.00	5,667,598,950.00
43	Mwanza CC	5,382,069,777.00	200,200,397.00	5,582,270,174.00
44	Rungwe DC	5,231,810,939.00	329,632,999.00	5,561,443,938.00
45	Ukerewe DC	5,039,541,772.00	417,962,637.00	5,457,504,409.00
46	Bahi DC	2,942,323,999.00	2,511,650,000.00	5,453,973,999.00
47	Mbulu DC	4,985,590,955.00	382,493,989.00	5,368,084,944.00
48	Rufiji DC	4,579,717,041.00	706,598,847.00	5,286,315,888.00
49	Singida DC	3,778,065,960.00	1,492,342,052.00	5,270,408,012.00
50	Hai DC	4,125,297,628.00	1,139,647,183.00	5,264,944,811.00
51	Bunda DC	4,378,074,300.00	860,467,024.00	5,238,541,324.00
52	Mkuranga DC	4,096,883,464.00	1,122,852,354.00	5,219,735,818.00
53	Hanang DC	3,539,574,602.00	1,672,513,970.00	5,212,088,572.00
54	Mbeya CC	4,956,668,575.00	221,400,000.00	5,178,068,575.00
55	Mpwapwa DC	4,004,495,178.00	1,169,615,552.00	5,174,110,730.00
56	Same DC	4,330,676,780.00	824,906,944.00	5,155,583,724.00

Annual budget per council cash and in kind 2013/14				
S/N	**Council Name**	**Annual Budget Cash**	**Annual Budget In Kind**	**Annual Budget**
57	Sumbawanga DC	4,723,529,766.00	342,175,000.00	5,065,704,766.00
58	Kondoa DC	4,233,007,511.00	756,128,791.00	4,989,136,302.00
59	Kiteto DC	2,915,034,164.00	2,068,085,423.00	4,983,119,587.00
60	Korogwe DC	4,614,582,507.00	367,461,851.00	4,982,044,358.00
61	Tabora MC	4,740,450,500.00	193,500,000.00	4,933,950,500.00
62	Njombe TC	4,647,000,554.00	255,817,745.00	4,902,818,299.00
63	Mpanda DC	3,776,181,150.00	1,123,800,300.00	4,899,981,450.00
64	Njombe DC	4,580,186,758.00	278,600,000.00	4,858,786,758.00
65	Itilima DC	2,028,319,800.00	2,818,447,217.00	4,846,767,017.00
66	Manyoni DC	4,352,702,835.00	468,099,742.00	4,820,802,577.00
67	Busokelo DC	4,648,496,557.00	160,668,085.00	4,809,164,642.00
68	Morogoro MC	4,526,178,700.00	194,700,000.00	4,720,878,700.00
69	Nzega DC	4,224,275,879.00	487,734,000.00	4,712,009,879.00
70	Bariadi TC	3,117,996,984.00	1,560,707,071.00	4,678,704,055.00
71	Misenyi DC	3,231,740,900.00	1,441,629,713.00	4,673,370,613.00
72	Iringa MC	3,127,087,694.00	1,516,355,604.00	4,643,443,298.00
73	Bukombe DC	3,971,933,883.00	623,540,734.00	4,595,474,617.00
74	Newala DC	4,518,533,427.00	0.00	4,518,533,427.00
75	Kyela DC	4,271,655,110.00	225,493,257.00	4,497,148,367.00
76	Rombo DC	4,270,837,353.00	226,068,513.00	4,496,905,866.00
77	Morogoro DC	4,192,881,000.00	241,900,000.00	4,434,781,000.00
78	Lindi DC	3,687,315,584.00	732,569,217.00	4,419,884,801.00
79	Handeni DC	4,319,155,924.00	0.00	4,319,155,924.00
80	Kalambo DC	4,306,038,104.00	0.00	4,306,038,104.00
81	Mwanga DC	4,018,327,000.00	284,475,956.00	4,302,802,956.00
82	Kilwa DC	4,236,557,308.00	0.00	4,236,557,308.00
83	Mbarali DC	3,901,610,100.00	301,027,488.00	4,202,637,588.00
84	Ludewa DC	3,990,591,580.00	170,170,427.00	4,160,762,007.00
85	Kyerwa DC	1,868,091,173.00	2,291,502,790.00	4,159,593,963.00
86	Nachingwea DC	3,971,428,212.00	164,200,000.00	4,135,628,212.00
87	Urambo DC	3,805,999,713.00	252,550,389.00	4,058,550,102.00
88	Nanyumbu DC	3,925,560,550.00	119,700,000.00	4,045,260,550.00
89	Moshi MC	3,946,907,243.00	76,230,667.00	4,023,137,910.00
90	Mtwara DC	3,767,047,530.00	193,600,001.00	3,960,647,531.00
91	Serengeti DC	3,219,469,900.00	726,009,465.00	3,945,479,365.00
92	Monduli DC	3,757,358,864.00	186,536,690.00	3,943,895,554.00
93	Kibondo DC	3,337,805,110.00	582,265,893.00	3,920,071,003.00
94	Tarime DC	3,686,830,080.00	220,447,400.00	3,907,277,480.00
95	Siha DC	2,081,822,800.00	1,795,831,348.00	3,877,654,148.00

Annual budget per council cash and in kind 2013/14				
S/N	**Council Name**	**Annual Budget Cash**	**Annual Budget In Kind**	**Annual Budget**
96	Lushoto DC	2,678,224,000.00	1,114,931,236.00	3,793,155,236.00
97	Arusha DC	3,260,100,000.00	514,869,647.00	3,774,969,647.00
98	Kisarawe DC	3,745,914,808.00	0.00	3,745,914,808.00
99	Kishapu DC	2,619,887,100.00	1,104,005,193.00	3,723,892,293.00
100	Makete DC	3,710,218,753.00	0.00	3,710,218,753.00
101	Shinyanga DC	3,416,468,400.00	267,253,440.00	3,683,721,840.00
102	Namtumbo DC	3,438,039,761.00	222,170,429.00	3,660,210,190.00
103	Karatu DC	3,473,728,092.00	171,100,002.00	3,644,828,094.00
104	Iramba DC	3,281,653,097.00	348,507,422.00	3,630,160,519.00
105	Kigoma/Ujiji MC	2,121,005,700.00	1,492,582,200.00	3,613,587,900.00
106	Mkinga DC	1,803,616,252.00	1,793,535,500.00	3,597,151,752.00
107	Uvinza DC	3,187,113,663.00	268,134,000.00	3,455,247,663.00
108	Chemba DC	2,822,075,172.00	612,275,400.00	3,434,350,572.00
109	Masasi TC	3,227,253,200.00	200,108,693.00	3,427,361,893.00
110	Songea DC	3,012,163,700.00	395,400,000.00	3,407,563,700.00
111	Buhigwe DC	3,183,198,940.00	149,093,160.00	3,332,292,100.00
112	Tandahimba DC	3,023,398,005.00	265,977,913.00	3,289,375,918.00
113	Ikungi DC	2,937,543,193.00	346,768,000.00	3,284,311,193.00
114	Nkasi DC	3,000,256,316.00	190,400,000.00	3,190,656,316.00
115	Chunya DC	2,934,148,818.00	224,898,712.00	3,159,047,530.00
116	Mbogwe DC	2,474,133,964.00	651,034,600.00	3,125,168,564.00
117	Biharamulo DC	2,473,774,300.00	631,908,483.00	3,105,682,783.00
118	Songea MC	2,956,566,586.00	116,100,000.00	3,072,666,586.00
119	Kilolo DC	2,741,586,000.00	283,422,704.00	3,025,008,704.00
120	Tabora DC	2,603,576,850.00	399,299,900.00	3,002,876,750.00
121	Muheza DC	2,772,179,000.00	167,781,623.00	2,939,960,623.00
122	Ileje DC	2,755,729,400.00	150,470,432.00	2,906,199,832.00
123	Rorya DC	2,673,001,820.00	211,400,000.00	2,884,401,820.00
124	Shinyanga MC	2,862,668,574.00	0.00	2,862,668,574.00
125	Mafia DC	1,511,471,456.00	1,313,644,241.00	2,825,115,697.00
126	Sikonge DC	2,445,311,421.00	302,987,277.00	2,748,298,698.00
127	Simanjiro DC	1,986,731,100.00	737,101,279.00	2,723,832,379.00
128	Ngorongoro DC	2,690,107,100.00	0.00	2,690,107,100.00
129	Ruangwa DC	2,471,402,351.00	203,383,912.00	2,674,786,263.00
130	Kigoma DC	2,655,356,214.00	0.00	2,655,356,214.00
131	Butiama DC	2,332,838,177.00	274,676,091.00	2,607,514,268.00
132	Babati TC	2,553,979,448.00	0.00	2,553,979,448.00
133	Makambako TC	1,755,433,054.00	766,229,182.00	2,521,662,236.00
134	Musoma DC	2,354,097,328.00	142,368,600.00	2,496,465,928.00

Annual budget per council cash and in kind 2013/14				
S/N	**Council Name**	**Annual Budget Cash**	**Annual Budget In Kind**	**Annual Budget**
135	Tarime TC	2,374,926,879.00	117,694,000.00	2,492,620,879.00
136	Gairo DC	2,239,375,613.00	219,767,684.00	2,459,143,297.00
137	Singida MC	2,043,778,417.00	390,827,074.00	2,434,605,491.00
138	Kibaha TC	2,374,748,353.00	40,482,500.00	2,415,230,853.00
139	Masasi DC	2,096,965,341.00	295,814,800.00	2,392,780,141.00
140	Kakonko DC	2,027,827,100.00	284,458,113.00	2,312,285,213.00
141	Pangani DC	2,184,066,100.00	102,574,929.00	2,286,641,029.00
142	Sumbawanga MC	2,121,308,162.00	128,600,000.00	2,249,908,162.00
143	Mkalama DC	2,030,055,054.00	172,371,400.00	2,202,426,454.00
144	Liwale DC	1,754,552,192.00	444,834,829.00	2,199,387,021.00
145	Musoma MC	1,854,172,099.00	102,400,000.00	1,956,572,099.00
146	Geita TC	1,590,411,055.00	341,944,400.00	1,932,355,455.00
147	Mtwara MC	1,804,951,100.00	88,536,250.00	1,893,487,350.00
148	Mlele DC	756,046,200.00	1,105,882,313.00	1,861,928,513.00
149	Kilindi DC	1,659,653,700.00	194,399,800.00	1,854,053,500.00
150	Msalala DC	1,254,360,500.00	454,410,003.00	1,708,770,503.00
151	Longido DC	1,527,701,500.00	142,412,750.00	1,670,114,250.00
152	Kaliua DC	1,441,857,616.00	209,109,616.00	1,650,967,232.00
153	Kahama TC	1,257,583,750.00	371,912,968.00	1,629,496,718.00
154	Nsimbo DC	747,391,700.00	782,007,000.00	1,529,398,700.00
155	Ushetu DC	1,225,843,206.00	277,782,727.00	1,503,625,933.00
156	Lindi MC	1,361,286,574.00	44,612,500.00	1,405,899,074.00
157	Bumbuli DC	735,420,000.00	424,109,578.00	1,159,529,578.00
158	Korogwe TC	1,064,932,150.00	45,759,811.00	1,110,691,961.00
159	Nyang'hwale DC	788,372,768.00	207,303,085.00	995,675,853.00
160	Mpanda TC	670,711,000.00	258,548,693.00	929,259,693.00
161	Momba DC	781,159,763.00	106,807,500.00	887,967,263.00
	Total	**625,249,198,289.00**	**185,286,960,006.00**	**810,536,158,295.00**

Annex 4

	TOTAL BUDGET SHARE BY REGION 2013/2014			
S/N	**Region Name**	**Annual Budget Cash**	**Annual Budget In-Kind**	**Sum Annual Budget**
1	Kagera	30,393,659,936.00	42,000,196,848.00	72,393,856,784.00
2	Dar es salaam	56,077,293,952.00	15,703,996,182.00	71,781,290,134.00
3	Dodoma	28,448,318,898.00	33,742,717,662.00	62,191,036,560.00
4	Mwanza	40,997,586,321.00	5,245,016,279.00	46,242,602,601.00
5	Mbeya	41,375,563,208.00	2,470,356,647.00	43,845,919,855.00
6	Morogoro	32,544,755,051.00	7,465,973,372.00	40,010,728,423.00
7	Simiyu	28,072,572,161.00	9,661,140,833.00	37,733,712,995.00
8	Tanga	27,119,987,334.00	6,994,665,742.00	34,114,653,076.00
9	Kilimanjaro	27,842,586,104.00	5,273,361,180.00	33,115,947,284.00
10	Pwani	26,111,463,150.00	6,139,124,531.00	32,250,587,681.00
11	Ruvuma	25,856,502,192.00	4,519,810,062.00	30,376,312,254.00
12	Arusha	25,463,526,296.00	4,310,598,544.00	29,774,124,840.00
13	Tabora	26,176,827,070.00	2,699,423,473.00	28,876,250,543.00
14	Manyara	20,462,165,929.00	6,182,882,575.00	26,645,048,504.00
15	Kigoma	22,565,095,828.00	3,403,927,910.00	25,969,023,738.00
16	Mara	22,873,410,583.00	2,655,462,580.00	25,528,873,162.00
17	Geita	17,432,874,924.00	7,485,752,824.00	24,918,627,748.00
18	Mtwara	22,363,709,152.00	1,163,737,657.00	23,527,446,809.00
19	Singida	18,423,798,556.00	3,218,915,690.00	21,642,714,246.00
20	Iringa	15,743,254,794.00	5,482,703,962.00	21,225,958,756.00
21	Njombe	18,683,430,698.00	1,470,817,355.00	20,154,248,053.00
22	Lindi	17,482,542,221.00	1,589,600,458.00	19,072,142,679.00
23	Shinyanga	12,636,811,529.00	2,475,364,331.00	15,112,175,860.00
24	Rukwa	14,151,132,348.00	661,175,000.00	14,812,307,348.00
25	Katavi	5,950,330,050.00	3,270,238,306.00	9,220,568,356.00
	Total	**625,249,198,285.00**	**185,286,960,003.00**	**810,536,158,289.00**

Annex 5

SUMMARY OF APPROVED BUDGET PER PRIROITY AREAS 2013-2014

S/N	Description Priority	Total Amount	Percent Allo-cation
1	Medicines, medical equipment, medical and diagnostic supplies management system	90,924,225,241.00	11.22
2	Maternal, Newborn and Child Health	468,860,191,016.00	57.85
3	Communicable Disease Control	85,010,371,879.00	10.49
4	Non – Communicable Disease Control	8,385,708,429.00	1.03
5	Treatment and care of other common diseases of local priority within the Council	4,950,580,598.00	0.61
6	Environmental Health and Sanitation	7,531,778,396.00	0.93
7	Strengthening Social Welfare and Social Protection Service	2,605,432,055.00	0.32
8	Strengthen Human Resources for Health Management Capacity for improved health services delivery	27,986,914,456.00	3.45
9	Strengthen Organizational Structures and institutional manage-ment at all levels	51,103,267,081.00	6.30
10	Emergency preparedness and response	2,807,420,208.00	0.35
11	Health Promotion	1,652,327,951.00	0.20
12	Traditional Medicine and alternative healing	279,045,339.00	0.03
13	Construction, rehabilitation and Planned Preventive Maintenance of physical Infrastructures of Health facilities	58,437,956,072.00	7.21
	Total	***810,535,218,721.00***	***99.99***

Annex 6

PLANNED BUDGET FOR REHABILITATION AND CONSTRUCTION UNDER MMAM BY REGION 2013/2014							
S/N	**Region**	**No of HFs**	**Construction**	**Rehabilitation**	**Equipment**	**Staff Houses**	**Total**
1	Geita	53	920,172,184.00	146,734,092.00	17,000,000.00	755,900,316.00	1,839,806,592.00
2	Mwanza	65	1,202,490,000.00	268,238,000.00	51,838,750.00	279,150,000.00	1,801,716,750.00
3	Singida	40	1,591,790,296.00	30,000,000.00	15,000,000.00	162,000,000.00	1,798,790,296.00
4	Dar es sa-laam	20	1,259,285,350.00	80,000,000.00	25,000,000.00	397,084,000.00	1,761,369,350.00
5	Ruvuma	46	888,535,800.00	487,749,000.00	0.00	177,000,005.00	1,553,284,805.00
6	Shinyanga	45	838,352,919.00	143,168,240.00	30,000,000.00	453,800,685.00	1,465,321,844.00
7	Mbeya	72	889,975,000.00	38,263,000.00	131,324,550.00	352,000,000.00	1,411,562,550.00
8	Arusha	60	719,963,700.00	94,887,526.00	104,603,094.00	432,781,195.00	1,352,235,515.00
9	Kagera	77	397,204,751.00	64,511,000.00	53,605,000.00	770,397,001.00	1,285,717,752.00
10	Morogoro	56	758,279,981.00	286,758,040.00	89,000,000.00	146,086,000.00	1,280,124,021.00
11	Dodoma	37	779,024,533.00	180,000,000.00	9,817,100.00	169,798,467.00	1,138,640,100.00
12	Simiyu	41	828,169,000.00	70,000,000.00	14,000,000.00	163,000,337.00	1,075,169,337.00
13	Njombe	30	765,434,000.00	116,036,000.00	40,000,000.00	139,699,000.00	1,061,169,000.00
14	Kilimanjaro	42	632,662,500.00	180,235,500.00	55,000,000.00	171,441,000.00	1,039,339,000.00
15	Tabora	34	581,935,900.00	79,948,000.00	37,237,000.00	337,552,000.00	1,036,672,900.00
16	Mara	46	496,018,280.00	149,222,000.00	0.00	376,741,000.00	1,021,981,280.00
17	Mtwara	48	467,365,001.00	152,000,000.00	14,282,000.00	325,519,105.00	959,166,106.00
18	Tanga	79	419,535,000.00	187,582,995.00	147,583,004.00	165,000,010.00	919,701,009.00
19	Kigoma	33	492,381,600.00	120,807,000.00	40,000,000.00	221,354,000.00	874,542,600.00
20	Pwani	51	346,356,000.00	156,075,500.00	54,487,980.00	199,268,000.00	756,187,480.00
21	Manyara	33	480,048,579.00	79,960,571.00	51,000,000.00	103,443,000.00	714,452,150.00
22	Rukwa	20	574,250,804.00	38,712,000.00	0.00	30,000,006.00	642,962,810.00
23	Lindi	22	240,590,000.00	68,785,100.00	0.00	209,033,500.00	518,408,600.00
24	Iringa	31	318,180,014.00	50,000,003.00	0.00	16,000,001.00	384,180,018.00
25	Katavi	3	117,800,000.00	0.00	0.00	0.00	117,800,000.00
		1,084	**17,005,801,192.00**	**3,269,673,567.00**	**980,778,478.00**	**6,554,048,628.00**	**27,810,301,865.00**

Annex 7

Status of Vehicles and Motorcycles in Health Facilities by Council 2012

Category	S/N	Item Name	Total Equip	Function-ing	Percentage Functioning	Not Func-tioning	Percentage Not Function-ing
Vehicle	1	Tanga City Council	23	17	73.90	6	26.10
	2	Mpwapwa District Council	22	21	95.50	1	4.50
	3	Kilombero District Council	21	18	85.70	3	14.30
	4	Same District Council	21	21	100.00	0	0.00
	5	Mbulu District Council	20	18	90.00	2	10.00
	6	Kinondoni Municipal Council	19	14	73.70	5	26.30
	7	Mbeya City Council	19	10	52.60	9	47.40
	8	Bukoba Municipal Council	18	18	100.00	0	0.00
	9	Rombo District Council	17	15	88.20	2	11.80
	10	Ngorongoro District Council	17	17	100.00	0	0.00
	11	Makete District Council	16	16	100.00	0	0.00
	12	Ilala Municipal Council	16	13	81.30	3	18.80
	13	Moshi District Council	16	15	93.80	1	6.30
	14	Mwanza City Council	15	15	100.00	0	0.00
	15	Lindi District Council	15	13	86.70	2	13.30
	16	Morogoro District Council	15	8	53.30	7	46.70
	17	Serengeti District Council	15	10	66.70	5	33.30
	18	Kisarawe District Council	13	13	100.00	0	0.00
	19	Bagamoyo District Council	13	10	76.90	3	23.10
	20	Arusha City Council	12	9	75.00	3	25.00
	21	Mafia District Council	12	12	100.00	0	0.00
	22	Ulanga District Council	11	7	63.60	4	36.40
	23	Temeke Municipal Council	11	11	100.00	0	0.00
	24	Lushoto District Council	11	9	81.80	2	18.20
	25	Sikonge District Council	11	9	81.80	2	18.20
	26	Hai District Council	11	9	81.80	2	18.20
	27	Kilwa District Council	11	8	72.70	3	27.30
	28	Shinyanga District Council	11	10	90.90	1	9.10
	29	Mbeya District Council	10	10	100.00	0	0.00
	30	Chamwino District Council	10	8	80.00	2	20.00
	31	Iringa Municipal Council	10	10	100.00	0	0.00
	32	Hanang District Council	9	8	88.90	1	11.10
	33	Magu District Council	9	6	66.70	3	33.30
	34	Korogwe District Council	9	7	77.80	2	22.20
	35	Nzega District Council	9	7	77.80	2	22.20

Status of Vehicles and Motorcycles in Health Facilities by Council 2012							
Category	**S/N**	**Item Name**	**Total Equip**	**Function-ing**	**Percentage Functioning**	**Not Func-tioning**	**Percentage Not Function-ing**
	36	Biharamulo District Council	9	8	88.90	1	11.10
	37	Mufindi District Council	9	5	55.60	4	44.40
	38	Handeni District Council	9	9	100.00	0	0.00
	39	Iringa District Council	9	7	77.80	2	22.20
	40	Karagwe District Council	9	8	88.90	1	11.10
	41	Ukerewe District Council	8	8	100.00	0	0.00
	42	Geita District Council	8	5	62.50	3	37.50
	43	Mbinga District Council	8	5	62.50	3	37.50
	44	Tandahimba District Council	8	8	100.00	0	0.00
	45	Rufiji District Council	8	5	62.50	3	37.50
	46	Bahi District Council	8	7	87.50	1	12.50
	47	Ngara District Council	8	8	100.00	0	0.00
	48	Meatu District Council	8	4	50.00	4	50.00
	49	Kilosa District Council	8	3	37.50	5	62.50
	50	Kahama Town Council	8	3	37.50	5	62.50
Vehicle	51	Kigoma/Ujiji Municipal Council	8	4	50.00	4	50.00
	52	Kigoma District Council	8	5	62.50	3	37.50
	53	Kwimba District Council	8	7	87.50	1	12.50
	54	Kibondo District Council	8	8	100.00	0	0.00
	55	Nkasi District Council	8	8	100.00	0	0.00
	56	Ludewa District Council	7	6	85.70	1	14.30
	57	Simanjiro District Council	7	7	100.00	0	0.00
	58	Tunduru District Council	7	5	71.40	2	28.60
	59	Chunya District Council	7	7	100.00	0	0.00
	60	Songea District Council	7	5	71.40	2	28.60
	61	Nachingwea District Council	7	1	14.30	6	85.70
	62	Dodoma Municipal Council	7	5	71.40	2	28.60
	63	Mbarali District Council	7	5	71.40	2	28.60
	64	Misungwi District Council	7	7	100.00	0	0.00
	65	Igunga District Council	7	5	71.40	2	28.60
	66	Ilemela Municipal Council	7	2	28.60	5	71.40
	67	Urambo District Council	7	7	100.00	0	0.00
	68	Mtwara District Council	7	5	71.40	2	28.60
	69	Pangani District Council	7	5	71.40	2	28.60
	70	Musoma Municipal Council	7	6	85.70	1	14.30
	71	Songea Municipal Council	7	4	57.10	3	42.90
	72	Maswa District Council	7	5	71.40	2	28.60
	73	Kishapu District Council	7	7	100.00	0	0.00

Status of Vehicles and Motorcycles in Health Facilities by Council 2012							
Category	**S/N**	**Item Name**	**Total Equip**	**Function-ing**	**Percentage Functioning**	**Not Func-tioning**	**Percentage Not Function-ing**
	74	Ruangwa District Council	6	6	100.00	0	0.00
	75	Monduli District Council	6	4	66.70	2	33.30
	76	Liwale District Council	6	3	50.00	3	50.00
	77	Chemba District Council	6	6	100.00	0	0.00
	78	Sumbawanga District Council	6	4	66.70	2	33.30
	79	Mwanga District Council	6	5	83.30	1	16.70
	80	Manyoni District Council	6	6	100.00	0	0.00
	81	Tabora District Council	6	6	100.00	0	0.00
	82	Kasulu District Council	6	5	83.30	1	16.70
	83	Mbozi District Council	6	4	66.70	2	33.30
	84	Kyerwa District Council	6	5	83.30	1	16.70
	85	Sumbawanga Municipal Council	6	6	100.00	0	0.00
	86	Kilindi District Council	6	5	83.30	1	16.70
	87	Namtumbo District Council	6	4	66.70	2	33.30
	88	Kongwa District Council	6	6	100.00	0	0.00
	89	Moshi Municipal Council	6	5	83.30	1	16.70
	90	Meru District Council	6	6	100.00	0	0.00
	91	Singida Municipal Council	6	6	100.00	0	0.00
	92	Ileje District Council	5	5	100.00	0	0.00
	93	Rungwe District Council	5	5	100.00	0	0.00
	94	Iramba District Council	5	4	80.00	1	20.00
	95	Kyela District Council	5	5	100.00	0	0.00
	96	Muheza District Council	5	4	80.00	1	20.00
	97	Siha District Council	5	4	80.00	1	20.00
	98	Shinyanga Municipal Council	5	5	100.00	0	0.00
	99	Njombe District Council	5	5	100.00	0	0.00
	100	Mpanda District Council	5	5	100.00	0	0.00
	101	Babati District Council	5	4	80.00	1	20.00
	102	Nanyumbu District Council	5	2	40.00	3	60.00
	103	Chato District Council	5	5	100.00	0	0.00
	104	Arusha District Council	5	5	100.00	0	0.00
	105	Mvomero District Council	5	5	100.00	0	0.00
Vehicle	106	Kibaha District Council	5	3	60.00	2	40.00
	107	Kilolo District Council	5	4	80.00	1	20.00
	108	Newala District Council	5	4	80.00	1	20.00
	109	Bukombe District Council	5	4	80.00	1	20.00
	110	Mkuranga District Council	5	2	40.00	3	60.00
	111	Kondoa District Council	5	5	100.00	0	0.00
	112	Bunda District Council	4	4	100.00	0	0.00

Status of Vehicles and Motorcycles in Health Facilities by Council 2012							
Category	S/N	Item Name	Total Equip	Function-ing	Percentage Functioning	Not Func-tioning	Percentage Not Function-ing
	113	Bukoba District Council	4	3	75.00	1	25.00
	114	Singida District Council	4	4	100.00	0	0.00
	115	Ushetu District Council	4	4	100.00	0	0.00
	116	Mkalama District Council	4	1	25.00	3	75.00
	117	Momba District Council	4	4	100.00	0	0.00
	118	Njombe Town Council	4	3	75.00	1	25.00
	119	Kiteto District Council	4	3	75.00	1	25.00
	120	Karatu District Council	4	3	75.00	1	25.00
	121	Morogoro Municipal Council	4	4	100.00	0	0.00
	122	Muleba District Council	4	4	100.00	0	0.00
	123	Bariadi District Council	4	4	100.00	0	0.00
	124	Musoma District Council	4	3	75.00	1	25.00
	125	Longido District Council	4	4	100.00	0	0.00
	126	Kaliua District Council	3	2	66.70	1	33.30
	127	Lindi Municipal Council	3	3	100.00	0	0.00
	128	Sengerema District Council	3	3	100.00	0	0.00
	129	Mbogwe District Council	3	3	100.00	0	0.00
	130	Busokelo District Council	3	1	33.30	2	66.70
	131	Mtwara Municipal Council	3	3	100.00	0	0.00
	132	Nyasa District Council	3	2	66.70	1	33.30
	133	Tabora Municipal Council	3	3	100.00	0	0.00
	134	Bariadi Town Council	3	3	100.00	0	0.00
	135	Mkinga District Council	3	3	100.00	0	0.00
	136	Tarime District Council	3	3	100.00	0	0.00
	137	Misenyi District Council	3	2	66.70	1	33.30
	138	Mlele District Council	2	2	100.00	0	0.00
	139	Masasi District Council	2	0	0.00	2	100.00
	140	Kibaha Town Council	2	2	100.00	0	0.00
	141	Makambako Town Council	2	1	50.00	1	50.00
	142	Tarime Town Council	2	2	100.00	0	0.00
	143	Kakonko District Council	2	2	100.00	0	0.00
	144	Rorya District Council	2	1	50.00	1	50.00
	145	Itilima District Council	2	1	50.00	1	50.00
	146	Buhigwe District Council	2	2	100.00	0	0.00
	147	Msalala District Council	2	2	100.00	0	0.00
	148	Gairo District Council	2	1	50.00	1	50.00
	149	Geita Town Council	1	1	100.00	0	0.00
	150	Mpanda Town Council	1	1	100.00	0	0.00
	151	Korogwe Town Council	1	1	100.00	0	0.00

Status of Vehicles and Motorcycles in Health Facilities by Council 2012							
Category	**S/N**	**Item Name**	**Total Equip**	**Function-ing**	**Percentage Functioning**	**Not Func-tioning**	**Percentage Not Function-ing**
	152	Babati Town Council	1	1	100.00	0	0.00
	153	Busega District Council	1	1	100.00	0	0.00
	154	Bumbuli District Council	1	1	100.00	0	0.00
	155	Nyang'hwale District Council	1	1	100.00	0	0.00
		Total	***1118***	***920***		***198***	
trycycle	1	Kyela District Council	2	2	100.00	0	0.00
			2	*2*		*0*	
Other	1	Kahama Town Council	2	2	100.00	0	0.00
Other	2	Bariadi Town Council	2	2	100.00	0	0.00
	3	Meatu District Council	1	1	100.00	0	0.00
	4	Bukoba District Council	1	0	0.00	1	100.00
	5	Iramba District Council	1	1	100.00	0	0.00
	6	Rufiji District Council	1	1	100.00	0	0.00
	7	Ilemela Municipal Council	1	1	100.00	0	0.00
	8	Shinyanga Municipal Council	1	0	0.00	1	100.00
	9	Mbogwe District Council	1	1	100.00	0	0.00
	10	Nkasi District Council	1	0	0.00	1	100.00
		Total	*12*	*9*		*3*	
Motorcycle	1	Babati District Council	22	22	100.00	0	0.00
	2	Iringa District Council	21	18	85.70	3	14.30
	3	Lushoto District Council	19	7	36.80	12	63.20
	4	Mvomero District Council	19	19	100.00	0	0.00
	5	Kwimba District Council	16	14	87.50	2	12.50
	6	Kongwa District Council	15	15	100.00	0	0.00
	7	Bunda District Council	15	15	100.00	0	0.00
	8	Dodoma Municipal Council	15	14	93.30	1	6.70
	9	Lindi District Council	15	15	100.00	0	0.00
	10	Chamwino District Council	14	13	92.90	1	7.10
	11	Sumbawanga District Council	14	12	85.70	2	14.30
	12	Kiteto District Council	14	14	100.00	0	0.00
	13	Kilolo District Council	13	13	100.00	0	0.00
	14	Ludewa District Council	13	11	84.60	2	15.40
	15	Nanyumbu District Council	13	12	92.30	1	7.70
	16	Sikonge District Council	12	11	91.70	1	8.30
	17	Mkuranga District Council	12	10	83.30	2	16.70
	18	Kibondo District Council	12	12	100.00	0	0.00
	19	Bariadi Town Council	12	12	100.00	0	0.00
	20	Bariadi District Council	12	12	100.00	0	0.00
	21	Misungwi District Council	11	11	100.00	0	0.00
	22	Kibaha District Council	11	11	100.00	0	0.00
	23	Simanjiro District Council	11	11	100.00	0	0.00

Status of Vehicles and Motorcycles in Health Facilities by Council 2012							
Category	**S/N**	**Item Name**	**Total Equip**	**Function-ing**	**Percentage Functioning**	**Not Func-tioning**	**Percentage Not Function-ing**
	24	Nkasi District Council	11	9	81.80	2	18.20
	25	Ngara District Council	11	11	100.00	0	0.00
	26	Korogwe District Council	11	10	90.90	1	9.10
	27	Ukerewe District Council	11	11	100.00	0	0.00
	28	Mufindi District Council	10	9	90.00	1	10.00
	29	Urambo District Council	10	7	70.00	3	30.00
	30	Nzega District Council	10	9	90.00	1	10.00
	31	Kilosa District Council	10	10	100.00	0	0.00
	32	Longido District Council	10	9	90.00	1	10.00
	33	Handeni District Council	10	10	100.00	0	0.00
	34	Meatu District Council	10	10	100.00	0	0.00
	35	Mwanga District Council	10	10	100.00	0	0.00
	36	Namtumbo District Council	9	9	100.00	0	0.00
	37	Chato District Council	9	9	100.00	0	0.00
	38	Kalambo District Council	9	7	77.80	2	22.20
	39	Igunga District Council	9	7	77.80	2	22.20
	40	Sengerema District Council	9	8	88.90	1	11.10
	41	Siha District Council	9	9	100.00	0	0.00
	42	Iramba District Council	9	9	100.00	0	0.00
	43	Moshi District Council	9	9	100.00	0	0.00
	44	Kishapu District Council	8	8	100.00	0	0.00
	45	Mtwara District Council	8	7	87.50	1	12.50
Motorcycle	46	Manyoni District Council	8	8	100.00	0	0.00
	47	Morogoro District Council	8	8	100.00	0	0.00
	48	Rorya District Council	8	8	100.00	0	0.00
	49	Iringa Municipal Council	8	8	100.00	0	0.00
	50	Hanang District Council	8	7	87.50	1	12.50
	51	Liwale District Council	8	6	75.00	2	25.00
	52	Makete District Council	8	8	100.00	0	0.00
	53	Tabora District Council	8	8	100.00	0	0.00
	54	Musoma District Council	8	7	87.50	1	12.50
	55	Shinyanga District Council	8	8	100.00	0	0.00
	56	Bukoba District Council	8	8	100.00	0	0.00
	57	Tanga City Council	8	8	100.00	0	0.00
	58	Kilindi District Council	8	7	87.50	1	12.50
	59	Mtwara Municipal Council	7	7	100.00	0	0.00
	60	Monduli District Council	7	5	71.40	2	28.60
	61	Nachingwea District Council	7	5	71.40	2	28.60
	62	Kyela District Council	7	3	42.90	4	57.10
	63	Karagwe District Council	7	6	85.70	1	14.30

Status of Vehicles and Motorcycles in Health Facilities by Council 2012							
Category	**S/N**	**Item Name**	**Total Equip**	**Function-ing**	**Percentage Functioning**	**Not Func-tioning**	**Percentage Not Function-ing**
	64	Chunya District Council	7	7	100.00	0	0.00
	65	Mbeya District Council	7	7	100.00	0	0.00
	66	Njombe Town Council	7	4	57.10	3	42.90
	67	Ileje District Council	7	6	85.70	1	14.30
	68	Rombo District Council	7	7	100.00	0	0.00
	69	Babati Town Council	6	6	100.00	0	0.00
	70	Maswa District Council	6	6	100.00	0	0.00
	71	Misenyi District Council	6	6	100.00	0	0.00
	72	Newala District Council	6	6	100.00	0	0.00
	73	Geita District Council	6	6	100.00	0	0.00
	74	Kahama Town Council	6	5	83.30	1	16.70
	75	Mkinga District Council	6	6	100.00	0	0.00
	76	Ngorongoro District Council	6	6	100.00	0	0.00
	77	Pangani District Council	6	6	100.00	0	0.00
	78	Bagamoyo District Council	6	1	16.70	5	83.30
	79	Karatu District Council	6	5	83.30	1	16.70
	80	Bahi District Council	6	6	100.00	0	0.00
	81	Kigoma District Council	6	6	100.00	0	0.00
	82	Bukombe District Council	6	6	100.00	0	0.00
	83	Songea District Council	6	6	100.00	0	0.00
	84	Muleba District Council	5	5	100.00	0	0.00
	85	Arusha City Council	5	5	100.00	0	0.00
	86	Mbarali District Council	5	5	100.00	0	0.00
	87	Songea Municipal Council	5	3	60.00	2	40.00
	88	Singida Municipal Council	5	5	100.00	0	0.00
	89	Tarime District Council	5	5	100.00	0	0.00
	90	Njombe District Council	5	5	100.00	0	0.00
	91	Biharamulo District Council	5	5	100.00	0	0.00
	92	Moshi Municipal Council	5	4	80.00	1	20.00
	93	Itilima District Council	5	5	100.00	0	0.00
	94	Mbinga District Council	5	5	100.00	0	0.00
	95	Tunduru District Council	5	4	80.00	1	20.00
	96	Shinyanga Municipal Council	5	5	100.00	0	0.00
	97	Chemba District Council	5	5	100.00	0	0.00
	98	Ulanga District Council	5	5	100.00	0	0.00
	99	Kondoa District Council	5	4	80.00	1	20.00
	100	Kilwa District Council	5	5	100.00	0	0.00
Motorcycle	101	Rufiji District Council	4	4	100.00	0	0.00
	102	Mpanda Town Council	4	4	100.00	0	0.00
	103	Morogoro Municipal Council	4	4	100.00	0	0.00

Status of Vehicles and Motorcycles in Health Facilities by Council 2012							
Category	**S/N**	**Item Name**	**Total Equip**	**Function-ing**	**Percentage Functioning**	**Not Func-tioning**	**Percentage Not Function-ing**
	104	Ilemela Municipal Council	4	4	100.00	0	0.00
	105	Magu District Council	4	4	100.00	0	0.00
	106	Mbeya City Council	3	3	100.00	0	0.00
	107	Bumbuli District Council	3	3	100.00	0	0.00
	108	Rungwe District Council	3	3	100.00	0	0.00
	109	Mwanza City Council	3	3	100.00	0	0.00
	110	Kasulu District Council	3	2	66.70	1	33.30
	111	Masasi Town Council	3	2	66.70	1	33.30
	112	Kyerwa District Council	3	3	100.00	0	0.00
	113	Korogwe Town Council	3	3	100.00	0	0.00
	114	Kibaha Town Council	3	3	100.00	0	0.00
	115	Ushetu District Council	3	3	100.00	0	0.00
	116	Tabora Municipal Council	3	3	100.00	0	0.00
	117	Buhigwe District Council	3	2	66.70	1	33.30
	118	Ilala Municipal Council	3	3	100.00	0	0.00
	119	Singida District Council	2	2	100.00	0	0.00
	120	Mpanda District Council	2	2	100.00	0	0.00
	121	Tarime Town Council	2	2	100.00	0	0.00
	122	Lindi Municipal Council	2	1	50.00	1	50.00
	123	Mbozi District Council	2	2	100.00	0	0.00
	124	Kinondoni Municipal Council	2	1	50.00	1	50.00
	125	Mafia District Council	2	2	100.00	0	0.00
	126	Masasi District Council	2	2	100.00	0	0.00
	127	Mbogwe District Council	2	2	100.00	0	0.00
	128	Kaliua District Council	2	2	100.00	0	0.00
	129	Busega District Council	1	1	100.00	0	0.00
	130	Nsimbo District Council	1	1	100.00	0	0.00
	131	Makambako Town Council	1	1	100.00	0	0.00
	132	Momba District Council	1	1	100.00	0	0.00
	133	Ruangwa District Council	1	1	100.00	0	0.00
	134	Nyang'hwale District Council	1	1	100.00	0	0.00
	135	Busokelo District Council	1	1	100.00	0	0.00
	136	Sumbawanga Municipal Council	1	1	100.00	0	0.00
	137	Temeke Municipal Council	1	1	100.00	0	0.00
	138	Gairo District Council	1	1	100.00	0	0.00
	139	Musoma Municipal Council	1	1	100.00	0	0.00
	140	Ikungi District Council	1	1	100.00	0	0.00
		Total	***983***	***906***		***77***	
Bajaji	1	Chemba District Council	1	1	100.00	0	0.00
			1	*1*		*0*	