implementation of comprehensive council health plan: a case of maternal health services in Rukwa region, Tanzania

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IMPLEMENTATION OF COMPREHENSIVECOUNCIL HEALTH PLAN: A CASE OF MATERNAL HEALTH SERVICES IN RUKWA REGION, TANZANIA

By

Nicholaus Kennedy

A Dissertation Submitted in (Partial) Fulfillment of the Requirements for the Degree of Master of Public Health of

Muhimbili University of Health and Allied Sciences
October, 2019

CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance by Muhimbili University of Health and Allied Sciences a dissertation entitled: **"An Assessment of Implementation of Comprehensive Council Health Plan: A case of Maternal Health Services in Rukwa Region, Tanzania",** in (partial) fulfillment of the requirements for the degree of Master of Public Health of Muhimbili University of Health and Allied Sciences.

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Dr. Gasto Frumence

Supervisor

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Date

DECLARATION AND COPYRIGHT

I, **Nicholaus, Kennedy,** declare that this **dissertation** is my own original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

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DEDICATION

I dedicate this dissertation work to the memory of my father Nicholaus Kritha Mahitha, my living mother Dativa Nicholaus Kritha and my family for their encouragement and support. My special thanks to my family; my wife Joyce Kennedy Kyauke, my children; Hellen Kennedy Kyauke, Eliana Kennedy Kyauke and Herbert Kennedy Kyauke for being there for me and for their tolerance and support throughout my studies. My special thanks to my young brother Emmanuel Nicholaus Kyauke without forgetting Jesca Christian Kyauke, Paulina Krita Mahitha, Josephina Kritha Mahitha, Christian Kritha Mahitha and Magdalena Kimosso. My appreciation also to the late Kritha Mahita, Rosada Kritha, Krisensia Kritha and Kelvin Christian Kyauke, I missed them every day.

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ABSTRACT

Background: Preparation of Comprehensive Councils Health Plans (CCHP) in Tanzania mainland is well guided with well stipulated guideline and Strategic Health Plans. The government has facilitated the process of preparing CCHPs by introducing the use of planning software and tools. In the implementation of CCHPs interventions, maternal health services have been receiving a considerable amount of support to ensure that the plans are well implemented, and their indictors are achieved each year.

Objectives: The main objective of this study was to to assess how Councils in Rukwa region have been able (or not able) to implement the planned CCHP maternal health service interventions

Methods: The study employed an exploratory qualitative study. Data collection was conducted through FGDs involving a total of with 41 participants from CHMTs from four councils in Rukwa Region. Data were also collected by reviewing CCHPs documented interventions for 2017/2018 from four councils in Rukwa region. A thematic approach was employed in analyzing the qualitative data obtained from the field.

Results: Enabling factors for the implementation of planned CCHP maternal health services interventions in Rukwa region's councils include: health facility participatory in planning; partner contribution toward maternal health; direct health financing system; centralized web-based planning and reporting software; and, good communication and coordination system. In addition prohibiting factors for the effective implementation of CCHP were identified, namely: limited maternal health interventions at the community level; lack of maternity waiting homes; inadequate specific supportive supervision; limited referral transport facilities; inadequate technical package; late disbursement of funds; limited human resources; limited planning, budgeting and management capacity at HFs level; inadequate monitoring and

evaluation; and, low quality and unreliable data at the facility level. The implementers' opinions on how to improve the implementation of CCHP include: partners' maternal interventions contribution to the CCHP; community sensitization on maternal health; construction of maternity waiting homes; training of HFs planning team; the use of bylaws at the community and council level to reduce incidents of home delivery; review of guidelines for health plans; health education package at the community; presence of M & E personnel at the council level; and, timely quarterly fund disbursement.

Conclusion: In Tanzania, the preparation of CCHPs at the council level is well articulated. Planning for CCHPs has been found to be participatory by all stakeholders in all the councils visited. However, the implementation process at the council level still requires more inclusion and proper implementation of all planned maternal health intervention and capacity building to HFs planning team and HFGCs. Several challenges should be addressed for efficiency and effective implementation of CCHP to achieve the desired indicators. The findings of this study give room for more improvements in CCHPs implementation at the district, regional and national levels.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
BEmONC	Basic Emergency Obstetric and Newborn Care
AMREF	Africa Medical & Research Foundation, Inc.
BANC	Basic Antenatal Care
CCHP	Comprehensive Council Health Plan
CEmONC	Comprehensive Emergency Obstetric and Newborn Care services
DED	District Executive Director
DHFF	Direct Health Facility Financing
DMO	District Medical Officer
DPLO	District Planning Officer
FFARS	Facility Financial Accounting and Reporting System
HFGC	Health Facility Governing Committee
HFGCs	Health Facility Governing Committees
HFs	Health Facilities
HMIS	Health Management Information System
HSSP IV	Health Sector Strategic Plan IV
HSSP IV	Health Sector Strategic Plan IV - 2015-2020
LGAs	Local Government Authorities
MoHCDGEC	Ministry of Health Community Development, Gender, Elderly and Children
MTEF	Mid Term Expenditure Budget Framework
NMCP	National Malaria Control Programme
NTLP	National Tuberculosis and leprosy Programme
PO- RALG	President Office- Regional Administration and Local Government
TDHS	Tanzania Demographic Health Survey
TSHS	Tanzanian Shillings
WDCs	Ward Development Committees

DEFINITION OF TERMS

Activity: Is the action taken or work performed in order to produce a given target (MoHCDGEC-Tanzania, 2011).

Target: Is the action taken or work performed in order to produce a given objective (MoHCDGEC-Tanzania, 2011).

Health Budget: A health budget is the portion of the national budget allocated to the health sector, including all ministries and agencies involved in health-related activities (Chatora, 2004).

Burden of Disease: It is a summary measure of a population health (in a district) by combining data on mortality and morbidity. (Harvard School of Public Health, 1990).

Comprehensive Council Health Plan: Annual health and social welfare plan for Council which collates the health and social welfare plans at all levels and involves all stakeholders (MoHCDGEC-Tanzania, 2011).

Comprehensive Council Health Plan Implementation: The execution of annual health and social welfare plan for a council which collates the health and social welfare plans at all levels and involve all stakeholders to achieve the set targets and indicators

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 (MoHCDGEC-Tanzania, 2011).

Health Planning: The orderly process of defining health problems, identifying unmet needs and surveying the resources to meet them, establishing priority goals that are realistic and feasible, and projecting administrative action, concerned not only with the adequacy, efficacy and efficiency of health services but also with those factors of ecology and of social and individual behavior that affect the health of the individual and the community (Hogarth, 2011).

Health Indicator: Is a measure designed to summarize information about a given priority topic in population health or health system performance (CIHI-Canada, 2013).

Health Intervention: Is an act performed for, with or on behalf of a person or population whose purpose is to assess, improve, maintain, promote or modify health, functioning or health conditions (Hogarth, 2011).

Health Program Implementation: The translation of the National Health Policy/Strategy/Plan (and in some cases its Medium-Term Expenditure Framework), into annual operational plans that form the basis for program implementation (WHO, 2010).

Interventions: A set of actions to be taken that addresses a solution to a particular problem or disease (Prime Minister's Office, 2011).

Maternal Health: Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. A reduction in maternal mortality has traditionally been used as a critical measure of progress in improving maternal health (Hogarth, 2011).

Maternal Mortality Ratio: Is the number of maternal deaths per 100,000 live births, a measure of the risk of death once a woman has become pregnant (Morse, 2014).

Maternal Mortality Rate: The number of maternal deaths (direct and indirect) in a given period per 100,000 women of reproductive age during the same time period (Morse, 2014).

Monitoring and evaluation: Refers to the progress reviews undertaken periodically by stakeholders supported by established reactive mechanisms for corrective actions; and the performance evaluation based on a set of indicators and well defined baselines and targets (WHO, 2010).

Morbidity: Any departure, subjective or objective, from a state of physiological or psychological well-being. In practice, morbidity encompasses disease, injury, and disability (CDC, 2008).

Mortality: The state of being mortal, or susceptible to death (Wikipedia, 2018).

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Postpartum (or postnatal) period: begins immediately after the birth of a child as the mother's body, including hormone levels and uterus size, returns to a non-pregnant state. The terms are commonly used to refer to the first 6 weeks following childbirth and can last up to 6 month (Hogarth, 2011).

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CHAPTER ONE

1.0 INTRODUCTION

1.1Background

Studies on plans execution have shown that plans execution is a considerable challenge in various organizations. Nevertheless, several studies highlight only the theoretical considerations without focusing on the actual process mechanisms of the implementation aspects. Implementation problems involve failing to periodically alter the plan or adapt it to changes in the business environment, deviation from original objectives, and lack of confidence about success (Magbool, 2014).

Magbool further argues that in order to improve execution in various programs, certain challenges must be tackled. These include inadequate or unavailable resources, poor communication of the strategy to the organization, ill-defined action plans, ill-defined accountabilities, and organizational/cultural barriers.

In many countries, and particularly in Africa, governments and health ministries are given the responsibility of ensuring that health plans and implementation usually occurs in yearly cycles. Statistics indicate clearly that existing district health planning and implementation processes have not been able to cope with the development challenges, including AIDS, maternity related complications, communicable diseases and others (Chatora, 2004). Health plans, however, are consequently reduced to mere words on paper. Effective implementation to achieve the desired results requires reliable implementing organization. In most cases, it is the state's public service or bureaucracy which is designated as the implementing agent. The effectiveness of the government organization's work will determine the final output of the health plan being devised or implemented (Turner and Hulme, 1997).

In Tanzania, policy makers, planners, health managers and other stakeholders are involved in the overall provision of quality health services in the country. The provision of key health services to the entire population could generally be assessed through the evaluation of key

health status indicators of the population which included in the Comprehensive Council health Plans (MoHCDGEC-Tanzania, 2016).

The Ministry of Health, Community Development, Gender, Elderly, and Children (MoHCDGEC) together with PO-RALG office have 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 wellbeing outcomes

The Government of Tanzania through the MoHCDGEC 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. All these should be planned and implemented in the Comprehensive Council Health Plans (CCHPs)

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 Strategies and Policies. Local priorities should also be included in the preparation of CCHPs. The goal is to improve health and social welfare services through decentralization of decision.

Among other CCHP interventions, the preparation and Implementation of CCHP interventions in Tanzania, and especially maternal health services, is an area which is supported by many stakeholders in addressing gaps and issues in the provision of maternal health services whereby most of the council CCHPs have addressed this indicator in their annual health plans. As stated in Tanzania's Health Sector Strategic Plan IV - July 2015 – June 2020, Maternal Mortality Rate has increasingly been high in most of the districts in the country, including those in Rukwa region. According to the National Bureau of Statistics, Tanzania registered a total of 454 MMR in the year 2010 and 556 MMR in the year 2015 ((NBS-TDH-Tanzania, 2015). Nationwide, maternal mortality decline is slow, and statistics show that maternal mortality within institutions is not declining.

1.2 Problem Statement

The government of Tanzania through the MoHCDGEC and PO-RALG authorities has restated its commitment towards ensuring that health services are provided at high quality at the community level. This commitment is stated through the planned annual CCHP interventions to achieve outcome and impact indicators. The government has shown the good trends of support on health sector to ensure that CCHP interventions, including maternal health services, are well implemented.

Despite maternal health services receiving a considerable support in the preparation of CCHP in the country in general and in councils for Rukwa region, its related output and impact indicators, particularly MMR, have not been achieved as expected. The Tanzania Demographic Health Survey 2015indicates that nationwide wide MMR in the years 2010 and 2015 were 454 and 556, respectively (NBS-TDH-Tanzania, 2015)(NBS-TDH-Tanzania, 2015)(NBS-TDH-Tanzania, 2015). Data shows that in Rukwa Region, MMR was 120, 117 and 132 respectively for the year 2015, 2016 and 2017 respectively. Similar situation was observed in 2015, 2016 and 2017 whereby MMR in the four councils in Rukwa region, namely: Sumbawanga Municipal Council were 208, 211, and 261; Nkasi District Council 171, 112, and 141; Kalambo District Council 56, 124 and 58; and in Sumbawanga District Council 31, 33 and 50 respectively for each year.

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Previous studies have examined the process of developing CCHP, including barriers hindering effective community participation in developing CCHP (Kilewo eta Frumence, 2015). Other studies have shown that there is a progress towards identification of community needs and priorities (Kamuzora et al., 2013). However, only a limited number of studies have been conducted to assess the manner and extent to which the implementation of planned CCHP interventions has achieved output and impact indicators. It is against this background that this study aims at assessing the implementation of the Comprehensive Council Health Plan in the four administrative councils in Rukwa Region, in Tanzania, using MMR as a proxy indicator of the status of maternal health services.

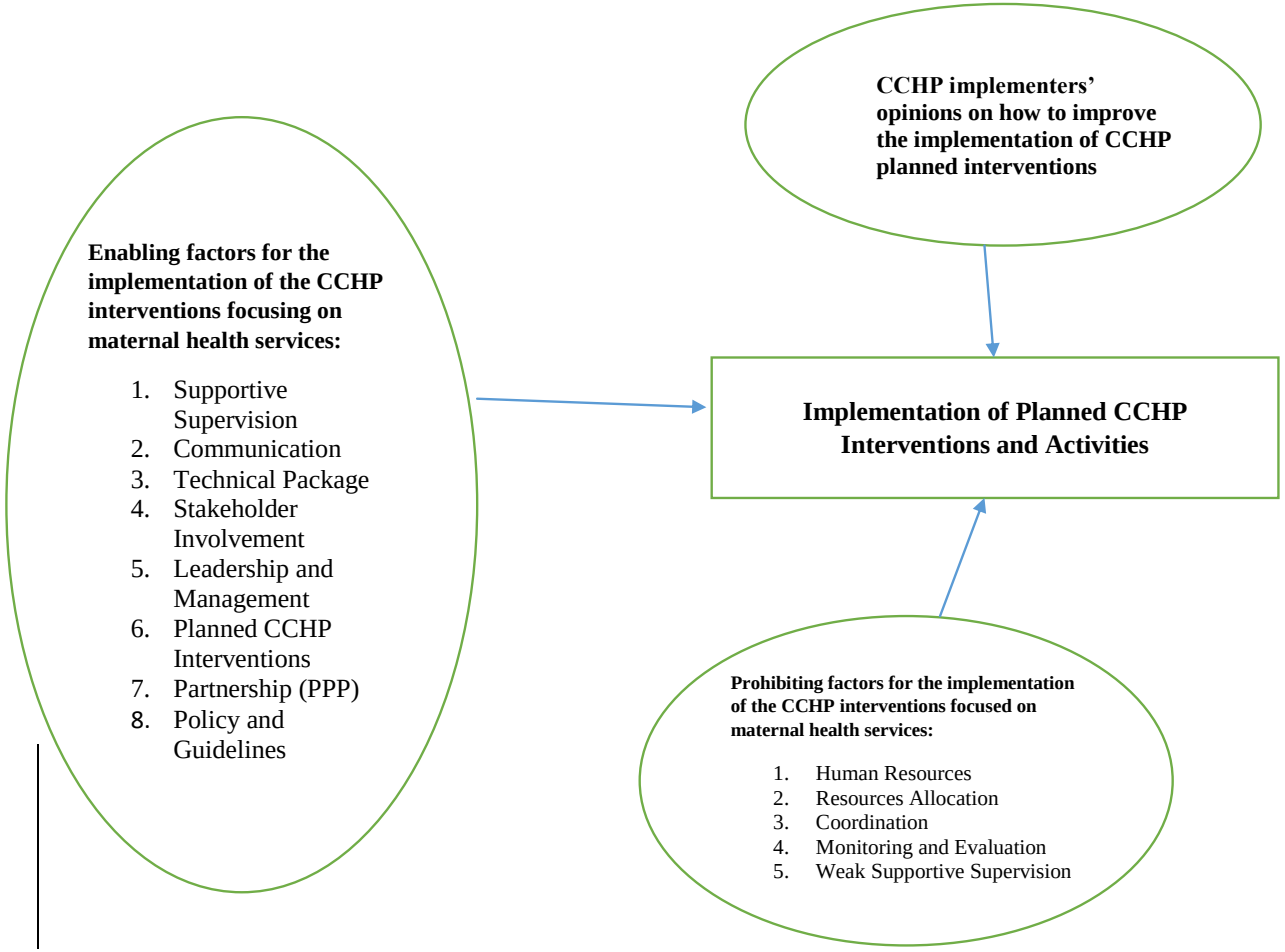
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1.3 Conceptual Framework

The conceptual framework for this study focuses on three important components affecting the implementation of CCHP interventions and output indicators focusing on maternal health services. The first component includes enabling factors for the implementation of the CCHP interventions focusing on maternal health services. The factors are: supportive supervision, good communication, technical package, stakeholder involvement, leadership and management, planned CCHP interventions, partnership (PPP) and using the appropriate policy and guidelines. The second component focuses on the prohibiting factors for the implementation of the CCHP interventions focusing specifically on maternal health services. These factors are: human resources, resources allocation, monitoring and evaluation, weak supportive supervision and coordination. The third component comprises Opinions and perceptions of CCHP implementers on how to improve the implementation of CCHP planned interventions:

Figure 1: Conceptual Framework for Implementation of CCHP Interventions



1.4 Rationale of the study

The findings from this research will be useful at the council and regional levels in addressing the facilitating and prohibiting factors for the effective implementation of Comprehensive Health Plans. The findings will particularly inform the efforts aimed at improving the ways that councils use in implementing health plans and their views on how to improve the implementation of CCHP planned interventions at the council level. Various managerial organs at the councils will use the findings to improve the implementation of Council Health Plans through advocating the application of the recommendations from this study among various stakeholders and health workers. Furthermore, the study gives more insight on the new way of implementing the CCHP at council and HFs level.

1.5 Research Questions

1.5.1 Broad research question

How Councils in Rukwa region have been able (or not able) to implement the planned CCHP maternal health service interventions?

1.5.2 Research questions

1. What are the enabling factors for the implementation of planned CCHP maternal health services interventions in Rukwa region's councils?
2. What are the prohibiting factors for the implementation of planned CCHP maternal health services interventions in Rukwa region's councils?
3. What are the CCHP implementers' opinions on how to improve the implementation of planned CCHP maternal health services interventions in Rukwa Region's councils?

1.6 Objectives

1.6.1 Broad objective

To explore the implementation of planned CCHP maternal health services interventions in Rukwa region's councils.

1.6.2 Specific objective

1. To assess the enabling factors for the implementation of planned CCHP maternal health services interventions in Rukwa region's councils.
2. To assess the prohibiting factors for the implementation of planned CCHP maternal health services interventions in Rukwa region's councils.
3. To analyze CCHP implementers' opinions on how to improve the implementation of planned CCHP maternal health services interventions in Rukwa region's councils.

CHAPTER TWO

2.0 LITERATURE REVIEW

Globally, effective plans implementation is looked at in many ways to include a large variety of criteria. However, in its simplest terms, effectiveness of planning implementation can be thought of as incorporating four basic facets. A plan is generally considered to be successfully implemented if it comes in on-schedule (time criterion), comes in on-budget (monetary criterion), achieves basically all the goals originally set for it (effectiveness criterion), and is accepted and used by the clients for whom the project was intended (client satisfaction criterion). By its basic definition, a plan comprises a defined time frame to completion, a limited budget, and a specified set of performance characteristics (Schultz, 2009).

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Further, the plan is usually targeted for use by some client, either internal or external to the organization and its planning team. It seems reasonable therefore, that any assessment of plan implementation effectiveness should at least include these four measures among others (Anyango, 2016)

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2.1 Enabling factors to the implementation of CCHP Maternal health Services interventions

There are several enabling factors for the implementation of planned CCHP maternal health service interventions. These include: Supportive Supervision, Communication, Technical Package, Stakeholders involvement, Leadership and Management, Planned CCHP Interventions, Partnership (PPP) and using the appropriate Policy and Guideline

2.1.1 Coordination

Study on Factors influencing successful implementation of the basic antenatal care approach in primary health care facilities in eThekwini district, KwaZulu-Natal shows that the development and effective use of integrated healthcare systems is an absolute necessity in the support of the delivery of low cost, high-quality care. However, this requires cooperation and coordination (Ngxongo eta Sibiya, 2013).

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As stated by (Kiwia eta Foster, 2016) findings shows that district planning teams (CHMTs) members play significant role in the coordination of CCHPs implementation in most of the districts. Planned activities are often delayed by ad hoc activities and sometimes get postponed to the next fiscal year. CHMTs do not have a good system for coordinating the implementation of the CCHPs or periodically reviewing progress in plan execution to evaluate performance.

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2.1.2 Supportive supervision

Study on Factors influencing successful implementation of the basic antenatal care approach in primary health care facilities in eThekwini district, KwaZulu-Natal shows that support from their managers play an important role. The study shows that 72 % of the facilities receives Supportive supervision to implement BANC approach from their managers' ((Ngxongo eta Sibiya, 2013)

Implementation of a district Health plan inevitably requires involvement of the state and district level officers. In the government system, lower-level functionaries can act only when approved by their superiors. The staff at lower levels are either unaware of their administrative powers or are afraid of using them. This situation will change only when the administrative powers get decentralized and the staff at lower levels learn to use those powers (Murthy, 1998)

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2.1.3 Communication

Effective communication can lead to behavior change, but, more importantly, it can lead to increased political commitment and program effectiveness by engaging a wide range of civil society sectors and by contributing to a change in the public perception of an issue. New communication tools and technologies facilitate interactive conversations, giving public health practitioners the ability to have dialogues with people from affected communities and other stakeholders. Effective communication can convey critical information, convince key individuals to support or lead an initiative, and, perhaps most importantly, change the context for public health action (Frieden, 2014).

Communication aspects should be emphasized in the implementation process seems to be a very simple one. Even though studies point out that communication is a key success factor within project implementation, communicating with employees concerning issues related to

the project implementation is frequently delayed until the changes have already crystallized (Holland, Light and Gibson, 1999).

Study on Factors Determining Project Implementation of Health Projects in Gedo Region Somalia 2016; found out that the level of communication in the organization determines the effectiveness of project implementation. The study found that poor or lack of communication result to difficulty in finishing projects (Anyango, 2016)

2.1.4 Technical package

Health program managers have a dual responsibility when managing program plans : (a) managing the technical components of the program (plans, schedules, budgets, statistical analysis, monitoring, and control involved in the various knowledge areas and processes) and (b) managing the people in such a way to motivate the team to successfully complete the anticipated goals (Neuhauser, 2007).

The most effective public health program plans are based on an evidence-based technical package: A technical package of proven interventions focuses on what is to be implemented by committing to implementation of specific interventions known to be effective. It also avoids using several interventions, many of which have only a small impact health program plan. A technical package ensures focus on the most effective, feasible, and sustainable interventions and can sometimes achieve synergy among intervention elements. Pressure to include all approaches can make the establishment of a technical package difficult; a technical package established with inclusiveness of approaches as a goal is likely to fail. The key is to identify elements that are both highly effective and scalable to reach populations of varying size, demographic composition, or geographic location, and that can be sustained over a long period. This may mean that some interventions with proven evidence of effectiveness will not be included because their effect is small, is not sustainable or cannot be scaled for population impact (Frieden, 2014).

2.1.5 Stakeholder's involvement

The most visible challenge for health promotion development in Africa arises from the fact that most programs and activities are in most cases planned, managed and controlled exclusively by professionals, especially from within the health sector. The main actors are specialists whose concept of health is based on the public health model and whose focus is on interventions revolving around curative services. Ordinary people usually participate only passively in the health promotion process (Nyamwaya, 2003).

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Study on factors Influencing Effective Implementation of Health Projects: A Case of AMREF Health Africa in Kenya by Elizabeth Maina shows that for a health project to be successfully implemented all the stakeholders in the project should be involved throughout the project implementation phases. The study established that the mechanism for engaging stakeholders should be well devised at the planning stage to avoid disputes during project implementation. The study shows that the stakeholders had considerable influence on the decision making and problem-solving processes during project implementation. Further the study also established that the stakeholders help in improving on reporting and project performance. Finally, the study found that the level through which stakeholder's can be engaged it was dependent on the organization resources, culture and time. The study found that it was beneficial for the implementing team to help in building capacity for the stakeholders as it was economically beneficial as it also contributed to cost cutting (Maina, 2016)

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2.1.6 Leadership and Management

A leader is a person who sees something that needs to be done, knows that they can help make it happen, and gets started (Groves, 2007)

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For many public health programs, implementation is essentially a management role. Even if political commitment, resources, and a technical package are in place, effective management may not be. Management of public health activities is particularly difficult because, unlike in the private sector where metrics such as product sales provide prompt feedback on performance, there is often no automatic, accurate, and affordable way to track public health program performance in real time. In addition, the impact of public health programs may not

be evident for months or years, further complicating measurement of performance (Frieden, 2014).

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Effective public health programs require accurate, timely information systems for disease or risk factor surveillance and program implementation. For this reason, every effective technical package includes surveillance and information systems that can be sustained and that provide accurate, simple, timely, and critical information on health program implementation and impact over the long term (Frieden, 2014)

2.1.7 Planned CCHP interventions

Study on the Improving the process of setting maternal health priorities and allocating resources on maternal health shows that in terms of improvement in priority setting, actual process for developing maternal health priorities should be established. Such a process should: apart from planning team specialized physician should be buy-in and involved so that the outcome of maternal health be more systematic; be explicit/transparent; and efficiency and be understood by everyone so there is a fair opportunity to argue each person's case. A long-term planning cycle is necessary and that communication between managers and clinicians should be improved. The study shows that data (both financial and outcome) was raised as a major shortcoming. As for the clinical department heads, they wanted more control of resources and stated that a better understanding of 'need' was required to determine where the resources should go. It was clearly recognized that involvement of physicians in the maternal health priority setting process is important, but less clear how this should occur due to their already extremely busy schedules. The planning team members clearly wanted better outcome measures (Mitton eta Donaldson, 2002).

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2.1.8 Partnership

Public health is increasingly complex, with key roles played by public- and private-sector partners that are critical to sustaining and improving the population's health. Coalitions are often essential to progress. Getting many organizations to collaborate can be slow and frustrating but is often crucial to create the advocacy needed to support budgetary, legislative, or regulatory change and to implement new or improved programs. Government programs are

more likely to succeed—and to be sustained—when organizations outside of government advocate for them (Frieden, 2014)

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2.1.9 Policy and Guideline adherence

To establish an effective intervention package, it is critical to understand the full range of available evidence-based strategies and policy guides, the size and characteristics of the population to be reached, the projected impact of each intervention, and the estimated cost. The more expensive or complex each intervention is, the less likely it will have broad population impact. More strategies in a technical package result in more costly and unwieldy programs with a lower likelihood of success. An analysis that determines the burden caused by each risk factor can help identify which risk factors have the greatest impact on population health and thus can lead to the greatest health improvements if addressed effectively (Frieden, 2014)

2.1.10 Monitoring and Evaluation

A well-designed M&E system ensures that quality data is regularly collected during and after the implementation of a health program. The data collected guides program implementation teams and informs decisions to be taken by actors in the health sector. To achieve a sustainable M&E system, competencies and capacities are required and assessed based on the following dimensions: technical skills; managerial skills; existence and quality of data systems; available technology; available fiscal resources; and institutional experience (MoH-Kenya, 2016).

There is a positive relationship between management and evaluation and project implementation. The study on Factors Determining Project Implementation of Health Projects In Gedo Region, Somalia 2016 found that that World Vision Somalia consider monitoring and evaluation as an important factor since adequate monitoring and evaluation gives the project manager and field officials the ability to anticipate problems thus resulting in effective project implementation In Gedo Region, Somalia (Anyango, 2016).

Monitoring is done in accordance to the prior set targets and all its activities are as predetermined during the planning phase. These activities ensure that everything is on track and can let the project managers detect early enough when deviations occur. If monitoring is conducted as expected, it is a very important management tool that acts as a basis for project evaluation since through it the concerned parties establish the sufficiency and adequacy of the available resources and whether they are optimally used and in the case of human resources if they are competently constituted to do what was planned. Basically, project monitoring involves a careful and ongoing assessment of how the project is being implemented against initially set plans, activities, and other deliverables (Magbool, 2014).

A study conducted by (Mboera *et al.*, 2015) on investigation of 75 countries annual plans implementation shows that 77% of these countries are conducting annual reviews of their health sectors. The study shows that annual review helps to measure if implementation of a strategic plan and annual plans indicators are reached. Annual reviews are often conducted after midterm review are conducted. In Tanzania Annual review of national health plans shows that, most indicators and targets that are implemented have not been sufficient to provide a comprehensive picture of progress and performance of strategic plans and annual plans (Mboera *et al.*, 2015)

2.2 Prohibiting factors to the implementation of CCHP Maternal Health Services interventions

There are several prohibiting factors to the implementation of planned CCHP maternal health service interventions. These include: Human Resources, Resources allocation, Coordination, Monitoring and Evaluation and weak supportive supervision

2.2.1 Human Resource

Report on the activities of the World Health Organization in the African countries 1998, shows that factors that constrained implementation of health activities involves limited human for some programmers, (WHO, 1998).

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The human resource crisis is caused by many factors such as inadequate production in some countries, inability to hire in others, brain drain, poor motivation, conflict of interest, corruption, and misuse of resources including time in most countries. In many countries, an overwhelming majority of health workers are concentrated in a few urban areas. All categories, particularly doctors and nurses, are in short supply compared to the standards of population ratios for nurses and other health workers. All these contributed on failing to achieve planned indictors in health sector (WHO, 2006)

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According to (Kiwia eta Foster, 2016) districts in Lindi Region face an acute shortage of health workers, which ultimately affects the delivery of health services. Several issues were cited as reasons for the shortage of staff, including remoteness of the districts, delayed salaries and other statutory benefits, poor working environment, lack of adequate housing, and cumbersome recruitment procedures. CHMT staff interviewed noted that the centralized recruitment by the Public Service Management takes 6-12 months and sometimes results in posting staff who are not interested in working in that district or do not have the skill set matching the open position.

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2.2.2 Resources allocation

Implementation of health service activities is largely dependent on central government funding. In Tanzania health plans depend on two main sources of funds from the central government: block grants for personal emolument and other charges, and the basket funds for the operation of service delivery. However, the findings shows that excessive delays over funds from the central government, particularly basket funds affect activities implementation. (Kilewo eta Frumence, 2015)

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Study on challenges affecting implementation of health Sector Basket Fund activities in the Tanzania Local Government shows that challenges affecting implementation of health sector basket fund activities in the Tanzania local government includes delayed disbursement of funds, merged accounts system of the councils, transport facilities problem, loss of funds request letters, poor team working from council co-workers, procurement (time, people and

complexity), MSD (distance, monopoly), ad hoc activities and late submission of activities implementation reports (Mapunda eta Swyinney, 2015).

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The process of delayed and insufficient domestic resources included dropping activities, or transferring funds across sectors, affect implementation of health plans. There is a concern that although communities are engaged with district managers in the development of health plans, decisions to re-allocate funds across sectors or to cancel or modify planned activities are usually made by district stakeholders without lower level consultation. This is still a challenge (Borghi *et al.*, 2018)

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Districts depends on donor-supported activities by integrating them into the CCHP. The CHMTs reported involving stakeholders in various ways during the planning process. Some stakeholders provide activities/ideas which need to be included in the CCHP and inject funds directly, while others do not contribute funds directly to the district but rather provide in-kind support. It was also observed that CCHPs in most districts depend heavily on donor funds for implementation. To large extent CHMTs do not have mechanisms in place to implement activities in case donor funds get delayed (Kiwia eta Foster, 2016).

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According to (Ngxongo eta Sibiya, 2013) Study on Factors influencing successful implementation of the basic antenatal care approach in primary health care facilities in eThekwini district, Kwa Zulu-Natal shows that Constant availability of material resources is also noted as an important factor that influenced the successful implementation of BANC approach. The study shows that certain facilities indicated that they had stopped providing BANC because they had run out of BANC checklists and they perform poor in implementing BANC approach. This indicates the need for the organization to ensure that material resources are available and sustained.

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Study by Chitama *et al.,* 2011 has shown that there is little technical support to district planning team in allocation of resources regarding the maternal health. The few resources available are more likely to be allocated to interventions with a negligible improvement in FMNCH outcomes. In this context, capacity building through priority setting trainings and other activities like technical and supportive supervisions, mentoring and coaching are very

much needed. In the same vein, the issue of low skills and knowledge of the priority setting team members was reflected in the capacity to use the available priority setting tools. The priority setting tool is required for priority setting to target resources to interventions addressing the largest share of burden of disease. However, we the study found the opposite scenario. The findings show that interventions addressing the lower BOD were allocated a reasonable share of expenditures and the corresponding outcome indicators for these interventions are worse than the national averages. However, explanations for it would be either the inaccurate information, the priority setting teams lack necessary capacity to analyze available information and proper use of the priority setting tool. In the event of low capacity, priority setting teams tend to opt for simple solutions to complex problems resulting in less improvement of the desired outcomes.

2.2.3 Weak Supportive supervision

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Findings from (Kilewo eta Frumence, 2015) shows that weak supportive super-vision from CHMT to lower-level facilities caused by insufficient human resources as well as lack of reliable means of transport contribute much on the quality of health service delivery at health facility level. High shortage of human resources in the health sector, particularly in the rural areas, affects the quality of health services since there is no frequent supportive supervision hence inadequate monitoring of health plans activities**.**

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In Tanzania, Routine CHMTs supportive supervision has often been reported as infrequent, inefficient and ineffective in tackling performance gaps (Renggli et al., 2018) Although national supportive supervision guidelines exist, they are not followed in practice. Also, councils have been using a general supportive supervision checklist to develop their own list, which makes comparison between councils impossible. Routine CHMT supportive supervision concentrates on quantity (reviewing record books) with insufficient focus on quality elements (delivery processes). It is often more of an inspection, whereas the supportive element is hardly practiced. Supportive supervision was also reported as fragmented, incomplete and inconsistent with no or solely negative feedback (Renggli *et al.*, 2018). CHMTs struggle to systematically follow-up and report back about issues identified during

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supportive supervision. Additionally, there is a lack of accountability of CHMTs to RHMTs and supervision of CHMTs by RHMTs is weak (Renggli *et al.*, 2018).

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Poor routine CHMT supportive supervision has been reported to slow down progress in quality improvement, negatively affecting job satisfaction, staff presence, performance, motivation and retention as well as impairing other quality improvement interventions (Renggli *et al.*, 2018).

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2.2.4 Coordination

Failing to involve all actors and institutions at local level resulted in an inability to generate comprehensive responses to solve community needs. According to (Mosquera *et al.*, 2013) The study shows that public institution fails to coordinate community involvement during planning phase to the implementation.

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Health care coordination interventions represent a wide range of approaches at the service delivery and systems level. Their effectiveness is most likely dependent upon appropriate matching addressing health interventions and the way the coordination approaches are handled at all levels. Most of the health care facilities fails to deliver their services due to the gape of coordination from the high level. Healthcare workers are missing necessary components and package in delivering their services due to poor coordination in most of developing countries (Vandana Sundaram *et al.*, 2007)

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2.3 CCHPs' implementers' perceptions on how best to improve the implementation of CCHP planned interventions

2.3.1 Health Management bodies

Report on the activities of the World Health Organization in the African countries 1998, shows that implementation of organization health activities depend on availability of relevant Management frameworks and technical tools; increase in human resources, successful mobilization of financial resources, team spirit, better collaboration between units and divisions; delegation and decentralization; improved partnerships; better communication and collaboration; and commitment (WHO, 1998).

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Implementation of a district Health plan inevitably requires involvement of the state and district level officers. In the government system, lower-level functionaries can act only when approved by their superiors. The staff at lower levels are either unaware of their administrative powers or are afraid of using them. This situation will change only when the administrative powers get decentralized and the staff at lower levels learn to use those powers (Murthy, 1998)

Studies in Tanzania shows that there is no systematic way to determine the role of participatory organs in improving the provision of quality health services even though it is now more than two decades since Tanzania initiated decentralization. There are concerns about the quality of health services provision. Health management boards and CHMTs has the responsibility in improving the provision of quality health care in the country. The findings show that factors behind the declining provision of quality health services included the shortage of human resources, poor working equipment, lack of commitment on the part of members of the CHMT, lack of effective CHMTs' supervision, as well as the lack of good networking and collaboration with other stakeholders. The study recommends that policy makers and planners in the health sector and local government authorities should ensure that CHMTs have quality assurance as their primary goal. Also, CHMT members should be held accountable for poor quality of services in their respective areas. In addition, local government authorities should allocate adequate resources for participatory organs to execute their functions as well as improving working conditions and motivation for health professionals (Frumence, Nyamhanga eta Mwangu, 2013)

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2.3.2 Community Participation

(Kilewo eta Frumence, 2015) state that, lack of awareness on the roles and responsibilities of HFGCs. In their study indicate that members of HFGC reported that after their appointment as members of the committees, they never received any capacity building training concerning management in general and planning. For that reason, they lack management skills and knowledge to perform their duties in development and implementation of CCHP as narrated by one of the respondents.

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According to (Mosquera *et al.*, 2013) Community participation in health plans is usually dominated by the individual interests. Leaders collude with district institutions and political parties for their interest. In his study he stated that some health care team members and communities' representatives abandoned collective goals when they realized they could receive private benefits

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2.4 Knowledge gap

The literature convincingly demonstrates the existence of limited knowledge on studies regarding the actual implementation process of health plans at Regional, sub-regional and at districts level and in Tanzania as well. Reviewed Literature in Tanzania has shown that several studies have been conducted on preparation and involvements of key planners in CCHP but there is a limited knowledge on how these CCHPs achieve the planned output and impact annual indicators; the question remain: are the planned output indicators achieved as planned at council level? Also, literature review reveals that there was a little knowledge on how councils set health targets and annual output indicators, how these indicators are measured, monitored and evaluated annually, how planned health indicators data are collected, monitored, and managed at district level. The process of developing CCHP including barriers facing community participation in developing CCHP has been explored but there is limited knowledge on how the planned health interventions reach the output and impact indicators. Studies in Tanzania have shown progress towards identification of community need and priorities, increased knowledge of community representativeness about priority setting, increased transparency and accountability during planning has been in place. However, less has been studied on the actual implementation process of health plans including the CCHP in Tanzania. Generally, there is limited study on the implementation of CCHP interventions in Tanzania

CHAPTER THREE

3.0 MATERIALS AND METHODS

3.1 Study design and approach

The study employed an exploratory qualitative study design in which qualitative methods of data collection, particularly Focus Group Discussion and document review were used. The selection of the method was based on the nature of CCHP planning and Implementation. The planning and implementation process of CCHP are collective process which involve CHMTs who are the key informants and thus they provided in-depth information to this study through FGDs.

3.2 Study Area

The study was conducted in Rukwa Region which is geographically located in the Southern Highland zone of Tanzania. The region has a total of 4 councils, which are: Sumbawanga Municipal Council, Sumbawanga District Council, Nkasi District Council and Kalambo District Council. Rukwa also has a total of 230 health facilities as a region. Health facilities are also involved in the planning and implementation of health facility annual plans as part of CCHPs. In the previous years, the Council Health Management Teams (CHMTs) were only involved in preparing the CCHPs on behalf of the health facilities. However, from the financial year 2017/2018, all health facilities were facilitated to have their own Annual Health Plans which are consolidated by CHMTs to make one Council CCHP plan.

In the Financial Year 2018/2019 all health facilities prepared their own plans and funds were directly transferred from the central government to the health facilities cost center in their respective accounts. The CHMTs facilitate all the health facilities in preparing these annual

plans which are later on consolidated to make one council plan. CHMTs are responsible for management and facilitation of the entire exercise to ensure that all the planned CCHPs interventions are implemented accordingly. The CHMTs are also responsible for preparing CCHPs plan of their interventions and activities.

Rukwa region was selected as a case for this study. The Region is in the periphery zone of the country. Moreover, Rukwa has been steadily registering an increase in MMR. The region has been supported by various partners on maternal health services who contribute toward effective implementation of CCHP maternal health services interventions since 2011. The Region has one regional referral facility for complicated pregnancies as compared to other regions with more than one referral facilities from the council to regional levels.

3.3 Study Population

The study population was made of members of Council Health Management Teams (CHMTs) from the four councils found in Rukwa region. The participants are involved in the preparation of CCHPs. These participants included District Medical Officer, District Health Secretary, District Pharmacist, District Social Welfare Officer, District Health Officer, District Laboratory Technician, District Nursing Officer, District Nutritional Officer, and District Dental Officer. CHMT co-opted members involved were the District Immunization Officer, District Reproductive Health Officer and Children Affairs Coordinator. In order to obtain rich information, the study involved CHMTs from four councils who provided the required information on the implementation of CCHPs in their respective areas and in Rukwa region generally. The CHMTs were from Sumbawanga District Council, Nkasi District Council, Sumbawanga Municipal Council and Kalambo District Council.

3.4 Sample Size and Sampling

Purposeful **sampling** was employed in recruiting participants for this study. Purposeful sampling is commonly used in qualitative research. It involves selecting research participants according to the need of the study (Payls, 2008). Researchers choose the right participants who

would give a richness of information that is suitable for detailed research. Purposeful sampling technique was used to recruit the focus group discussion (FGD) participants for this study.

According to (Dolores eta Tongco, 2007), choosing the purposive sample is fundamental to the quality of the data gathered. Therefore, the reliability and competence of the informants must be ensured. The participants for this study were purposively selected based on the experience, roles and responsibilities they performed in the preparation and implementation of CCHP. The study included forty-one (41) CHMT members who are the key planners and implementers at the council level, in each of the four councils in Rukwa. On average ,11 CHMTs members were involved in the study from each council.

3.5 Data Collection Procedure, Methods and Instruments

Qualitative data was collected through Focus Group Discussion with CHMTs at the council level using an already prepared FGD guide. The FGD guide was focused on the specific objectives of this study. There was also a review of implementation reports/records using a checklist form. The information that was collected enabled the researcher to show the extent to which CCHP interventions, output and impact indicators, especially on maternal health services, have been achieved. The FGDs method with the CHMT was crucial as planning and implementation of CCHP are collective process which involve CHMTs so the FGDs provided in-depth information to this study.

There were two (2) data collection tools – FGD guides and checklist form that were developed in line with the study specific objectives or research questions. The FGD guide was used to address issues related to specific objective 1, 2 and 3. The FGDs guide was used to guide the discussion with CHMT members. The FGD guide was based on key thematic areas of the study, which include: enabling factors for the implementation of planned CCHP maternal health services interventions in Rukwa region's councils; factors hindering the effective implementation of planned CCHP maternal health services interventions in Rukwa region's councils and CCHP implementers' views and perceptions on how to improve the implementation of planned CCHP maternal health services interventions in Rukwa region's

councils. In addition, the FGD guide was developed based on literature review and working experience in this area. The second data collection tool was a checklist form which was used to capture information from the reviewed CCHP implementation reports of 2017/2018 from the 4 councils in Rukwa Region.

The process of data collection involved two (2) processes. The first data collection process involved FGD with members from CHMTs. Data was collected by the principal investigator who was assisted by a research assistant. The research assistant was trained on the overview of CCHP preparation of planning and implementation. In addition, the research assistant was oriented on how to use the FGD interview guide for this study.

The second data collection process involved filling in the checklist form from which information regarding the implementation of CCHP interventions and activities for the year 2017/2018 were captured. Reports of the implementation CCHPs were obtained from the District Health Secretary offices in the 4 councils in Rukwa region after obtaining the approval from the District Executive Officer and the District Medical Officer (DMOs) of each council. The checklist form was used to extract information to test if the plan addresses all the required interventions according to the planning guidelines, particularly on maternal health services**.**

Focus Group Discussion (FGD) was a useful method in this study because CCHP preparation is a collective process and it helped to obtain a deep understanding of the ways CCHP is implemented. The research team obtained the written consent form from the participants before any interview was conducted. The consent forms were administered first to the participants and were signed before conducting the FGDs. The FGDs with CHMTs were conducted at DMOs conference room, which provided adequate privacy. Approximately, each FGD lasted for 75 minutes.

3.6 Pre-testing of Tools

The data collection tools were pre-tested to identify ambiguous or unclear questions in the FGD guide. All issues of clarity of the questions included in the FGD guide were modified accordingly. In addition, the pre–test was crucial to familiarize with the administration of the

research instrument. Pre-testing was administered in Mpanda District Council in Katavi Region. The pretest was conducted to determine credibility, transferability conformability and dependability, as well as whether the instruments enable the researcher to determine if the respondents understand the questions so that the tool could be adjusted accordingly. This data collection tool was also checked for clarity by the research supervisor who approved it upon his satisfaction.

3.7 Data Collection Procedure

A semi-structured guide with open-ended questions was used to guide the FGD with members of the CHMTs. Different questions were designed depending on the role of the CHMTs in CCHP interventions planning and implementation. All CHMTs participants were given a specific number and the question were asked systematically based on the FGDs guide and those respondents were selected randomly based on the questions until required information were captured. Four FGDs were conducted, one FGD in each council. A total of 41 CHMTs members from four (4) councils in Rukwa Region participated in the FGDs. With exception of one FGD which consisted of 11 participants, the remaining 3 FGDs consisted of 10 members each. In each FGDs the information was collected based on the FGD guide until a saturation point was reached when there was no new information was obtained. A digital audio recorder was used to help the researcher in his efforts to capture all the necessary information during the data collection process.

3.8 Data Analysis and Presentation

A thematic approach was employed in analyzing the qualitative data obtained from the field. This involves reading through the transcribed text of each interview and identifying themes and codes relevant to the main question under investigation.

According to Marshall and Rossman (1999), thematic data analysis is the process of bringing order, structure and interpretation to the mass of collected data. It is the search for general statements about relationships among categories of data. The collected qualitative data in the form of audio were transcribed, cleaned, summarized and organized to create established and

meaningful patterns with the aim of identifying themes within the data. This process provided an avenue for the researcher to familiarize with the collected information.

The emerging patterns on the implementation of CCHP based on maternal health services in Rukwa region were identified. The data were displayed in tabular form for descriptive content analysis. The researcher repeatedly read the materials, including the audio files and notes, and transcribed the data into written form. The researcher created a start list of potential codes. Data reduction was done while searching for themes among the listed codes. The obtained themes were revised to align with the objectives of the study and thereafter themes were named.

3.9 Ethical Consideration

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In this study, the researcher requested and received an ethical clearance from the Muhimbili University of Health and Allied Sciences (MUHAS) Expedited Review Sub-Committee of Senate Research and Publication. In addition, permission to conduct the study was obtained from the Rukwa Regional Administrative Secretary (RAS) who informed all the four councils about this study. In each of the council visited consent was obtained from the District Executive Officers. Confidentiality was maintained throughout and after the study. All participants were informed on the objectives of the study for them to make informed decision to participate or not to participate in the study. Before starting the FGDs, participants were asked to sign a consent form.

3.10 Trustworthiness

We used the four criteria by Guba (1981) credibility, dependability, transferability and conformability to assess the trustworthiness of our study findings. Credibility of our findings was enhanced through adoption of well-established research methods, checking with participants on whether the researcher has accurately described what they stated during the interviews and consulting colleagues and experts on the subject matter. The dependability of this study was enhanced through the triangulation of the study setting, researchers and carrying out the data collection in the familiar settings of the informants. The themes in this

study were inductively generated from the data in order to ensure that they reflect the informants' perspectives in order to enhance conformability and these were presented with the support of quotes. Thick description of the study setting, and process enhances the transferability of the findings of this study.

CHAPTER FOUR

4.0 RESULTS AND KEY FINDINGS

The results section is divided into three parts: The first part focuses on findings on the enabling factors in the implementation of planned CCHP maternal health services interventions in Rukwa region's councils. The second part focuses on the prohibiting factors toward the implementation of planned CCHP maternal health services interventions in Rukwa region's councils. The third part of the findings focus on implementers' opinions on how to improve the implementation of planned CCHP maternal health services interventions in Rukwa region's councils.

Table 1: Table of Themes and Categories showing the result findings

SN	Themes	Categories
1	Enabling Factors in the Implementation of Planned CCHP Maternal Health Services Interventions in Rukwa region's Councils.	Health facility participation in planning,
		Partner contribution towards maternal health campaigns
		Direct health financing system,
		Centralized web-based planning and reporting software,
		Good communication and coordination
2	The Prohibiting Factors for the Implementation of Planned CCHP Maternal Health Services Interventions in Rukwa Region's Councils	Inadequate of maternal health interventions at the community level,
		Lack of maternity waiting home
		Inadequate specific supportive

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		supervision
		Limited referral transport facilities
		Inadequate technical package
		late disbursement of funds
		Inadequate human resources
		Limited Planning, budgeting and management capacity at health facility (HF) level,
		Lack of M & E Officers
		and the quality and reliable data at the facility level.
3	Implementers' Opinions on How to improve the Implementation of Planned CCHP Maternal Health Services Interventions in Rukwa region's Councils.	Reflection of partner's maternal interventions contribution in the CCHP
		Community sensitization on maternal health,
		Construction of maternity waiting homes,
		Training of HFs planning team,
		The use of bylaws at community and council level to restrict home delivery,
		Review of guidelines for health plans
		Health education package at the community,
		Presence of M & E personnel at council level
		Timely quarterly fund disbursement of funds.

4.1 Enabling Factors in the Implementation of Planned CCHP Maternal Health Services Interventions in Rukwa region's Councils

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Based on the first objective of this study, the interviewed members of the CHMTs pointed out enabling factors in the implementation of CCHPs focusing on maternal health services. The analysis of the findings generated five themes, namely: health facility participation in planning, partner contribution towards maternal health campaigns, direct health financing system, centralized web-based planning and reporting software, and good communication and coordination. The identified themes are presented in the following sub-sections:

4.1.1 Participation of Health Facility in Planning

The involvement of health facilities in planning is a mechanism which has now contributed towards some more realistic CCHPs and implementation of planned maternal health services activities. They explained that the ownership of CCHPs planned maternal health activities has increased at the health facilities, adding that the Health Facility Governing Committees (HFGCs) are currently able to implement maternal health activities at their cost centers without big interferences from the district level authorities. They explained that the ownership of CCHPs in general has increased and the budget credibility has increased as well. It is now convenient to tell the HFs workers to implement maternal health activities in a specific way as compared to the past when decisions regarding the implementation of CCHPs were made by the CHMTs. Maternal health activities such as fuel subsidy for referral of pregnant women and allowances for staff accompanying pregnant women to referral facilities are paid smoothly without delay. One of the FGD participants said that:

"Ownership of CCHPs has increased now, and the budget credibility has increased also. Now it is easier to tell the health facility workers to implement activities in a given way. But if you can recall when the decisions regarding the of implementation were within the CHMTs, things were difficult. (Participant No. 5, FGD No.3)

The CCHP interventions are now planned and implemented at the HFs based on their needs and priorities as compared to the previous years when interventions were planned for only a few selected health facilities according to CHMTs wish. The study shows that this approach

has facilitated the HFs planning teams to decide according to their needs and priorities in their localities rather than depending on the CHMTs as it was previously the case.

In addition, one FGD participant explained that during the implementation of the CCHPs at the facility level, HFGCs are informed of the activities and interventions that are going to be implemented. He stated that the HFGCs are the ones which make the decisions regarding the implementation of the planned activities. Another participant claimed that although they are currently implementing the activities themselves, they are accountable to Ward Development Committees (WDCs). CHMTs normally direct HF management and the HFGCs to provide implementation feedback to the WDCs of what has been implemented in each quarter.

The preparation of CCHPs involved all the HF governing committees. After the preparation of the HFs plan, the document should be submitted to the WDCs meeting which discusses and add more inputs before it is submitted to the CHMTs. The FGD participants emphasized that WDCs participation in the preparation of the health plans is evidence indicating how CCHP is now a community centered activity.

On the other hand, funds are received at the HF level, the HFGCs are informed of the arrival of the funds and what activities are going to be implemented. The same information will be communicated to the WDCs quarterly regarding what has been implemented.

The CHMT participants explained that when funds are received at the health facilities level, the main implementers are the superintendents of the health facilities and the chairperson of the HFGCs. The signatories involved are the Health Facilities superintendent and HFGC chairman in group A, and in group B they include any health facility worker or any other community representative from the HFGCs and the DMO. The participating members of the CHMTs have shown that the community participation exists both at the planning and implementation stages. When they have implemented the planned activities, they must prepare the income and expenditure accounts for that quarter and submit to the respective authorities for discussion. The committee can agree or not agree with what has been implemented.

In general, HFGCs and WDCs are involved in planning whereby members offer their inputs appropriately, but the implementation of HF plan is discussed in the HFGCs without regular feedback to WDCs. All these are indicators of improved community involvement at the grassroots level. In general, bureaucracy has been significantly decreased much as the communities are now implementing CCHPs themselves compared to the past when the councils used to implement the plans on their behalf.

4.1.2 Centralized Web-based Planning and Reporting Software

Participants stated that the web-based plan – Rep software – has facilitated the CHMTs and HFs to be flexible in preparing the CCHPs. Currently, the CHMTs and HFs are flexible in preparing the plans as they can enter data into the system at any place provided there is an internet network. The participants reported that the web-based 'Plan-rep' system has reduced the time spent in preparing plans as the regional and national level directly receive what has been planned and they can give feedback on the planned interventions almost instantly. The findings show that the web-based 'Plan rep' system has facilitated the implementation of planned CCHP maternal interventions to be implemented more smoothly compared to the way it was previously when the council level authorities used to re-allocate the funds. Currently, each planned activity must be reported through the FFARS which are linked with the Plan-Rep web-based program.

"The Web based 'Plan-rep' software is now linked with the FFARS which is a web-based finance, reporting and expenditures system whereby HF implementers should implement what has been planned otherwise you cannot implement differently" (Participant No. 7, FGD No.3)

The findings show that CHMTs appreciate the web-based planning and reporting software as they have reduced the time in planning and reporting. Participants stated that this makes everyone aware of what maternal health interventions have been planned and implemented.

4.1.3. Partner Contributions toward Maternal Health Interventions

Participants in FGDs claimed that partners have contributed adequately in addressing the council level interventions. Although some of these interventions are not included in the CCHPs directly, still they have facilitated to address some of the council priority areas. One participant stated that:

"Interms of *planning, we are collaborating with some of the partners. For instance, some partners may invite us when they are planning, and their interventions and activities are incorporated in the CCHP. So, for some partners their interventions planned are implemented as planned. But there are other partners that we do not know what activities are planned in each quarter and during the implementation they come to us to introduce their work as ad-hoc activities. Their activities are not included in the CCHP"* (Participant No. 5, FGD No.2)

Most of the FGD participants explained that some partners do not include their budget in the CCHPs, they rather collaborate with CHMTs during the implementation phase. They stated that providing the CHMTs with feedback on what has been done on the field signals improvement in the overall implementation strategy. Other participants explained on how partners have facilitated the CHMTs and council in general. They further explained that partners have contributed toward enabling the HFGCs training on their roles and responsibilities, training of health facilities on BEmONC and CEmONC approaches which are interventions aimed at reducing maternal deaths, training of CHWs on identifying pregnant women to attend antenatal clinics and procurement of some supplies related to maternity issues.

"In last year, we tried our level best; we received assistance from UZAZI SALAMA, and we were facilitated in training of HFGCs which included the HFs staff on how to prepare HF plan" (Participant No. 6, FGD No.4)

4.1.4 Direct Health Financing System

Participants explained that implementation of HF plans has been facilitated by the direct health facility financing system. Most of the participants during the discussions expressed

their views that having individual bank accounts for each facility, has made the HF management and the HFGCs to plan themselves based on problems and priorities. This has enhanced accountability of these organs (Health Facility Management Teams and HFGCs) on what they have implemented. It can be found that all activities implemented are audited by the council authorities something making them accountable.

"Health facilities have their own sources of funds that are deposited in their own bank accounts as compared to the previous time where such funds were deposited in DED accounts. The sources of funds are Basket Fund, CHF, NHIF, user fee and other community contributions. Currently, they have the drug revolving funds which started in this year." (Participant No. 2, FGD No.3)

They further stated that although they have these accounts, but the funds are always insufficient in meeting their needs in maternal health intervention as there are only few maternal interventions which are planned in the CCHP. The review of CCHP implementation of CCHP has shown that only 39% of the required interventions are planned in the CCHP.

4.1.5. Good Communication and Coordination

Participants in almost all the FGDs explained how communication among the CHMTs and from the CHMTs to the HFs has facilitated the CCHPs implementation. CHMTs communicate among themselves through formal routine meetings when there is a need to do so as well as when there is an issue raised and share feedback with each other. The CHMTs have both weekly and monthly meetings. On the other hand, they use the CHMT guardians who have been assigned to certain HFs for any correspondence and feedback. In addition, most of CHMT members stated that they have a WhatsApp group among themselves and among them with HFs.

"We gather together for meetings every Friday for both weekly and monthly meetings. We also we convene meetings during an emergency or during whenever there emerges an ad-hoc issue. In that case, we do not wait until Friday." (Participant No. 10, FGD No.1)

The participants further stated that good communication has helped all CHMTs to effectively carry out their duties especially those related to maternity issues. This includes incidents such as when there is an emergency or when making referral arrangements for pregnant women from lower level facilities. They stated that the response by the CHMTs is good and referrals are not delayed.

Regarding the types of communication, the CHMTs have three types of communication. The first one is by the official letter where all directives are communicated to them. The second method is mobile phones used at the HF levels, vertical Programme phones and WhatsApp group. All these have facilitated good communication with the CHMTs and to HFs.

"We CHMTs are not restricted in communicating with each other or with all HFs. Whenever maternal cases for referral are reported, you can communicate that at any time. . In the case of CHMTs, we have our routine meetings and if there is an emergency we communicate immediately." (Participant No. 1, FGD No.4)

The discussion shows that District Health Secretaries who coordinate all health issues at the council and HF level are the main center for coordination of implementation of CCHP activities. They usually coordinate with the CHMTs and the responsible person is involved and advised to implement the activities for each intervention, including maternal health services. Each intervention is implemented by a person qualified in that area. So, the coordination is good at the CHMT level and at HF level. Health facilities also implement the activities with assistance of CHMTs which provide technical assistance to ensure that maternal health interventions are implemented as planned and based on the sources of funds at the HF cost centers.

4.2. The Prohibiting Factors for the Implementation of Planned CCHP Maternal Health Services Interventions in Rukwa Region's Councils

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The second objective of this study focused on exploring the prohibiting factors toward the implementation of planned CCHP maternal health services interventions in Rukwa region's councils. Eleven themes were identified from the analysis, namely: Inadequate of maternal health interventions at the community level, Lack of maternity waiting home, Inadequate specific supportive supervision, limited referral transport facilities, inadequate technical package, late disbursement of funds, Inadequate human resources, Limited Planning, budgeting and management capacity at health facility (HF) level, Lack of M & E Officers and the quality and reliable data at the facility level. The identified themes are presented in the following sub-sections:

4.2.1 Inadequate Maternal Health Interventions at the Community Level

During the discussion with CHMTs, participants insisted on issues of inadequate number of maternal health interventions in the CCHPs.

"Let's say that in the CCHPs as you have said, large part of it is covered by RCH, but when you go further to the details inside the plans, when you measure it. RCH covers a big part and particularly focuses on the medical supplies. In my experience, we do not focus on the communities which are the direct beneficiaries and the ones with the final decision. We are shouting that antenatal visit below 12 weeks are low, people visit clinics late so if they have a problem will be difficult to discover unless the people are educated." (Participant No. 9, FGD No.1)

Participants further stated that community sensitization efforts have not yet been done to a large extent. It can be found that much emphasis is placed on medical equipment. In the CCHP plans, there is a limited amount of activities concerning community interventions. Participants stated that there are only a few activities which focus on community sensitization. These activities are such as traditional birth attendant meetings. It was the opinion of most participants that community sensitization efforts should be increased and should be treated as a cross cutting issue involving all sectors so that the community can take advantage of the

available conventional maternity and related services. For instance, there are TBAs who attend pregnant women. Most of TBAs have no time to direct their clients to attend clinic until things are difficult to them to handle. This culture, if not timely addressed, will continue to accelerate maternal death.

Participants states that there are limitations in the inclusions of maternal health interventions in the CCHPs. (Table 1below).

Table 2: Maternal Health Interventions Planned in CCHPs by All Councils in Rukwa Region in the Year 2017/2018

SN	Interventions
1	Focused Antenatal Care
2	Family Planning
3	Adolescent Friendly Sexual Reproductive Health
4	Nutritional supplementation for Mother, Neonates and Children
5	Delivery Kits
6	Safe and Clean Delivery Care by Skilled Attendants in Health Facilities
7	Comprehensive Emergency Obstetrics and Neonatal Care
8	Basic Emergency Obstetric and Neonatal Care
9	Integrated Management for Emergency and Essential Surgical Care
10	Labor and Delivery Care
11	RMNCAH Cross Cutting Interventions

Source: DMO office; CCHP implementation reports 2018,

In the year 2017/2018 all the 4 councils in Rukwa Region had planned to carry out 11 maternal health interventions in their annual plan CCHPs although most of them did not implement all the 11 interventions. Most of them implemented about 6 interventions in their plans.

Study participants said that most of the interventions incorporated in the CCHPs involve issues of blood collection, family planning, delivery care, and procurement. The results of the FGDs on planned interventions were compared with review of the CCHP annual reports for the year 2017/2018 which shows that only 25.9% of all interventions required were planned in the CCHP as shown in table 1 above.

Participants explained the contribution of partners toward improving maternal health services in the study area. They stated that partners have contributed to supplement the CCHPs in areas of Basic Emergency Obstetric and Newborn Care and Comprehensive Emergency Obstetric and Newborn Care (BEmONC and CEmONC) supervision and training. Despite the good efforts of the partners, participants insisted on putting more efforts to the community interventions geared toward behavioral change. Most of the CHMT members emphasized that they provide health education yet noting the need for providing more health education to the people.

"There is one maternal death that occurred in the community in one village. The woman has a previous scar, so she was advised to deliver at a high referral facility when her days were approaching. But she did not follow that advice, she died due to ruptured uterus. We need to incorporate maternal health interventions in the village health day for health education." (Participant No. 8, FGD No.2)

One CHMT member stated that CHMT members further stated that some of the pregnant women do not know if they receive all the commodities at the HFs free of charge and they must pay for the services, something which is not true. One participant insisted that people at the community level are usually honest and speak the truth that we as CHMTs must act upon.

"When you go to the field to the community, people ask many questions. They ask if iron tablets, mosquito nets, malaria medicines are provided free of charge; so you ask yourself that why are they not receiving such information when they go to clinic! Sometimes you might end up concluding that maybe they don't go to clinic. So, this is an area which needs to be revised." (Participant No. 5, FGD No.3)

Generally, the councils and the partners must rethink new ways of improving information flow and public education regarding maternal health interventions to change the worsening situation.

4.2.2 Lack of Maternity Waiting Homes

Although maternal waiting homes are very crucial, they are not adequate to accommodate all pregnant women who need such service. Among the participants, one senior staff reported that maternity waiting homes is another area which will reduce the problem of maternal deaths in Rukwa.

"Myself, fortunately or unfortunately, I study in a college with a maternity waiting home in Sengerema. For sure, I saw that their benefit is very crucial because those who are far from the facility came and stay there before delivery and if there is any emergency they move to the nearby facilities for delivery and after delivery they return back home. In their facilities of origin, patients are always advised to deliver at a Health Centre, or a hospital and you will find that they don't come because of economic hardships." (Participant No. 3, FGD No.1)

Participants also stated that some of the pregnant women who are given referral for delivering at referral facilities, become concerned about where are they going to stay before delivery. These are some of the challenges that discourage women from seeking conventional maternity services and decide to seek the services of TBAs. They stated that TBAs should be trained and insisted on escorting pregnant women to the HFs.

Almost all members of CHMTs who participated in the focus group discussions insisted that maternity waiting homes are not a priority now. But according to most of them, they insisted that if these waiting areas are established, the efforts could save the lives of several pregnant women who are advised to deliver at referral facilities.

4.2.3 Inadequate Specific Supportive Supervision on Maternal health services

Supportive supervisions are planned quarterly in each council in the CCHP as a means of improving the delivery of health services to the community. Despite the planned quarterly supportive supervision in each council, its implementation remains a challenge in all the

visited councils due to several factors. One participant reported that the supervision matrix, supervision teams, and supervision routes in each quarter are in place but are not well implemented as planned.

"In general, we conduct supportive supervision but not in all quarters as planned in the CCHPs. You will find that sometimes funds can be received at the council level in a given quarter, but during that time vehicles will also need maintenance and you should maintain the vehicles first before the supervision. Therefore, the supervision delays to be conducted at lower level which makes coaching and mentoring on maternal intervention issues not effectively done in each quarter in the health facilities due to lower number of HFs supervised." Participant No. 6, FGD No. 2)

Participants of this study further pointed out that late disbursement of funds has contributed to a compromised quarterly supervision activity. Funds are disbursed late. For instance, in this financial year 2017/2018, some of the councils received the funds for first quarter at the end of December 2018, something which makes the team unable to perform activities as stated in their action plans.

"We as the council, if we can be supported with one vehicle, it will be a good idea." (Participant No. 9, FGD No.1)

Another factor which the participants pointed out are the ad-hoc activities at council level and emerging emergencies such as diseases outbreak, which have hindered them from performing their action plan for supportive supervision. One participant claimed that in case of their CHMT, they had conducted the first supervision in December 2018 and second supervision was conducted in May 2019 which covered almost 50% of HFs in the council and the year is nearly ending. Therefore, supervision in the remaining areas would be implemented as ad-hoc.

Regarding supervision feedback, one senior participant during the interview reported that during the supervision they provide on spot oral feedback and written feedback using the Health Management Information System (HMIS book number 2), Thereafter, they provide a

written feedback to the health facilities visited. For instance, all visited HFs in this quarter have received written feedback. One participant added that the feedback reports they provide are based on the integrated supervision checklist.

"Our checklist is general and integrated which consist of all the intervention areas whereby everyone is involved. Each CHMT is asked to include crucial areas that require follow up, and then we combine it together in one report. Before we move to the field, each one of us should have a general understanding of the checklist. We usually hold a CHMT meeting before conducting supervision." (Participant No. 8, FGD No.1)

During the discussion with CHMTs, participants claimed that supervision consists of 4 members and when they conduct such supervision, they normally use between two and a half and three hours to complete. One participant pointed that:

"We have general supervision which consists mainly of managerial issues and some clinical areas. But also, there is other specific vertical Programme supportive supervision which is conducted in detail by a specific Programme" (FGD Group 1, Participant 4)

One participant insisted that that there is no specific supervision for maternal health services. All maternal health service supervision activities are included in the general supervision. The study finds that partners have adequately contributed to the area of supportive supervision whereby they conduct specific supervision on maternal health services. For instance, partners have a special checklist book known as Standard Based Management and Recognition which involves all interventions on maternal health, and they use it for supportive supervision in each quarter. When these specific supportive supervision activities are conducted, some HF health workers are empowered on issues pertaining to maternal health area. The challenge is the sustainability of such specific supportive supervision activities for maternal health interventions when these projects are phased out and leave the region. The participant continues insist in the quotation below.

"These partners conduct special supervision as a separate activity. It is not integrated. They go for maternal issues only, you see! Now when the project is over, these cannot be done, because in a budget of CCHP you cannot enter all these as separate supervision activities. It is difficult, they must be integrated. This specific supervision is very important as it gives more room and time to focus on specific issues when you go to the HF. Such kind of focus on specific issues cannot be paid when you go into the integrated supervision activities." (Participant No. 7, FGD No.2)

4.2.4 Limited Referral Transport Facilities

Inadequate referral and transport facilities emerge as a subtheme. During the discussions, participants reported that one of the challenges in the implementation of maternal health services in Rukwa region is inadequate transport facilities at the lower levels. Each health center should have an ambulance which should be permanently stationed there for any referral whenever emergencies, including for pregnant women, happened. But the situation is not like that. Most of the health centers are not equipped with transport facilities. There is a limited number of such transport facilities almost in all councils. It may take some hours to reach an area where an emergency has reported, a situation that has contributed to the increase in the number of maternal deaths due to complications because of late arrival to the designated areas.

"You will find that a pregnant woman has severe bleeding due to a ruptured uterus, and because we have poor transport facilities and infrastructure, ambulances come late! To degree large extent, those cases of severe bleeding, PPH and other issues could have been avoided if those ambulances were stationed at the health centers! In addition to our complex geographical position and poor infrastructure, all what will help us are the interventions at the community to create more awareness. So, community sensitization on maternal health issues is crucial to overcome all these challenges." (Participant No. 2, FGD No.4)

Participants stated that there should be improvements in transport facilities at each health centers. It was found that one of the four councils that participated in this study has only one ambulance for referral services a situation which becomes more challenging when there is more than one referral case to attend to.

"We have only one vehicle for referral cases from health facilities. If there are incidents of multiple cases, it will be a challenge. Sometimes you will find that the transport facility is there, but fuel is also challenge. To improve the situation, we must improve the collaboration of all sectors and partners in implementing the planned interventions." (Participant No. 9, FGD group 3)

Most of the FGD participants emphasized that what is needed is each health center to have one ambulance stationed at the respective health facilities rather than one ambulance stationed at the council headquarter. They further insisted that the available ambulances should be also equipped with all the required accessories.

4.2.5 Inadequate Technical Package

There is no enough technical capacity among members of the HFs planning team in using the web-based planning software. Most of the HF superintendents are not capable of planning themselves using the system and it can be found that HF plans are sent to the CHMTs for them to feed their plans in the system although the plans have originated from them. More technical capacity to them is needed for them to appropriately carry out their duties.

"*The understanding is not high, especially in using the planning software, and we are still helping them. We are still helping them, but the CHMTs have planned to organize a training to health center and few dispensary staff located in urban areas on the use of web-based "Plan-Rep" tool to enter their activities."* (Participant No. 10, FGD No.3)

The participants explained that Health Facility workers to prepare the plans themselves although the CHMTs still use their planning accounts to prepare their plans. So, health workers at facility level are required to be empowered for them to effectively handle their responsibilities.

Participants have also expressed that HF staffs and HFGCs have not yet been empowered enough on issues pertaining to health planning and implementation. It can be found that some of HFs can have enough funds in their bank accounts, but it become difficult for them to spend the money until the CHMTs push them to do what is required. They explained that all these

have led to non-implementation of some of the interventions, including the maternal health services at the community level.

"For example, we have started this DHFF in the FY 2017/2018 but most of the funds were carried over to the next year because people have no experience in accessing the funds since most of these activities were carried out by the CHMTs on behalf of HFs. But so far, the Government through PO-RALG has tried to send an accountant at this level, especially at health centers to help with that." (Participant No. 5, FGD No.2)

Participants in the FGDs explained that a few employed accountants must serve all nearby HFs which a challenge is still. They lack enough skills in expenditure, preparing income, expenditure and bank reconciliation processes. In efforts to cope with this challenge, the CHMTs and DED office assisted them on technical issue.

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4.2.6 Late disbursement of funds

During the discussions with CHMT members, most of them expressed their views on the quarterly implementation of planned interventions and the way funds are being disbursed from the central government. One participant pointed out that,

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"There is a challenge, the implementation of quarterly planned maternal health interventions is difficult as funds are not disbursed on time. You can find that funds for the first quarter are disbursed in the second quarter or nearly in the third quarter. For example, in this year up to now (June 2019), we have not yet received the fourth quarter and we are in the end the month of of the financial year." (Participant No. 8, FGD No. 4)

The implementation of some CCHP is not conducted as planned. Those activities which require no funds will be implemented as usual but those which require funds will not be implemented until funds are disbursed. Participants stated that late disbursement of funds makes the HFs to have funds in their accounts at the end of financial year which are carried over to the next financial year. They continued that the disbursement of funds has affected routine planned maternal health intervention activities which require implementation on a quarterly basis. Such activities are not implemented as planned. Other impacts of late

disbursement of funds explained is the implementing of maternal intervention activities with high time pressure resulting in inadequate efforts and undesired result.

Table 3: Implementation of the Planned Maternal Health Intervention Activities In 4 Councils by 80% in Rukwa Region in the Financial Year 2017/2018

Percentage of Maternal Health Interventions Activities Implemented				
SN	**Councils**	**Required**	**Implemented**	**Percentage of implementation**
1	Sumbawanga DC	6	3	50
2	Sumbawanga MC	7	2	29
3	Nkasi DC	7	3	43
4	Kalambo DC	9	5	56
	Region	**29**	**13**	**45**

Source: DMO office; CCHP implementation reports 2018,

Participants showed that not all the funds are disbursed late; there are other sources of funds that are collected routinely from user fee, Community Health Fund (CHF) and National Health Insurance Fund (NHIF) that they are directly used as planned in their plans but there are those of Other Charges (OC) and Basket Funds (BF) are not disbursed on time.

4.2.7 Inadequate of Human Resources

All discussions with members of CHMTs revealed the concern of lack of human resources which affects the implementation of CCHP intervention activities, including the provision of maternal health services. The CHMT members from one council reported that their council has only 40 percent of the needed healthcare staff. They suggested that the government needs to use another strategy like allowing the councils to provide short term contracts to potential employees to work in the health facilities for a certain period before someone is permanently employed. One FGD participant made emphasis on issue of contract.

"That is an important point; the scarcity of public servants is being experienced since the power to hire was removed from the Local Government Authorities! Currently, councils are not directly employing but they only employ operation staff only – Drivers, Personal Secretaries. But for professional, they don't! We depend on the central government only. The problem becomes further complicated because those who seek employment from the central level would not select Rukwa. The lack of interest in working in Rukwa will continue to make us suffer the scarcity of manpower. But if we would have the power and budget to hire, we would have addressed the shortage of human resources in the region." (Participant No. 9, FGD No.1)

Other participants insisted that some of the health facilities have only two health workers who are required to plan for the annual budget on maternal and other health interventions. Because of shortage of other cadres, their ability to think widely, including areas such as maternal interventions in the health plans becomes minimal. Consequently, the budget would focus on the few intervention activities that are largely informed by personal interest. If there could be staff according to manning level, there would have been good plans which would also be implemented easily. The FGDs participants pointed out further that the same staff has to multitask! They are required to implement plans, attend meeting and seminars, conduct, and outreach activities! Consequently, their performance will be minimal.

4.2.8 Limited Planning, Budgeting and Management Capacity

Other participants expressed their views on training institution arguing that policy makers should consider including leadership and management aspects in the curriculum of training institutions which produce future health workers. They stated that in the environment where there is a scarcity of health workers, there should be well prepared health staff in the concept of leadership and management for them to be able to come up with good plans.

"We actually know that health facility superintendents are going to monitor resources. They act as budget officers, they plan, and lead the committees! Are they empowered to perform all these duties? They are the managers of health services in their catchment area! For example, you will find one in-charge has the responsibilities of almost 21 thousand people but what are

their capacities in managerial issues? And not to forget that they are also clinicians at the same time! Policy makers should ensure that training institutions consider including management and leadership in their curriculum." (Participant No. 11, FGD No.4)

Other participants stated that the allocated accountants in HFs to support the planning and implementation of the plans are few as one accountant is responsible for supporting one health center and all dispensaries present in the catchment area. They further said that it can be found that the HF superintendents instead of being involved in medical issues, they are involved in the implementation of the health plan in preparing requests and other issues. In addition, they reported that HFs have several audit queries because of the failure of not submitting implementation reports on time due to lack of adequate planning and financial management capacity. There have been incidents whereby when HFs implemented activities, they did not make any retirements or submitted their reports on time. All these, to a large extent, have been attributed by the scarcity of human resources.

The CHMT members from another council stated that they have 70 percent of the required human resources but there is a challenge of having more medical attendants as compared to the other health professionals. This is still a challenge in these areas. They suggested that such situation should be reviewed again so that the next time when the government distributes health staff, they put into consideration the balance of all health professionals required to run a health facility.

"The problem we have in our Municipal Councils is the maldistribution of health staffs. We have a greater number of semi-skilled staff, especially medical attendants. You will find that in the whole council we need only 30 medical attendants, but there are 100 such staff. So, you will find that the number is 3 times the required number of staffs." (Participant No. 11, FGD No.4).

4.2.9 Shortage of Monitoring & Evaluation Officers

All the CHMT participants expressed their views on the monitoring and evaluation regarding the implementation of planned maternal health services interventions in the CCHPs. The study has found out that in all councils there is no M & E officers at the council level although those

cadres are within the manning level guidelines. So, it can be found that the monitoring and evaluation activities are conducted by CHMTs themselves but not in a proper way because their lack of expertise in the field.

"CHMTs are the ones to know which activities have been implemented and which activities have not yet been implemented. In the actual sense, we are supposed to monitor but other councils, such as those in Dar es Salaam regions, there are M & E officers whose responsibility is to monitor the progress of implementation of health plans." (Participant No. 6, FGD No.1)

Most of the participants stated that M & E officers have the specific responsibility of tracking whether the responsible persons have implemented the assigned activities or not. M&E officers are the ones that know that a certain planned indicator has any progress as planned or not. But that is not the case in the councils in Rukwa as evaluation is conducted together by the CHMT as a team. On the other hand, there is a District Health Financing (DHF) Coordinator, who monitors the health plans and their implementation at the health facility level.

Study participants further stated that monitoring becomes difficult due to the flow of budget. Flow of budget is a big challenge, if you need to monitor the actual implementation of the planned CCHP maternal health services, the flow of funds should go as planned in each quarter. That way, it is easier to track the whole budget if an activity has been implemented as planned.

The CHMTs are conducting monitoring and evaluation based on the partner's contribution. When CHMTs meet with the partners they share feedback from their activities with each other. This is a challenge as these activities are not in the CCHP, hence they cannot be monitored using the existing framework unless the partners would be making their own monitoring and evaluation. Participants also explained that they conducted evaluation in each facility every six months and the facility heads were adequately involved.

Other participants explained that they conducted evaluation of the whole plans for the previous years during the pre-planning session at the councils. The meeting evaluates what have been implemented in the previous year and what is to be planned in for the next financial year.

4.2.10. Quality and Reliability of Data at the Facility Level

Participants stated that there is low quality a data especially at the health facility level. Although there is an improvement of data collection at the facility level compared to the past, more efforts should be made toward data collection and reporting. There are frequent incidents of missing information. The participants insisted that there should be a special register at the village level to use for a follow up on all pregnant women in the specific villages as this will help in the sensitization of the antenatal visits and on the importance of delivering at health facilities.

Furthermore, the CHMTs explained that HFs do not have the evidence if they conduct monthly data review meetings in their facilities. Some HFs have minutes, others miss any evidence of conducting data review meetings. All HFs are required to submit their monthly data reports to the councils which then are entered in the *DHIS2* system. Most of the HFs prepare monthly reports, but more follow up on data quality audit should be there. One of the participants stated the challenges of huge workload and limited human resources is attributed attribute to poor data quality.

"We as CHMTs are making a follow up, but the main challenges are that the number of HFs has work overloads. You ask the HFs in-charge! They say that they must multitask! Some of them are making follow up of their issues at DMO and DED offices. Others are overloaded with patient flow! But there are few others who meet on time to review the data." (Participant No. 3, FGD No.2)

4.3. Implementers' Perceptions on How to improve the Implementation of Planned CCHP Maternal Health Services Interventions in Rukwa region's Councils.

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The third objective of this study focused on the implementers' perceptions on how to improve the implementation of planned CCHP maternal health services interventions in Rukwa region's councils. The analysis of the findings generated ten (10) themes, namely: reflection of partner's maternal interventions contribution in the CCHP, community sensitization on maternal health, construction of maternity waiting homes, training of HFs planning team, the use of bylaws at community and council level to restrict home delivery, review of guidelines for health plans, health education package at the community, presence of M & E personnel at council level and timely quarterly fund disbursement of funds.

4.3.1 Reflection of Partner's Maternal Health Intervention Contribution in the CCHPs

Most of CHMT FGD participants suggested that partner interventions, activities and budget of planned maternal health interventions with other CCHPs interventions must be reflected in the CCHPs in all councils. They further recommended that the inclusion of partners' budget on maternal health interventions in CCHP will facilitate the smooth implementation of the planned maternal intervention activities in the CCHP. They explained that it will enable CHMTs to participate fully in the monitoring and evaluation of all maternal health interventions. One participant added that some partners are implementing activities according to their wish. Although they are usually required to submit their schedule, however, in most cases, they do not submit them.

"Sometimes you will find that there are HFs which have more needs and are far from the council headquarter but when you look in their timetables you will find that the partners have selected the nearby HFs. But we advise them according to the needs and we ask them to change their plans and focus on certain intervention areas." (Participant No. 5, FGD No.2).

Most of the CHMT participants insisted that the partner contribution in the CCHPs on maternal health interventions should be reflected in their annual plans. You will find out that the partner maternal interventions are not reflected in the council health plans, something that makes monitoring and evaluation to become more complicated. Some of the participants

expressed their concern regarding this omission with some of them sending an official letter to them to which some have responded, and some have not.

4.3.2 Community Sensitization on Maternal health

Participants explained that one area which will facilitate the decrease of the maternal deaths is the community sensitization. The communities are the ones to be sensitized. One participant insisted about the following during the discussion.

"In my view, vision and mission should be directed to the community people. They are the ones who are required to change first, because we can construct improved Health Centers, Improved Hospitals but if community members have not changed their attitude, there is nothing much we can do. This is enough the government has constructed improved facilities, we must change! This is the time! In this era we have more improved constructed HFs as compared to the past; we must change people's attitude regarding the use of these health facilities. So, we must go to the grassroots. If the community changes, everything will be solved." (Participant No. 9, FGD No.3)

The emphasis was on providing health education to the community for people to change attitude. Pregnant women should attend clinic on time and prepare their personal plans for delivery as a family. The family should prepare themselves when approaching delivery. More emphasis was to the local leadership which should be sensitized. All these community interventions are not included in the CCHPs although to some extent some efforts have been made toward achieving the goal.

4.3.3 Construction of Maternity Waiting Homes

Generally, the study participants proposed the construction of maternity waiting homes which play a very crucial part in helping pregnant women with accommodation before delivery. Such facilities will save lives of pregnant women from the peripheral areas. The maternity waiting homes are currently more important because of the emphasis that all pregnant women should deliver at the health facilities regardless of their conditions. The unavailability of maternity waiting homes has resulted in an increase number of pregnant women who deliver at the

TBAs. The main challenge facing majority of women is household poverty which makes it unaffordable for them to afford transport, accommodation and other costs during pregnancy. Maternity waiting homes will help them to overcome these challenges a large extent.

"I studied in a health college with maternity waiting homes, and these maternity waiting homes were almost full all the times. This shows that the need is high by the society, but still there is no political will on this area. Still, the need should be advocated at all level" (Participant No. 7, FGD No.1)

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4.3.4 Training of HFs Planning Team

Participants expressed their perceptions on how to improve planning and implementation of the planed CCHP maternal health services and other CCHP interventions. They emphasized that because of the use of planning software and guidelines, there is a need of regular refresher training on maternal health interventions to the lower level facilities.

"On my side, first I can see, because at HFs level, the understanding is very low; we are supposed to conduct regular training on maternal health interventions so as to make them understand how the software works and introduce them to some new concepts to enable them plan for themselves." (Participant No. 4, FGD No.3).

Participants reported that they need training for this new web-based planning and reporting tools such as FFARS. They further said that it is long time since some CHMTs were trained on planning, and that some of them are new members who have not been trained. Regular training on planning and budgeting using software will make them more aware of the plans.

4.3.5 The Use of Bylaws at Community and Council Level to Restrict Home Delivery

Participants suggested the use of bylaws at the community and council levels as a means of restricting the TBAs from conducting home deliveries. Participants explained that TBAs are the ones who make these pregnant women use their services and they provide them with misleading information. The TBAs usually mislead pregnant women on their due dates without planning or having the ability to handle any unforeseen complications.

"Traditional birth attendants (TBAs) in our district should be regulated; Local leaders should consider having bylaws to regulate the TBAs. If these laws are applied to all villages, they would decrease the number of pregnant women attended by the TBAs. (Participant No. 4, FGD No.3)

4.3.6 Review of Guidelines for Health Plans

During group discussions, the CHMT members insisted that there is a need to review the guidelines for health plans. For instance, there are new intervention areas such as nutrition which require each council to set aside Tanzania shillings 1,000 for each child under the age of five years. When this intervention is accounted to the whole budget, taking for example the Nkasi DC where there are almost 70,000 under-fives, it means that Tshs: 70,000,000 should be set aside. However, nutrition is not indicated as top priority in the guidelines. Participants stated that this will reduce the funds for maternal health interventions which are priority in the guidelines. Therefore, if the guidelines will be reviewed and nutrition will be added in the guideline as a priority, the government will increase the budget accordingly.

"Since it is not currently stated in the guideline as a top priority, it should be addressed in the guideline that nutrition now is a top priority in health. You cannot have one intervention which you budget for OC budget but is not stated in the guideline as a top priority while you have other interventions to budget for." (Participant No. 11, FGD No.2)

4.3.7 Health Education Package at the Community Level

CHMT members explained that the health education package at the council and at the community level should be uniform. There is no uniformity in providing health education regarding maternal health services, especially at the facility level. Each HF has its way of giving health education regarding maternal health issues. In addition, participants stated that in each HF they have visited they have found that there is no specific timetable and topics to cover in the health education session. Policy makers should consider producing a uniform message. Moreover, councils should customize the national message to fir their community audiences.

'When you move to supervision at HFs, you will find most of HFs have no uniform topics to cover during the health education sessions. Similarly, most of the HFs have no specific timetable for health education sessions." (Participant No. 5, FGD No.3)

4.3.8 Presence of M & E Personnel at Council level

The study participants suggested on the importance of having M& E personnel at the council level to monitor progress of the CCHP maternal health interventions in all councils. M & E officers will assist with determining the extent to which maternal health interventions have been implemented, including specifically to tracking the maternal health indicators planned – that is, determining if certain indicators are being achieved or not. Although the CHMTs and the health secretaries perform some monitoring activities, their efficiency is still minimal.

'The efficiency of M& E at the council is very minimal as there are no technical personnel in that area. The activities have been conducted by the health secretaries in our council who are overwhelmed with other duties and are not professional." (Participant No. 2, FGD No.4)

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4.3.9 Timely Disbursement of Funds in Each Quarter

Timely disbursement of funds in each quarter has emerged as one of the sub themes representing the key factors for effective implementation of CCHP planed interventions. Most of the participants in all four CHMT group discussions explained this as an important strategy recommendation that will help to improve the implementation of all councils' plans, including maternal health plans. If funds are disbursed as planned, then they will implement the activities smoothly and on time.

'We are approaching the end of fourth quarter, but we received only funds for two quarters. In our district, this has limited the implementation of specific interventions." (Participant No. 5, FGD No.1)

CHAPTER FIVE

5.0 DISCUSSION

The primary purpose of this study was to assess the implementation of planned CCHP focusing on maternal health services interventions in Rukwa region's councils. The discussion of the study findings focuses on the following three (3) areas. Firstly, the discussion concentrates on the enabling factors on the implementation of planned CCHP maternal health services interventions in Rukwa region's councils. Secondly, the discussion focuses on the prohibiting factors hindering the effective implementation of planned CCHP maternal health services interventions in Rukwa region's councils. Thirdly, the discussion looks at the implementers' views and perceptions on how to improve the implementation of planned CCHP maternal health services interventions in Rukwa region's councils. The following sub-sections present the discussion of key findings in more detail.

5.1 Enabling Factors on the Implementation of Planned CCHP Maternal Health Services Interventions in Rukwa region's councils

The study has observed the key factors enabling the effective implementation of the Comprehensive Council Health Plan focusing on maternal health services. These factors include: participation of health facility in planning, partners contribution to maternal health, direct health financing system, good communication and coordination, and the use of centralized planning and reporting software.

5.1.1 Participation of Health Facility in Planning

The key findings reveal that the participation of members from health facility level in planning has facilitated the implementation of Comprehensive Council Health Plans, including maternal health plans, as the ownership of the health plans increased among the health facilities management and the HFGCs.

A study conducted by Chitama et al, (2011) demonstrates that maternal health interventions were not well addressed in the CCHPs as some of the technical personnel in that area were not fully involved in planning when planning was managed by the CHMTs. But following the

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DHFF approach, this study has shown that there is full participation of HFs and HFGCs members during the planning and implementation stage of the interventions. HF management and HFGCs are the ones currently at the center of planning and implementing activities and interventions, including maternal health interventions at their respective cost centers. The CHMTs provide technical support to the Health Facilities and they are not involved directly in planning. Therefore, the bureaucracy of priority setting, and implementation has been reduced although HFs must follow the CCHP guidelines and seek technical advice from the CHMTs during the planning.

Nyamwaya (2003) reported that the most visible challenge for health promotion development in Africa arises from the fact that most programs and activities are in most cases planned, managed and controlled exclusively by professionals, especially from within the health sector. The main actors are specialists whose concept of health is based on the public health model and whose focus is on interventions revolving around curative services. Ordinary people usually participate only passively in the health promotion process. Our study findings have shown a different approach in Rukwa region. The HFGCs are now involved in giving their views on planned interventions and involved in endorsing funds for implementation of planned activities as some of the members are signatories. When funds are received by the HFs, the chairpersons of the HFGCs are informed accordingly. The Health Facilities chairpersons are also informed of any anticipated activity prior to its implementation as there are HFGCs members and signatories, making it mandatory that they are aware of any planned expenditure to be made.

In this regard, the finding of this study has shown the participation of Community through the HFGCs and Health Facilities planning team following the introduction of DHFF system will facilitate the efficiency in the implementation of CCHP interventions and activities. The bureaucracy will now be reduced, no reallocation by the council's authorities and now there will be much accountability at the health facility level compared to when the implementation of all CCHP activities were implemented and managed at the Council level**.**

5.1.2 Partner Contribution on Maternal Health

This study findings showed that partner contributions to maternal health interventions is vital in reducing maternal deaths. Partners have contributed in terms of financial and technical support in the efforts to implement various maternal health interventions. The support areas include supporting training which focuses on reducing maternal deaths – such as CEmONC and BEmONC approaches, training of CHWs who help with sensitization of the community on the importance of antenatal clinic visit, training of HFGCs Committees, procurement of maternal intervention supplies such as HB machines, delivery kits and other supplies which focus on reducing maternal deaths at the health facility level.

A study by Frumence et al. (2018) reported that partners have contributed adequately toward maternal health interventions and in the reduction of maternal deaths although there are still challenges on the effective coordination mechanism of partners at all levels. This study recommends that a forum be established to advocate and discuss interests and priorities in order to avoid the duplication of efforts in addressing maternal health interventions. This study agrees with the stated finding that partners have contributed adequately that they have filled the vacuum. However, it calls for more improvements to ensure that all interventions are reflected in the CCHPs and that there must be a good mechanism for coordination at the council and regional level.

In other health related interventions, partner contribution has played a significant role in health sector, but it requires a close collaboration with these partners from the planning phase up to the implementations phase of maternal interventions. In this regard the Councils authorities and the community level must work closely with these partners from the beginning. The government at all levels should strengthen the collaboration between the two parties.

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5.1.3 Direct Health Financing System (DHFF)

Key findings have vividly shown that currently all HFs have their own bank accounts whereby all funds are directly collected there as compared to what the past when collections were sent to the accounts managed by the District Executive Director. Direct Health Facility Financing has helped to improve the implementation of maternal health interventions at the HFs and

council levels as the implementation of planned activities are implemented as planned. Direct Health Facility Financing also involves locally collected revenues, government funds from central government and donor funds, which are directly sent to HFs. The findings show that there is an autonomy brought to primary healthcare facilities and their governance structures by these reforms and has an impact in decision making in HFs and therefore influence the health system outputs

According to Opwora et al. (2009), DHFF was perceived to have had a highly positive impact in Kenya. The utilization of facilities was thought to have increased, especially through the expanded outreach programs, thus improving the people's access to health services. Although this resulted in a heavy workload for staff, there were no complaints about this as the increased workload was offset by the improved working environment, namely the availability of supplies and a better infrastructure, and by the ability to hire more support staff. Health worker motivation was also improved through provision of allowances; and, as a result of these changes, it was felt that quality of care had improved.

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5.1.4 Good Communication and Coordination

The findings of this study have identified good communication and coordination as a strategy useful for effective implementation of CCHPs at the council level. The findings show that good communication among the CHMTs and from the CHMTs to HFs has facilitated the implementation of maternal planned interventions in CCHPs in all the four (4) councils in Rukwa region. Good communication and coordination have facilitated the CHMTs to have a common understanding on the implementation of planned maternal health interventions in the CCHPs. The CHMTs together help all the HFs to implement their planned interventions. The areas of assistance are such as procurement of medicines and supplies for maternal health services.

According to Anyango (2016) in a study on the factors determining project implementation of health projects in Gedo Region, Somalia, the level of communication in the organization determines the effectiveness of health project implementation. The study shows that poor or lack of communication results in difficulty in finishing the projects. The finding of this study

concurs with the Anyango study that good communication and coordination determine the effectiveness of implementation of CCHPs in the study area with the analogy standing the chance of applying elsewhere.

It is very crucial to continue making smooth communication and coordination from the national level to the HFs level involving all required approaches in communication so as to improve the delivery of quality health services at Health facilities level. The CHMTs and the RHMTs are the one who can play the smooth communication and coordination.

5.1.5 Centralized web-based planning and reporting software

The study findings further show that the use of a centralized web-based planning and reporting software has positively contributed toward the success of the CCHP plans and reporting. It has simplified program implementation at health facility level as the system is linked with the other expenditure and reporting software (FFARS). These systems work together, and all the implemented activities are reported quarterly. Planned maternal health interventions such as referral activities are implemented without any fund reallocation at HF level, a situation which makes planned maternal activities to be implemented as scheduled.

According to Bjerkan, Vatne and Hollingen (2014), web-based planning system can be effectively productive and cost effective in the health sector if the planning teams are pro-active in planning using web-based system. However, this study has observed that some of the health workers are reluctant to use these systems for planning, a situation which may result in delays, confusion and generally unsuccessful implementation of the activities.

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Though the use of Centralized web-based can positively contributed to the CCHP plans and reporting, but the use of this system requires commitment to those who use it at planning and implementation level. In addition, there are challenges of networks in some of the remote areas which should be improved and furthermore health workers should periodically update on technical issues regarding planning and reporting using this software. In addition, the government should ensure that there is power connection in HFs so as to ensure smooth use of planning softwares at HFs level. On the other hand, there should be a special training on the computer literacy so as to facilitate the smooth planning process at the HFs level.

5.2 Prohibiting Factors for the Implementation of Planned CCHP Maternal Health Services Interventions in Rukwa Region's Councils

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This study has found out the key factors hindering the implementation of planned CCHP maternal health services interventions in Rukwa region's councils are: limited maternal interventions at the community level, inadequate maternity waiting homes, inadequate specific supportive supervision on maternal health services, limited referral transport facilities, inadequate technical package, late disbursement of funds, limited human resources, limited planning, budgeting and management capacity at the HF level, inadequate monitoring and evaluation and quality and reality of data at the facility level. Discussion on the identified follows in the sub-sections:

5.2.1 Inadequate number of Maternal Health Interventions at the Community Level

This study has identified limited maternal interventions at the community level to have partly contributed to the increased maternal deaths in almost all the councils in Rukwa Region. Community interventions focused on reducing maternal deaths are not well articulated in the CCHPs in all councils in Rukwa Region. The review of CCHPs implementation reports for 2017/ 2018 in Rukwa region has shown that the maternal health services has had 28 sub interventions which must have been planned in the CCHPs each year. However, the review shows that only a few community maternal interventions are addressed in annual CCHPs. The review shows that in 2017/2018 only 25 percentage of all maternal intervention were planned

in the CCHPs in Rukwa region. Furthermore, the review also shows that among all the planned interventions which were incorporated in the CCHP, only 21 percentage were implemented.

Although partners have facilitated the environment to ensure that all the villages in Rukwa Region have village health workers who play an important role in the area of maternal and reproductive health, the challenges are still there. The village health workers sometimes may not reach each sub village within the catchment areas due to geographical complexities and limited access to transportation.

Despite the partners' initiative at the community level toward bettering maternal health services, not all maternal health services interventions are covered in the CCHPs. More efforts are required to ensure that all community interventions are covered. Although the CCHP Guidelines (2011) indicate that all the maternal interventions must be reflected in the CCHPs, this is not practically the case. It can be realized sometimes that the HFs and HFGCs may not include the prescribed content in their health plans due to prioritization and budget allocation. In this case, the CHMTs must ensure that all interventions are implemented on time. According to Chitama et al. (2011), there are competing interests in the criteria used in priority setting in the health sector, especially at the office of the RCH coordinator. In order to resolve this confusion, CCHPTs needs to be considered during priority setting and general planning. The study shows that the absence of a consensus and clear criteria for setting priorities has implications on the district priority setting decisions and the beneficiary population at large. Findings from Chitama's study agree with the findings of this study which have shown that in the year 2017/2018 only 25.9% of all maternal health interventions, which were supposed to be included in the CCHP, were incorporated.

5.2.2 Lack of Maternity Waiting Homes

The finding of this study shows the absence of maternity waiting homes in Rukwa region. Given the nature of the region, the findings show that most of the maternal deaths occurring in all the councils could be blamed on the complex geography of the areas making it hard for patients to access the referral facilities, transport problems, economic hardships and among

pregnant women who cannot afford to travel or stay at the prescribed referral facilities. There are no maternal waiting homes providing accommodation to pregnant women in Rukwa Region.

According to WHO (1996), maternity waiting homes are residential facilities, located near a qualified medical facility, where women defined as "high risk" can wait for their delivery periods and be transferred to a nearby medical facility shortly before delivery, or earlier should complications arise. Many consider maternity waiting homes to be a key element of a strategy to "bridge the geographical gap" in obstetric care between rural areas, with poor access to equipped facilities, and urban areas where the services are available. As one component of a comprehensive package of essential obstetric services, maternity waiting homes may offer a low-cost way to bring women closer to the needed obstetric care.

A study conducted by Daddi (2018) shows that maternity waiting homes contributes more than 80% toward the reduction of maternal deaths among users in Ethiopia. Moreover, Daddi reports that more than 70% of stillbirth incidents are reduced among the users of maternity waiting homes in Ethiopia.

The observed difference between this study and other studies, suggest that the government should consider the construction of maternity waiting home. As the approach of maternity waiting home will require big investments in terms of financial resources, the Council and HFs planning team should look on the temporary approaches during the transition period before the construction of maternity waiting home, which will involve interventions to facilitate and support pregnant women to reach the referral facilities on time without delay. More advocacy to the community should be there on having delivering plans to all pregnant women.

5.2.3 Inadequate Specific Supportive Supervision on Maternal Health Services

The study has found out that CHMTs and HFs prepared their integrated supportive supervision reports quarterly in their CCHPs, including maternal health interventions. Despite the planned

maternal health interventions supportive supervision in the CCHPs each quarter, there are challenges which involve timely disbursement of funds, inadequate human resources, late disbursement of funds, ad-hoc activities and lack of reliable transport facilities for supervision.

The study further observes that the CHMT supervisions are integrated with other program areas which involve looking monitoring the selected indicators at the HF level. The integrated supervision does not seek specific interventions, rather it involves other program interventions with maternal health services intervention included. The findings show that only specific supportive supervisions are conducted by vertical programs and partners. In addition, there is no uniform maternal health intervention checklist in the councils, a situation which makes comparison of supervisions impossible.

This study finding is in line with other findings elsewhere. Findings from a study conducted by Kilewo and Frumence (2015), shows that weak supportive super-vision from CHMTs to lower-level facilities caused by insufficient human resources, as well as lack of reliable means of transport, contribute much to the poor quality of health service delivery at health facility level. According to Renggli et al. (2018), routine CHMT supportive supervision has often been reported as infrequent, inefficient and ineffective in tackling performance gaps. Also, councils have been using a general supportive supervision checklist to develop their checklists. The similarity of the contents of the checklists makes comparison between councils to become almost impossible.

5.2.4 Limited referral transport facilities

The finding of this study shows that availability of adequate transport facilities is one of the challenges facing the implementation of CCHP at the council and HF level. All the councils in Rukwa region have inadequate number of ambulances for referral of patients, including pregnant women. Most of the councils have less than 3 ambulances which serve the whole councils and HFs scattered across the vast administrative areas. The findings also show that most of the ambulances are not equipped with all life-saving equipment, a situation which may also contribute to the risk of maternal deaths in the councils. The findings further reveal that ambulances are stationed in just a few health centers and sometimes stationed at the council

headquarters; when an emergency involving pregnant women arises, the vehicle must move to the specified HF to pick up the client irrespective of the time taken to reach the patient which is usually longer than expected.

Other studies on the use of maternal referral services in rural Tanzania indicate that delays of pregnant women to referrals facilities is contributed by community perceptions of the seriousness of the condition, inadequate transport facilities and cost involved in transport and living at the hospital (Pembe et al., 2008)

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5.2.5 Inadequate Technical Package

This study findings show the absence of enough technical capacity of the planning process among members of the HFs planning team in using the web-based planning software. Most of the HF superintendents are not capable of using the system when planning. It can be found that HF plans are sent to the CHMTs for them to feed their plans into the system although the plans have originated from them. The findings further show that HF health facility staff and HFGCs have not yet been adequately empowered on health planning and implementation software. It can be the case that some of the HFs can have enough funds in their bank accounts, but because of low capacity to utilize funds it become difficult for them to spend until the CHMTs push them to do what is required.

On the other hand, most of HFs superintendents lack managerial skills in their HFs as most of them are clinicians who concentrate on their clinical services. Frieden (2014) conducted a study on the components necessary for effective public health program implementation and reported that the most effective public health programs are based on an evidence-based technical package of proven interventions committing to the implementation of specific interventions known to be effective. Any interventions in the health sector should be effective and must devise an approach to achieve the objectives. Findings from another study have shown that health program managers have a dual responsibility when managing program plans, which include: (a) managing the technical components of the program (plans, schedules, budgets, statistical analysis, monitoring, and control involved in the various

knowledge areas and processes) and (b) managing the people in such a way to motivate the team to successfully complete the anticipated goals (Neuhauser, 2007).

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The technical packages of using several interventions in maternal health services are limited. According to Frieden (2014) the use of combined technical interventions such as RCH package has proved to increase the efficiency in delivering health services. Although CCHP technical packages of maternal interventions involve 28 interventions, only few interventions are planned and implemented. It is only about only **25.9%** of the interventions that are planned, a situation that has resulted in some intervention not being addressed, which in turn accelerates maternal deaths.

5.2.6 Late disbursement of funds

This study reveals that the quarterly fund disbursements are not released as planned and funds are released at irregular intervals. Most of the CHMTs explained their concerns that their inability to implement action plans emanates from the lack funds unless those uses own sources funds and those which does not require funds. There are several consequences if maternal interventions and activities are not implemented as planned. The finding shows that only 45% of the planned interventions are implemented due to inadequate funds, especially funds from the central government.

Other similar studies show that late disbursement of funds interrupts the implementation of health activities in the district health system. This situation delays the implementation of some activities, while a few activities may not be implemented at all. Consequently, most of the councils have opted for other methods to cope with the situation such as obtaining supplies on credit, borrowing money from other projects in the council and using funds from the own sources (Frumence et al., 2014).

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5.2.7 Lack of Human Resources

Findings show that human resources have been critically affecting the health services delivery in most of the health facilities in Rukwa Region. According to the responses from members of the CHMTs, the scarcity of human resources has contributed to the overloading of work

among health workers, which affects the implementation of health activities, including maternal health. A few health workers available at the Health facilities are responsible for coordination of all activities from all levels including the national, regional and council levels.

According to Kiwia eta Foster (2016), districts in Lindi Region face an acute shortage of health workers, which ultimately affects the delivery of health services. Several issues were cited as reasons for the shortage of staff, including remoteness of the districts, delayed salaries and other statutory benefits, poor working environment, lack of adequate housing, and cumbersome recruitment procedures. The CHMT staff interviewed for this study noted that the centralized recruitment by the Public Service Management takes 6-12 months and sometimes results in posting staff who are not interested in working in a particular district or do not have the skill set matching the open position.

5.2.8 Limited Planning, Budgeting and Management Capacity

In this study, it has been found that most of the newly employed healthcare staff are not empowered in the areas of health planning, budgeting and management capacity especially at the dispensary and health center levels which are now implementing the CCHPs at their cost centers. Health institutions should consider incorporating in their curriculum such skills in order to empower their existing and future staff.

According to Kaur eta Singh (2013), the current medical education should prepare healthcare professionals to be able to deal with challenges facing healthcare delivery systems. It has been shown that planning and management issues are incorporated in the teaching at various medical intuitions. This study, however, recommends that more time and hours should be devoted to these areas so to enable healthcare staff in their efforts at providing good healthcare services

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The findings of this study agree with other studies as stated above. In Tanzania most of the health institutions are incorporating planning, budgeting and management capacity to the medical students professional, there should a short courses of health staffs who are newly employed in HFs level. This should be arranging annually to build HFs staffs capacity in management.

5.2.9 Lack of M & E Officers

The findings of this study indicate that monitoring and evaluation are not well implemented in all the councils. In all the councils visited there is no M&E Officers who monitor the implementation of CCHP in each quarter as required. The M & E are conducted partially by the district health secretaries who, in some way or another, work together with the CHMTs to monitor the way CCHP plans are implemented.

Another challenge which hinders proper monitoring of the plans is the irregular budget flow. This has partly contributed to the failure to implement the planned CCHP activities. If the activities would be effectively implemented as planned on a quarterly basis, it could be easier to monitor. But the situation is different in all the councils in Rukwa Region since the implementation of the activities is not done as planned.

On the other hand, the implementation of the CCHPs has been facilitated by partners who support the maternal health intervention in Rukwa Region. However, sometimes CHMTs do not monitor the plans effectively to understand what has been implemented as some of the activities are not included in their CCHPs.

Monitoring is done in accordance with the prior set targets and all their activities as predetermined during the planning phase. These activities ensure that everything is on track and can allow the project managers detect early enough when deviations occur. If monitoring is conducted as expected, it is a very important management tool that acts as the basis for project evaluation since through it the concerned parties establish the sufficiency and adequacy of the available resources and whether they are optimally used. In the case of human resources, monitoring helps in determining if the available manpower is competently constituted to do what was planned (Magbool, 2014).

5.2.10 Quality and Reliability of Data at the Facility Level

This study shows that there are discrepancies of health data at the health facility level regarding the number of maternal deaths that has occurred in the community. Most of the health facilities collect their data in their HFs HMIS registers but incidents of missing

community register which may contain important data on maternal issues, such as number of maternal deaths that has occurred in the community, has been commonplace.

The findings of this research agree with the study by Anwar et al. (2018), which shows that data coverage improvement and completeness are still a challenge and there is need for more reconciliation of maternal data. It is possible to obtain the accurate data regarding maternal, perinatal and neonatal mortality data at a local level in collaboration with local facility management.

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5.3 Implementers' Opinions on How to Improve the Implementation of Planned CCHP Maternal Health Services Interventions in Rukwa Region's Councils

The implementers' opinions on how to improve the implementation of planned CCHP maternal health services interventions in Rukwa region's councils are categorized as follows: reflection of partners' maternal interventions contribution to the CCHP, community sensitization on maternal health, construction of maternity waiting homes, training of HFs planning teams, the use of bylaws at the community and council levels to restrict delivery, review of guidelines for health plans, health education package at the community, presence of M & E personnel at council level, and timely disbursement of funds.

5.3.1 Reflection of Partners' Contribution toward Maternal Health Intervention in the CCHP

In this study, it has been found out that partners' contribution toward maternal health services are not well reflected in most of the councils' CCPs. Most of the CCHPs are missing the maternal health interventions that are planned by the partners. This situation has contributed to the process of monitoring and evaluation of partners' activities to be difficult in most of the councils.

According to Frumence et al. (2018), effective coordination mechanisms between all the stakeholders at each level should be advocated to provide a forum to discuss interests and priorities of all stakeholders to harmonize them and facilitate the implementation of development partner funded activities in the recipient countries.

5.3.2 Community Sensitization on Maternal Health

This study has found out that there is inadequate knowledge at the community level on maternal health services. The reviewed reports in the CCHP for 2017/2018 shows that only 29% of the required interventions are included in the CCHP. The components that are left out in the community interventions play crucial part in the overall planning. Most of the councils do not include maternal health services in their plans for community interventions. This has reduced the levels of awareness among pregnant women in Rukwa region.

Other studies, including Jacobs et al. (2018), have shown that strengthening community-based action groups in poor and remote districts through community workers can lead to increased coverage and uptake of maternal and newborn health interventions. In remote and marginalized settings where there is more need of maternal health intervention, context-specific and innovative task-sharing strategies using community health volunteers can be effective in improving coverage of maternal and neonatal services and hold promise for better maternal and child survival in poorly-resourced parts of sub-Saharan Africa.

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5.3.3 Training of HFs Planning Teams

CHMTs members who participated in the FGDs also recommended that given their limited technical package in the planning team at community and HFs levels, there is a need to have a special package for training HF workers and HFGCs teams on the planning and reporting using a web-based software to increase the effectiveness and efficiency in implementing the planned CCHPs interventions. This will help in reducing the burden of supervision from the CHMTs members. It will also increase the accountability of the HF planning teams at the lower level.

A study by Chitama et al. (2011) has recommended that maternal health intervention stakeholders should be involved in setting process, training and providing the technical and supervisory support to priority setting teams; improvement in the use of maternal health

information and planning tools; and development of an efficient and fair priority setting process or framework.

5.3.4 Construction of Maternity Waiting Homes

As a way of improving the implementation of most of the planned maternal health intervention in the CCHP, CHMT members had the perception that there is a need to establish maternity waiting homes. If maternity waiting homes are established in strategic areas in each council – they will help in reducing the number of maternal deaths especially in those areas with transport difficulties and with low income households. Without comprehensive intervention plans, there is the danger of hosting increased numbers of maternal deaths.

A study conducted by Daddi (2018) provided similar recommendations regarding the importance of maternity waiting homes. The author said that maternity waiting homes contribute more than 80% in the reduction of maternal deaths among users in developing countries and Ethiopia in particular. Its contribution toward the reduction of incidents of stillbirth is also commendable. More than 70% of stillbirth is reduced among the users of maternity waiting homes.

4.3.5 The Use of Bylaws at the Community and Council Levels

The findings of this study have revealed that there are several malpractices in the area of maternal health at local level where by Traditional Birth Attendants (TBAs) predominate. Due to inadequate health education and the high level of illiteracy in some communities, still some traditional birth attendants (TBAs) use the advantage of conducting home delivery. This is not allowed as far as the guidelines are concerned. Also, the findings show that TBAs' home child delivery services are go unchecked as there is no reasonable measure taken to address the situation.

The finding shows that the use of bylaws in the area of maternal health should go together with the health education package in the community. The use of bylaws will increase the number of pregnant women attending clinic, increase the number of antenatal visits to clinics

and will enable HFs to make effective decisions regarding the areas where should deliver according to the needs of the people in a given respective area.

According to Koch (2013), restrictive laws are likely to reduce the incidence of maternal deaths when combined with adequate health and social policies. It should go hand with hand with an increased level of female education, which synergistically influences other factors such as access and efficient utilization of available maternal health services, and promotes changes in the reproductive behavior, especially decreasing fertility and delaying motherhood.

5.3.6 Health Education Package at the Community Level

This study also reveals that there is no uniformity in the health education packages delivered at different health facilities. Each council and health facility have its own package of providing health education in their locality regarding maternal health services. In some of the HFs visited, there is no timetable for providing health education sessions to the visiting clients.

More health education is needed for pregnant women during ANC visits to address different aspects related to pregnancy, delivery, and infant care. More organized educational activities should be employed by physicians, health educators, or nurses at the health facility level.

5.3.7 Presence of M & E Personnel at Council Level

The study finds that in improving the CCHPs implementation the government should ensure that they employ M&E in each council. The council and central government should ensure that a reasonable number of M&E officers is employed in the councils to facilitate CCHP implantation in terms of monitoring and evaluation.

A well-designed M&E system ensures that quality data is regularly collected during and after the implementation of a health program. The data collected guides program implementation teams and informs decisions to be taken by the actors accordingly (MoH-Kenya, 2016).

5.3.8 Increase the Employment in Health Sector

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There is critical shortage of health workers in all the councils in Rukwa region. Most of the councils have health workers less than 50% of their needs, a situation which makes the health workers overloaded with responsibilities in their working areas. This situation should be well

addressed to ensure that health services are delivered at the minimum level of required health staff as required. This study suggests that the government should consider employing healthcare staff on short term contracts in the needy health facilities. This approach will help fill the gap of scarcity of healthcare staff in most of HFs. Short term contracts to healthcare workers will facilitate the smooth implementation of some of the planned maternal health interventions in the HFs and councils at large. It was reported that some of the intervention are not implemented because of limited human resources.

Studies show that human resources for health should be treated differently from other cadres. According to Mæstad (2006), the health sector is probably different though as it is to a larger extent dependent on the cooperation between cadres at various skill levels. If there are no doctors, there is not much a medical assistant can do. Internationally, there has been some discussion as to whether the health worker crisis can be dealt with through increased supply of low skilled workers. All what is needed is the minimum requirement of all the needed health staff.

5.3.9 Timely Disbursement of Funds

For the smooth implementation of CCHPs in most of the councils, the study has revealed that quarterly and timely disbursement of funds will facilitate smooth implementation of CCHPs for all planned interventions and the maternal health services. Planning guidelines such as the CCHP Guidelines of 2011 in Tanzania indicate that CCHPs should have action plans which are required to be implemented quarterly as planned. The current situation in Rukwa region is not in accordance with the guidelines and therefore it leads to inefficiency of CCHP implementation in most of councils. In most cases, most of planned activities are not implemented on time because of late disbursement of funds.

Late disbursement of funds affects the way councils can monitor the planed CCHPs intervention including maternal health intervention in councils. Therefore, CHMT members recommended that in order to have smooth monitoring of each activity, quarterly implementation of planned activities should be done.

The research findings agree with other studies conducted in Tanzania, in Africa and elsewhere. According to (Frumence *et al.*, 2014)), late disbursement of funds from the central government has interrupted the implementation of planned health activities in each quarter in most of councils in Tanzania. This finding reveals that if funds are not released on time monitoring cannot be done accurately.

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5.4 Study Limitation

This study focused only on the CHMTs, who are the key planners and implementers of the CCHP at the council level are. The study did not involve the HFs planning team who also plans and implement the CCHP. Therefore, conducting only FGDs with CHMTs members could result into biasness of the findings reported. However, to address this limitation, the researchers clearly informed all FGDs participants of the purpose and objectives of this study and that their honesty and genuine information could help in achieving the study objectives. The review of annual CCHP implementation reports was conducted for only one year, more years could have given up more general observations.

Another limitation of this study was social desirability, in which some of the key informants may have provided answers, which have shown positive or favorable images only as a way of avoiding negative evaluation. In addressing this limitation, researchers explained clearly the objectives of this study to the study participants and that findings from this study will help council health management teams and other stakeholders to address some of the challenges facing implementation of CCHP in the district

CHAPTER SIX

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6.0 CONCLUSION AND RECOMMENDATION

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6.1 Conclusion

In Tanzania, the preparation of CCHPs at the council level is well articulated. Planning of CCHPs has been a participatory exercise in all the councils visited. However, the implementation process at the council level still requires several aspects to be addressed for efficiency and effective implementation to reach the planned indicators. These involves improving maternal health interventions at the community level, Construction of maternity waiting home, Conducting supportive supervision on maternal health services, addressing referral transport facilities, disbursement of funds on time, addressing human resources on health services, Supporting Planning, budgeting and management capacity at health facility (HF) level, Employing M & E Officers at council level and improving the quality of data at the facility level. The findings of this study may give room for more improvements in CCHPs implementation.

6.2 Recommendations

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6.2.1 Recommendations to the Council Level Planning

For the good improvement of CCHPs implementation focusing on provision of maternal health services in Rukwa region, this study recommends the following at Council level:

1. The council management and the CHMTs should consider the harmonization of supervision checklist on maternal health which will be used in supportive supervision
2. The council should ensure the reflection of partner contributions toward the provision of maternal health services.
3. Coordinate the partners in the council
4. The Council should use bylaws to restrict home delivery
5. The council should ensure that there is a uniform health education package on maternal health services at all HFs within the council.

6.2.2 Recommendations to the Regional Level.

The study recommends the following to the regional level:

1. The RHMTs should ensure good coordination and communication to the council to understand what is going on within councils
2. Harmonize the supervision checklist for better comparison among councils
3. Coordinate partners on maternal health services
4. Ensure maternal health interventions are included in CCHPs during securitization
5. Develop a uniform training package to HF staffs
6. Strengthen the use of by-laws at community level.

6.2.3 Recommendations to the National Level

1. The health stakeholders at national level should review the policy on the construction of maternity waiting home.
2. The Ministry of PO-RALG to ensure early quarterly fund disbursement to Councils and HFs
3. PORALG should ensure employment of health staff meets a minimal staffing level
4. The PORALG should re-distribute maternal health partners evenly in the country
5. The Ministry of Health, Community Development, Gender, Elderly and Children should prepare comprehensive health education package and distribute it to the regions and councils' levels.

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APPENDICES

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Appendix I: FGD guide for CHMTs and Health facilities planning team (English Version).

Interview Guide for FGD – District council level (English Version).	
Respondents: CHMTs & Health Facility planning teams **OBJECTIVE 1**	
A	**Kindly describe how actual planning are conducted at Council?**
i	Probe how guidelines and tools are used in maternal planning of CCHP at Council?
ii	Probe who are the key actors involved in maternal CCHP planning?
iii	Probe how maternal priorities are set during CCHP?
iv	Probe how indicators for maternal health are developed at the council level?
v	Probe participation of members during planning?
vii	Observe written reports for planning session?
1	**Supportive Supervision**
i	Kindly describe how actual maternal supportive supervision are conducted by CHMTs
ii	Probe how many maternal supervisions conducted annually
iii	Probe for maternal supportive supervision schedule and matrix
iv	Observe the maternal SS feedback and schedule for Supportive supervision
v	Probe for the available maternal checklist for supportive supervision?
vi	Probe whoa are involved in supportive maternal supervision?
vii	Probe time for maternal supportive supervision?
2	**Communication**
i	Probe how communication is conducted during implementation of CCHP at council?
ii	Probe kind of communication available among CHMTs themselves
iii	Probe how communication is conducted between the CHMTs

3	**Technical Package**
i	Kindly describe how Technical package is used in implementing CCHP?
ii	Probe technical personnel involved in CCHP implementation at CHMTs level?
4	**Stakeholders involvement**
i	Kindly describe how key Stakeholders are involved in maternal CCHP Implementation?
ii	Probe key stakeholders involved and how they are involved in maternal implementation in CCHP?
iii	Probe who are the key stakeholders in maternal planning?
5	**Leadership and Management**
i	Kindly describe Good leadership and Management practices in CCHP Implementation
ii	Probe the involvement of District and HF/Local leaders on implementing CCHP
6	**Planning**
i	Probe if maternal intervention is planned as per guidelines
ii	Probe if maternal Interventions implementation is as planned?
iii	Probe if maternal activities are implemented as planned?
iv	Probe for the realistic of planned maternal activities?
7	**Partnership (PPP)**
i	Kindly describe the existing Partnership in implementing CCHP
ii	Probe what partnership available in CCHP implementation at Council level
8	**Policy and Guideline**
i	Describe the available maternal guideline, strategies and policies for implementation of CCHP

ii	Probe if these guidelines are fully used and utilized
C	**OBJECTIVE 2. In your views what are the prohibiting factors affecting implementation of the CCHP?**
1	**Human Resources**
i	Kindly describe human resource affecting maternal implementation of CCHP
ii	Probe for the available human resources at CHMTs level
iii	Probe key human resources for maternal CCHP implementation
2	**Resources allocation**
i	Kindly Describe about Financial support and resource mobilization in maternal implementation of CCHP
ii	Kindly Describe about resource mobilization in implementing CCHP
iii	Probe type of Financial support in maternal CCHP implementation
iv	Probe for the available resources mobilization in implementing CCHP
v	Probe time will take for funds disbursement for maternal implantation of planned activities
vi	Probe how resources are allocated during CCHP?
3	**Coordination**
i	Probe the coordination process during the maternal implementation of CCHP?
ii	Probe who are the key coordinator of the CCHP during maternal implementation?
iii	Probe about coordination process from the CHMT themselves and to the HFs level
iv	Kindly describe how Coordination is done during implementation of CCHP?
4	**Monitoring and Evaluation**
i	Kindly describe on how maternal Monitoring and Evaluation of CCHP are conducted?
ii	Probe about monitoring system available at District CHMTs in maternal

	implementation of CCHP
iii	Probe if Health facilities HFGCs are involved in maternal implementation of the HFs Plan
5	**Weak Supportive Supervision**
i	Kindly describe how actual maternal supportive supervision are conducted by CHMTs
ii	Probe how many maternal supervisions conducted annually
iii	Probe for maternal supportive supervision schedule and matrix
iv	Observe the SS feedback and schedule for Supportive supervision
v	Probe for the available maternal checklist for supportive supervision
vi	Probe whoa are involved in maternal supportive supervision
vii	Probe time for maternal supportive supervision
D	**OBJECTIVE 3. CCHPs' implementers' perceptions on how to improve the implementation of planned CCHP maternal health services interventions**
1	**Health Management bodies**
i	Probe the CHMTs planning team perceptions on how to improve the implementation of planned CCHP
ii	Probe the available health management bodies at Council level
iii	Probe how Health Management bodies affect implementation of CCHP
iv	Probe how Health Management bodies affect implementation of CCHP
2	**Community participation**
i	Probe the HF planning team perceptions on how to improve the implementation of planned CCHP
ii	Probe community HF planning team on their
iii	Probe how Community participation are involved in CCHP
iv	Probe how Community participation affect implementation of CCHP

Appendix II: FGD guide for CHMTs and Health facilities planning team (Swahili Version).

Kiongozi cha FGD 1 – Ngazi ya Halmashauri	
Muhusika: Timu ya uendeshaji wa huduma ya wilaya na Timu ya kuandaa mipango ya ngazi ya vituo vya kutolea huduma za Afya	
A	**Tafadhali elezea ni jinsi gani mipango ya Afya inavyoandaliwa ngazi ya halmashauri ya Manispaa?**
i	Chunguza jinsi miongozo ya mipango invyotumiwa katika mipango ya CCHP katika ngazi ya wilaya?
ii	Chunguza wahusika wakuu katika kuandaa mipango katika ngazi ya wilaya?
iii	Chunguza ni jinsi gani vipaombele vinavyoandaliwa wakati wa kuandaa CCHP latika wilaya?
iv	Chunguza jinsi viashiria vya mpango wa CCHP vinavyo andaliwa?
v	Chunguza ushiriki wa wajumbe wanaoshriki uandaaji wa CCHP?
vii	Angalia uwepo wa ripoti za kuandaa mipango ya CCHP?
	Lengo la 1: Kwa mtazamo wako ni mambo yanayowezesha na kuathiri utekelezaji wa CCHP?
1	**Usimamizi shirikishi**
i	Tafadhali elezea ni kwa jinsi gani usimamizi shirikishi unavyo fanyika na CHMTs?
ii	Chunguza usimamizi shirikishi umefanyika mara ngapi kwa mwaka?
iii	Chunguza uwepo wa ratiba za usimamizi shirikishi kwa CHMTs?
iv	Chunguza kama mrejesho wa usimamizi shirikishi toka kwa CHMTs kwenda HFs?
v	Chunguza uwepo wa Checklist ya usimamizi shirikishi kwa CHMTs?
vi	Chunguza ni nani wanaoshiriki usimamizi shirikishi?
vii	Chunguza usimamizi shirikishi unachukua muda gani kumalizika katika kituo kimoja?

2	**Mawasiliano**
i	Chunguza ni jinsi gani mawasiliano yanavyofanyika wakati wa utekelezaji wa CCHP katika ngazi ya Wilaya ?
ii	Chunguza aina ya mawasiliano yaliyopo kati ya CHMTs
iii	Chunguza mawasiliano kati ya CHMTs na kituo katika utekelezaji wa CHHP?
3	**Mbinu za kiufundi**
i	Tafadhali elezea njia za kiufundi zinazotumika katika utekelezaji wa CCHP?
ii	Tafadhali elezea wataalam wanaohusika katika utekelezaji wa CCHP katika ngazi ya Wilaya?
iii	Chunguza mhusika muhimu ambaye anayewezesha katika utekelezaji wa CCHP?
4	**Kuwahusisha wadau mbalimbali**
i	Tafadhali elezea ni jinsi gani wadau mbalimbali wanavyohusika katika utekelezaji wa CCHP
ii	Chunguza njia zianazotumika kuwahusisha wadau mbalimbali katika utekelezaji wa CCHP?
iii	Chunguza ni wadau wapi muhimu wanaohusika katika utekelezaji wa CCHP?
5	**Uongozi na usimamizi**
i	Tafadhali elezea ni jinsi gani uongozi na usimamizi unavowezesha utekelezaji wa CCHP?
ii	Chunguza ushiriki wa viongozi wa wilaya na jamii wanavyo husika katika utekelezaji wa CCHP?
6	**Afua za CCHP zilizopangwa**
i	Chunguza kama mikakati ya CCHP inapangwa kulingana na CCHP?
ii	Chunguza kama mikakati ya CCHP inatekelezwa kama ilivyopangwa?

iii	Chunguza kama shughuli za CCHP zinatekelezwa kama zilivyopangwa?
iv	Chunguza uhalisia wa shughuli za CCHP zilizopangwa?
7	**Sera na Miongozo**
i	Tafadhali elezea miongozo, mikakati na sera zilizopo katika utekelezaji wa CCHP?
ii	Chunguza kama miongozo hii inatumika ipasavyo?
8	**Usimamizi Shirikishi**
i	Tafadhali elezea ni kwa jinsi gani usimamizi shirikishi unafanyika na CHMTs
ii	Chunguza idadi ya simamizi kwa mwaka
iii	Chunguza ratiba za usimamizi shirikishi
iv	Chunguza jinsi vituo vinavyopata mrejesho wa usimamizi
v	Chunguza dodoso la Supervision
vi	Chunguza wanaohusika na usimamizi shirikishi
vii	Chunguza mda unaotumika katika supervision
B	**Lengo la 2. Kwa mtazamo wako ni mambo yayozuia na kuathiri utekelezaji wa CCHP?**
1	**Rasilimali watu**
i	Tafadhali elezea ni kwa jinsi gani rasilimali watu inavyoathiri utekelezaji wa CCHP?
ii	Tafadhali elezea watumishi waliopo kwa sasa katika ngazi ya CHMTs na katika ngazi ya vituo katika utekelezaji wa CCHP?
iii	Chunguza rasilimali watu waliopo katika utekelezaji wa CCHP?
2	**Mgao wa Rasilimali fedha**
i	Tafadhali elezea juu ya msaada wa fedha katika utekelezaji wa CCHP?
	Tafadhali elezea juu ya uhamasishaji wa fedha katika utekelezaji wa CCHP?
ii	Chunguza aina ya msaada wa fedha uliopo katika utekelezaji wa CCHP?

iii	Chunguza uhamasishaji uliopo katika utekelezaji wa CCHP?
iv	Chunguza ni kwa jinsi gani utoaji wa fedha za utekelezaji wa CCHP unavyofanyika?
v	Chunguza ni kwa jinsi gani rasilimali fedha zinavyotengwa katika uandaaji wa CCHP?
3	**Uratibu**
i	Chunguza ni kwa jinsi gani taratibu za uratibu wakati wa utekelezaji wa CCHP?
ii	Chunguza mratibu mkuu wa utekelezaji wa CCHP katika ngazi ya Halmashauri?
iii	Tafadhali elezea ni jinsi gani uratibu wa utekelezaji unafanyika wakati wa utekelezaji wa CCHP?
4	**Uangalizi na Tathmini**
i	Tafadhali elezea ni jinsi gani tathmini ya utekelezaji wa CCHP inavofanywa?
ii	Chunguza njia za ufuatiliaji na tathmini zilizopo katika utekelezaji wa CCHP?
iii	Chunguza kama kamati za vituo zinahusishwa katika utekelezaji wa CCHP?
8	**ukosefu wa Usimamizi Shirikishi**
i	Tafadhali elezea ni kwa jinsi gani usimamizi shirikishi unafanyika
ii	Chunguza idadi ya simamizi kwa mwaka
iii	Chunguza ratiba za usimamizi shirikishi
iv	Chunguza jinsi vituo vinavyopata mrejesho wa usimamizi
v	Chunguza dodoso la Supervision
vi	Chunguza wanaohusika na usimamizi shirikishi
vii	Chunguza mda unaotumika katika supervision
C	**Lengo la 3. Mtizamo wa mamlaka na timu zinazotekeleza CCHP katika nia bora za utekelezaji wa mipango ya CCHP**
1	**Mamlaka za Uandaji wa miapngo na utekelezaji wake**
i	Nini mtizamo wa CHMT katika njia bora za kutekeleza mpango wa CCHP?

ii	Chunguza mamlaka mbalimbali zilizopo zinazosaidia utekelezaji wa CCHP?
iii	Chunguza ni kwa jinsi gani Mamlaka mbalimbali zinavyoathiri utekelezaji wa CCHP?
2	**Ushiriki wa jamii**
i	Nini mtizamo wa timu ya mipango ya kituo katika njia bora za kutekeleza mpango wa CCHP?
ii	Chunguza ni jinsi gani ushiriki wa jamii unavyohusika katika utekelezaji wa CCHP?
iii	Chunguza ni jinsi gani ushiriki wa jamii unavyo athiri utekelezaji wa CCHP?

Appendix III: Checklist form for review of Annual Implementation CCHP Reports:

Checklist form for review of Annual Implementation CCHP Reports		
SN	**Indicator/Item**	**2017/ 2018**
A	**Planning**	
1	List down all the CCHP maternal health and related target indicators that were planned for the 2017/18 financial year	
2	List of all annual planned CCHP Maternal health and related activities 2017/18	
3	List all the Financial Resources allocated for CCHP Maternal health for FY 2017/18	
B	**Implementation**	
1	Annual implementation report of CCHP available 2017/18	
2	List of all fully implemented activities on CCHP Maternal health and related activities 2017/18	
3	List of all partially implemented activities on CCHP Maternal health and related indicators	
4	List of CCHP Maternal health and related activities not implemented at all 2017/18	
5	List of all CCHP Maternal health and related activities planned activities carried over for the next year 2018/19	
6	List of activities implemented on time on CCHP Maternal health and related activities 2017/18	
C	**Achievements**	
	List of achieved CCHP Maternal health and related indicators for the year 2017/18	
	List of activities achieved as planned on CCHP Maternal health and related activities 2017/18	

D	**Available Reports**	
1	List of reports on monitoring of implementation of CCHP Maternal health and related indicators annually 2017/18	
2	List of monitoring reports on implementation of CCHP Maternal health and related indicators annually 2017/18	
3	List of evaluation reports on CCHP Maternal health and related indicators annually 2017/18	
E	**Financial Resources**	
4	Amount of funds planned for CCHP Maternal health and related indicators annually 2017/18	
5	Amount of funds received for CCHP Maternal health and related indicators annually 2017/18	
6	Amount of funds spent for the CCHP Maternal health and related indicators annually 2017/18	
7	Amount of funds carried over for CCHP Maternal health and related indicators annually 2017/18	
10	List down sources of funds used in CCHP Maternal health and related indicators annually 2017/18	
F	**Data Quality Assessment**	
13	Check the outcome indicator for CCHP Maternal health by the year 2017	
14	Check the Data quality Audit report available on CCHP Maternal health and related indicators annually in DHIS2 at CHMT level	
15	Check the monthly review meeting reports available CCHP Maternal health and related indicators annually at Council level	
16	Check the monthly review meeting reports available CCHP Maternal health and related indicators annually at health facility level	

Appendix IV: Consent Form

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Title: AN ASSESSMENT OF IMPLEMENTATION OF COMPREHENSIVE COUNCIL HEALTH PLAN: A CASE OF MATERNAL HEALTH IN RUKWA REGION.

Foreword

My name is Nicholaus, Kennedy. I am a researcher from Muhimbili University of Health and Allied Sciences. I am conducting a study on An Assessment of Implementation of Comprehensive Council Health Plan: A Case of Maternal Health in Rukwa region, Tanzania

How to participate in this study

You are asked to participate in this study because you are one among key informants involved in health planning and implementation. If you are willing to participate in this study, I will conduct FGDs with you on implementation of Comprehensive Council Health Plan especially on maternal health.

Purpose and Rationale of the study

The findings from this research will be useful in the Council, and Regional level on addressing facilitating and prohibiting factors for the effective implementation of Comprehensive Health Plans. The findings will be useful to improve the ways councils implement health plans. Various managerial organs at the councils will use the findings to improve the implementation of Council Health plans through advocating the application of the recommendations from this study among various stakeholders and health workers.

Confidentiality

Everything will remain confidential and will be used only for research purposes. The research team will compile a report that will contain information about all key informants participated in this study and information will be treated confidentially and anonymously as no person links (name, form etc. will be documented.

Risks

I do not expect that any harm will happen to you as a result of participating in the study.

Right to participate in the study

Taking part in this study is completely of your choice. You have the right to participate or decide otherwise without giving any reason for your decision. Once you have decided to participate you are also free to terminate your participation at any time.

Who to contact?

If you have any questions about this study you are free to contact, the principal investigator, Nicholaus, Kennedy (**0754 982 992).**

If you have any questions/concerns about your rights as a participant you may contact Dr. Bruno Sunguya, Chairman of MUHAS Research and Publications Committee. P.O.BOX 65001 Dar es Salaam. **Tel 0221503026**

If you agree to participate in this study, please sign this consent form.

I …… have read and understood the contents of this consent form and my questions have been sufficiently answered. I therefore consent for the interview for this study.

Signature of the respondent ……..... Date ……

Signature of the interviewer ……....……. Date ……

Appendix V: Ethical approval

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E-mail: dpgs@muhas.ac.tz

Ref. No. DA.287/298/01A/

22nd May, 2019

Mr. Nicholaus Kennedy
MPH-Executive Track
MUHAS

RE: APPROVAL OF ETHICAL CLEARANCE FOR A STUDY TITLED: "AN ASSESSMENT OF IMPLEMENTATION OF COMPREHENSIVE COUNCIL HEALTH PLAN: A CASE OF MATERNAL HEALTH IN RUKWA REGION, TANZANIA"

Reference is made to the above heading.

I am pleased to inform you that, the Chairman has, on behalf of the Senate, approved ethical clearance for the above-mentioned study. Hence you may proceed with the planned study.

The ethical clearance is valid for one year only, from **21st May, 2019 to 20th May, 2020.** In case you do not complete data analysis and dissertation report writing by **20th May, 2020,** you will have to apply for renewal of ethical clearance prior to the expiry date.

Dr. Emmanuel Balandya
ACTING: DIRECTOR OF POSTGRADUATE STUDIES

cc: Director of Research and Publications
cc: Dean, School of Public Health and Social Sciences, MUHAS

Appendix VI: Permission letters

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Ref. No. HD/MUH/T.350/2016

24th May, 2019

Regional Administrative Secretary
Rukwa Region
P.O. Box 128
SUMBAWANGA.

Re: INTRODUCTION LETTER

The bearer of this letter Mr. Kennedy Nicholaus a student at Muhimbili University of Health and Allied Sciences (MUHAS) pursuing MPH-Distance Learning.

As part of his studies he intends to do a study titled: ***"An assessment of implementation of comprehensive council health plan: A case of maternal Health in Rukwa Region, Tanzania".***

The research has been approved by the Chairman of University Senate.

Kindly provide him the necessary assistance to facilitate the conduct of him research.

We thank you for your cooperation.

Ms. Sharifa Kamby
For: DIRECTOR, POSTGRADUATE STUDIES

cc: Dean, School of Public Health and Social Sciences

JAMHURI YA MUUNGANO WA TANZANIA
OFISI YA RAIS
TAWALA ZA MIKOA NA SERIKALI ZA MITAA

MKOA WA RUKWA
Telegraphic: "REGCOM"
Simu.No:0252802137/2802138/2802144
Fax No. (025) 2802217/2802318
E-mail:ras.rukwa@tamisemi.go.tz

OFISI YA MKUU WA MKOA,
S. L.P. 128,
SUMBAWANGA.

Kumb.Na. CB.10/227/01 "C"/200

27 Mei, 2019.

Mkurugenzi,
Halmashauri ya Manispaa,
Sumbawanga.

Wakurugenzi watendaji,
Halmashauri za Wilaya,
Sumbawanga, Kalambo na Nkasi

YAH: KUMTAMBULISHA NDUGU KENNEDY N. KYAUKE

Tafadhali husika na mada tajwa hapo juu.

Ofisi imepokea barua yenye Kumb. Na. HD/MUH/T.350/2016 ya tarehe 22 Mei, 2019 kutoka Chuo Kikuu cha Sayansi za Afya Muhimbili (MUHAS) kuhusu mada tajwa hapo juu.

Ndugu Kennedy N. Kyauke, ni mwanafunzi wa Shahada ya Uzamili katika Chuo Kikuu cha Afya Muhimbili mwenye namba ya usajili HD/MUH/T.350/2016

Ili kukamilisha masomo yake anatakiwa kufanya utafiti wenye somo linalosomeka ***"An Assessment of Implementation of Coprehensive Council Health plan: A case of Maternal Health in Rukwa Region, Tanzania"***

Kundi la watu anaolenga ili kukamilisha utafiti huo ni Wajumbe wa Timu ya uendeshaji wa Huduma za Afya (CHMTs) katika Manispaa na Halmashauri za Wilaya.

Kwa barua hii, unaombwa kumpokea mtajwa hapo juu na kumpa ushirikiano atakaouhitaji.

Nashukuru kwa ushirikiano.

Dr. Boniface D. Kasululu
KNY: KATIBU TAWALA WA MKOA
RUKWA

Nakala:- Katibu Tawala wa Mkoa - Aisome kwenye Jalada
S.L.P 128
Sumbawanga, Rukwa