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Maternal and Child Survival Program

Strengthening Comprehensive Council Health Planning to Increase Immunization Coverage

A Pilot Activity in Kagera Region, Tanzania

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MCSP is a global USAID initiative to introduce and support high-impact health interventions in 25 priority countries to help prevent child and maternal deaths. MCSP supports programming in maternal, newborn, and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment. MCSP will tackle these issues through approaches that also focus on household and community mobilization, gender integration, and digital health, among others.

This study is made possible by the generous support of the American people through the United States Agency for International Development (USAID) under the terms of the Cooperative Agreement AID-OAA-A-14-00028. The contents are the responsibility of the Maternal and Child Survival Program and do not necessarily reflect the views of USAID or the United States Government.

January 2019

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Acronyms and Abbreviations

CCHP	Council Comprehensive Council Health Plan
CHMT	council health management team
CHPT	council health planning team
CHSB	Council Health Service Board
HFGC	health facility governing committee
HMIS	health management information system
IVD	Immunization and Vaccine Development
LPG	liquefied petroleum gas
MCHIP	Maternal and Child Health Integrated Program
MCSP	Maternal and Child Survival Program
MOHCDGEC	Ministry of Health Community Development, Gender, Elderly, and Children
MOHSW	Ministry of Health and Social Welfare
PORALG	President's Office for Regional Administration and Local Government
RAPID	regular appraisal of program implementation in district
REC	Reaching Every Child
RED	Reaching Every District
RHMT	regional health management team
TZS	Tanzanian Shillings
USAID	United States Agency for International Development
VPD	vaccine-preventable disease
WDC	ward development committee

Executive Summary

In Tanzania, the Maternal and Child Survival Program (MCSP) provides technical support to the Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC) focused on ensuring that all women, newborns, and children who are most in need have equitable access to quality health care services that save lives. In 2014, based on earlier work supported by MCSP's predecessor project, the Maternal and Child Health Integrated Program (MCHIP), MCSP conducted an in-depth assessment of the Comprehensive Council Health Plan (CCHP) development process in Tanzania's Kagera Region. The objective of the assessment and resulting activities was to explore ways councils could develop more accurate CCHPs to support improved council-level vaccination program delivery, which leads to higher vaccination rates in children and reduced rates of vaccine-preventable diseases (VPDs).

In Tanzania, CCHPs are developed through an annual process where councils (an administrative-level equivalent to districts in other countries) plan and budget for the coming year's essential health and social welfare programs. Despite the existence of comprehensive development guidelines for CCHPs, there have been challenges effectively applying them at operational level. For example, in the case of immunization program planning and budgeting, a 2013 regular appraisal of program implementation in district (RAPID) assessment identified that, among other things, some councils did not budget properly for the recurring costs of annual immunization program delivery. Inaccurate budgeting in CCHPs (e.g., insufficient funds to support immunization outreach clinics, purchase of liquefied petroleum gas [LPG] to fuel cold chain equipment, electricity, and transport costs for distributing vaccines) compromised Immunization and Vaccine Development (IVD) Program performance at council level throughout the year.

From 2014 to 2017, MCSP and the MOHCDGEC undertook a series of activities focused on strengthening the CCHP planning process in two select councils (Muleba and Ngara) of Tanzania's Kagera Region. Activities included:

- Developing an immunization microplanning tool and piloting its use within the CCHP planning process with the Muleba council
- Analyzing the effects of microplanning tool use in Muleba on CCHP and immunization program performance, and comparison to the Ngara council's (control council) performance during the 2016/2017 financial year
- Discussing conclusions, lessons learned, and dissemination of recommendations with national and regional MOHCDGEC stakeholders
- Expanding microplanning tool use to additional councils in Kagera Region and in Shinyanga, Tabora, and Simiyu regions
- Disseminating recommendations to national and regional MOHCDGEC stakeholders to expand coverage of reproductive, maternal, newborn, and child health services beyond immunization by applying the microplanning concept to other areas of CCHP planning

Results of the microplanning tool use pilot activity with the Muleba council were impressive. Post-intervention, budgeting in Muleba for the 2016/2017 financial year improved greatly. Annual CCHP budgets matched the required funds needed for outreach, vaccine distribution, purchase of LPG, electricity, and immunization costs overall. In Ngara, the control site, budget improvements were not as significant in 2016/2017, as allocations fell short of requirements in each category except electricity. Importantly, accurate CCHP budgeting may have played a role in increasing immunization coverage on the Muleba council. While it is difficult to directly attribute increased coverage to use of the microplanning tool, Penta 3 coverage in Muleba increased during the intervention period, whereas the number of children receiving the Penta 3 vaccination remained unchanged for the same time period in Ngara. This suggests that strengthening CCHP planning and budgeting may be an important and effective way to increase coverage of critical immunization (and potentially other) services.

Acknowledgments

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MCSP would like to acknowledge USAID Tanzania and USAID Washington, and the Tanzania MOHCDGEC through its IVD Program, President's Office for Regional and Local Government Authority, Kagera Regional Health Management Team, and Council Health Management Team for their financial support, guidance, and close collaboration in the implementation of this report.

MCSP would like to acknowledge the hard work and dedication of the authors of this report: Dorosella Njunwa from the President's Office Regional and Local Government Authority in Kagera, and Nassor Mohamed, Green Sadru, Wendy Prosser, and Asnakew Tsega from MCSP.

CCHP Overview

In Tanzania, MCSP provides technical support to the MOHCDGEC focused on ensuring that all women, newborns, and children who are most in need have equitable access to quality health care services to save lives. In 2013, MCHIP, the predecessor to MCSP, supported Tanzania's IVD Program in conducting a RAPID immunization service assessment that found, among other things, that some councils did not budget properly for the recurring costs of annual immunization program delivery. As a result, in 2014, MCSP conducted a more in-depth assessment of the CCHP development process in Tanzania's Kagera Region as part of a broader learning activity. The objective was to explore ways in which councils could develop more accurate CCHPs to support improved council-level vaccination program delivery, which leads to higher child vaccination rates and reduced rates of VPDs.

In Tanzania, CCHPs are developed through an annual process where councils (an administrative-level equivalent to districts in other countries) plan and budget for the coming year's essential health and social welfare programs. CCHP guidelines were developed in 1999 and revised over the years to support councils' CCHP preparation and ensure that health facilities within councils use allotted funds effectively. Health facilities' appropriate use of CCHP funds has become a particularly important issue, as the government shifted in the past few years to funding facilities directly instead of sending funds to them via provincial or council levels. While CCHP guidelines are comprehensive, there have been challenges effectively applying them at operational level. For example, a 2013 CCHP analysis conducted by the Tanzania Ministry of Health and Social Welfare (MOHSW) found that inadequate knowledge of the planning process and/or ineffective application of CCHP guidelines resulted in mismatches between stated annual plan objectives and performance indicators monitored by the MOHSW.[1]

Box 1. Council health planning team members

- Council medical officer (chair)
- Council health secretary (secretary)
- Council planning officer (technical advisor)
- Council health officer
- Council dental officer
- Council lab technologist
- Council nursing officer
- Council pharmacist
- Council social welfare officer
- Council health management teams
- Co-opted members (district immunization and vaccine officer, district reproductive and child health coordinator, district TB and leprosy coordinator, district AIDS control coordinator, malaria focal person, school health and neglected tropical diseases coordinators)
- Medical officer in-charge
- Council health accountant
- Representatives from private sector, nongovernmental organizations, community-based organizations, and faith-based organizations
- Representative from community development department
- Representative of the regional health management team

The CCHP planning process uses a bottom-up approach: community stakeholders, health facilities, hospitals, and dispensaries communicate their annual health program priorities to their council health planning team (CHPT). CHPTs then use that information to develop the annual CCHP. To facilitate this process, CHPTs specifically:

- Invite stakeholders to participate in preplanning meetings.
- Ensure that essential documents and planning tools are in place, including the previous year's CCHP, annual implementation and quarterly progress reports, and health management information system (HMIS) reports.
- Review previous years' health performance indicators and targets.
- Invite resource people to contribute information on specific topics.

[1] United Republic of Tanzania, MOHSW, PORALG. 2013. *Summary and Analysis of the Comprehensive Council Health Plans 2013/14.*

- Coordinate the work of stakeholders and council members (see Box 1), and ensure that all lower-level plans are incorporated in the CCHP.
- Ensure that CCHPs are consistent with the National Essential Health and Social Welfare Package, the local epidemiological context, and available resources.

The financial year in Tanzania begins in July and ends in June of the following year. CCHP planning processes begin in early October and end in June before budgets are approved by parliament. Table 1 lists the schedule for all steps.

Table 1. Annual Comprehensive Council Health Plan (CCHP) planning process

S/No	Activity	Responsible	Completion Deadlines
1	Council hospitals, health centers, and dispensaries consult communities, faith-based organizations, civil society organizations, and private, for-profit providers to identify priorities and needs to include in annual plans.	Council hospitals, health centers, and dispensaries	Early October
2	Pre-CCHP planning meetings take place with all stakeholders.	Council health management team (CHMT) and all stakeholders	Early November
3	Council/ CHMT collects priorities/needs from hospitals, health centers, dispensaries, the community, and other stakeholders to incorporate in the CCHP.	Council/CHMT	Early November
4	Councils are notified or collect information about resources available from Health Block Grant, Health Basket funds, and partners for the coming financial year.	President's Office for Regional Administration and Local Government (PORALG); Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC); councils; partners	End of November
5	The Council Health Service Board (CHSB) and CHMT receive annual plans and budget projections from council hospitals, health centers, dispensaries, faith-based organizations, civil society organizations, and private, for-profits to be incorporated into the CCHP.	CHMT and CHSB	December
6	The CHSB reviews the CCHP before submission to the regional secretariat/regional health management team (RHMT).	Council health planning team/CHSB	Mid-January
7	CCHP entered into Medium Term Expenditure Framework (recurrent and development budgets prepared from the CCHP).	District treasurer/district planning officer/district medical officer	End of February
8	The CCHP is submitted to the regional secretariat, which checks the CCHP for conformity with national guidelines. All recommendations from the secretariat to the council are submitted in writing.	Regional secretariat/RHMT	End of March
9	The CCHP and budget are approved by the full council through different standing committees.	Standing committees and full council	End of April

S/No	Activity	Responsible	Completion Deadlines
10	The CCHP and budget are submitted to the regional secretariat (five hard copies and electronic copy).	CHMT	First week of May
11	The regional secretariat forwards the CCHP assessment report with the assessed CCHP PORALG in hard and soft copy, and copies the MOHCDGEC.	Regional secretariat/RHMT	Third week of May
12	The PORALG and MOHCDGEC consolidate assessed CCHP reports from the regional secretariat and make recommendations for funding approval.	PORALG/MOHCDGEC	First week of June
13	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 fiscal year to Basket Fund Committee members.	PORALG/MOHCDGEC	Third week of June
14	Basket Fund Committee meeting held.	Basket Fund Committee	Fourth week of June

Improving Immunization Coverage through CCHP Refinement Pilot

The 2013 RAPID assessment identified specific reasons for IVD underperformance at council level, including that, among other things, some councils did not budget properly for the recurring costs of annual immunization program delivery. For example, some annual CCHP budgets could not support immunization outreach clinics, purchases of LPG and fuel cold chain equipment, electricity, and transport costs for distributing vaccines. Inadequate funding compromised immunization program delivery in these councils during the year.

In response to this finding, in 2014, MCSP conducted a more in-depth assessment of the CCHP planning process in Tanzania's Kagera Region. The objective of the activity was to explore ways councils could develop more accurate CCHPs to support improved council-level vaccination program delivery, leading to higher rates vaccination in children and reduced incidence of VPDs.

MCSP followed the assessment with a series of CCHP strengthening activities with the Muleba council (see Figure 1)—primarily the pilot of an immunization microplanning tool for use at health facility level—to improve the overall planning process there. MCSP conducted activities from 2014 to 2017 (see Figure 2).

Figure 1. Map of Tanzania, with Muleba and Ngara councils in Kagera Region highlighted.

Figure 2. Maternal and Child Survival Program (MCSP) Comprehensive Council Health Plan (CCHP) strengthening activities in Kagera Region, 2014 to 2017.

2014	2015 July	2015 December	2016	2016 September	2017 September
CCHP planning process assessment in eight councils in Kagera Region	Start of MCSP CCHP strengthening activity, development of microplanning tool, identification of Muleba council as the intervention council and Ngara as the control council	Start of immunization microplanning tool use within CCHP planning process with Muleba council	CCHP implementation with the immunization microplanning tool with Muleba council	Analysis of effects of microplanning tool use in Muleba on the CCHP and immunization program performance during the 2016/2017 fiscal year, discussion of lessons learned and dissemination of recommendations to improve immunization coverage through CCHP planning process refinement	Dissemination of lessons learned and recommendations for expanding coverage of reproductive, maternal, newborn, and child health services beyond immunization by applying the microplanning concept to other areas of CCHP planning

This report documents MCSP and the Government of Tanzania's experience piloting this CCHP strengthening intervention. The report is organized according to each of the above steps, detailing approaches, methods used, and lessons learned.

Step 1: CCHP Assessment

In November 2014, MCSP conducted an in-depth analysis of the CCHP planning process focusing specifically on immunization with all eight councils of Kagera Region to identify strengths, weaknesses, and gaps in the health programming process. MCSP conducted desk reviews, interviewed key informants (e.g., core CHPT members from all eight councils), and observed actual CCHP preplanning and planning meetings. MCSP specifically:

- Mapped out the CCHP process in Kagera Region, including:
  - Prioritization of geographical areas and activities by CHPT/CHMTs and others
  - Use of data by CHPT/CHMTs to identify priorities
  - Linking priorities with activities and performance indicators
  - Linking training, procurement, nongovernmental organization involvement, and monitoring of budgets and expenditures
- Examined how CCHP planning was operationalized at council level and how annual recurrent costs could be better budgeted (i.e., how costs could be better adjusted for local context and operational needs).
- Identified bottlenecks to applying CCHP guidelines at council level.
- Compared past CCHP funding with immunization program needs and identified gaps (anticipated versus actual).
- Determined what health systems elements (e.g., operational planning and preventive services) were lacking or underrepresented in the CCHP and how the CCHP process linked with the government's payment-for-performance and health system strengthening initiatives.

CCHP Assessment: Findings

Similar to the MOHSW assessment a few years prior, MCSP's assessment identified strengths and gaps in CCHP implementation and root causes of problems in Kagera. Strengths included existence of clear guidelines at council level on how to prepare the CCHP, existence of well-established planning teams from health facility to regional level, and close follow-up of the CCHP process by higher levels. Gaps included:

- **Conflicting CCHP guidelines/templates at council and facility levels:** Council-level CCHP guidelines were issued in 2011 and updated several times since. Guidelines and annual health planning templates for health facilities and dispensaries were issued in 2009 but have not been updated in line with council-level guideline revisions. The assessment found that many health workers did not understand how to complete planning templates due to their complexity and because they were in English. Also, mismatches between facility-level templates and council-level guidelines meant that facility-level inputs could not be easily transferred to CCHPs at council level.
- **Poor logistical arrangement of preplanning meetings:** Although preplanning meetings were conducted, poor logistical arrangement (e.g., no copies of previous year's plans and implementation reports for review; no HMIS reports; no relevant resource people, such as RHMT and CHMT members, to provide information and technical support) made it difficult for participants to achieve meeting objectives. In addition, due to limited budgets, health center and dispensary staff were inadequately represented in preplanning meetings.

- **Late or no sharing of planning information among councils and lower levels:** Sharing of critical planning information was often delayed among council and lower levels, with information sometimes not shared at all. For example, information about budget ceilings for dispensaries and health facilities was not shared, resulting in unrealistic council plans and budgets. Also, there was minimal/no involvement of health facility governing committees (HFGCs) and ward development committees (WDCs) at community level in CCHP planning or reviewing of plans.

- **Inappropriate health facility inputs sent to council-level/facility inputs not included in CCHPs:** Conflicting CCHP guidelines used by health facilities and councils, and little/late communication of information between the levels resulted in development of inappropriate health facility plans that could not be included in the CCHP (for example, health facility activities using Health Basket funds, which have separate guidelines and requirements). Lack of feedback from CHPTs to health facilities about facility plans meant that facilities did not know to make corrections from year to year. Annual health facility inputs seemed to be largely pro forma (i.e., developed because they are required by CCHP guidelines), but annual facility plans were not included in CCHPs as planned.

- **Inadequate use of HMIS data in planning:** HMIS data from the DHIS2 should be used in CCHP development. However, the assessment found that available HMIS data were not adequately analyzed, and performance indicators are not sufficiently reviewed during the CCHP development process, leading to inaccurate identification of gaps and inadequate use of data in priority setting, planning, and budgeting.

- **Inadequate linking of situational analyses with interventions/activities in the CCHP:** Similarly, the assessment found that during CCHP preplanning, CHPTs did not have access to well-informed situational analyses and therefore did not effectively link existing local challenges with interventions/activities they included in the CCHP. Resultant CCHPs were less data driven and based more on anecdotal information and CHPT perceptions.

- **Inadequate knowledge among of CCHP guidelines some CHPT members:** Though most CHPT members were trained in planning, knowledge gaps existed due to CCHP guideline changes and revisions.

- **Inadequate use of policy reference documents during planning as stipulated in CCHP guidelines:** CCHP guidelines require CHPTs to refer to key health policies (Health Sector Strategic Plan, Health Policy, Human Resources for Health Strategic Plan) while setting annual priorities. The assessment found that many CHPTs did not comply with this requirement, leading to CCHPs that did not reflect existing policy and guidelines. As a result, some CCHPs submitted to regional or national level were later rejected. In making corrections, CHPTs sometimes removed important operational activities, such as vaccine distribution, LPG procurement, allowances for outreach services, etc.

CCHP Assessment: Recommendations/Next Steps

Based on assessment results, MCSP made the following recommendations to national, regional, council, and community-level stakeholders:

- The President's Office for Regional Administration and Local Government (PORALG) should revise planning templates used at dispensary and health facility levels to be in line with current CCHP guidelines, simplify them so that they are more user-friendly, and translate them into Kiswahili.

- CHMT/CHPTs should improve preplanning meetings by ensuring that all relevant and important materials are in place, and that resource people are available to facilitate/participate in meetings. CHMTs could employ planning checklists and a calendar of activities to track progress of preplanning meeting preparations.

- Councils should communicate critical information, such as annual budget ceilings, to health facilities well in advance. Given information on budget ceilings is often received late from central government, councils and health facilities can use previous years' ceilings to start planning while waiting for ceiling amounts to be released. Starting early by using previous years' figures will help health facilities prioritize their interventions and develop more realistic plans and budgets.

- Community representatives from HFGCs should be more engaged in planning for health services. Health facility plans should capture community needs and address existing gaps at community level; these plans should then be fed into the CCHP.

- Feedback mechanisms should be created so that health facilities know what is being funded in the plans they submitted. Mechanisms should include distributing approved CCHPs at facility level and having stakeholder meetings to discuss/disseminate approved CCHPs.

- During planning processes, stakeholders should review the past year's performance indicators to identify needs and gaps. A review meeting before starting the planning process will help councils analyze data and ensure that CHPT members understand the past year's performance against relevant indicators.

- CHPT members should receive training and/or refresher training on CCHP development, especially on interpreting data and using data for planning and priority setting.

- Councils should ensure that reference guides (Health Sector Strategic Plan, Health Policy, Human Resources for Health Strategic Plan, etc.), are available during CCHP development.

- The councils, with support from MCSP, should pilot use of a microplanning tool to strengthen immunization planning under the CCHP.

Step 2: Development of CCHP Microplanning Tool

In 2015, MCSP proposed to adapt a Reaching Every District (RED) or Reaching Every Council (REC) microplanning tool that had been used successfully by MCHIP India to improve bottom-up health planning to the Tanzanian context and pilot its use to improve immunization planning within the CCHP planning process. REC is a strategy used to build district capacity to increase immunization coverage, with a focus on planning and monitoring. Two key components of the REC strategy are linking services with communities and developing district microplans based on analyses of local health facility and community data. District microplans enable the national level to better ensure that needed financial and human resources are available to districts and to enable districts to use resources efficiently (i.e., according to the microplan). In many different settings, REC implementation successfully improved planning processes, involved community leaders in planning, and improved monitoring and use of data for action. These improvements led to increased immunization coverage rates.

MCSP Tanzania worked with a consultant, the Kagera RHMT, and CHMTs from the Muleba and Ngara councils to adapt the REC microplanning tool to the Tanzanian context. Beginning with the REC microplanning tool that had been used effectively by MCHIP India, MCSP worked to adapt and pilot the tool to specifically:

- Improve the overall CCHP planning process and ownership of plans by incorporating stakeholders' inputs.

- Improve the link between health facility plans and the CCHP.

- Ensure budgeting of sufficient levels of immunization operational funding into the CCHP.

While the pilot was intended to improve the immunization portion of the CCHP, lessons learned from the pilot were collected for possible application to other interventions in the future.

The consultant visited the Ngara and Muleba councils to observe their CCHP planning process and document weaknesses, strengths, and opportunities (Table 2), which could be used to adapt the microplanning model to the Tanzanian context.

The consultant held detailed discussions with RHMT and CHMT members and health facility staff to understand how they developed annual plans and what hindered development of quality plans. The consultant explained proposed use of the REC microplanning tool in CCHP planning. RHMT members (the regional health secretary and regional immunization and vaccines officer) accompanied the consultant and team during the visits, and provided valuable inputs during these discussions.

Figure 3. Consultant field visit to Muleba Council, Kagera Region.

Photo by Nassor Mohamed, MCSP.

Figure 4. Consultant field visit to Ngara Council, Kagera Region.

Photo by Nassor Mohamed, MCSP.

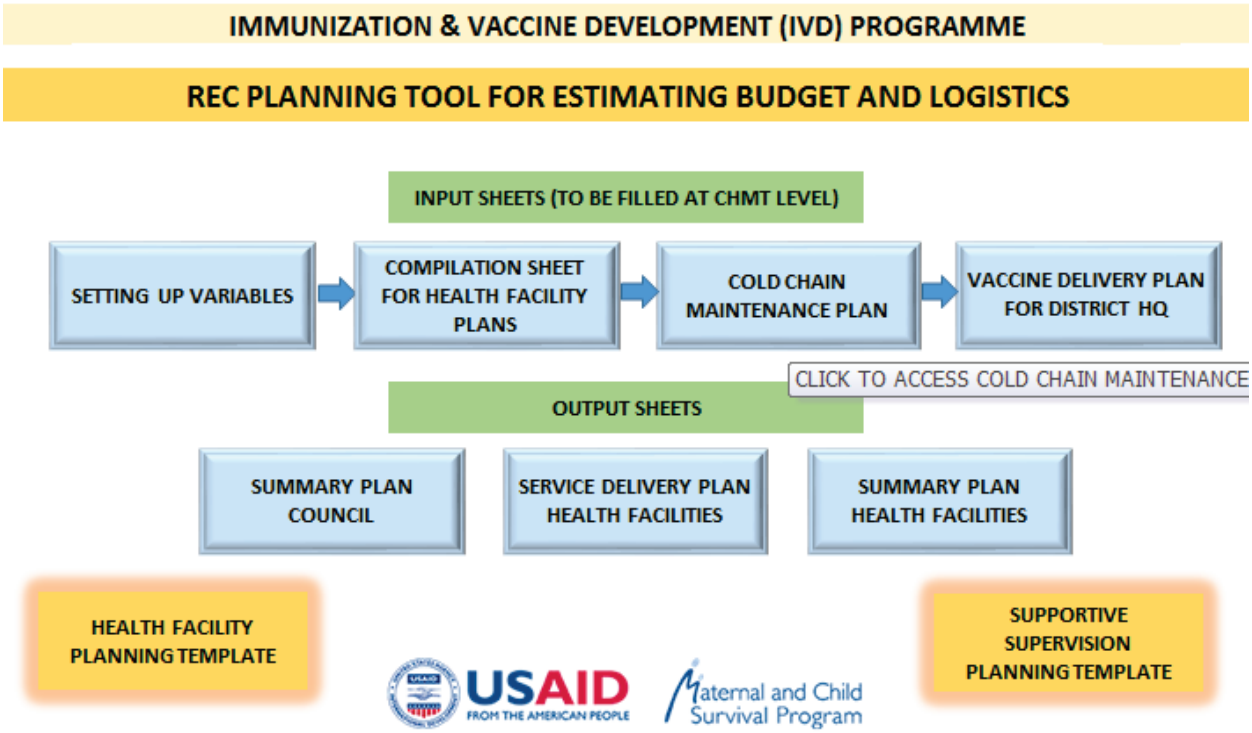
Table 2. Comprehensive Council Health Plan (CCHP) planning process and underlying strengths, gaps, and opportunities

Planning Process	Strengths	Gaps	Opportunities
Used national guidelines to develop CCHP at council health management team (CHMT) level with integration of health facility plans.	• National-level guidelines exist for CCHP planning at CHMT level (2011) and health facility level (2009). • CCHP emphasizes bottom-up planning approach with integration of community-level priorities in health facility plans. • Majority of team members from CHMT and health facilities are oriented on the planning process at different levels.	• Health facility guidelines are not updated; additions/modifications made in CHMT-level guidelines are not reflected in health facility guidelines. • There is inadequate understanding among the CHMT about the national CCHP planning guidelines for council level, particularly among newly appointed staff. • There was poor or no understanding among health facility staff about facility-level planning guidelines (2009), particularly among newly appointed staff. • National guidelines for CHMT and health facility-level planning are in English, which some staff cannot understand. • Health facility guidelines do not have standard templates for planning essential reproductive, maternal, newborn, and child health interventions. As a result, plans differ from facility to facility and cannot be compiled appropriately at CHMT level.	• Well-established government structures at all levels • Existence of planning department at council level, which provides technical assistance to CHMTs • Existence of electronic planning tool at council level utilizing the Plan-Rep 3 system, which is currently used to develop CCHP
CHMT informs health facilities in the beginning of planning year to prepare annual plans and shares vital information (e.g., priority interventions and budget ceilings).	• Based on CCHP guidelines, in early October, CHMTs are required to officially notify health facilities to develop health facility-level plans, which include council priorities and budget allocations.	• Sharing of vital information, such as budget ceilings, is required for planning at facility level but is sometimes delayed or not shared at all. As a result, facility plans submitted are often unrealistic, not focused on council priorities, and, in most cases, contain very high budgets.	• Existence of health facility governing committee (HFGC) and guidelines for planning at health facility level
Council and health facility planning teams use data from the health management information system (HMIS) to conduct situational analysis during development of health facility plans.	• The HMIS/DHIS2 has a well-structured data collection and reporting system.	• Facility-level planning is not data driven (not based on HMIS data), so chosen interventions included in plans are mismatched with actual problems, objectives, targets, and priority areas. • The capacity of health facility technical teams involved in developing plans is often insufficient, leading to unrealistic plans. • CHMTs and health facility staff have inadequate understanding of health facility planning guideline. • The wide variation in structure and content of health facility plans make upstream compilation and comprehension difficult.	• Existence and use of reporting structure (DHIS2) in all councils; can be strengthened to share updated reports with councils and health facilities • Availability of health facility planning guidelines. with the possibility of developing standardized planning templates that can be used at the facility level and compiled at the council level to inform the CCHP

Planning Process	Strengths	Gaps	Opportunities
Facility plans are reviewed by ward development committee (WDC) and HFGC.	• Per guidelines, health facility plans are required to be reviewed by the WDC and HFGCs before being submitted to the CHMT to ensure that community priorities are included in plans.	• In many health facilities, the plans are not effectively shared with HFGCs. • WDCs are not effectively involved in development and review of facility plans.	• Well-established government structures at ward and health facility level
Preplanning meeting held at CHMT level to review facility-level plans.	• replanning meetings are organized at council level to review and provide inputs into health facility plans. • CHMT members must participate and provide technical support in these meetings. • A majority of health facilities are represented by at least one person during preplanning session.	• Due to limited budget, often only the facility in-charge participates in preplanning meetings. • The duration of meeting is also sometimes cut short due to lack of funds. • The HFGC chair is often not invited to participate, so there is lack of community representation. • A limited number of CHMT members participate in preplanning sessions, so some components (especially reproductive, maternal, newborn, and child health components) are not well represented in plans.	• Preplanning meetings: good forum for representatives from CHMT and health facilities to discuss CCHPs and agree on priority interventions to be included; meetings could be strengthened with appropriate budget allocation and ensuring that technical resource people participate and provide inputs
Facility plans are compiled at council level to feed into the CCHP, from which Plan-Rep3 is generated.	• All health facilities submit their plans for review, compilation, and incorporation into the CCHP.	• Facility-level plans are not developed using a standard format and do not have uniform content, making it difficult for council health planning teams to review and consolidate multiple facility plans into the CCHP. As a result, many times, facility plans do not get incorporated into CCHPs, leading to inaccurate CCHPs (e.g., incorrect estimation of medical supplies, funding needs for electricity, liquefied petroleum gas procurement, and outreach allowances).	• Existence of partners that can provide technical assistance to develop standardized planning templates for health facilities, which can facilitate easier compilation of multiple facility plans and development of summary plans that can be used to inform CCHPs

In early December 2015, MCSP shared a draft version of the microplanning tool (see Figure 5 for the tool dashboard) with the CHMT at the Ngara council, the IVD Technical Working Group, and other partners during a meeting convened by the MOHCDGEC.[2] Feedback about the tool was received and incorporated into a refined version of the tool.

Figure 5. Dashboard of the Reaching Every Council microplanning tool showing content of the tool



Along with tool development, MCSP supported other capacity-building activities to further strengthen planning processes, including:

- Orientation meetings for CHMT and health facility team members in Muleba to sensitize participants about using the tool
- Pre-testing of the tool with the Muleba council during CCHP preplanning meetings: The team originally planned to pre-test the tool with the Muleba and Ngara councils, with pre-test activities organized and funded by the councils themselves, but due to delayed release of Basket Funds, pre-testing was only conducted in Muleba, which solicited funds from other council sources to facilitate the preplanning meeting. MCSP designated Muleba as the intervention council and Ngara as the control site.
- Orientation meetings with IVD officers, the IVD Technical Working Group, and other immunization partners regarding use of the tool in Muleba, and sharing of feedback from tool pre-testing

Step 3: Building Capacity to Use Microplanning Tools

MCSP trained the Kagera RHMT and the Muleba CHMT on how to use the microplanning tool to develop immunization outreach and fixed-session plans, budget for immunization operational costs, and determine annual needs for vaccines and related supplies. MCSP supported all 42 Muleba health facilities to prepare annual plans and budget for immunization activities, taking into account each facility's target population, expected demand for immunization services, and projected costs of immunization activities (see Figure 8 for

[2] Formerly the MOHSW, which changed its name in 2015.

a sample completed health facility plan). MCSP then supported the Muleba council to compile facility plans into one summary council plan and budget for immunization services (Figure 9).

Figure 6. The Muleba council health secretary orients health facility workers on 2016/2017 priorities during the preplanning session.

Photo by Green Sadru, MCSP.

Figure 7. Health workers from all health facilities in Muleba listening to the instructions from the district officials during 2016/2017 CCHP preplanning session.

Photo by Green Sadru, MCSP.

Figure 8. A sample page from a health facility annual budget and logistical requirements for immunization services from the Reaching Every Child microplanning tool

IVD REC Plan Summary Sheet - Health Facility

KAIBANJA

Name of Region: **KAGERA** Name of Council: **BUKOBA DC** Planning Year: **2018/2019**

Annual beneficiaries: Pregnant Women: **518** Surviving Infants: **518** 12-24 month children: **502**

Total villages: **4** Service delivery by: Health facility: **1** Outreach: **8** Mobile clinic:

1. Operational plan for outreach immunization service delivery :

		Monthly	Annual
1.1	**Number of man-days/overnight stays for organizing outreach sessions/mobile clinics**		
a	Man-days planned for health facility staff organizing outreach & mobile clinics	16	192
b	Man-days planned for community members at outreach sessions & mobile clinics	16	192
c	Total overnight stays planned for health facility staff at outreach sessions		
1.2	**Cold chain maintenance**		
a	Total number of LP gas cylinders required to be refilled		

2. Estimate of budgetary requirements for the planning year (in TZS):

		Monthly	Annual
a	Extra duty allowance to health facility staff at outreach sessions/mobile clincs	320,000	3,840,000
b	Extra duty allowance to community members at outreach sessions/mobile clinics	160,000	1,920,000
c	Overnight allowance (per diem) to facility staff at outreach sessions	-	-
d	Fare required for transporting vaccines to outreach sites	57,000	684,000
e	Cost for refilling of LP gas cylinders	-	-
f	Budget required for electricity cost incurred in cold chain maintenance	20,000	240,000
	TOTAL BUDGET REQUIRED FOR IVD DURING THE PLANNING YEAR	**557,000**	**6,684,000**

3. Estimate of vaccines and logistics requirement during the planning year

	Vaccine	Requirement of vaccines (in doses)			
		Annual (as per beneficiaries)	Annual (including wastage rate)	Annual (including 25% buffer stock)	Monthly requirement
3.1	BCG	518	1727	2159	180
3.2	OPV	2072	2302	2878	240
3.3	PCV 13	1554	1636	2045	171
3.4	Rota	1036	1091	1364	114
3.5	Penta	1554	1727	2159	180
3.6	MR	1036	1263	1580	132
3.7	TT	1036	1151	1439	120
3.8	IPV	518	576	720	60
3.9	HPV	1036	1091	1364	114

	Syringes and Logistics	Requirement of other logistics			
		Annual (as per beneficiaries)	Annual (including 10% wastage rate)	Annual (including 25% buffer stock)	Monthly requirement
3.10	0.05 ml AD syringe	518	570	713	60
3.11	0.5 ml AD syringe	6734	7408	9260	772
3.12	5 ml disposable syringes	130	143	179	15
3.13	Safety boxes	74	82	103	9
3.14	RCH1 Cards	518	570	713	60

Figure 9. A sample page from a council annual budget and logistical requirement plan for immunization services, to be incorporated into the Comprehensive Council Health Plan

IVD REC Plan Summary Sheet - Council level

Name of Region: **KAGERA** Name of Council: **BUKOBA DC** Planning Year: **2018/2019**

Annual beneficiaries: Pregnant Women: **10800** Surviving Infants: **10800** 12-24 month children: **10447**

Total villages: **94** Service delivery by: Health facility: **42** Outreach: **110** Mobile clinic:

1. Operational plan for outreach immunization service delivery :

		Monthly	Annual
1.1	**Number of man-days/overnight stays for organizing outreach sessions/mobile clinics**		
a	Man-days planned for health facility staff organizing outreach & mobile clinics	216	2592
b	Man-days planned for community members at outreach sessions & mobile clinics	214	2568
c	Total overnight stays planned for health facility staff at outreach sessions		
1.2	**Number of man-days/overnight stays for transportation of vaccines from district HQ**		
a	Total distance to be covered for transporting vaccines from district (in Km)	1750	21000
b	Man-days planned for officer from district level	6	72
c	Man-days planned for driver of vaccine van	6	72
d	Over night stays planned for officer from district level		
e	Over night stays planned for driver of vaccine van		
1.3	**Cold chain maintenance**		
a	Total number of LP gas cylinders required to be refilled		
b	Number of new LP gas cylinders to be purchased from CHMT level		
c	Health facilities using electricity for cold chain maintenance	1	

2. Estimate of budgetary requirements for the planning year (in TZS):

		Monthly	Annual
a	Extra duty allowance to health facility staff at outreach sessions/mobile clincs	4,320,000	51,840,000
b	Extra duty allowance to community members at outreach sessions/mobile clinics	2,140,000	25,680,000
c	Overnight allowance (per diem) to facility staff at outreach sessions	-	-
d	Fare required for transporting vaccines to outreach sites	1,064,500	12,774,000
e	Budget for fuel to transport vaccines from district HQ to health facilities	729,167	8,750,000
f	Extra duty allowance to officer responsible for vaccine transport from district HQ	180,000	2,160,000
g	Extra duty allowance to driver of vaccine van	120,000	1,440,000
h	Overnight allowance to officer responsible for vaccine transport from district HQ	-	-
i	Overnight allowance to driver of vaccine van	-	-
j	Cost for refilling of LP gas cylinders	-	-
k	Cost for purchasing new LP gas cylinders at CHMT level		
l	Budget required for electricity cost incurred in cold chain maintenance	20,000	240,000
	TOTAL BUDGET REQUIRED FOR IVD DURING THE PLANNING YEAR	**8,573,667**	**102,884,000**

3. Estimate of vaccines and logistics requirement during the planning year

	Vaccine	Requirement of vaccines (in doses)			
		Annual (as per beneficiaries)	Annual (including wastage rate)	Annual (including 25% buffer stock)	Monthly requirement
3.1	BCG	10800	36000	45000	3750
3.2	OPV	43200	48000	60000	5000
3.3	PCV 13	32400	34105	42632	3553
3.4	Rota	21600	22737	28422	2369
3.5	Penta	32400	36000	45000	3750
3.6	MR	21600	26341	32927	2744
3.7	TT	21600	24000	30000	2500
3.8	IPV	10800	12000	15000	1250
3.9	HPV	21600	22737	28422	2369

	Syringes and Logistics	Requirement of other logistics			
		Annual (as per beneficiaries)	Annual (including 10% wastage rate)	Annual (including 25% buffer stock)	Monthly requirement
3.10	0.05 ml AD syringe	10800	11880	14850	1238
3.11	0.5 ml AD syringe	140400	154440	193050	16088
3.12	5 ml disposable syringes	2700	2970	3713	310
3.13	Safety boxes	1539	1693	2117	177
3.14	RCH1 Cards	10800	11880	14850	1238

Step 4: Comparison of Budget Allocations versus Requirements for Immunization Services in the Muleba and Ngara Councils

To assess the impact of using the microplanning tool on CCHP development and immunization service delivery, MCSP developed questionnaires (see Annex 1 and 2, respectively) to compare what was proposed by Muleba health facilities during preplanning with what was actually allocated to health facilities in the CCHP. MCSP collected similar information for Ngara health facilities; the Ngara council did not use the microplanning tool to inform its CCHP. MCSP conducted a systematic analysis of all operational costs required for running immunization services in Muleba and Ngara for 2015/2016 (pre-intervention) and 2016/2017 (post-intervention). MCSP compared allocated budgets for outreach, LPG procurement, payment of electricity bills, and distribution of vaccines and supplies with required budgets in Muleba and Ngara. MCSP also compared both councils' total budget allocations with total budget requirements and the percentage of each council's budget allocated for immunization.

Immunization Budget Allocations versus Requirements: Findings

During the initial CCHP assessment in 2014, MCSP observed that councils did not share critical planning information (including budget ceilings) with health facilities during preplanning stages. Following the microplanning tool pilot, in 2016/2017, the Muleba council shared all vital information needed for planning preparation (including budget ceilings) with health facilities as required by CCHP guidelines.

In Muleba in 2015/2016 (pre-intervention), allocated immunization budgets for outreach and LPG purchase were lower than what was required to deliver these services (Figure 10). Allocated budgets for electricity and vaccine distribution were about equal to required amounts. The total budget allocated for immunization services was lower than the required budget by approximately 20% (Figure 10). In Muleba in 2016/2017 (post-intervention), the allocated immunization budget for all components (outreach/mobile, Liquified Petroleum Gas (LPG) cylinders purchase, electricity, vaccine distribution) was the same as or within 5% of the required budget developed using the microplanning tool (Figure 11), indicating a marked improvement in CCHP budgeting accuracy for that year. The total budget allocated for immunization services was actually higher than the required budget by 1% (Figure 11). The shrinking gap between allocated and required funds pre- and post-intervention meant that Muleba did not face any immunization program funding deficits in 2016/2017, and all planned outreach, vaccine distributions, and immunization services were able to take place as planned.

Figure 10. Budget allocated versus required for immunization services in Muleba council in 2015/2016

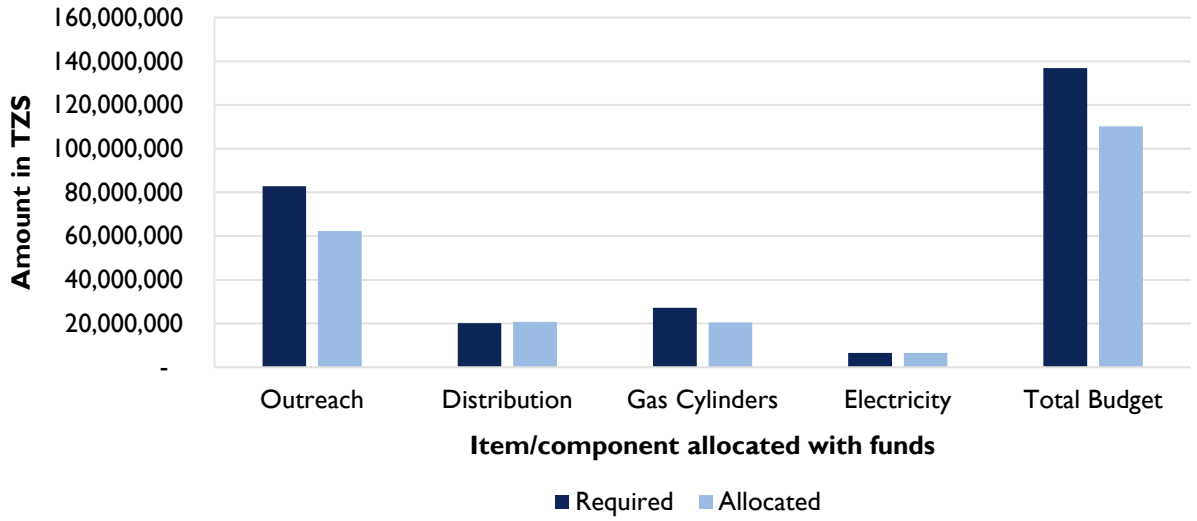
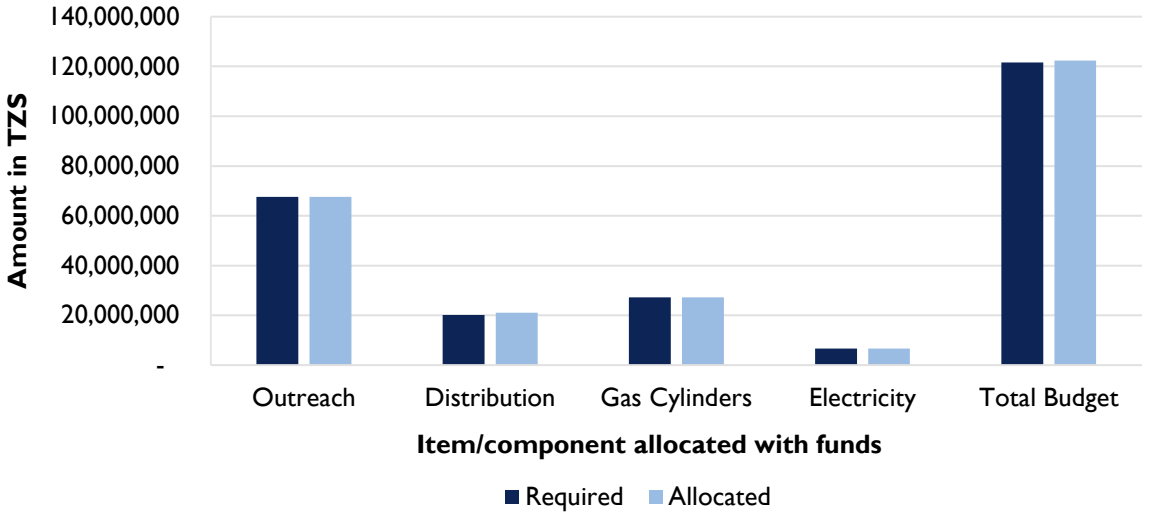
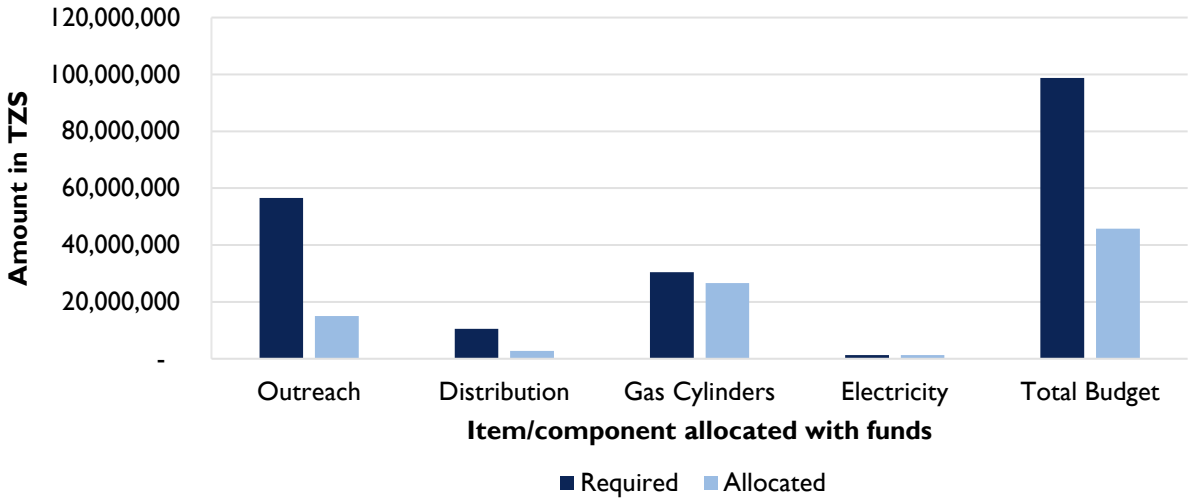


Figure 11. Budget allocated versus required for immunization services in Muleba council in 2016/2017



In contrast, in the Ngara council (control council), gaps between required and allocated immunization budgets were present in both 2015/2016 (pre-intervention period) and 2016/2017 (post-intervention period). In 2015/2016, Ngara allocated only 45% of the total budget required for immunization services (Figure 12), with allocated budgets for all components lower than required budgets (except for electricity, which was not budgeted for at all). In 2016/2017, budget gaps remained (Figure 13), with Ngara allocating more of the total budget to immunization than in the previous year (67% versus 45%[3]) but still not closing the gap entirely. Budget shortages in 2015/2016 and 2016/2017 meant that the Ngara council could not deliver needed levels of immunization services required by the community in either year.

Figure 12. Budget allocated versus required for immunization services in Ngara council in 2015/2016



[3] The increase in the budget allocation from 45% in 2015/2016 to 67% in Ngara in 2016/2017 was likely a result of sensitization of health care workers by MCSP and MCSP-supported training of HFGCs.

Figure 13. Budget allocated versus required for immunization services in Ngara council in 2016/2017

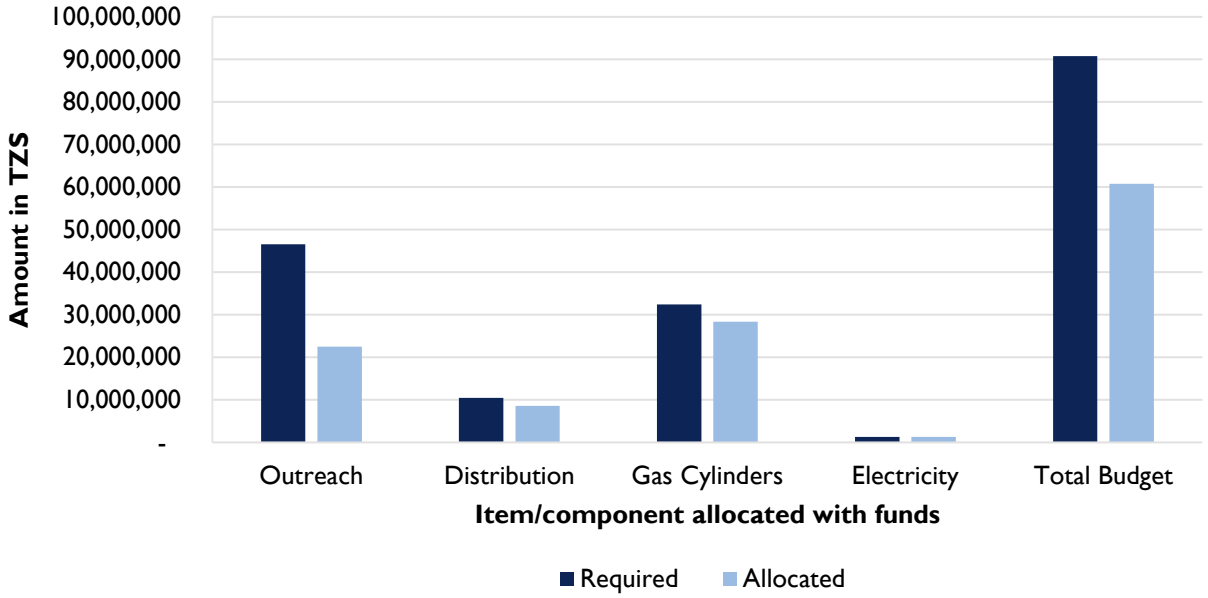


Figure 14. Comparison of percentage of budget allocated for immunization operational cost in 2016/2017

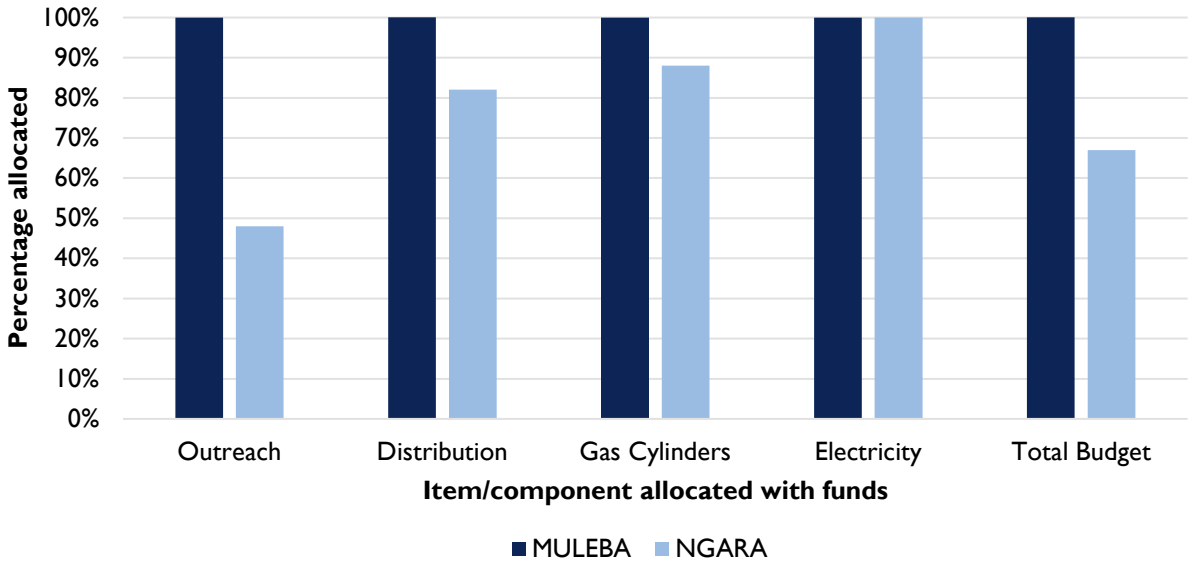
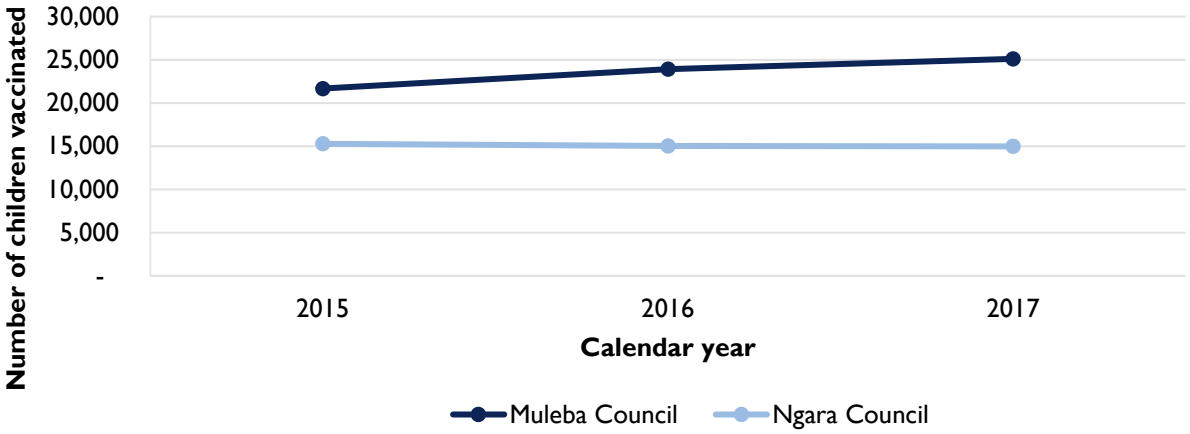


Figure 14 shows that post-intervention, Muleba's allocated budget matched its required budget for outreach, vaccine distribution, purchase of LPG, electricity, and immunization costs overall. In Ngara, the control site, improvements in budgeting were not as marked in 2016/2017, as allocations fell short of requirements in each category except electricity.

Figure 15. Children receiving pentavalent vaccine 2015 to 2017 in Muleba and Ngara Councils



Importantly, accurate CCHP budgeting may have played a role in increasing immunization coverage in Muleba council. While direct attribution of results is difficult, Figure 15 shows that Penta 3 coverage in Muleba increased between 2015 and 2017, whereas the number of children vaccinated with Penta 3 remained unchanged for the same time period in Ngara. This suggests that strengthening CCHP planning may be an important and effective way to increase coverage of critical health services.

Immunization Budget Allocations versus Requirements: Recommendations/Next Steps

Given anticipated budget shortfalls in Ngara in 2016/2017, MCSP worked with the Kagera RHMT, Ngara CHMT, and Ngara council planning officer to put emergency plans in place to avoid cancellation of outreach services and purchase of LPG cylinders, both of which would have compromised immunization service delivery. Recommendations included:

- Using the window for CCHP budget review in December 2016 to reallocate funds from lower-priority activities to immunization outreach and LPG cylinder purchase
- Combining non-immunization-related distribution activities with vaccine distribution activities to save costs (i.e., become more efficient in distribution of health supplies): This was proposed as a short-term measure to fill the vaccine distribution to the health facilities gap while waiting for the midyear review to accommodate cost for distribution on a monthly basis.
- Using the microplanning tool to prepare the 2017/2018 CCHP to avoid the situation repeating itself the following year

Step 5: Scaling Up Use of the Microplanning Tool

In January 2017, the Kagera RHMT and MCSP provided technical assistance in the 2017/2018 CCHP planning sessions with the Muleba, Ngara, and Bukoba councils. Similar to 2016/2017 discussions in Muleba, an objective of these sessions was to support CHPTs in use of the microplanning tool to ensure inclusion of immunization operational costs in CCHP planning. Soon thereafter, an additional three councils (Karagwe, Kyerwa, and Missenyi) adopted the microplanning tool in CCHP planning, bringing the total to six councils in Kagera Region using the tool for improved immunization planning and budgeting.

Regions outside of Kagera also began using the microplanning tool in CCHP immunization planning with MCSP support. Councils in Shinyanga, Tabora, and Simiyu regions adopted the tool for 2017/2018 planning, meaning nationally, 19 councils in four regions used the microplanning tool in 2017/2018 CCHP planning with MCSP support.

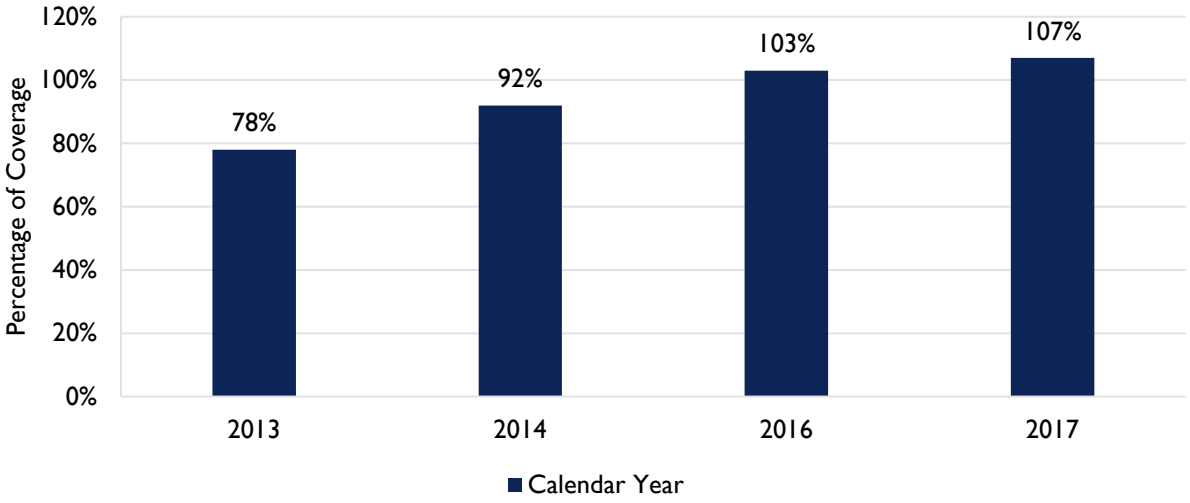
In late 2017, following nearly 2 years of implementation support, MCSP organized a stakeholder meeting in Kagera to share and discuss lessons learned, successes, challenges, and specific recommendations for scaling up approaches identified during the activity. The meeting was attended by representatives from all levels of the health system.[4] Topics discussed included:

- Findings from the original 2013 and 2014 baseline assessments
- A summary of the microplanning tool development process
- Capacity-building support (over and above microplanning support) provided to HFGCs, health facility workers, and council members to strengthen CCHP planning and budgeting, including:
    - Helping CHMTs more easily compile health facility plans
    - Training health care workers from all health facilities on microplanning
    - Orienting HFGC members on their roles in planning
    - Supporting preplanning sessions

Muleba council members also presented key achievements and successes in improving immunization service coverage following use of the microplanning tool. Successes included:

- All health facilities had LPG cylinders during 2016/2017.
- Over 90% of all planned immunization outreach sessions were conducted, and health workers and community health workers were paid their outreach allowances.
- Distribution of vaccines and related supplies was conducted as planned, and all health facilities correctly forecasted their vaccine and related supplies needs.
- Most importantly, Muleba achieved and maintained Penta 3 vaccination coverage above 100%[5] in 2016 and 2017 (Figure 16).

Figure 16. Pentavalent vaccine coverage in Muleba, 2013–2017.



[4] From national level: representatives from PORALG and the IVD Program. From Kagera: regional administrative secretary, regional medical officer, regional health secretary, and regional immunization and vaccine officer. From district level: district executive directors, district planning officers, district medical officers, district health secretaries, and district immunization and vaccine officers from all eight councils in Kagera. From health facility level: four health facility in-charges from Muleba. From community level: four HFGC chairs.

[5] Coverage rates above 100% may be a result of inaccurate population size estimations, receipt of services from clients from outside of the service delivery catchment area, or other factors.

After dissemination of findings, meeting participants discussed remaining challenges, including delays in fund disbursements from the central government to councils and the lack of sufficient trained health personnel in the councils. Since representatives came from all levels of the health system, recommendations related to each level were taken for further discussion and action.

Finally, meeting participants from all councils agreed to adapt lessons learned in Muleba for use in 2018/2019 CCHP planning. Participants thought that CCHP strengthening through microplanning at health facility level was highly relevant and timely, in light of the government's recent decision to send funds directly to health facilities rather than sending funds to be managed at council level. Participants also recommended that the microplanning tool be adapted to include other technical areas in addition to immunization so that health facilities can use the tool to prepare comprehensive health facility plans in the future.

Conclusions and Way Forward

Improving annual planning at the council level must start with improving planning at the health facility level (the point of service delivery). Lessons learned in this activity include:

- Involving health facilities (health facility staff and HFGCs) in the process of planning is critical in terms of developing reasonable and realistic council-level plans and budgets.
- Building capacity of health facilities in planning and budgeting is critical to effective planning and budgeting at that level.
- Uniform, standardized planning templates for health facilities are needed so that facility inputs can be easily incorporated into CCHPs at council level.
- CHMTs need capacity-building support so that they can better assist with health facility planning and CCHP development.
- Once plans are developed, health facilities and councils need additional technical support to implement plans effectively. Supportive supervision, routine monitoring of HMIS data, and feedback from higher levels are needed to ensure that health services are being delivered as expected.

These lessons learned and recommendations can and should be applied to other technical areas in addition to immunization to increase coverage of all critical health services.

A final report containing these lessons learned will be disseminated in different fora within Tanzania and internationally. In its final year, MCSP will also continue to support the remaining 18 focused councils in four regions (Shinyanga, Tabora, Kagera, and Simiyu) to strengthen comprehensive health planning, ultimately with an eye toward improving immunization coverage and reducing the incidence of VPDs in these regions.

Annex 1. Follow-Up Questionnaire: Linking Microplanning with Comprehensive Council Health Plan (2015/2016)

	Questions	Response		
1	Was the Comprehensive Council Health Plan (CCHP) shared with all council health management team members?			
	a) If yes, how was it shared?			
2	Was the CCHP shared with all health facilities?			
	a) If yes, how was it shared? See the copy of document used to share.			
3	How much was allocated to support immunization services?			
	a) Outreach/mobile (allowances and transport cost)			
	b) Distribution of vaccines and related supplies			
	c) Liquefied petroleum gas (LPG) cylinder refilling and procurement of additional cylinders			
	d) Payment of electricity bills to health facilities using electricity			
4	What was the minimum cost of running immunization services?			
	a) Outreach/mobile (allowances and transport cost)			
	b) Distribution of vaccines and related supplies			
	c) LPG cylinder refilling and procurement of additional cylinders			
	d) Payment of electricity bills to health facilities using electricity			
5	Complete the budget allocated and minimum cost required	Required	Allocated	Percentage Allocated
	a) Outreach/mobile (allowances and transport cost)			
	b) Distribution of vaccines and related supplies			
	c) LPG cylinder refilling and procurement of additional cylinders			
	d) Payment of electricity bills to health facilities using electricity			
TOTAL				
6	If funds allocated were less than required, how were immunization services conducted given the deficit? (All planned outreach was conducted, LPG cylinders available, vaccines and related supplies distribution done as planned, etc.)			
7	Were all funds for 2015/2016 released to support immunization activities?			
8	In case funds delayed, how did you handle the situation to minimize the impact?			

Annex 2. Follow-Up Questionnaire-Linking Microplanning with Comprehensive Council Health Plan (2016/2017)

	Questions	Response		
1	Has the Comprehensive Council Health Plan (CCHP) been approved?			
	a) If yes, see the CCHP.			
	b) If no, when is it expected?			
2	Has the CCHP been shared to all council health management team members?			
	a) If yes, how was it shared?			
3	Has the CCHP been shared with all health facilities?			
	a) If yes, how? See the copy of document used to share.			
4	How much has been allocated to support immunization services?			
	a) Outreach/mobile (allowances and transport cost)			
	b) Distribution of vaccines and related supplies			
	c) Liquefied petroleum gas (LPG) cylinder refilling and procurement of additional cylinders			
	d) Payment of electricity bills to health facilities using electricity			
5	What is the minimum cost of running immunization services based on microplans?			
	a) Outreach/mobile (allowances and transport cost)			
	b) Distribution of vaccines and related supplies			
	c) LPG cylinder refilling and procurement of additional cylinders			
	d) Payment of electricity bills to health facilities using electricity			
6	Complete the budget allocated and minimum cost required	Required	Allocated	Percentage Allocated
	a) Outreach/mobile (allowances and transport cost)			
	b) Distribution of vaccines and related supplies			
	c) LPG cylinder refilling and procurement of additional cylinders			
	d) Payment of electricity bills to health facilities using electricity			
TOTAL				
7	If funds allocated were less than required, how will you ensure immunization services are not affected? (All planned outreach are conducted, LPG cylinders available, vaccines and related supplies are distributed as planned, etc.)			
8	Have funds for 2016/2017 been released to support the ongoing activities?			
9	If funds are not released, when do you expect to receive the funds based on last years' experience?			
10	In case funds are delayed, how do you handle the situation to minimize the impact?			