FACTORS INFLUENCING IMPLEMENTATION OF COUNCIL HEALTH PLANS: A CASE STUDY OF SUMBAWANGA URBAN AND IRINGA URBAN DISTRICTS

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By

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A Dissertation submitted in partial fulfillment of the Requirements for the Masters Degree of Arts in Health Policy and Management of Muhimbili University of Health and Allied Sciences

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CERTIFICATION

The undersigned certify that they have read and hereby recommend for examination of dissertation entitled ***Factors influencing implementation of council health plans: a case study of Sumbawanga urban and Iringa urban districts,*** in fulfillment of the requirements for the degree of Master of Arts in Health Policy and Management of Muhimbili University of Health and Allied Sciences.

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Signature ..... Date 29th Sept 2010

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DEDICATION

This work is dedicated to my husband and our beautiful daughter

ABSTRACT

Introduction: Effective implementation of policy is a challenging process especially in resource constrained countries. The district is the main implementation unit of the Tanzania national health policies and programmes. Implementers at district level face various constraints when implementing health plans therefore understanding their views on factors influencing implementation of plans is important in ensuring effective execution of health plans to achieve the desired goals. The objectives of this study were to explore the views of Council Health Planning Team (CHPT) on factors influencing implementation of council health plans, and to identify ways of addressing constraints to implementation.

Methods: A cross sectional descriptive study was conducted in Sumbawanga and Iringa municipals among CHPT and in-charges of health facilities that had roles in planning and implementation of Comprehensive Council Health Plans (CCHP) through in depth interviews using an interview guide. The participants were purposively selected and a total of 16 people were enrolled in the study.

Results: Factors influencing implementation of CCHP were identified. Majority of respondents perceived delay in disbursement of funds, lack of capacity of workers and top down approach to planning as constraints to implementation of health plans. The existence of CCHP guideline, manpower and good leadership at the councils were among the identified enablers. The poor road infrastructure of Sumbawanga and existence of a number of incapable people at decision making positions were further found to undermine performance of implementation of health plans in Sumbawanga municipal compared to Iringa municipal. Proposed solutions include the need to change the procurement act to reduce present bureaucracy, the participatory planning should be strengthened and more motivation of staff especially those allocated in rural areas is required. In addition further training of workers at health centres and dispensaries on planning issues is essential.

Conclusion: The delayed in disbursement of funds, lack of human capacity and long bureaucratic procedures are among the constraints to implementation of plans whereas enabling factors include availability of CCHP guideline, good leadership skills and transparency. It is recommended that the constraints should be addressed by the relevant authorities and the enabling factors should be sustained

ABBREVIATIONS

BOD	Burden of disease
CHF	Community Health Fund
CCHP	Comprehensive Council Health Planning
CHMT	Council Health Management Team
CHPT	Council Health Planning Team
DMO	District Medical Officer
FBOs	Faith Based Organizations
HERA	Health Research for Action
HMIS	Health Management Information System
IMR	Infant Mortality Rate
JICA	Japan International Co-operative Agency
MMR	Maternal Mortality Rate
MDGs	Millennium Development Goals
MoHSW	Ministry of Health and Social Welfare
MSD	Medical Store Department
MTEF	Medium Term Expenditure Framework
MTUHA	Mfumo wa Taarifa za Uendeshaji wa Huduma za Afya
MUHAS	Muhimbili University of Health and Allied Sciences
NHIF	National Health Insurance Fund
NGO	Non Government Organization
NSGRP	National Strategy for Growth and Reduction of Poverty
O&OD	Opportunities and Obstacles to Development

PMORALG	Prime Minister's Office for Regional Administration and Local Government
RAS	Regional Administrative Secretary
RCH	Reproductive and Child Health
SWAp	Sector Wide Approach
U5MR	Under-five Mortality Rate
WDC	Ward Development Committee

DEFINITION OF TERMS

Policy: the term policy can be defined as a set of decisions or non-decision taken by those in-charges of a particular area such as an organization or institution. Health policy takes account of all actions or intended actions by private or voluntary organizations that have effect on health. Walt described health policy as

"Health policy is about process and power ... it is concerned with who influences whom in the making of policy, and how that happens" [30]

Policy may be in the form of unrecorded/ traditional practices or a written document. When one talks about public policy it has the same implication as talking about government policy.

Implementation of policy: according to the Oxford Dictionary the verb implement means to make something that has been officially decided start to happen or be used. Policy implementation involves '*what happens between policy expectation and (perceived) policy results'* [43] A concise definition of policy implementation can be stated as those actions by public or private individuals (or group) that are aimed at the accomplishment of objectives set forth in earlier policy decisions [3]. In practice it is quite common to observe difference between what is planned to happen and the final result of a given policy, ie implementation gap.

Health planning: this consists of translation of policy document or statements into implementation strategies and plans. Implementation of plans is part of the planning cycle. Appropriate implementation is vital to the success of planning [14]

Stakeholders: these are the people who are involved in or affected by policy implementation. They play important roles as they can either support or block the process of policy implementation depending on their interests, value, influence and power.

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CHAPTER ONE

1.0 INTRODUCTION

1.0.1 Background

Health planning is necessary as resources are almost always limited worldwide and thus prioritization becomes part and parcel of this process. Priority setting is a process of allocating resources according to specified criteria [1]. When this process is not done appropriately, unfair distribution of available resource may occur, leading to inequality among affected communities. Decision makers have very delicate and important roles to play to ensure that resources are fairly distributed to bring about quality of health care that considers value for money.

The processes of planning and implementation are interlinked and implementation is one of the planning steps. To achieve effective implementation, one has to understand both processes in detail. Planning can be defined as the act or process of making thorough arrangements for something you want to do in the future, whereas implementation is process of ensuring that something that has been officially decided actually happens. In health, planning implies the process of recognizing means for making available, in future, useful and effective health care that addresses the needs of a particular population, all in a context of resource scarcity.

Planning process was explained by Hill [2] to include the following: involvement of important stakeholders, give full situation analysis, prioritize areas of need and identify solution, coordinates all actions, keep record of contribution, set up timetable for project implementation and identify indicator for monitoring and evaluate project implementation and ensure commitment of participants in all steps of planning process. The stakeholders include the community, government, faith based organizations (FBO) and nongovernmental organizations (NGO) and manner in which these stakeholders participate in policy development and implementation greatly influence the outcome of the particular policy [3].

The steps involved in planning include situation analysis, review of available resources, problem prioritization, setting objectives, formulating interventions, developing plans, implementation of plans of action and lastly monitoring and evaluation. Thunhurst et al had described similar process in their study on using problem structuring methods in strategic planning [4]. For the purpose of this study a brief detail of some of these steps is provided,

because understanding of these processes of planning and implementation is a key to successful attainment of better outcomes. Situation analysis assesses the current state of affairs from different angles based on problems, needs and priorities. This entails studying of all areas that usually have impact on the performance of council health plans and programmes; it is necessary to involve all the stakeholders that will be affected by these plans and get their views. Review of resources is a process concerned with identifying all the resources that are required for planning and implementation of health plans. It involves finding out what resources are available and what others are missing, then clarify the deficiency. The next step is to prioritize problems that are facing the particular population concerned. This is a complex process anywhere, and there are different ways of going about it.

Different criteria and frameworks are used by countries for setting health priorities. One example is the use of program budget and marginal analysis, which applies economic ideology of opportunity cost and marginal analysis to guide decision makers on how to allocate resource [5]. In recent times several studies have been interpreted to support the view that the "accountability for reasonableness" framework with its four conditions of relevance, publicity, revision and enforcement is the best approach for setting priorities fairly [6-8], though others think differently. Other approaches that have been proposed, range from guidelines, checklists and minimum packages to explicit criteria [1]. Rosen comments when the process of resource allocation is well known and the criteria used are clear then justice is attained [9].

The step of preparing objectives and targets is usually carried out with attention to the need to achieve the desired outcomes. The objectives are supposed to be specific, quantifiable, realistic, attainable and time bound. The step that describes the plan of action (POA) is important as it explains how implementation of the plan can be done efficiently and in a coordinated way. It also helps in reviewing the progress of implementation and achievements obtained. The monitoring and evaluation processes deals with periodically looking at what is being done periodically and quantifying what has been attained. Fretheim et al [10] define monitoring in their study on support tools for evidence informed policy making as follows:

"*Monitoring is commonly used to describe the process of systematically collecting data to inform policymakers, managers and other stakeholders whether a new policy or programme is being implemented in accordance with their expectations. Indicators are used for*

monitoring purposes to judge, for example, if objectives are being achieved, or if allocated funds are being spent appropriately"

In Tanzania the tools that are used for resource allocation in health at district level are the Comprehensive Council Health Planning (CCHP) guidelines and planning and reporting database (PlanRep2). The essential health package (EHP), which is the component of the CCHP guidelines, has six priority areas that address main diseases and health conditions that contribute most to the burden of diseases (BOD) in Tanzania. The EHP is integrated in the district health plan to enable the districts to utilize available resources effectively. The PlanRep2 data base software assists district planning teams in planning and budgeting and in tracking funds received, physical implementation and expenditures using computers. Within PlanRep2 there is a district health accounting tool (DHA) which is required for priority setting. These tools play an important role in linking districts plans with the national and international health strategic plans such as the government vision 2025 and the millennium development goals (MDGs)

Apart from these tools the Tanzanian government uses a specific formula to allocate health funds to the district. The formula takes into account the following factors [11]: Population 70%, Poverty count 10%, District vehicle route 10%, under five mortality (U5MR) 10%. The central government uses these factors to allocate basket and block grant funds to local government authorities. The arithmetic expression of the resource allocation formula is as follow:

$$C= (P \times 0.7 \times F) + (W \times 0.1 \times F) + (M \times 0.1 \times F) + (B \times 0.1 \times F)$$

Where C= Total grant allocation for eligible council

P = Population index

M = Mileage index

W = Population weighted Poverty index of the council

B = Population weighted U5MR index as proxy of burden of diseases

F = Total basket fund amount

For each of the four factors incorporated in the formula, an index is calculated for each council. This index is used to determine the amount which each council gets.

Following transfer of power from central government to local government through decentralization by devolution (D by D), which occurred in the 1990s, the districts have been given more power in setting their health priorities and plan for all the health issues according to the needs of the district through the council health planning team (CHPT). Implementation of sector wide approach (SWAp) was expected to lead to increased efficiency and transparency of aid and efficient utilization of resources. Furthermore it was expected to lead to implementation of more vigorous health activities [12]. In the study by Semali et al on health sector reform and decentralization in Tanzania, it was shown that the advantages of decentralization could be expected to include better efficiency; more involvement of people at local level, and those local problems would be addressed according to the needs of the people [13]. Similarly it is documented by Asante et al that decentralization is among the key policy reforms employed to strengthen district health management and planning capacities [14]

Despite having good planning and resource allocation tools, the CHPT often encounter several challenges when preparing their annual CCHPs, these may impair effective resource allocation and the subsequent implementation of planned interventions.

"Bad implementation," as argued by Cloete [15], is a significant barrier to effective progress in development in developing countries. Clear understanding of implementation process will help to clarify reasons as to why desired outputs have not been attained [15, 16]. The whole process of health planning is complex and involves several stages that are interlinked; to understand factors influencing implementation of health plans, it is necessary to be clear about factors related to resource allocation and prioritization.

The major concern in resource allocation for health is the insufficiency of financial resource which cannot be overemphasized especially in developing countries. It has been noted that one difficulty that decision makers face in setting priorities is weak health information systems [17]. Other obstacles that decision makers encounter include; unawareness of available priority setting tools, (lack guidance) and the actual composition of decision makers groups. Politics can also influence the process of priority setting, for example, through influential people, donors and agencies [19, 20]

Poor planning and implementation of policy guidelines and plans have direct impact on the health status of the citizens. If interventions that address the burden of disease are not effectively carried out, the morbidity and mortality due to illness will continue to worsen. Since sick people are less productive, eventually the country's economy will also be impaired.

1.0.2 The planning and implementation of CCHP in Tanzania

The health system at the district is structured in such a way it matches the administrative structure of local government. The health services in local areas are provided by the districts, the Prime Minister's Office Regional Administrative and Local government (PMO-RALG) and MoHSW main duty with regard to local authorities is supervision, support and technical backstopping. At the district level there is a council which has District Executive Officer and councilors (representing communities) as council leadership. Then there is the District Health Board which is generally concerned with district health service policy decisions and is answerable to the council. The District Medical Officer is the in charge of funds and resources for managing district health service, together with the help of the Council Health Management Team (CHMT). At the ward and village levels there is the Ward Development Committee (WDC) and Village Health Committee (VHC) respectively, these link the communities to the council [21]

The Tanzania mainland has 21 regions with a total of 132 councils. Each council is supposed to prepare CCHP annually according to the guideline. The CCHP is considered to be a policy document. The whole process of policy implementation is complicated and depends on various factors such as the way it has been designed and the available resources.

According to the guideline, a comprehensive plan is one that includes all sources of funding in the council, activities of all health care providers and addresses the National Essential Health Package (NEHP), national strategy for growth and reduction of poverty (NSGRP), MDGs, government vision 2025, places with high burden of disease (BOD), national health policy and health strategic plan, and without forgetting the council own strategic plan. It should also respond to the local health problems [22].

The NEHP contains six priority areas each with its own interventions. The priority areas are i) reproductive and child health (ii) communicable disease control (iii) non communicable disease control (iv) treatment and care of other communicable diseases of local priority in the council (v) health promotion and environmental health sanitation, (vi) strengthening organizational structures and institutional capacities

The districts use the CCHP guideline and PlanRep2 as tools to guide them in preparing plans, describing implementation processes and specifying how the resources are going to be utilized. In general the guideline portray the way the CCHP should be prepared, give explanation on what is needed for preparing health plans and the schedule of when all the activities are to be completed. According to the guideline the bottom-up approach is to be used in council health planning process.

Through this approach the CHPT have to incorporate views of communities and health facility priorities based on the BOD and NEHP. Ideas from communities can be gathered using the various instruments available including Opportunities and Obstacles to Development (O&OD), Participatory Rural Appraisal and community dialogue. From health facilities, views of Health Facility Governing Committee (HFGC) are to be considered. Before the CHPT prepare the CCHP they have to meet with all key stakeholders in the council including the FBO, NGO and private practitioners as their adequate involvement will help to strengthen ownership of plans.

The CHPT consists of the district medical officer (DMO), district health secretary (DHS), district planning officer, council health management team (CHMT), some co-opted CHMT members, representative from private sector, representative from NGOs, representative from community development department, representative of faith based service providers, representative from regional health management team (RHMT) and council health accountant [22]. Of all the CHPT members the CHMT is the main functional unit in the council and each CHMT has an obligation of drafting chapter 1-3 (ie introduction, situation analysis and review of available resources) before the whole planning team seat for official preparation of CCHP. The CHMT is made up of head of departments of a district hospital. This include DMO, DHS, district nursing officer, district pharmacist, district dental surgeon and district medical laboratory technologist.

The CCHP is supposed to have the following contents:

1. Table of contents
2. List of Council Health Planning Team
3. Acknowledgment
4. Acronyms
5. Executive summary
6. Budget summary
7. Chapter 1: Introduction
8. Chapter 2: Situation Analysis
9. Chapter 3: Review of Resources Availability
10. Chapter 4: Priority problems
11. Chapter 5: Objectives, Targets and Planned Interventions
12. Chapter 6: Plan of Action
13. Chapter 7: Targets and Monitoring Performance Indicators
14. Chapter 8: Assumptions and Risks
15. Annexes: 1-14

The councils are required to prepare their performance progress reports, both technical and financial reports, on quarterly and annual bases. The technical report provide information on implementation status of CCHP, it includes a summary of major factors affecting implementation. The councils submit these reports to the Regional Secretariat (RS) for assessment and compilation of regional reports which will then be submitted to the Prime Minister's Office Regional Administrative and Local Government (PMORALG) and the Ministry of Health and Social Welfare (MoHSW)

When the RS assess the CCHP they use ten major criteria which are explained in the annex 4 of the CCHP guideline. Three examples of criteria are as follow: general quality of the plan; appropriateness of target, strategies and activities to the stated problems, their feasibility and relevance to the outputs and targets; all sources of funding targeted at priority interventions. A maximum scored value is assigned for each criterion and if the CCHP score less than 40 total points it will not be recommended for funding. These reports aim to monitor the implementation of activities and funds expenditure.

In the recent technical review meeting [23] it was revealed that some regions in Tanzania performed below the minimum required level on financial and technical report. The evaluation was based on consistency, accuracy, completeness, relevance in measuring approved priority health problems. Also the same document showed that on the general regional performance of CCHP, based on planned assessment criteria, Rukwa region had performed below the minimum pass point which was 70. The other regions had performed well ranging between 90 and 70 points as illustrated in figure 1 below.

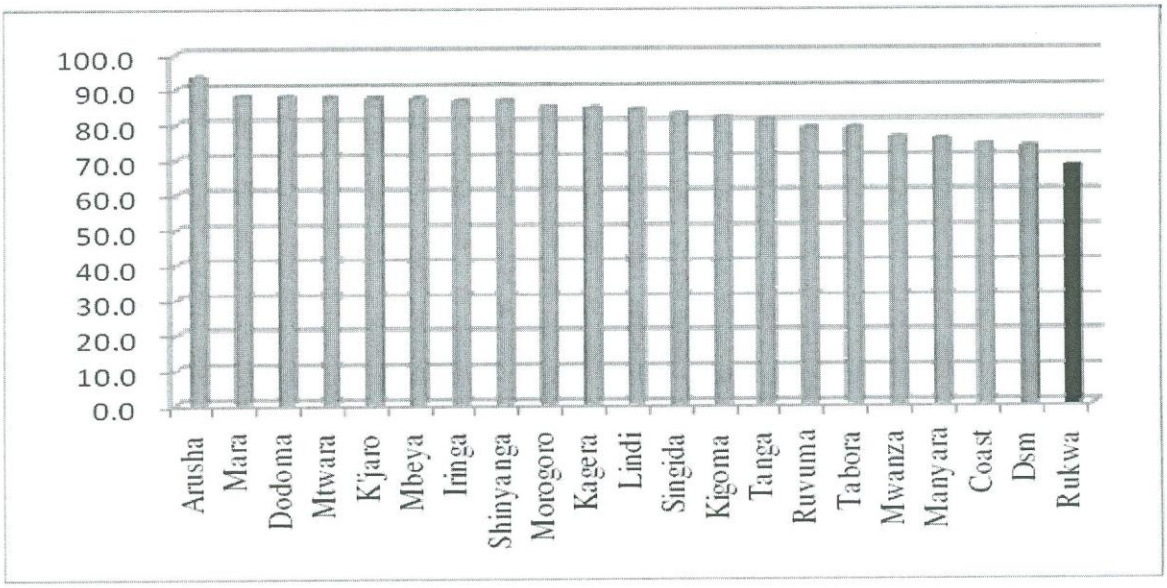


Figure 1:CCHP 2009/2010 Performance per Region (Source: Report by Nswila A [23])

This outcome was explained to be due to several factors including low capacity in planning skills among CHMT members, poor team work, incompatibility of PlanRep2 with planning guide, majority of CHMT are on acting position and CHMTs' not being involved in preparation of CCHPs

Sources of funds for the CCHP

The district health system is mainly financed through public taxation, user fees payments, government and donor funding. User fee was initiated along with other cost sharing schemes of Community Health Fund (CHF) and National Health Insurance Fund (NIF). The block grant from the government is the major source of funding of CCHPs. The CHF and NHIF are prepayment schemes whereby the communities make a down payment for their future health needs. On the other hand the user fee entails collection of money from the household members who are not enrolled in one of the prepayment voluntary schemes when they seek health services at the health facility.

Sufficient availability of resource would make development and implementation of CCHPs much easier but this is often not the reality. The councils allocate resources based on the cost centres which are office of DMO, council hospital, voluntary agency hospital, health centre, dispensary and communities. According to the CCHP guideline the sources of funds for CCHP consist of [22]:

1. Health Block Grants/Council grants -personnel emoluments (P.E), other charge (O.C), development
2. Local Government Capital Development Grant (LGCDG)
3. Joint Rehabilitation Fund
4. Council-own sources consists of: Recurrent Costs, Development Budget
5. Health Basket Funds
6. Vertical Programmes (NMCP, NACP, NTLP, FP, others specify)
7. MOHSWF-Fund for drug, supplies, equipments, MSD
8. Capitalization of hospital Pharmacies (Drug Revolving Fund-DRF)
9. Cost sharing money- User fees from the hospital.
10. Community health funds
11. National Health Insurance Fund

12. NGO funds (eg World Vision)

13. Development partners, UN Agencies (WHO, USAID etc)

Though the list is quite promising the actual situation is not as the funds are not predictable and not all the councils get funds from all the listed sources. The report by Nswilla revealed that in some councils there were only two funding sources [23]. The health planners need to have timely, reliable and complete information on financial resources to facilitate them in developing sound policy, planning and allocate resources in a way that reflects the priorities of the country [24]

The previously described resource allocation formula is used for allocation of health block grant and health basket funds from the central government to the councils. These funds, together with other available resources at the council such as cost sharing, community health fund etc are allocated to six cost centers as necessary. There is no direct relationship between the cost centers and the resource allocation formula. The allocation range to the cost centers is indicated in table 1 below. The CHPT are allowed to allocate funds within the range specified in the table but the total allocation sum for all cost centers combined is not supposed to exceed or be below 100% of total health basket and block grant allocations

Table 1: Allocation range for cost centers

Cost center	**Allocation Ceiling Range within allocation to Council**
Office of DMO	15% - 20%
Council Hospital /CDH /Regional Hospital serving as a Council Hospital	25% - 35%
Voluntary Agency Hospitals (VAH) / if none exists, this should be allocated to other priority health interventions in the Council.	10% - 15%
Health Centre	15% - 20%
Dispensary	15% - 20%
Communities	5% - 10%

Source: CCHP guideline [22]

1.0.3 Problem statement

Decision makers have to take effective measures to ensure that selected priorities adequately address needs of the public. It is well recognized that the district level is where it is most possible to realize opportunities for shared action and accountability however according to statistics it has been shown that in majority of African countries the current district planning and implementation process have failed to cope with the development challenges such as HIV/AIDS [25]

Despite been given a mandate to plan and budget since over ten years ago, the districts in Tanzania have not been able to improve the health status of their people as much as expected by the planners. For example among the NSGRP targets is to reduce maternal mortality ratio to 265/100,000 live births by 2010, but the chances of achieving this are doubtful since currently the ratio stands at 578/100,000 live births [26]. At least 51,000 newborns die each year, and two third (about 34,000) of those new lives could possibly be saved if essential care reached mothers and children [27]. If the necessary intervention to address pregnant women and childhood illnesses were adequately implemented, it is quite likely these figures would not be as high.

Failure to achieve health goals may be a result of poor allocation of the scarce resources, which as argued by Green [16], is caused by, among other things, inadequate information base for planning and underfunding. It is explained by Olsen that the Tanzanian districts '*priority setting flexibility is still limited'* regardless of the autonomy they are given [28].

Tanzania is over burdened by many diseases which are causing significant disabilities and deaths within the population; these include malaria, tuberculosis, HIV/AIDS and pneumonia. A study by Makundi et al on priority setting on malaria interventions, found that current interventions have left a persisting high burden of malaria in Tanzania [29].

There is often a gap between what is planned and what is implemented [30]. In Tanzania's most recent joint annual health sector review, reasons identified for incomplete implementation of district health activities included delays of funds from government and partners, delays in obtaining services of facilitators for training activities, long tendering procedures for procurement of goods and services, and shortage of skilled human resources for health[23]. In the report on analysis of regional CCHP, several weaknesses were noted including low capacity in planning skills among CHMT members, CHMT not involved in

preparations of CCHP plans, and the majority of CHMT members being in "acting" positions. It was also observed in the Health Research for Action (HERA) report that evaluation of whether "right" priorities are being set and subsequent activities are being undertaken was omitted [31]. In addition, the HERA report revealed other challenges facing district health service delivery: poor information base for planning; uneven involvement of FBO, NGOs and private sector/ services; less representation of the poor in district and facility governing committees; and chronic under funding.

Little is known about what council health planners consider to hinder effective implementation of their health plans. Few published research findings are available that describe the views of CHPT with regard to the challenges that they face during priority setting and development and especially implementation of council health plans.

Therefore this study aim to explore the views of the CHPT with regard to factors that influence effective implementation of council health plans, with attention to how they deal with the challenges that they often encounter and the way forward.

1.0.4 Rationale

Following health reforms the districts have become key areas for planning and implementing health programmes and policy. If the CHPT views on factors that influence implementation of council health plans are well understood and documented and the mechanisms to deal with these dilemmas are explicit, the CHMT and other planning committee members should be able to work more effectively and efficiently in allocating the limited resource for health and increase the likelihood that health plans are adequately and effectively implemented. It is important to know whether CHPT are able to identify their weaknesses, appreciate the magnitude of CCHP implementation challenges and have a vision as to how to overcome those challenges.

The findings from this study will help to provide an in-depth understanding of CHPT views with regard to factors influencing implementation of CCHP and thus to inform policy makers on ways to ensure effective implementation of district health plans. This should help explain discrepancies between the existing and the desired health outcome of the targeted population.

1.0.5 Research questions

1. What are the factors that the CHPT believe to be influencing implementation of council health plans?
2. What do the CHPT propose should be done to address the challenges they face when planning and implementing health plans?

1.0.6 Research objectives

Broad Objective

To explore the views of CHPT on factors influencing implementation of council health plans, and to identify ways of removing constraints to implementation.

Specific Objectives

1. To determine CHPT views on factors influencing implementation of council health plans
2. To determine CHPT understanding of CCHP guideline and PlanRep2 database and their roles in setting health priorities
3. To determine involvement of FBO, NGOs, private providers and community in implementation of council health plans
4. To determine CHPT perceptions and suggestions with regard to ways to improve implementation of council health plans

CHAPTER TWO

2.0 LITERATURE REVIEW

2.0.1 General

In health system it is important to have health plans that address the needs of people effectively, although it is equally important to make sure that the plans are put into actions accordingly. The challenges that face effective implementation of health policy and plans are many and have been observed globally. Lack of qualified human resources is recognized as the main limiting factor worldwide for effective implementation of health policies and reforms [28]

Although low income countries are known to have available effective interventions for many priority health problems, sluggish progress towards agreed health goals results in poor health outcomes [30]. Several studies have documented that there is often a gap between agreed plans and what is actually implemented [17, 30]. There are problems in many developing countries of weak policy implementation capacity; low level of policy decision making related knowledge, skills and expertise; gaps in information and repeated incidences of policy failure endorsed chiefly by infective or bad policy implementation [15]. Several strategies have been applied to improve health planning at district level in deprived countries without much sustainable accomplishment of the desired goals [31].

Decision makers in Tanzania, like those in other developing countries, set goals and targets to pave the way for achieving the health related MDGs requirements, with, however, little success in achieving them. Considering some of the objectives of the multinational second poverty reduction strategy [12] of reduction of infant mortality rate (IMR) to 50/1000 by year 2010, compared to the current IMR 68/1000; and reduction of maternal mortality rate (MMR) to 265/100,000 as compared to current statistics of 578/100,000; more efforts need to be made to attain those targets on time.

In a study done in Uganda on using BOD and cost effectiveness as instrument for district health planning [33] it was quite clearly seen that health planning was a complicated process that involves political, social, cultural, technical and human right issues. The authors emphasized on three things that have to be taken into account at all time in health planning and implementation: these are effectiveness, equity and accountability. The area of equity and

accountability can be well addressed through enhanced participation of the concerned population.

It is important to ensure that all stakeholders are involved during planning of the desired activities/interventions. This will make them feel that they own the plans and thus will help to reduce obstacles or negativity towards implementation process. The CCHP guideline of Tanzania has considered this issue and it is required that community, FBO, NGO and private providers' representatives to be among the CHMT members. Several studies [16, 34] have also emphasized that it is important to involve these representatives and consider their views in the planning process. However it has been noted that in some councils in Tanzania there is inadequate involvement of these people [31]. For a health planning process that encourages 'decentralized decision making' and community involvement it should have these features; effortlessness and transparency, recognize community as active subjects and a bottom-up planning approach [4]. A study by Norman et al on community involvement in planning process in Tanzania, which was conducted in one of the country's municipals, revealed that there is inadequate community involvement in identification of priorities as entailed by decentralization by devolution process.

Several articles in the literature describe factors influencing inadequate implementation of health policies and plans. These factors may be due to different issue in the specific institutions or organizations involved. The CHPT need to be able to identify and set health priorities, plan for interventions to be carried out, and ensure that the agreed plans are effectively implemented.

It is reported in the study on malaria by Makundi et al that the Tanzanian health system at district and community levels is weak to implement current interventions, resulting in a persisting high burden of malaria in Tanzania. They identify contributing factors for this to include weak district management capacity and lack of training of key health staffs members [29]. This weakness in planning and budgeting was also observed among district health officers in Nigeria by Nnaji et al [36]. The obstacles that implementers at lower levels in the health care pyramid, such as lack of resources, low morale and motivation among staff and lack of adequate qualifications, often contribute to poor policy implementation [28]

A study by Asante et al identified health human resource availability, local capacity to utilize funds, donor involvement in health sector and commitment to promote equity as factors that

influenced resource allocation decisions and equity in the health system in Ghana [37]. In Tanzania, the HERA report identified the challenges of district health sector delivery to include, among others, poor information base for planning; variable RHMT assistance and technical capacity; uneven involvement of FBO, NGOs and private sector/providers; weak community involvement; less representation of the poor at districts and facility governing committee ; and chronic underfunding [31]. It is important for developing countries to scrutinize their management capacity before deciding implement an intervention however good the outcome of using the intervention is projected to be.

When decision makers are not clear of their duties or do not have the guidelines that they could use to identify their roles and functions it will impair their performance [38, 39]. It has also been noted that one of the difficulties that decision makers get in setting priorities is weak health information system [18]. It has been described that data collection weakness usually occurs when there is lack of standard tools and procedures for recording patient information during provision of service [40]. From the same document it was revealed that there was poor information quality and use particularly at peripheral levels of facility, this undermines the strategies to improve health systems performance. In another study [41] it was shown that for importance of information use to be emphasized the senior management staffs have to start inquiring about the information and make use of it obviously such that the subordinate can imitate them.

Politics can also influence the process of priority setting through the influential people, donor and agencies [19, 20, 42]. The donors may influence the way a health intervention is chosen, instead of planners to base their decision on the health problems and needs of the people they serve they base on donors' preferences.

It is important for decision makers, at all levels, to bear in mind that health planning success radically depends on proper implementation of plans [15]. It is not enough for CHPT to know that plans need to be implemented; they have to make sure the plans are actually implemented and this will ultimately lead to improvement of the health status of their people. Though availability of funds will likely be a problem, but Victora et al [42] reminds us in their study on achieving universal coverage with health interventions that barriers to achieving universal coverage for health are quite more than just the financial concerns.

2.0.2 A framework for policy implementation

Several theories that try to explain the policy implementations are available including both top down and bottom up approaches. The 'top-down' approach includes six conditions [43] that are essential and adequate for effective policy implementation, if those conditions were realized, then the policy would be implemented as planned. The six conditions are as follow:

- Clear and logically consistent objective
- Adequate causal theory- how particular actions would lead to intended outcomes
- Implementation process structured to enhance compliance by implementers
- Committed, skillful, implementing officials
- Support from interest groups and legislature
- No change in socio-economic conditions that undermine political support or the causal theory underlying the policy.

The implementation of council health plans is a complex process and it is difficult to frequently fulfill even the first condition. This top-down approach adopts the perspective of central decision making; and the role of other stakeholders is not appreciated so that it will not be useful for CHPTs to use it.

On the other hand the 'bottom- up' approach takes a different view of the implementing process: "implementers often play an important function in implementation, not just as managers of policy handed down from above but as active participants in a complex process that inform those higher up in the system, and that policy should be made with this insight in mind" [43]. Similarly the planning process of the CCHP stresses the use of a bottom up approach. The CHPT has to incorporate the views of communities and health facilities priorities in accordance with the National Essential Health Package and the extent of burden of disease.

This study drew on Friedman's conceptual framework for policy implementation as it was developed based on a broad review of policy development and implementation literature. In developing a conceptual framework for development and implementation of effective policy in children's mental health, Friedman [3] came up with a framework that focused on four dimensions:

1. The stages of policy development and implementation
2. The levels at which policy is developed and the inter relationships among levels
3. The service sectors or systems affected by policy and the inter-relationship among policy in different sectors
4. The variables that are likely to affect the level of impact of a policy

According to this framework the factors that influence policy implementation are mapping approach, policy instruments, resources, accountability procedures and the implementing organization.

A forward mapping for implementation of council health plans would define what must occur at each level, from the district to the community level, it would describe the actions to be taken and assign responsibility for implementing units. A backward approach would entail identification of the actions at local level that need to be modified, with the intention to improve local capacity to implement the agreed plans.

The CHPT should find better ways of cooperating with all the stakeholders in the council to ensure that the council health plans are adequately implemented.

The issue of resources is a major concern for all the districts in Tanzania. This includes human, financial, technological and material resources. The councils have to struggle to ensure sufficient resources are available and/or use efficiently the available resources. Useful management process and organization cultures are needed to support effective implementation of council health plans. The councils in Tanzania still face many challenges; some councils fail to link PlanRep outputs, some CHPT are not working as a team, and delays of funds and shortages of human resource are still a setback [23].

The processes of development of council health plans and the implementation of the agreed plans are interlinked. The failure of implementation of plans might be a result of deficiency in planning, design or control. It is important to promote communication among all stakeholders affected by council health plans and service delivery system so as to improve collaboration, harmonization and exchange of information and ideas. The framework for implementing council health plans is provided in figure 2 below, modified from Friedman's framework.

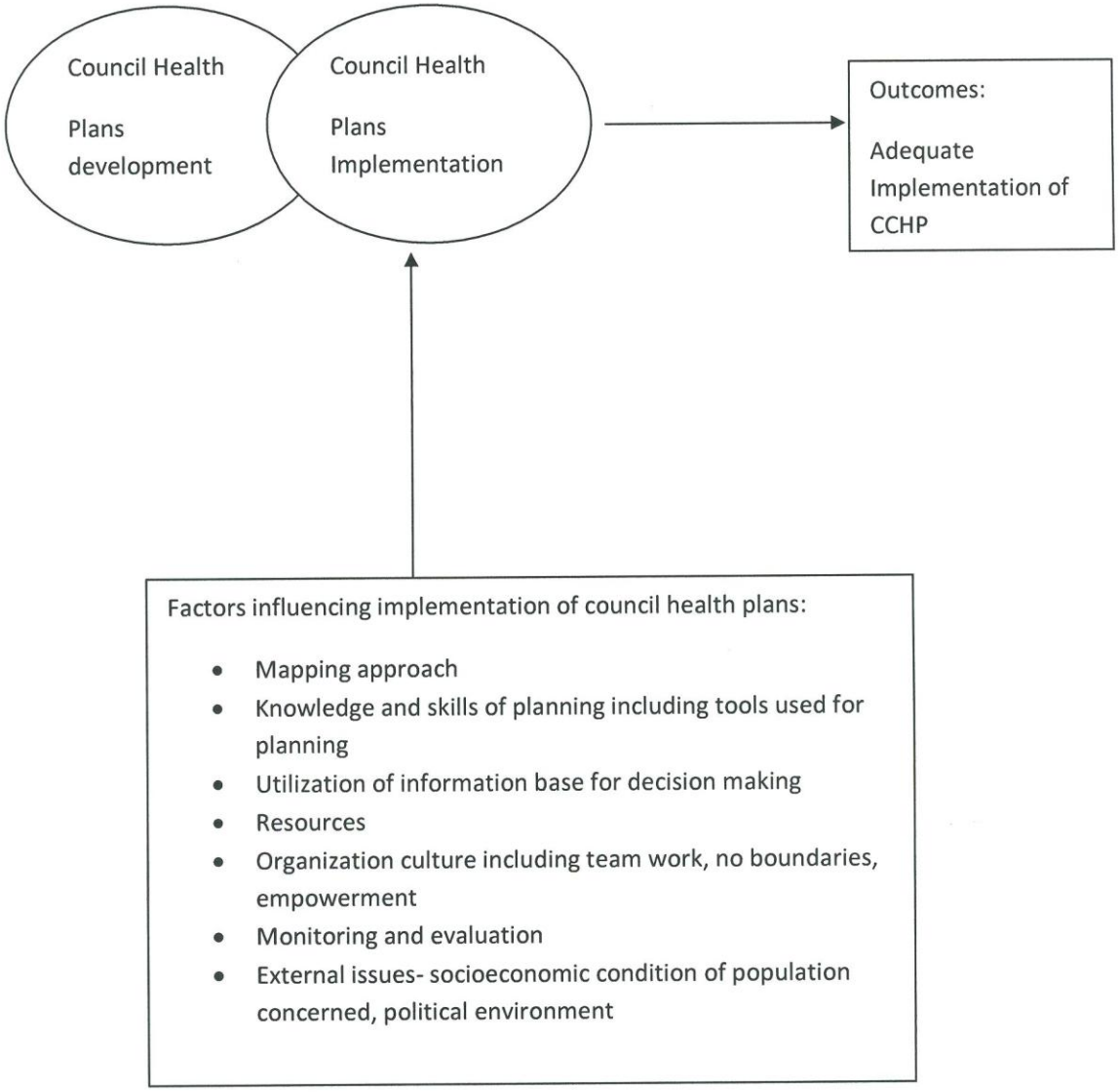


Figure 2: Framework for implementation of Council Health Plans (Modified from Friedman's framework [3])

CHAPTER THREE

3.0 METHODOLOGY

3.0.1 Study Area

The study was conducted at Sumbawanga urban district in Rukwa region and Iringa urban district in Iringa region. Both regions have an average availability of human resources for health. The health worker percentage deficit for Rukwa is 42.1% and that of Iringa is 45%. In terms of water sources 60% of population in Rukwa has access to clean and potable water and that of Iringa is 62%. The percentage of population in both regions that has acceptable latrines is above the national average of 64.5% [23]

In terms of finance, Rukwa region is among the peripheral regions disadvantaged with distance and infrastructure that got a lesser amount of block grant fund. The Iringa region being one of regions with big cities and town and with increased number of staff got bigger volume of allocation of block grant compared to Rukwa. The percentage of population that is living within five kilometers from health facilities in Rukwa is 39.1% which is below the national average of 48.6%, while for Iringa it is 55.2%.

The areas were chosen based on CCHP 2009/10 general issues planned assessment criteria which revealed Rukwa region to have performed below minimum pass point [23] , thus one of the districts from Rukwa region was selected. Also one of the districts from Iringa region was selected since the region had performed well in the above mentioned assessment, and also for logistic and comparison purposes Iringa is closer to Rukwa. The districts that were involved in the study are in the urban areas of their regions, because most of the rural roads in Rukwa are usually not passable during the rainy season and it was not predictable how the weather will be when data collection for the study begins. In this case the Sumbawanga urban district from Rukwa region was selected and Iringa urban district from Iringa region was purposively selected for comparison purposes. From this point onward the names Sumbawanga urban and Iringa urban districts will be used interchangeably with Sumbawanga municipal and Iringa municipal respectively.

Sumbawanga municipal

The Sumbawanga municipality is among the four districts of Rukwa region. The municipal has a total population of 195,336. Administratively it is divided into 13 wards and municipal (and regional) headquarters is Sumbawanga. There are 6 urban wards and 7 rural wards with 25 villages.

The municipal has two hospitals, three health centres and 27 dispensaries. The access to water is 68% and latrine coverage is 67%. The town accessibility is by use of Sumbawanga-Tunduma road, Sumbawanga- Kasesya road and Sumbawanga-Mpanda road. (Sumbawanga municipal council, CCHP, July2009-June 2010)

Iringa municipal

The Iringa municipality is among the seven districts in Iringa region. The municipality is bordering Singida and Dodoma regions to the north, Morogoro region to the east. In the south there is Ruvuma and Lake Nyasa and to the west there is Mbeya region.

There is a population of 113,350 people according to the 2002 census. Of these 58,879 are female and 54,471 are male. Of the total population the under five years are 22,675. Administratively the municipal has 14 wards. There are 3 health centres and 20 dispensaries. About 90% of total population has access to clean water.

Iringa municipal is connected to Dar es Salaam/Mbeya/Morogoro/Zambia by a tarmac road that is all weather. It also has a good telecommunication system. The main economic activities consist of agriculture, livestock, industry and commerce. About 40% of the municipal population depends on agriculture and livestock [44]

3.0.2 Study Design

The study was a cross sectional descriptive study and comparative case study using a qualitative approach

3.0.3 Study Population

The targeted population was Council Health Planning Team (CHPT) members and those in-charges of institutions that were mandated to have roles in planning and implementation of

CCHP. The selection was based on the 6 cost centers ie one member from each cost center except the voluntary agency hospital.

1) the office of the DMO
2) district hospital
3) health center
4) dispensary
5) community (representative from community development department)

The voluntary agency hospital was not included in the study as it was found not to exist in one of the study areas. In addition to these the council health accountant, one other member from the CHMT and the District Planning Officer were also interviewed because of their significant roles in council health planning and implementation.

3.0.4 Sampling Techniques and Sample size

Criteria for selecting the interviewees for this study was as follow

- From the DMO office the DMO was purposively selected (1 study unit)
- From the district hospital the medical officer in charge (MOI) or the hospital secretary was purposively selected. (1 study unit)
- The health center and dispensary were selected randomly using simple random sampling technique from the list of all public owned dispensaries in the council. This was done at the DMO office in front of- the DMO and the secretary for Sumbawanga municipal and in front of the DMO and a CHMT member in Iringa municipal. Then the in-charges of the randomly selected health facility were interviewed. (2 study units)
- The representative members of CHPT from the community development department were purposively selected. (1 study unit)
- The council health accountant and the council planning officer were purposively selected (2 study units)
- The other CHMT member was randomly, using simple random technique, from the list of members that were available. (1 study unit)

Thus the total sample size was 16 participants, 8 participants from each council. As explained by Bryman, researches that use qualitative methods can be based on quite small samples [45].

3.0.5 Data Collection & Analysis

Method of Data collection: the approach that was used for data collection and analysis was qualitative. This design was selected by the researcher based on the type of information desired. As Hoepfl had demonstrated, a qualitative research uses a naturalist approach which tries to understand phenomena in context- specific settings; it gives details and insights into participants' experiences of the world [46]. Since the researcher wanted to explore the views of those dealing with planning and implementation of council health plans, the qualitative method was found to be suitable for the study.

In depth face to face interviews were conducted by the researcher using an interview guide. There are different ways of designing an interview, these include semi structured interviews, structured interviews and open ended interviews this study semi structured interview was used as it allow for follow up of points. The interview guide was developed based on objectives of the study and information gained from literature. This guidance allowed the researcher to continue asking questions in the specific area of study. Prior to the beginning of each interview, the participant were asked for permission to be audio-recorded, all the participants agreed to be audio recorded. The interviews were conducted in Kiswahili. A pre-test of the tools was done in Ilala district council in Dar es Salaam region

Data was collected between 10^{th}- 17^{th} of March 2010 involving the Sumbawanga municipal and Iringa municipal. The interviews were carried out in during the day as was convenient for the respondents.

Data Analysis: Qualitative data analysis is an ongoing process that is carried out simultaneously with data collection, interpretation and writing reports. The researcher analyzes data for themes or perspectives [47].

For this study content analysis approach was followed. This involves reading through the transcribed texting of each interview and identifying responses relevant to the main questions raised by the study [48]. It is used in qualitative research generated from existing theories.

Content analysis can be divided into manifest content analysis which concerns with what the text says and latent content analysis which concerns with what the text is about, that is an implied unstated message. In this study latent content analysis was used. The unit of analysis can be person, organization, the whole interview etc. The approach involves shortening of the text (reduction, distillation, condensation) and creating categories [49]

For this study the main steps used in analysis were organizing and preparing the data for analysis, reading through the data, coding the data, generating categories and finally interpretation of data.

Organization and preparation for data analysis: the recorded interviews were transcribed by the researcher in the Kiswahili language. This started to be done at the field concurrently with data collection, transcription continued after data collection was completed. Each transcribed data had identification information which included the location (IRI= Iringa and SUM= Sumbawanga), category of interviewee (whether CHPT member or Non CHPT), age, sex and education level. The transcripts were then translated into English, an assistant was hired to help with translation of some of the transcripts, the researcher reviewed all the translated transcripts for accuracy and made correction were needed. The transcripts were then typed into computer files using Microsoft word 2007. The computer files were named based on location. When all transcripts were typed the recorded interviews were deleted to protect the identity of interviewee.

Reading through all the data: the researcher read and reread the data several times to get a preliminary sense of the data and interact with it. It allowed the researcher to get general ideas regarding what the respondents were saying. The reading helps to set up ground for analysis.

Coding the data In this study the coding was done using computer software named open code. According to its description the software (Open Code 3.4) is a tool for coding qualitative data generated from interviews, observation or field notes. Though it was developed to follow the first steps of Grounded theory but it can also be used as a tool for classifying and sorting any kind of qualitative text information.

The grounded theory describe the inductive process of identifying analytical categories as they emerge from data and involves developing theories from the research field [45]. This

was not applied in this study as the research intention was not to develop a new theory rather to use the existing one to describe the identified problem

The whole interview was chosen as a unit of analysis. The transcripts were converted from Microsoft word into text format then imported into the software programme. The meaning unit or coding unit had similar meaning to what Graneheim et al described ie a meaning unit was regarded as "*...words, sentences or paragraphs containing aspects related to each other through their content and context*" [49]. The meaning units were coded throughout the transcripts. The codes were allowed to emerge during data analysis

Generating categories: the coding process was used to develop a small number of categories. Codes with similar concepts were grouped together to form a category. The researcher had to go through the transcribed data to obtain main themes from the respondents with regard to what the questions were about. The information concerning the categories was summarized into memos that captured the differences between respondents. These provided the ground for writing results.

3.0.6 Ethical considerations

Ethical clearance was granted by Muhimbili University of Health and Allied Sciences (MUHAS) research and publication committee. Formal request for permission to study in the municipals was obtained from the District Executive Director (DED) and District Medical Officers (DMO). All participants were informed about the purpose of the study and informed consent was obtained for participation as well as for recording of interviews 9

CHAPTER FOUR

4.0 RESULTS

In this study a total of 16 respondents were interviewed comprising of the CHPT members (DMO, CHMT members, representative from Community Development Department, municipal Health Planners and Accountants) and non CHPT members (in-charges of health centres and dispensaries). The following table shows demographic data of respondents.

Table 2: Background characteristics of Respondents by location

VARIABLE	LOCATION		TOTAL
	SUMBAWANGA	IRINGA	
Age 25-35	3	4	7
In 36-45	2	2	4
yrs 46+	3	2	5
Sex: Male	4	5	9
Female	4	3	7
Educ: Degree/Post grad	4	5	9
Diploma/Advan. Dipl	4	3	7

Educ= Education, Post grad= post graduate, Advan Dipl= Advance Diploma

8 of the respondents were from Sumbawanga urban.

Majority of the participants were male.

4.0.1 Understanding of CCHP guideline and PlanRep

i) CCHP guideline

When preparing council health plans the main tool that is used is the CCHP guideline which was developed by the ministry of health (MoHSW). The CHPT members seem to have a better understanding of the CCHP guideline in both districts compared to the non CHPT members. Among the CHPT members those with higher level of education were able to give a clear description of CCHP guideline as illustrated by one of them from Iringa:

"What I know is that CCHP is a comprehensive sort of planning. By comprehensive it means to take in all activities which are being done in the council, by private and the government... and it considers key international areas which have been suggested by the government. There are six priority areas, I can mention a few eg Reproductive and child health, communicable diseases etc... The main purpose of CCHP is to solve health problems in the council across all the levels of implementation, from the community, dispensary up to the council level." [CHPT member, Iringa]

There was similar observation in Sumbawanga as one of CHPT explained about CCHP guideline as the tool they used when preparing council health plans:

"We are using a guideline from the ministry of health, which gives us the areas of concentrations. While planning we have to look upon what the national policies and the millennium development goals (MDGs) say. For example MDG number four says that you have to reduce child death rate to the year 2015 up to 2017, number five you have to reduce mortality rate by two third to the year 2015, number six says that you have to reduce infection diseases for example we have malaria, TB, pandemic diseases and HIV. And MDG number seven talks about environment conservation and sanitation so as to fight malaria. Also we have Essential Health Package which is stated in the guideline." [CHPT member, Sumbawanga]

Of note was the role of experience that is gained after being involved with council health planning in understanding the guideline. In both districts, there was a new member from community development department; these participated for the first time in preparation of this year CCHP. When asked to provide an explanation of what they understood about CCHP guideline one of them said:

"I have not read it as this is my first time, what I was told is that I should look in my department and find out what things need to be implemented and the suggestions I have received from the community and prepare my plans according to the priorities. I have not yet been able to go through the CCHP guideline and understand it well" [CHPT member]

In general the guideline is described to be useful tool and addresses significant issues related to health. However it was perceived that some changes are needed to make it more efficient to suit the needs of the concerned council, particular attention was given with regard to

accessibility of basket fund as this was considered the most reliable source of fund for implementation of various development activities in the council.

"*I think there is nothing to be reduced instead to increase some e.g in the CCHP guideline there is no place which allow the authorization to use money or ceiling which is out of the plan itself as it is directed.....to empower these cascade nodes we need transport facilities such as motorcycle so as to make easy supervision and collection of the information for compilation at a district level. But it becomes difficult to buy these facilities because the guideline does not allow the basket fund to be used for such purposes.*" [CHPT member, Sumbawanga]

ii) PlanRep software

Concerning the use of PlanRep it was illustrated quite clearly that the software is not used during preparation of CCHP, but what is commonly practiced is that CHPT sit together as a team and prepare the CCHP and put it in a Microsoft Word and Excel format then the DMO, accountant and health secretary are responsible for putting this into the PlanRep software so that it can be entered in the medium term expenditure framework (MTEF) of the council. This is clearly shown in the following statements:

"We *always go to the planning of CCHP with our accountants who understand it. We have two stages in planning, at first we... write everything by using Microsoft word, for example table of contents, introductions, executive summing of situation analysis and we use Microsoft Excel for technical things such as cost analysis. After that we leave the work to accountants so that they can put them into Plan Rep*" [CHPT member, Sumbawanga]

"*We do not use Plan Rep in the preparation of the CCHP but we are using it when we prepare the council plan i.e. MTEF. Last year we used Plan Rep for preparation of our reports of CCHP but when we present them at the Regional offices, it was said that the Plan Rep is not needed for the CCHP, so we had to break it down those activities, remove them from PlanRep and returned them to Excel*" [CHPT member, Iringa]

Weakness of PlanRep software

Those who use the software in preparation of the whole council plan ie Medium Term Expenditure Framework (MTEF), consider it to be very helpful but there are some weaknesses that were reported. First the software is not able to display some information in the print out document as one respondent remarked:

"*...in the CCHP guideline in the section of cost analysis we enter plan and the responsible person for implementation and at which quarter it will be done. But when you insert those details in the PlanRep they will be shown in the computer but not in its print out. The responsible personnel and the time of the implementation of the activities are not shown in the print out.*" [CHPT member, Iringa]

Second issue is that the source of funds in the software are outdated, some no longer exist but are present in the software. Another thing is that the software does not allow one to enter several sources of funds for a single activity, the following sentence elaborates this

"*...in the CCHP you can use more than one sources of fund for one activity. But the Plan Rep is not a user friendly, you need to insert the same activity more than thrice for different sources of funds.*" [CHPT member, Sumbawanga]

The respondents who were non CHPT members from both municipals were not aware of PlanRep software, however, they all reported to have heard about CCHP of which they had a narrow understanding. This is illustrated in the following statement from one of them:

"*...CCHP are plans that people make by themselves so as to improve and develop health centres*" [non CHPT member]

4.0.2 Perception on factors influencing implementation of health plans

These are divided into four categories: resources, tools, approach and organization factors. Among these factors there are those which facilitate implementation of health plans (the enablers/strengths) and the constraints.

Resources that are needed in the planning and implementation of council health plans:

The main resources that were identified include human resource, financial resource, transport and material/equipment resources. The deficiency of human capacity was reported in both councils to significantly impair implementation of health plans. Capacity in terms of number of staff needed as well as their skills, at the council level and facility level as well. One CHPT member from Iringa was concerned with the capacity of council health planning team (CHPT) in planning and was of the opinion that they do not recognize their limit.

"...one of them is the capacity of CHPT...there is shortage of staff at the municipal but also capacity in terms of ability to do the work. Here there is issue of shortage and issue of skills and knowledge. The other thing I think the CHPT are over ambitious. Sometimes they set too many activities compared to their ability to implement." [CHPT member, Iringa]

Similar perception regarding capacity of workforce was observed in Sumbawanga and that poor understanding of staffs influence implementation output.

"Setbacks for the implementation of the council health plans is low level of understanding of the working personnel ... The people in our municipal who are supervising various departments are not capable" [CHPT member, Sumbawanga]

In any given work ideally one should use the qualifications and skills that she or he has to make judgment or decision, nevertheless it was expressed that the planning team was perceived to be doing the other way round as shown in this statement by a CHPT member:

"...another issue is on the planning team itself; they make plans using experience and people's opinions than using skills. What I can say is that there are very few members in the CHMT that have skills on planning..." [CHPT member, Iringa]

The situation in Sumbawanga was perceived to be worsened by having a number of acting personnel at decision making positions as one CHPT from this study area explained:

"At the moment some of the positions in the municipal and CHMT are held by people who are acting and are not capable, but we thank them because if they were not there it means the municipal would not exist." [CHPT member, Sumbawanga]

Lack of qualified workers was also observed at the lower level where implementers were reported not to have adequate skills to carry out their jobs effectively as the following statement illustrates:

"...we lack enough qualified personnel. You may find most of implementers in the ward are not qualified. They might know their responsibilities but you have to remind them now and then for example we may have to remind them to call a meeting in their communities" [CHPT member, Sumbawanga]

The in-charges of facilities also reported to have deficiency of skilled workers that weakened their ability to implement their plans. Sometimes they get complaints from community due to this deficiency as illustrated below.

"...another thing concerning my centre people do complain on the deficit of health personnel. We have a few numbers of qualified doctors and nurses. So people spend a long time before they can get medical services." [Non CHPT member, Iringa]

The on job trainings are important so as to improving workers capacity and keep them up to date regarding various developments in their fields. In both districts the training of staffs including CHPT was reported to be done though not frequently enough as these require money.

The lack of sufficient financial resource was reported by all respondents to be one of the factors that inhibit implementation of health plans. Apart from getting insufficient funds the funds were not received on time. The respondents were seriously distressed by the unpredictable flow and amount of funds. This further worsened the situation as the planning teams were forced to rearrange activities according to fund influx, this ended up in not abiding to the CCHP guideline which specify activities to be done on quarter basis. The delay in disbursement of funds affect the budget intended to be used for a particular activity since the price of materials and services vary over time. The following statements from Sumbawanga and Iringa CHPT respondents respectively illustrate this:

"The planning that we do is done based on the ceiling which we are given for example we had planned to buy incinerator for four million but we ended buying it for 6.6 million. You may plan for this year but money come the next year and considering the issues of currency fluctuation etc you find the cost changes" [CHPT member, Sumbawanga]

"*...because we have so many activities and always funds are late, for example when it reaches March-June there are so many activities. It reaches a moment you decide to implement activities roughly for the purpose of avoiding the donors seeing the money just held in the bank accounts"* [CHPT member, Iringa]

The in-charges of health facilities also reported to have the same problem when it comes to implementation of their health plans as illustrated by two of the in-charges when asked about what were the factors that inhibit effective implementation of their plans:

"*It is being hindered by delaying of funds. The planning is made clearly but the funds do not come on time"* [Non CHPT member, Sumbawanga]

"The only obstacle is the insufficient fund, sometimes the funds may come or may not come, thus when it doesn't come we fail to implement the plans." [CHPT member, Iringa]

In these health facilities they usually use the cost sharing money to cover for the deficit of funds however it is seldom sufficient. The in-charges of these facilities can get access to the cost sharing money from the bank after they request it and it is approved by the DMO office.

Poor infrastructure, especially with regard to road conditions, was also reported by a number of respondents from Sumbawanga to hinder execution of health plans, none of respondents from Iringa mentioned road conditions as a hindrance to implementation of health plans. The following statements from different Sumbawanga CHPT respondents illustrate this

"Another thing is our locality. You might use three days to go to Dar es Salaam to pick up some medicines and vaccines compared to someone from Morogoro who may use one day to go to Dar es Salaam and return back. The infrastructure does not favor our implementation to be good". [CHPT member, Sumbawanga]

"There are some places such as Ipanga are not accessible during rainy seasons, even if you have a land cruiser bought from Japan today you still cannot go there . There are very steep hills which are slippery, so how can you go there to vaccinate children?" [CHPT member, Sumbawanga]

"*...our road condition as you see it is a great problem, communication between villages is difficult*" [CHPT member, Sumbawanga]

Regarding the equipment resources lack of sufficient laboratory equipments and computers and delay in supplying of drugs and supplies by medical store department (MSD) were the main issues that caused inadequate implementation of health plans in both municipals.

"There is a delay in receiving medicine, and people are not satisfied with the services they have been provided... You may go to the government hospitals and be told that a particular drug is not available" [CHPT member, Sumbawanga]

"The hospital supplies and medicines arrive very late from the MSD such that sometime the drugs at the health facilities run out" [CHPT member, Iringa]

"People prefer to get services from dispensaries which have laboratory. And we do not have such service here, that's why we receive very few patients ..." [Non CHPT member, Sumbawanga]

"*...always the medicines they bring to us are not those which we requested. We were informed that the way things should be done is for us to request order of 3 months but the stock that they bring cannot cover even for 2 months... I don't know what is wrong with the MSD*" [Non CHPT member Iringa]

For the case of Iringa it was reported that unavailability of municipal hospital was a barrier to effective execution of council health plans. In Sumbawanga they have a designated district hospital (DDH) which is used as municipal hospital. To emphasize the problems of not having a municipal hospital one respondent from Iringa said:

"*The municipal is building its hospital now, so our doctors are in the regional hospital and our medicines are going there. We cannot even take the proper statistics of our patients and other health problems because people from different areas do attend the regional hospital.*" [CHPT member, Iringa]

In both councils the lack of a special car for garbage collection, as one of the equipments, was reported to be a problem. The suitable vehicle which is required is too expensive the councils cannot buy it using the council own sources. Despite lobbying in higher places in the government and ambassadors they have not yet successes to acquire one.

Tools used in planning:

The tools that were considered include the CCHP guideline, PlanRep software, health management information system ie HMIS and the procurement act. The first two have

already been mentioned earlier. The council health planning team usually uses the health information that is collected at the health facilities using the HMIS books, herein referred to as MTUHA books, to make decisions. The books were mentioned by the respondents to be outdated such that those at facility level are forced to add columns so as to capture important information. At the same time the planning team reported to occasionally find the books are not appropriately filled by health facility workers and they don't utilize the information for their own benefit. The following quotations were taken from one CHPT and one in-charge of health facility respectively:

"The information is sometime not complete. So we have to go back to the health facilities to counter check for the missing information and fill the gaps. Another thing is at the health facilities, those who collect the data and prepare information they do not see the usefulness of the information and they do not use them. They think they only have to prepare them for us" [CHPT member, Sumbawanga]

"To be honest the books of MTUHA should be reviewed because there are many new things which have added up. For instance when you consider the mother and the child, this system of checking up of the mothers HIV status was not there before, it is new. In MTUHA there is no area for checking HIV, giving out the hematenics or giving of SP to the pregnant women. But as for now we have to add the column." [Non CHPT member, Iringa]

With regard to procurement act of Tanzania, when the councils have to order materials or equipment they have to abide to regulations according to the act. The system is good in that it prevent possibilities of misuse of money or theft. However it usually takes a long time and there are a lot of bureaucracy that contribute to delay of accessibility of materials or supplies needed for various activities of the councils.

"We have the procurement unit and we follow the procedures. There are times when the donors' complained that they bring the money but we do not utilize them. We don't utilize them because we are following the government purchasing procedures." [CHPT member, Iringa]

"One big obstacle is long government procedures on procurement ...the procedure is very long..." [CHPT member, Sumbawanga]

The approach used in planning and implementation:

The planning approaches that were described by respondents were top down and bottom up approaches. The top down approach is one whereby the decision on what should be done and how for a particular activity or project is set by the top officials without including the views of the community or implementers. The bottom up approach is characterized by involvement of community or those in the lower level in making decision how the project or a particular activity is to be done. One CHPT member explained:

"I would like most of the project to start at the grass root from there we can know how people feel about these projects. Example the joint rehabilitation which is now MMAM should be initiated from the grass root so that they can feel it is theirs and they can contribute. Another thing in implementation is to incorporate stakeholders. Because you cannot stay in the office and prepare plans, I mean it should not be top down approach" [CHPT member, Sumbawanga]

This implies when plans are initiated at the grassroots they are more likely to be accepted and thus their implementation will not be a problem.

"We use bottom –up approach mainly in the project initiated at village or ward level, from ward plans, example building of dispensaries... from ward plans they mainly use O and OD" [CHPT member, Iringa]

Organizational factors: these relate to issues of leadership, transparency, monitoring and evaluation and coordination (planning process and politics)

i) Planning Process

The findings showed a significant difference in the way the planning process was carried out between the two councils. In Iringa, as of this year, the health centres and dispensaries prepare their health plans according to the priorities and problems they have and submit the plan to the council planning team. Prior to that they used to prepare report on problems that they have and the CHPT used these problems from health facilities to prepare CCHP, this is what is still applied in Sumbawanga council. The new system introduced by the government, implies that the lower levels are being empowered with decision making concerning the

health of their particular areas. This is a way of ensuring decentralization processes are effectively put into practice. The following statement from a CHPT respondent illustrates how planning process is done Iringa:

"We go to our dispensaries and health centers we note problems that are there. Those problems that we collect from those areas are the ones which we used in the preparations of CCHP. Currently the plan which is on process for this year instead of every head of department going to his/her subordinates and ask for problems, list them, organize and file them then submit to the municipal, nowadays the health facilities are responsible for making their own plans from the problem they are facing, we just directs and advice them". [CHPT member, Iringa]

The non CHPT members from Iringa agreed to above explanations as one of them said:

"We usually prepare the activities which we need to be done at the health center and bring them to the municipal office; they are the ones who enter them in the CCHP. But for this year there were some changes, that is we prepared our whole plan then the municipal crosschecked it. In past years we used to prepare list of things we need and submit them to the municipal but now we prepare it (...) then they counter check and include our plan in the CCHP" [Non CHPT member, Iringa]

This was not the same case for Sumbawanga as elaborated by a CHPT member and a non CHPT member in the following statements respectively:

"Before we prepare our CCHP plans we sit and discuss with all health facility committees about their challenges and problems and take them for use in the preparation of the CCHP plan for the current year" [CHPT member, Sumbawanga]

"Yes, we are involved in the council plans but to a small extent (...), usually I am told to call a meeting with the health committee (...) whereby we discuss with them our problems and what we want to be done eg updating our laboratory. Then we present our suggestions to the committee which is involved with CCHP for farther processes. That's it; we do not go further than that." [Non CHPT member, Sumbawanga]

Both the council planning team and the in-charges of health facilities in Iringa are pleased with this new system. But the non CHPT have not been well prepared to carry out this new responsibility, they have no much knowledge about planning and have no clear understanding of sources of funds used in preparation of plans such as the basket fund. When the non CHPT from Iringa were asked what do they understand about basket fund this is what they said:

"*We were told that is the money brought by people to help the health services"* [Non CHPT member, Iringa]

"They just bring money and they are the ones who are dividing it." [Non CHPT member, Iringa]

"I know is the money brought to help health services in dispensaries and health centres and for municipal if I am not mistaken. It was not transparent before but for this year is transparent. We make plans; there is money from basket fund and O.C money etc this has started this year." [Non CHPT member, Iringa]

It was explained that there was training of people from the health facilities on planning before they were assigned this new responsibility. This was elaborated by one CHPT member:

"(...) the municipal sent some member of the CHMT (...) to attend training on how to prepare plan as training of trainers (TOT). So after that they came and conducted training for people from health facilities" [CHPT member, Iringa]

Findings show that this training did not reach all that were involved with planning at health facilities as one of the non CHPT member when asked whether he had received any training concerning planning said:

"*Personally I have never got (...) I have never heard that anyone among us has received any training on planning*" [Non CHPT member, Iringa]

It was found that the non CHPT do not follow protocols that are uniform to all. When the time come for deciding which area should be given priority some base on reproductive health, top ten diseases and building condition. Others identify priorities when they sit at health committee meetings basing on what the committee members consider to be product or service needed most by the patients. This is illustrated in the following statements from two different non CHPT members:

"We first look at the reproductive services, we look at the top ten OPD diseases and lastly we check whether any building needs renovation" [Non CHPT member, Iringa]

Mainly we sit with the health committee and identify areas with deficiencies or problems (…)The criteria we are using is when we see that patients need so much that product or the service is demanded a lot at the centre (...) [Non CHPT member, Sumbawanga]

ii) Leadership: team work, communication, supervision, transparency, motivation, coordination

In this study it was found that good leadership of the council director played a key role in ensuring that the planned activities are implemented. This was more elaborated by the respondents from Iringa municipal. It seems the District Executive Director (DED) is approachable and listens to his subordinates. Whenever the subordinates have problems eg shortage of funds for implementation of activities, he makes certain that the subordinate has tried other means and really failed before providing assistance.

"If there is serious problem examples say the gas tanks need to be refilled we can go to the DED's office and ask him to assist us. Because he has got many sources of fund he can assist us by taking from another source and he will know how to balance it later. If you present the problem to the DED office and try to explain how you have struggled and where have you reached he will also know how to help you." [CHPT member, Iringa]

"...we have good organization culture (...) the District Executive Director (DED) who is leaving did not discriminate the sectors in terms of doing work; we were implementing activities together as the council. For example there are some times when we are in the crisis and we get help from the other sectors such as educational sector or the agriculture sector." [CHPT member, Iringa]

For the case of Sumbawanga the DED was mentioned by only 2 CHPT respondents and was linked with submission of reports and giving approval for borrowing money

"*…sometimes we borrow funds from other projects by writing a request letter to DED and pass it through appropriate committee then when our funds come we to replace them"* [CHPT member, Sumbawanga]

"...so when you receive that action plan you know what to do and thereafter you only have to make follow up. If you are needed to do training you do that and submit a report to the DED" [CHPT member, Sumbawanga]

The role of team work and communication

The issue of good team work and communication as facilitator of implementation of health plans was reported in both councils. This was the case at council as well as the health facility level. It was also shown that the DMOs communicate well with their subordinates and involve them in decision making.

There is such good team work in our organization (...) when we meet in the office every member makes a report of what he/she has been doing. If there will be an emergence issue raised then the DMO call us on emergence basis we meet and find solution to the problem" [CHPT member, Sumbawanga]

"The team work is good, I'm saying these because in our team you can ask any person about the issues going on in other departments and he/she can answer you effectively example if you ask a person from laboratory example what has happened in RCH today he will be able to tell you. This shows that there is a significance amount of team work". [CHPT member, Iringa]

Of all the respondents only one did not perceive their organization as having a good team work, this respondent said:

"There is team work but it is not very good because many employees are new comers. The job is done but team work is not good" [CHPT member, Sumbawanga]

Support from the top levels seems to influence good implementation of plans. The councils receive support from the regional authority when they consult them and the health facilities also get support from the council. In addition to this also community support is recognized to facilitate execution of health plans.

"(...) what help us are the meetings, ie staff meetings and the ward development committee (WDC) meetings done in their streets (...) with regard to council (...) they usually attend our monthly meetings, when we invite them they come. If we need anything from them maybe to give us answers about something they come. Sometime when we phone them they respond quickly. We have good support from the top." [Non CHPT member]

Importance of motivation on performance of workers

Motivation was mentioned to be a catalyst for good work performance. Some respondents from Sumbawanga pointed out that it is necessary for those allocated to work in that region to be given their incentives eg subsistence allowances and houses immediately on arrival to motivate them to stay and work there, since the place is so remote and only the committed people accept to work there. It was also perceived that arrival of new people influence others on willingness to contribute in health issues, as one CHPT member from Sumbawanga said:

"At first people had the perception that the government is responsible of providing each and everything, so they do not have to contribute anything (...) nowadays people are changing, may be because of the increased influx of immigrants who have positive response." [CHPT member, Sumbawanga]

A CHPT from Iringa, in relation to motivation issue, said:

"(...) poor incentive packages sometime demoralize the workers performances" [CHPT member, Iringa]

Effect of transparency on implementation of plans

Findings also show that transparency is required to enable activities to be implemented well. It increases the trust of people to their leaders. It was mentioned that transparency improves accountability of the people concerned. This is illustrated by the following statements from CHPTs:

"(...) *when we receive funds...we prepare a list of activities to be done and money allocated and we distribute to all health centres and dispensaries. Thus everyone knows the amount of money that has been received and activities to be implemented by the money. Initially there was no such a thing but we came to realize that if we are transparent people will understand us."* [CHPT member, Iringa]

This implies even the community know what is going on.

"*If there is transparency in implementing plans it will help to increase accountability of the people involved*" [CHPT member, Iringa]

Coordination of activities between the district and ministry of health and social welfare (MoHSW), government leaders

Another issue that was mentioned to weaken effective execution of health plans was poor coordination of activities between the MoHSW and the municipal. The people from the MoHSW may demand something without prior notification and this will force the people at municipal to stop all that they were supposed to do so as to attend their bosses' requirements. This also applied to sudden arrival of political leaders as explained by one CHPT member from Iringa:

"(...) we do not have the coordination between the central government and the lower level. You may plan to do something at the municipal but unfortunately you can receive some directives from the ministry that you are needed to do another thing. There is no a proper coordination between the council and the ministry (...) we can have our schedule for the whole quarter but due to those emergencies, may be a prime minister is paying a visit, so we can skip the activities and attend the prime minister." [CHPT member, Iringa]

Contextual factors

The main contextual factors identified to influence implementation of council health plans were the role of donors' interest and politics. Some respondents had views that some donors only funded activities or programmes that were of significance to them and did not considered the grassroots priorities. Sometimes even the activities that they support are not well understood by the council people.

"...example sometime they may call only two people from the council and mix them with other people from the region may be for the training. So you can ask yourself that is the activity they told us that, they will do?" [CHPT member, Iringa]

The arrival of political leaders at the councils was also mentioned to sometimes undermine the effective execution of council health plans. A CHPT respondent from Sumbawanga commented on effect they get of arrival of political leaders at their municipal:

"Political issues do influence very much (...) sometime we may be visited by a political leader for example honorable prime minister (...) in our plan we may not have such activity

but we are needed to contribute for the event (...) There may be a particular activity that we had plan for about five million and we do not have other sources of fund. So in that activity we may borrow two million and contribute it to the event (...) when we take money from these areas we fail to implement planned activities" "...It could be very good if the donors could look at the priority problems of the specific area so that their assistance should base on the problems identified" [CHPT member, Sumbawanga]

With respect to this issue it was reported that the municipal has already talked to regional administrative secretary (RAS) in order for them to be provided with an extra fund or establish an emergence fund for political activities at the municipal eg political leaders' visits. This is still being discussed.

The issue of politics was also raised by another respondent with regard to allocation formula used by central government to bring funds to councils.

"This formula is good because it is based on the size of the population and transport route but there are some directives which come from leaders which do not go along with the formula. For example to have health centres in each village, it affects the implementation of the other activities." "...It could be very good if the donors could look at the priority problems of the specific area so that their assistance should base on the problems identified" [CHPT member, Iringa]

Supportive supervision, monitoring and evaluation of plans

In both study areas there was follow up of implementation of plans and evaluation of the progress. It was explained that there are supportive supervision that are carried out on regular bases, they usually prepare checklist of things to be reviewed during supervision. The in-charges of health facilities and the CHPT prepare reports of activities done as feedback and send them to DED office through the DMO. Apart from this there are also internal auditors from the municipal office to look for value for money; they check whether the price of the items corresponds to documents available.

4.0.3 Involvement of stakeholders in planning and implementation

Community participation:

In both councils the community was reported to be involved during planning of health plans as well as during implementation. The participation of community is through their representatives who are members of health committees. No member from the community is included in council planning team that prepares the CCHP as illustrated by a CHPT member:

"We don't directly select members from the community to represent the community during preparation of CCHP but they are represented through the health center concerned using their ward representative" [CHPT member, Sumbawanga]

The participation of community is regarded to be more directly linked to implementation of projects. Few respondents mentioned that the priorities are initiated by the community through use of opportunities and obstacles to development (O & OD) as one CHPT from Iringa said:

"...For the projects such as we have the projects of building the municipal hospital and theater, they will obtain the information in their meeting in which they can contribute on the projects may be by making blocks or collecting soil for the construction of the hospital. There is also O & OD this means that they are participating in the raising of various priorities and when we implement them we have to come to them so that they can give their suggestions." [CHPT member, Iringa]

Several respondents raised the issue that it is difficult to get people from the community to participate in the meetings to discuss the health problems without providing them with some allowance

"...the community participation is good I can say to the extent of 70% but still education to them is needed. They always think that they are going to pay/contribute some money but if you call them and tell them there is an allowance of Tsh. 5000 no problem, they will come" [CHPT member, Iringa]

Similar difficulties were observed in Sumbawanga as shown in the following sentence

"...there is a meeting called full council meeting of the municipal, in these meetings all people are people are usually invited (...) at first they had a negative response, but now they are slowly improving." [CHPT member, Sumbawanga]

It was also perceived, at the dispensary and health centres, that community involvement in giving their ideas concerning what should be done to solve their health problem was good and was executed through their representatives. When the in-charges of health facilities receive information from the council that they should prepare list of their problems and needs, the in-charges in turn inform the health committees that they should talk to their people through meetings and get the communities views and ideas. Once the information is gathered it is included in the report to be submitted to the council planning team.

"*...it should be the community that sends the committee members*" [Non CHPT member, Sumbawanga]

This gives an impression that the views regarding health problems and needs should originate from the grassroots which ideally it very good. However the ability to really represent community ideas depends who are the community that was involved, how they were gathered and how the meetings of community and health committee were conducted. The in-charges of health facilities are not aware of how these meetings are being arranged or conducted. When one of the in-charges of health facilities was asked how the meetings of health committee and community are conducted the response was as follow:

"*I am not very much sure on how they call the meeting. I usually inform them that on a certain day we are supposed to meet and discuss about our needs and problems so prior to that they should discuss with the community. They have been telling me that they conduct what is so called WDC*" [Non CHPT member, Sumbawanga]

It is through these Ward Development Committees (WDC) meetings that the health committee members are selected. It is not always that peoples suggestions are implemented by the council, this may de-motivate the health committee to continue with work. This is illustrated in the following statement made by one non CHPT member:

"*To be honest sometime peoples' ideas from the health committee are not implemented. That is why sometimes when you call the health facility committee they refuse to attend and say 'how comes what we had asked for they have not implemented?* [Non CHPT member, Iringa]

When the in-charge make follow up at the municipal they are usually told that the activities were omitted due to lack of funds. The community also does get disappointed when their plans are not implemented and have different ways of expressing this as one CHPT member narrated:

"...some time they are so furious but we try to inform them it is just because of the scarce budget" [CHPT member, Iringa]

Another area where community participation is observed is on contributing for the cost of health service through cost sharing which may be in the form of user fees. In some areas it seems to be a problem but in others it is not. The communities are reported to have been overburdened by many contributions that they have to make, such as building of primary and secondary schools, and this may impair their ability to contribute in health issues. The political leaders have a significant role to play to persuade people to participate in contribution as reported by CHPT members from Sumbawanga and *Iringa* respectively:

"...we always get assistance from the community in various projects, but it reaches a time that the community is unable to contribute as they are overburdened by contributions... but it depends on the area and the convincing power of their leaders" [CHPT member, Sumbawanga]

"...generally people are responding but they are sometime over burden by many contributions (...) in each project they are told to contribute 20% which has been proved to be so difficult for them" [CHPT member, Iringa]

Participation of private, NGOs/ FBOs:

The respondents from both councils showed that there is no direct inclusion of representatives from private sector in the CHPT. It was further explained that in Sumbawanga there used to be a representative from voluntary agency who used to be included in the CHPT but the voluntary agency hospital has been upgraded to designated district hospital (DDH). Thus as of this year CCHP preparation meeting the representative from DDH participated as medical officer in charge (MOI) of district hospital. When asked to describe the representation of private/NGOs in the CHPT one of the CHPT members said:

"...there is a challenge, they are supposed to be among the CHPT according to the guideline... but it is not possible to fulfill all the requirements because the money that is being allocated for conducting CCHP planning is not sufficient to accommodate all the suggested planning team members. The actual planning team consists of about 20 people but the money which is provided can hardly cover for 12 people." [CHPT member, Sumbawanga]

Nevertheless the views of stakeholders from the private sector are usually taken into account since before the CHPT start to prepare CCHP the team has a forum with the entire private

health providers in the council and discuss with them major issues of health that they think should be included in CCHP as this statement from a CHPT illustrates:

"...about five days before we go and sit as CHPT to prepare CCHP we usually convene a meeting with the entire private, FBO, NGOs. We sit with them and discuss all that they think should be included in the council health plan and we give them their per diems." [CHPT member, Iringa]

Involvement of these organizations during implementation paves way for smooth implementation of activities later on. This is not always the case, the private/NGOs are reported not to be very transparent with activities so the CHPT are not sure how they are implementing the agreed activities. Moreover, they choose activities to be reported to the CHPT.

"...the problem with FBO/NGO is that they are not so open with their budget. If they help children whose parents have died because of HIV/AIDS paying school fees or providing food to them there is no problem. They cooperate with us during preparation, they submit to us their activities but problem comes at the time of implementation. You can pass in the street and see them servicing the community, if you ask them they will tell you that, we came in your office but you were so busy" [CHPT member, Iringa]

The main issue with donor that was raised is that they often come with their own interest; they may become involved in activities of their choice. Usually they identify people who will implement the activities they want, discuss with them about the plans/activities, and then supply the fund for the activities through or not through the DMO office. This loose connection between council and donor allows possibility of repetition of activities.

Perceived impact of inadequate implementation of health plans

The perceived impact that may occur if there is failure to implement health plans as projected are mainly directly related to health of community and these include poor health services that may lead to increase in mortality rates (especially maternal and infant), eruption of communicable diseases such as cholera if the council fail to keep the towns clean. Also outbreak of the preventable childhood illnesses may occur when the council fails to acquire enough vaccines on time or there are no skilled personnel to carry out vaccination activities. The following are some of the statements from respondents that illustrate this:

"...they will suffer because of poor health services, example if I fail to purchase the tools or employ new employees that will have an effect on the services we are going to provide,

automatically it will be poor hence the community will be greatly affected because of that. Deaths can increase because of poor working environment." [CHPT member]

"The impact is big, for example increase in mortality rate. If we plan to buy certain things to reduce maternal mortality but fail to do so it may affect the outcome of maternal mortality. We had mortality rate of 258/100,000 in year 2007 and we planned to reduce it to 245/100,000 within three years, but unfortunately we managed to reach 249/100,000. We succeeded, but it is not very much" [CHPT member]

"*...there could be eruption of communicable diseases if there will be no cleanness. If the health services are not good there may be increase of death rate eg maternal and infant*" [Non CHPT member]

It is reported that the community is affected economically and psychologically. When the public health facilities fail to offer adequate health services it may compel the people to seek private health service where the cost is much higher compared to if they receive those services in public facilities. For example in one of the health facility there was no laboratory services offered due to technical problems which forced the pregnant women to access the at a nearby public facility, where they had to pay for it, after being attended by the public clinician. Another issue that was mentioned by the respondents is loss of trust that the public has on council and health system in general. This can be illustrated in this statement:

"...when you fail to build the dispensary as you had promised you will impair the community morale and motivation, reduce trust that they have made and become reluctant in contributing to other public/community projects" [Non CHPT member]

Another effect of not carrying out plans effectively such as not conducting supportive supervision is that the CHPT will not know the working conditions of people at health centres and dispensaries; as a result they won't know how to help them.

From these descriptions it is clear that the respondents are aware that failure to implement health plans as required has negative impact on community health wise, economically and psychologically.

4.0.4 Recommendation to improve implementation of health plans

In order to improve execution of council health plans it was suggested by one CHPT that participatory planning should be emphasized and the CHMT should strengthen implementation of planned activities by using the strategic plan because it has mid and final evaluation

"*First is to strengthen the participatory planning. That is the foremost important because everyone will be involved and will be aware of what is going on.*" [CHPT member, Iringa]

Financial resource: it was advised that there should be a meeting between the government and development partners to avoid repetition of activities. That the development partners look at the priority problem of a specific area so that their assistance should base on problems identified. Also the procedure and regulation to use the basket fund should be simplified because this is the only reliable fund for the municipals. The other suggestion was on use of cost sharing money that a certain percentage of the money should be left at the center where it was collected for emergence purpose. It was also suggested the emergence fund for social welfare should increased because the current 2 million shillings is not enough.

"We must have the meeting between the government and the development partners because there is repetition of various things, the development partners may implement the same thing that the government has planned to do. It could be very good if the donors could look at the priority problems of the specific area so that their assistance should base on the problems identified". [CHPT member, Iringa]

"*Furthermore the procedures and regulations put on the use of basket fund should be simplified because it is the only reliable fund; if they simplify rules on the use of basket fund it could facilitate better implementation of council health plans.*" [CHPT member, Sumbawanga]

Human resource: in both municipals it was suggested that there should be increased allocation of qualified skilled health personnel to strengthen their capacity. Also the need to train workers on how to use MTUHA books was emphasized.

"For implementation to be effective the important thing to be done is to increase manpower that has the capacity and ability to influence the implementation of the plans" [CHPT member, Sumbawanga]

"(...) people who are responsible to filling the books were trained very long time ago (...) for example in our sector there are only three people who had the training and one of them will retire at any time, so they have to train other personnel. [CHPT member, Iringa]

Community participation: it was suggested that for health plans to be carried out well the ideas should start at the community level. There should be more transparency in health sector issues to the community and this should start from the central government to the lower level. It was also suggested there should be more participation of men in reproductive and child health services. The participation was emphasized on PMTCT services that without male involvement this service will not be sustainable.

"First we should educate the society so that they can understand their importance and roles in participating in these projects in different activities such as fund contribution and other activities" [CHPT member, Iringa]

"...the participation of men in reproductive health area is difficult-it is a very big challenge. There is a need to increase their participation because if they don't participate effectively that serve become unsustainable" [CHPT member, Sumbawanga]

Regarding the issue of tools; it was proposed that there should be changes in the procurement act. The process is too long so they should give permission to municipals to use funds for their plans on condition that the municipals should comply with the rules and required standards set by procurement management unit (PMU). It was also suggested that there should be a CHMT member who knows specification of medical equipment to accompany the PMU to buy medical products. Concerning EPICA and PlanRep software it was suggested that the system of linking these two should be put in place to improve efficiency of using money.

"*First of all this system of linking Plan Rep and the EPICA systems should be put in place. This will help all activities that have been planned to be implemented well*" [CHPT member, Sumbawanga]

Transport, material/ equipment: the infrastructure particularly the roads should be improved to increase accessibility of remote areas especially during raining season. The MSD should deliver the supplies and drugs on time based on what was requested.

"Road conditions need to be improved to enable good communication between villages because this will help to improve services to people" [CHPT member, Sumbawanga]

"In my opinion if possible the MSD should bring the drug on time and what we request should be the one which is actually brought. You become happy when you hear that the drugs and supplies are coming but once it reaches and open you find something else." [CHPT member, Iringa]

Organization factors: motivation was mentioned to be needed at work place eg have socialization activities such as end of year parties for all worker to facilitate workers output. And for those who collect cost sharing money or go for supervision in remote villages should be given incentives such as allowances to make them work more efficient. It was also suggested that those who are responsible for planning at the dispensary and health centres should be educated on how to prepare a plan and at what time should the planning start. In addition to this the professional from the MoHSW were urged to go to the municipals and make evaluation of the progress of the new system of planning at dispensary and health centres. Also there should be time discipline which must start from the top management to the lowest level this could be achieved by having timetable for work activities at all levels.

"...the time discipline must start from the top managers to the lowest level, but if there will be a time discipline at the lower level and no at the top level, it will be nothing. We have to make even the lower management level to have time table for work activities." [CHPT member, Iringa]

"I suggest that professionals from the ministry to come and make evaluation on the progress of the system of planning at the dispensary and health centers and if they identify any problems or deficit they should be ready to provide orientation." [CHPT member, Iringa]

"*I think what should be done is to increase equipments, improve motivation eg when new employees come their subsistence allowance should be ready and intact, and then there should be available houses*" [CHPT member, Sumbawanga]

"I think the cost sharing fund must be divided, and we can be given a certain percentage for emergency purposes. This can help implementation of some activities which occur at the center" [CHPT member, Sumbawanga]

The following figure shows the framework developed regarding the factors that influence implementation of council health plans based on the study findings.

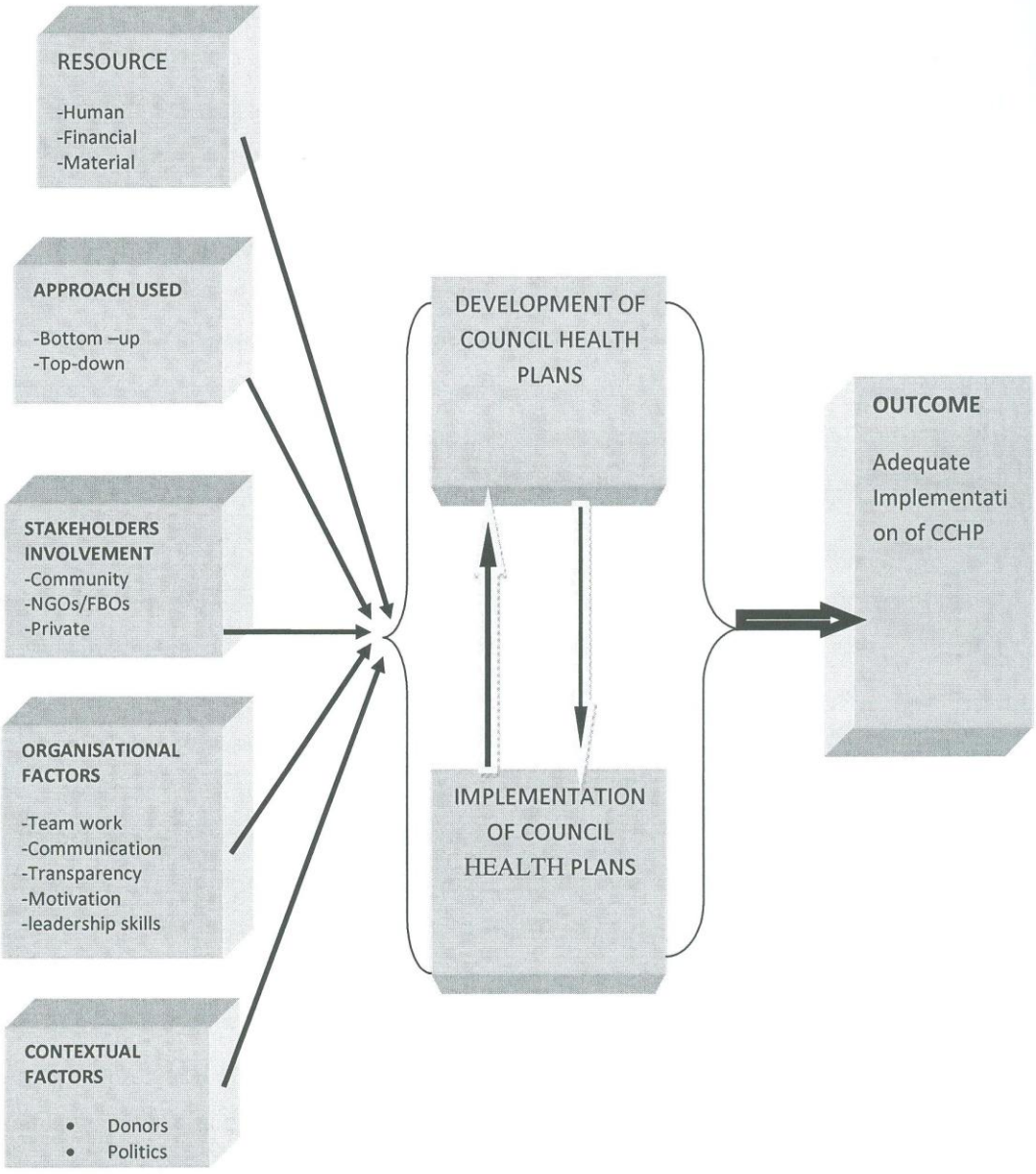


Figure 3: Factors influencing implementation of council health plans

CHAPTER FIVE

5.0 DISCUSSION

Being able to plan for health and effectively implement the agreed plans and activities is still a challenging issue for district planning teams in Tanzania. Various studies have described factors influencing implementation of health plans at district level [23, 30, 31] but there is less documentation on the views of those responsible for health planning and implementation at district level in Tanzania. The development and implementation of health plans at district level is based on Comprehensive Council Health Plan (CCHP) guideline. This study has illustrated the views of those who are directly and indirectly involved with preparation of CCHP on factors influencing planning and implementation of health plans at district level. The findings show there are constraints and enabler issues that influence implementation of health plans.

With regard to availability of resources, the one major constraint that was described to hinder effective implementation of health plans was delay in disbursement of funds. A finding similar to that observed by Asante et al that untimely release of funds was a significant barrier to effective delivery of health service [14] For the case of delay of basket fund it is quite recognized to be beyond the councils' ability [23]. The findings also revealed that the donors aid though it's needed but due to unpredictability of when it will be available and what amount exactly, the council fail to make effective use of it. This is consistent to what other studies have found that it is difficult to predict the disbursement of earmarked funds or get information from development partners concerning their upcoming commitment plans in health sector [17, 50]. The unpredictability of information on financial resources implies that their allocation is quite improbable to imitate the priority health needs of the country [24] which is the main objective of utilizing the funds.

It was explained in both study areas that basket fund was the only reliable source for implementation of planned activities. They usually rely on council own source to cover for funds deficiency and sometimes on resources under DED control. But this is greatly influenced by the leadership of DED and his/her relationship with the subordinates. The health planning team could borrow money from the district director office and continue with implementation of a particular activity then when the fund arrives the borrowed money is replaced. The district managers in Ghana were observed to apply similar technique but in addition they obtained supplies on credit by forming alliance with the willing suppliers [14].

The other mechanism the planning team uses is that of lobbying at higher authorities and some nongovernmental institutions eg when they were seeking assistance to get appropriate vehicle for garbage collection. At the health center and dispensary levels the means of ensuring activities are implemented in case of fund deficiency is through use of cost sharing money.

Lack of capacity and skills among working personnel was a common issue in both study areas and has also been reported elsewhere [23, 28, 31] to be contributing factors to inadequate implementation of health plans. It was explained that there was weak capacity at the CHPT level as well as at non CHPT level. However of significant note was that a number of positions in Sumbawanga municipal were held by acting people who were perceived to be incapable, this was not considered the case for Iringa. The reason could be that due to the poor infrastructure most qualified personnel do not prefer to go and work there. This is echoed in the study by Olsen [28], which was conducted in Northern Tanzania, whereby it was observed that the rural districts were characterized by tremendous understaffing of qualified health staff at the level of dispensary as compared to urban districts. The same study documented that the failures and constraints (such as lack of resource and motivation) of implementers at lower levels in the health care system are barriers to effective policy realization. As it was observed in this study the roads are not in good conditions such that it may take three days to travel from Sumbawanga (compared to one day from Iringa) to Dar es Salaam during the rainy season. The situation is even worse when moving from Sumbawanga center to remote villages and this also contribute to ineffective execution of health plans. This situation may de-motivate people to go and work in such an environment.

According to this study the bottom up approach was described to be the best one for initiation of programmes and ensuring that what was planned is implemented. This implies that effective stakeholder involvement from planning stage is necessary so as to guarantee adequate implementation of agreed plans which is echoed by other studies [4, 16, 34]. The findings revealed that community are not willing to attend meetings to discuss their health problems unless they are provided with some allowance. This could be explained by the fact the community are overwhelmed by various contributions that they are often required to make for various development activities but on the other end it might be that they have observed that their leaders or other people in administration when attending meetings they are given allowances so why not them too? Another possible scenario might be the communities

are not well informed about the importance of their participation, as explained elsewhere [35] it is difficult for community to make decisions on issues that they are not conversant with. In addition in order to strengthen local planning and implementation systems there is a need for people to change their way of thinking, their attitudes and way of linking to others as stakeholders [25].

The new planning process that is supported by the government [51] which enables those at lower levels to plan for themselves ie health centres and dispensary is being practiced in Iringa. Though Iringa's adaption of the new planning approach cannot explain its better CCHP performance compared to Sumbawanga, still this is a good system as it empowers the lower levels and makes them more accountable/responsible with funds they receive. In addition this system has an added advantage of increasing transparence, the health facility committees and community will know exactly what they have. Even when they are told a certain activity or programme cannot be implemented due to lack of funds they will easily understand and could contribute for it if asked to do so without a doubt. The challenge here is those responsible for preparing those plans at health centres and dispensaries have no experience in planning and the prior training which was provided did not reach all the key people. It was also observed that the in-charges of facilities were not very conversant with criteria to be used in setting priorities or components of monitoring and evaluations of plans. Even among the recommendations made by respondents on how to improve implementation of health plans was the call for more training on health planning for health center and dispensary personnel.

Another thing which was revealed by the study that is worth mentioning is the role of district executive director (DED) on implementation of health plans at district level. She/he has capacity to support council health plans when funds are not available using the various sources that are at her/his disposal. However this depends much on the relationship and leadership skills that the DED and subordinates have at their organization. As it was observed in one of the councils that due to 'good' leadership of DED the council were able to implement several health activities as a result of support they got from their director.

Despite of the challenges that decision makers face when planning and implementing programmes and activities at councils they need to understand and use efficiently the available tools such as CCHP guideline and computer software. The study showed some of

CHPT especially the new ones do not understand the guideline well, this often weaken the performance of workers as shown in the study by Baez et al [38]. Another concern is with regard to HMIS books, from the results obtained in this study it was shown that there was lack of uniformity in recording data in HMIS books especially on PMTC services as the books are outdated. The lack of standard tools and procedure for keeping patient record was also explained elsewhere to impair data collection system [40]. The people at the dispensary and health center levels who prepare and fill data into MTUHA books, sometimes they don't fill the books accurately and usually they do not utilize the information for the development of their facilities.

In the study by Cibulskis et al it was found that if the senior management inquire about information and utilizes it explicitly then this will help to reinforce the significance of information throughout the system [41]. Thus likewise the subordinate will develop tendency to use information for the benefit of the facilities and community at large. The study revealed that supportive supervision is done by the CHPT and during these activities they collect missing data and educate health facilities workers regarding their mistakes. It is also highlighted that supportive supervision with regular feedback is the key to improvement of performance of workers at lower levels including in the area of HMIS [40]

From the study it was shown that community participation was as they have their representatives in the facility governing committees and they are involved in development of Opportunities and Obstacles to Development (O and OD). But the respondents indicated that they include the problems identified by community through their ward meeting and include them in the CCHP, it was not clearly elaborated that it is the actual O and OD plans from the community that are incorporated in the CCHP. Furthermore one of the non CHPT respondents commented that sometimes the people's views are not implemented and this weakens the moral of health facility committee members to continue with preparations other plans. This raises one important issue, if not the people's views then whose view is being implemented? It is quite possible that due to scarcity of funds some activities cannot be implemented, in such a case feedback becomes crucial, the facility health committed should be well informed about the reasons of not implementing their suggested priorities as they had planned. One can just imagine if the health committee members themselves are not satisfied or clear on the reasons for not getting funds to implement their prioritized activities then what about the lay people?

In general the study findings show that the views of council health planning teams and other decision makers at the district level on factors influencing planning and implementation of health plans to a large extent conform to what the theory and other findings indicate. The study has revealed that having many acting people in CHPT in the district council and the poor road infrastructure were the main different issues found in Sumbawanga urban district compared to Iringa urban district.

Study limitations

Due to the type of methodology used ie qualitative with selection of only two councils limits generalization of findings. The purposively selected sample may not accurately be representative of the target population. The researcher should have conducted a study at the community level so as to clarify information obtained from council planning team members and in-charges of health facilities, particularly with regard how the priorities identified through Opportunities and Obstacles to Development (O and OD) and the ward plans are included in the council health plans. This could have provided a broader picture of issues related to planning and implementation of health plans at district level. However time and financial resources allocated to the study could not allow for this to happen. Nevertheless these findings do provide important insights into the challenges involved in planning and implementing district health plans.

CHAPTER SIX

6.0 CONCLUSION AND RECOMENDATIONS

The health planning teams at the district have been found to recognize the factors that influence implementation of health plans. The delayed disbursement of funds, lack of human capacity, and long bureaucratic procedure are among the issues that negatively affect implementation of plans whereas enabling factors include availability of CCHP guideline; funds from the government, donors and council sources; good leadership skills and transparency. All these need to be adequately addressed to ensure better health output for all. Specifically the following recommendations are made for the attention of the municipal authorities as well as the MoHSW:-

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- The issue of delay in fund release and late disbursement of funds is a long standing problem. It is high time that real actions are taken to rectify this problem. When giving directives the government should take into account the capacity of the lower levels to carry out the given instructions so as to ensure that they bring about the desired output.

- More effective coordination of activities is needed from the central government to the district levels in order to facilitate the districts to have better implementation of their plan. This could be achieved through preparation of timetable by the MoHSW concerning their visits to councils and this should be sent to the particular council at least one month before the actual visit.

- The MoHSW should make more effort to capacitate the councils in ensuring the dispensary and health centres have skilled human resource who can prepare plans for their facilities according to the template for developing annual health plans for heath centres and dispensaries.

- There is a need to improve the capacity of community representative so that they become conversant with concepts used in health allocation of resources and in planning. This will make them participate effectively in the planning sessions.

- The HMIS books should be reviewed to accommodate the missing information particularly with PMTCT data to allow uniformity. PlanRep software need to be updated to allow more than one source of fund be allocated to a single activity and the sources which are obsolete should be removed.

- Though it has been indicated that there is participation of all stakeholders in planning and implementation of health plans in the study areas, there is a need to conduct another study to explore the extent of their participation with a focus on the views of community, private, FBOs and NGOs.
- The government should ensure that funds are released on time to allow effective implementation of plans

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