THE UNITED REPUBLIC OF TANZANIA

Comprehensive Council Health

Planning Guidelines

JULY 2011

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and Social Welfare
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FOREWORD

The Government of Tanzania through Decentralization and Sector-Wide Approaches has made great achievement on the set milestones, in its endeavours to improve the health services for the people. One important milestone it has achieved is the arrangement on the disbursement of the Health Block Grant and Basket Fund, to the Local Government Authorities (LGAs). Since 1999, a number of guidelines were developed to support the Councils or LGAs in preparing the Comprehensive Council Health Plans (CCHP), for improving delivery of health services and to ensure that, there is cost effective utilization of the funds.

With the same perspective, this fourth version of the CCHP guidelines, has been developed to accommodate issues from the Health Policy (2007), the Primary Health Development Services Programme (MMAM -2007-2017) and Health Sector Strategic Plan III (July 2009-June 2015), other agreed sector strategies and experiences gained by the LGAs /Councils, in using the previous guidelines and the arising need of incorporating the Social welfare services into the guideline. This new guideline will also serve as a tool to ensure that, the change process is well moderated by the Council Health Management teams and other stakeholders, in achieving the goal of improving Health service delivery through decentralization.

It is envisaged that, all partners in the health sector, including the Local Government Authorities, Faith Based Organizations, Private sectors, Health institutions, Civil Societies, Local and International organizations, both bilateral and multilateral, will make use of these guidelines in improving the performance, both in planning, monitoring and evaluation of the health service delivery. It requires the support of every expert to effect the changes that are desired. Those who may want to support the LGAs/Councils in whatever form, are highly welcome to do so.

This fourth guideline therefore, replaces all previous CCHP guidelines and shall be effective from July, 2011.

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune-Deficiency Syndrome
AFI	Acute Febrile Illnesses
ANC	Antenatal Care
ARI	Acute Respiratory Infection
ART	Anti- retroviral treatment
ARV	Anti Retroviral
BFC	Basket Financing Committee
BFHI	Baby friendly Hospital Initiative
CB DOTS	Community Based Directly Observed Therapy Short course
CBDAs	Community Based Distributing Agents
CBHI	Community Based Health Initiatives
CCHP	Comprehensive Council Health Plan
CDH	Council Designated Hospital
CFR	Case Fatality Rate
CHF	Community Health Fund (households prepayment scheme)
CHMT	Council Health Management Team
CHPT	Council Health Planning Team
CHSB	Council Health Service Board
CIMCI	Community Integrated Management of Childhood Illnesses
CORPs	Community Owned Resource Persons
CRCHC	Council Reproductive and Child Health Coordinator
CSD	Civil Service Department
CSSC	Christian Social Services Commission
CTC	Care and treatment clinic
CYP	Couple Year of Protection
DDH	Designated District Hospital
DHAT	District Health Accounting Tool
DHS	Demographic Health Survey
DMO	District Medical Officer
DNO	District Nursing Officer
DOTS	Directly Observed Therapy Short Courses
DPT – HB-Hib	Diphtheria, Pertussis, Tetanus, Hepatitis, Haemophillus Influenza
DSSA	District Strenghthening Support Advisor
DT	District Treasurer
EHP	Essential Health Package
EPI	Expanded Program of Immunization
ERV	Exchequer Revenue Voucher
FANC	Focused Antenatal Care

FBOs	Faith Based Organizations
FGM	Female Genital Mutilation
FP	Family Planning
FY	Fiscal Year
GFS	Government Financial Statistics
GoT	Government of Tanzania
GRN	Goods Received Note
GTZ	Gesellschaft fuer Technische Zusammenarbeit
HB	Haemoglobin
HC	Health Center
HF	Health Facility
HFGC/ HFC	Health Facility Governing Committee / Health Facility Committee
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HRHIS	Human Resource for Health Information System
HSDG	Health Sector Development Grant
HSPS	Health Sector Programme Support
HSR	Health Sector Reform
HSSP	Health Sector Strategic Plan
HSRS	Health Sector Resource Secretariat
HTC	HIV testing and Counseling
IEC	Information Education Communication
IMCI	Integrated Management of Childhood Illness
IMEESC	Integrated Management for Emergency & Essential Surgical Care
IPT2	Intermittent Presumptive Treatment second dose (SP)
ITN	Insecticide Treated Nets
JICA	Japanese International Co-operative Agency
JRF	Joint Rehabilitation Fund
LGAs	Local Government Authorities
LGCDG	Local Government Capital Development Grant
MDGs	Millennium Development Goals
LPO	Local Purchase Order
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania
MNCH	Maternal, Newborn and Child Health
MMAM	Mpango wa Maendeleo wa Afya ya Msingi
MoFEA	Ministry of Finance and Economic Affairs
MOH	Medical Officer of Health
MoHSW	Ministry of Health and Social Welfare
MSD	Medical Store Department

MTUHA	Mfumo wa Taarifa za Uendeshaji wa Huduma za Afya
MVC	Most Vulnerable Children
NACP	National AIDS Control Program
NAO	National Audit Office
NCD	Non- Communicable Diseases
NEHP	National Essential Health Package
NGO	Non Governmental Organization
NHIF	National Health Insurance Fund
NMCP	National Malaria Control Programme
NMS	National Minimum Standards
NSGRP	National Strategy for Growth and Poverty Reduction
NPEHSWI	National Package of Essential Health and Social Welfare Interventions
NPEHI	National Package of Essential Health Interventions
NTDs	Neglected Tropical Diseases
NTLP	National Tuberculosis and Leprosy Programme
O&OD	Opportunities and Obstacles to Development
O.C.	Other Charges
OPD	Outpatient Department
OVC	Orphan vulnerable children
P4P	Pay for Performance
PBF	Performance Based Financing
P.E.	Personal Emoluments
PHAST	Participatory Hygiene and Sanitation Transformation
PID	Pelvic Inflammatory Disease
PITC	Provider Initiative Testing and Counseling
PLHIV	People Living with HIV
PMO-RALG	Prime Minister's Office**,** Regional Administration and Local Government
PMTCT	Prevention of Mother to Child Transmission
POA	Plan of Action
PO PSM	Presidents' Office Public Service Management
PRA	Participatory Rural Appraisal
RAS	Regional Administrative Secretary
RBF	Results Based Financing
RBM	Roll Back Malaria
RDT	Rapid Diagnostic Test
RHMT	Regional Health Management Team
RS	Regional Secretariat
SBAS	Strategic Budget Allocation Software
SR	Stores Requisition

SRIN	Stores Requisition and Issue Note
SRV	Stores Receipt Voucher
SSI	Sight Savers International
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
SWAPs	Sector Wide Approaches
SWOT	Strengths, Weaknesses, Opportunities and Threats
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TIKA	Tiba kwa Kadi
TMIS	Transport Management Information System
TMOF	Town Medical Officer of Health
TT	Telegraphic Transfer
UNICEF	United Nations Children's' Fund
USAID	United State Agency for International Development
USD	United States Dollar
VAH	Voluntary Agency Hospital
VCT	Voluntary Counseling and Testing
VHW	Village Health Worker
WHO	World Health Organization

DEFINITIONS OF TERMS

Activity is the action taken or work performed in order to produce a given target

A target is defined as a desired amount of progress towards an objective through a number and quality of specified activities that have to be carried out before the objective can be reached.

Budget: An estimate of expected incomes and expenditures for achieving financial and operational goals of an entity or healthy facility.

Burden of Disease – Is the number of years of life lost (YLL) in a year due to premature deaths from a disease, plus number of years lived with disability (YLD). It is a summary measure of a population health (in a district) by combining data on mortality and morbidity.

OR

Is the total amount of health life lost, to all causes, whether from premature mortality or from some degree of disability over some period of time. This disability can be physical such as crippling or blindness or mental such as retardation or mental illness.

Cascade – Is defined as hierarchal functional arrangement of the district health department that allows CHMT to delegate their functions to the lower level of care

CCHP – (Comprehensive Council Health Plan (CCHP) - is an annual health and social welfare plan for a Council which collates the health and social welfare plans at all levels and involve all stakeholders.

Cost Analysis - is a process of estimating cost of each input for every activity by putting together the activity to be implemented and the related inputs, quantity of inputs, and price per unit costs and total cost in a matrix forms. (Unit cost must be known).

DOT - Daily observed treatment by a health worker or by treatment supporter throughout the 6 month duration

DPT-HepB+Hib combination vaccine
DPT-HepB+Hib vaccine is called a ***pentavalent*** vaccine because it protects against five diseases: ***diphtheria, tetanus, pertussis, hepatitis B, and Haemophilus influenza type b infections.***

Environment: commands a very broad meaning; it includes; air, land and water, plant and Animal and human life; the socio, economic, recreational, cultural and aesthetic condition and factors that influence the lives of human beings and their communities; buildings structures, machines or, other devices made by man; any solids , liquids, gases,

odour, heat sounds, vibration or radiation resulting directly or indirectly from the activities of man and any part or combination of the foregoing and inter-relationships between or more of them.

Environmental health -Those aspects of the human health and disease that are determined by factors in the environment. It also refers to the theory and practice of assessing and controlling factors in the environment that can potentially affect health.

OR

refers to keeping clean and avoiding dirty in human surroundings which may lead to the infectious communicable disease such as diarrhoea, cholera, in particular dirty water in ponds or ditches may result to mosquito breeding, careless throwing of garbage

For this case environmental health differ from **environment cleanliness which is under the Prime minister Office,** and it is the task of the council to keep environment clean i.e. towns and cities or areas around to be attractive and beautiful, this include planting tree for shades, protecting water catchment areas from human activities so as to cause rainfall formation, increase of oxygen for clean air for people and other creatures, to avoid land degradation, planting flowers and grasses. It is a cross-cutting issue thus why it is under the prime minster office so as to be connected with other sectors.

Epicor – Accounting software, formerly known as Platinum

Essential National Health Package- Is an integrated collection of cost- effective interventions that address the main diseases, injuries and risk factors, plus diagnostic and health care services to satisfy the demand for common symptoms and illnesses of the population to be served.

Health Planning is a process of getting agreed priorities and direction for health sector in the light of available resources

Indicator, a number having a particular measurement purpose. A Quantitative or qualitative factor or variable that provides a simple and reliable means to measure achievement, to reflect the changes connected to an intervention, or to help assess the Performa of a party or institution. Or, a variable that allows the verification of changes in the development intervention or shows results relative to what was planned. Indicators are usually indirect measures of an underlying phenomena or quality (the way "smoke indicates fire" and are usually stated in SMART format. Indicators are often disaggregated to compare results and frequently have time-specified target and baseline values.

Input, the financial, human, and material resources used during the completion of an activity. Inputs are frequently measured in terms of financial costs.

Interventions - set of actions to be taken that addresses a solution to a particular problem or disease.

Morbidity - refers to the state of illness and disability in a population – usually the data on morbidity are obtained from death.

Mortality - Is a process whereby deaths occur in a population

Outcome, the likely or achieved short-term and medium-term effects of an intervention's outputs. A direct, but intermediary change or improvement in the welfare of the customer or beneficiary as a result of the use of a service (or output). Examples include improved health after visiting a dispensary, or increased knowledge after completing school.

Output, the products, goods and services which result from an intervention; may also include changes (usually of an immediate nature) resulting from the intervention which are relevant to the achievement of outcomes

Performance, the degree to which an intervention or an implementer operates according to specific criteria/standards/guidelines or achieves results in accordance with stated objectives or plans.

Physical implementation- the actual carrying out of an activity or target.

PlanRep –The local government Planning and Reporting Database (e.g. PlanRep2 and PlanRep3) is a database designed to assist local authorities in planning, budgeting, projecting revenue from all sources, and tracking funds received, physical implementation and expenditure.

Priority areas: are areas that have been given first consideration which are included in the health strategic plan III for example communicable Disease Control.

Sanitation is hygienic which means promoting health through prevention of human contact with the hazards of wastes. Hazards can be physical, microbiological, biological or chemical agents of disease. Wastes that can cause health problems are human and animal faeces, solid wastes, domestic wastewater (sewage, silage, and grey water), industrial wastes and agricultural wastes. Hygienic means of prevention can be by using engineering solutions (e.g. sewerage and wastewater treatment), simple technologies (e.g. latrines, septic tanks), or even by personal hygiene practices (e.g. simple hand washing with soap).

SMART: Attributes of indicators, but sometimes applied to other planning entities, such as Targets or Objectives. SMART stands for: Specific, Measurable, Achievable, Realistic, and Timely; a means for assessing performance indicators.

Stakeholders, all of those who have an interest (either direct or indirect) in an institution, its activities and its achievements. These may include clients or customers, partners employees shareholders/owners, government or regulators

Strategies - (tactics) are broad statements about how something is to be done. Or plan of action designed to achieve a particular goal for example Ministry of Health has identified 11 strategies in health sector such as Strategy 1: District Health Services; (1. Increase accessibility to health services based on equity and gender balanced needs. 2. Improve quality of clinical services in hospitals.

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INTRODUCTION

The Ministry of Health and Social Welfare (MoHSW) and Prime Minister's Office, Regional Administration and Local Government (PMO- RALG) are striving to realize the Government intention of providing quality health and social welfare services to all people. This is in line with the National Health and Social Welfare policies.

Vision:
The vision of the Ministry of Health and Social Welfare is to have a healthy society, with improved social well being that will contribute effectively to personal and national development.
To realize this vision the National Health Policy stipulates clearly its mission and objectives as follows:

Mission of the Ministry of Health and Social Welfare:
To facilitate the provision of basic and comprehensive health and social welfare services that are of good quality, equitable, accessible, affordable, sustainable and gender sensitive

Policy Objectives of the Ministry of Health and Social Welfare:

1. Reduce the burden of disease, disability and mortality especially maternal, infant and under five child mortality and increase life expectancy.

2. Ensure availability of medicines, equipment, medical supplies and reagents.
3. Ensure availability of quality health facilities, transport and communication system.
4. Ensure that health and social welfare services are available and accessible to all people in the country, both urban and rural areas.

5. Monitoring and Supervision of quality and safety of food, medicines, chemicals and cosmetics.
6. Ensure availability of a training system that ensures availability of adequate numbers of competent and skilled health staff to manage health services with gender perspective at all levels.

7. Facilitate the promotion of environmental health, personal hygiene, occupational health and safety at the work place.

8. Improve social welfare services for high risks groups, through sensitization, promotion and safeguard their rights.

9. Prevention and control of communicable and non- communicable diseases including deficiency nutritional disorders.

10. Improve care services and reduce new HIV/AIDS infection

11. Promote and sustain public-private partnership in the delivery of health services.
12. Promote traditional medicine and alternative healing health system and regulate their practice.

13. Support Professional Councils and Associations which supervise professional conduct of health care providers in order that the public receives safe health and social welfare services of a high standard of quality.

The Government through the MoHSW and PMORALG took remarkable initiatives to realize these policy intentions. Among these is the introduction of CCHPs which ensures the appropriate translation of health policies objectives and effective utilization of health resources.

This reviewed guideline contains the following chapters:

Chapter 1: The Comprehensive Council Health Plan (CCHP)

This chapter gives an overview and definition of the CCHP, the National Package of Essential Health Interventions, Planned targets, the different actors, their roles and responsibilities.

Chapter 2: Preparation of a Comprehensive Council Health Plan

This chapter describes the process of preplanning, identifying the priorities and planning. It includes the format for a CCHP and provides clear instructions/guidance on how to prepare plans and timetable for developing the CCHP.

Chapter 3: Principles on the use of Funds Disbursement and Accounting of funds from different sources

The chapter gives guidance on the allocation and use of Health Block Grant, Health Basket Funds and other sources of funds and procedures regarding disbursement of basket funds is.

Chapter 4: Preparation of Progress Implementation and Performance Reports

This chapter describes preparation of the required progress reports.

Chapter 5: Accounting, Procurement, Stores and Auditing

This chapter describes the health department accounting structure, accounting for health Funds, stores and financial auditing.

Chapter 6: Implementation of the Primary Health Services Development Programme (PHSDP-MMAM) 2007-2017

This chapter states briefly on the construction and rehabilitation of Primary Health Care facilities.

Chapter 7: Supervision, Monitoring and Evaluation

This chapter describes the outputs and indicators for the CCHP. This guideline is meant to be used by LGAs particularly members of the Health Planning Teams to improve the quality of CCHP. Quality plans and reporting are crucial for improving performance of the Council Health Services. However, in the process of CCHP preparation, Councils are encouraged to use other relevant documents including those indicated in Annex 1.

Chapter 8: Transport, Training and Human Resources Development

This chapter describes briefly on transport management focusing on compliance to route schedules and capacity building and training of the in service staffs

Chapter 9: PlanRep as a tool for planning, budgeting, reporting and accounting

This chapter describes the planning and reporting database, how to use to assist in developing the CCHP, in entering the CCHP in PlanRep, producing burden of disease data linking with resource allocated to cost effective interventions and how to export the data from the PlanRep to Epicor

CHAPTER ONE

1.0 THE COMPREHENSIVE COUNCIL HEALTH PLAN OVERVIEW

1.1 Introduction

The Ministry of Health and Social Welfare (MoHSW) has developed a framework to reform the health and social welfare sector in order to improve quality of services of health and social welfare services and thereby produce better health and social well being outcomes.

The Government of Tanzania through the MoHSW and PMO-RALG is empowering the Local Government Authorities (LGAs) through decentralization by devolving powers of decision making to the LGAs. Support will be given to them in prioritizing and planning their health and social welfare interventions based on priority needs. The LGAs will mobilize, manage and account for health and social welfare resources and implement health and social welfare activities in line with the National Health and Social Welfare Policies

The goal of improving health and social welfare services through decentralization of decision-making and resources mirrors the vision of the Government for autonomous, empowered and accountable LGAs.

However, in this era when the Government is implementing several reforms, the Council Health Management Teams (CHMTs) are faced with the challenge of efficiently spearheading the implementation of the Health Sector and Social welfare Reform, which aim at strengthening the health and social welfare systems.

Human Resources for Health (HRH) is a cross-cutting challenge that may impede effective implementation of CCHP taking into account shortage of health care workers in some cadres, especially in rural districts is up to an average of 60 percent. Human resource capacity for social welfare is also a key challenge with only 114 Social Welfare Officers across the districts in the country. This is a considerable deficit compared to the 4 Social Welfare Officers per district recommended by PMO-RALG.
The new CCHP version should therefore accommodate HRH issues for minimal and effective use of resources.

LGAs should therefore, prepare the Comprehensive Council Health Plans (CCHPs) under the guidance of the CCHP guidelines and the PlanRep3 software. The CCHP Guidelines and PlanRep3 will ensure linkage of the CCHP targets to the National Strategy for Growth and Reduction of Poverty (NSGRP) herein referred to as MKUKUTA II, the health related MDGs l 4, 5 and 6, and the Government Vision 2025. Also, the National Health and Social Welfare Protection Policies, the Law of the

Child Act (2009) and the roles and responsibilities defined for Social Welfare Officers, National Costed Plan of Action for Most Vulnerable Children (2011 – 2015), Primary Health Services Development Program (Popularly known as MMAM), Health Sector Strategic Plan (HSSP), HRH Strategic Plan and Council Strategic Plan.

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. In order to promote coordinated planning and implementation of services within the health sector, the MoHSW has adopted a Sector Wide Approach (SWAp). This addresses the provision of accessible quality health and social welfare services by the LGAs, which are well supported, cost effective and gender sensitive with priorities developed according to the National Package of Essential Health and Social Welfare Interventions (NPEHSWI) of Tanzania.

The Health Block Grants, Health Basket Funds, Cost Sharing funds (NHIF, CHF/TIKA, User fee, Drug Revolving fund), Global Funds, Council own source, Receipt in kind, community contribution and other funding sources will finance health activities identified in the HSSP and in the NPEHSWI. In order to take into account disparities between councils, the allocation of the Health Block Grants and the Health Basket Funds to the Councils uses a formula based on four factors Population 70 percent Poverty count 10 percent, District vehicle route 10 percent and Under five mortality 10 percent as a proxy for Burden of Disease in the local population.

Funds for the implementation of the annual CCHPs have to be integrated into the Council's budget. The CCHP therefore, contains both recurrent and development activities within the sector that have to be matched with the identified source of funding for each activity.

1.2 Definition of a Comprehensive Council Health Plan (CCHP)

1) CCHP is an annual health and social welfare plan for a Council which collates the health and social welfare plans at all levels and involve all stakeholders. It addresses:
    i) the Policy and guidelines objectives related to:-
        (1) National Health Policy (2007)
        (2) Health Sector Strategic Plan III (2009-2015)
        (3) Primary Health Services Development Programme (2007-2017)
        (4) Millennium Development Goals (MDGs)
        (5) Government Vision 2025
        (6) National Strategy for Growth and Reduction of Poverty (NSGRP)
        (7) The National Essential Health Package (NEHP) (2000)
        (8) National HRH Strategic Plan (2008-2013)
        (9) Council Health Strategic Plans.
        (10) Specific Programmes Strategic Plans and Projects
        (11) The Law of the Child Act (2009)

ii) the Burden of diseases nationally and locally.
iii) all sources of health funds including donations in funds and in kind

A comprehensive plan has 3 aspects, namely Technical, Financial and Structural:

Technical aspect:
The CCHP should act on the main health and social welfare, problems and needs of the Council including promotive, preventive, curative and rehabilitative aspects. These main problems will be identified and analysed in detail under the subjects of Situational Analysis, Review of Resource Availability and Priority Problems. All CCHPs activities should be captured in the PlanRep software for monitoring purpose according to the set indicators.

Financial aspect:
CCHP is prepared taking into account the following sources of funds:

i) Block grant,
ii) Health Basket Fund,
iii) Council own sources,
iv) Cost sharing arrangements including prepayment schemes (fees for services, Community Health Funds, National Health Insurance, out of pocket)
v) Projects funds, programmes and development partners.
vi) Receipts in kind

Utilization of Health Block Grants and Health Basket Funds is accompanied with a number of regulations and ceilings that have to be adhered. These regulations and ceiling are clearly elaborated in chapter 3. All CCHPs activities should be captured in the accounting system (IFMS/Epicor) in order to be able to monitor actual expenditure against what was budgeted.

Structural aspect:
Council Health and Social Welfare services will operate at three levels which are:-

i. Household and communities
ii. Dispensaries and Health centres, Child Care Institutions, Centres for Persons with Disabilities, Retention Homes
iii. District and other hospitals

The services of all Health and Social Welfare Providers have to be considered when preparing the CCHPs, these Health and Social Welfare providers are:-

i. Public /Government providers
ii. Voluntary agencies/ FBOs
iii. Private for profit providers

iv. Parastatal providers
v. Non Governmental Organizations (NGOs)
vi. Community based initiative activities for health promotion
vii. Alternative medicine

1.3 The National Package of Essential Health and Social Welfare Interventions of Tanzania

The National Package of Essential Health and Social Welfare Interventions (NPEHSWI) contains priority areas that have to be covered in the CCHPs and includes the main diseases and health conditions responsible for the Burden of Disease in Tanzania as may be revised from time to time. The details of the priority areas are in Annex 3.

The CCHP takes on board eleven (11) strategies explained in the Health Sector Strategic Plan III, namely:-

Strategy 1: District Health Services
Strategy 2: Referral Hospital Services
Strategy 3: Central Support
Strategy 4: Human Resources for Health
Strategy 5: Health Care Financing
Strategy 6: Public Private Partnerships
Strategy 7: Maternal, Newborn and Child Health
Strategy 8: Disease Prevention and Control
Strategy 9: Emergency Preparedness and Response
Strategy 10: Social Welfare and Social Protection
Strategy 11: Monitoring & Evaluation and Research

Other interventions will be selected based on the local needs of the Council and population.

1.4 Planned Targets

Every Council should develop a 5 year Councils Health Strategic Plan, based on HSSP III, which should be a basis for developing annual health plans. In addition, each council should develop annual target based on their baseline and what can be achieved within a year. The annual targets, which are guided by the national targets (see Annex 4**),** will be the basis for rewards under P4P strategy.

1.5 Payment for Performance (P4P)/ Results Based Financing (RBF)/ Performance Based Financing (PBF)

Over the past decade, there has been little progress made in the reduction of Maternal and Newborn Mortality despite many interventions and efforts. The Government has recently embarked on P4P strategy focusing on performance management of health care workers in-order to improve Maternal, Newborn and Child Health (MNCH) services which are articulated in the Health Sector Strategic Plan III (HSSP III) to address MDG 4 & 5.

Payment for Performance (P4P) is geared to reaching agreed targets as per indicators set related to MNCH. In addition P4P will motivate and retain health care workers at health facilities, CHMT and RHMT levels. However, it will only be paid if those set targets (see Table 1 below) are reached and they are not as a "stand-alone" strategy but part of a broader effort to make the health system more results-oriented.

Implementation of Pay for Performance will cover all health facilities in all councils in Tanzania Mainland that are providing MNCH services. The units eligible for the Payment for Performance will be; dispensaries, health centres, district and regional hospitals, FBO/VA facilities, CHMTs and RHMTs including the co-opted members. CHMTs should update the list of health facilities that will be enrolled in the scheme and update the list annually.

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CHMTs must budget in their CCHPs training of their health facility providers on issues related to P4P especially data reporting, accuracy, timeliness, and also allocate budget for Pay for Performance to health providers for achievement of the targets. The implementation of P4P will be monitored monthly, quarterly and annually using selected HMIS indicators which are all reported on monthly basis, and are intended to be the means for self assessment as well as a focus for supportive supervision from the CHMTs and RHMTs. In turn, P4P will stimulate timeliness, reliability and use of collected data on site, at council and regional levels, setting the momentum for MTUHA strengthening. The indicators selected for the first two years 2008/09 and 2009/10 are as follows:

Table 1: P4P Indicators per Facility or Team

Facility / Team	Indicator	Targets
Dispensaries	Immunization - DTP-Hb- Hib 3	Equal or above 80%
	Immunization - OPV 0	equal or above 60%
	Deliveries in health facilities	equal or above 60%
	IPT 2 for pregnant women	equal or above 60%
	Quarterly MTUHA report timely, complete and accurate	100%
Health Centres	As for dispensaries.	

Facility / Team	Indicator	Targets
Hospitals	As for Health centres	
CHMTs and co-opted members	Aggregate performance of council on facility indicators (above)	
RHMTs and co-opted members	Aggregate performance of region on facility indicators (above)	

1.6 Public Private Partnership (PPP)

During preparation of CCHP, available financial, human and material resources have to be jointly and rationally allocated at all levels in the proportion of services delivered by public and private partners. Performance outputs, monitoring and reporting for each stakeholder have to be agreed and documented. Each private provider including (VA hospital) allocated public resources for delivery of health services have to sign a Service Agreement to be monitored by the Council Health Services Board (CHSB) and respective Facility Governing Committee (FGC).

i) Provision of core health services- Core health services include; - Clinical, preventive, promotive and rehabilitative services.

ii) Provision of non- core services – Non Core health services include; - catering, laundry, and security, maintenance of equipments and vehicles and estate management.

The LGAs will contract out provision of non- core services to private providers using existing Government procurement procedures (Government procurement Act 2004).

1.7 Health Centres and Dispensaries Planning Template.

The MoHSW in collaboration with PMO-RALG have designed the planning template that assists the lower health facility planning teams to use when preparing their plans and budgets for submission to CHMTs. The template intends to facilitate and guide the Health Centre and Dispensary teams, during the annual planning process, including the expected outputs, for their facility. It is expected that after submission to the CHMT; all the facility plans will be collated and integrated into the overall respective Comprehensive Council Health Plan. This is one of the prerequisites for the Health Plan to qualify as an integrated and comprehensive plan.

All CHMTs should ensure that all health centers and dispensaries adhere to the Template for developing Annual Health Plans for their facilities during their planning sessions. All annual plans from health centers and dispensaries should be approved by the respective Health Facility Governing Committees (HFGC) before the plans are submitted to the Council through the CHMT.

1.8 Operational Research

The use of correct and reliable information is crucial for both planning and assessing success and failure of heath service interventions implemented towards improving and maintaining of the health status of the population of the Council. The majority of this information can be derived from data generated by a well functioning Health Management Information System (HMIS) or *MTUHA*. Additional information requirements will need either further analysis of the existing *MTUHA* data or operational research to find answers or solutions to health systems challenges for example:

- Why do many pregnant women in your Council prefer delivering at home than health facilities?
- What are the reasons for pregnant women in difficult labor to be delayed to go to health facilities for delivery?
- How effective is the supportive supervision conducted by CHMTs?

Operational research is about searching for solutions to common health system challenges, where additional data, and therefore information, will need to be generated. It is not about conducting sophisticated biomedical research requiring many scientists, laboratories, sophisticated equipment and chemicals. Operational research is about conducting local studies tailored towards identification of solutions for main health issues with the objective of improving interventions, as an important requirement for continually improving on health services delivery.

All Councils should therefore plan and allocate some resources to finance operational researches in their respective Councils to generate and promote utilization of locally generated scientific knowledge. Councils will save resources and health status will be improved through provision of more appropriate, cost effective, affordable, quality and accessible health services through the utilization of the operational research findings. In addition, all Councils should plan to continually improve and update their HMIS systems and promote better use of routine data to inform CCHP formulation.

Where the Councils is near a public or private university or a research institution, the CHMTs should liaise with them to establish collaboration in undertaking health related researches by their students. Useful researchable topics or questions could be developed by members of the CHMTs for the students to conduct their researches and thesis. The CHMTs could also use already available research information, for example dissertations about the respective Council and other research reports. Finally, during the planning and development of the annual CCHPs, CHMTs should seek to utilize professional expertise from these institutions.

1.9 Nutrition

Nutrition is a very strong factor in the delivery of health services. When nutrition is addressed the following will be realized: reduction of malnutrition; prevention of low birth weight; reduction of high maternal mortality and morbidity; reduction of infant

mortality and morbidity; reduction of anaemia and elimination of micro-nutrient deficiencies.

Councils should work with other public and non-public institutions to promote and ensure adequate nutrition of all people in the council. CCHPs should plan to use locally appropriate mass campaigns and house to house outreach to promote appropriate nutritional behaviour of all people in the council. In these activities, the CCHP should plan to utilize expertise of Community Development Workers and other civil servants who work at ward level.

1.10 Community Based Health Services and Linkages with formal Council Health System

The MMAM plan to establish a dispensary in every village and a health centre in every ward has been well-publicized and is underway. The MMAM also includes plans to establish a cadre of Community Health care workers (a minimum of form 4 leavers) that have a formal standardized training and paid by the system. These CHWs will be accountable to the village authorities where they will be posted and monitored by a nearby Health facility.

For the implementation of the Community based health interventions and linking household and formal health services, CHMTs have to allocate the resources to facilitate their role in:

- providing the link between households and formal health service delivery facilities to ensure the needed continuum of care.
- improving referral including access to MNCH and other services
- providing households quality promotive, preventive, and rehabilitative services
- mobilizing communities for CHF/NHIF, enrollment, nutrition, and outreach services, etc.
- Collecting, document and use of community data

1.11 The Roles of Different Levels in the preparation of CCHP

The Local Government Authorities are responsible for the following:

a) Preparation of the CCHP and discussion with the Regional Secretariat and Regional Health Management Teams
b) Control and management of funds.
c) Management of service delivery including developing and signing service agreements with FBOs and private facilities
d) Preparation of quarterly progress reports and discussion with the Regional Secretariat.

The Regional Secretariat (RHMT) is responsible for the following:

a) Assessing the CCHPs and HMT plans and quarterly performance progress reports and undertaking the necessary follow up. The RS assessment of CCHP plan and progress report should follow the reporting format for both Plan and progress reports.

b) Ensure that Councils adhere to the schedule for annual CCHPs, HMTs plans and quarterly reports submission. The date of receipt of plans and progress reports will be shown in the schedule which is submitted to PMO-RALG and MoHSW.

c) Ensure that all the CCHPs comply with the National vision 2025, National Strategy for growth and reduction of Poverty, National Health Policy, guidelines and sector strategies.

d) Ensure consistency and accuracy of data presented in different tables and executive summary.

e) Ensure that budget figures comply with the approved budget ceilings. Where they differ, documentary evidence for the reallocation approval should be submitted (e.g. Council Minutes to support the revised budget or supplementary budget)

f) Ensure that all progress reports submitted to PMO-RALG and MoHSW are scrutinized in as per assessment criteria (annex 9 a &b)

g) Assess and collate all Council reports and prepare a Regional consolidated report to submit to PMO-RALG and MoHSW. The regional financial report will be derived directly from the Accounting Returns of the Councils showing:

   i. Approved budget of different sources including Personal Emoluments and Other Charges separately.
   ii. Actual receipts and payments, including receipts in kind
   iii. Consolidated income and expenditure

h) Recommend on councils qualifying for funding.

j) Providing written feed back to under-performing Councils and providing technical assistance to ensure that such Councils re-write the plans and progress reports to conform to the guidelines.

The ZHRCs is responsible for the following:

a) Provide continuous Technical Support/ capacity building to the Council Health Management Teams/ Council Health Planning Teams during development of CCHPs
b) Coordinate and conduct training on CCHP and PlanRep3 for new CHMT members
c) Conduct Supportive Supervision and Mentoring to CHMTs on implementation of CCHPs including ensuring the CCHPs comply with the CCHP Guideline, Government Health Policy and National Health Strategies.
d) Collaborate with RHMTs in assessment of CCHPs and Performance Progress Reports
e) ZHRC to be part of the team in the review of CCHP Guidelines including other Ministry's policy guidelines

The MoHSW and PMO – RALG are responsible for the following:

(a) Scrutinize the Regions' assessment reports and recommendations to ensure that the Regions and Councils have correctly utilized the allocated funds, progress towards planned targets and status of implementation in line with the Council, Regional and MOHSW priorities guidelines.

b) Scrutinize the reports for compliance with financial regulations and the consolidated report will be submitted to the BFC. The report will indicate the following:

i. A summary of health sector accounting returns including a recommendation for each Council

ii. Summary of Regional and Council's main achievements and challenges derived directly from collated Councils quarterly financial and technical reports by the RS.
iii. The means of overcoming the challenges.

1.12 Process and Timetable for Developing CCHP

The timetable below indicates all actions and timing required for developing the CCHP and all stakeholders should comply with. However, the preparation of the CCHP should not wait for the budget ceiling from PMO-RALG and MOHSW.

Table 2: Timetable for developing CCHP

S/No	Activity	Responsible	Completion Deadlines
1.	Councils Hospitals, Health Centers and dispensaries consult communities, FBOs, CSOs, and Private for profit providers to identify priorities and needs to include in the annual plans	Council Hospitals, Health centers and dispensaries	Early October
2.	Pre-planning meeting should take place with all stakeholders before the planning process so that the recommendations are incorporated into the CCHP.	CHMT & all Stakehlders	Early November
3.	Council/CHMTs collect priorities/ needs from Hospitals, Health Centres, Dispensaries, Community levels and other stakeholders through their plans to accommodate them in the CCHP	Council/CHMT	Early November
4.	Councils notified or collect information of resources available for Health Block Grant, Health Basket Funds and other partners for the next financial year.	PMO-RALG, MoHSW, Councils, Partners	End of November
5	Council Health Board and CHMT receive annual plans and budget projections from Council Hospitals, Health Centres, Dispensaries, FBOs, CSOs, and private for profit to be accommodated in the CCHP	CHMT & CHSB	December
6.	Comprehensive Council Health Plan reviewed by the Council Health Service Board (CHSB) prior to submission to RS/RHMTs	CHPT/CHSB	Mid January
7.	CCHP entered into MTEF (Recurrent and Development budgets prepared from the CCHP)	DT/DPLO/DMO	End of February
9.	The CCHP is submitted to the Regional Secretariat (RS). The RS checks the CCHP for its conformity with national guidelines. All recommendations from the RS to the Council are submitted in writing	RS/RHMT	End of March
10.	CCHP and budget approved by the full Council through different standing committees.	Standing Committees and FULL COUNCIL	End of April
11.	CCHP and Budget submission to Regional	CHMT	First Week of May

S/No	Activity	Responsible	Completion Deadlines
	Secretariat (**5 copies hard and electonic copy)**		
12.	The CCHP assessment report together with the assesed CCHP will be forwarded by RS to PMO-RALG and copied to MoHSW both in hard and soft copy	RS/RHMT	Third week of May
13.	PMO-RALG and MoHSW consolidate assessed CCHP reports from RS and recommend for funding approval	PMO-RALG/ MoHSW	First week of June
14.	Distribution of papers and recommendations for funding approval based on Preliminary summary and analysis of CCHP and third quarter financial income and expenditure for current financial year to BFC members	PMO-RALG/ MoHSW	Third week of June
15.	BFC meeting	BFC	Fourth week of June.
16.	Final summary and analysis of CCHP report presented at JAHSR	PMORALG & MOHSW	September

NB: CCHP shall be submitted to RS/RHMT for assessment and compilation before being submitted to PMORALG and MoHSW.

The preparation of the CCHP should not wait for the budget ceiling from PMO-RALG and MOHSW. Councils should use the last years' ceilings as the basis for planning.

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CHAPTER TWO

2.0 PREPARATION OF A COMPREHENSIVE COUNCIL HEALTH PLAN

Introduction

The Comprehensive Council Health Plan (CCHP) is a principal prerequisite for a well functioning Council health and social welfare system. All priority health and social welfare activities in the Council Strategic Plan and previous plans are incorporated into this annual plan; it has also to incorporate the National Package of Essential Health and Social Welfare Interventions including local priorities. The plan should be realistic, logical and linking the available resources with the health and social welfare needs. In developing the plan the following processes should be taken into account.

2.1 Pre-planning for the CCHP Planning.

The planning process emphasizes a bottom up planning approach. The planning team has to integrate the views and priorities of communities, health facilities from the lower facility's annual plans (health centers and dispensaries plans) and stakeholders' in line with the National Essential Health and Social Welfare Package, the Burden of Disease and available resources.

Initiatives to identify community health problems and social needs may be obtained using existing tools such as Opportunities and Obstacles for Development (O &OD), Community dialogue, Triple 'A' (Assessment Analysis and Action) and Participatory Rural Appraisal (PRA) applied during the development of lower health facility's annual plans etc.

Pre-planning meetings are important to ensure ownership and involvement of all stakeholders both public and private for profit and not for profit (FBOs, CBOs, NGOs and health service providers)

In the preparation of pre-planning session, the following important issues have to be adhered to:

- Ensure logistics and essential supplies are in place including availability of sufficient copies of the previous year CCHP and Previous year Annual implementation and Quarterly Progress reports and HMIS reports. (For example: In preparing the CCHP plans for 2011/2012, the CHMTs must have in hand the CCHPs of 2010/2011, Annual Progress Reports of 2009/10 and Quarterly Progress Reports of July 2010 – March 2011)
- Resource persons for specific topics should be invited
- Stakeholders of the pre-planning meeting to be invited well in advance (e.g. one month)

- Review previous year health performance indicators and targets.
- Stakeholders (FBOs, NGOs, CBOs, Hospitals, CHMT, Health Centres and Dispensaries) should hand-in their proposals in written form to the Council Medical Officer.
- Annual health centres and dispensaries plans

2.2 Composition of the Council Health Planning Team

The following members should compose the Council Health Planning Team responsible for the CCHP:

1. Council Medical Officer (Chairperson)
2. Council Health Secretary (Secretary)
3. Council Planning Officer (Technical Advisor)
4. Council Health Officer
5. Council Dental Officer
6. Council Lab Technology
7. Council Nursing Officer
8. Council Pharmacist
9. Council Social Welfare Officer
10. Co-opted members (DCCO, DRCH, DTLC, DACC, Malaria Focal Person, HMIS, School Health and NTD Coordinators)
11. Medical Officer In-charge
12. Council Health Accountant
13. Representative from the Private Sector
14. Representative from NGOs
15. Representative from Community Development Department
16. Representative of Faith based service providers (religious organizations, voluntary agencies)
17. Representative of the RHMT

2.3 Format of a Comprehensive Council Health Plan

The main objective of this format is to facilitate and provide clear instructions to the Council Health Planning Teams to prepare the required CCHP. In developing this plans the following annexes should be applied Annexes: 1- 14

In this context, the CCHP should have the following contents (formant):

Table of Content
List of Council Health Planning Team
Acknowledgement
Acronyms
Executive Summary
Budget Summary
Chapter 1: Introduction
Chapter 2: Situation Analysis
Chapter 3: Review of Resource Availability from all sources

Chapter 4: Health Problems and Priority Setting
Chapter 5: Objectives, Targets and Planned Interventions
Chapter 6: Plan of Action
Chapter 7: Targets and Monitoring Performance Indicators
Chapter 8: Assumptions and Risks

These contents are elaborated chronologically below:-

2.3.1 Table of Contents

A table of contents shows major topics and subtopics with respective page numbers while developing the CCHP to help the reader to trace and find relevant information easily.

2.3.2 List of Council Health Planning Team

Full names, titles and organization of all members of the CHPT should be clearly shown in the CCHP document to evidence participation of all stakeholders responsible for the preparation of the CCHP.

2.3.3 Acknowledgement

This is a paragraph where appreciation of the persons/institutions involved in the preparation of the CCHP and those who provided inputs in the planning process is written by the CHMT members and compulsory signed by the DMO/MOH.

2.3.4 Acronyms

Abbreviations used in the document should be listed for clarity.

2.3.5 Executive Summary

The Executive Summary should be prepared and signed by the **Council Director.** It is expected to be brief, not exceeding 2-3 pages and divided into two parts.

Part 1: Contains information reflecting a **summary** review of the previous year's plan implementation status. This should include intervention achieved and activities implemented in-terms of percentage, reasons, any issues that are of importance to be reported e.g. status of human resources, immunization coverage, status of facilities etc. (both positive and negative), The way forward should include re-planning of activities and related unspent funds in the new CCHP and implementation be reported in the first quarter. *Not listing presentation*.

Part 2: Contains a **brief summary** of the new plan. It should be written clearly to enable the reader to pick up essential information. It is expected to answer the following questions:

- What are the main challenges?
- How the Council cope with these challenges?

- What are the major interventions in the year and the linkage to the overall Council strategic health plan?
- Have last year's unachieved interventions been addressed in the current plan?
- What are the available resources and sources of funding?
- Who are the key collaborators in the Council
- Generally the executive summary presents the summary of the information presented in the tables available in the plans.

2.4 Detailed explanation for each chapter

2.4.1 BUDGET SUMMARY

There are four Budget Summary tables that should be prepared by Council Planning Teams and reflected in the CCHP: These Budget summary tables are:-

- Main Budget Summary reflecting all sources of funds and the amounts allocated to the Health Sector in the Council – see Annex 2.1
- Specific Budget Summary for Health Basket Funds – see Annex 2.2
- Specific Budget Summary for Health Block Grant – see Annex 2.3
- Specific Budget Summary for allowances, fuel for supervision and distribution and minor repair and maintenance of infrastructures – see Annex 2.4 (Reference should be made to paragraph 3.5 of this guideline whereby ceilings in percentage to these types of expenditures are stipulated).
- Summary of budget allocated to priority areas – see Annex 2.5
- Summary of BOD and budget allocated cost effective interventions 2.6

2.4.2 Chapter 1: INTRODUCTION

This chapter should include the following:

(i) The Council Profile showing:

a) Map of the Council with all health facilities (Public and Private) including those under construction
b) Geography: nature, climate, season
c) Administration: borders, structures (list of division etc.)
d) Human Resources for Health (HRH) and Social Welfare
e) Transport and communication: (roads, road conditions, phone/fax, e-mail and website

f) Water supply and electricity
g) Socio-economical information with gender perspective: ethnic groups, main economical activities, employment situation, education (literacy rate).
h) Population: total, per division, important population groups, vital statistics (pop. growth, Total fertility Rate (TFR), birth rate, mortality rate, urban-rural distribution, and poverty rate
i) Community involvement
j) Multi -sectoral collaboration including partners working in the Council.

NB: Most of this information is also found in previous years CCHPs and might only need minor modifications.

(ii) Review of previous year's performance
a) Have the planned targets been achieved?
b) What are the reasons for failure to achieve targets?
c) How have the allocated and carried forward resources been utilized?

(iii) Current CCHP:
a) Purpose of the CCHP (main Objectives and Targets)
b) How the needs were picked and prioritized
c) Inclusion of the annual health centre and dispensary plans
d) Available resources and sources

2.4.3 Chapter 2: SITUATIONAL ANALYSIS

This is a process of analyzing and interpreting health system information, the current situation from various perspectives in terms of needs and priorities linked with promotive, preventive, curative, and rehabilitative health challenges. The situational analysis needs to involve the study of all areas that will normally affect the performance of the council's health plans and programs.

SWOT/C is a simple framework for generating strategic alternatives from a situation analysis. The CHMTs /CHPT should conduct a SWOT analysis to identify and analyze the **S**trengths and **W**eaknesses of their councils which, are the internal factors influencing the performance of the council which could be improved by the council such as management performance, teamwork, planning skills, as well as the **O**pportunities and **T**hreats which, are the external factors influencing organizational performance such as: inflation, community support, and poverty etc. revealed by the information you have gathered on the external environment/factors. The O&OD concept can also be used to identify opportunities and obstacles for development. Also it is based on the data from the routine HMIS and Operational research.

The following tables are in Annex 5 and should be filled to provide/give the reader of the CCHP important information on the Council health situation:

(1) Important Primary Indicators of Health Status – table 1
(2) Vital General Council Health Indicators– table 2
(3) Main OPD Diagnoses (list the top 10 diseases depending on the prevailing situation in the district Council – table 3
(4) In Patient Admissions and Deaths per Diagnosis (list the top 10 diseases depending on the prevailing situation in the Council) – table 4
(5) Notifiable Diseases– table 5
(6) Summary of important HMIS Indicators showing the trend – table 6
(7) Health and Social Welfare Training institutions and other institutions - table 7
(8) Community Based Initiatives (CBI) available in the Council– table 8
(9) Status of Health Facilities (Dispensaries, Health Centers, and Hospitals), their Catchments Population and their Physical State and Health facilities planned for rehabilitation and constructions – table 9(a)
(10) Health Facilities planned for rehabilitation, construction under MMAM –PHSD table 9 (b)

(11) Summary of P4P Annual performance report Jan. – Dec. - table 10
Improve Maternal and Child Health performance indicators under Payment for Performance (P4P) Strategy

2.4.4 Chapter 3: REVIEW OF RESOURCES AVAILABILITY

Review of resources availability involves checking both the current as well as the future situations in the Council with respect to human resource for health, material/transport, infrastructure, equipment, information, time and finance.

The following tables are in Annex 5 and should be filled:

1. **Human Resource Requirement:**
   a. Human Resource for Health and Social Welfare requirement-table 11(a)
   b. CHMT core staff and co-opted members – table 11 (b)
   c. Health and Social Welfare Staff availability trend – table 11 (c)
   d. The Health and Social Welfare staff attrition – table 11 (d)

2. **Material / Equipment/ Medicines/ Supplies:**
   a. Overview on the availabilities and conditions of essential Medical Equipment and Apparatus – table 12
3. **Transport:**
   a. Vehicles and their use – table 13
4. **Sources of Funds**:
   a. The different Sources of Financing – table 14

2.4.5 Chapter 4: HEALTH AND SOCIAL WELFARE PROBLEMS AND PRIORITY SETTING

Problem identification

Based on the situational analysis, the CHPT should identify and prioritize health problems/challenges. Considerations should be given to health and health related problems, as these will require the CHPT's experiences, skills and knowledge in coming up with implementable plans (activities) and programs in the councils.

In this case the problem is the gap between the ideal situation and what exists. Problems can either be primary or secondary.

Primary health and social welfare problems

These are problems which are associated with the immediate causes of morbidity and mortality for example Malaria, Pneumonia, Diarrhea, etc. In Tanzania the following tools are well developed to give us guidance for priority setting of primary health problems.

- National Package of Essential Health and Social Welfare Interventions (NPEHSWI) – (Annex 3).
- Burden of disease profile (addressable shares) using DSS- Census, surveys, HMIS
- Council Performance Indicators
- HSSP III 2009-2015

The NPEHSWI focuses on the most important health problems in Tanzania. All planned activities should be in line with this package.

The Concept of Burden of Disease (BOD)

Definition:

The Burden of Disease is defined as total amount of healthy life lost over a specific period of time in a given population to all causes, whether from premature mortality and/or some degree of disability (physical or mental).

- *The unit used to measure the total amount of healthy life lost is time- Disability Adjusted Life Years (DALYs)*

The DALY measures health in terms of time per person, i.e. A Year of Future Healthy Life Lost per person. It is the sum of:

- Years of Life Lost due to premature death (YLLs), and
- Years Lived with Disability (YLD)

I.e. DALYs = YLLs + YLDs

Traditional Measures of Health Problems Used for Priority Setting

- Health service attendance (HMIS "Top 10 Diseases")
- Prevalence (Number of existing cases in the population now)

- Incidence (Number of new cases in the population per year)
- Severity
- Mortality

NB: Each one of these by itself presents only one, incomplete facet of the total amount of health problems in the community.

The Burden of Disease Profile as resource for District Health Planners

What is A BOD profile?

It is summary data on the BOD for a group of adjacent district/zones with similar ecological conditions.

- The profile is provided in the form of graphs in a manual.
- The profile gets the information from active DSS, HMIS and surveys.
- The graphs show the shares of the BOD that can be tackled using interventions included in the CCHP. These shares are therefore called "Intervention Addressable Shares of the BOD".

Note: Profiles are updated and provided annually by the MOHSW.

Why do we need a District Burden of Disease Profile?

- Distribution of the Burden of Disease is **not intuitively understood** by communities or health planners; needs graphical interface.
- **HMIS statistics** for ''top 10 disease'' is **biased** by attendance and misleading with regard to household and community problems
- Many **interventions and strategies are now integrated** beyond single diseases.
- What are the most important **cost effective intervention addressable burdens** of disease?
- What **proportional resources** should be directed to the interventions?
- **Objective data** on burden of disease and associated attributes **now available** from sentinel demographic and health surveillance systems (DSS)

The Burden of Disease (BOD) profile has identified disease conditions and interventions, which are the most cost effective and have a measurable impact on morbidity and mortality by 80% of the burden. These disease conditions and cost effective interventions are:

Burden of Disease and Cost Effective Interventions

Childhood Illnesses:

- Expanded Programme for Immunization Plus (EPI+)
- Integrated Management of Childhood Illnesses (IMCI)

Malaria

- Malaria case management with artemisinin combination therapy (**ACT, ALU**)
- Insecticide Treated Nets (**ITNs**)
- Indoor Residual Spraying (**IRS**)

Maternal Conditions

- Focused Antenatal Care (includes: birth preparedness, PMCTC, nutritional supplementation, IPT, FP counseling, TT, Syphilis Screening etc.)
- Comprehensive Post-Abortion Care
- Basic/Comprehensive Emergency Obstetrics and Neonatal Care (CEmONC)
- Safe and Clean Delivery Care by Skilled Attendants in Health Facilities
- Post-natal Care
- Family Planning

Newborn Conditions

- Kangaroo Mother Care
- Exclusive Breast-Feeding for the first six months and Infant feeding
- Essential New-born Care and
- New-born Resuscitation

STIs, HIV and AIDS

- Counselling and Testing (includes VCT, PITC, PMTCT)
- Management of STIs
- Condom Promotion
- Safe Blood Transfusion Services
- Antiretroviral Therapy (ART)

Injury/Trauma Care

- Integrated Management for Emergency & Essential Surgical Care(IMEESC)

TB Management

- TB DOTS (TB/HIV, MDR-TB, etc)

Secondary Health problems

These are the underlying causes of primary health problems e.g. inadequate/unsafe water supply, malnutrition, poor environmental health sanitation, low coverage of immunization, poor hygiene etc.

Structure and Management Related Problems

Besides the health problems reflected in the NPEHSWI, the interventions for the Burden of Disease profile and the set of indicator, the planning team should look deeper into the following topics:

Infrastructure and equipment shortcomings

a) Annex 5, table 12 gives a guideline to develop a list with medical equipment needed at a facility.

b) Annex 5, table 9 (a) & (b) gives a guideline to develop a list of Health facilities with rehabilitation and construction work needed and indicates the status of villages and Wards having these facilities and requirement per year.
c) There is inefficiency of the referral system due to problems of transport and communication. .

Management and supervision

a) Problems concerning management can be outlined, where are the shortcomings in management skills, what is hampering the management of the council, which skills are needed (e.g. leadership and management skills, supervision skills, computer, and others,) are some of the areas that could be discussed.
b) It should be mentioned whether supervision activities were carried out as planned both regarding the supervision carried out by the CHMTs and the supervision of the Council by higher authorities.

Problem analysis

Problem analysis is the art of critical examination of problems against prevailing conditions in an area e.g. a district. It is important that the CHMT/CHPT members analyse identified problems in the context of their prevailing conditions in the council of focus using problem and needs trees (*Using But Why Techniques*).

Priority Setting

Planning is essential because resources are always scarce and inadequate. Having identified there council health problems, using available resources the next logical step is to rank the problems in order of importance. Since the Councils will not be able to address all problems, challenges and needs identified above in one fiscal year, the planning team will need to do priority setting. This is known as problem prioritization. During this exercise national priorities need to be considered, the national priorities including the Health policy, HSSP III, MMAM, ONE Plan etc , National Package of Essential Health Interventions and Social Welfare, Councils Strategic Plan, Stakeholders Plans from lower area health priority, availability of resources, capacity to implement, and Magnitude of the problems facing the Councils (morbidity and mortality) NPEHSWI

While prioritizing problems, the CHMTs/CHPTs need to focus selection in consideration of the following factors:

1. Equity
2. Community participation
3. Acceptability by consumers
4. Availability of appropriate technology
5. Affordability to the consumers
6. Community expressed needs

Criteria for ranking health problems

1. Magnitude

In terms of the proportion affected such as women, pre-school children, school children and the elderly. This basically describes how big the problem is.

2. Severity/danger

To the individual and the community. How serious is the condition? Does it threaten life, because major suffering, and decrease the ability to lead a normal life, reduce productivity? At this stage BoD should be applied.

3. Vulnerability to intervention (feasibility)

If a problem is not vulnerable to intervention, it makes no sense to include it in the list of those targeted for action.

4. Cost of intervention

Expressed in terms of cost-effectiveness. This criterion should answer the question whether the problem, if addressed, is worth the financial cost involved.

5. Political expediency

Even if a problem fulfils all of the above criteria, if it is not recognized by the central authority, it is very difficult to include it among the high priority list.

Criteria for ranking secondary problems

Secondary/contributory problems are usually prioritized according to the following three criteria:

a) Extent to which the secondary problem is a cause or a major contributing factor to the primary problem(s)
b) Its amenability to change in terms of acceptability, case and technical feasibility of bringing about change
c) Cost effectiveness associated with such change

In the process of prioritising the problems, the CHMT's will have to consider national priorities, health service needs, and community expressed needs. Communities expressed needs are essential to be included in plans as they ensure community ownership of the interventions and this leads in sustainability of activities

NB: The identification of problems (Primary and Secondary) should be linked with the situation analysis and should be the basis for priority setting, intervention planning and resources allocation.

2.4.6 Chapter 5: OBJECTIVES, TARGETS, INTERVENTIONS, ACTIVITIES AND COST ANALYSIS

Based on the status identified under situation analysis in chapter two and the priorities set in chapter 4, relevant intervention packages and their contents should be identified and linked to the resources available. From the intervention the Council Health Planning Team needs to establish clear targets and activities. The activities should address the provision of quality health services; therefore include activities such as supportive supervision of hospital by HMT, on the job training and clinical mentorship in specialized areas.

Setting objectives and targets.

There are different planning approaches and certain terms used in a different way. Therefore, it is crucial to have a common understanding of these terms. The following definitions are generally used.

Objectives define the ultimate achievements one wishes to obtain with a given input and process. They are found in Council strategic plans which describe goals for a period of 5 years and above. Objectives are broad statement of what is to be achieved, they describe an intended outcome or impact and summarizes why a series of actions have been undertaken. Objectives should be considered institutional and lettered A to Z. This does not imply prioritization as all carry equal importance. When selecting objectives the planning team should select objectives defined in the Council Strategic Plan as denoted below:

Objective A: Improve services and reduce HIV/AIDS infection

Objective B: Enhance, Sustain and effective implementation of the National anti-Corruption Strategy

Objective C: Improve access, quality and equitable social services delivery

Objective D: Increase Quantity and Quality of social services and infrastructure

Objective F: Improve social welfare, gender and community empowerment

Objective G: Improve Emergency and Disaster Management

Targets need to be stated in terms of what can be achieved within a relatively specified period of time (e.g. 1 year), which ultimately lead to achieving objectives**.** Targets must be SMART meaning Specific, Measurable, Achievable, Realistic and Time Bound, further elaboration of this term and examples of targets can be found in Annex 4. National Targets. Targets are of three types: **Capacity Building (C)**, activities related to developing the capabilities of the institution to deliver services. **Service Delivery (S),** the provision of a service to the public or

to other institutions, and **Capital Investment (D),** the acquiring of capita assets, either through purchase or construction.

A target is defined as a desired amount of progress towards an objective through a number and quality of specified activities that have to be carried out before the objective can be reached. A *target is a final good or services produced over a given period of time by an institution in order to achieve its objectives*.

Targets are ordered under their objectives as 01, 02, etc. This reflects a priority ordering where the lower numbered targets are deemed more important than the higher numbered targets

Developing targets:
Targets are developed in a consultative manner, by reviewing objectives, considering relevant findings from the situation analysis and defining a series of strategies. Strategies may be derived from MKUKUTA or may be specific to an institution.

Strategies
Strategies are broad statements about how something is to be done.
In this context, they describe **how** the institution/council will achieve its objectives, they link objectives to targets. Strategies are contained in the MKUKUTA (and are called cluster strategies) while others are derived independently by the institution/council. A single strategy may result in the derivation of several targets.

Performance indicators
An indicator is a Quantitative or qualitative factor or variable that provides a simple and reliable means to measure achievement, to reflect the changes connected to an intervention, or to help assess the performance of an institution or a variable that allows the verification of changes in the development of interventions or show results relative to what was planned. Indicators are usually stated in SMART format. Indicators are often disaggregated to compare results and frequently have time-specified target and baseline values.

For all councils a set of 20 indicators has been identified, please refer annex 6**.** The Council Health Planning Team should address those indicators that are not satisfying e.g. low vaccination coverage, and others to be specified

The format in Table 3 can be used when identifying targets. The columns have to be filled out as follows:

Problem: list all priority health problems identified during the priority setting discussion in the planning team.

Targets: Define targets that can be achieved in 1 year's time (refer Annex 4) Rolling in 3 to 5 years according to the CHSP/National Targets

Activities: Determine activities by which the targets can be reached.

Priority area: Write here for each activity the priority area according to the essential health package (NPEHSWI- (refer annex 3)

Area of intervention: Write the intervention area, which you find under the respective priority area in the NPEHSWI

Table 3: Formulating Objectives, Targets and Activities
Council……..

Priority Area (EHP)	**Area of interventio n (EHP)**	**Problem**	**Objectives (Code & description)**	**Target: (Code Description)**	**Activity (code & description)**	**Cost Cent re**
1	2	3	4	5	6	7
Maternal Newborn and Child Health	New born care	High under 5 children mortality rate.	**C:** Improve access , quality and equitable social services delivery	**01S:** Under 5 years mortality rate reduced from 109/1,000 to 95/1,000 by June, 2015	**C01S01:** To procure baby resuscitation supplies and medicines for 5 Health facilities by June, 2012	
					C01S02: To Conduct orientation on Care of high risk neonates premature birth asphyxia and macromic neonates (HELP BABIES BREATH) to 10 Health centre workers for 5 days by June 2012.	

The example above is in relation to the stated problems NB: you can have several targets to achieve the objectives.

NOTES:

1. This table shows clearly that every priority area is addressed fully and serially starting from priority 1 to 11. It will be easy to track in every priority area if all important problems and targets are captured.
2. All targets and activities in a given priority area will easily be seen at every cost centre.
3. The cost effective interventions be identified to address the burden of disease
4. Because the cost analysis matrix and plan of operation matrix is prepared by cost center, activities per cost centre can be easily obtained by filtering or sorting procedures if excel is used to prepare this table. Therefore, when preparing this table use **Excel** to facilitate preparations of the following tables.

5. Activities in this matrix should be numbered serially and should be the same as those appearing in the plan of operation

Intervention

Is an action that is taken over a period of time to address priority health problems. An intervention comprises a set of several activities. (Note: Strategies and interventions are described in the Essential Health package, **MKUKUTA**).

Activities

Activity is the action taken or work performed in order to produce a given target.
Activities are what institutions do and describe processes which are largely internal to the institution. They describe how a target is to be produced. Activities are ordered under their targets as 01, 02, etc. This reflects a priority ordering as it did with targets. Specific actions taken to produce the outputs,(end results) and have to be SMART .

Inputs

Input, the financial, human, and material resources used during the completion of an activity. Inputs are frequently measured in terms of financial costs. Inputs are denoted by GSF codes, which are describes as follows for example: Perdiem, extra duty allowance, diesel, petrol, ticket, medicines, medical supplies, Salary, contract, stationery, etc.

Cost Analysis

Costing is a process of estimating cost of each input for every activity by putting together the activity to be implemented and the related inputs, quantity of inputs, and price per unit costs and total cost in a matrix forms. (Unit cost must be known). Go to table 4 below to fill out the cost analysis matrix.

Table 4: Example of Cost Analysis of Training

1. Cost Centre and Ceiling: Code & description: (E05: Hospital**: (No 1) Ceiling: 25% -35% = 60,000,000 – 80,000,000 Tshs.**

2. Priority area: Maternal, Newborn and Child Health

Intervention	S/No	Activity (code & description)	Output/ indicators	GFS Code	Description	Unit Cost			Total unit cost	Source of funds
3	4	5	6	7	8	9			10	11
Obstetric Care	1	**C01S01**: To conduct a 2 weeks training of Service Providers on LSS for 12 participants and 4 facilitators		E05K 220709	Conf. facilities	12	1	50,000	600,000	BF
				E05K 220301	Petrol	1	1	300,000	300,000	
				E05K 221404	Food and refre	12	12	1,000	144,000	
				E05K 220103	Stationary	1	10	20,000	200.000	
				E05K221005	Daily allow					
				E05K221005	Perdiem -Participants	14	12	15000	2,520,000	
				E05K221005	Perdiem - Facilitators	12	4	20000	480,000	
				E05K221005	Perdiem – Driver	14	1	5000	70,000	
	Subtotal								**4,794,000**	

It is advisable to develop this table using EXCEL to avoid mistakes in mathematical calculations

Explanations:

1. Cost Centre and Ceiling: - Write the cost Centre you are planning for. (E.g. E05- Rural Hospital) and the related ceiling amount.

Ceiling: Related to "Basket Funds" and "Block Grants", to each cost centre a certain percentage range is allocated (see chapter 3 Table No. 6). Insert the percentage range at the space marked as No. 1

For other sources of financing (council own resources, cost sharing money) there is no need of filling in this box, because the ceilings are not applicable to them. Multiply this percentage range with the total available budget and write the amount in front of the percentage space marked No. 1 (Example: total budget: 200.000.000 Tshs. to the cost Centre "hospital" 25% - 35% are allocated: 200.000.000 Tshs. x 0.25 =50.000.000 Tsh / 200.000.000 x 0.35 =70.000.000) Consequently for the cost centers "Hospital" from 50.000.000 to 70.000.000 Tshs. can be spent.

2. Priority area: See chapter 1: There are 11 priority areas

i. Maternal, Newborn and Child Health
ii. Communicable Disease Control
iii. Non – Communicable Disease Control
iv. Treatment and care of Neglected Tropical Diseases and local priority
v. Environmental Health and Sanitation
vi. Strengthen Organizational Structures and institutional capacities for improved Health Services Management at all levels;
vii. Social Welfare and Social Protection
viii. Strengthen Human Resources for Health Management Capacity for improved health services delivery
ix. Emergency Preparedness and Response
x. Traditional and Alternative Medicine
xi. Health Promotions

3. Intervention: According to Annex 3 (NPEHSWI)

4. Number: Each activity has to be serially numbered. The same number has to be kept in all other tables and reports (Operational Plan, in the report tables 5). To keep the same number is crucial, because numbering the same activities differently in different tables leads to confusion.

5. Activity: Put activities in the space marked No. 5 in table 4. If additional activities have been identified; add them to table 4.

6. Output/indicators: Write the expected output indicators No. 6 in table 4, output-indicators are mainly the process indicators should be SMART.

7. Cost center: Insert Cost center code number at the space marked No. 1 in table 4. The following are the code number of the cost centers for the District/Rural Councils starting with **"E"** and Urban Councils starting with **"B"**

Cost Centre for Rural Councils

DMO/CHSB	E04
Hospital	E05
Health Center	E02
Dispensary	E03
VAH	E06
Community	E07

Cost Centre for Municipalities/Town Councils

DMO/CHSB	B14
Hospital	B02
Health Center	B03
Dispensary	B04
Community	B16
VAH	B15

8. Source of fund code: Refer No. 7 of table 4 - The following three main sources of funds have codes: **Block grants (K), Council own source (M)** and **Basket Fund (Z).** Other sources of funds refer charts of accounts issued by PMO-RALG.

9. GFS-Code: Refer No 7 of table 4- The appropriate item of expenditure code should be entered for each input.

10. Description of the GSF -Code: Refer No. 8 of table 4 - Break down activities as much as possible. Sometimes, however, it is difficult to do so. Example: Rehabilitation of a dispensary. In this case it is advised to estimate the costs per unit and to multiply the costs by the number of facilities you want to rehabilitate.

11. Unit costs: Refer No. 9 of table 4 - Write the unit costs. Example:

- Allowances for 20 participants in a 2 days' workshop: 20 x 2 x 45.000
- BP machines: 2 per 5 HC 2 x 5 x 80.000

12. Total unit cost: Refer No. 10 of table 4 - Write total unit costs. Examples:

- - 20 x 2 x 45000 = 1.800.000,
- - 2 x 5 x 80.000 = 800.000

13. Sub-total of activity cost: Add the total costs per activity, for example the total cost for a workshop/training and write it here.

14. Sources of funds: Refer No. 11 of table 4 - Write sources of funds in words.

2.4.7 Chapter 6: PLAN OF ACTION

Plan of Action (POA) describes when activities will take place and who is responsible for implementing them. Plan of Action describes when activities will take place and who is responsible for implementing them. This describes when each activity is planned to start and finish. Action plans are sometimes termed "work plans". Typically action plans assign responsibility for who will initiate and manage each activity. Action plans incorporates procurement plans, since an activity can be considered to have two broad stages: a procurement stage and an implementation stage. Plan of Action cover one year only. POA is closely related to interventions and activities in Cost Analysis table 5 below. The POA is produced automatically if the Cost Analysis table is filled correctly and properly in PlanRep3.

Table 5: The Plan of Action - Example

1. Cost Center: Code and Description e.g. E03- Dispensary

Intervention	S/No	Activity (code & description)	Outputs Indicators	Time Frame	Sources of Funding/ amount							Responsible person
					Block Grants	Basket funds	Counc Own source	Cost Sharing (U/NHIF/ CHF	Receipt in Kind	MMAM	Other Funding	
2	3	4	5	6	7	8	9	10	11	12	13	14

NB: This POA table will be produced automatically if the Cost Analysis table is filled correctly and properly. It's not done manually. When printing Health printout, this also will be printed.

Components of the Plan of Action

Columns numbered 1-14 indicate the followings

1. **Section/ Level/Cost Centre: Write Hospital, Dispensary, Community etc**
2. **Intervention:** Write intervention (identical with the column "Intervention" in "Cost analysis)
3. **S/No:** The serial number of activities has to be the same as in the cost analysis table
4. **Activity:** Write activity code & description (C01S01) -Write activities (identical with the column "Activities" in "Cost analysis)
5. **Output / Indicators:** Write the expected output indicators, you defined. Output-indicators should be independent from the activities.
   They also have to be SMART (specific, measurable, attainable, relevant, and time-bound)

Example: Activity: "train 40 health care workers in Life Saving Skills"
Good indicator: In 80% of all Health Facilities (measurable) with maternity ward the partographs are correctly used (specific, relevant, attainable) by the end of the year (time bound) Bad indicator: 40 health workers are trained.
Define indicators for all activities!

6. Time frame: Indicate the quarter when the activity is going to be carried out.
7. to 13: The respective amount per activity should appear in the respective column
14. **Responsible person**: Indicate the person responsible for facilitating implementation of the identified activity.

2.4.8 Chapter 7: MONITORING OF PERFORMANCE INDICATORS

The implementation of the CCHP has to be followed by appropriate monitoring tools. This is very often a cumbersome exercise requiring a lot of additional resources. Therefore, the MoHSW and PMO-RALG has opted for an alternative approach by determining a set of 20 indicators, for which each district has its own baseline data, for each performance indicator. This is further explained in chapter 7 and annex 6. This exercise is part of priority setting and has to be done at this phase.

2.4.9 Chapter 8: ASSUMPTIONS AND RISKS

Assumptions and risks are defined as anticipated barriers to implementation of plans or performance. These may be barriers to performance or barriers to achieve implementation of objective. The assumptions and risk that should be mentioned are those that might affect the CHMTs ability to meet their targets. The assumptions should be realistic otherwise it might be necessary to go back and revise the plan. The assumptions may be:

1. Financial resources and their availability
2. Inflation
3. National health policy and realization of the Health sector reform
4. Availability of qualified human resource for health
5. Supply of medicines, supplies and equipment
6. Emergencies and Outbreaks
7. Availability of Technical Assistance
8. Political support
9. Ad-hoc Plans and instructions
10. The capacity of the RHMTs

CHMT must take presumptive measures or precaution to mitigate the risks

ANNEXES: Annex 1 – 14

N B: **Annexes 8&9** should be used as a self assessment tool to evaluate the quality of the developed CCHP. The tool is also used by RS/RHMT for assessing the CCHP and performance progress reports**. For self assessment of quarterly reports, Councils can us Annex 9(a) and 9(b) for the same, which are also used by the RHMT to evaluate the quality of the reports.**

CHAPTER THREE

3.0 GUIDING PRINCIPLES ON THE USE AND DISBURSEMENT OF FUNDS FROM DIFFERENT SOURCES

3.1 Overview of funds currently available for the CCHP

The CCHP can easily be developed if all financial resources available are known because most of activities need to be matched with funds. Sources of funds for CCHP include:

Funding Flowing through the Councils:

1) Health Block Grants/ Council grants consist of:
   a) Personnel Emoluments (P.E.): salaries for the staff
   b) Other Charges (O. C.): recurrent costs
   c) Development Grant
2) Health Basket Funds
3) Cost sharing money - User fees, from Facilities, CHF/TIKA, NHIF, NSSF
4) Local Government Development Grant (LGDG)
5) Health Sector Development Grant (HSDG) (Health window)
6) Council-own sources consist of:
   a) Recurrent Costs
   b) Development Budget

Other Funding:

1) Block Grant from MOHSW to Council Designated Hospitals
2) Bed and staff grant to VAs Hospitals
3) MOHSW-Fund for medicines, equipments and supplies through MSD
4) Global Fund
5) National programs (NMCP, NACP, EPI, NTLP, FP, others specify)
6) NGO (Plan international, World Vision etc)
7) Development partners Bilateral and Multilateral.
8) Donations (cash/receipts in kind)

It is essential that the respective authorities (MoHSW, PMORALG, and Councils), National programmes, NGOs and other partners working in the Councils must provide the planning team with reliable financial figures in time. But it is also the responsibility of the CHMT to actively request for this information.

3.2 Guiding Principles for the Health Block Grant and Health Basket Funds and Other sources of funds

a) The Health Block Grants are divided into Personnel Emoluments (PE) (Salaries), Other Charges (OC) and Development.
b) OC of the Health Block Grants and Health Basket Funds are intended to support mainly the recurrent budget of health sector. The Health basket should not be funding PE activities.

c) Funds for rehabilitation/construction are provided for under LGDG and Health Sector Development Grant (HSDG) through PMO-RALG as stipulated in the Primary Health Services Development Programme –MMAM (2007-2017).

d) Complementary sources such as CHF, NHIF and TIKA are spent at the Health facility where it was collected, in line with financial regulations of the Government.
e) The CDH and VA hospitals receiving Basket Funds or signed the Service Agreement will not charge MNCH services.

3.3 Budgeting and spending of Health Block Grant and Health Basket Fund resources

LGAs should comply with:

a) All technical and professional regulations provided by MoHSW in the delivery of health services.
b) Their own set performance targets within the context of local health and social welfare plans, which takes into account national priorities, local conditions, local priorities and the availability of local resources.

c) All financial standards and budget procedures as mandated by PMO-RALG in the Local Government Authorities Accounting Manual.

3.4 Resource allocation formula for Health Block Grants and Health Basket Funds

The annual allocation of funds from Central Government to the LGAs is based on a resources allocation formula that is used to distribute the Health Basket Funds and Health Block Grant. It takes into account the following allocation factors:

- Population (70 %)
- Poverty count (10 %)
- District medical vehicle route (10%)
- Under-five mortality (10%)

a) In recognition of the individual as the main client-recipient of health and social welfare services, 70 percent of the Health Block Grant and the Health Basket are distributed in proportion to the population of each council. In addition to the

overall population, districts receive additional resources for the special needs of a poor population (10% of the grant resources), the special needs of rural population and the needs of local governments with a higher Burden of Disease.

b) The formula recognizes the higher expenditure needs of rural areas by directing 10% for the route mileage regularly travelled by health sector vehicles. As such, the formula takes into account the higher operational cost of delivering health services to a rural population and to sparsely populated areas; including higher costs faced in drug distribution, immunization and supervision.

c) The formula also aims at directing resources (10%) to places with high burden of diseases; here the under-five mortality (U5M) is considered as an appropriate proxy for burden of diseases.

d) The funds allocated through the resources allocation formula is translated into action through the CCHP and its six cost centres. It is important to note that the resource allocation formula and the cost centres have no direct relationship.

3.5 Allocation to Cost Centers in the Council

Funding is allocated to the following 6 cost centres:

a) Office of DMO
b) Council Hospital (including CDH)
c) Voluntary Agency Hospitals (VAH) / Service Agreement (SA)
d) Health Centre (Public and VA owned)
e) Dispensary (Public and VA owned)
f) Communities

For each cost centre the percentage allocation range for the combined funding from the health basket and OC of the Block Grant is as follows:

Table 6: Allocation Ceiling for the Health Basket Fund and Block Grant (OC)

Cost center	**Ceiling range for allocation by Council**
Office of DMO	15% - 20%
Council Hospital /CDH	25% - 30%
Voluntary Agency Hospitals (VAH) *	10% - 15% (Health basket funds only)
Health Centre	15% - 20%
Dispensary	20% - 25%
**Community Initiatives	2% - 5%

**** If not exist, Funds should be allocated to other cost centres in the Council.***

** **NOTE:** Community initiatives apply only to activities that are initiated by the Community that have to be supported by this cost center. Not activities done/implemented at the community level by Health Providers

Explanation for Allocation of Resources to Cost Centres

a) Allocation given to each cost centre should not be less than the minimum percentage or more than maximum percentage provided for within that cost centre range.

b) The health planning team can allocate within the range given in the table above, however, the total allocation sum for all cost centres combined should not exceed, or be below, 100% of total Health Basket and Block Grant Allocations.

c) CDH and VAH will receive funds from the Health Basket. The Health Block Grant will not be given to CDH and VAH because they receive their allocation directly from the central government.

d) If there are Voluntary Agency Hospitals in the Council which have signed the Service Agreement, then the basket fund contribution should be in the range of 10%-15% of Basket Funds.

e) If there is more than one VAH with a signed Service Agreement, the planning team has to allocate the Basket Fund budget according to service/work load criteria agreed with the VAH. If the requirements are more than what is available, it can be complemented from other source if any.

f) Where there is no VA hospital the 10%-15% amount will be allocated to other cost centres.

g) DMO office allocation includes distribution and supervision related costs and cost for running the Council Health Service Board activities.

h) Health Centres and Dispensaries allocation should include costs for operation of facility governing committees.

i) Community allocations include costs for Community Based Health Initiatives (CBHI).

j) Councils should honour all approved activities in the CCHP, no re-allocation of funds is permitted.

k) Councils should account the funds they receive by providing acknowledgement receipts (exchequer receipt voucher (ERV)), quarterly and annual reports reflecting financial income and expenditure. All funds are subject to an audit by the Controller and Auditor General (CAG) or any audit firm appointed by the CAG.

l) Allocation of the Health Block grants and Basket funds for LGAs and VAs Health Centres and Dispensaries are mainly not in cash terms. For Health Centres and dispensaries that have no bank accounts, should maintain a vote book. The

commodities to be procured must be in the procurement plan of the LGAs and VAs Health Centres and Dispensaries. Therefore, the Councils will make the payment for purchase /services rendered to the LGAs/VA health centres and dispensaries.

m) LGAs should allocate amount of funds for specialised clinical services which they may seek from the Regional Referral hospital, zonal or national level in their CCHP.

3.6 Resources Allocation by Type of Expenditures

This section gives guidance on the resource allocation to be used on allowance, transport and maintenance in order to maximise expenditures on actual service provision targeted to the clients.

Table 7: Allocation of allowances for supervision, distribution, transport and minor repair

Ceilings for basket funds.		
Type of expenditure	Allocation Ceilings/ Range	Examples of Expenditure
Allowances	Maximum 20%	Allowances for supervision and distribution activities only
Transport	Maximum 20%	Fuel, maintenance of vehicles
Minor Repairs/ Maintenance	Range 10- 20%	Planned Preventive Maintenance of technical, medical equipment and HF

a) Funds for allowances for supervision and distribution from basket funds should not exceed 20%.
b) Allowances for training activities allocated to the respective interventions from basket fund are not part of the 20% ceiling
c) Funds for fuel for supervision, distribution and maintenance of vehicles should not exceed 20% of the Health Basket Funds.
d) Councils are allowed to meet the cost of training within training institution in Tanzania
e) It should be noted that vehicles procured/allocated to the health sector are to be used strictly for health activities
f) Funds for minor repairs and maintenance of buildings and repairs of technical equipment should be in the range from 10%- 20%. Major rehabilitation of health centres and dispensaries are described in chapter 6.

3.7 Resource Allocation Formula for Medicines and Health Supplies for Primary Health Care facilities

Schedule for Allocation

There is funding for medicines and medical supplies from MOHSW through MSD as Receipts in Kind. This budget line is allocated for the individual government health facilities and designated non-government facilities nationwide at the Medical Stores Department (MSD). The decisions on allocation of funds are the responsibility of the MoHSW.

The MoHSW has revised the resource allocation formula for medicines and medical devices from the flat rate allocation of TShs 810,000 and 390,000 per month for Health centres and dispensaries respectively, to the new formula based on facility workload.

The new allocation scheme has two-stages:

1) Population based allocation to Councils; The parameters considered are;
    a. 70% council population
    b. 15% council poverty index and
    c. 15% council under 5 years mortality index

2) Division among health centres and dispensaries within each council based on facility service population.

NB:

- The source of the data and information is the current data available from the National Bureau of Statistic.
- District hospitals receive a medicines budget proportionate to district population.

3.8 Allocation of budget for medicines and medical supplies out of stock from MSD

The Councils should set aside funds using other sources of funds from Basket fund, Other Charges, Complementary Financing Schemes (User fees, CHF, NHIF etc) to purchase additional medicines and equipment which are out of stock at MSD. Evidence of out of stock has to be provided by the order forms/invoices showing the missed items, which have to be approved by the Council Director (CD). These medicines or equipment must be purchased by the DMO-Office through PMU in accordance to the Public Procurement Act of 2004 and its related Regulations.

3.9 Special Exemptions to Specific Conditions

During implementation of the CCHP if specific peculiarities necessitate special requirements for change of approved activities in the CCHP for the use of the Health Block Grant or the Health Basket Fund the CHMT, will submit a request through the CHSB and Council Standing Committees and approved by the Full Council. After the approval the changes should be communicated to the RHMTs and the respective ministries. The proposed activity should be in line with the CCHP guideline.

3.10 Disbursement of Funds

3.10.1 Disbursement of Health Block Grants and Health Basket Funds

Disbursement mechanism for both Health Block Grant and Health Basket Funds from the Centre to Councils will follow government procedures. However, condition for disbursement of Health Basket Fund is different from Block Grants. This section outlines in details the actual disbursement of Health Basket Funds.

3.10.2 Disbursement Mechanisms for Health Basket Funds to Councils

a) PMO - RALG in collaboration with MOHSW recommends to the BFC, CCHPs and/or progress reports for approval and funding.

b) BFC will approve transfer of funds from the Holding Account to Councils through Treasury, based on the recommended list of Councils compiled by PMO-RALG and MOHSW.

c) The PMO-RALG prepares a request to the Accountant General to transfer the approved amount of funds from the Health Basket Funds holding account into the Exchequer Account. MoF will notify PMO-RALG and the BFC on the released of funds to Councils in writing.

d) The Accountant General facilitates the transfer of funds from Exchequer Account to the respective Council's Development account. The Council Treasurer must immediately inform the Council Medical Officer in writing that funds is available in the Councils' account. Auditors have to verify compliance to this requirement.

e) PMO-RALG notifies Councils with a copy to MOHSW, RS and Basket Partners on the amount of Health Basket Funds transferred for records, follow up and comparison with the approved budgets.

f) The Disbursement of 1st quarter (July-September) funds depends upon submission of satisfactory January - March technical and financial progress reports and approved Comprehensive Council Health Plan for the current year.

g) The disbursement of 2nd quarter (October – December) funds is subject to correct and timely submission of the Annual Council's technical and financial reports of the previous year (July – June).

h) Disbursement of the 3rd quarter (January- March) funds to the Council subject to correct and timely submission of the first quarter (July –September) technical and financial report that also reports on progress made to attain expected outputs for that quarter.

i) The disbursement of 4th quarter (April – June) funds will depend on October – December technical and financial reports.

CHAPTER FOUR

4.0 PREPARATION OF PROGRESS IMPLEMENTATION AND PERFORMANCE REPORTS

4.1 Performance Reporting, Monitoring and Evaluation

This chapter describes an institutional reporting framework for Government institutions/ LGAs, in the form of a set of reporting requirements. These requirements aim to improve internal decision making enhance accountability and transparency. The content of these performance reports will be generated through a series of M&E initiatives, to be practiced by LGAs. These M&E initiatives will go beyond the implementation monitoring (of financial expenditures and activities) often practiced in the past and will include assessments of efficiency and effectiveness. Reporting requirements consist of three main reports: quarterly progress reports, annual performance reports, and three-year outcome reports.

Performance Reporting

What is a Performance Report

A performance report is defined as a written document, prepared by a Government institution/LGA, which describes the institution's/LGA's efficiency and effectiveness in terms of its use of resources, outputs it produced, and whether it was successful in providing benefits to and improving the condition of its clients. All reports cover a specific time frame. This definition of "performance" extends far beyond matters of implementation and includes analysis and interpretation of the reasons **why** performance may have met or may have failed to meet expectations or standards.

A good performance report is readable and easy to understand, analytical and evidence based, objective, and accessible to both stakeholders and decision makers. Such a report is used and actionable, rather than a document for the shelf. The report may be supported by a series of standard forms, sheets, tables, or matrices, but in isolation these support documents do not constitute a complete performance report.

Why Performance Reporting

By providing feedback in terms of plans and budgets, performance reporting serves a number of key functions. It:

- Assists management to identify problems, assess progress, and take corrective action at an early stage. Performance reporting contributes towards more systematic decision making.

- Satisfies accountability requirements both within and outside the organization. Within Government, performance reporting can support an environment for enhancing transparency and accountability to the public.

- Stirs debate about key issues both within an institution and across society.

- Shapes organizational culture by communicating a common story, documenting an organization's history, and thus unifying an organization and contributing towards its institutional memory.

- By achieving these functions, effective reporting contributes towards improved institutional performance.

Qualities of a Good Performance Report

Performance reports will meet their objectives only if they are available, accessible, read, and understood by their audience and only if stakeholders provide feedback and management takes action based on the report (where required). In writing performance reports, the contents, style, and detail should be determined by the intended audience and by the frequency of the reporting process. In general, a good performance report should have the following features. It:

- Is readable and easily understandable; it "captures" the audience and encourages the audience's participation

- Provides enough background so readers can put the main results into their proper context.

- Documents the methods used in gathering data and information and drawing inferences or conclusions.

- Clearly separates the key points from the minor, secondary ones. This allows readers with different goals or different amounts of time to make better use of the report. Highlights are generally found in an executive summary with details and long matrices placed in an annex.

- Is analytical and evidence based; this establishes the logic of the results presented. Where recommendations are made or inferences are drawn, these need to logically flow from the data and analysis undertaken.

- Makes use of graphs or pictures to make numbers more "digestible". (A picture tells a thousand words).

In summary

Progress reports are intended to provide feedback on the implementation of the planned interventions and activities including how the allocated budget has been spent.

The reports are part of the monitoring tools that help to inform about challenges encountered during implementation to facilitate improvement. These reports are prepared quarterly (quarterly progress report) and Annually (Annual report). The quarterly progress report (Technical & Financial) help to monitor the implementation of the plan to enable implementers to take corrective measures while implementation is in progress. It also helps to trigger disbursements of the quarterly funds (Income and expenditure). The annual report (Technical & Financial) is used to provide information on evaluation of the implementation of the plan (performance of the Council) on annually basis. All Councils are thus required to prepare and submit quarterly and annual technical and financial implementation reports to the RS.

4.2 Tracer Lines for HMIS (MTUHA)

The Ministry of Health & Social Welfare has revised and updated the indicator on availability of medicines, medical supplies, laboratory reagents and vaccines that will be part of the pilot new HMIS (MTUHA). The indicator will report on a number of "tracer lines (items)" that is set to a maximum of 10, to keep the burden of reporting manageable. There can be an additional two lines left as blanks on the data collection form to be defined according to local interest (at district/region each year), for example safe delivery kits/packs for mothers.

Definition of Availability

For each tracer line "availability" is defined as continuous supply of the specified item or therapeutic equivalent. If the required service or treatment was provided to clients and patients of all age groups throughout the month, then the tracer line is defined as **available**.

Example 1: If labour was managed with oxytocin injection while ergometrine injection was out of stock, then the Tracer Line 6 is reported as **available**, because the case was managed with a therapeutic equivalent. If all of the therapeutic alternatives oxytoxin, ergometrine or misoprostol were out of stock, then Line 6 is reported as **not available** because the recommended treatment could not be provided.

Example 2: If cases of malaria in one of the age groups could not be treated, then the Tracer Line 2 for the ant malarial medicine "ALu" is reported as **not available.** If an adult with malaria was dispensed ALu in two strips of 6 X 2 (instead of one strip of 6 X 4) then ALu is reported as **available**, because the treatment dose was provided.

Purpose

The purpose of this tracer indicator is to report on the CCHP indicator on availability: "**Proportion of health facilities by level with constant supply of medicines/medical supplies and laboratory agents at hospital, health centre, and dispensary level".**

Reporting

Each health facility will report availability (Yes/No) of tracer items during the reporting period (one calendar month). If "No", then facility reports the duration of stock-out (<1 week/1-3 weeks/whole month). The district report will tabulate the number and proportion of health facilities reporting continuous supply for **each** tracer line. Secondary analysis will tabulate the number of facilities having stock-out of all therapeutic alternatives in the tracer line, and the number falling in each category (A, B or C). Table 5 in annexes (10 and 11).

4.3 Preparation of Progress Reports

Progress reports shall cover the technical and financial folds of implementation.
Production of accurate performance progress technical and financial reports assists Council Management and other partners in:

a) Developing policies and planning for the future operations
b) Making informed and effective decisions on the allocation of resources
c) Measuring the performance of the health department in the Council
d) Controlling and monitoring the operations and
e) Ensure that funds from Government, donors and other partners are utilized for the purpose for which they were authorised.

The parties that are responsible for preparation of implementation/progress Technical and Financial reports are:

a. The DMO is responsible for preparing sound technical performance reports, which provide information on the implementation status of the CCHP.

b. The Council Treasurer is responsible for the preparation and distribution of the accurate financial reports

c. The Council Director is responsible for scrutinising and signing the report in the executive summary of the progress report for accountability and ownership.

4.4 Progress Reports Technical and Financial

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

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

Councils **shall** submit quarterly technical and financial reports duly signed by Council Director to the RS for assessment and compilation of regional report to be submitted to PMORALG and MoHSW.

4.4.1 Quarterly Technical and Financial Progress Reports

The Quarterly Progress Report is intended to provide an overview of implementation progress on a cumulative basis against an institution's set targets and budget. The report will also provide information on the implementation of priority interventions.

The quarterly technical and financial progress reports shall comprise the following parts:

(a) The executive summary
(b) Technical/physical
(c) Combined Technical and financial performance
(d) Report on the status of tracer medicines/items
(e) The financial or accounting return statement.
(f) Constraints /challenges encountered during implementation
(g) Way forward how to address the constraints/ challenges reported
(h) Summary of budget variations and their justification

Executive summary is a summary made from Annex 10; tables 1, 2, 3, 4, 5 and 6**.** It summaries the activities performed and achievements in qualitative and quantitative form such as (1) the number/percentage of supervision coverage done, (2) the outreach services conducted, (3) number of health staff/providers trained in service delivery e.g. Malaria case management, (4) the percentage of children vaccinated, mothers and underfive attended at MNHC services, (5) the number/percentage of patients followed such as TB defaulters, (6) the number/percentage of patients who received ARVs, number of health facilities providing EmONC services etc. Also (7) the status of medicines and medical supplies in the health facilities- out of stock (tracer medicines), Percentage of activities implemented against planned, Percentage of partial and carried forward activities, etc. Summary of financial trends (opening balance, receipts for the period, funds available for the period, expenditure for the period and closing balance), and explain by giving reasons if there is any negative balance in any source .

The detail explanation and tables are in Annex 10. The tables to be filled out are as follows:

- Table 1: Summary of Quarterly Financial position
- Table 2: Technical/ physical progress report
- Table 3: Summary of quarterly implemented activities status by quantity
- Table 4: Summary of approved budget against expenditure according to priority areas
- Table 5: Availability of tracer medicines/items (Vaccines, Medicines, contraceptives, medical and Laboratory supplies)
- Table 6: Combined Technical and Financial Performance Reports for Comprehensive Council Health Plan
- Table 7: Health Sector Accounting Return (Recurrent) Schedule A- Summary, Schedule B1 of 2, Schedule B2 of 2 and Schedule C

4.4.2 Annual technical and financial performance reports

The Annual Performance Report is intended to provide a detailed description of an institution's main achievements in terms of the targets reached and the progress it is making in realizing its outcomes and in improving its service delivery. The report should also address performance on revenues and expenditures as well as HR (Human Resources). Responsibility for the preparation and accuracy of the report lies with the Accounting Officer for each LGA

The report should be prepared and submitted to PMO-RALG through RSs and a copy to MOHSW. It should also be made available to other stakeholders, including appropriate Parliamentary Committees and members of the public (on the institution's web site or through other relevant media).

The annual technical and financial performance report writing format is the same as the format for the quarterly reports.

However, the tables are different and as shown in Annex 11. The tables to be filled out are as follows:

- Table 1 : Summary of annual Financial position
- Table 2: Annual Technical/ physical report
- Table 3: Summary of annual implemented activities status by quantity
- Table 4: Summary of expenditure according to priority areas
- Table 5: Annual report on availability of tracer medicines/items (Vaccines, Medicines, contraceptives, medical and Laboratory supplies)
- Table 6: Annual combined Technical and Financial Performance reports for Comprehensive Council Health Plan
- Table 7: Health Sector Accounting Return (Recurrent) Schedule A-Summary, Schedule B1 of 2, Schedule B2 of 2 and Schedule C

4.4.3. Annual Financial income and expenditure statements

(a) Councils shall prepare a separate health basket fund statement of income and expenditure (IPSAS compliant) for auditing.

(b) PMO-RALG shall prepare and submit to the BFC the summary of the LGAs Annual Expenditure Report showing budgeted against actual expenditure for recurrent expenditure included in the Consolidated Comprehensive Councils Health Plans.

Note: *The format for the annual expenditure report will be exactly as that of the accounting return as for financial report see (annex 10 table 7)*

4.4.4 Additional Information on the Preparation of Financial Reports

Accounting return should be straight forward as the procedure applies.

a. The Treasurer should ensure that financial reports are reviewed for accuracy and compliance to the approved Comprehensive Council Health Plans Guideline format before submission to RS/RHMT.
b. Schedule A will be completed after filling of schedule B1 and B2

c. Schedule C of the Accounting Return has been included, which requires Councils to summarize expenditures on Personal Emoluments (PEs), Allowances and Other Charges. The Treasurer should monitor regularly to ensure that the **PE expenditure does not exceed the Conditional Block Grant figure**. This provides assurance that, Basket Funds are not spent on PE. Also allowances do not exceed the receipts from conditional grant plus the Council's own sources. RS will focus in this area when undertaking the financial checks of the return.

d. After the report has been accepted by the Council it should be forwarded to the RS in **5 five hard copies and soft copy.**

4.4.5 Monitoring Technical and Financial progress status.

a. The Council Director is responsible for monitoring financial and operational performance. The Head of Health Department is responsible for keeping an update Vote Book.
b. The Treasurer collects bank statements for the account and reconciles with the Health department cashbook records on a monthly basis. Bank reconciliation statements shall form part of the quarterly financial report.

c. The Council Treasurer and the Head of Health Department present the quarterly reports to the Council's Health Service Board, Finance Committee and Full Council as per format provided in this guideline.
d. The Council Director forwards five (5) hard copies and a soft copy of the progress reports to the Regional Secretariat.

e. The Regional Secretariat checks the progress reports for compliance with the approved annual Comprehensive Council Health Plans and forwards the assessment reports and 2 hard copies and the soft copy of each Council to the PMO-RALG and MOHSW.

Important reminders

1. The table should be prepared in Excel/PlanRep/Epicor to facilitate easy and accurate mathematical operations.
2. The reports are cumulative, therefore, the second quarter financial report should contain the information of the first and second quarter in column B of the Accounting return; the third quarter report should contain the information of the first, second and

third in Column B of the Accounting return; the fourth should contain information of all quarters in Column B of the Accounting return. However, Councils are required to prepare separate annual report both Technical and Financial according to the guideline. The Financial part of the annual report should comprise all quarter's information including the opening balance reported at the beginning of the fiscal year as reported in the first quarter.

3. Each cost center should have sub-totals at the end
4. All implemented activities carried over from the previous year should be clearly indicated in the report with reference of activity number and the year of the CCHP
5. Executive summary should have two tables indicating 4th quarter and the other one annual report. ***This does not exclude preparing the annual implementation report (Technical and Financial)***
6. Please all data must be correct and same in all tables including the executive summary

4.4.6 Frequency of Reporting and Reports Submission

The Council Treasurer will report on a monthly basis to the Finance Committee the financial performance of the Council health services, disclosing receipts, expenditures and balances of all the funds allocated to the Council. The report will be accompanied by bank statement, bank reconciliation and certificate of the Bank balance. The Council will then submit the quarterly report to Regional Secretariat for the scrutiny and further submission to PMO-RALG and MOHSW.

Table 8: Quarterly and Annual Implementation of CCHP Reporting timetable

Activity	**Responsible for action**	**Timing of Action**
1. Councils produce and submit Progress reports • January – March report for the approval and release of 1st Quarter funds • July to June report for the approval and release of 2nd Quarter	Council Director submits Progress Reports to RS (RMO)	• January – March report by 15th of April • July-June report by 31st July

Activity	Responsible for action	Timing of Action
2. RS (RHMT) produce and submit Progress reports • January – March for the approval and release of 1st Quarter • July to June for the approval and release of 2nd Quarter	RS (RMO) submits Progress Reports to PMO-RALG and MoHSW	• January – March report by the 30th of April • July-June report by the 15th of August
3 Councils produce and submit October – December report	Council Director submits Progress Report to RS (RMO)	By the 15th of January
4. RS (RHMT) scrutinise and submit October – December report	RS (RMO) submit Progress Report to PMO-RALG and MoHSW	By the 31st of January
5. Councils produce and submit April – June report	Council Director submits Progress Report to RS (RMO)	By the 15th of July
6. RS (RHMT) scrutinise and submit April – June report	RS (RMO) submit Progress Report to PMO-RALG and MoHSW	By the 31st of July
7. Presentation and submission of the draft report for the 1st to 3rd quarter CCHP performance (Income & Expenditure)	PS (PMO-RALG/ MoHSW) submit to BFC	By Third week of June
8. Final summary and analysis of progress reports compiled for submission to the BFC/ Bi-Annual TC SWAP	PS (PMO-RALG/ MoHSW) submit to BFC/ Bi- Annual TC SWAP	By April/May
9. Presentation of the Annual CCHP Plans (Performance) reports	PS (PMO-RALG/ MoHSW)	Joint Annual Health Sector Review (Sept.)
10. Request the Accountant General to transfer Council Health Basket Funds from USD Account to the respective Council Accounts	PS (PMO-RALG)	Within 1 week after BFC meeting
11. Copy of Telegraphic Transfer (TT) sent to PMO-RALG and RS and RS notify Councils	PS (MoF)	2 weeks after BFC approval

CHAPTER FIVE

5.0 ACCOUNTING, PROCUREMENT, STORES AND AUDITING

5.1 Accounting

5.1.1 Local Authority Accounting Procedures

The Local Government Authorities will use the normal LGAs' accounting procedures as laid down in the Financial Memorandum and Local Government Finance Act in force. The following descriptions emphasize those procedures and their application to the Health Funds.

a. The Basket Funds are transferred to Development Account No. 2 through which all income and expenditure for health are channelled.

b. All income and expenditure on health services will be brought into the accounts of the local authority through its general ledger system and must be adhered to.

c. The signatories to the authorisation of expenditure for Council Health Department within Development Account No. 2 are in two groups:

Category A - The Council Medical Officer (DMO)/Medical Officer of Health (MOH) and her/his appointee from among CHMT members.

AND

Category B - Council Director and her/his appointee

d. The DMO or MOH or their deputies **must sign** all payment vouchers drawn on this account.

e. The Treasurer will manage the bank account and all accounting through the normal Council accounting procedures.

f. The Treasurer should inform the Health Department on receipt of funds immediately after being credited in the Development Bank Account.

g. The Treasurer must acknowledge receipts of funds to PMO-RALG copy MoF.

h. Receipts of non-monetary resources such as medical supplies and equipment (Receipt in kind) will be valued on receipt and included in the Council's accounts, debiting the relevant expenditure account and crediting government grants or another appropriate revenue source.

It should be emphasized that there is redress within the Law against any officer who interferes with the delivery of services resulting from using Basket Funds contrary to the guidelines.

5.1.2 Health Sector Accounting Return

In Annex 12 there are notes that are intended to assist Council Staff in completing the Health Sector accounting Return. Note the following:

1. The return should include recurrent receipts and payments only
2. Returns should be made within four weeks of the end of the quarter
3. Returns should be made to the Regional Administrative Secretary, who should be the first point of contact in the case of any question on the content of the return

5.2 Procurement:

CHMTs should prepare the Council health procurement plan just after approval of the CCHPs and submit to Procurement Management Unit (PMU) of the Council as required by Public Procurement Act 2004.

5.2.1 Accounting for Stores

The purpose of this section is to describe the system and procedure to be followed and the documentation which shall be used to account for and control of stores.

5.2.2 Stores System:

The supplies officer receives all non-consumable and consumable materials procured, loaned by council, donation or grants received from other partner(s) into the store.

In co-ordination with the receiving and inspection of goods committee, the Supplies Officer examines, inspects, test deliveries to ensure if they are of the right quantity, quality, price and supplied from the right source. All receipts must comply with the contract of supply. Goods or materials that do not comply with the stipulations of the contract shall not be accepted. An expert shall be invited to advice in case of a technical or scientific test or experiment.

a) The Supplies Officer in collaboration with the receiving/inspection committee shall sign acceptance, damage, and shortage or rejection certificate and thereafter write a report to the accounting officer.

b) Issues of consumables and non consumables materials shall be issued after receiving the dully authorized stores requisition and issue note (SRIN) or the stores issue voucher from the relevant cost centre for direct use.

c) When the issues are for stock/kit replenishment on new items not originally stocked, a dully authorised distribution list shall be prepared by the District Medical Officer (DMO) to request the Stores Officer issue from the store. The Stores Officer shall prepare a stores issues voucher to be signed at the cost centres. The cost centre shall after satisfactorily receiving the material/goods,

raise the Goods Received Note (GRN) or the Store Receipt Voucher (SRV) to be retained at their centres for records and auditing purpose.

d) The Supplies Officer should update the bin cards/stock cards after reconciliation of entries with the stores ledgers and physical stock.

e) At the end of the council financial year an annual stock count shall be carried out under the overall supervision of the Councils Internal Auditor.

5.2.3 Stocktaking

There are four types of stock taking:-

a) Perpetual stock counts:-

1. It is a continuous or daily stock taking
2. The stores Officer in collaboration with another person checks the items in stock to verify physical balances against the records
3. Usually a certain percentage fixed should be counted daily depending on the type of store and volume of activities involved.
4. More weight should be given to higher values and fast moving items
5. The information given should be used to reconcile and update the records

b) Periodic independent counts

1. Physical checks after a fixed interval of time usually at least after each quarter of a year.
2. An independent person or a team shall be appointed by the supervisor at irregular interval as to verify physical stock and the records.

c) Surprise stock counts

1. It is a surprise count by an independent person e.g. the supervisor, auditor or stock verifier. The purpose is to check if the stores procedures are followed.

d) Annual stock taking

1. It should be carried out at the end of a financial year.
2. Depending on the type of the store and the volume of activities involved, a stocktaking team shall be appointed by Council Director.
3. The External Auditor may be involved to carry the stock taking.
4. The stocktaking sheet is used to record the transactions.
5. The stores officer shall prepare a stocktaking report assisted by the stocktaking team leader.
6. The Stock taking team leader shall approve a stocktaking report and submit it to the Council Director.

The decision to dispose the items either by tender or public auction should follow the Local Govt Finance Act and Regulation and Procurement Act and Regulation.

5.2.4 Board of survey

a) In each, financial year a board of survey shall be appointed by Council Director to Survey the items in stock/inventory and submit its recommendations for disposal. The composition of a board of survey shall include the heads of Departments or Senior Officer in the council.

b) Duties of a board of Survey shall include:
   1. Survey the items for disposal and condemnation
   2. Check if the items for disposal or condemnation are correctly posted in the suspension or Unserviceable ledger and updated accordingly
   3. Recommend the ways to dispose scraps, obsolete and dormant items
   4. Assess the residual value of the items to be disposed
   5. Endorse the unserviceable stores form after the recommendation.

c) Duties of the stores officer:
   1. Report the items for disposal
   2. Post the items in suspension or unserviceable ledger and update accordingly.
   3. Arrange for a place to allow the board of survey inspect the items
   4. Prepare a list to show the items description, series numbers, code numbers, available quantity and its locations
   5. Fill in the unserviceable stores form.
   6. Ensure the Board of survey members write their recommendations and sign accordingly
   7. Submit the dully filled forms to the Head of department (DMO/MMOH) for approval and forward to the Council Director.
   8. The decision to dispose the item either by tender or public auction should follow the Local Government Finance Act and Regulation.

5.2.5 Losses

Classified as normal loss and abnormal loss:-

a) Normal loss: - Allowed loss because it is caused by the nature of the item or natural factors causes, e.g. leakage of sugar, rice or nails from the sacks and fuel during handling. The evaporation of fuel caused by natural factors such as temperature etc.

b) Abnormal losses: - Caused by ignorance, natural hazards such as fire, and theft.

1. The Stores Officer shall write a normal loss report to account for the loss, forward it to the supervising officer for approval and thereafter to the

Accounting Officer. Usually a fixed percentage is allowed by management after consultation with the product expert.

2. To issue the items the Stores Officer shall write the stores write off issue note/voucher, endorsed by supervisor and Accounting Officer.

3. Abnormal loss: - shall be reported by writing a Loss Report immediately to the Accounting Officer.

4. In case of theft the loss shall be reported to the police by supervising officer or Accounting Officer.

5. In order to issue the lost items in the records the Stores Officer shall write a write off suspense issue note/voucher pending police inquiries and investigation.

The Local Government Finance/ Procurement Acts, Regulations, Rules and Procedures will apply in accounting for losses

5.2.6 Accounting for Funds deposited at Medical Stores Department (MSD)

The purpose of this section is to describe the system and procedures to be followed and documentation to be used to account for funds deposited at MSD by MOHSW for medicines, equipment and medical supplies to the councils. The DMO/MMOH must make sure that each Health facility receives invoices and Statement of Account showing the transactions and balance in the facility account with MSD at each delivery together with other necessary documents.
In monitoring and accounting for funds deposited at Medical Stores Department, the following system will be applied to monitor Government funds deposited at MSD:-

1. It is the responsibility of the Ministry of Health and Social Welfare (Chief Pharmacist), to inform the Council Directors on the funds deposited at the MSD for the procurement of medicines and medical supplies whenever allocation is done.

2. Upon receiving information from Ministry of Health and Social Welfare on the amount deposited at MSD, the Council should debit MSD ACCOUNT and credit Ministry of Health and Social welfare.

3. On receiving medicines and medical supplies from MSD the Hospital Therapeutic Committee (HTC) or the Health Facility Committee (HFC) and Facility Management Team should inspect the goods to ensure that, they are of right quantity, good quality and condition. The following entries should be

passed, DEBIT stores respective item and CREDIT MSD with value printed on the invoice. Items supplied at zero cost e.g. contraceptives and other vertical program medicines should be valued and entry should be passed.

4. If the HTC or HFC is not satisfied with the physical condition of equipment or if the medicines are expired or short expiry date, the products should be rejected and returned to MSD immediately together with the Verification and Claim Form detailing the items rejected.

5. When medicines are issued from stores to the respective cost centre, the following entries should be passed to record the value of the medicines and medical supplies, DEBIT Cost centre Receipt in kind and CREDIT stores respective item.

6. MSD should provide Councils with statement of accounts on quarterly basis. Councils should reconcile the MSD statements with the account maintained by Councils to identify and deal with discrepancies.

5.3 Auditing

Financial Audit

Two types of audits are carried out to audit the Health sector department accounts in the Local Government Authorities, namely Special and Annual / year-end audit.

Special Audit

Special audit is normally undertaken by the Auditor to investigate and report on findings. Areas that may be covered in such investigations may relate to fraud, embezzlement and review of specific accounts.

Annual Audit

(a) The National Audit Office (NAO) will undertake the annual audit or any Auditor appointed by his / her office to audit Basket and other funds.

(b) Councils are required by law to maintain Books of Accounts as provided in the Local Authority Accounting Manual. These accounts should be closed at the end of the financial year and final statements prepared and submitted for audit as stipulated by the Local Government Finance Act No. 9 of 1982.

(c) The Basket Financing Committee may recommend special audit of any Council with approval of CAG for the Health Basket Funds if the need arises.

Annual Audit Reports

(a) After the end of the Financial Year (FY) within three months, Local Government Authority shall prepare and submit its accounts inclusive of Health Basket Funds to the Auditors for audit, who shall complete the audit not later than six months after the end of the FY.

(b) An Internal Auditor as well as External Auditor shall audit the accounts of the Council.

(c) The Internal Auditor shall report the findings to the accounting officer and a copy to the National Audit Office.

(d) The Council Director must ensure that all audit queries raised are correctly replied on time and take appropriate action.

(e) Council Treasurers and the DMO/ MMOH/ TMOH shall prepare Action plan to address all Health Basket Fund audit issues and recommendations and report on actions taken to Councils and PMORALG on quarterly basis. Disciplinary action shall be taken against the defaulters.

Performance Audit or Value for Money

Performance Audit is looking Value for Money liking with the service that has been provided. In broad terms, it can be applied to:

- those activities involving a considerable level of resources
- projects that are at risk of failing in their objectives
- issues which are of concern to Parliament or the PAC.

It is important that any public sector organization including health in the country should ensure that optimal VFM is achieved from the resources provided. The term "**value for money**" refers to the way in which resources (financial, human or physical) have been allocated and utilised by the Ministry/ LGA. On the other hand, performance audit is defined as an objective and systematic examination of a public sector organization's programme, activity, function or management systems and procedures to provide an assessment of whether the entity, in the pursuit of predetermined goals, has achieved economy, efficiency and effectiveness in the utilization of its resources".

Pursuant to section 28 of the Public Audit Act No. 11 of 2008, the Controller and Auditor General have been mandated to carry-out Value-for-Money (VFM) or Performance Audit in the Ministries, Departments, and Agencies (MDAs), Regions, Local Authorities and Public Authorities and other Bodies. The purpose is to establish the economy, efficiency and effectiveness of any expenditure or use of resources in the respective audited entity.

CHAPTER SIX

6.0 IMPLEMENTATION OF THE PRIMARY HEALTH SERVICES DEVELOPMENT PROGRAMME

The purpose of this chapter is to have an overview of physical status (operational/non operational) and location of the existing health facilities and to assist Councils with the planning of rehabilitation and construction activities. In addition, the chapter is meant to guide each district to develop plans and budgets for a comprehensive infrastructure development plan, maintenance and repair works and for the disposal of waste.

6.1 Introduction

The Primary Health Services Delivery System in Tanzania consists of a pyramidal network of facilities that begins with dispensaries, progresses to health centres, and then advances to district hospitals. In principle, the referral system is designed such that the dispensary refers patients to health centres that, in turn, refer patients to district hospitals. Unfortunately this system does not function as intended. A number of factors contribute to this situation including, among others, an inadequate standard for required buildings, under-funding, weak management arrangements, inadequate staff, and difficulties in transport communication, MIS, logistics and supplies. In addition, accessibility to health care services is still inadequate due to many reasons. In some areas, people depend on health facilities in more than 10 kilometres distance. Even where health facilities are accessible within 5 kilometres, facilities are in disrepair and human resources, medical equipment, medicines, supplies and laboratory reagents are insufficient. These conditions contribute to inequitable access to health services. The revised National Health Policy (2007) and the Primary Health Services Development Strategy (MMAM, 2007-2017) intend to address these issues in order to improve access to health services.

The existing Tanzanian health infrastructure requires better maintenance, major rehabilitation, upgrade of buildings to carter for the required services, upgrade in equipment, and a well-planned expansion to the village level in synchrony with the necessary expansion of human resources. Most dispensaries and health centres lack appropriate staff housing[1]. Many existing staff houses are in a bad state of repair. This housing situation affects the attraction and retention of health workers, especially in rural areas, and compromises health service delivery. Thus, this is an important area, which is up to the discretion of the Councils to address.

NB: It is important to observe the cleanliness and safety of the premises. It is the responsibility of all staff members to keep the working environment clean and safe for their patients and visitors.

[1] According to "Situation analysis report for preparation of standard guidelines and drawings by PMO-RALG" 80% of dispensaries and 30% of health centres have no staff housing

6.2 Different Funding Sources

There are currently many different funding sources for infrastructure rehabilitation. Funding may come from the following:

- Block Grant – Development
- MoHSW MTEF budget
- Health Basket
- LGDG – Local Government Development Grant
- HSDG – Health Sector Development Grant
- Councils – own resources
- Projects and Programmes – TASAF, CDC, PEPFAR, NGOs, FBOs etc.

All parallel funding for health facility rehabilitation and construction should be captured in Table 1, 2, 3&4 of Annex 14 including a list of the physical and financial status of the facilities as well as the completion date of the activity. Each Health Facility should fill out table 5 & 6 in Annex 14 for any new construction or major rehabilitation works. This table will be used by the health facilities themselves and will not be part of the CCHP report, but it may be used for future auditing.

6.3 Comprehensive Infrastructure Development Plan and Mapping of Facilities

6.3.1 Comprehensive Infrastructure Development Plan

Each district should have a comprehensive infrastructure development plan for 2009 – 2015 (part of the LGA Health Strategic Plan 2009 – 2015) with the basic necessary utilities (clean water, electricity, sewage, waste). The plan will ensure that existing health facilities are functional and not duplicated or underused, and that additional service is provided with the best value for money. The comprehensive infrastructure development plan is based on the assessment of existing health facilities, the infrastructure shortcomings and a prioritization of rehabilitation, extension and new constructions. For each health facility (existing or new), the infrastructure development plan must show the following:

1. the additional cost for investment
2. staff and operation cost per inhabitant served after implementation

The prioritization of investments shall be based on the principle of best service for money. Hence, priority should be given to assure functioning of the existing health facilities by prioritising rehabilitation, renovation, and maintenance. For new health facilities staff houses must be built and title deeds obtained. LGAs should use the Standard Drawings and Guidelines for Health Facilities presently developed by PMORALG in collaboration with MOHSW. PMORALG will support LGAs with existing mapping information in the establishment of these comprehensive infrastructure development plans.

6.3.2 Mapping of Facilities

PMORALG will support LGAs with existing mapping information in the establishment of these comprehensive infrastructure development plans. Each district should produce a map listing all available health facilities (private, public and faith based). It should indicate availability of some basic supplies (clean water, electricity, sewage waste) and the overall physical status, whether it is:

1. under construction
2. extension
3. rehabilitation
4. new and non-operational
5. new and operational

The map should also indicate access to the health facilities with variables including access in rainy seasons, types and/or quality of access roads, etc. The maps should also note facility communication capacities, as well as access to medical waste facilities by type, including incinerators and dumps by quality and proximity. Fill out table 1 in Annex 14

6.4 Maintenance and Repairs

All health facilities should have a PPM (Planned Preventive Maintenance) Plan and accompanying budget for infrastructure and equipment maintenance, including one for minor repairs, from the health basket. The Budget for maintenance and repair must be based on an intensive inspection (at least yearly) of the buildings and equipment. The highest priority for a health facility is to have adequate supply of water. The CHMT in collaboration with the District Engineer will support the basic health facility in this activity.

For the Health facilities' own internal reporting and monitoring system fill out table 3 & 4 in Annex 14. This table will only be filled out and used by the health facilities themselves and will not be part of the CCHP report, but it may be used for future auditing.

6.4.1 The budget must include the following for infrastructure/buildings

1. Funds to carry out yearly intensive and comprehensive inspection of the building
2. Funds to include yearly adequate amount for small repairs
3. Develop an systematic "facility development plan"/Planned Preventative Plan on what should be improved and when
4. Include adequate resources for routine yearly improvements as per development plan (e.g. rooms should be re-painted every few years)
5. Funds to ensure that the basic supplies/utilities such as clean water, electricity, sewage and waste are operational and a budget for repairs available
6. Funds for minor repair of any waste incinerators or other medical waste systems, including waste receptacles

6.4.2 The budget must include the following for medical equipment:

1. Plan for cost of at least one preventive maintenance and calibration visit for medical equipment per year
2. Establish a facility strategic equipment development/replacement plan (which equipment to improve, add, or replace and when)
3. Provide adequate resources according to the strategic plan for the activities for the year

For all activities there should/must be some support by adequately qualified district staff or Technical Services (Engineer for maintenance/repair of buildings, Biomedical Engineer/ technician for maintenance/repair of medical equipment). Funds from the basket and CBG can also be used for training and upgrading technicians.

6.4.3 Medical waste management

A medical waste management strategy for the facility is an essential component of these plans. The facility should review the mapping exercises for the following: 1) identification of the nearest medical waste destruction or containment service center and 2) establishment of a strategy and related system for medical waste management. Each facility should have its own waste strategy. Each unit of the facility should have a section in that plan. All plans must take into consideration both medical waste management resources, including everything from warning labels and disposal units to appropriate gloves, as well as standard operating procedures (SOPs). Shortages in necessary resources to meet plans should be placed in a list and provided to the CHMT. Facilities already possessing waste disposable infrastructure should provide upkeep and maintenance plans and funding to assure the proper operation of those services. Those that do not must develop feasible alternatives, combining their own respective plans with those of the closest facilities offering such infrastructure with the support of local government.

6.5 Guideline for the LGDG and the Health Sector Development Grant (HSDG Health Window)

The Government and the Development Partners have agreed to establish a Health Window within the Local Government Development Grant (LGDG) for complementing the development budget for the health sector at the local level. All rules and regulations of the LGDG will apply also to the Health Window. This sector window will fund construction, rehabilitation and procurement of equipment as well as holistically planned expansion of health facilities within the jurisdiction of the Local Government Authorities (LGAs). To address existing inequity[2] in distribution of health services, LGAs should in their planning exercises consider giving priority to remote and underserved areas within their jurisdictions, taking into account both public and private services. HSDG funds will be available for the rehabilitation both of public and non-profit private health facilities (NGO/faith-based). LGAs shall avoid constructing a health facility where there is already a non-profit private health facility. It is foreseen to increase the LGDG Basket Capacity Building Grant (CBG) in each fiscal year in order to allow LGAs to seek support in improving their planning capabilities for

[2] Tanzania Services Availability Survey, 2007

the benefit of the expansion of health services in line with the guidance from PMORALG and MOHSW.

6.5.1 Minimum conditions

Minimum conditions for access to the Health Window are the fulfillment of the minimum conditions within the general LGDG assessment and the timely submission of the Comprehensive Council Health Plans (CCHP). At least 10%-20% of OC (out of Health Block Grants and Health Basket Funds) have to be budgeted for minor repairs and maintenance of buildings and repairs of technical equipment (see section 3.6 table 7).

6.5.2 Resource Allocation

*****The resource allocation formula follows the allocation of block grants in the health sector, reflecting health needs and poverty. Qualifying criteria reflecting the service coverage may be developed and applied in subsequent years upon adoption of the Technical and Steering Committee of the LGDG. The allocation formula for Health Window development funding will be as follow:

Population	70%
Poverty index	10%
Council medical route	10%
Under-five mortality	10%

***The resource allocation formula may change to address actual problems facing Local Government Authorities.**

The LGDG Steering Committee will decide and inform on Health Window allocations together with the discretionary LGDG allocations. Each council will be allocated an amount from the Health Window based on the minimum conditions and performance measures used for allocating the discretionary LGDG as outlined in the LGDG System Assessment Manual. Table 9 below illustrates the system:

- A council meeting the minimum conditions of the LGDG assessment will receive 100% of its health window allocation if it receives an aggregate score of more than 75 points while obtaining a passing score of 5 in each of the functional areas.
- A council meeting the minimum conditions will receive 80% of the allocation if it receives an aggregate score of between 51-74 points while receiving a minimum passing score of 5 in each of the functional areas.
- All other councils meeting the minimum conditions will receive 50% of the amount allocated through the formula.
- If the council did not meet the minimum conditions, the council would receive 50% of the transfer amount subject to strict oversight by PMO-RALG and the Regional Secretariats as outlined in Section 3 of the 2010 LGDG System Assessment Manual.

Table 9: Percentage of MMAM/HSDP budget allocation to be received by Council

Minimum Conditions	**CDG Performance Measures**		**Health Window Allocation to be Received**	**Performance Status**
Meet CDG Minimum Conditions	**Minimum Score in Each Functional Area**	**Aggregate Score**		
YES	5	≥75	100%	Very Good
YES	5	51-74	80%	Good
YES	<5	≤50	50%	Poor
NO	N/A	N/A	50%	Failed

6.5.3 Eligible expenditure

The general eligibility criteria of the LGDG apply. However, there is no fixed repartition between higher local government (HLG) and lower local government (LLG) projects.
The Health Window funds shall be used for the rehabilitation of public and non-profit private health facilities (NGO/ faith based), as included in the LGA annual budget based on the local priorities as identified through a participatory approach and consistent with the CCHP guidelines. Construction funds shall be used for public facilities only for dispensaries, health centres and district hospitals, regional hospitals are not eligible.
Criteria for Health Window expenditure:

1. Construction or rehabilitation of a health facility[3]. The term rehabilitation comprises major repairs, extension, staff housing, infection control related infrastructure and equipment of existing facilities.
    - The Construction or Rehabilitation of health facilities should include the extension of health facility buildings and the construction of staff housing for the health facilities where needed.
2. Construction or rehabilitation and procurement of medical equipment and furniture for health facility is eligible only where an established Health Facility Committee is operational
3. Rehabilitation and procurement of medical equipment and furniture for health facility is eligible only where minimum staffing is in place[4]
    - Only medical equipment recommended by MOHSW for the specific type of health facility is eligible[5]

[3] Dispensary, Health Center and District Hospital only. Rehabilitation, extensions or equipment of Regional Hospitals are not eligible.
[4] Two trained staff for a dispensary and five trained staff for a health centre
[5] "Manual for quantification of national requirements of equipment and supplies for laboratory, radiology, dental and health care technical services in Tanzania, 2002; level A equipment for dispensary, level B equipment for Health Centres, level C equipment for District Hospitals.

4. New constructions require a comprehensive infrastructure development plan (see 7.5.4 below) ensuring that new health facilities will be staffed from the beginning, have an account opened with MSD, an allocation agreed on with MOHSW and will provide cost efficient services for underserved areas. Single projects including staff housing must be fully financed
5. Before the start of any new construction (extension, staff housing or new construction) a letter of offer for the land is required in Urban Authorities. The land title deed or the certificate for occupancy shall be acquired subsequently
6. Procurements of medical equipments should follow standard and specifications recommended by MOHSW.
7. Any new construction should follow Standard Drawings and Guidelines for Health Facilities presently developed by PMORALG in collaboration with MOHSW.
8. Construction, rehabilitation or extension of regional hospitals are not eligible for funding from HSDG
9. Procurement of medical equipment and medical supplies are not also allowable for regional hospital.

The rehabilitation and medical/technical needs assessment (see Table 1 in Annex 14) for health centres and dispensaries will be the basis for prioritizing rehabilitation and equipment for the LGAs.

6.5.4 Institutional Arrangements

As outlined in the MoU governing the LGDG, the LGDG Steering Committee and Technical Committee are the decision making bodies governing the Health Window. At the LGAs level, the Council Health Management Team (CHMT) facilitates the participatory process of project planning and implementation by the different Health Facility Committees. To ensure sustainability, accountability and create a sense of ownership, the communities will participate in the planning, implementation and monitoring of the equipment, rehabilitation or construction works through their Health Facility Committees. The CHMT in collaboration with the CMT (spell out) will provide technical support to the HFC. The specifications regarding own contribution of communities are identical with those made for LGDG as a whole. Hence communities will be required to contribute in cash or in kind at least 5% of the cost of rehabilitation/ construction works.

6.5.5 Construction and rehabilitation implementation

Rehabilitation and Construction of Health facilities is vested to the Health Facilities Committees, the Council is responsible to assists the Health Facilities to make sure that procurement of contractors and utilization of health window funds follows the Procurement Act of 2004 and its Regulations of 2005, either they should make sure that Public Finance Act of 2001 are strictly followed and value for money are attained in construction and rehabilitations of those health facilities. The Health Facility Committees planning should be assisted from the Council technical staff i.e. CHMT members, Engineer, planning Officer, District Treasury, procurement unit etc. The Council Health Management Team should make sure that the plans prepared by health facilities conformed to the comprehensive infrastructure development plan requirements. The approval of these plans should follow the normal

procedure of council approving authorities. Implementations should also be done by the health facilities, procurement of contractors should be closely supervised by the council technical staff mentioned above. The Joint Rehabilitation Funds for Primary Health Care Facilities Procedure Manual (2006) be used.

6.5.6 Financial Management

The LGDG arrangements for financial management apply also for the Health Window. In addition, the following specific conditions apply:

1. Stakeholders, especially the general public will be informed of the release of HSDG to ensure accountability and transparency.

2. LGAs may delegate monitoring and day-to-day control functions to Health Facility Committees or to lower local governments, but they preserve entire responsibility for the proper use of Health Window funds.

3. The Current Public Procurement Act 2004 and its regulations of 2005, and rules for LGAs apply. However, LGAs may purchase equipment directly from the Medical Stores Department.

4. LGAs supporting non-profit private health services must sign health service agreements and grant agreements with these service providers in line with the guidance from PMORALG and MOHSW.

5. Where LGAs conclude grant agreements with non-profit private health service providers, the grant agreements must require application of the Public Procurement Act, 2004 and the Public Procurement Regulations, 2005

6. Funds given to the non profit organisation should be given as an imprest and they will be required to retire the same in order for the Council to oversee the value for money and implementation of the planned activities, observes the Finance Act of 2004 and Public procurement Act of 2004 and its Regulations of 2005.

7. Health window funds transferred to account No 2 of development account for implementation of rehabilitation and construction of health facilities activities should be controlled by the District/Council Medical officer. Therefore, the mandate of signing any payment related to these funds in account No 2 should be rested to the DMO and other appointed staff from Health Department in group A and Council Director and Council Treasury in group B. Arrangement should be made to avoid un authorised personnel to sign the cheques of Health Sector Development Grant – HSDG (Health Window) related expenditure, either the flow of payments should be channelled from health facilities, council Engineer, DMO through Council Director and finally cheque issuance.

6.5.7 Reporting

The LGAs will include the Health Window funds in their overall technical and financial reporting system. The Council Health Management Team (CHMT/DMO) will take care that all health related LGDG (Health Window and discretionary funds) and CDG expenditure will be included in the CCHP reporting as outlined in the present Guideline.

Report from the Health facility should be prepared and submitted to the CHMT, the Council will consolidate report from HFC into one (timeline?) The report will be part of the CCHP reports, thus need to be submitted Quarterly as it is done for the CCHP reports.

6.5.8 Monitoring and Evaluation

The Health Window monitoring and evaluation is based on the CCHP guideline. The monitoring of the indicators 18 and 19 as contained in the CCHP are mandatory, if a LGA accesses the Health Sector Development Grant.

Indicator 18 reads as follows:
Usable surface in good state / total usable surface (note: usable surface related to building surface including garden, waiting area etc.)

Hospital	___%
Health Center	___%
Dispensary	___%

Indicator 19 reads as follows:

Bed occupancy rate (Total Patient Days / Total No. of Beds x 365)
a) Hospitals
b) Health Centres

Number of consultations / population of service area
c) Dispensaries

The monitoring of these plans will give specific attention to LGA expenditure on minor repairs and maintenance of buildings and technical/medical equipment. To ensure sustainability LGAs will have to set side sufficient funds for minor repairs and maintenance.

6.5.9 Funds for Monitoring and Supervision

PMORALG via its MTEF (vote 56) will set aside adequate funds for central activities to cover expenditure for monitoring and short term consultancies. Such amount shall not exceed 5% of the earmarked funds. Supervision funds for councils shall not exceed 5% of the fund received by the council for MMAM activities. PMO-RALG will budget and transfer funds to RS for monitoring and evaluation. This amount shall not exceed 1% of the total fund received by all councils in that region.

6.5.10 Auditing

The audit provisions for the LGDG apply also for the Health Window. MOHSW in collaboration with PMORALG and development partners financing the Health Window may recommend specific performance audits to be conducted by the NAO or by NAO appointed performance auditors.

CHAPTER SEVEN

7.0 SUPERVISION, MONITORING AND EVALUATION

7.1 Supervision

Supervision is a management function planned and carried out in order to guide, support and assist health providers in carrying out their assigned tasks. It involves on job transfer of knowledge and skills between the supervisor and the one being supervised through opening of administrative and technical communication channel. The aim of supervision is to determine staff performance in relation to quality and standard so as to identify gaps and address them.

Supportive Supervision

Supportive supervision is a process which promotes quality outcomes by strengthening communication, identifying and solving problems, facilitating team work, and providing leadership and support to empower health providers to monitor and improve their own performance. It expands the scope of supervision method by incorporating self assessment, peer assessment as well as community input. Supportive supervision has the following characteristics: problem identification and solving, to improve quality and meet client needs; quality improvement and the attention shifts from individuals to teams and processes; empowering health providers to monitor and improve their own performance; external supervisor acting as a facilitator, trainer and coacher, participation of health providers in supervising themselves and one another; participatory decision making involving the whole team and peer assessment, self assessment and community input consideration.

Levels and Scope of Supervision

Supervision roles are undertaken at different levels; National, Regional, District, Hospitals and primary health care facilities (Health Centers, Dispensary levels and community level). However, supervision should be integrated although some vertical programs and other specialized services may need to develop detailed checklists.

The council is the focal point for the implementation of the health policy and interventions. Its major role is planning, implementing, supervising, monitoring and evaluation of health intervention packages for quality improvement. At the council level, the supervision team will be the Council Health Management Teams together with program coordinators and other health professional at the district level that will also ensure collaboration with other health related sectors within the council.

The main areas for supervision that should be looked into are inputs, processes and outputs within the health care system which when co-coordinated effectively, will lead to quality improvement in health-care services, that is promotive, preventive, curative and rehabilitative health care. Supervisors should, however, be aware that it is neither desirable nor possible to supervise each and everything during each visit. Objectives and prioritization should be the key guide in determining what to supervise, (Detail supervision use National Supportive Supervision Guidelines for Quality Health -Care services (September 2010)

7.2 Monitoring

Monitoring is a systematic collection and analysis of data for management control and decision making. Monitoring and evaluation enable to see how things are going and assess whether results are being achieved. Monitoring and evaluation for the implementation of CCHP have addressed National Health Performance indicators

The implementation of the Comprehensive Council Health Plan has to be monitored by appropriate monitoring tools. This is one of the key responsibilities of the Council Health Management Team.
Monthly and quarterly progress reports will monitor the implementation of the plan. The annual report will be used as an evaluation of the implementation of the annual plans for the respective year, hence the performance of the Council. Each department/programme and staff performance is to be measured for rewards.
Nationally established monitoring indicators and other indicators applying to the district health services need to be part of the plan.

Monitoring Process

Monitoring the implementation of the CCHP requires identification of areas within the health care delivery system that need strengthening, taking action for improvement and sustaining achievements attained. CHMTs/CHPTs Planning teams should include M&E within the plan. To facilitate M&E the data should be continuously collected through the HMIS and other sources of information including operational research, surveys and census analysed and interpreted on a quarterly basis by CHMTs and used to monitor the progress towards achievement of set targets. It is important to define monitoring indicators in the plan that will be used to track performance of Council health services as well as progress towards achieving the overall goal.

Other means of monitoring progress include:

a) Regular supportive supervision by CHMT
b) Assessment and feedback of quarterly implementation reports
c) Feedback from all stakeholders (consultative meetings)
d) Participation and exchange of experiences by departments and other hospitals through peer reviews and forums
e) Regular professional meetings
f) Financial and Performance audit for the hospital (internal and external)
g) Adherence and implementation of Client Service Charter
h) Open Performance Appraisal System (OPRAS)

7.3 Evaluation

Is periodic assessment of the efficiency, effectiveness, impact, sustainability and relevance of something. It is done within the context of stated objectives.

There is internal and external evaluation. Evaluation is a means of measuring the achievement obtained and identification of any challenges encountered so as to find effective ways of addressing them. Evaluation is very important because it analyzes results, their causes and effects. It also assesses efficiency, effectiveness, impact, sustainability of services etc.

Internal Evaluation

Internal evaluation is progressive and carried out through monitoring and progress reporting. Both evaluations should use indicators that are in the plan. Annual evaluation should be done when the plan has been implemented.

The evaluation is internally conducted by CHMT by measuring the progress against selected service targets, based on the indicators (refer Annex 6). However, it is very important to know the source of data and ensure that the data management is of good quality (correct, complete, adequate and realiable). It is also crucial to define before hand, the numerator and denominator for each indicator (refer Annex 7. The evaluation results are usually used as an input for planning for the following year activities. The implementation team will prepare a report as per their evaluation

External Evaluation

External evaluation shall use the same indicators used during internal evaluation. The internal evaluation report is an input to external evaluation. The External Evaluator will have to use all the progress reports, semi and annual reports and any other report relevant to the implementation of plan. External evaluation is done by independent evaluators once every year or as it may be determined by CHMT or any other relevant authority. The external evaluator may refer to other relevant sources of data such as:

- National population Census reports
- Demographic Health Surveys reports
- House hold health survey reports
- National Sentinel Surveillance reports
- Sentinel Statistics Abstracts reports
- Health Management Information reports
- Periodic health service delivery survey and other surveys reports
- National programmes reports
- Study reports as they may be commissioned from time to time
- Information accessed through use of internet relevant to hospital
- Comprehensive Council Health Plan
- Regional and District Strategic Plans
- National Health Policy
- Health Sector Strategic Plans
- Relevant National guidelines

CHAPTER EIGHT

8.0 TRANSPORT, TRAINING AND HUMAN RESOURCE DEVELOPMENT

8.1 Transport Management

Definition: Transport Management system is an effective process of planning, distribution, controlling, directing and monitoring of transport in-terms of fuel, maintenance, services and route scheduling.

Transport management system at Health department is very important for distribution of medicines, equipments, vaccines and medical supplies, Supervision, health outreach services and referral of patients at all levels of health care delivery. Quality delivery of medicines and health supplies direct to health centres and dispensaries may be contracted out to MSD according to terms laid out in a Memorandum of Understanding.

Health department's vehicles allocated for supervision, distribution, outreach/mobile services and referrals shall be used according to health schedule.

Compliance to route schedules

- **Distribution Route**:
  The councils are required to comply with the freight routes operation in order to assure the availability of medicines, medical supplies and equipments at the health facilities. Compliance by not less than 90 percent of the route schedules is the set standard.
  A report from the Department Transport Officer showing the compliance to freight route schedule must be submitted to the Council Transport Officer. Every Council should meet this standard and a report from the Council showing the compliance to supervision route schedule must be submitted quarterly to the Regional Secretariat.

- **Supervision Routes**:
  The councils are required to comply with supervision routes operation in order to assure the provision of quality health services rendered at the health facilities. Compliance by not less than 75 percent of the route schedules is the set standard. Every Council should meet this standard and a report from the Council showing the compliance to supervision route schedule must be submitted quarterly to the Regional Secretariat.

- **Vehicle maintenance**
  Vehicles must be kept in good working condition, clean and roadworthy at all times. In this connection, it is essential that responsible officers follow the

manufacturer's recommendations on vehicle servicing schedules and ascertain that periodic maintenance of vehicles is carried out prior to extend field trips.

8.2 Capacity Building and training of the In-service Staff

The CHMTs should prepare the human resource for health capacity development plan at the LGA level, which will show all cadres training needs identified systematically through Training Needs Assessments as well as performance appraisal of staff. These training needs should be incorporated in their plan and budget (operational and strategic). The plan should also be guided by the existing Continuing Professional Development (CPD) policy of the Ministry of Health and Social Welfare.

As such capacity building and training plan in the district should put emphasis on aspects related to training needs of the districts, professional development of staff and career development.

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The plan should consider the financial resources availability and will include on job, short-term and long-term training. It is also important that the plan to train individual health care workers should be regarded as an incentive for health care workers and where appropriate the council should provide contract to health care workers to ensure they retain them. All training should be reported in the normal scheduled meetings in the districts and should be included in their M & E structure.

CHAPTER NINE

9.0 PLANREP AS A TOOL FOR PLANNING, BUDGETING AND REPORTING

9.1 Planning and Reporting (PlanRep3) Database

PlanRep is a single unified computer-based application used by all decentralised sectors. It was introduced by PMORALG in 2007 and has undergone continuous refinement since then, with numerous improvements resulting from input by MoF and MoHSW. It is firmly established in every LGA as a planning and budgeting tool for producing the councils' overall multi-sectoral strategic plan based round the medium-term expenditure framework (MTEF). It has been specially developed with MoHSW to assist CHMTs in their work of producing the CCHP.

The use of PlanRep offers the CHMT a number of significant advantages, namely:

- Saving of time by only having to enter information once
- Accuracy of numerical calculations assured
- Automatic calculation and graphical presentation of allocation ceilings for both cost centres and types of expenditure
- Automatic production of most reports specified in the Planning Guideline, alleviating the reporting burden
- Automatic calculation of budget allocation to the burden of disease
- Incorporation of performance indicators
- Automatic presentation of the plan of action
- Consistency within all reporting in standard formats
- Ease of aggregation at regional and national level of all district-level data, allowing cross-district and cross-region analysis
- Potential for integrated reporting on physical implementation and expenditure

9.1.1 How to use PlanRep3 to assist in developing the CCHP

It is important to ensure that the latest version of PlanRep is used. It is always available from the PMORALG website (www.pmoralg.go.tz) in the MIS section. Alternatively, it can be obtained from the PMORALG ICT specialists, based at each regional headquarters. A comprehensive fully illustrated operational manual is also available from the PMORALG website. (**Note:** the installation file(not update file) is corrupt- new file to be uploaded.

9.1.2 The Medium-Term Expenditure Framework

The use of PlanRep is based on the MTEF which in turn uses the following format: Objectives (e.g. A, B, C …); (SMART) Targets (e.g. 01S, 02C, 03D, where S = service delivery, C = capacity building and D = development); and Activities (01, 02 …). The CCHP should follow this format to ensure consistency with MoF and PMORALG reporting requirements.

9.1.3 Objectives

PlanRep objectives are entered by the District Planning Team covering all sectors. However, every LGA is mandated to have as its first objective (A) 'Services Improved and HIV/AIDS

infections reduced' and as its second objective (B) 'Enhance, sustain and effective implementation of the National Anti-corruption Strategy'. PlanRep therefore forces planners to use these two objectives. Subsequent objectives may be inserted as required and normally a single objective would be used to cover all other health interventions, e.g. 'Access and quality of social services improved'. It is important that the CCHP starts with its HIV-related interventions under objective A and the other interventions under the general health objective.

9.1.4 Entering the CCHP in PlanRep

Having inserted the general health objective (e.g. C 'Access and quality of social services improved'), each target should be entered under either objective A, B, C, D, F or G and the appropriate cost centre (see 2.5.6 table 3). Targets should be SMART (Specific, Measurable, Achievable, Realistic and Time Bound) as mentioned earlier in the CCHP Guidelines. The relevant standard indicator, if any, which the target will address can be selected and the district baseline and target value entered.

Activities under each target are then entered and linked to the responsible person and the quarter in which they are planned to start. If marked as 'training', note that they will not be included in the 20% ceiling on allowances under basket funding. Finally the budget should be entered for each activity, using the standard GFS codes. The funding source must be selected, together with the priority area and the particular intervention to which the activity relates.

Table 10: PlanRep Cost Centre Codes

Below are the cost centres for health sector department

Guideline cost centre Codes		**Description**
Rural	**Urban**	
E04	B14	DMO's Office
E05	B02	Council Hospital/DDH
E06	B15	Voluntary Agency hospital if present
E02	B03	Health Centres
E03	B04	Dispensaries
E07	B16	Community Initiatives

9.1.5 Instant reports available

Having entered all the relevant data described above, among the many outputs immediately available are:

- detailed OC and Development budgets by cost centre
- percent distribution of the budget between cost centres
- allocation ceilings for types of expenditure under the basket fund
- All Health reports

9.1.6 Entering budgets and in-kind contributions outside council accounts

The CCHP must include all relevant budgets and in-kind contributions related to the district. PlanRep includes a screen for entering all such inputs. Each separate contribution must be linked to an appropriate priority area and intervention and must be fully costed. Examples of

this type of input are the MSD contribution, vertical programme contributions, including the cash value of drugs, vouchers and vaccines, etc., Global Fund and PEPFAR contributions and all bilateral and other aid. Only when all significant contributions are entered all important Intervention Burden graphs, described below can be meaningful.

9.1.7 Intervention Burden graph

One of the most powerful functions within the PlanRep tool is the ability to carry out a vast number of complex calculations to display the distribution of the estimated overall financial costs compared with the burden of disease. One main task of the CHMT is to allocate the available resources so as to best address the burden of disease. In other words, the overall health expenditure in the district should be greatest where the disease burden is greatest and least where the disease burden is least.

9.1.8 Producing the Plan of Action

A further functionality of PlanRep is to produce the Plan of Action described in paragraph 2.4.7. This is not only created instantaneously but is also completely consistent with all data entered.

9.1.9 Producing the Cost Analysis Matrix

As all the data behind the matrix is already contained in PlanRep, the Cost Analysis Matrix as specified in the Guideline is produced instantaneously.

9.1.10 Producing Annexes

In a similar way, PlanRep is able to automatically produce Annexes 2.1, 2.2, 2.3, 2.4, 2.5 and 2.6 from the data entered.

9.1.11 How to enter Data into PlanRep

Annex 13 gives detailed guidance and tutorials designed to assist Council Health Management Teams to prepare their annual budgets according to the PMORALG and MOHSW budget guidelines.

9.1.12: Exporting data from PlanRep to Epicor.

The CCH plans after developed and entered into the PlanRep, then will be exported into the Epicor Accounting system

9.2 EPICOR System & IFMS

9.2.1 The EPICOR System & IFMS

Under the Government's overall accounting system known as the Integrated Financial Management System (IFMS), EPICOR accounting software has been installed in most council and is designed to be used for all financial transactions. Each year, the Chart of Accounts must be entered into Epicor in order to track expenditure on the MTEF/ CCHP/PlanRep. To assist in this data entry, PlanRep produces a printout of the entire budget from the strategic plan in a format that enables Council accounts staff to create the required chart of accounts. Once entered, expenditure data from EPICOR can be imported into PlanRep and reports on CCHP expenditure can be produced. Satisfactory inter-operation of EPICOR and PlanRep requires a high degree of experience and support from PMORALG may be required.

PART TWO:
ANNEXES 1-14

ANNEX 1 - LIST OF REFERENCES DOCUMENTS

Relevant inputs from the following documents have been incorporated in this document:

1. Memorandum of Understanding Between the Government of Tanzania and Development Partners regarding Management of Health Basket Funds 2008-2015

2. Ministry of Health and Social Welfare and Prime Minister's Office Regional Administration and Local Government, The United Republic of Tanzania: *Comprehensive Council Health Planning Guideline* (2007).

3. Ministry of Health and Social Welfare and Prime Minister's Office Regional Administration and Local Government, The United Republic of Tanzania: *Template for Developing Annual Health Plans for Health Centres and Dispensaries,* (2009).

4. Ministry of Health and Social Welfare, The United Republic of Tanzania: *Health Policy,* (2007)

5. Ministry of Health and Social Welfare, The United Republic of Tanzania: *Health Sector Strategic Plan III 2009-2015,* (2009)

6. Ministry of Health and Social Welfare, The United Republic of Tanzania: *Health Sector Strategic Plan II 2003-2008,* (2009)

7. Ministry of Health and Social Welfare, The United Republic of Tanzania: *Guidelines for management and operation of local government transport system,* September 2003

8. Ministry of Health and Social Welfare, The United Republic of Tanzania: *Primary Health Services Development Programme 2007-2017*

9. Ministry of Health and Social Welfare, The United Republic of Tanzania: *Medium Term Strategic Plan 2007-2010 (2007)*

10. Ministry of Health and Social Welfare, The United Republic of Tanzania *Draft Implementation Guideline Payment for Performance* (2009).

11. Ministry of Health and Social Welfare, The United Republic of Tanzania: *Malaria Medium Term Strategic Plan 2008-2013* (2009).

12. Ministry of Health and Social Welfare, The United Republic of Tanzania*: Human Resources for Health Strategic Plan, 2008-2013* (2008)

13. Ministry of Health and Social Welfare, The United Republic of Tanzania: *The National Environmental Health, Hygiene and Sanitation Strategy 2007-2016 (2007)*

14. Ministry of Health, The United Republic of Tanzania, *National District Health Planning Guidelines, Second Edition,* (1998).

15. Ministry of Health, The United Republic of Tanzania: *District Health Management Training Module IV,* (2001).

16. Ministry of Health, The United Republic of Tanzania: *National Package of Essential Health Interventions in Tanzania,* (2000)

17. Ministry of Health, The United Republic of Tanzania: *National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Death in Tanzania 2008-2015*, (2008).
18.
19. Ministry of Health and Social Welfare, The United Republic of Tanzania: National *Supportive Supervision Guidelines for Quality Healthcare Services* (2010).

20. Ministry of Health/ Civil Service Department, The United Republic of Tanzania: *Staffing levels for Health Facilities/Institutions*, (1999).

21. *PlanRe*p User Manual. Version 6.4

22. Prime Minister's Office Regional Administration and Local Government, The United Republic of Tanzania: *Joint Rehabilitation Funds for Primary Health Care Facilities Procedure Manual* (2006)

23. The United Republic of Tanzania: *National Strategy for Growth and Reduction of Poverty (MKUKUTA),* (2005).

24. Vision 2025

ANNEX: 2.1- 2.6: BUDGET SUMMARIES

2.1: MAIN BUDGET SUMMARY

PRIORITY AREA	INTERNVETION	SOURCES OF FUNDS												
		CHBG	BLOCK GRANT	RECEIPT IN KIND	COUNCIL OWN SORCES	LGDG	HSDG/ MMAM	COST SHARING				GLOBAL FUNDS	OTHERS	GRAND TOTAL
								USER FEES	CHF	NHF	DRF			
Maternal Newborn and Child Health	Focused Antenatal Care													
	Basic/Comprehensive Emergency Obstetrics													
	Post -natal Care													
	Sexually transmitted infections (STI)													
	HIV, early infant diagnosis and PMTCT													
	Post-Abortion Care,													
	Family Planning													
	Integrated Management of Childhood illnesses (IMCI)													
	Perinatal Care													
	Care of Newborn													
	Immunization													
	Nutritional Supplementation													
	Adolescent sexual reproductive health													
	Other maternal conditions including infertility, rape and FGM													
	Reproductive System Cancers													
	Care for most vulnerable													

PRIORITY AREA	INTERNVETION	SOURCES OF FUNDS												
		CHBG	BLOCK GRANT	RECEIPT IN KIND	COUNCIL OWN SORCES	LGDG	HSDG/ MMAM	COST SHARING				GLOBAL FUNDS	OTHERS	GRAND TOTAL
								USER FEES	CHF	NHF	DRF			
	children including orphans with disabilities, abuse and neglected children													
	Early childhood development													
	Community Based Health Care Services for MNCH													
	Sub-total													
Communicable Disease Control	Malaria													
	TB Management													
	Leprosy Management													
	HIV/AIDS and STIs													
	Epidemics (Cholera, Plague, Yellow Fever, Measles, Polio, Meningitis, others specify,etc)													
	Subtotal													
Non-Communicable Disease Control	Acute and Chronic Respiratory Diseases													
	Cardiovascular Diseases/ Cerebral Vascular Accidents													
	Diabetes Mellitus													
	Neoplasm/ cancer													
	Injury/Trauma Care													
	Mental Health													
	Substance Abuse													

PRIORITY AREA	INTERNVETION	SOURCES OF FUNDS												
		CHBG	BLOCK GRANT	RECEIPT IN KIND	COUNCIL OWN SORCES	LGDG	HSDG/ MMAM	COST SHARING				GLOBAL FUNDS	OTHERS	GRAND TOTAL
								USER FEES	CHF	NHF	DRF			
	Anaemia and Nutritional Supplementation													
	Congenital diseases and anomalies													
	Abdominal Surgical Conditions													
	Subtotal													
Treatment and Care of other common diseases of local priority within the Council	Eye Care (Cataract, Trachoma, etc.)													
	Oral and Dental Conditions													
	Skin Diseases													
	Neglected Tropical Diseases (NTDs)-													
	- Schistosomiasis,													
	- Onchocerciasis													
	- Filariasis													
	- Plague													
	- Rabies													
	- Trypanosomiasis													
	- Relapsing fevers													
	- Soil Transmitted Helmithesis													
	- and others (specify)													
	Sub total													
Environmental Health and	Hazardous waste													
	Water, Hygiene and Sanitation													

PRIORITY AREA	INTERNVETION	SOURCES OF FUNDS												
		CHBG	BLOCK GRANT	RECEIPT IN KIND	COUNCIL OWN SORCES	LGDG	HSDG/ MMAM	COST SHARING				GLOBAL FUNDS	OTHERS	GRAND TOTAL
								USER FEES	CHF	NHF	DRF			
Sanitation	Food control and Hygiene. Housing													
	Occupational Health and Safety													
	By-laws and regulations related to environmental health													
	Solid and Liquid waste in health facilities													
	Vermin and Vector control around the health facilities environment													
	Sub total													
Strengthen Social Welfare and Social Protection Services	Adolescent sexual reproductive health													
	Maternal conditions including infertility, rape and FGM													
	Care for most vulnerable children including orphans, children with disabilities, abuse and neglected children													
	Early childhood development													
	Rehabilitative support													
	Injuries/Trauma including rehabilitative support and counselling for self help													
	Mental Health													
	Drug and Substance Abuse													
	Exemptions and waivers of the													

PRIORITY AREA	INTERNVETION	SOURCES OF FUNDS												
		CHBG	BLOCK GRANT	RECEIPT IN KIND	COUNCIL OWN SORCES	LGDG	HSDG/ MMAM	COST SHARING				GLOBAL FUNDS	OTHERS	GRAND TOTAL
								USER FEES	CHF	NHF	DRF			
	vulnrable groups													
	Sub total													
Strengthen Human Resources for Health Management Capacity for improved health services delivery	Personal Emolument													
	Staffing level standard													
	Retention for health care workers													
	Staff Productivity													
	Professional development													
	Good working environment (availability of housing, water, etc)													
	Staff safety (including Protective gears, post exposure prophylaxis)													
	Human Resources Information System													
	Sub total													
Strengthen Organizational Structures and institutional Management at all levels	Health Transport management system													
	Health management information system (HMIS)													
	Supportive supervision (including cascade) and inspection													
	Council Health Service Boards , Health Facility Governing Committees function													

PRIORITY AREA	INTERNVETION	SOURCES OF FUNDS												
		CHBG	BLOCK GRANT	RECEIPT IN KIND	COUNCIL OWN SORCES	LGDG	HSDG/ MMAM	COST SHARING				GLOBAL FUNDS	OTHERS	GRAND TOTAL
								USER FEES	CHF	NHF	DRF			
	CHMT, Health Facility Management Teams and Council Health Planning Team													
	Utilities													
	Preventive maintenance and repair of health facilities equipment.													
	Physical infrastructure (health facility construction),													
	Physical infrastructure health facility rehabilitation and PPM													
	Medicines, medical equipment, medical and diagnostic supplies management system													
	Public Private Partnership													
	District health referral													
	Health facility financial management systems													
	Sub total													
Emergency Preparedness and Response	Mapping for susceptible areas for emergencies in the Council													
	Advocacy for Prevention													
	Detection of Vulnerable Communities													
	Institutional capacity building													
	Injuries/Trauma/ Surgical Services													

PRIORITY AREA	INTERNVETION	SOURCES OF FUNDS												
		CHBG	BLOCK GRANT	RECEIPT IN KIND	COUNCIL OWN SORCES	LGDG	HSDG/ MMAM	COST SHARING				GLOBAL FUNDS	OTHERS	GRAND TOTAL
								USER FEES	CHF	NHF	DRF			
	Subtotal													
Health Promotion (It caters in all priority areas)	Advocacy and IEC													
	School Health programmes													
	Community IMCI													
	Community Based initiatives													
	Sub total													
Traditional Medicine and Alternative Healing	Mapping and registrations													
	Advocacy													
	Laws and practice													
	Subtotal													
	GRAND TOTAL													

ANNEX 2.2: SPECIFIC BUDGET SUMMARY FOR HEALTH BASKET GRANT YEAR

PRIORITY AREA	INTERNVETION	DMOs / MMOH OFFICE/	COUNCIL HOSPITAL	HEALTH CENTRES	DISPENSARIES	VOLUNTARY AGENCY/SA	COMMUNITY	TOTAL
Maternal Newborn and Child Health	Focused Antenatal Care							
	Basic/Comprehensive Emergency Obstetrics							
	Post -natal Care							
	Sexually transmitted infections (STI)							
	HIV, early infant diagnosis and PMTCT							
	Post-Abortion Care,							
	Family Planning							
	Integrated Management of Childhood illnesses (IMCI)							
	Perinatal Care							
	Care of Newborn							
	Immunization							
	Nutritional Supplementation							
	Adolescent sexual reproductive health							
	Other maternal conditions including infertility, rape and FGM							
	Reproductive System Cancers							
	Care for most vulnerable children including orphans with disabilities, abuse and neglected children							
	Early childhood development							
	Community Based Health Care Services for MNCH							
	Sub-total							
Communicable Disease	Malaria							
	TB Management							

PRIORITY AREA	INTERNVETION	DMOs / MMOH OFFICE/	COUNCIL HOSPITAL	HEALTH CENTRES	DISPENSARIES	VOLUNTARY AGENCY/SA	COMMUNITY	TOTAL
Control	Leprosy Management							
	HIV/AIDS and STIs							
	Epidemics (Cholera, Plague, Yellow Fever, Measles, Polio, Meningitis, others specify, etc)							
	Subtotal							
Non-Communicable Disease Control	Acute and Chronic Respiratory Diseases							
	Cardiovascular Diseases/ Cerebral Vascular Accidents							
	Diabetes Mellitus							
	Neoplasm/ cancer							
	Injury/Trauma Care							
	Mental Health							
	Substance Abuse							
	Anaemia and Nutritional Supplementation							
	Congenital diseases and anomalies							
	Subtotal							
Treatment and Care of other common diseases of local priority within the Council	Eye Care (Cataract, Trachoma, etc.)							
	Oral and Dental Conditions							
	Skin Diseases							
	Neglected Tropical Diseases (NTDs)-							
	- Schistosomiasis,							
	- Onchocerciasis							
	- Filariasis							
	- Plague							
	- Rabies							
	- Trypanosomiasis							

PRIORITY AREA	INTERNVETION	DMOs / MMOH OFFICE/	COUNCIL HOSPITAL	HEALTH CENTRES	DISPENSARIES	VOLUNTARY AGENCY/SA	COMMUNITY	TOTAL
	- Relapsing fevers							
	- Soil Transmitted Helmithesis							
	- and others (specify)							
	Sub total							
Environmental Health and Sanitation	Hazardous waste							
	Water, Hygiene and Sanitation							
	Food control and Hygiene. Housing							
	Occupational Health and Safety							
	By-laws and regulations related to environmental health							
	Solid and Liquid waste in health facilities							
	Vermin and Vector control around the health facilities environment							
	Sub total							
Strengthen Social Welfare and Social Protection Services	Adolescent sexual reproductive health							
	Maternal conditions including infertility, rape and FGM							
	Care for most vulnerable children including orphans, children with disabilities, abuse and neglected children							
	Early childhood development							
	Rehabilitative support							
	Injuries/Trauma including rehabilitative support and counselling for self help							
	Mental Health							
	Drug and Substance Abuse							
	Exemptions and waivers of the vulnrable groups							
	Sub total							
Strengthen Human	Personal Emolument							
	Staffing level standard							

PRIORITY AREA	INTERNVETION	DMOs / MMOH OFFICE/	COUNCIL HOSPITAL	HEALTH CENTRES	DISPENSARIES	VOLUNTARY AGENCY/SA	COMMUNITY	TOTAL
Resources for Health Management Capacity for improved health services delivery	Retention for health care workers							
	Staff Productivity							
	Professional development							
	Good working environment (availability of housing, water, etc)							
	Staff safety (including Protective gears, post exposure prophylaxis)							
	Human Resources Information System							
	Sub total							
Strengthen Organizational Structures and institutional Management at all levels	Health Transport management system							
	Health management information system (HMIS)							
	Supportive supervision (including cascade) and inspection							
	Council Health Service Boards , Health Facility Governing Committees function							
	CHMT, Health Facility Management Teams and Council Health Planning Team							
	Utilities							
	Preventive maintenance and repair of health facilities equipment.							
	Physical infrastructure (health facility construction),							
	Physical infrastructure health facility rehabilitation and PPM							
	Medicines, medical equipment, medical and diagnostic supplies management system							
	Public Private Partnership							
	District health referral							
	Health facility financial management							

PRIORITY AREA	INTERNVETION	DMOs / MMOH OFFICE/	COUNCIL HOSPITAL	HEALTH CENTRES	DISPENSARIES	VOLUNTARY AGENCY/SA	COMMUNITY	TOTAL
	systems							
	Sub total							
Emergency Preparedness and Response	Mapping for susceptible areas for emergencies in the Council							
	Advocacy for Prevention							
	Detection of Vulnerable Communities							
	Institutional capacity building							
	Injuries/Trauma/ Surgical Services							
	Subtotal							
Health Promotion (It caters in all priority areas)	Advocacy and IEC							
	School Health programmes							
	Community IMCI							
	Community Based initiatives							
	Sub total							
Traditional Medicine and Alternative Healing	Mapping and registrations							
	Advocacy							
	Laws and practice							
	Subtotal							
	GRAND TOTAL							
	% of allocation by the Council							
	% of allocation by the Guideline							

ANNEX 2.3: SPECIFIC BUDGET SUMMARY FOR HEALTH BLOCK GRANTS YEAR

PRIORITY AREA	INTERNVETION	DMOs / MMOH OFFICE/	COUNCIL HOSPITAL	HEALTH CENTRES	DISPENSARIES	VOLUNTARY AGENCY/SA	COMMUNITY	TOTAL
Maternal Newborn and Child Health	Focused Antenatal Care							
	Basic/Comprehensive Emergency Obstetrics							
	Post -natal Care							
	Sexually transmitted infections (STI)							
	HIV, early infant diagnosis and PMTCT							
	Post-Abortion Care,							
	Family Planning							
	Integrated Management of Childhood illnesses (IMCI)							
	Perinatal Care							
	Care of Newborn							
	Immunization							
	Nutritional Supplementation							
	Adolescent sexual reproductive health							
	Other maternal conditions including infertility, rape and FGM							
	Reproductive System Cancers							
	Care for most vulnerable children including orphans with disabilities, abuse and neglected children							
	Early childhood development							
	Community Based Health Care Services for MNCH							
	Sub-total							
Communicable Disease Control	Malaria							
	TB Management							
	Leprosy Management							
	HIV/AIDS and STIs							

PRIORITY AREA	INTERNVETION	DMOs / MMOH OFFICE/	COUNCIL HOSPITAL	HEALTH CENTRES	DISPENSARIES	VOLUNTARY AGENCY/SA	COMMUNITY	TOTAL
	Epidemics (Cholera, Plague, Yellow Fever, Measles, Polio, Meningitis, others specify, etc)							
	Subtotal							
Non-Communicable Disease Control	Acute and Chronic Respiratory Diseases							
	Cardiovascular Diseases/ Cerebral Vascular Accidents							
	Diabetes Mellitus							
	Neoplasm/ cancer							
	Injury/Trauma Care							
	Mental Health							
	Substance Abuse							
	Anaemia and Nutritional Supplementation							
	Congenital diseases and anomalies							
	Subtotal							
Treatment and Care of other common diseases of local priority within the Council	Eye Care (Cataract, Trachoma, etc.)							
	Oral and Dental Conditions							
	Skin Diseases							
	Neglected Tropical Diseases (NTDs)-							
	- Schistosomiasis,							
	- Onchocerciasis							
	- Filariasis							
	- Plague							
	- Rabies							
	- Trypanosomiasis							
	- Relapsing fevers							
	- Soil Transmitted Helmithesis							

PRIORITY AREA	INTERNVETION	DMOs / MMOH OFFICE/	COUNCIL HOSPITAL	HEALTH CENTRES	DISPENSARIES	VOLUNTARY AGENCY/SA	COMMUNITY	TOTAL
	- and others (specify)							
	Sub total							
Environmental Health and Sanitation	Hazardous waste							
	Water, Hygiene and Sanitation							
	Food control and Hygiene. Housing							
	Occupational Health and Safety							
	By-laws and regulations related to environmental health							
	Solid and Liquid waste in health facilities							
	Vermin and Vector control around the health facilities environment							
	Sub total							
Strengthen Social Welfare and Social Protection Services	Adolescent sexual reproductive health							
	Maternal conditions including infertility, rape and FGM							
	Care for most vulnerable children including orphans, children with disabilities, abuse and neglected children							
	Early childhood development							
	Rehabilitative support							
	Injuries/Trauma including rehabilitative support and counselling for self help							
	Mental Health							
	Drug and Substance Abuse							
	Exemptions and waivers of the vulnrable groups							
	Sub total							
Strengthen Human Resources for Health	Personal Emolument							
	Staffing level standard							
	Retention for health care workers							
	Staff Productivity							

PRIORITY AREA	INTERNVETION	DMOs / MMOH OFFICE/	COUNCIL HOSPITAL	HEALTH CENTRES	DISPENSARIES	VOLUNTARY AGENCY/SA	COMMUNITY	TOTAL
Management Capacity for improved health services delivery	Professional development							
	Good working environment (availability of housing, water, etc)							
	Staff safety (including Protective gears, post exposure prophylaxis)							
	Human Resources Information System							
	Sub total							
Strengthen Organizational Structures and institutional Management at all levels	Health Transport management system							
	Health management information system (HMIS)							
	Supportive supervision (including cascade) and inspection							
	Council Health Service Boards , Health Facility Governing Committees function							
	CHMT, Health Facility Management Teams and Council Health Planning Team							
	Utilities							
	Preventive maintenance and repair of health facilities equipment.							
	Physical infrastructure (health facility construction),							
	Physical infrastructure health facility rehabilitation and PPM							
	Medicines, medical equipment, medical and diagnostic supplies management system							
	Public Private Partnership							
	District health referral							
	Health facility financial management systems							
	Sub total							

PRIORITY AREA	INTERNVETION	DMOs / MMOH OFFICE/	COUNCIL HOSPITAL	HEALTH CENTRES	DISPENSARIES	VOLUNTARY AGENCY/SA	COMMUNITY	TOTAL
Emergency Preparedness and Response	Mapping for susceptible areas for emergencies in the Council							
	Advocacy for Prevention							
	Detection of Vulnerable Communities							
	Institutional capacity building							
	Injuries/Trauma/ Surgical Services							
	Subtotal							
Health Promotion (It caters in all priority areas)	Advocacy and IEC							
	School Health programmes							
	Community IMCI							
	Community Based initiatives							
	Sub total							
Traditional Medicine and Alternative Healing	Mapping and registrations							
	Advocacy							
	Laws and practice							
	Subtotal							
	GRAND TOTAL							
	% of allocation by the Council							
	% of allocation by the Guideline							

ANNEX 2.4: BUDGET SUMMARY FOR ALLOWANCES, FUEL FOR SUPERVISION AND DISTRIBUTION, REPAIR AND MAINTENANCE OF EQUIPMENTS VEHICLES AND BUILDINGS FOR BASKET GRANTS FOR THE YEAR

ITEM		GUIDELINE CEILLING PERCENTAGE ALLOCATION	ALLOCATION AS PER GUIDELINE CEILLING	ACTUAL ALLOCATION BY THE TEAM	PERCENTAGE BY PLANNING TEAM ALLOCATION	VARIANCE IN PERCENTAGE	REMARKS
TOTAL APPROVED BASKET FUNDS	**L**						
	A	B	C	D	E	F	G
	Allowances	20%	LxB		D/Lx100	B-E	
	Fuel (Diesel & petrol etc)	20%	LxB		D/Lx100	B-E	
	Repair and maintenance of vehicles and buildings	10-20%	LxB		D/Lx100	B-E	
	Repair and maintenance of Equipments	10-20%	LxB		D/Lx100	B-E	

L = Total approved annual Health Basket Funds (Ceiling)

This table is used to compare actual budget/percentage with allocated budget and allowed ceilings percentage and variance in percentage.

Annex 2.5: Summary of approved budget allocated to priority areas

Priority areas	Budget allocated	Percentage allocated (%)
Grand total		

Annex 2.6: Summary of BOD and budget allocated to cost effective interventions

This graph shows the burden of disease against the resources allocated, in addressing the cost effect effective interventions This graph will be automatically produced in the PlanRep. It is part of your Plan

Annex 2.6: Burden of diseases interventions

Burden of disease	Intervention
Childhood Illness (MDG 4)	Integrated Management of Childhood Illnesses (IMCI)
	Medicine, Medical equipment, Medical and Diagnostic Supplies management system
Childhood Immunizable disease (MDG 4)	Expanded Programme of Immunization (EPI)
	Provision of Vaccines
Neonatal (MDG 4)	Essential Newborn Care
	Exclusive Breast feeding for the first six months
	Kangaroo Mother Care
	New Born Resuscitation-Helping Baby Breathe
Malaria (MDG 6)	Diagnosis and Treatment of Malaria Cases with combination therapy Artemisinin (ACT, ALU)
	Indoor Residual Spray (IRS
	Insecticide treated nets (ITNs)
	Intermittent Presumptive Treatment in Pregnancy (IPTp)
	Integrated Management of Childhood Illnesses (IMCI)
HIV/AIDS (MDG 6)	Antiretroviral Therapy (ARV)
	Counselling and Testing (VCT, PITC, PMTCT)
	Promotion of Condom Use
	Safe Blood Transfusion Services
	Treatment of STIs
TB (MDG 6)	Provision of Essential TB medicines
	TB DOTs plus (TB-HIV/AIDS,MDR-TB)
Maternal (MDG 5)	Basic/Comprehensive Emergency Obstetric Care
	Comprehensive Post Abortion Care
	Family Planning/ Contraceptives
	Focussed Antenatal Care (includes PMTCT, Birth Preparedness, Iron, Folic Acid Supplementation, IPT, Syphilis Screening, TT, etc)
	Post Natal Care
	Safe and Clean Delivery by Skilled personnel in a facility
Injury Care	Integrated management for Emergency and Essential Surgical Care (IMEESC)
Other	Promotion and Prevention on Diseases specific predisposing factors at community level.
	Case management (Diagnosis and Treatment) for NCDs
	Promotion and Prevention of predisposing factors for NCDs at community level
	Provision of Essential Medicines for Non Communicable Diseases
	Rehabilitative Support for patients with Non Communicable Diseases
	Medicine, Medical equipment, Medical and Diagnostic Supplies management System
	Case Management (Diagnosis and Treatment) of locally important diseases and Neglected Tropical Diseases (NTDs)
	Essential medicines to specific diseases for NTDs
	Promotion and Prevention predisposing factors for NTDs at community level

ANNEX 3: NATIONAL PACKAGES OF ESSENTIAL HEALTH AND SOCIAL WELFARE INTERVENTIONS PRIORITY AREAS

The interventions under each priority area includes, but not limited to the following:

Priority area 1: Maternal, Newborn and Child Health[6] **-***Interventions*:

1) Adolescent friendly sexual reproductive health
2) Focused Antenatal Care (includes: birth preparedness, PMCTC, nutritional supplementation, IPT, FP counseling, TT, Syphilis Screening etc.)
3) Comprehensive Post-Abortion Care
4) Basic Emergency Obstetric and Neonatal Care (BEmONC)
5) Comprehensive Emergency Obstetrics and Neonatal Care (CEmONC)
6) Integrated Management for Emergency and Essential Surgical Care (IMEESC)
7) Safe and Clean Delivery Care by Skilled Attendants in health facilities
8) Post-natal Care
9) Family Planning
10) STIs, HIV and AIDS Management (HTC, HBC, CTC, PMTCT)
11) Prevention, Control and Management of Reproductive System Cancers
12) Prevention and Management of Gender Based Violence and Other Harmful Traditional Practices
13) Kangaroo Mother Care
14) Exclusive Breast-Feeding for first six months
15) Essential New-born Care and New-born Resuscitation
16) Early Infant Diagnosis of HIV
17) Expanded Programme of Immunizations (EPI)
18) Underfive growth and development monitoring
19) Management of severe malnutrition
20) Nutritional Supplementation for mother, neonates and children
21) Community Based Health Care Services for MNCH (Community Health care workers, Community Based Distributers for FP, etc.)

Priority area 2: Communicable Diseases - *Interventions:*

1) Malaria case management with artemisinin combination therapy (**ACT, ALU**)
2) **Insecticide Treated Nets (ITNs**)
3) Indoor Residual Spraying (**IRS**) and
4) Intermittent Presumptive Treatment (**IPTp**) of malaria

- **TB Management**
  1) TB DOTS, plus (TB/HIV, MDR-TB), etc.

[6] Districts are encouraged to use the existing guideline/ strategies/tool for the different MNCH components

- **Leprosy Management**
  1) Prevention
  2) Diagnosis
  3) Treatment of Cases
  4) Rehabilitative Support for leprosy patients

- **HIV/AIDS and STIs**

  1) Reproductive Health and Integrated Management of Adolescent and Adult Illness (IMAI)
  2) Prevention of Mother-to-Child Transmission of HIV
  3) Antiretroviral Therapy (ART)
  4) Testing and Counselling (VCT, PITC, PMTC)
  5) Promotion of Condom use
  6) Management of STIs
  7) Safe Blood Transfusion Services
  8) Early Infant Diagnosis of HIV

- **Management of Epidemics** (Cholera, Meningitis, Plague, Yellow fever, Measles, Polio, Others (specify)
  1) Surveillance, Early Case Detection, Treatment and Control.
  2) Proper Liquid and Solid Waste Disposal including handling of infectious materials (Environmental Sanitation)
  3) Infection Precautions and Control (IPC)
  4) Vaccination Campaigns
  5) Control measures

Priority area 3: Non – Communicable Disease Control - *Intervention areas:*

a) Acute and chronic respiratory diseases
   1) Health Promotion and Prevention through IEC on change of lifestyle (smoking, excessive alcohol consumption, exercises and diet) at community level
   2) Early Diagnosis
   3) Proper Management of cases and complications
   4) Rehabilitative Support

b) Cardiovascular diseases/ Cerebral Vascular Accidents
   1) Health Promotion and Prevention through IEC on change of lifestyle (smoking, excessive alcohol consumption, exercises and diet) at community level
   2) Early Diagnosis
   3) Proper Management of cases and complications
   4) Rehabilitative Support

c) Diabetes Mellitus

1) Health Promotion and Prevention through IEC on change of lifestyle (smoking, excessive alcohol consumption, exercises and diet) at community level
2) Early Diagnosis
3) Proper Management of cases and complications
4) Rehabilitative Support

d) Neoplasms / cancers
1) Health Promotion and Prevention through IEC on change of lifestyle (smoking, excessive alcohol consumption, exercises and diet) at community level
2) Early Diagnosis
3) Proper Management of cases and complications, referral of cases
4) Rehabilitative Support

e) Injuries/Trauma Care
1) Integrated Management for Emergency & Essential Surgical Care(IMEESC)

f) Mental Health/Substance Abuse
1) Health Promotion and Prevention through IEC at community level
2) Early Diagnosis of cases
3) Proper management of cases
4) Referral of complicated cases to level II or III hospitals for management
5) Establish Psychiatric ward of 8-10 beds

g) Anaemia & Nutritional Deficiencies
1) Health Promotion and Prevention through IEC on diet and improved food production at community level
2) Early Diagnosis of cases
3) Proper management of cases
4) Referral of complicated cases to level II or III hospitals for management

h) Congenital Diseases and anomalies
1) Health Promotion and Prevention through IEC on change of lifestyle (smoking, excessive alcohol consumption and diet) at community level
2) Early Diagnosis
3) Proper Management of cases and complications
4) Rehabilitative Support

i) Abdominal Surgery
1) Integrated Management for Emergency & Essential Surgical Care(IMEESC)

Priority area 4: Treatment and care of other common diseases of local priority within the Council - *Intervention areas:*

These include but not limited to
a) Eye Care (Cataract, Trachoma, etc.)

1) Health Promotion and Prevention through IEC on body hygiene and diet at community level
2) Case Management
3) Rehabilitation

b) Oral health conditions,

1) Health Promotion and Prevention through IEC on change of lifestyle (oral hygiene, smoking and diet) at community level
2) Emergency Oral Care including Dental Surgery
3) Proper Management of cases and complications
4) Rehabilitative Support

c) Skin diseases

1) Health Promotion and Prevention through IEC on body hygiene and diet at community level
2) Early Diagnosis and Proper Case Management

d) Neglected Tropical Diseases (NTDs) which includes

a. Schistosomiasis
1) Health Promotion and Prevention through IEC at community level
2) Early Diagnosis
3) Treatment of Cases
4) Rehabilitative support
5) Vector Control

b. Onchocerciasis
1) Health Promotion and Prevention through IEC at community level
2) Early Diagnosis
3) Treatment of Cases
4) Rehabilitative support
5) Vector Control

c. Filariasis
1) Health Promotion and Prevention through IEC at community level
2) Early Diagnosis
3) Treatment of Cases
4) Rehabilitative support
5) Vector Control

d. Plague
1) Health Promotion and Prevention through IEC at community level
2) Early Diagnosis
3) Treatment of Cases

4) Rehabilitative support
5) Vector Control

e. Rabies
1) Health Promotion and Prevention through IEC at community level
2) Early Diagnosis
3) Treatment of Cases

f. Trypanosomiasis
1) Health Promotion and Prevention through IEC at community level
2) Early Diagnosis
3) Treatment of Cases
4) Rehabilitative support
5) Vector Control

g. Relapsing fevers
1) Health Promotion and Prevention through IEC at community level
2) Early Diagnosis
3) Treatment of Cases
4) Vector Control

h. Soil Transmitted Helmithesis and
1) Health Promotion and Prevention through IEC at community level
2) Early Diagnosis
3) Treatment of Cases
4) Control Measures

i. Others (specify**).**
1) Health Promotion and Prevention through IEC at community level
2) Early Diagnosis
3) Treatment of Cases
4) Rehabilitative support/Control Measures

Priority area 5: Environmental Health and Sanitation - ***Intervention areas:***
(1) Hazardous waste
(2) Water, hygiene and sanitation.
(3) Food control and hygiene.
(4) Housing conditions.
(5) Occupational Health and Safety
(6) By-laws and regulation related to environmental health
(7) Solid and liquid waste in health facilities environment.
(8) Vermin and Vector control around the health facilities environment.

Priority area 6: Strengthen Social Welfare and Social Protection Services -*Intervention areas:*

(1) Adolescent sexual reproductive health
(2) Women's and girls' reproductive health issues including infertility, rape/ sexual assault and FGM
(3) Care and protection for most vulnerable children including orphans, children with disabilities, abused and neglected children, street children and young offenders.
(4) Early childhood development
(5) Rehabilitative support
(6) Injuries/Trauma including rehabilitative support and Counselling for self help
(7) Mental Health
(8) Drug and Substance Abuses
(9) Exemption and waivers of the vulnerable groups (Health Facility -social protection system)
(10) Family support and counselling to prevent breakdown and protect children in the home.

Priority area 7: Strengthen Human Resources for Health and Social Welfare Management Capacity for improved health services delivery –

Intervention areas:

(1) Personal Emolument.
(2) Staffing level standard
(3) Professional development
(4) Retention for health care workers.
(5) Staff productivity
(6) Good working environment (availability of housing, water, etc)
(7) Staff safety (including Protective gears, post exposure prophylaxis)
(8) Human Resource Information System

Priority area 8: Strengthen Organizational Structures and institutional management at all levels - *Intervention areas:*

(1) Health transport management system.
(2) Health management information system (HMIS).
(3) Supportive supervision (including cascade) and inspection.
(4) Council Health Service Boards (CHSBs), Health Facilities Governing committees (HFGC/ HFC) function.
(5) CHMT and Health Facilities Management Teams; Council Health Planning Teams.
(6) Utilities
(7) Preventive maintenance and repair of health facilities equipment.
(8) Physical infrastructure health facilities construction
(9) Physical infrastructure rehabilitation and PPM
(10)
(11) Medicines, medical equipment, medical and diagnostic supplies management system
(12) Public Private Partnership

(13) District health referral (such as emergency medical, surgical, anaesthesia, diagnostic, rehabilitation) services.
(14) Health facility financial management systems
(15) Mobilised adequate funding for Health and Social Welfare services (CHF, NHIF, P4P, userfees etc.)

Priority area 9: Emergency preparedness and response - *Intervention areas:*

(1) Mapping for susceptible areas for emergencies in the council
(2) Advocacy for prevention.
(3) Detection of Vulnerable Communities.
(4) Institutional capacity building

Priority area 10: Health Promotion/ Behaviour Change Communication (BCC) (It caters in all priority areas) - *Intervention areas:*

(1) Advocacy and IEC
(2) School Health programmes
(3) Community IMCI
(4) Community based initiatives

Priority area 11: Traditional Medicine and alternative healing - *Intervention areas:*

(1) Mapping and registrations
(2) Advocacy
(3) Regulatory framework and practice

ANNEX 4: NATIONAL TARGETS

Council should set annual implementation targets above the national targets. Incentives should be related to performance outputs of key targeted indicators.

Priority area 1: Maternal, Newborn and Child Health

Many of these targets are based on the National Road Map to be achieved by 2015.

a) 80% of health facilities provide adolescent friendly reproductive health services
b) Increased modern contraceptive prevalence rate from 20% to 60%
c) 75% of HIV+ women of reproductive age attending CTC receive FP services
d) Increased ANC attendance for four visits from 64% to 90%
e) 100 % of ANC clients are tested for syphilis
f) 80% of pregnant women access folic acid and iron supplementation
g) 85 % of pregnant women receive at least 2 doses of TT
h) 80% of pregnant women receive IPT2
i) At least 80% of all HIV positive pregnant women and their babies receive Antiretroviral prophylaxis to prevent mothers to child transmission
j) Increased coverage of health facility based deliveries from 47% to 80%
k) 70% of health centres and dispensaries provide Basic EmOC

l) 100% of hospitals and 50% of Health Centers provide Comprehensive EmOC
m) 50 % of women receive postnatal care services
n) 80% of postpartum women receive Vitamin A supplementation
o) 75% of Health Facilities provide essential newborn care
p) 100% of district hospitals have a unit/room for the care of neonates
q) 100 % of the hospitals attain Baby Friendly Hospital Initiative (BFHI) standards
r) At least 50% to HIV exposed babies receive HIV testing within the first 18 months of life (DNA PCR or Antibody test)
s) Immunization coverage for DPT- HepB-Hib and measles above 90% in 90 % of the districts
t) Vitamin A supplementation and deworming reach at least 90% of children under five years.
u) 80% of health facilities should have at least 60% of health care workers trained on IMCI
v) Increased coverage of under fives sleeping under ITNs from 26% to 80%
w) 70% of villages have community health care workers offering MNCH services at community level
x) 90% of households consume iodated salt.

Priority area 2: Communicable Disease Control

a) All eligible patients are put on ART Treatment
b) At least 80% of dispensaries providing improved STI case management
c) All health facilities implement standard package of HBC and support services
d) Increased number of condoms distributed through different innovative approaches in private –public partnership at all levels
e) All CTCs screening PLHIV for TB
f) All health facilities have essential medicines for treatment of communicable diseases
g) At least 90 percent of health facilities are implementing and reporting collaborative TB/HIV activities.
h) All TB patients are offered HIV testing and counselling
i) At least 70 percent of TB-patients are detected and correctly treated (by DOTS) both in health facilities and communities
j) At least 85 percent treatment success of TB patients is attained.
k) 80 percent of disabled people affected by leprosy identified and facilitated to have access to corrective surgery, technical aids and advice on prevention of further disabilities.
l) All health facilities and staff adhere to infection prevention measures
m) The proportion of pregnant women sleeping under Insecticides Treated Nets (ITN's)/ Long lasting Insecticidal (LLINs) nests raised from 23% to 80%
n) The percentage of children under fives sleeping under ITN's /LL raised from 36% to 80%
o) Percentage of children under 5 years of age with fever receiving appropriate treatment within 24 hours of onset for fever increased from 28% to 80%

p) Council should have essential equipment and facilities for early containment of Malaria epidemics.

q) All health facilities in council should have no stock out of recommended Ant malaria drug any time of the year

r) All children under 5 years of age diagnosed with uncomplicated malaria in health facilities are appropriately managed
s) Laboratory confirmed malaria cases increased from 20% to 80%
t) IPTP 1 uptake for pregnant women raised from 65% to 80%
u) IPTP 2 uptake for pregnant women raised from 31% to 80%
v) Household owning at least 1 ITN's raised from 36% to 80%
w) Household owning at least 2 ITN's/LLIS raised to 80%

Priority area 3: Non – Communicable Disease Control

a) All health facilities are equipped with appropriate equipment, medicines and medical supplies for screening, diagnosis and treatment of non-communicable diseases according to the National Minimum Standard (NMS) levels.
b) At least 30% of community members are reached by essential and effective health promotion and education messages addressing NCDs (e.g., healthy life styles, appropriate health seeking behaviour, associated risk factors and regular medical check up)
c) All councils have integrated out-reach services for NCDs

Priority area 4: Treatment and care of other common diseases of local priority within the Council:

a) At least 80-100% therapeutic coverage of all eligible population covered with mass NTD medicine administration campaigns
b) Council have integrated out-reach services for diseases of local priority.
c) Community have accessibility to eye care supplies and consumables
d) Passive case detection, treatment and organized campaign for community awareness on sleeping sickness control is carried out in all Tsetse endemic areas
e) All dental clinics are equipped with state of the art equipment, instruments, materials and supplies.
f) Oral health education is provided at all dental and RCH clinics, 30% primary schools and institutions caring for special groups (disabled)
g) At least 50% of health facilities should provide emergency oral health care services and in addition the district hospital should provide oral care services
h) All health facilities provide treatment and care of skin diseases

Priority area 5: Environmental Health and Sanitation

a) All health facilities have adequate safe water supply
b) Number of household with permanent sanitary latrines increased from 47% to 73%
c) Number of household using toilet increased from 90% to 100%
d) Coverage of improved sanitary toilets in schools increased from 50% to 100%
e) Collection and disposal of solid waste increased from 25% to 50%
f) Council to have safe and sound sanitary landfill which operating properly
g) Hospitals and Health facilities surroundings kept clean
h) All health facilities have appropriate medical waste management
i) Sewerage services (liquid waste collection) increased from 17% to 30% in urban councils area
j) Number of unsanitary settlements reduced from 70% to 35%
k) Vector breeding sites reduced from 80% to 20% in all settlement
l) Water, hygiene and sanitation related diseases reduced from 60% to 30%

Priority area 6: Social Welfare Services

a) All Early Childhood Development Centers identified, registered and supervised.
b) Awareness campaign to the communities on causes and interventions of disability in place
c) Early childhood development including psychosocial stimulation to be addressed in the HF in the communities
d) At least 50 % of People Living with Leprosy are supported economically
e) At least 200 numbers of poor and vulnerable older people, identified, supported and enrolled in pre-payment, exemptions and waivers Schemes and socially rehabilitated and resettled.
f) Access to basic social services for all orphans and vulnerable children in need of care and protection is ensured
g) Early childhood development initiatives including psycho-social stimulation are to be addressed in the HF and the communities
h) Number of MVC/OVC identified increased from current number of 800,000 to 1.5 million and access Care, Support and Protection.
i) Support groups established for older people and those rehabilitated from leprosy.
j) Community Facilitators trained on Community Justice Facilitation Skills
k) Traditional social protection systems mapped and partnership strengthened.
l) At least Local Partners providers of Social Welfare services mapped and coordinated.
m) MVC Adolescents Trained on Life skills and provision of youth-friendly reproductive health services
n) Victims of Emergencies identifies and Counselled and rehabilitated and support
o) 80 Ward and Community Facilitators trained on MVC Care taking Skills.

p) Local community structures sensitized to carry responsibilities for monitoring and protecting most vulnerable children from abuse and neglect.
q) 80 percent of congenital anomalies and disabled people identified and facilitated to have access to corrective surgery, technical aids and advice on prevention of further disabilities.
r) Councils address health and social problems of adolescents and elderly people sufficiently.
s) Disabled people are socially fully integrated in their communities with gender sensitive care and consideration for the special needs of girls and women
t) All Children's Homes identified, registered and monitored.
u) Non residential alternative family care (e.g. foster care and adoption) available for children who cannot live with their parents
v) A register of certified foster carers is maintained and support provided to foster carers to look after children placed with them.
w) Emergency accommodation is available for children who are lost, abandoned or need temporary protective care
x) Social Welfare Officers provide parental and family counseling in order to prevent family breakdown.

Priority area 7: Strengthen Human Resources for Health Management Capacity for improved health services delivery

a) At least 30% of the HRH gap is budgeted in PE
b) All councils to identify and prioritize HRH gaps and forward request to POPSM
c) Skilled staff increased by number from the current level to at least by 10%
d) 70% of the health facilities have at least 30% of total number of mix skilled staff required
e) All new and 50% of promoted staff at all levels are oriented on their roles and responsibilities
f) 50% of staff undertake on the job training to address the identified skills gap
g) At least 05% of budget allocation is used for short and long term training to address skills gaps.
h) Develop incentive package to attract and retain skilled staff
i) At least 20% of the facilities implement performance appraisal system to all of the staff
j) Personnel information is updated at least quarterly and used by a functional computerized HRHIS/ Data base
k) Increase skilled staff on preventive services e.g. Health Officers by at least 10%

Priority area 8: Strengthen Organizational Structures and institutional management at all levels.

a) All health facilities by level have at least 80% constant supply of medical and diagnostic supplies, medicine, vaccines and hospital equipments

b) Percentage of health facilities that experienced stock out at least one or more of the essential medicines during a defined period or percentage of health facilities with less than 75% of the 10 tracer medicines.

c) All health facilities are supervised and supervision reports copied to facility in-charges by CHMT or cascade supervisors at least monthly.

d) Every community member accesses a health facility services, which is equipped according to national minimum standard requirements.

e) All health facilities by level have reliable communication and transport facilities for improving access, reporting and referral services.

f) All health facilities by level have their buildings including staff houses in a good state of repair with sanitary facilities.

g) Council has functional CHSB and HFGCs (Board present according to the guideline, number of meetings, minutes available, activities, decisions made by the board, activities planned for the CHSB and HFGCs).

h) All health facilities have a functional Health Management Information System (HMIS) including Human Resource for Health Information System (HRIS)

Priority area 9: Emergency preparedness and response

a) Over 50% of vulnerable community sensitized on impending health emergencies.
b) Council conduct vulnerability assessment in the event of emergency,
c) Health and Social Welfare Staff with knowledge and skills on emergency management available at levels of healthcare delivery.
d) Material resources necessary for emergency preparedness and response available at all level.
e) Health emergency contingency plan according to IMEESC WHO tool kit available at each council
f) Council establish functioning emergency unit for surgical care for injuries and trauma

Priority area 10: Health Promotion (It caters in all priority areas).

a) Council establish continuous health promotion, prevention and control of diseases and disabilities at community and health facilities (Health talks in RCH clinics IEC materials and advocacy)
b) Council health facilities adhere to school health programme guideline
c) Council advocate and implement community based health interventions (cIMCI, cBPM, PHAST, VHD, cHBC, etc).

Priority area 11: Traditional Medicine and alternative healing

a) All Traditional practitioners and healers identified and geographically located
b) All Traditional practitioners and healers adhere to National guideline

ANNEX 5 – Chapter 2: SITUATION ANALYSIS TABLES & REVIEW OF RESOURCES AVAILABILITY

Introduction and important:

Its important to make sure all tables are filled with the required accurate data. Every table must be interpreted then use the results for your decision when developing your plan. The summary from the tables interpreted must be part of the executive summary. The information from these tables will be additional to the problems identified by the planning team, then be addressed according to the resources available

Table: 1 Important Primary Indicators of Health Status DHS 2010

Indicator	No of death in health facility	No of death in the Community	Total	How to calculate the indicator	Rate
Maternal mortality rate				No of maternal deaths (in the Community + HF) x 100,000 Total live births (HF + Community)	454
Neonatal deaths rate				No of death <_ 28 days (in Community + HF) x 1000 Total live births (HF + Community)	26
Infant mortality rate				No of death <_ 1 year (in Community + HF) x 1000 Total live births (HF + Community	51
Under Five mortality rate				No of death <5 years (in Community +HF x 1000 Total No of children < 5 years	81

Table 2: Vital Health Indicators

Indicators	National	Region	Council
Total population (mainland)	33,461,849		
Growth rate	2.9%*		
Births rate	4.6%*		
Children< 1 year	4.0%*		
Children <5 years	21%		
Women: 15 – 49 years	18%		
Young people (10-24)	32.4%		
Maternal Mortality ratio	454/100,000**		
Perinatal Mortality Rate			
Neonatal Mortality Rate	26/1,000**		
Infant Mortality Rate	51/1000**		
Under Five Mortality	81/1,000**		
Number of elderly aged 60+ (1.4%)			
MVC (10-12% of < 18 years)			
Permanent Toilet	* 47%		

*Census Tanzania 2002, DHS of Tanzania 2004, DHS**2010

Table 3: Main OPD Diagnoses (list the top 10 diseases depending on the prevailing situation in the Council.

Diagnosis	<5 years			5+ years		Total
	M	F	%	M	F	
Malaria						
ARI						
Diarrhoeal disease						
Intestinal worms						
Pneumonia						
Eye conditions						
Oral conditions						
Ear conditions						
Skin diseases						
Fractures						
Cardiovascular Disorders						
Neoplasm						
Clinical AIDS						
Genital Discharge						
Genital ulcer						
Other STD						
PID						
Anemia						
PEM						

TB						
Leprosy						
Injuries						
Emergency surgical condition						
Other diagnosis						
Normal Pregnancy attendances						
Complicated Pregnancy attendances						
Total diagnoses						

Table 4: In Patient Admissions and Deaths per Diagnosis (list the top 10 diseases depending on the prevailing situation in the district.

Diagnosis	**< 5 years**				**5+ years**				**Total**				**CFR in %**
	Admission		**Deaths**		**Admission**		**Deaths**		**Admission**		**Deaths**		
	M	F	M	F	M	F	M	F	M	F	M	F	
ARI													
Diarrhea diseases													
Malaria severe													
Malaria uncomplicated													
Tuberculosis													
Anemia													
Pneumonia													
PID													
Complications of Pregnancy													
Normal deliveries													
Birth Asphyxia													
Neonatal sepsis													
Prematurity/Low birth weight													
Animal Bites													
Burns													
Poisoning													
Clinical AIDS													
Other Injuries													
Cardiovascular Diseases													
Fractures													
Neoplasm													
Emergency surgical conditions													
Other diagnosis													
Total diagnoses													

Note: AIDS has to be mentioned among one of the most pressing conditions even if it is not on the top ten lists.

Table 5: **Notifiable Diseases**

Diagnosis	**<5 years**				**Total**	**5+ years**				**Total**
	M	**F**	**Death**	**CFR**		**M**	**F**	**Death**	**CFR**	
Acute Flaccid Paralysis										
Cholera										
Dysentery										
Malaria										
Relapsing Fever										
Measles										
Meningitis										
Neonatal Tetanus										
Plague										
Rabid Animal Bite										
Rabies										
Typhoid										
H1N1(Swine Flu)										
Avian flu										
Ebola										
Others										

NB: Community based information to be collected using Village Registers, and Disease Surveillance Systems where available

Table 6: Summary of important HMIS Indicators showing the trend

S/N	**Indicator**	**Year…**	**Year…**	**Year…**
1	OPD attendances (persons attending) (in %)			
2	Outpatient attendance per health worker ratio			
3	ANC new attendance rate (in %)			
4	ANC clients receiving TT2+ (in %)			
5	IPT 2 (in %)			
6	OPV 0 (in %)			
7	DPT-HB-HIB3 immunization < 1 year (in %)-*Pentavent 3*			
8	BCG (%)			
9	Measles (%)			
10	Vitamin A Supplementation (in %)			

S/N	**Indicator**	**Year…**	**Year…**	**Year…**
11	Family Planning New Acceptance Rate (in %)			
12	Percentage Births attended at health facility (%)			
13	Percentage Community delivery (%)			
14	Percentage of health centres that provide basic EMoC %			
15	Percentage FSB among reported births (in %)			
16	Caesarean Sections per expected births (in %)			
17	Number of maternal death per year (give full number)			
18	Emergency surgeries as percentage of general Surgeries recorded			
19	Number of TB cases diagnosed in the last 12 months			
20	Percentage TB cases treated successfully (%)			
21	Percentage of TB cases cure rate (%)			
22	Percentage of TB patient offered HIV testing (%)			
23	Percentage of PLHIV screened for TB (%)			
24	Percentage of under 5 deaths due to malaria (%)			
25	Severe malnutrition rate (in %)			
26	Moderate malnutrition rate (in %)			
27	Percentage of low birth weight (in %)			
28	No. of PLHIV cases recorded			
29	No of PLHIV patients on ARVs			
30	HIV Prevalence among Pregnant women (PMTCT)			
31	Prevalence of HIV among people tested through VCT			
32	Prevalence of HIV among people tested through PITC			
33	Prevalence of HIV among blood donors			

Table 7: Health and Social welfare training institutions, other institution, initiatives and programs:

Name of Health and SW training Institute	**Other Institutions**	**Other Initiatives**	**Other Programme**

Short description of the community based initiatives related to the following issues:

i. Functioning of a Council Health Service Boards.
ii. Functioning of the Health Facility Governing Committees at all levels of Health Facilities
iii. Health promotion and environmental health activities e.g. water supply, toilets, hand washing facilities, refuse collection and disposals of medical waste etc.
iv. cIMCI (cIMCI - CORPs), FP (CBDAs), SMI (TBA), CBHMIS, Growth Monitoring, Community based pregnancy Monitoring (VHWs), CBDOTS, PHAST, HBC

v. Financing schemes e.g.: CHF, NHIF, etc.
vi. Participatory Planning Process (O&OD, PRA)
vii. Care and support MVC
viii. Community based rehabilitation of people with disability
ix. Function of MVC committees

Table 8: Community Based Initiatives (CBI) available in the Council

Priority Area	CBI	No of CORPs available	No of HFs covered	No of Villages/ Mtaa covered	Remarks
Maternal,Newborn and Child Health	CBPM,				
	cIMCI				
	VHDs(VHWs)				
	CBDAs of FP				
Communicable Disease Control	Community based malaria control (CBMC)				
	Community based HBC				
	CBDOTS				
Non communicable Disease Control	CBGM, Community based Iodated salt monitoring				
Strengthening	CBHMIS/DSS				
	CHSB& HFGCs				
	Participatory planning (O&OD)				
Environmental Health	PHAST,WASH				
Treatment and care of NTDs	Mass medicine administration				
Social Welfare	Community based ECD centres				
Traditional and alternative medicine	TBAs &THs				

Table 9 (a): Status of Health Facilities and ownership (Dispensaries, Health Centers, and Hospitals)

HF (Name)	Ward	Village/Mtaa	Type	Ownership	Population *	Distance 5 KM *	Physical State**
					(Total)		

Add those under construction; show also ward and village/Mtaa
* If reliable figures are not available, use estimates.
** Use the following classification
A = good
B = minor rehabilitation needed
C = major rehabilitation needed
D = demolition and reconstruction
E= under construction
F= under rehabilitation

Table 9(b): Facilities planned for rehabilitation, constructions under MMAM

Name of facility	Type	Owner	Budget planned				Remarks
			Construction	Rehabilitation	Equipment	Staff House	

Interpret the two tables table 9(a) & (b) must be linked and taken into consideration during planning and setting of priorities.

Table 10: Summary of P4P Annual Performance report January – December…..

Facility	Immunization - DTPHb_Hib3 *(Equal or above 80%)*		Immunization - OPV0 *(Equal or above 60%)*		Deliveries in health facilities *(Equal or above 60%)*		IPT 2 for pregnant women *(Equal or above 60%)*		MTUHA reports *(Timely, complete and accurate 100%)*	
	L YR	C YR	L YR	C YR	L YR	C YR	L YR	C YR	L YR	C YR

NOTE: LYR = Last year: C YR = Current Year according to HMIS data- calendar year report

NOTE*: All tables must be interpreted and the results are used by the Council Health Planning teams.*

Chapter 3: REVIEW OF RESOURCES AVAILABILITY

3. 1. Human Resource Requirement

Human Resource is crucial for a well functioning health system. Tables 11(a) – 11 (d) should be completed according to the "Staffing Levels (MoH/CSD 1999) for Health Facilities/ Institutions" and Social Welfare Guide for Staffing Levels year…...

Table: 11 (a): Human Resource for Health and Social Welfare requirement

Type of Personnel	No of posts requested by LGAs last year*	No of funded posts as per permit last year*	No of New Employees		Staff Establishment			Gap identified		Remarks
								Surplus	Deficit	
					No of staff available		No Staff required			
			Recruited last year	Retained at the end of the year	M	F				
Med Specialist										
Medical Doctor										
Ass.Med. Off										
Nursing Officer										
Social Welfare Officer										
Others Specify										
Total										

*Source: according to approved posting permit per financial year

E.g. if the planning period is for 2012/2013 plan, Data to be filled should be of 2010/2011

Table 11 (b): CHMT Core Staff and Co-opted Members

Type of personnel (Cadre)	Staff Available		Acting position	Newly appointed	Attrition (Death, transfer)	The staff availability trends		
	F	M				-3 Fiscal year	-2 Fiscal Year	Current fiscal Year
DMO/MOH								
DNO								
DHS								
DLT								
DPh								
DHO								
DDO								
DSW								
Total								
Co-opted Members								
DRCHCo								
DTLC								
DAC								
HMIS								
Etc…								

Table 11 (c): Health and Social Welfare Staff availability trend

Type of Personnel	Requirement ** (Staff Establishment)	Staff availability		Attrition (Death, Left Jobs Transfer, Retired)	The staff availability trends		
		(F	(M)		-3 fiscal year	-2 fiscal year	Current fiscal Year
The Council Hospital							
Medical Specialists							
Medical Doctor	1	1	0				
Ass. Med. Off.	4	1	1				
Nursing Officer	5	5	3				
Soc. Welfare Off	2	0	0				
Other Staff specify…..							
Total	**11**	**7**	4				

Health Centres							
Ass. Med. Officer	2						
Clinical Officers	4						
Nursing Officer	2						
Other Staff specify..							
Total	**8**						
Dispensaries							
Clinical Officers	2						
Nursing Officer	3						
Other Staff specify….	**5**						
Total							

-3 the last fiscal year back
-2 the last fiscal year
Current year = New + existing staff)

Table 11 d): **The Health and Social Welfare staff attrition**

Type of Personnel	**Available staff last year**	**Training of more than 9 months**	**Attrition last year**				
			Staff retired	**Death**	**Training of more than 9 months**	**Left Job /transfer**	**Total**
The Council Hospital							
Medical Specialists							
Medical Doctor							
Ass. Med. Off.							
Nursing Officer							
Total							
Health Centres							
Ass. Med. Officer							
Clinical Officers							
Nursing Officer							
Total							
Dispensaries							
Clinical Officers							
Nursing Officer							
Others specify							
Total							

ource and year

3.2. Material / Equipment/ Drugs/ Supplies

Information on material, equipment and medicine supply in the last year should be included in the CCHP. Main problems should be identified and a list of essential equipment (X-Ray, ultrasound, autoclave, etc

Table 12: Overview on the availabilities and conditions of essential Medical Equipment and Apparatus

Type of Health Facility	Item	Quantity			Comment
		Available	Status/condition	Required	

3.3 Transport

If there are any serious transport problems this should be indicated in the executive summary and explain in detail in the situation analysis. Transport is very important for facilitation of quality delivery of services, used for supervision, distribution and administrative issues e.g. Procurement and referral of patients.

Information on transport management system, a table with the following format should be worked out:

Table 13: Vehicles and their use

Type of vehicle	Registration Number	Date of acquisition	Station	"Used for" (purpose)*	Condition	Mileage	Comments
1	2	3	4	5	6	7	8

* **Indicate the use of the vehicle:**

Choose: **"A"** and fill in the column No 5 if it is used for Distribution
"B" and fill in the column No 5 if it is used for Supervision
"C" and fill in the column No 5 if it is Ambulance
"D" and fill in the column No 5 if it is used for Administration

"E" and fill in the column No 5 if it is used for other function and specify
"AB" if it is used for Supervision and distribution

3.4 Sources of Funds

Funds received last year and funds allocated for the planning period has to be included in the CCHP. Find a proposed format below:

Table 14: The Different Sources of Financing

Source of financing		**Last year Approved Budget …**	**Last year Actual Received….**		**Last year actual expenditure**	**Allocation for the Current planning Year…**
		Amount	**Amount**	**%**		
Block Grant	PE					
	OC					
Health Basket Fund						
Block Grant Dev. budget						
HSDG						
Council Own Source	Recurrent					
	Dev.					
MoHSW(Receipt in Kind– Medicines & medical equipment & supplies - MSD)	(MSD)					
Global Funds						
Cost sharing	User fees					
	NHIF					
	CHF/ TIKA					
	DRF					
	NSSF					
	Others					
Projects/Programs						
PEFFER						
TUNAJALI						
NGOs	Plan Intern.					
	BMAF					
	World Vision					
	JIHPGO					
	Others(Specify)					

Source of financing		**Last year Approved Budget …**	**Last year Actual Received….**		**Last year actual expenditure**	**Allocation for the Current planning Year…**
Other Development Partners	USAID					
	JICA					
	GTZ					
	UN – Agencies					
	WHO					
	UNICEF					
	Others (Specify)					
Donations	Cash/ receipt in kind					
Grand total						

Most NGOs get funds from USAID, Global Fund or PEPFAR hence there may be duplication of reporting here. Usually funding from PEPFAR are disbursed to the US based NGOs such as FHI/Tunajali, EGPAF etc. hence there may be duplication of reporting if we maintain PEPFAR, TUNAJALI, JHIEPGO categories. Please seek advice from USAID on how best to itemise/categorise this table for US related funding.

NOTE*:* ***All tables must be interpreted and the results are used by the Council Health Planning teams during planning.***

ANNEX 6 : COUNCIL HEALTH (20) PERFORMANCE INDICATORS FOR HEALTH

MOHSW/ PMO-RALG Council Health Guide	**Council Minimum Health Standards**	**COUNCIL**	**COUNCIL**	**COUNCIL**	**REMARKS**
OBJECTIVE	**DATA TO BE COLLECTED/ PERFORMANCE INDICATORS**	**BASELINE INFORMATION OF PREVIOUS YEAR (Jan – Dec.)**	**ACTUAL ACHIEVEMENT YEAR (Jan-Dec…….),**	**EXPECTED OUTPUT AT THE END OF THE YEAR (Jan – Dec.)**	**REMARKS**
Improve Reproductive Health Care	1. proportion of clients attending for purposes of: i. ANC ii. Deliveries iii. Post delivery complication iv. Postnatal Care 2. Family Planning indicators (a) Proportion of women of child bearing age using family planning method (b) Proportion of clients receiving family planning by method: i. Pills ii. Injection iii. IUD iv. Condom 3. Proportion of women of child bearing age attending ANC clinic receiving Tetanus Toxoid Immunization 4. Under five clinic attendees i. Proportion of under five children attending under five clinic.				

MOHSW/ PMO-RALG Council Health Guide	**Council Minimum Health Standards**	**COUNCIL**	**COUNCIL**	**COUNCIL**	**REMARKS**
OBJECTIVE	**DATA TO BE COLLECTED/ PERFORMANCE INDICATORS**	**BASELINE INFORMATION OF PREVIOUS YEAR (Jan – Dec.)**	**ACTUAL ACHIEVEMENT YEAR (Jan-Dec…….),**	**EXPECTED OUTPUT AT THE END OF THE YEAR (Jan – Dec.)**	**REMARKS**
	ii. Proportion of under five children with a body weight for age less than 60% 5. proportion of children under one year immunized against i. Measles ii. Polio iii. BCG iv. DPT3-HB-HiB (Pentavalent)				
Improve malaria case management	6) Malaria Morbidity indicators a) Proportion of malaria cases for under 5 years b) Proportion of malaria cases above 5 years 7)Malaria Mortality Indicators a) Proportion of death due to malaria under 5 years b) Proportion of death due to malaria above 5 years				

MOHSW/ PMO-RALG Council Health Guide	**Council Minimum Health Standards**	**COUNCIL**	**COUNCIL**	**COUNCIL**	**REMARKS**
OBJECTIVE	**DATA TO BE COLLECTED/ PERFORMANCE INDICATORS**	**BASELINE INFORMATION OF PREVIOUS YEAR (Jan – Dec.)**	**ACTUAL ACHIEVEMENT YEAR (Jan-Dec…….),**	**EXPECTED OUTPUT AT THE END OF THE YEAR (Jan – Dec.)**	**REMARKS**
Improve STI care management and HIV new transmission	8) HIV/AIDS/STI Indicators a) Number of STI episodes treated b) Proportion of male and female who received HTC and know their HIV status c) Proportion of eligible PLHIV receiving ART				
Improve TB/Leprosy care management and disease transmission	9) TB/Leprosy indicators (a) Proportion of TB cases treatment success (b) Proportion of Leprosy cases completed treatment (c) No of TB cases per 1000 patients Notified				
Strengthen disease Surveillance and Case Management of specific Epidemic diseases	10) Surveillance a) Proportion of treated cases of Cholera who died b) Proportion of treated cases of meningitis who died				

MOHSW/ PMO-RALG Council Health Guide	**Council Minimum Health Standards**	**COUNCIL**	**COUNCIL**	**COUNCIL**	**REMARKS**
OBJECTIVE	**DATA TO BE COLLECTED/ PERFORMANCE INDICATORS**	**BASELINE INFORMATION OF PREVIOUS YEAR (Jan – Dec.)**	**ACTUAL ACHIEVEMENT YEAR (Jan-Dec…….),**	**EXPECTED OUTPUT AT THE END OF THE YEAR (Jan – Dec.)**	**REMARKS**
Improve non-Communicable disease Cases management	11) Non communicable indicators (a) Proportion of patients diagnosed with the Following diseases: i) Hypertension ii) Trauma/injuries iii) Mental disorders iv) Neoplasms v) Diabetes vi) Acute and Chronic Respiratory Diseases (b) Proportion of deaths due to i) Hypertension ii) Trauma/injuries iii) Mental disorders iv) Neoplasm v) Diabetes vi) Acute and Chronic Respiratory Diseases vii) Abdomen Surgical Condition viii) Hernia ix) Congenital anomalies				

MOHSW/ PMO-RALG Council Health Guide	**Council Minimum Health Standards**	**COUNCIL**	**COUNCIL**	**COUNCIL**	**REMARKS**
OBJECTIVE	**DATA TO BE COLLECTED/ PERFORMANCE INDICATORS**	**BASELINE INFORMATION OF PREVIOUS YEAR (Jan – Dec.)**	**ACTUAL ACHIEVEMENT YEAR (Jan-Dec…….),**	**EXPECTED OUTPUT AT THE END OF THE YEAR (Jan – Dec.)**	**REMARKS**
Improve availability Drug/medical supplies Laboratory reagents and Vaccines	12) Proportion of health facilities by level with constant supply of drugs/medical supplies /vaccines and Laboratory reagents: (a) Hospital (b) Health Centre (c) Dispensary				
Improve financial Management system	13) Respect/Adherence to allocation ranges to cost centers stipulated in the CCHP guidelines: a) DMO's Office b) Hospital c) Health Centre d) Dispensary e) Community f) VAH/un-allocated				
Improve human Resource for health in terms of number professional Mix at all levels.	14) Proportion of trained personnel per level actually available compared to the national minimum standards: a) Hospital b) Health Centre c) Dispensary 15) Proportion of health personnel who have undertaken				

MOHSW/ PMO-RALG Council Health Guide	**Council Minimum Health Standards**	**COUNCIL**	**COUNCIL**	**COUNCIL**	**REMARKS**
OBJECTIVE	**DATA TO BE COLLECTED/ PERFORMANCE INDICATORS**	**BASELINE INFORMATION OF PREVIOUS YEAR (Jan – Dec.)**	**ACTUAL ACHIEVEMENT YEAR (Jan-Dec…….),**	**EXPECTED OUTPUT AT THE END OF THE YEAR (Jan – Dec.)**	**REMARKS**
	short term training: a) Hospital b) Health Centre c) Dispensary 16) Proportion of facilities supervised by CHMT a) Hospital b) Health Centre c) Dispensary				
Improve control of Communicable diseases	17) Indicators of Water and Sanitation a) Proportion of households with acceptable toilets and hand washing facilities, refuse bins/refuse bin or pit and access to safe water b) Proportion of HF with IEC Materials				
Ensure facilities are in good state of repair	18) Proportion of facilities in good state of repair: a) Hospital b) Health Centre c) Dispensary				

MOHSW/ PMO-RALG Council Health Guide	**Council Minimum Health Standards**	**COUNCIL**	**COUNCIL**	**COUNCIL**	**REMARKS**
OBJECTIVE	**DATA TO BE COLLECTED/ PERFORMANCE INDICATORS**	**BASELINE INFORMATION OF PREVIOUS YEAR (Jan – Dec.)**	**ACTUAL ACHIEVEMENT YEAR (Jan-Dec…….),**	**EXPECTED OUTPUT AT THE END OF THE YEAR (Jan – Dec.)**	**REMARKS**
Improve Health Facilities Utilization rate at all levels	19). Proportion facility with bed occupancy rate of 60% and above: a) Hospital b) Health Centre c) Dispensary				
Improve Community participation and ownership	20). Community Participation a) Number of CHSB, meetings b) Number of facility governing committees meetings				

How to fill the indicators:
Baseline Information of previous year – Jan. – Dec. 2010 (2009/2010 plan) (July/June plan
Actual achievement year (Jan. – Dec …. Data that have been achieved in this year e.g. 2011(July/June plan (
Expected output at the end of the year (Jan- Dec) 2011/2012 data to be recorded expect in Dec 2012

ANNEX 7: EXPLANATORY NOTES ON SOURCES OF INFORMATION TO ASSIST IN DETERMINING QVALUES FOR THE 20 PERFORMANCE INDICATORS

Indicators	Source of data	Instruction
(1)Proportion of clients attending for purposes of (a) ANC (b) Deliveries (c) Post delivery complication (d) Postnatal care	(a) MTUHA D5.3 part 3 (b) MTUHA D5.3 part 9 (c) MTUHA D5.3 part 9 (d) MTUHA D5.3 part 3 (e) MTUHA D5.4 part 3	No. of ANC clients (at least one visit) (a) ---------- Total population x 0.046 (b) Total deliveries* ---------- Total Population x 0.046 *Deliveries in HF, and registered deliveries by TBA Total of post delivery complications according to MTUHA* (c) ---------- Total of registered deliveries * Post delivery complications according MTUHA, D5 .7 part 9 : - Post partum Haemorrhage - Retained placenta - 3rd degree tear - Other complications - Deaths (d) Postnatal clients ---------- Total of registered deliveries
2 (a) Proportion of women in childbearing age using family planning methods (b) Proportion of clients receiving family planning by method	MTUHA D. 5 (3)	Total current users (a) ---------- Total population x 0.18 (b) No of women using pills Pills: ----------

Indicators	Source of data	Instruction
(a) Pills (b) Injection (c) IUCD (d) Condom (e) Natural		Total current users Injection: No of women using injection ---------- Total current users
		No of women using IUCD (a) IUD: ---------- Total current users (b) Condom : No of couples using Condoms ---------- Total current users (c) Natural : No. of couples using natural methods ---------- Total current users
3. Proportion of women attending ANC clinic receiving Tetanus Toxoid immunization	MTUHA D4 6. part 7	(a) ANC clients receiving TT2+ ---------- Total of ANC Clients
4. (a) Proportion of under five children attending under five clinic (b) Proportion of under five children with a body weight less than 60%	MTUHA D4 6. part 7	(a) Children <5 years registered in <5 clinic ---------- Total children 5 years (b) Children <5 years with body weight <60% ------ ---------- total children ,5 years weighted
5. Proportion of children under one year immunized against (a) Measles	MTUHA D4, 5, part 7	(a) Measles Children vaccinated against measles …… Total children< 1 year

Indicators	Source of data	Instruction
(b) Polio (c) BCG (d) DPT3-HB-HiB (Pentavalent)		(b) Polio Children vaccinated against polio ……. Total Children < 1 year (c) BCG Vaccinated children …….. Total children < 1 year (d) DPT3 –Hepatitis B DPT3-Hepatitis B vaccinated children ……. Total Children < 1 year
6.. (a) Proportion of malaria cases for under 5 years (b) Proportion of malaria cases above 5 years	MTUHA 5.5., part 4-8	(a) OPD Children <5 years with diagnosis malaria ---------- Total children 5 years (c) OPD patients with diagnosis malaria > 5 years ------ ---------- Total population >5 years
7 (a) Proportion of deaths due to malaria under 5 years (b) Proportion of deaths due to malaria above 5 years	MTUHA	(a) No of patients with malaria died <5 years ---------- Total No. of malaria patients <5 years (b) No of patients with malaria died >5 years ---------- Total No. of malaria patients >5 years
8 (a) Number of STI episodes diagnosed and treated	MTUHA, D0005, part 9, page 88	(a) STI: STI episodes diagnosed and treated (b) HTC: No of M & F 15-49 years received HTC

Indicators	Source of data	Instruction
(b) Proportion of M & F 15-49 years received HTC and knows their status	HCT Register	---------- Total of people received HTC and know their status
c) Proportion of eligible PLHIV receiving ART	CTC Register	c) ART: Eligible/Enrolled
d)Proportion of PLHIV enrolled for care and treatment and eligible for cotrimoxazole prophylaxis and currently receiving cotrimoxazole prophylaxis	CTC Register	d) PLHIV enrolled: PLHIV receiving Cotrimoxazole/Number of PLHIV enrolled
e)Proportion of HBC Patients effectively linked to CTC and other support services	HBC Register	e) HBC: HBC Patients effectively linked to CTC / number of HBC patients registered
f)Proportion of TB patients tested for HIV	TB register	f) TB: TB patients tested for HIV / Number of TB patient notified
g)Proportion of HIV infected patients screened for TB	CTC register	g) HIV: HIV infected patients screened for TB / HIV patients enrolled
h)Number of pregnant mothers screened for Syphilis during their first visit	MTUHA	h) Number of pregnant mothers screened for syphilis at ANC during 1st visit
9 (a) Proportion of TB cases with treatment success (b) Proportion of Leprosy cases completed treatment	MTUHA, D 5. 14 District TB & Leprosy Registers	a) Tuberculosis patients with treatment success = Cohort initiating treatment – (Total of "failure" +"out of control " + Transfer ") (b) Leprosy patients completing treatment = Cohort initiating treatment – (Total of "failure" +"out of control " + Transfer
10. Proportion of treated cases of	MTUHA, D 3 .1	

Indicators	Source of data	Instruction
cholera/meningitis who died		
		No of cholera patients died (a) ---------- Total No of cholera patients No of meningitis patients died (b) ---------- Total No of meningitis patients
11. (a) Proportion of patients diagnosed with the following non-communicable diseases (a) Hypertension (b) Trauma/injuries (c) Mental disorders (d) Neoplasm's (e) Diabetes	OPD AND IPD Disease Returns	Patients suffering from Hypertension (a)---------- Total Population Patients suffering from Trauma/Injuries (b) ---------- Total Population Patients suffering from Mental Disorders (c) ---------- Total Population Patients suffering from Neoplasm's (d) ---------- Total Population Patients suffering from Diabetes (e)---------- Total Population

Indicators	Source of data	Instruction
11 (b) Proportion of death due to (a) Hypertension (b) Trauma/injuries (c) Mental disorders (d) Neoplasm (e) Diabetes (f) Abdomen Surgical Conditions (g) Hernia (h) Congenital anomalies	OPD AND IPD Disease Returns	Patients suffering from Hypertension died (a)---------- Total patients suffering from Hypertension Patients suffering from Trauma/Injuries died (b) ---------- Total patients suffering from Trauma Injuries Patients suffering from Mental Disorders died (c) ---------- Total patients suffering from Mental Disordered (d) Patients suffering from Neoplasm's died ---------- Total patients suffering from Neoplasm's (e) Patients suffering from Diabetes died ---------- Total patients suffering from Diabetes f) Patients suffering from Abdomen Surgical Conditions ---------- Total Population g) Patients suffering from Hernia ---------- Total Population

Indicators	Source of data	Instruction
		i) Patients suffering from Congenital anomalies --- Total Population
12) Proportion of facilities by level with constant supply of medicine/medical supplies, vaccines and laboratory reagents (a) Hospital (b) Health Centre (c) Dispensary	MTUHA, Quarterly report, D004 , page 57s Need to be updated using the nedlid and Revised Treatment Protocols for Different Conditions	<u>Key medicines:</u> <u>Register the commodity days out of stock(EXAMPLE)</u> Number of health facility Reports _____ Amoxycillin tablets /capsules _____ days Amoxycillin – suspension _____days Artemether + Lumefantrine _____ days Cotrimoxazole – suspension _____days Contrimoxazole – tablets _____days Doxycycline – tablets _____days Ergometrine – Injection _____days Ferrous / folic acid tablets _____days Lidocaine – injection _____days Mebendazole – tablets _____days Metronidazole – tablets _____days ORS Sachets _____days Oxytetracycline eye ointment _____days Paracetamol – tablets _____ days Procaine Penicillin fortified injection _____days Water for injection _____days Examination gloves _____days Povidone iodine solution _____days Silk suture _____days Surgical gloves _____days Syringe Autodisable _____days Oral contraceptives _____ days Medroxyprogestrone injenction _____days Measles vaccine _____days

Indicators	Source of data	Instruction
		Polio – Vaccine _____days BCG – vaccine _____days DPT3 Hib-HB vaccine _____days Tetanus toxoid <u>Essential equipment and apparatus</u>: Adult weighing scale _____/_____ Baby weighing scale _____/_____ Baby Trouser _____/_____ BP Machine _____/_____ Delivery Kit _____/_____ Fetoscope _____/_____ Fridge _____/_____ Sterilizer _____/_____ Stethoscope _____/_____ Autodisable Syringe _____/_____ Thermometer _____/_____ <u>Essential Laboratory Reagents</u> Blood Transfusion _____/_____ Malaria and Other blood parasites _____/_____ Malaria Acridine orange method _____/_____ HB estimation _____/_____ White cell count _____/_____ Sickling _____/_____ Urinalysis (Benedicts solution and dry Chemistry for reducing substances) _____/_____ Gram stain for common organisms _____/_____ Widal test _____/_____ Blood Glucose _____/_____ Specimen collection _____/_____

<table>
<tr><th>Indicators</th><th>Source of data</th><th>Instruction</th></tr>
<tr><td>13. Respect of guideline ceilings in the CCHP for Basket Funds</td><td>Comprehensive Council Health Planning Guideline</td><td>
<table>
<tr><td>(a)
Item
Budget</td><td>(b)
Approved budget ceiling</td><td>(c)
Actual budget allocation</td><td>(b-c)

Variance</td><td>(d)
Actual expenditure</td><td>(c-d)
Variance</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="6">Note: This matrix will be applied for a Hospital or Health Centre or Dispensary</td></tr>
</table>
</td></tr>
<tr><td>14. Proportion of facilities having achieved at least 50% of required skilled staff at different levels</td><td>MTUHA D001/Official staffing level</td><td>I: a) Hospitals

Number of Hospitals having achieved at least 50% of required skilled staff /Total Number of Hospitals

b) Health Centres

Number of Health Centres having achieved at least 50% of required skilled staff /Total Number of Health Centres

c) Dispensaries
Dispensaries having achieved at least 50% of required skilled staff/ Total Number of Dispensaries
II: Number of skilled staff/Total number of skilled staff according to manning levels</td></tr>
<tr><td>15) (i) Proportion of health personnel planned to undertake training who have actually undertaken short or and long term training
(a) Hospital
(b) Health Centre
(c) Dispensary</td><td>HRHIS</td><td>I: (a) Hospital

Number of staff attended training less than 9 months

Number of staff planned to undertake training less than 9 months

(b) Health Centre
Number of staff attended training less than 9 months</td></tr>
</table>

Indicators	Source of data	Instruction
		---------- Number of staff planned to undertake training less than 9 months (c) Dispensaries Number of staff attended training less than 9 months ---------- Number of staff planned to undertake training less than 9 months Number of staff attended training for more than 9 months ---------- Number of staff planned to undertake training for more than 9 months
15. (ii) At least 50% of recruited skilled staff in the previous financial year are retained at different facility levels	HRHIS	Total number of retained staff from previous financial year ---------- Total number of recruited staff from previous financial year
15 (iii) Presence of a functioning computerized Human Resources for Health Information System (HRHIS)	HRHIS	1. Functioning 2. Not functioning N:B i) Need for External Evaluation Annually to Assess use of HRHIS ii) If data on indicators 14-16 is entered & updated in HRHIS, the system is functioning
16. Proportion of facilities supervised by CHMT (a) Hospital (b) Health Centre (c) Dispensary	MTUHA D1.4	Supervision visits carried out ---------- Supervision visits planned
17. (a) Proportion of households with acceptable toilets, refuse bin or pit and access to safe water	MTUHA , D5.1, page 66	No of Households with acceptable toilets ---------- Total No. of households

Indicators	Source of data	Instruction
(b) Proportion of HF with IEC material		No of households with refuse bin or pit ---------- Total No of households No of households with access to safe water sources ---------- Total No of households Penile model available _____/_____ Set of contraceptive for Demonstration available _____/_____
18. Proportion of facilities in good state of repair (a) Hospital (b) Health Centre (c) Dispensary	MTUHA Table D2.4	No of HF rated as High/Excellent _____/_____ Good _____/_____ Fair _____/_____ Poor _____/_____
19. Proportion of facilities with bed occupancy rate of 60% and above (a) Hospital (b) Health Centre	District Record	Total Patient Days ---------- Total No of beds x 365
20) Community Participation (a) Number of CHSB meetings (b) Number of facility governing committees meetings	Quarterly and annually Council Health reports	At least four meetings per year are necessary, refer to the instrument on the establishment of CHSB and HFGC

ANNEX 8: CRITERIA FOR ASSESSMENT OF AN ANNUAL TECHNICAL COMPREHENSIVE COUNCIL HEALTH PLAN

Year: …… July/June

Name of the Region …….. Name of the Council ……

S	Criteria	How to assess?	How to score?	Maximum assigned value	RS/RHMT	Central	Comments
1	General Outlay of the plan	Check cover page, flow of contents, consistence, page numbers and editing of the plan, formatting and neatness.	All components well presented : 3 Part not well presented : 1-2 All part are not well presented : 0	3			
2.	Executive Summary (content and quality)	Both parts: Summary of implementation of last plan and new year plan (including data, statements of summary of all tables available in the plan **annex 5 table 1-14)** in the CCHP planning guideline	All essential information available: 4 Some essential information lacking: 1-3 All essential information lacking: 0	4			
3.	Main budget summary	Should include all sources of funding from all funders for which activities are budgeted in the Plan	All sources as indicated in annex 2.1 : 5 If any among the following funding is missing: NGO, Council Own sources, Other sources and not reported in the executive summary = 2	5			
4.	Specific budget summary for B.F.	Is the respective annex available and according to cost centers in line with NEHIP as per Planning Guide?	Available and correct: 4 Not fully in line with EHP = 1-3 Not available: 0	4			

S	Criteria	How to assess?	How to score?	Maximum assigned value	RS/RHMT	Central	Comments
5.	Basket Fund budget summary for allowance and fuel for management team, supervision and distribution.	Is this annex available and does it respect the given ceilings? **Refer annex 2.4** in the CCH planning guideline	Available ceilings respected: 4 Available ceilings partly respected: 2 Available and no ceiling respected: 1 Not available: 0	4			
6.	Targets are SMART.	Asses <u>all</u> available targets refer **chapter five** of the Plan being assessed and CCH Planning guideline	80 -100% of the targets: SMART: 5 70 - 79% of the targets: SMART: 4 60 - 69% of the targets: SMART: 3 50 -59% of the targets: SMART: 2 40 – 49% of the target: SMART: 1 < 40% of the targets: SMART: 0	5			
7.	Appropriateness of target, and activities to the stated problems – Disease Burden, their feasibility, and relevance to outputs and targets.	Take a sample of 20 activities out of table 3&4 and asses according to the criterion	16 – 20 appropriate and achievable: 4 10 – 15 appropriate and achievable : 3 5 – 9 appropriate and achievable : 1 – 2 < 5 appropriate and achievable : 0	4			
8.	All sources of funding targeted at priority interventions as per Planning Guide. In relation to burden of diseases as	Case management and prevention for acute febrile illnesses (AFI) including malaria/ Insecticide treated Nets (ITN) for prevention of Malaria (	Above two activities = 2 One activity = 1 No any activity = 0	2			

S	Criteria	How to assess?	How to score?	Maximum assigned value	RS/RHMT	Central	Comments
	shown in the situation analysis table	Budget for delivery kits available	Yes = 2 No = 0	2			
		Safe Mother hood initiatives (FANC)	Above two activities = 2 One activity = 1 No any activity = 0	2			
		STI Syndromic Management	Above two activities = 2 One activity = 1 No any activity = 0	2			
		Integrated Management for Emergency & Essential Surgical Care (IMEESC)	Above two activities = 2 One activity = 1 No any activity = 0	2			
		Immunization (EPI)	Above two activities = 3 One activity = 1 No any activity = 0	3			
		HIV/AIDS related activities	Above two activities = 2 One activity = 1 No any activity = 0	2			
		Integrated Management of childhood illnesses (IMCI)	Above two activities = 2 One activity = 1 No any activity = 0	2			
		TB-DOTS / TB/HIV activities	Above two activities = 2 One activity = 1 No any activity = 0	2			
		Oral Health, Mental health, Injuries and other non-communicable disease interventions	Above two activities = 2 One activity = 1 No any activity = 0	2			
		Environmental Health and Sanitation interventions	Above two activities = 2 One activity = 1 No any activity = 0	2			
		Social Welfare and social Protection	Above two activities = 2 One activity = 1	2			

S	Criteria	How to assess?	How to score?	Maximum assigned value	RS/RHMT	Central	Comments
		interventions included	No any activity = 0				
		Nutrition Interventions	Above two activities = 2 One activity = 1 No any activity = 0	2			
		Traditional medicine Interventions	Above two activities = 2 One activity = 1 No any activity = 0	2			
		Human resources for Health intervention Included	Above two activities = 2 One activity = 1 No any activity = 0	2			
		Treatment and care of other diseases of priority including NTDs	Above two activities = 2 One activity = 1 No any activity = 0	2			
		Health promotion interventions included	Above two activities = 2 One activity = 1 No any activity = 0	2			
		Emergency preparedness and response included	Above two activities = 2 One activity = 1 No any activity = 0	2			
9.	Availability of updated performance indicators and new targets using processed HMIS data	Check availability of indicator set which is based on What has been achieved last year and what would be realistically achieved for the current year.	Indicator set available with targets: 4 Indicator set available, but targets are not realistic = 1- 3 No indicator set available: 0	4			
10	Other pre-requisites of a plan of high quality	Catchments area of all facilities in the District known: check annex 5 table 9 (a &b) each village/Mtaa has a dispensary and ward have a health centre and new	Yes = 2 No = 0	2			

S	Criteria	How to assess?	How to score?	Maximum assigned value	RS/RHMT	Central	Comments
		construction					
		Are the calculations correct? Select randomly 20 calculation operations in table "cost analysis" and check them	All correct: = 3 15 – 19 = 2 10 – 14 = 1 < 10 = 0	3			
		Are the Cost centers respected and activities related to the cost centre?	Yes = 2 No = 0	2			
		Are GFS and cost centers codes correctly indicated	Correctly indicated = 2 Partially indicated = 1 Not indicated = 0	2			
		Composition of the planning team: Were Co-opted members, private providers, FBO, and NGOs with their organizations represented.	All representatives involved = 2 Some representative involved = 1 No representative = 0	2			
		Community Cost centre show Community initiatives budget	Available = 2 Not available = 0	2			
		Map of the district with all health facilities clearly visible	Available = 1 Not available = 0	1			
11	Medicine and supplies budget	Receipts in Kind budget reflected (MSD)	Available = 2 Not available – 0	2			
		Medicines, diagnostic equipment, and related supplies budgeted from Basket Fund, OC, complementary Schemes (NHIF, CHF and Cost sharing/user fees)	Available = 3 Not available – 0	3			
12	Activity planned for P4P services (Budget for bonus &	All cost centres budget adhered to and indicators showing all health facilities annexed and activity for	Yes = 3 50% correct = 2 No = 0	3			

S	Criteria	How to assess?	How to score?	Maximum assigned value	RS/RHMT	Central	Comments
	orientation) including filled table for Indicators refer *annex 5 table 10*	orientation for data management available					
13	Institutional Arrangements	Activities and budget for CHSB and FGC functions	Available = 2 Not available – 0	2			
		Table filled well • Status of health facilities • Summary of MMAM status • Human resources for health, medical supplies, vehicles etc. *Refer annex 5 tables 9 (a&b) 11(a- d), 12 and 13 in the Planning guideline*	*Available and filled well = 2 Not available – 0 *If not explanation for missing data in Tables	2			
		In the Executive summary of plan under review states the inclusion of Health facility plans	Available = 2 Not available - 0	2			
		Budget for maintenance of equipment and buildings	Available = 2 Not available – 0	2			
	Total			100			

Recommended/ not recommended.

The respective Councils, Regional Secretariat, MOHSW, PMO-RALG will use this criteria to assess Council Plans. Any CCHP plan, which is assessed by Regional Secretariat – RS , MOHSW and PMO-RALG and does not meet the above major criteria with a score of less than 70 out of 100 points will not be recommended for funding and will be referred back to the respective Council for rectification prior to – resubmission to the BFC for funding.

In addition the plan has to be technically assessed by the Regional Secretariat and should have been approved by the Full Council and signed by the Council Director (CD).

No	Name of Assessor	Designation	Signature	Date

ANNEX 9 (A) ASSESSMENT OF QUARTERLY TECHNICAL PROGRESS REPORTS.

Year...…….....July-June
Quarter …… (Period: from ……..to……)
Name of Region ……Name of Council ……..

SN	Criteria	How to assess?	How to score?	Maximum assigned value	RS/RHMT	Central	Comments
1	General Outlay of the report	• Cover page present • flow of contents is consistent • page numbering well presented	• The outlay of the report and the presentation well organized presented according to priority areas: 3 • Inconsistence in organization and content not followed priority areas 1- 2 • General outlay with poor formatting of the report: 0	3	1		
2.	The report conforms to approved formats (Executive summary, annex 10 tables 1, 2, 3,4, 5,6 &7 for quarterly report. Or annex 11 table 1, 2,3 ,4,5 ,6&7 for annual report of the planning guideline)	Executive summary (including implementation data e.g. % of staff trained in particular areas, supervision routes, Facility delivery etc.), annex 10 table 1, 2,3,4,5,6 &7. Or annex 11 table 1, 2,3,4,5 ,6& 7 are available and contain the required information	• Available Executive summary with summaries from the tables presented well with correct information 10 • Available executive summary with inadequate information : 2-8 • Executive summary and annexes not available: 0	10			
3	Performance status in terms of outputs reported (accuracy	• Report presented with qualitative and quantitative	• Qualitative or quantitative information available : 5 • Missing information : 0	5			

SN	Criteria	How to assess?	How to score?	Maximum assigned value	RS/RHMT	Central	Comments
	data reported)	information					
4.	Activities reported for the quarter include: Planned activities in the CCHP Any ad hoc activity during the quarter outside the CCHP Brought forward activities from the previous quarter	• Compare reported activities with planned activities in the CCHP • Compare the volume of activities implemented outside the plan • Activities brought forward **(Annex 10 or 11 tables 2&3)**	• All reported activities are in the respective quarter in the CCHP including brought forwards and adhoc: 10 • Only Part of the reported activities are in the respective quarter in the CCHP: 6 • Brought forward activities and adhoc from the previous quarter not reported (compare with the budget carried forward): 4 • All reported activities are not in the respective quarter in the CCHP: 0	10			
5.	% of activities fully implemented in the quarter/ per annual	Number of activities fully implemented against total activities for the quarter or annual, times 100	80%-100%: 5 60%-79%: 4 40%-59%: 3 Below 40%: 2	5			
6.	Reasons for partial implementation of activities (if any) given	Provide acceptable reasons for activities partially implemented	Reasons given: 2 Reasons given to part of the activities : 1 Not given : 0	2			
7.	Explanations for the carried over/ forward activities	Outline activities carried over/ forward **(Annex 10 or 11 tables 2&3)**	Reasons given: 2 Reasons given to part of the activities : 1 Not given : 0	2			
8.	Explanations for ad hoc activities	Outline ad hoc activities if any. **If none give 2 points in (Annex 10 or 11 tables 3)**	Reasons given: 2 Reasons given to part of the activities: 1 Reasons not given: 0	2			

SN	Criteria	How to assess?	How to score?	Maximum assigned value	RS/RHMT	Central	Comments
			(No indication of adhoc activities = 2				
9.	Cumulative achievements shows progress towards annual targets * (Annex 10 or 11 tables 3& 6)	See annex 10 or 11 tables 3 & 6 if cumulative achievements shows progress towards the annual targets	80%-100%: 5 60%-79%: 4 40%-59%: 3 Below 40%: 2	5			
10.	Progress report has been submitted timely at the RS / RHMT for assessment.	Timely submission **(look when the stamp at the region was received and signatures for council level)**	RS / RHMT: Timely submitted: 5 Not timely submitted: 0	5			
	Total			50			

Recommended/not recommended for funding

Quarterly reports should show cumulative achievements towards achieving annual targets. Ideally activities are completed over four quarters with each quarter reporting 25% of the total target in the first quarter will be 25% second quarter 50% (of the total) and so on. The fourth quarter report will also be the Annual Report. However, some activities may be fully completed in a quarter or two in which 50% or 100% achievement respectively will be reported. Achievement cannot be reported beyond 100% after the activity has been completed (even before the end of the year).

Any report which scores a total of less than 35 points will be rejected, sent back for rectification, before being considered for further disbursement of funds				
Assessors who will assess CCHP plans and reports should have undertaken orientation on how to properly conduct the assessment exercise using the forms				
SN	Name of Assessors	Qualification	Signature	Date

ANNEX 9 (B): CRITERIA FOR ASSESSMENT OF QUARTERLY FINANCIAL REPORT

Year...…….....July-June
Quarter …… (Period: from ……..to……)
Name of Region ……Name of Council ……..

SN	Criteria	How to assess?	How to score?	Maximum assigned value	RS/RHMT	Central	Comments
1	The financial report conforms with approved formats provided in the guideline	i. Financial executive Summary available ii. Account return statement available **iii.** If there is no over expenditure in any source of funds iv. If there is over expenditure in any source **(extract the data – separately)**	All three components Conforms = 5 If only two conforms = 3 Deduct = 2	5			
2.	Report includes all source of funds i.e. block grant, Basket funds, receipt in kind, and vertical programmes, cost sharing, Global funds, Council own sources, LGDG- HSDG,	Comparison on reported funds in technical and Financial report.	All funds = 5 Half present = 2 Less present = 0	5			

SN	Criteria	How to assess?	How to score?	Maximum assigned value	RS/RHMT	Central	Comments
	bilateral/Multi- lateral and NGOs						
3.	Accounts are consistent (in agreement) executive summary tallies with annex 10 table 5 for quarterly or annex 11 table 5 annual, Accounting Return table 6 and Bank reconciliation statement	Yes No with sound explanation No without explanation	5 3 0	5			
4.	Contribution of Council own funds for CCHP activities	Annex 10 table 5 and Accounting Return statement table 6, or annex 11 table 5 and Accounting Return statement table 6 (budget and Expenditure) state how much	Available =3 Not available 0	3			
5.	Budget year to date in column C of the accounting return correspond to the approved budget during that period and apportioned accordingly.	corresponding	Yes = 5 Not = 0	5			
6.	There are no Arithmetic errors i.e. additional error, transposition of figure etc.	No major error If minor error If Major error	= 5 = 3 = 0	5			
7.	Total allocation of funds quarterly Annex 10 table 5 or annual annex 11 table 5 matching with funds available (opening and receipts during the period) in Accounting Return table 7 (Schedule A, B and C)	Matching Not matching but explain No explanation	= 5 =3 = 0	5			
8.	If there is no cut and paste in the financial reports	Serious ones Minor ones No errors	=0 =2 =3	3			
9.	P.E. does not exceed the amount	• Does not	=5	5			

SN	Criteria	How to assess?	How to score?	Maximum assigned value	RS/RHMT	Central	Comments
	of block Grant received to that Quarter.	exceed • Exceeds with sound explanation • Exceeds without Explanation	= 2 =0				
10.	Required Bank statements and certificates of the Bank are available.	B/Certificate available and signed B/Statement available but not signed	5 2	5			
11.	Expenditure/utilization in Annex 10 table 4 quarterly or annex 11 table 4 annually does not exceed the amount allocated to each cost centres in the same Annex 10 table 4 or annex 11 table 4, (i.e. quarter/annual allocation and quarter /annual expenditure)	Each cost centre one mark		6			
12.	Bank reconciliation statements with supporting schedules for all accounts are available and signed reconciling items adjusted.	Availability of correct supporting schedules with Signature Without signature	5 1	5			
13.	Names and signature of authorities and authorized persons as well as official stamps are available.	With names and signature Names/signature alone No Names/ signature	*2* 1 0	3			
14.	Report submitted and received by RHMT timely or not. (indicate date of submission by each council)	Yes No	5 0	5			
15.	In annex 10 table or 11 table 4 total quarterly/annual budget allocation,	Yes No with sound	5 3	5			

SN	Criteria	How to assess?	How to score?	Maximum assigned value	RS/RHMT	Central	Comments
	total quarterly expenditure tally to the Account Return (Annex 10 table 7 or 11 table 7 schedule A)	explanation No without Explanation	0				
16	Expenditure exceed the budget allocation in Block grant with negative balance	Yes No	0 5	5			
17.	Basket funds are not used for payment of Salaries of employees procurement of cars etc.	Yes No	5 0	5			
18.	The value of medicines is reflected as a receipt in kind as a receipt and as expenditure.	Yes No	5 0	5			
	TOTAL			**85**			

Any report which scores a total of less than 70 points will be rejected, sent back for rectification before being reconsidered for further disbursement of funds.

SNo	NAME OF ASSESSORS	QUALIFICATION	SIGNATURE	DATE

Important information to be included in the assessment criteria

1. Activities reported in the Councils' Technical and financial progress reports are in line with the approved CCHP and support the national health policies and performance objectives.
2. Quarterly cumulative achievements show progress towards the annual targets (e.g. quarter one 25%, quarter two 50%, quarter three 75% and quarter four 100%)
3. Ensure that data presented in different pages or chapters are the same. In-terms of reliability and validity,
4. Ensure that there are no inconsistencies, arithmetical inaccuracy, cut and paste mistakes.
5. Ensure that opening adjusted cashbook balances agreeing with the closing balances as per previous quarter returns.
6. Ensure that the adjusted closing cashbook balances stated in the report agrees with balances on the bank reconciliation statements.
7. Ensure that the differences remaining on the bank reconciliation statements have been cleared since the last quarter report.
8. Ensure that if there are any variances in the budget, explanations are provided
9. Ensure that Personnel Emoluments does not exceed the Block Grant allocation for that quarter.
10. Ensure that the total expenditure on allowances is within the approved ceilings.
11. Ensure that the financial report is in line with the technical report.

12. Ensure that the carried forward funds and activities are well explained and included in the plans and reports of the proceeding year and quarter respectively

ANNEX 10: PREPARATION OF QUARTERLY PROGRESS IMPLEMENTATION REPORTS – (TECHNICAL AND FINANCIAL)

Summary of Quarterly technical and financial report

1. Major achievements of the major activities performed in that quarter.
2. Summary of major constraints
3. Reasons for significant variances from budgets approved in the CCHP
4. The way forward
5. Signature of the Council Director

Table 1: Summary of Quarterly Financial position

S/N	Sources of funds	Opening Balance	Approved Budget per quarter	Receipt this quarter	Total Funds available	Date received at Council level	Date received at departmental level	Expenditure this quarter	Closing balance end of quarter
1	Block Grant								
2	Basket Fund								
3	Council own source								
4	LGCDG								
5	HSDG/MMAM								
6	**Cost haring**								
	User fee								
	DRF								
	CHF								
	NHIF								
	NSSF								
	Others (Specify)								
7	Global fund								
8	Receipt in Kind								
9	Others (specify)								
	Total								

Note: ** If closing balances of any source is/are unreasonably big in amounts, Councils should provide explanations for the reasons for such unspent balances in a foot note or in number 3 above.

Table 2: Quarterly Technical/physical progress report:

1. Cost Centre…….

A/ No	Planned activities according Priority areas	Status of implementation quantify performance (where necessary)	Achievements in %	Comments
2	3	4	5	6

	Name	Title	Signature	Date
Prepared by:		Health Secretary		
Confirmed by:		Council Planning Officer		
Checked by:		DMO/MOH		
Checked by:		Council Director		
Authorised by:		RMO		

Explanations

Column 1: Fill in the respective cost centre
Column 2: Write down the same number of activity as it appears in the plan of operation section of the CCHP.
Column 3: Write down the activity as they appear in the CCHP.
Column 4: Make a short statement on the status of actual implementation e.g. 20 Health providers out of the targeted 25 have been trained.
Column 5: Estimate/calculate in percentage to which extent the activity has been implemented.
Column 6: To be filled only if there are particular observations. Such as additional fund available, activity insufficiently implemented.

Note: Reports are cumulative; the second quarter report contains all information of the first quarter.

Table 3: Status of quarterly implemented activities by quantity

Number of Quarterly approved activities	Number of activities implemented per quarter	Percentage quarter implemented activities	Percentage quarter activities partial implemented	Number of activities implemented that were not included in the CCHP	Percentage quarter activities not Implemented	Comments on reasons for not implemented or partial implementation

Table 4: Summary of approved budget against expenditure according to priority areas

Priority areas	Budget allocated per quarter	Funds carried forward	Total funds available per quarter	Total Expenditure per quarter	Percentage
Total					

Table 5: Availability of Tracer Medicines/Items for CCHP (Vaccines, Medicines, Contraceptives, Medical and Laboratory Supplies)

Select 1 or 0: 1= Available; 0=Not available

If Not available, then select A, B, or C:

A= Not available less than 1 week;

B= Not available for 1-3 weeks;

Line No	Description	Available?	If "No"
1	DPT + HepB/ HiB vaccine for immunization	1=Yes 0=No	A: < 1 week B: 1-3 weeks C: whole month
2	Artemether / Lumefantrine (ALu) oral		
3	Amoxycillin **or** Cotrimoxazole oral		
4	Albendazole **or** Mebendazole oral		
5	Oral Rehydration Salts		
6	Ergometrine **or** Oxytocin injectable, **or** Misoprostol oral		
7	Medroxyprogesterone injectable contraceptive		
8	Dextrose 5% **or** Sodium Chloride + Dextrose IV solution		
9	Syringe and needle, disposable		
10	Malaria rapid diagnostic test (MRDT) **or** Supplies for malaria microscopy		
11	Optional Line 1:		
12	Optional Line 2:		

(a) Combined Technical and Financial performance reports:

Combined physical and financial performance report is prepared for the purpose of monitoring the implementation of the planned activities and corresponding funds allocated to each activity and actual expenditure incurred as shown in the table 6 below.

Table 6: Quarterly Combined Technical and Financial Progress Reports

1. Cost centre….

Annual Target	S/N	Planned Activities (according to Priority areas)			Planned for this quarter and carried forward		Actual Implementation this Quarter		Cumulative Implementation per target (according to Priority areas)				Remarks
		Activities	Amount (TSHS)	Source of Funds	Activities	Amount (TSHS)	Achievement %	Amount Spent (TSH)	Achievement Quantify	Achievement %	Amount spent (TSHS)	Amount Spent %	
2	3	4	5	6	7	8	9	10	11	12	13	14	15

Explanation:

Column 1 to 6: Copy from CCHP (Cost Analysis)
Column 7-8 Activities and budget planned for the reporting quarter and carried from previous quarter
Columns 9: Put achievements for the quarter in percentage.
Column 10: Amount spent for the activity in the respective quarter
Column 11: Cumulative achievements physical performance (quantify where possible).
Column 12: Cumulative achievement physical performance in percentage
Column 13: Cumulative expenditure (expenditure to date).
Column 14: Cumulative expenditure in percentage
Column 15: Important comment on implémentation status

Table 7: Health Sector Accounting Return (Recurrent) Schedule A- Summary

Council: ……			**Date**	**Month**	**Year**
Region: ……..					
		A	**B**	**C**	
		Current Quarter	**Cumulative to date**	**Budget YTD**	
		TZS	**TZS**	**TZS**	
B1	**Cashbook balance at start of period**				
	Amount Received				
R1	Block Grants				
R2	Basket Funding				
R3	Council Funding				
R4	**Cost sharing:-**				
	User fee				
	Drug Revolving Fund				
	NHIF				
	CHF/TIKA				
	NSSF				
	Others(Specify)				
R5	Receipts in Kind				
R6	HSDG				
R7	Global Fund				
R8	Other sources (specify)				
R9	Total fund Received				
R10	**Total Funds Available**				
	Expenditures - Cost Centre				
S1	Council Health Department				
S2	Council/CDH Hospital Costs				
S3	VA Hospital Costs				
S4	Health Centre Costs				
S5	Dispensary Costs				
S6	Community Initiatives				
S7	**Total Payments for Period**				
B2	**Fund Balance at the End of the Period (Surplus/Deficit)**				

Prepared by (Name)….. Title: Health Depart Accountant Signature…... Date……
Checked by: (Name)……Title: Council Treasury Signature…. Date……
Authorized by: (Name)….Title: DMO/MOH Signature…. Date…….
Confirmed by: (Name)…..Title: Council Director Signature…. Date……
Confirmed by: (Name)……Title: Regional Accountant Signature…. Date…..

HEALTH SECTOR RECURRENT ACCOUNTING RETURNS

Schedule B1 of 2

Council/CDH Hospital Costs

Council ……

Quarter

		A		B		C
		Current Quarter		**Cumulative to date**		**Budget YTD**
		TSHS		**TSHS**		**TSHS**
	DMO's Office					
P1	Salaries and Wages					
P2	Other Payroll Costs					
P3	Allowances					
P4	Vehicle Running Costs					
P5	Office Running Costs					
P6	Others: (Specify)					
P7	**Total DMO**					
	Council/ CDH Hospital Costs					
P8	Salaries and Wages					
P9	Other Payroll Costs					
P10	Allowances					
P11	Hospital Running Costs					
P12	Medical Supplies					
P13	Inpatients Costs					
P14	Food Costs					
P15	Repairs and Maintenance					
P16	Other: Specify					
P17	**Total Council Hospital Costs**					
	VA Hospital Costs					
P18	Salaries and Wages					
P19	Other Payroll Costs					
P20	Allowances					
P21	Health Running Costs					
P22	Medical Supplies					
P23	In-Patient Costs					
P24	Repairs and Maintenance					
P25	Other: Specify					
P26	**Total VA hospital costs**					

HEALTH SECTOR RECURRENT ACCOUNTING RETURNS

Schedule B2 of 2

Council …… **Quarter**

		A		**B**		**C**
		Current Quarter		**Cumulative to date**		**Budget YTD**
		TSHS		**TSHS**		**TSHS**
	Health Centre					
P27	Salaries and Wages					
P28	Other Payroll Costs					
P29	Allowances					
P30	Health Centre Running Costs					
P31	Medical Supplies					
P32	In patient Costs					
P33	Food Costs					
P34	Repair and maintenance					
P35	Others: (Specify)					
P36	**Total Health Centre**					
	Dispensary Costs					
P37	Salaries and Wages					
P38	Other Payroll Costs					
P39	Allowances					
P40	Dispensary running Costs					
P41	Medical Supplies					
P42	In-Patient Costs					
P43	Food Costs					
P44	Repairs and Maintenance					
P45	Other: Specify					
P46	**Total Dispensary costs**					
Community Initiatives						
P47	Salaries and Wages					
P48	Other Payroll Costs					
P49	Allowances					
P50	Dispensary running Costs					
P51	Medical Supplies					
P52	Repairs and Maintenance					
P53	Other: Specify					
P54	**Total Community costs**					

HEALTH SECTOR RECURRENT ACCOUNTING RETURNS

Schedule C

Council …… **Quarter**

	A	**B**	**C**
	Current Quarter	**Cumulative to date**	**Budget YTD**
	TSHS	**TSHS**	**TSHS**

Summary of Personnel Emoluments and allowances

T1	Total Salaries and Wages					
T2	Total Other Payroll Costs					
T3	Total Allowances					
T4	Total other Charges					
	Total					

ANNEX 11: PREPARATION OF ANNUAL PERFORMANCE IMPLEMENTATION REPORTS (TECHNICAL AND FINANCIAL)

(a) Executive summary shall contain the following information:

1.) Summary of the annual major achievements focusing implemented key activities linking with the set planned targets, priority areas and interventions that have contributed into specific targets achievements.

2) Executive summary (Including implementation data e.g. % of staff trained in particular areas, supervision routes, % activities planned against implemented, partial implemented and reasons why, % of performance achievement, vaccination coverage, Facility delivery, delivery, frequency of CHSB/HFGC meetings etc .)

3) Summary of availability of tracer medicines per quarter

3) Summary of activities that have been rolled forward from last fiscal year with explanations why, and the major achievements accomplished this Financial Year.

4). District Health performance report based on performance indicators should be interpreted and annexed to the annual report.

5). Summary of annual financial position – see table below

Table 1: Summary of annual financial position

SOURCES		Approved Budget F/Y…	Balance B/F	Actual Received	Expenditure	Closing Balance	Utilization capacity
Block Grant	PE						
	OC						
Basket Funds							
Global Funds							
HSDG							
LGDG							
Cost sharing (Note .....)	userfees						
	NHIF						
	CHF						
Council Own							
Others Specify..							
Total							

5). Summary of major constraints affected the implementation of the planned activities and achievement of results.

6) Lessons learned in the implementation of the plan and the best practices that need to be shared with other Councils and any other knowledge gained from research, monitoring and evaluation of activities conducted in the year have to be reported.

7) Report key management and financial issues (if any) and reasons for significant variances from approved budgets in the CCHP

8) The way forward.

9) Signature of the Council Director approving the report for accountability and ownership.

(b) Annual Technical /Physical progress report:

The technical annual progress report shall be prepared in the format specified in table 2 below, summarizing the technical performance. Details of performance against the CCHP should be clearly stated including reasons for not implementing or partial implementation of activities.

Table 2: Annual Technical /Physical progress report

Priority Area	Activity number	Planned Activities	Status of implementation Commutative quantify performance (where necessary)	Achievement in %	Comments
1	**2**	**3**	**4**	**5**	**6**

	Name	Title	Signature	Date
Prepared by:		Health Secretary		
Confirmed by:		Council Planning Officer		
Checked by:		DMO/MOH		
Checked by:		Council Director		
Authorised by:		RMO		

Explanations

Column 1: Fill in the respective cost centre
Column 2: Write down the same number of activity as it appears in the plan of operation section of the CCHP.
Column 3: Write down the activity as they appear in the CCHP.
Column 4: Make a short statement on the status of actual implementation e.g. 20 Health providers out of the targeted 25 have been trained. (Year achievements)
Column 5: Estimate/calculate in percentage to which extent the activity has been implemented.
Column 6: To be filled only if there are particular observations such additional fund available, activity insufficiently implemented.

Table 3: Status of performance of activities implemented per year

Number of annual approved activities	Number of activities implemented per year	Percentage of annual implemented activities	Percentage of annual activities partial implemented	Percentage of activities implemented that were not included in the CCHP	Percentage of annual activities not Implemented	Comments on reasons for not implemented or partial implementation

Analyse, interpret and comments this table with reasons

Table 4: Summary of budget allocated against expenditure according to priority areas

Priority areas	Budget allocated per year	Funds carried forward	Total funds available per year	Total Expenditure per year	Percent age
Total					

Table 5: Annual data availability of Tracer Medicines/Items for CCHP (Vaccines, Medicines, Contraceptives, Medical and Laboratory Supplies)

Select 1 or 0: 1= Available; 0=Not available
If Not available, then select A, B, or C**:**
A= Not available less than 1 week;
B= Not available for 1-3 weeks;

Line No	**Description**	**Available?**	**If "No"**
1	DPT + HepB/ HiB vaccine for immunization	1=Yes 0=No	A: < 1 week B: 1-3 weeks C: whole month
2	Artemether / Lumefantrine (ALu) oral		
3	Amoxycillin **or** Cotrimoxazole oral		
4	Albendazole **or** Mebendazole oral		
5	Oral Rehydration Salts		
6	Ergometrine **or** Oxytocin injectable, **or** Misoprostol oral		
7	Medroxyprogesterone injectable contraceptive		
8	Dextrose 5% **or** Sodium Chloride + Dextrose IV solution		
9	Syringe and needle, disposable		
10	Malaria rapid diagnostic test (MRDT) **or** Supplies for malaria microscopy		
11	Optional Line 1:		
12	Optional Line 2:		

(c) Annual combined Performance Implementation Technical and Financial Reports:

Councils should prepare the annual combined physical and financial performance report for the purpose of monitoring planned activities, funds allocated to each activity and actual expenditure incurred as shown in the table 5 below.

Table 6: Annual combined Technical and Financial Performance implementation reports

Cost Centre	Annual Target	S/N	Planned Activities (according to Priority areas) per year			Cumulative Implementation per target (according to Priority areas)							Remarks
			Activities	Budget allocated (TSHS)	Source of Funds	Amount Received (TSHS)	Source of Funds	Achievement Quantify-technical	Achievement %	Amount spent (TSHS)	Amount Spent %	Balance end of year (TSHS)	
1	2	3	4	5	6	7	8	9	10	11	12	13	14
DMO													
CH/CDH													
HC													
DISP													
VA/SA													
COMM													

Explanation:

Column 1 to 6: Copy from CCHP (Cost Analysis)
Column 7-8 Total funds received per year and sources of funds.
Column 9: Cumulative achievements physical performance (quantify where possible e.g. No of H/w trained etc).
Column 10: Cumulative achievement physical performance in percentage
Column 11: Cumulative expenditure (expenditure end of June).
Column 12: Cumulative expenditure in percentage
Column 13: Balance end of the year – June (7- 11)
Column 14: Important comments on implementation status

(d) Accounting Return: Schedule A - summary

This accounting return reflects summarized income and expenditures for the period under Review: Table 6

The annual Income and Expenditure statement have to be prepared and must be supported by schedules of cost centers expenditure analysis, bank reconciliation statements, with detailed schedules of un-reconciled items, bank statements and certificates of bank balances.

Note: To complete the following tables read instruction in Annex 12
Schedule A will be completed after filling of schedule B1 and B2

Table 7: Health Sector Accounting Return (Recurrent and Development) Schedule A-Summary

Council: ……			**Date**	**Month**	**Year**
Region: ……..					
		A	**B**	**C**	
		Current Quarter	**Cumulative to date**	**Budget YTD**	
		TZS	**TZS**	**TZS**	
B1	**Cashbook balance at start of period**				

Amount Received

R1	Block Grants			
R2	Basket Funding			
R3	Council Funding			
R4	**Cost sharing:-**			
	User fee			
	Drug Revolving Fund			
	NHIF			
	CHF/TIKA			
	NSSF			
	Others(Specify)			
R5	Receipts in Kind			
R6	HSDG/MMAM			
R7	LDGD			
R8	Global Fund			
R9	Other sources (specify)			
R10	Total fund Received			
R11	**Total Funds Available**			

Expenditures - Cost Centre

S1	Council Health Department			
S2	Council/CDH Hospital Costs			
S3	VA Hospital Costs			
S4	Health Centre Costs			
S5	Dispensary Costs			
S6	Community Initiatives			
S7	**Total Payments for Period**			
B2	**Fund Balance at the End of the Period (Surplus/Deficit)**			

	Name	**Title**	**Signature**	**Date**
Prepared by:		Health Dept Accountant		
Checked by:		Council Treasury		
Authorized by:		DMO/MOH		
Confirmed by:		Council Director		
Confirmed by:		Regional Accountant		

HEALTH SECTOR RECURRENT AND DEVELOPMENT ACCOUNTING RETURNS

Schedule B1 of 2

Council …… **Quarter**

A

B **C**

Current Quarter **Cumulative to date** **Budget YTD**

TSHS **TSHS** **TSHS**

DMO's Office						
P1	Salaries and Wages					
P2	Other Payroll Costs					
P3	Allowances					
P4	Vehicle Running Costs					
P5	Office Running Costs					
P6	Others: (Specify)					
P7	**Total DMO**					
Council/ CDH Hospital Costs						
P8	Salaries and Wages					
P9	Other Payroll Costs					
P10	Allowances					
P11	Hospital Running Costs					
P12	Medical Supplies					
P13	Inpatients Costs					
P14	Food Costs					
P15	Repairs and Maintenance					
P16	Construction /Rehabiliation of Health facilities					

P17	Other: Specify					
P18	**Total Council Hospital Costs**					
	VA Hospital Costs					
P18	Salaries and Wages					
P19	Other Payroll Costs					
P20	Allowances					
P21	Health Running Costs					
P22	Medical Supplies					
P23	In-Patient Costs					
P24	Repairs and Maintenance					
P25	Construction /Rehabiliation of Health facilities					
P26	Other: Specify					
P27	**Total VA hospital costs**					

HEALTH SECTOR RECURRENT AND DEVELOPMENT ACCOUNTING RETURNS

Schedule B2 of 2

Council …… **Quarter**

		A		**B**		**C**
		Current Quarter		**Cumulative to date**		**Budget YTD**
		TSHS		**TSHS**		**TSHS**
	Health Centre					
P27	Salaries and Wages					
P28	Other Payroll Costs					
P29	Allowances					
P30	Health Centre Running Costs					
P31	Medical Supplies					
P32	In patient Costs					
P33	Food Costs					
P34	Repair and maintenance					
P35	Construction/Rehabiliation of Health facilities					
P36	Others: (Specify)					
P37	**Total Health Centre**					
	Dispensary Costs					
P38	Salaries and Wages					
P39	Other Payroll Costs					
P40	Allowances					
P41	Dispensary running Costs					
P42	Medical Supplies					
P43	In-Patient Costs					
P44	Food Costs					
P45	Repairs and Maintenance					
P46	Construction/Rehabiliation of Health facilities					
P47	Other: Specify					
P48	**Total Dispensary costs**					
	Community Initiatives					
P47	Salaries and Wages					
P48	Other Payroll Costs					
P49	Allowances					
P50	Dispensary running Costs					
P51	Medical Supplies					
P52	Repairs and Maintenance					
P53	Construction/ Rehabiliation of Health facilities					
P54	Other: Specify					
P55	**Total Community costs**					

HEALTH SECTOR RECURRENT ACCOUNTING RETURNS
Schedule C

Council …… **Quarter**

	A	**B**	**C**
	Current Quarter	**Cumulative to date**	**Budget YTD**
	TSHS	**TSHS**	**TSHS**

Summary of Personnel Emoluments and allowances

T1	Total Salaries and Wages					
T2	Total Other Payroll Costs					
T3	Total Allowances					
T4	Total other Charges					
	Total					

ANNEX 12: HEALTH SECTOR ACCOUNTING RETURN – NOTES FOR GUIDANCE

	Item Reference	Explanations
	Column A	In this column, actual receipts and payments for the quarter should be entered.
	Column B	Enter the cumulative receipts and payments Q1 =Q1,Receipts, Q2= (Q1+Q2), Q3= (Q1+Q2+Q3),Q4=(Q1+Q2+Q3+Q4 (Q stands for Quarter)
	Column C	Enter the quarterly budget and cumulatively for succeeding the following quarters as per approved Council Health Plan. Any variation from this should be accompanied by the appropriate Council minute authorizing a virement.
	B1	Enter the opening cash book balance at the beginning of the first quarter. This figure is taken from the Cash book closing balance of the 4th quarter financial return.
	R1	The amount of Block grant received in the current quarter.
	R2	Total Basket grant received in the current quarter
	R3	The amount of funds transferred from the Councils General Account to fund Health account
	R4	Cost sharing includes receipts from user fees, CHF, DRF, NHIF,NSSF etc. and charges for health services.
	R5	Receipts in kind are receipts, reflecting the value of the goods received in monetary terms such as drugs, medical supplies, vaccines, laboratory reagents, medical equipment and general supplies. This entry should have a corresponding entry under the Payments section of this return in the appropriate box.
	R6	Total Health Sector Development Grant received in the Current quarter
	R7	Total Global fund funds received in the current quarter
	R8	Any other funds received, for example any funds intended for recurrent expenditure from donors, NGO's.
	R9	Enter the total of boxes R1 to R7
	R10	Enter the total of boxes B1 +R8
	S1	Enter figure from P7 which reflects total payments made at DMO's office cost centre
	S2	Enter figure from P17 which reflects total payments made at Council/CD Hospital cost centre
	S3	Enter figure from P26 which reflects total payments made at VA Hospital cost centre ….
	S4	Enter figure from P36 which reflects total payments made at Health Centre cost centre ….
	S5	Enter figure from P46 which reflects total payments made at Dispensary cost centre .
	S6	Enter figure from P52 which reflects total payments made at Community cost centre
	S7	Total of boxes S1 – S6
	B2	Enter the result figure of R9 minus S7, this reflects the cash

	Item Reference	Explanations
		balance at the end of the period.
	P1	Enter the salaries expenditure on health management and administration.
	P2	Enter the costs of NSSF contributions.
	P3	Enter all allowances paid to DMO's office staff, which is not correctly chargeable to any of the other cost centres.
	P4	Enter the fuel, vehicle maintenance, insurance costs of vehicles run by the DMOs office.
	P5	Enter Office running costs include: stationery, telephones, utilities and any other costs associated with running the office.
	P6	Enter any other cost which does not fall under category P1 to P5
	P7	Enter the total cost incurred at the DMO's office (P1 through to P6)
	P8	Enter total salaries and wages for District Hospital staff and labourers
	P9	Enter the cost of NSSF contribution made by employer
	P10 – P15	Enter costs which are incurred in the running of the Council/CD Hospital should be entered according to the classifications given. Where there are any costs which do not fall into the given classifications, they should be described and entered into box P16
	P12 P17	Hospital Running costs includes all utilities and supplies (such as cleaning materials) incurred in the day to day running of the hospital) Enter total cost incurred at Council Hospital cost center (P8 through to P16)
	P 18	Enter total salaries and wages for Voluntary Agent Hospital staff and Labourers
	P19	Enter the cost of NSSF contribution made by employer
	P20 – P24 P26	Costs incurred in running VA Hospital should be entered according to the classifications given. Where there is no VA hospital, enter zeros in the total box – Box P 26. Where there are any costs which do not fall into the given classifications, they should be described and entered into box P25 Enter the total cost incurred at the Voluntary Agent cost center (P18 through to P25)
	P27	Enter total salaries and wages for Health Center cost center staff and

	Item Reference	Explanations
		Labourers
	P28	Enter the cost of NSSF contribution made by employer
	P29 – P34	Costs incurred in running Rural Health Centre should be entered according to the classifications given. Where there are any costs which do not fall into the given classifications, they should be described and entered into box P35
	P36	Enter the total cost incurred at the Health center cost center
	P37	Enter total salaries and wages for Dispensaries cost center staff and Labourers
	P38	Enter the cost of NSSF contribution made by employer
	P39 – P44	Costs incurred in running dispensaries should be entered according to the classifications given. Where there are any costs which do not fall into the given classifications, they should be described and entered into box P45.
	P46	Enter the total cost incurred at Dispensaries cost center
	T1	Total salaries and wages (Add Boxes P1 +P8 +P27+P37), enter total
	T2	Total other payroll cost (Add Boxes P2 +P9+P28+P38)enter total
	T3	Total allowances- which should not exceed MOH Guidelines
	T4	Add Boxes containing all costs except salaries and wages, other payroll costs and allowances.

ANNEX 13: HOW TO ENTER DATA INTO PLANREP 3

A: PLAN REP[3] HEALTH SECTOR

The following tutorials are designed to assist Council Health Management Teams to prepare their annual budgets according to the PMORALG and MOHSW budget guidelines.

SETTING UP PLANREP[3]

1. Open PlanRep[3] software by entering user name and password (user and Plan Rep respectively).
2. Set up plan Rep for your Council (Utilities/set up/change Council).
3. Set vision and mission to include your Council name.
4. Set the financial year e.g. 2010/2011
5. Change US dollar exchange rate to e.g. 1245 and change mid-year rate to e.g. 1250.
6. Check that all health cost centres are activated by checking set/cost centre/select. From the drop – down list select 508 primary health services. Ensure that all primary health cost centres are ticked. Return to menu by clicking the return button on utilities screen.

7. Enter Health ceiling by clicking utilities/ceilings Entry and selecting health sector from the funders list. Enter figures click the button marked preview sector Budget ceiling and projection to see the graph. Enter an amount for the special grant for HIV/AIDS for your local authority select HIV/AID and Enter an appropriate amount.

B: ENTERING A HEALTH OBJECTIVE TARGET AND ACTIVITY

8. CLICK performance budget frame work button. Note that the objective A, "To improve Services and reduce HIV/AIDS Infections" already exists and cannot be altered or deleted. This objective is common to every Ministry department, agency, region and local government authority.

9. Enter objective B "To improve quality and access to health services in the District.

10. Select the objective and click the Target button. Select the cost centre E04 (508A) (CHMT/CHSP). Enter target, then select, then open drop down arrow to select target type (capacity building service (C) delivery (S) OR capital investment (D). After that Double Click on Cluster 2 linked MKUKUTA strategy. Example of the Target:-

TARGET

Support 2 Health care workers undergoing training by June 2011.
SELECT – TARGET TYPE FROM "THOSE THREE TYPES"
Capacity building as a target type and OC as category.

11. Add one or two responsible person for health sector activities, insert job title(s)
Insert an activity below the target "To pay fees for 2 Health care workers undergoing training. Click the box marked Training, as this is a training activity. Note that the activity appears in red with a green back ground because it is under MKUKUTA (red) and it is a training activity (green background).

C: ENTERING HEALTH REVENUE PROJECTION

12. Click the revenue Projection button from the main menu and select the cost centre E04 (DMO Office) select Health OC from the drop-down list labelled "source Ref" Enter an estimated amount of Health OC for your Council. Select Health PE and enter the estimated amount. Select Health service Basket Fund and enter an estimated amount. Click the revenue projection by category button to view all subventions in cost centre E04. Click the other buttons at the bottom of the screen to find out what they display. When finished, click the return button to return to the main menu.

D: ENTERING HEALTH OC

13. Click the budgets button and select other charges from the menu. Click the preview sectoral budget and projection button at the bottom of the screen. Explain the display. Select objective B activity which you entered earlier.
Notice that Plan Rep3 assumes the source of fund to be the Local Government (i.e. Health) Block Grant. Click the funding sources drop down list to view the other options which can be entered, and select the option fund to be. From the priority Area drop-down list, select the appropriate item. Double click the intervention box to see the list of possible items counted in this category. To see the options you have to double click the shadowed box.

14. Now go to the inputs section and click the binoculars and search for GFS Codes. From the list select GFS Code to be. Double click to enter this code in the budget. Select the unit cost.

Click the button marked Budget and enter the quantity for the year. Click the preview button to see the budget printout. Press the Escape to return to OC budget screen. Click the button marked 'preview sectoral budget, ceiling and projection to see graph.

15. In the Health sector section at the bottom of the screen, click the Basket Grant Graph button. Two graphs should then appear headed Council Basket Grant allocations. Make entries that will show up in the graphs. Note that when the activity is categorized as training, no associated cost will appear in the ceiling graph as training is exempted from inclusion under the ceiling.

16. Press the Heath Basket Fund figures button to see the Basket Grant allocations figures. Note that the total is shown at the bottom of the screen and that amount allocated is 100%. Note that also the minimum and maximum allocations permitted under the new health guidelines (15% to 20% respectively). Double click the description box to show the underlying activity which contributes to the total budget entered so far. Double click on the same box again to see the input for this activity (GFS Code). Return to OC budget screen.

17. Enter more target and activities under the other health sub votes, i.e Council Hospital, Voluntary agency hospital, dispensaries and communities. After each budget entry, monitor the allocations to the 6 cost centres. Try to make each one to lie within the "error bars" which indicate the permissible range for each cost centre.

18. Click the printouts/Health sector/comprehensive Plan–District Analysis.

19. Intervention Burden Graph:
    Still on the OC budget screen, click the Intervention Burden button to see the columns in the red indicate the percentage share of the burden of disease for different interventions, based on the most recent research at the DSS site at Rufiji. Note that there is no expenditure yet entered which will address this Burden of Disease directly.

    Budget expenditure affecting the burden of disease will appear in bright green. Click the button labelled preview sectoral budget and projection. Note the Health sector figure and how they relate to the revenue projection and budget already entered. Click escape to return to OC budget screen and return to budget menu. Click home to return to main menu.

20. From the main menu, select performance budget frame work the objective B and add target under selected cost centre, then select target type, link this target to MKUKUTA Cluster 2. Add activity and allocate to the appropriate responsible person and previous the sub-vote. Note how the information is displayed. Return to the main menu and select the Budget. Select the activity just entered and leave its funding source. Select the appropriate priority area for this activity and corresponding intervention. Enter the budget for GFS code and the unit cost. Enter the quantity for each year of the MTEF. Add second input to this activity. Select the unit and enter as the unit cost.

    Note that there is now light green column in the cost centres corresponding to the last budget amount entered. Note that also the change in the expenditure ceiling graph and ensure that these are understood clearly. Click the Figures button and note that cost centres now appear with an increased total budget. Double click the cost centre box to see the underlying activity. Double click this activity.

21. Intervention Burden Graph
    Still on the OC budget screen, click the Intervention Burden button to see the pattern of the burden of Disease graph. The columns in the red indicate the percentage share of the burden of

disease for deferent interventions, based on the most recent research at the DSS site at Rufiji. Note that there is no expenditure yet entered which will address this burden of disease directly. Budget expenditure affecting the burden of disease will appear in bright green. Click the button labelled preview sectoral budget and projection. Note the Health Sector figure and how they relate to the revenue projection and budget already entered. Click escape to return to OC budget screen and return to budget menu. Click home to return to main menu.

22. From the main menu, select performance budget Framework the objective B and add target under selected cost centre; then select target type, link this target name to display the inputs you have entered. Double click on either to return to the initial screen, return to the budget screen. Click the intervention burden button and discuss and explain the result.

HEALTH SECTOR PRINT OUTS

Check each printout in turn and ensure that you understand what is being displayed and which stake holders would be interested in seeing them.

From the main menu click printout, then click Health Sector, printouts/Health Sector will be displayed with nine components. Click each one and try to understand what it means or in other way interpret the massage.
Click component one in which it displays – Council Health Plan Basket Analysis of a council. This analysis:-

- Population
- Total District Health Budget
- Per capita Health Budget
- Council health Grant Budget projection
- Per capita Council Basket health Grant Budget Projection
- Council Basket health Grand
- Per capital Council Basket health Grant Budget

Part two of the component shows the Basket Budget or expenditure component shares to cost centres as to MOHSW guideline.

Part Three – Shows training activities budget share and the latest shares of allowance, Transport and minor maintenance according to MOHSW guideline. Escape to return to printouts/Health sector, and then click comprehensive health Plan – District analysis. It displays total District health Budget or expenditure component return to the screen printout/Health sector by pressing escape button; then click button intervention burden and expenditure share to display District Budget versus Disease burden. Escape to return to screen printouts/health Sector, click – Council Block Grant Allocations displays funding and guidelines, also expenditure totals and percentage allocated.

Escape to return to printouts/Health sector. Click – Block Grant figures. It displays allocation in numeric figures.

Click – Basket Grant allocations it displays allocation in figure according to essential Health Interventions and non specific delivery support. To return, escape.

Click partner shares in Council plan. It displays shares of different finances. Escape to return to printouts/Health sector.

Total health system support shares. It displays all share invested in the District. Escape to return.

Click – Annex to ALL interventions. It displays.

Click Health Sector funding sources. It shows different sources of funding in the District, Escape to return.

Click Annex 2.1 main budget summary – it displays priority Area, Intervention and source of funding in summary. Escape to return.

Click – Annex 2.2 specific Budget summary for Health Basket Grants. It displays priority Area, Interventions and allocated funds to cost centres, to return escape.

Click Annex 2.3 specific Budget summary for health Block Grant, it displays Priority Area, Interventions and allocated fund to cost centres, to return Escape.

Click Annex 2.4 Budget summary for allowances, etc. It displays budget summary for allowances, fuel transport for supervision and distribution, minor rehabilitation and maintenance of equipments for basket grants, to return Escape.

Click summary of total activities, resources and sources. It displays budgeted activity, sources of finances and essential Health interventions in respective District, to return Escape.

Source of Funds

This table 18 is reflected in PlanRep3. It shows Health Sector funding sources to access health Sector funding sources from the main menu click budget the select health Sector funding sources by clicking, Table 13 will display different sources of financing. Return the click home to return to main menu.

Click performance budget framework (MTEF) to open then print plan which it will incorporate objective, targets and activities. Click return button to return to main menu.

Click Printout then select core LGA printouts click the button, after that pick physical implementation and click and finally activity time chart. Click it to **open** activity time chart in which you select source of find e.g. Health Basket Fund, the deselect to choose the appropriate cost centre – for health. E.g. select CHMT/CHSB and click it to display the time frame activity chart, the schedule of activities will be shown. Use screw box below to view all the schedules. Escape, then click button home to return to the main screen.

From the main menu click printouts then core LGA printout follows budget and select break down of budget inputs to get budget analysis. Deselect then funding source and cost centre to view.

To move from there, escape and to return to main menu click home button.

From the main menu to view the health status – click budget then click personal emolument to see summary of personal emoluments estimates for existing employees on payroll and new employees to be recruited in the appropriate year; Also employees according to sub votes.

To move from here use return button to return to main menu.

ANNEX 14: IMPLEMENTATION OF THE PRIMARY HEALTH SERVICES DEVELOPMENT PROGRAMME (PHSDP- MMAM)

Table 1: Status of Health Facilities - Mapping

Type of Facility	Name of Facility	Location & Access	Distance to the nearest Facility	Catchment Area	Year of Operation	% of HR (trained)	Physical Status	Functioning utilities	Medical waste facility	Communication & Ambulance	Infrastructure Dev. Plan & PPM	Planned Activity	Date Planned Activities	Foreseen Completion Date	Funding Source / Amount/
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**
Disp./ Public	*Amani*	*Ilala / gravel road & rainy season not accessible*	*1 km*	*10,000*	*2001*	*60%*	*Operation but one wing closed & 3 wings need urgent rehabilitation*	*water, Electricity*	*2 Incinerators dumpster & Council Garbage collection*	*1 Ambulance & 1 mobile & radio system broken*	*Infra. Dev Plan implemented & PPM drafted*	*Extension OPD*	*Ongoing since November 2010*	*March 2011*	*Tsh 6 mill HSDG approved & received & Tsh 2 mill community contribution*

Column 1: Fill in the type of facility i.e. Dispensary or Health Centre and whether it is private, public or faith based
Column 2: Fill in the name of Facility
Column 3: State location (up to village level) and accessibility i.e. type of road
Column 4: Fill in the distance to the next Facility
Column 5: State the population it serves
Column 6: State the year it was built and when it started functioning
Column 7: State the percentage of human resources available
Column 8: State physical status of the Facility i.e. it is operational, closed, under rehabilitation, renovation, construction
Column 9: Fill in availability of clean water and electricity – if both are working or none, if non among water or electricity is available or working
Column 10: Fill in medical waste by type that is functioning i.e. incinerators
Column 11: State how many functional ambulances/vehicles there are and communication system
Column 12: Fill in if they have an Infrastructure Development Plan and a PPM
Column 13: State planned activity as per the comprehensive infrastructure plan i.e. will be under renovation/rehabilitation of ODP, or an OPD extension will be constructed, or staff house will be constructed, new facility under construction
Column 14: State when the activities are planned to commence
Column 15: State when the activities will be completed

Column 16: State what funding has been planned and whether it has been approved/secured/ the amount received i.e. Health Basket, Councils own source, HSDG, LGDG, Community, NGO, Project, Development Partners etc

Table 2: Council Summary of Construction and Rehabilitation Plan and Budget for the year.

Council……..Year…….

S/No.	Health Facility Name	HEALTH FACILITY BUDGET AND COUNCIL ENGINEER					TOTAL CONSTRUCTION / REHABILITATION
		CONSTRUCTION	REHABILITATION	INFECTION CONTROL	EQUIPMENTS/ SUPPLEMENTARY EQUIPMENTS	FURNITURE/ SUPPLEMENTARY FURNITURE	
1	Kaloleni Health Centre	115,000,000.00	0	30,000,000.00	40,000,000.00	15.000.000.00	200,000,000.00
2.	Maporomoko Dispensary	0	60,000,000.00	20,000,000.00	35.000.000.00	10,000,000.00	125,000,000.00

Table 3: Infrastructure Construction/Rehabilitation Combined Technical and financial Progress Report Form - Council Reporting

Region……..Council…… Facility …… Quarter Ended……..

Ward	Village	Facility Name & Location	Activities	Source of Fund	Physical Implementation	Physical Implementation in %	Total approved Budget	Forward from Previous period	Amount Received	Total amount Available	Cash Expenditure)	Balance	Community Contribution	Total Expenditure	Expenditure in percentage	Remarks and Last Supervision date by District Engineer
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17
Msanga	Chilenga	*Mtoni HC*	*Rehabilitation/Construction of OPD,2 ward*													
			Rehabilitation/Construction of 2 staff houses													
			Rehabilitation n of incenerator, water sewerage													

Prepared by (Name) …… …Council Engineer …… Signature……

Checked by (Name)…… … .Council Treasury……..Signature……

Checked by (Name)…… ……. District Medical Officer …… . Signature…….

Certified by (Name)…… .. ... District Executive Director…….. Signature……

Certified by Name……... Regional Accountant……Signature…….

Certified by Name……Regional Medical Officer……Signature……

Notes

Column 1: Fill in Name of ward
Column 2 : Fill Name of Village
Column 3: Fill name of Health facility
Column 4: Fill in the type of activity (major repairs, rehabilitation or new construction) of section e.g. OPD, staff house

Column 5: States the source of fund i.e. Health Basket, Block Grand, Councils own funds, HSDG, LGDG, NGOs etc
Column 6: Fill in the status of physical implementations
Column 7: Fill in the status of physical implementation in percentage
Column 8 Fill in the total period approved Budget
Column 9: State funds that were left over from previous period and rolled over for this period
Column 10 State amount received
Column 11: Total amount available
Column 12: State Cash Expenditure for the period
Column 13 Cash balance remaining
Column 14: State whether there is any community contribution in kind or cash
Column 15: State total expenditure
Column 16: State balance of funds left over in percentage **%** terms
Column 17: Remarks and State last supervision date from district engineer

Table 4: Infrastructure Rehabilitation and Construction Form

Council Reporting

Region……..Council…… Facility …… Quarter Ended…………..

Facility Name & Location	Activities	Funding Source	Total Budget approved	Forward from Previous FY	Amount Received	Expenditure)	Community Contribution	Total Expenditure	Balance in %	Physical status of Implementation in %	Furnished & equipped?	Staff approved by Local Government	Last Supervision date by District Engineer	Final Completion date/ Operation date
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

Prepared by (Name) ……Technician ……Signature……
Checked by (Name)……HFC Chairperson……Signature……
Checked by (Name)……VG Chairperson …… Signature…….
Certified by (Name)…….. District Engineer…….. Signature……

Notes

Column 1: Fill in Name and Location of the facility
Column 2: Fill in the type of activity (major repairs, rehabilitation or new construction) of section e.g. OPD, staff house
Column 3: States where the fund are from i.e. Health Basket, Councils own funds, HSDG, JRF, LGDG, NGOs etc
Column 4: Fill in the total budget approved
Column 5: State funds that were left over from previous year and rolled over for this FY
Column 6 State amount received
Column 7: State Expenditure for the current FY
Column 8: State whether there is any community contribution in kind or cash
Column 9: State total expenditure
Column 10: State balance of funds left over in percentage **%** terms
Column 11: Estimate the percentage**%** of activities implemented
Column 12: State whether the facility has been furnished and equipped (yes or no)
Column 13: State whether Central Ministry has approved staff for the facility
Column 14: State last supervision date from district engineer
Column 15: State final date for works to be completed and operationalised

ONLY FOR INTERNAL HEALTH FACILITY USE – NOT FOR CCHP REPORTING

Table 5: Comprehensive Infrastructure Development Plan - Planned Investments – for Health Facility use ONLY

Name of Health Facility……..						
Planned Type of Investment e.g.	**Timetable**	**Estimated Costs**	**Budgeted under**	**Activity/ Item**	**Completion/ Delivery**	**Status/ Comments**
Rehabilitation/Construction of health facility building/s						
Rehabilitation/Construction of health facility waste management facilities						
Procurement of Medical Equipment						
Procurement of Waste Management Equipment						
Procurement of Medical and Non-medical furniture						
Other						

- Column 1: Fill in the time frame that is expected to take from beginning to the end…eg. July 2012 – June 2013
- Column 2: Fill in estimated cost for the activity… cost it takes to finish the work.
- Column 3: State the source of funds allocated for the activity
- Column 4: Fill in either its rehabilitation or newly construction
- Column 5: State the percentage of work completed (ongoing or completed)
- Column 6: write comments as necessary

Table 6: Maintenance and Repairs (examples) – for Health Facility use ONLY

S/N	**Location & Item**	**Equipment/ Infrastructure**	**Activity**	**Price TSHS**	**Quantity**	**Funding Source**	**Supplier**	**Starting Date**	**Status Date**	**Completion Date**	**Approval by**
1	OPD Roof	Infrastructure	Repair 2 wholes	80,000	1	User fees	Local Name	01.01.11	Done	20.09.10	Facility in Charge
2	OPD Wall	Infrastructure	Painting	100,000	1	Health basket	Local Name	01.02.11	Ongoing	23.02.11	Facility in Charge
3	Furniture	Infrastructure	Repair 2 chairs and 3 benches	50,000	5	Community contribution	Local Name	01.01.11	Ongoing	15.01.11	Facility in Charge
4	Incinerator	Equipment	Order spare part (vault)	1,200,000	1	Community contribution	International	01.01.11	Ordered with MSD on 23 .05.2010	01.05.11	DMO
5	Dental Chair	Equipment	Repair	200,000	1	User fees	DSM TAMEC	01.02.11	To be sent	01.03.11	Facility in Charge