

**THE UNITED REPUBLIC OF TANZANIA
JOINT MINISTRY OF HEALTH
AND PRESIDENTS OFFICE
REGIONAL ADMINISTRATION AND LOCAL GOVERNMENT**



**Health Basket and Health Block Grants
Guidelines for the Disbursement of
Funds, Preparation of Comprehensive
Council Health Plans, Financial and
Technical Reports and Rehabilitation of
PHC Facilities by Councils**

12th March 2004

FOREWORD

Since 1999 through Decentralization and Sector-Wide Approach in the Health Sector the Ministry of Health has achieved many important milestones in its endeavours to improve services for the people of Tanzania. One of the milestones is the arrangement of the disbursement of the Basket Fund to the Councils. Since 1999, a number of guidelines were developed to guide Councils in the drawing up of Comprehensive Council Health Plans. . These guidelines sought to further bridge the performance gap among the Councils in the management of district health services and to enhance the decentralization process. The review of these guidelines has been carried out to accommodate new developments in line with the ongoing reform processes in the health sector and Local Government Authorities.

This review of documents is the implementation of the milestone of the HSR-Review March 2003 where it was observed that: “The basket partners acknowledge the budget rigidities arising from basket guidelines and procedures at the Council levels, that place restrictions on the use of Basket Funds. Basket partners are in agreement that this should be reviewed, using a phased approach to reduce the restrictions and in-line with basket partners’ own regulations on the use of funds. It was suggested that the Audit-Sub committee of the BFC review the restrictions and make recommendations to the BFC”

These planning and budgeting guidelines are tools that will ensure that the change process is well moderated by the Council teams and other stakeholders, in order to achieve decentralization. Moreover, the policy of Human Resources for Health stresses that a reformed health sector requires well-trained, motivated and well-managed workforce.

Consequently, these reviewed guidelines focus on:

- Enhancing an effective and efficient decentralization of health services in terms of problem identification, priority setting, planning, budgeting and decision making process.
- Promoting teamwork among Council Health Management Team (CHMT) members in the processes of delivering quality health care services
- Enhancing programme integration for a rationalized resource use in the Council.
- Empowering the Councils to make own decisions and set own priorities.
- Promoting and strengthening partnership with non health sector partners or actors who may have a role to play in the health issues
- Increasing the accountability of the Councils
- Shifting attitude of CHMTs’ towards services delivery.

The review of these guidelines process takes into consideration the recommendations of the Technical District Health Service Review and those of the HSR Review of March 2003.

We have every hope that all partners in the health sector - including the Governments, Non-Governmental Organizations, Local and International health institutions and faith based

organizations will find this process has facilitated the Councils to perform better. It requires the support of everybody to effect the change made. We welcome those who may want to support the Councils in whatever form to do so!

.....
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Permanent Secretary

Ministry of Health

Date:.....

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Presidents' Office, Regional
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Date:.....

ACKNOWLEDGEMENTS

The work of reviewing the three guidelines: Planning Guide for Utilization of Health Basket Grants, Joint Disbursement Manual and Prototype for Development of a Comprehensive Council Health Plan has been very much a consultative and a joint effort. A number of people, development partners, several institutions and organizations have contributed to the review process tremendously. We want to thank them all for their exemplary work to make the initiative a reality

Special thanks should go to Dr. Rainer Kuelker from GTZ, Dr Sam Nyaywa and Dr R.B.M. Kalinga and the following members of the task team that was appointed to review planning and budgeting guidelines for local authorities (Dr. Bergis SchmidtEhry, Ms. Jacqueline Mahon, Mr. Joseph Kelya Mr. Rashid Kitambulio, Mr. Richard Mkumbo and Mr. Maximilian Mapunda for their tireless effort towards review of these documents)

We are also thankful to Regional Medical Officers, Regional Secretariat members, District Medical Officers, and National facilitators who participated in the review exercise for their input.

The Ministry of Health would therefore like to express its appreciation to all development partners for their contribution to the production of this document.

Last, but not least, we would like to single out and mention a few names who co-coordinated this work: Dr. R.B.M. Kalinga, Anna Nswilla and P.W. Maganga who can be seen as overall National Coordinators of this work.

To all we are grateful.

Dr. G.L. Upunda

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Date.....

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune-Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BFC	Basket Financing Committee
CBD	Community Based Distribution
CCHP	Comprehensive Council Health Plan
CDH	Council Designated Hospital
CHF	Community Health Fund (households prepayment scheme)
CHMT	Council Health Management Team
CHPT	Council Health Planning Team
CHSB	Council Health Service Board
CORPs	Community Owned Resource Person
CSD	Civil Service Department
CYP	Couple Year Protected
DHS	Demographic Health Survey
CRCHC	Council Reproductive and Child Health Coordinator
DMO	Council Medical Officer
MOH	Medical officer of Health
DOTS	Directly Observed Treatment Short Courses
DPT - HB	Diphtheria, Pertussis, Tetanus, Hepatitis
EHP	Essential Health Package
EPI	Expanded Program of Immunization
ERV	Exchequer Revenue Voucher
GoT	Government of Tanzania
GTZ	Gesellschaft fuer Technische Zusammenarbeit
HC	Health Centers
HF	Health Facility
HSR	Health Sector Reform
IEC	Information Education Communication
IMCI	Integrated Management of Childhood Illness
JICA	Japanese International Co-operative Agency
LGA	Local Government Authorities
MTUHA	Mfumo wa Taarifa za Uendeshaji Huduma za Afya
MoF	Ministry of Finance
NACP	National AIDS Control Program
NGO	Non Governmental Organization
O.C.	Other charges
OPD	Outpatient Department
P.E.	Personal emoluments
PID	Pelvic Inflammatory Disease
PORALG	President's Office, Regional Administration and Local Government
RBM	Roll Back Malaria
RS	Regional Secretariat
STI	Sexually Transmitted Infections
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TT	Telegraphic Transfer
VHW	Village Health Worker
VAH	Voluntary Agency Hospital

POLICY VISION:

The vision of the Health Policy in Tanzania is to improve the health and well being of all Tanzanians with a focus on those at risk, and to encourage the health system to be more responsive to the needs of the people.

POLICY MISSION:

To facilitate the provision of equitable, quality and affordable basic health services, which are gender sensitive and sustainable and delivered for the achievement of improved health status.

POLICY OBJECTIVES:

1. Reduce the burden of disease, maternal and infant mortality and increase life expectancy through the provision of adequate and equitable mankind and child health services, facilitate the promotion of environmental health and sanitation, promotion of adequate nutrition, control of communicable diseases and treatment of common conditions.
2. Ensure that the Health Service is available and accessible to all the people in the country (urban and rural areas).
3. Train and make available competent and adequate number of health staff to manage health services with gender perspective at all levels. For capacity building of human resources at all levels in management and the Government to address health services provision.
4. Sensitize the community about common, preventable health problems and improve the capabilities at all levels of society to assess and analyse problems and design appropriate action through genuine community involvement.
5. Promote awareness among Government employees and the community at large that, health problems can only be adequately solved through multisectoral cooperation involving such sectors as education, agriculture, water, private sector including Non-Governmental Organization, Civil Society and Central Ministries such as Regional Administration and Local Government, Women Affairs and Children.
6. Create awareness through family health promotion that the responsibility for ones health nests in the individuals as an integral part of the family, community and nation.
7. Promote and sustain public-private partnership in the delivery of health services.
8. Promote traditional medicine and alternative healing health system and regulate their practice.

INTRODUCTION

This document is issued by the Ministry of Health (MoH) and President's Office, Regional Administration and Local Government (PORALG) and contains guidelines for the use of Block Grants and Basket grants. It contains four chapters.

- Chapter 1: General Guidelines for the Utilization of Basket funds and Block Grants
- Chapter 2: Guidelines on Disbursement procedures for Basket funds and Block Grants
- Chapter 3: Guiding Procedures for Preparation of Quarterly Financial, Semi-Annual Technical/ Financial reports and Annual Financial and Technical Reports
- Chapter 4: Format for a Prototype Comprehensive Council Health Plan (CCHP) including format for report writing
- Chapter 5: Rehabilitation Strategy for Health Centers and Dispensaries and Funding Mechanisms

Chapter 1: Addresses the current guidelines in regard to planning in the Health Sector and report writing for the follow up of the implementation of the Council CCHP.

Chapter 2: Deals with the Procedures on the Disbursement and use of Block and Basket funds. It has to be noted, that the document contains only guidelines on the use of these two sources of financing. For guidelines on the use of other sources of financing the reader is referred to the respective documents/guidelines

Chapter 3: Describes how Financial and Technical reports should be prepared; explains roles of the Council, Region and PORALG/MOH in this process; timetable to be followed during preparation of reports by the Councils

Chapter 4: Describes the format for a CCHP and provides clear instructions/guidance on how to produce plans and how to write quarterly progress and annual reports on the CCHP implementation. Whereas the first three chapters inform the reader on all details of planning and disbursements regulations, the fourth chapter can be considered a "cookbook" for the establishment of CCHP and the necessary reports.

Chapter 5: State briefly on the objectives of the rehabilitation of health facilities strategy, a joint rehabilitation fund, flow of funds, management of funds, monitoring and supervision, community participation and auditing.

The document is dedicated to the members of the planning teams and members of the CHMT. Every year they carry out the cumbersome task of working out a CCHP of high quality and report regularly on its implementation.

It was the main intention of this review to take into account the recommendations of the annual review meeting 2003. In order to ensure that the Council is in agreement with what is in the CCHP, it was agreed at the annual review meeting, that restrictions in the guidelines should be removed whenever possible. Furthermore, guidelines should focus more on the quality of service delivery based on the well-prepared health plans. The revised document accommodated these recommendations.

Planning, budgeting and report writing remain dynamic and in a process of continuous change. Therefore, the MoH/PORALG encourage all users of this document to offer feedback on its quality and user-friendliness. Only this feedback will allow all stakeholders to improve the whole process, which will finally result in high quality planning and reporting. Improved planning and reporting represent crucial preconditions for improving the performance of the Council health services in their aim to meet the health needs of the Tanzanian People.

CHAPTER 1: GENERAL GUIDELINES FOR THE UTILIZATION OF BASKET FUNDS AND BLOCK GRANTS – AN OVERVIEW

1.1 The MoH has developed a framework to reform the health sector in order to improve the impact of health services and thereby produce better health outcomes. The second Health Sector Strategic Plan (HSSP) covering the period July 2003-June 2008 has been developed and the main focus is provision of quality health services and client satisfaction. In order to promote co-coordinated planning and implementation of services within the health sector, the MoH has adopted a Sector Wide Approach.

1.2 The main vision of the Government of Tanzania is to create a reformed health system that will provide quality health services that are efficient, cost effective, gender sensitive and equitably distributed to all Tanzanians.

1.3 In order to achieve this goal the Ministry of Health (MoH) is committed to empowerment at the local level. This will be achieved through decentralization by devolving powers of decision making to the Councils. Support will be given to them in prioritizing and planning their health needs. The Local Authorities will mobilize, manage and account for health resources and implement health activities in line with their plans and budget allocations.

1.4 The vision of improved health services through decentralization of decision-making and resources mirrors the vision of the PORALG for autonomous, empowered and accountable Local Authorities.

1.5 The Sector Wide Approach is concerned with the provision of accessible quality health care services in the local authorities, which are well supported, cost effective with priorities developed according to the Essential Health Package (EHP) and in line with the National Health Policy. Local Health Block Grants and the Health Basket Grants will mainly finance this policy. The allocation starting from 2004 will be based on four allocation factors (population 70%, poverty count 10%, district vehicle route 10% and under five mortality 10%.)

The additional Basket Fund is conditional grant through which MoH/PORALG and development partners give a specific support to the Council health services in order to enable them to provide health services of good quality.

1.6 This additional fund is an additional source of financing for the implementation of the annual comprehensive Council Health Plan, which has to be integrated into the Council's budget. This health plan contains all recurrent and development activities within the sector, identifying the funding source for each activity

1.7 The elaboration of the Comprehensive Council Health Plan (CCHP) follows a certain procedure: After being drafted by the planning team, it is passed to the Regional Secretariat where it is checked for its conformity with national guidelines, and hereby, for its eligibility for Basket Funding. All recommendations from the RS to the Council should be submitted in writing. The plan has to be recommended by the RS before being presented to the Council for final approval.

1.8 The Regional Secretariats (RS) collate the CCHPs their Region and pass them to PORALG, copied to MoH, with recommendations and comments.

1.9 PORALG collates the Regional CCHP summary reports. After this, the MoH and PORALG meet to agree recommendations prior to the BFC meeting for the approval of funding. This ensures that recommendations meet both financial and technical performance requirements.

1.10 Quarterly financial and semi annual (6 months) technical reports will be submitted to the RS for checking.

1.11 On satisfying themselves that the report is correctly entered and that funds have been appropriately used, the RS will collate the reports received from the Councils and submit them to PORALG (copied to MoH) with their recommendations and comments including a recommendation as to the release of the next quarter funds.

1.12 PORALG will bring together all the reports received and make recommendations to the BFC (in consultation with the MoH on technical and performance issues) for the release of further funding.

1.13 Based on BFC approval, PORALG will request the Accountant General to transfer funds for the Council Basket from the US Dollar Holding Account into the consolidated fund. The Basket funds will be transferred directly to account number 6 of each of the Councils by the MOF.

1.14 This procedure makes sure that the Council is enabled to start implementation of the activities at the beginning of the financial year, so that no delay of money transfer hampers the system.

CHAPTER 2: GUIDING PROCEDURES FOR PREPARATION OF THE COMPREHENSIVE COUNCIL HEALTH PLAN USING HEALTH BLOCK GRANTS AND HEALTH BASKET FUNDS

2.1 Introduction

2.1.1 The CCHP brings together three elements:

The Council Health Department recurrent budget
The Council Health Department development budget
Technical Objectives, activities, and performance indicators.

2.1.2 The Local Health Block Grants are divided into “personnel emoluments” (salaries) and “other charges”. Other charges of the Block Grants and Council Health Basket Grants are intended to support the recurrent budget and not the development one.

2.1.3 The Comprehensive Council Health Plan is a key document whose elaboration is time consuming and requiring a lot of commitment from all stakeholders

2.1.4 Tasks of the Council -Planning team are the following

- a) Establish technical activities according to the health guidelines, including performance criteria and Council priorities.
- b) Prepare a health plan including both recurrent and development activities.
- c) Ensure funding is adequate for the identified activities
- d) If not adequate, revisit the technical activities to fit the funding available
- e) Submit the Comprehensive Council Health Plan to the Regional Secretariat for scrutiny as to compliance with sectoral and national guidelines
- f) Break down the CCHP into recurrent and development budgets for inclusion in the Council budget.
- g) Submit the budget to the Council through the responsible Committees.

2.1.5 Where there is a Council Health Service Board (CHSB), it should be involved in the evaluation of the CCHP and the budget. The CHMT should forward the plan to the Regional Secretariat who will scrutinize for adherence to the planning guideline. Recommendations and comments from the RS will be taken care by the Council before submitting to the Full Council for final approval.

2.2 Comprehensive Council Health Plan (CCHP)

2.2.1 Councils are expected to produce a Comprehensive Council Health Plan. A Plan is comprehensive if:

- Its activities reflect the priority areas of the Essential Health Package (EHP) for details refer to paragraphs 2.3 and 2.4 below
- All sources of funding are taken into consideration
- The plan includes all health care providers regardless of the ownership.

An illustration of how to prepare a comprehensive Health Plan is described in chapter 4 (pages 30- 66)

2.2.2 The Technical Plan is derived from the Council's Strategic Plan, and National Guidelines and includes the following:

- The objectives of the Council in the health sector
- The strategies to be undertaken to achieve those objectives
- The activities for the year to meet those objectives
- The implementers of the activities (Council Health Department, District Hospital, Health Centres, Dispensary, Ward and Village etc.)
- The performance indicators that will be used to measure the level of achievement of the planned objectives
- The likely source of funding of the activities and the overall cost

2.3 The Essential Health Package of Tanzania

The Health Sector Reform vision is to "provide equity of access to cost effective, quality health care as close to the people as possible" The Health Sector Strategic Plan covering the period July 2003-June 2008 places emphasis on integrated delivery of quality health services and client satisfaction. Integrated services delivery should be promoted at community, dispensary, health centre and district hospital level. The Essential Health Package (EHP), its priority areas and its intervention areas cover the main diseases and health conditions responsible for the bulk of disease burden in Tanzania. Consequently, it is important that all planned activities are in line with this package. This does not mean that there is a need to plan activities for *all* of the possible interventions mentioned above. . The interventions will be selected based on their effectiveness to address much of the total burden within the district. It is also very unlikely that any district or health facility will be able to implement every recommended intervention during the course of a single year. The guidelines aim is to assist CHMTs to set priorities according to local need and capacity. The Essential Health Package of Tanzania including Priority areas and different Interventions are described below

Priority area 1: Reproductive and Child Health

Interventions:

- Adolescent Reproductive health
- Maternal conditions
- ANC
- Obstetric care
- Post- Natal Care
- Gynaecology, STD/HIV
- Post Abortion Care
- Family Planning
- IMCI
- Perinatal

- Immunization
- Nutritional deficiencies

Priority area 2: Communicable Disease Control

Interventions:

- Malaria
- TB/Leprosy
- HIV/AIDS/STD
- Epidemics (Cholera, Meningitis)

Priority area 3: Non- Communicable Disease Control

Interventions:

- Cardiovascular diseases
- Diabetes
- Neoplasm
- Injuries/Trauma
- Mental Health
- Anaemia & Nutritional Deficiencies

Priority area 4: Treatment and care of other common diseases of local priority within the Council e.g. Eye disease, Oral Conditions etc.

Priority area 5: Community Health Promotion/Disease Prevention

Interventions:

- IEC
- Water hygiene and sanitation
- School Health Promotion
- Improved Housing
- Occupational Health and Safety
- Enforcement of by-laws and regulation related to health

Priority area 6:

Establish/Strengthen Organizational Structures and Institutional Capacities for Improved Health Service Management at all levels.

Interventions:

- Establishment of Council Health Service Boards
- Orientation /training of CHSB and HF – members and other people involved in health delivering services
- Preventive maintenance /rehabilitation/repair of facilities and equipment according to the planned and approved interventions
- Improve deployment of skilled and committed staff at all health centers and dispensary levels in order to increase utilization of services.
- Ensure attainment of minimum physical, infrastructure, equipment standards, drug, medical supplies and reagents at all health facilities in the Council.
- Supportive supervision and inspection

2.4 Planned Achievements and Targets to be Attained by Councils

The following list shows useful target, Councils should aim at, in order to improve the quality of health service delivery:

2.4.1 Under Curative Services

- Availability of drugs and equipment
- Number of visits per capita per year to outpatient facilities
- Trained personnel with appropriate attitudes and necessary skills
- Conducive facility infrastructure and environment in place
- Reliable communication and transport facilities.
- 70% deliveries undertaken by trained personnel
- Facilities for provision of basic emergency obstetric care available to cater for needs of the districts at district hospital or DDH
- Number of health staff available by category to provide both curative and preventive care at dispensary, health centre and district hospital assessed against recommended staffing levels
- Examination room and or screen to provide privacy for patients, examination table/couch and private room for delivery
- Availability of basic diagnostic laboratory equipment (malaria, STDs, anaemia, parasitic stool, routine microscopic urine test, haemoglobin-test etc.)
- Availability of basic examination equipment according to the equipment guidelines (thermometers, speculums, torch, auroscope, stethoscope, BP machine, foetoscope, tape measure, infant and bathroom scales. etc)
- Pressure sterilizer, handling forceps, disposal and sterile gloves, adequate number of sterile needles and syringes to be available at all times
- A functioning refrigerator, complete with thermometer, temperature recording sheets (if fridge uses paraffin or gas availability of gas or paraffin on regular basis
- Specified availability of clean beds, mattresses, bed sheets etc
- For the district hospitals some of the minimum standards needed such as lab facilities, theatre, X-ray and laundry

2.4.2 Under Preventive Services

- 80% of Immunization coverage
- Proportion of Health facilities providing Antenatal syphilis
- Percentage of pregnant women receiving anti-malaria prophylaxis (intermittent presumptive treatment) during antenatal care
- Number of clients accessing Family Planning Services
- Reliable outreach services: communities take role of supporting the health staff to carry outreach services.
- 80% of population reached by effective health education (e.g. education on immunization, nutrition, RH, STI/HIV/AIDS, water and environmental sanitation)
- Number of health staff available by category to provide both curative and preventive care including focused ANC and Safe Motherhood at dispensary, health centre and district hospital assessed against recommended staffing levels
- Availability of safe water supply to facility within 150 meters

- Availability of a protected deep pit, incinerator and policies procedures actually in use for handling discarding and disposal of expired drugs, discarded instruments, after delivery tissues like placentas etc.
- A functioning refrigerator, complete with thermometer, temperature recording sheets (if fridge uses paraffin or gas availability of gas or paraffin on regular basis
- State of the buildings (dispensary, health centre or hospital) including staff houses such as cleanliness, availability of appropriate roof, doors windows, drainage and VIP (Ventilated Improved Pit latrines)/flush toilets.

2.5 Basket Budget Cost Centers and Ceilings to Adhere to during Preparation of Comprehensive Council Health Plan and Implementation of the CCHP

2.5.1 Cost centers and allocations

Basket grants have to be allocated to six different cost centres. These cost centres are:

- 1 Office of DMO/MoH, CHSB
- 2 Council Hospital (including DDH and Regional Hospitals, which serve as Council Hospitals)
- 3 Voluntary Agency Hospitals (VAH) / if none exists, this is designated as “unallocated”
- 4 Health Centre (Public and VA owned)
- 5 Dispensary (Public and VA owned)
- 6 Communities

To each cost centre a certain percentage allocation range is provided for as follows

Cost center	Allocation Ceiling Range within allocation to Council
Office of DMO/MoH/CHSB	15% - 20%
Council Hospital /CDH /Regional Hospital serving only one Council as CDH	25% - 35%
Voluntary Agency Hospitals (VAH) / if none exists, this is designated as “unallocated	10% - 15%
Health Centre	15% - 20%
Dispensary	15% - 20%
Communities	5% - 10%

* Note: Regional Hospitals serving 2 or more Councils will get a share from each Council

2.5.2 Basket Budget allocation and spending Regulations

- The planning team can allocate within the range given in the table above, however the total allocation sum for all cost centres combined including fuel, per diem and minor repairs /maintenance of facilities and medical equipment should not exceed, or be below, 100% of total Health Basket Allocation
- Allocation given to each cost centre should not be less than the minimum percentage provided for within that cost centre range
- DMO/MoH office/CHSB allocation includes distribution and supervision related costs

- The allocations to each intervention of the Essential Health Package will be guided by disease burden of each Council based on disease burden data and other disease burden data approved by MOH
- Funds for allowances should not exceed 25%
- Funds for fuel should not exceed 20%
- For any Council specific peculiarities necessitating major changes to ceiling range given, Council should put a written justifiable proposal through RHMT/RAS/PORALG for approval by BFC before finalisation of Comprehensive Council Health Plans
- If there are Voluntary Agency Hospitals in the Council, 10%-15% of the funds have to be allocated to these Voluntary Agency Hospitals
- If there is no voluntary agency hospital, the planning team will allocate the 10%-15% to other health priority areas within the plan
- Release of funds to the District Designated Hospitals or Voluntary Agency Hospitals will be in the form of grant in aid and will be conditional to submission of activity plans by the District Designated Hospitals or Voluntary Agency Hospitals for inclusion in the Council Comprehensive plans during the planning period. Accountability of the funds will be through receipt of exchequer revenue voucher (ERV) from the District Designated or Voluntary Agency Hospitals, semi and annual reports that is in line with the service agreements. These funds being public government monies may be subject to an audit where or when required by the Local Authority.
- The Local Authorities will transfer 35% of the funds to the Regional Hospital to finance the implementation of Regional Hospital activities reflected in the Council Comprehensive Health Plan In return for purposes of accountability and Auditing, the Regional Hospital Administration will acknowledge receipt of the funds and provide implementation progress reports through quarterly Financial report and 6 monthly (semi annual) Technical reports
- For Minor repairs/ maintenance of facilities including maintenance of medical equipment minimum and maximum range is “ 5%-20%”. Procedures to follow for major rehabilitation of health centres and dispensaries are described in chapter 5 on page 69

2.5.3 Restrictions applicable on the use of Council Health Basket Funds

- Funds should not be used for long term and costly training.
- Funds should not be used for construction of new buildings
- Purchase of drugs is only allowed, when the Council has a confirmation from the MSD that the respective drugs are out of stock. RMO and Regional Pharmacist should verify and approve the procurement process.
- Funds should not be used for purchase of cars, and other technical equipment of which the price exceeds 2000 USD

Note: These restrictions will change with time and the Ministry of Health/PORALG will Issue revised guidelines on the usage of the funds from time to time.

2.6 Local Authorities Health Conditional Grants Budget Cost Centers and Ceilings to Adhere to during Preparation of Comprehensive Council Health Plan and implementation of the Plan

In budgeting and spending Health Block Grant resources, LGAs should comply with a number of general and specific sectoral Block Grant conditions

2.6.1 General Block Grant conditions:

- 2.6.1.1 LGAs shall abide by all financial standards and budget procedures as mandated by PO-RALG in the Local Authorities Accounting Manual.
- 2.6.1.2 LGAs shall abide by all technical and professional regulations provided by MoH in the delivery of health services. The comprehensive Council health plan shall adhere to the National Health Policy, National Gender Policy, and the Poverty Reduction Strategy
- 2.6.1.3 The LGAs shall ensure that combination of allocations for personnel emoluments (PE) and other charges are in accordance with the objective of efficiently providing local health services in accordance to the local health plan
- 2.6.1.4 All LGAs should set their own performance objectives within the context of local health plans, which takes into account national priorities, local conditions, local priorities and the availability of local resources.

2.6.2 Specific Block Grant conditions for “Other Charges”

The specific Block Grant conditions are divided into two types of conditions, namely: (1) allocation per cost centre, which guides the allocation of resources by type of provider or level of the health system, and (2) guidelines on the allocation by type of expenditure, such as guidelines on the use of Block Grant resources on allowance, transport, training and, maintenance.

2.6.3 Cost centres and allocations for Block Grants

The ranges and guidelines on resource allocation to cost centre within Block Grants	
Cost Centre	Allocation Range within allocation in the Comprehensive Council Health Plan
Office of DMO/MoH	15% - 20%
Council Hospital /CDH/Regional Hospital serving DCH to one Council only	25%-35%
VAHs (if present)	10%-15%
Health Centre (public and VA owned)	15%-20%
Dispensary (public and VA owned)	15%-20%
Communities initiatives in health	5%-10%

The ranges and guidelines on resource allocation by type of expenditure		
Type of expenditure	Allocation Range	Examples of Expenditure
Allowances	Maximum 25%	Supervision, distribution, outreach, short trainings
Transport	Maximum 20%	Fuel for supervision, all

The ranges and guidelines on resource allocation by type of expenditure		
		other fuel and fares
Training	Maximum 10%	Training at zonal training centres or Local short term training
Minor Repairs/ Maintenance	10-20%	At health facility level

2.6.4 Block Grant Budget allocation and spending Regulations

- The health team can allocate within the range given in table above, however the total allocation sum for all cost centers combined should not exceed, or be below, 100% of total allocation
- The allocation given to each cost centre should not be less than the minimum percentage provided for within that cost centre range
- DMO/MoH office allocation includes distribution and supervision related costs
- Release of funds to Designated District Hospitals and other Voluntary Hospitals will be in a form of grant in aids and will be conditional to submission of activity plans by the DDHs, VA Hospitals for inclusion in the Council Comprehensive plans, during the planning period. Accountability of funds will be through receipt of exchequer voucher (ERV) from the DDH or VA Hospital, semi and annual reports that are in line with the service agreements.
- The Local Authorities will transfer 35% of the funds to the Regional Hospital to finance the implementation of Regional Hospital activities reflected in the Council Comprehensive Health Plan. In return for purposes of accountability and Auditing, the Regional Hospital Administration will acknowledge receipt of the funds and provide implementation progress reports through quarterly Financial report and 6 monthly (semi annual) Technical reports
- Funds for allowances should not exceed 25%
- Funds for transport should not exceed 20%
- Funds for training should not exceed 10%
- Funds for minor repairs and maintenance should be in the range from 10% - 20%. Procedures to follow for major rehabilitation of health centres and dispensaries are described in chapter 5 on page 69
- The allocation ranges given above are for the overall budget
- Funds can be used for assets when unit cost is less than 2000 USD
- Funds should not be used for long term and costly training
- Funds should not be used for constructing of buildings
- Purchase of drugs is only allowed when the Council has evidence that MSD drug items are out of stock at the time of order. RMO and Regional Pharmacist should verify and approve the procurement procedure.

2.6.5 Special exemptions to specific conditions

For any Council for which specific peculiarities necessitate exemptions to the specific grant conditions, the Council should put a written proposal through RHMT/RAS/PORALG for approval by PORALG/MOH before finalization of Comprehensive Council Health Plans.

2.7 What can be Financed by Basket and Block Grants?

The Council Basket Fund for Health and OC of the Block Grants are at present generally restricted to expenditure on recurrent costs. All recurrent activities can be financed, through which the quality of health service is likely to be improved. **All activities however have to be in line with the EHP.** This includes also short-term training of staff and cost for maintenance of medical equipment and cars. Repair measures should not exceed 20% the allocated Basket Funds. Funds for rehabilitation is provided for under other separate funding mechanisms through PORALG as stipulated in the rehabilitation for PHC facilities strategy.

CHAPTER 3: GUIDING PROCEDURES FOR PREPARATION OF QUARTERLY TECHNICAL, FINANCIAL REPORTS AND ANNUAL REPORTS.

3.1 Disbursement of Basket Funds

3.1.1 Disbursement Mechanisms to Councils

- a) The Councils submit the draft CCHP to RS for comments and technical guidance before the Draft CCHP is submitted for approval to the council. The approved CCHP and the reports due for submission are submitted to the RS for collation
- b) PORALG will review the comments and recommendations of the RS, where necessary obtaining clarification from the RS, and form a view as to the recommendations to be carried forward to the BFC.
- c) PORALG will consult with the MoH as to the technical inputs, objectives and performance indicators, where the RS has made comments. The PORALG and MoH will consult on the final recommendations to ensure that a consistent view is presented to the BFC.
- d) The MoH gives its comments and concerns as feedback to the PORALG. Agreement must be reached between the MoH and PORALG regarding the recommendation to be made to the BFC for each Council
- e) PORALG will recommend to the BFC Councils to be funded and give reasons for those not to be funded or note those that have not yet submitted. This report must be submitted by the end of the first week of June
- f) The Disbursement of first quarter's funds will be dependent upon submission of first 6 months financial accounts, first 6 months technical report of previous year and approved comprehensive Council health plan for current year
- g) The disbursement of 2nd quarter funds will be automatic unless there are serious financial flaws detected in any of the council's first quarter financial reports
- h) Disbursement of the 3rd quarter's funds to the Council will be dependent on submission of the previous years' annual accounts and the annual technical report that also reports on progress made to attain expected outputs
- i) The disbursement of 4th quarter funds will also be automatic unless financial irregularities are detected in any preceding financial quarterly or technical report
- j) BFC will approve funding to be released from the Bank of Tanzania account to the consolidated Fund and approve a list of Councils to be funded and the amounts. The amount to be released will be equal to the amount of funds to be disbursed. The BFC will base this funding decision on:
 - The summary matrix of funding requirements prepared by PORALG and submitted to the BFC for approval
 - The paper summarising the recommendations for each Council, prepared by the PORALG, including reasons for not recommending funding (Appendix 9)

- Regional consolidated summary of CCHPs (Appendix 8)
 - A schedule of Financial and Technical reports that were expected and received, those not received and any follow up action taken.
- k) The PORALG will prepare a request to the Accountant General to transfer funds equal to the approved amount for Council Basket Funds into the Exchequer Account. The Accountant General transfers the funds from the Bank of Tanzania Account and raises an accounting warrant which releases funds for the quarter in line with the amounts approved by BFC through the vote of the PORALG. This warrant is copied to PORALG for the records.
- l) The Accountant General sends a payment voucher for the amounts approved for each Council to the Central Payments Office (CPO) for telegraphic transfer (TT) preparation and thereafter funds are transferred directly to the Council's Health Accounts No. 6.
- m) Councils and RS will be notified by the PORALG of amounts being transferred to Councils after the BFC meeting and Councils will compare actual receipts to budget allocations and where there are variances take necessary corrective action(s).
- n) Further disbursements will follow the same process.

3.1.2 The Disbursement Cycle and Triggers for the release:

3.3.1.1 Disbursement of Basket Funds cycle and Financial/Technical reports required to trigger releases			
3.3.1.2 Activity	3.3.1.3 Responsible for action	3.3.1.4 Timing of Action	
1. Councils produce specific reports needed for tabling at BFC meeting by PORALG to approve 1 st and 3 rd quarter funds	Council treasurer /DMO	8 weeks	before BFC meeting
2. Review of specific reports from Councils required for tabling at meeting & prepare summary Financial /Technical report	Regional Secretariat	6 weeks	before BFC meeting
3. Financial reports meet regional recommendations or otherwise	PORALG/MOH	4 weeks	before BFC meeting
4. Notify BFC members on next Meeting of BFC	MOH/PORALG	2 weeks	before holding of meeting
5. Distribute summary reports to BFC members	HSR Sec MOH	1 week	before BFC meeting
6. BFC make decisions re: tranche of funds	BFC		
7. Request for Council health Basket Funds to be released from USD account into vote of PORALG	PORALG	Within 1 week	after BFC meeting)
8. Transfer of funds into consolidated fund exchequer issued to PORALG	Accountant General	2 weeks	after BFC
9. PORALG provide to MOF payment instructions for individual Councils	PORALG	3 weeks	after BFC approval of funds

3.3.1.5 Activity	3.3.1.6 Responsible for action	3.3.1.7 Timing of Action
10. TT prepared funds transferred to Council health bank account	MOF	3 weeks after BFC approval
11. Copy of Telegraphic Transfer (TT) sent to PORALG	MOF	4 weeks after
12. Bank reconciliation	Council treasurer	Monthly
13. Produce quarterly financial reports for submission to Council and PORALG and then BFC	Council treasurer	Quarterly
14. 2 nd and 4 th quarter releases are automatic no BFC sittings required	PORALG	End of first week first and second quarter then follow steps 7 to 13 to ensure that funds are accessed by start of 2 nd and 4 th quarters

3.2 Financial and Technical Performance Monitoring of the Councils

- a) Head of Health Department of the Council manages and monitors financial and operational performance of the service outlets on a day-to-day basis with financial information and support from the Treasurer. The service outlet provides regular performance reports to both.
- b) The Treasurer receives the bank statements for the account and reconciles this on a monthly basis. Bank reconciliation statements form part of the quarterly financial report.
- c) The Head of Health Department of the Council and Council Treasurer inform the Standing Committee responsible for Health on financial and operational performance. The Council Health Service Board (CHSB), where existing, gives broad and detailed performance guidance.
- d) The Council forwards through the Regional Secretariat to the relevant sector Ministry details of financial and operational performance prepared by the Council Head of Health Department and the Treasurer. The Regional Secretariat checks that the expenditure has been incurred in line with sector policy and the CCHP, consolidates the reports for the region and forwards the reports to the PORALG and MoH. The reporting will be against the agreed CCHP, which will indicate the sources of finance and the expenditure thereon (Illustrations on write up Financial and Technical reports are described in chapter 4)
- e) The Council Standing Committee responsible for Health advised by the CHSB, (if the CHSB exists), informs the Council Finance Committee of financial performance; the Finance Committee in turn informs the Council of all the activities supervised by the various Council Committees.
- f) The Council sends reports to the RS on operational and financial performance in format and with such frequency as agreed by the Basket Financing Committee. Format of writing of Financial reports (refer to annex 7) and for Technical reports refer to chapter 4
- g) The PORALG and MoH confer on a regular basis concerning the performance of the local Councils' provision of services and financial propriety.

- h) The Controller and Auditor General (CAG) audit the Councils, with appropriate support, providing the audit certificate and report. Councils will respond to audit queries, as required by financial regulations.
- i) Regional Secretariat should monitor the responses of Councils to audit queries.

3.3 Reports Submission and Frequency of Reporting

- a) The Council Treasurer will report on a quarterly basis to the Council Social Services Committee on financial performance of the Council during implementation of health services. The financial report will report on expenditures and balances of all the funds allocated to the Council accompanied by a Bank statement, bank reconciliation and certificate of the Bank. No quarterly technical report will be required and, therefore, the financial report shall be submitted to the BFC for information and the same accounting return forms will continue to be used
- b) Technical reports from the Council should be written semi-annually (every 6 Months) and the reports will cover implementation status in 6 months. Since the 6 monthly reports are cumulative, the second six monthly report covers the implementation status for the whole year and thereby forms part of the annual report
- c) Since the financial quarterly reports are cumulative then the semi-annual technical reports should match with the second and fourth financial report
- d) Since final accounts for Councils will not be ready until around the start of the second quarter of the following year, the linkage between reports and approval of disbursements by the BFC will be twice a year
- e) The six monthly technical reports is a holistic report on the technical and financial performance of the Council vis-à-vis what was planned for. It should not be excessively burdensome to produce, but should summarise the critical data required for the Councils to manage the health services and allow the Council and Regional Secretariat to monitor the performance of the Council on a semi-annual and annual basis.

3.4 Preparation of Financial, Technical and Audit Reports

3.4.1 Financial Reports

3.4.1.1 Outline of quarterly financial reports

- (a) Executive summary should contain the following:
 - Summary of funds received, payments made, opening and closing balances
 - Summary of major achievements stipulating major activities performed in that Quarter.
 - Summary of major constraints.
 - Reasons for significant variances from budgets approved in the CCHP
 - The way forward

NB: an illustration and description on how to prepare financial reports is described under relevant paragraphs in chapter 4 table 21 page 65 and annex 7

This will include the health sector recurrent accounting return. The report will be submitted together with bank reconciliation statements, bank statements, certificate of bank balance and other relevant information.

The plan will be submitted to the Regional Secretariat in 5 copies. The Regional Secretariat will:

- Keep three copies at the Region (RAS, RA and RMO)
- Forward one copy to the MoH together with a Regional summary.
- Forward one copy to the PORLAG together with a Regional summary.

3.4.1.2 Additional information on Preparation of financial reports using Health Sector

3.4.1.2.1. Accounting Return

- a) Health Sector Accounting Return refers to annex 5 (similar to Appendix 3 of the previous Joint Disbursement System Procedures Manual for the Council Health Basket Funds) for details of the form and filling instructions.

This return allows reporting based on all of the transactions on Account Number 6 and is in line with the Local Government Reform Programme returns for conditional grants for all sectors. Therefore, the extraction of the information for the completion of this return should be straightforward as the procedures should be the same for all sectors. Consolidation should be relatively easy at the regional level and at the PORALG.

- b) The report has been designed to be as easy as possible to complete and is accompanied by interpretative notes for the Council Finance staff to follow on completion of the report.
- c) The return template will be provided on spreadsheet to Councils who will be given the choice of completing the report electronically or manually depending on the level of computing skills and availability of computer facilities. These may be integrated into the Platinum system, which uses Excel for the production of certain reports
- (d) Section has been included which requires Councils to summarize expenditures on PEs, Allowances and Other Charges. The Treasurer should monitor regularly to ensure that the PE expenditure does not exceed the conditional grant figure. This will then provide assurance that Basket Funds are not being spent on PE s. Similarly, there is a section which reveals the total allowances paid. Again, should the allowances figure significantly exceed the receipts from conditional grant plus the Council's own sources, further investigations should be made with the Council concerning the use of funds. This is one of the areas on which the RS will focus in undertaking the financial checks of the return.
- (e) After the report has been accepted by the Council it should be forwarded to the RS

3.4.1.3. Financial Quarterly report for Conditional Health Grant for districts with Platinum System

In addition to the Accounting Return, Councils with Platinum will be required to report against these classifications. The financial quarterly report for conditional health grant appears at the end of this section and describes the format the report should take. The report will be produced for management purposes on a monthly basis and returned in the usual way to the RS on a quarterly basis. The Total Payments in this report should be reconciled with the total payments in the recurrent accounting return, and any differences rectified before submission of the report.

3.4.2 Annual Financial Reports

3.4.2.1 It shall be the responsibility of the PORALG to ensure that the year's final accounts for the Councils are prepared within the period specified by the financial memorandum. The Councils will prepare standard annual reports required by the financial regulations.

3.4.2.2 In addition to the standard reports the PORALG will prepare and submit to BFC the Annual Expenditure Report showing budgeted against actual expenditure for the recurrent expenditure included in the Consolidated Councils Health Plans.

3.4.2.3 The Annual Expenditure Report will comprise an accounting return, showing receipts and payments for the year. The format for the annual accounts for the BFC will be exactly as that of the accounting return. Refer to chapter 4 on how financial reports should be prepared

3.4.3 Semi Annual (Six months) and Annual (12 months) Technical Reports

Details of performance against the Comprehensive Council Health Plan should be clearly stated. The contents are elaborated in Chapter 4 page 64. Note that the second six monthly reports, which are cumulative, will also be the annual report.

3.4.4 Preparation for Annual Audit

3.4.5.1 Submission of yearly accounts for Audit

Councils are required by law to maintain books of accounts as provided in the Local Authorities Accounting Manual. These accounts should be closed at the end of the financial year and final financial statement prepared and submitted for audit as stipulated by the Local Government Finances Act No.9 of 1982. The Basket Financial Committee may recommend an extraordinary external audit of any Council for the Health Basket Grant if the need arises

3.4.5.2 The annual audit will be undertaken by the Office of the Controller and Auditor General (OCAG) or any auditor appointed by him/her office.

3.4.5.3 The Council Treasurer will submit final accounts to the office of OCAG which include the following:

- a) Date when a draft set of annual accounts will be available; and
- b) Date when the audited annual accounts will be submitted to the PORALG.

3.4.5.4 The accounting return for the year will constitute the financial statement and will be subject to audit. The audit reports will be presented to the BFC.

3.4.5.5 Submission of annual financial reports and audits by Councils to BFC will trigger the release of 3rd quarter basket finances

3.5 The Role of the Different Levels in Regard to Financial Reporting

3.5.1 Regional Secretariat role in Council reporting

- a) The Council will submit the quarterly report in 3 copies to the Regional Secretariat (RS) within one month of the end of the quarter to which it relates. The Regional Medical Officer, Regional Accountant, Regional Planning Officer and Regional Local Government Officer should be involved in the review, and necessary follow up, of reports.
- b) The RS will keep a schedule of reports due and remind Councils if they are not received. The date of receipt of reports will be recorded in the schedule.
- c) The RS will check the financial report for the following:
 - Arithmetical accuracy
 - Opening adjusted cashbook balances agreeing with closing balances as per previous quarter returns.
 - The adjusted closing cashbook balances stated in the report agrees with balances on the bank reconciliation statements.
 - Differences remaining on the bank reconciliation statements have been cleared since the last quarter report
 - That the activities undertaken are in line with the priorities in the CCHP and technically support the national health policies and performance objectives
 - That the budget figures are the same as those approved by the BFC. Where they differ, documentary evidence should be obtained (e.g. Council Minute) to support the revised budget or supplementary budget
 - Variances from budget and explanations in the overview report for variances
 - That the total of Personnel Emoluments does not exceed the conditional grant from the GoT
 - That the total expenditure on allowances is reasonable and within MoH guidelines.
- d) The RS will then collate all reports received to date and prepare a regional report. The regional financial report will be derived directly from the Accounting Returns of the Councils and show for each Council in the region.
 - Budgeted receipts and payments
 - Actual receipts and payments
 - Budgeted and Actual PE's, allowances and OC's
 - A recommendation regarding the next quarters Basket Funding.This regional financial summary is given in Appendix 8.
- e) A Technical report, in the format specified by the MoH as is described under chapter 4 summarizing the technical performance and any financial issues raised by the Council reports will be prepared, including reasons for variance against approved budget in the CCHP budget. The RS will make recommendations as to actions required centrally including recommendations for each Council:
 - That the next quarter funds can be released.
 - If for technical or financial reasons, the report does not indicate that the Council has complied with MoH guidelines, recommend suspension of funding and give details of the reasons for the recommendation.
- f) This covering report should contain the following information:

- Region
 - Name of Council
 - Assessment of technical performance in the format required by the MoH
 - Assessment of whether the Council complies with financial guidelines
 - Recommendation to the PORALG on further disbursements from the Basket Fund.
- g) The Regional report and one copy of the Council reports will be sent to PORALG and MoH within two weeks of the deadline for the receipt of reports from the Councils.
- h) Unsatisfactory reports should be reported back to Councils in writing. Wherever possible, a regional representative should visit the Council to assist in rectifying the problem. In practice, in order to avoid the delays, which may arise in the rejection of a report and the requirement to meet the timetable, the Councils should consult with the RS during the quarter to avoid needs for clarification at the quarter end.
- i) Quarterly reports should be produced and distributed to the PORALG and MoH within six weeks after end of the quarter. The RS should not hold up the reports for Councils who have submitted their reports on time in order to wait for Councils, which have not submitted or submit late.

3.5.2 Roles of the MoH and PORALG

- a) It is the responsibility of the PORALG to ensure that reports are presented to the BFC together with a final recommendation regarding funding.
- b) As the BFC is also concerned with centrally pooled funds, it should be responsible for calling the meeting, in consultation with the MoH.
- c) The MoH will scrutinize the Council reports and the summaries from the Region to ensure that the Council has utilized the funds appropriately to improve health services within MoH guidelines.
- d) The PORALG will scrutinise and consolidate the reports to ensure that financial regulations have been complied with. The summary report for completion by the PORALG is included in Appendix I.
- e) The MoH and PORALG will ensure that they are in agreement with the Regional recommendations. In the event of a disagreement, discussions will take place prior to the BFC meeting to ensure that the recommendation concurs with the requirements of both ministries. A consolidated report for all Councils will be produced by the PORALG to the BFC indicating:
- A summary of health sector accounting returns including a recommendation to the BFC for each Council
 - Summary by Council of technical achievements, derived directly from Regional collated council quarterly financial/ and semi-annual financial and technical reports

3.6 Account Structure for the Council Health Department

- a) The account structure in the Health Department should reflect the activity areas in which it is operating and the activities undertaken. These will form the basis of budgeting and control against budgets.
- b) The Health Department must include the following **cost centres** under the Departmental Code.

1. Council Health Department/CHMT/CHSB
 2. Council Hospital/CDH
 3. Voluntary agency hospital / unallocated
 4. Health Centers
 5. Dispensaries
 6. Community Initiatives
- c) Other cost centres may be included but the above are those against which the Council will be expected to report.
- d) The number of expenditure items used under each of these cost centres should be limited so as to make the system manageable and to avoid becoming overwhelmed with detail. The following account headings should be in operation as they are the ones included in the reporting required, but others may be added as necessary
- e) The Recurrent and Development Budgets are produced in line with the normal Council budgeting procedures but based on the activities in the technical plan.

3.7 Local Authority Accounting Procedures

The Local Authority will use the normal accounting procedures as laid down in the Financial Memorandum and Finance Regulation in Force. The following descriptions emphasize those procedures in their application to the Health Account.

- 3.7.1 The Basket Funds are transferred to Account No.6 through which all income and expenditure for Health are to be channelled. This will include funding from the Council's own resources which will be transferred from the General Account to Account No.6 for disbursement and where appropriate transfer will be made to hospital and health centre level.
- 3.7.2 all income and expenditure on health services will be brought into the accounts of the local authority through its general ledger.
- 3.7.3 the signatories to the bank account for Council Health Department are in two groups:
- Category A** – the Council Medical Officer (DMO)/Medical Officer of Health (MOH) or her/his appointee
AND
Category B - Council Director of her/his appointee
- 3.7.4 All payment vouchers drawn on this account must be signed by the DMO in rural Councils or MOH in case of urban Councils or their deputies.
- 3.7.5 The Treasurer will manage the bank account and all accounting through the normal Council procedures.
- 3.7.6 Receipts of non-monetary resources such as medical supplies will be valued on receipt and included in the Council's accounts debiting the relevant expenditure account and crediting government grants or another appropriate revenue source.
- 3.7.7 It should be emphasized that there is redress within the law against any officer who interferes with the delivery of services. Basket Funds will be withdrawn if it is revealed that they are being spent in contradiction to the guidelines. This will constitute interference with the delivery of services, and will therefore result in legal redress against those concerned.

CHAPTER 4: AN ILLUSTRATION OF HOW TO PREPARE A CCHP BASED ON THE AGREED FORMAT FOR PREPARATION OF A COMPREHENSIVE COUNCIL HEALTH PLAN

4.1 Introduction

The Comprehensive Council Health Plan (CCHP) is the principal prerequisite for any well functioning district health system. All priority activities for the Local Authority are incorporated into the plan; it has also to guarantee that the package of essential health interventions is taken into consideration. Furthermore, with the Local Government reform, it will become the basic tool for funding purposes. Therefore this plan has to be realistic and logical and it has to marry the health needs and the restriction of the available resources.

The Council Health Management Teams (CHMT) are facing new challenges because of the HSR. After a period of 4 years (2000 –2003) all 121 Councils of the country are involved in the reform process, by which the GoT aims to strengthens the health system in order to offer better services to the population.

Relevant inputs from the following documents have been incorporated:

- National District Health Planning Guidelines (Second Edition, April 1998)
- District Health Management Training Module IV (Ministry of Health, 2001).
- National Package of Essential Health Interventions in Tanzania, Jan 2000
- Staffing levels for Health Facilities/Institutions, MoH/CSD, 1998
- District Health accounts Tool (DHAT) by TEHIP.

4.2 Timetable of the Comprehensive Council Health Plan

The **CCHP** will be prepared as part of the Council’s budget preparation cycle and the timetable is as follows:

	Activity	Responsible for actions	Completed by:
1	Councils notified of resources available – GoT and Basket Funds for next financial year. Council collect information on all other funds available.	PORALG, MOH	End November
2	Technical plan prepared	CHPT	Mid Jan
3	Recurrent and Development budgets prepared from technical plan	CHPT	End February
4	Health Technical plan and Budgets integrated into the Council budget	DMT	Mid March
5	Council Technical plan and Budget discussed with RS and any amendments required are made.	CHPT	End March

	Activity	Responsible for actions	Completed by:
6	Council Technical Plan and budget approved by the Council.	FULL COUNCIL	First week of April
7	Comprehensive Council Health Plan budget passed to Regional Secretariat (3 copies)	HEAD CHMT	Second week of April
8	CCHP forwarded by RS to PORALG and copied to MoH	RS	End of April
9	PORALG together with MoH assess and scrutinized CCHPs submitted by RS and prepare consolidated summary comment and recommendation for approval and funding	PORALG, MOH	Second week of May
10	Invitation and distribution of Papers to BFC members	MOH, PORALG	End of May
12	BFC meeting	BFC	Second week June

4.3 Format of a Prototype Comprehensive Council Health Plan

The main objective of this format is to give clear instructions to the planning teams and CHMTs in order to facilitate the elaboration of future CCHP so that the Council, the Regional authorities and the BFC can easily approve them.

This format is a revised version of the previous prototype (March 2001) and is dedicated to the Councils.

4.3.1 Definition of a Comprehensive Council Health Plan (CCHP)

A comprehensive plan has 3 aspects, namely professional, financial and structural:

Professional aspect

The CCHP should act on the main health problems in the Council, including promotive, preventive, curative and rehabilitative aspects. These main problems will be identified and analysed in detail in the chapters “Situational Analysis”, “Review of Resource Availability” and “Priority Problems.

If we look into the daily reality, we recognize, that problems are quite similar in all districts of the Region. All these problems are reflected in the “Components in the National Package of Essential Health Interventions” (short: Essential Health Package: EHP) so, from the professional point of view, a Comprehensive CHP takes into account five priority areas plus issues of an administrative nature (Priority Area 6).

a) The **5 priority areas** of the EHP:

- Reproductive and Child Health
- Communicable Disease Control
- Non – Communicable Disease Control
- Treatment and care of other common diseases of local priority
- Community Health Promotion and Disease Prevention

b) **Priority area 6:** activities to react adequately on these priority areas area for example:

- Establishment of Council Health Service Boards
- Orientation / training of CHSB and HF –members
- Preventive maintenance / rehabilitation / repair of facilities and equipment
- Supportive supervision / inspection / monitoring
- Make available essential drugs, medical supplies and diagnostics

Financial aspect:

No CCHP can be worked out without knowing the financial resources, which are available. The following sources of funds are known:

Block Grants/ Council grants consist of:

- Personal emoluments (P.E.): salaries for the staff
- Other charges (O.C.): recurrent costs

Other charges are calculated according to the population 70%, district vehicle route 10%, poverty, 10% and under five mortality rate 10%

Council-own resources consist of:

- Recurrent Costs
- Development Budget

Basket grants allocations

Is calculated taking into account the following:

The population 70%, district vehicle route 10%, poverty 10% and under five mortality Rate 10%

Cost sharing money:

Is mainly from user fees collected in the Council Hospitals

Vertical programs: Examples: NACP, RBM, IMCI, EPI

NGO: Examples: MEUSTA, World Vision

Other donors: Examples: GTZ, Ireland AID, JICA

CHF Community Health Fund (households prepayment scheme)

NHIF National Health Insurance Fund

According to the first step of the time schedule, it is essential that the respective authorities (MoH, PORALG, Council), the NGO and other donors provide the planning team with reliable figures in time. But it is also the responsibility of the CHMT to actively request these figures in particular from the NGOs and other donors.

Structural aspect:

The services of all providers have to be taken into consideration, in particular:

- Public providers
- Voluntary agencies
- Private for profit providers
- Parastatal providers
- NGO's

4.3.2 Regulations and ceilings for Block and Basket Grants

For utilization of Block Grants (OC) and Basket Grants numerous regulations and ceilings have to be respected. These regulations and ceiling are laid down in part 1 of this document in detail. In general, regulations and ceiling are the same for both, block and basket grants. But some of them are different.

Basket grants/ Block Grants have to be allocated to six different cost centres

- CHMT/Council Medical Officer's office/CHSB
- Council Hospital/DDH
- Voluntary Agency Hospital /unallocated
- Health Centres
- Dispensaries
- Community
-

(Please refer to paragraphs 2.5 and paragraphs 2.6 for details)

4.3.3 Answers to some frequently asked questions

Question 1:	For which activities can Block Grants and basket grants be used.
Answer:	For all activities which are covered by the EHP of Tanzania
Question 2:	For which activities can Block Grants and basket grants <u>not</u> be used
Answer:	For long term and costly training, for the construction of new buildings, for the purchase of cars and all equipment for which the price exceeds 2000 (5000) US\$. (Long term training are those exceeding 4-6 weeks, costly are those, which cost more than 2000 US\$)

Question 3:	Are the ceilings for allowances and fuel only compulsory for block and basket grants or also for district own resources and other funds?
Answer:	These ceiling ranges apply to Basket Grants and health Block Grants only .
Question 4:	The 10%-15% allocated to the “voluntary agencies” are they only allocated to the voluntary hospital or to voluntary agency health facilities in general?
Answer:	The 10%-15% is to be only allocated to Voluntary Agency Hospitals, not to other Voluntary Agency Facilities like HC or dispensaries. The cost centres “health centre” and “dispensary” will take care of all Health Centres and Dispensaries to cover short-term training, distribution of drugs and all other activities, which make the first level of the Council health services functioning. No cash will be transferred to Voluntary Health Centres and Dispensaries
Question 5:	How should the 10%-15% applicable to Block Grants and Basket Fund for VAH be allocated if there is more than one VAH in the Council? (E.g. Kagera Region - Muleba District Council)
Answer:	If there are more than one VAH, the planning team allocate the budget according to certain criteria: <ul style="list-style-type: none"> - Bed occupancy rate - Utilization rate - Catchments area.
Question 6:	How should the 25%- 35% of either the Block Grant or Basket Fund for the cost centre “hospital” be allocated if there are more than one DDH in the Council?
Answer:	The fact that a Council has more than one DDH is exceptional. In this case, the planning team will allocate the budget according to certain criteria: <ul style="list-style-type: none"> - Bed occupancy rate - Utilization rate - Catchments area.
Question 7:	Can the ceilings for allowances and fuel be considered together, so that for example money can be used for allowances if the ceiling for fuel is not reached?
Answer:	This is not allowed

Question 8:	If there is only a Regional Hospital in the district, are there any conditions for the Regional Hospital Management Team to qualify for the allocation
Answer:	Block and Basket Funds are intended to strengthen the district health services. Consequently the basket grants and health conditional grant for the hospital should be used to implemented activities, which improve the hospital services for the population in general. Normally, this is the case, when the planned activities are in line with the EHP. In order to strengthen the relationship between the Council and the Regional hospital: <ul style="list-style-type: none"> - A representative of the RH should be member of the Planning team - The planning for the cost-centre “hospital” should be owned by the planning team and the RH - The RH should commit itself to report quarterly on the progress of the implementation
Question 9:	In the case, that the hospital grants are allocated to the regional hospital, should the money be transferred quarterly - directly to the hospital’s account?
Answer:	It will facilitate the flow of funds, if money is directly transferred to the Regional Hospital account, provided that the Council has the mandate to inspect the implementation of the funds related activities.
Question 10:	Are Councils allowed to buy drugs, reagents and medical supply through bock and basket grants?
Answer:	In general, MSD should provide all health facilities in Tanzania with drugs and medical supply. Experiences however show that sometimes MSD runs out of stock for essential drugs. In this case, CHMTs are authorized to buy additional drugs and medical supply using bock or basket grants, provided that there is a confirmation by MSD that the respective items are out of stock.
Question 11	Is there a ceiling for minor rehabilitation?
Answer	Yes, the range is 5%-20% of the total amount should be used for minor rehabilitation

4.4 Content of the Comprehensive Council Health Plan (CCHP)

The CCHP should have the following chapters:

I – III FIRST PAGES

1. INTRODUCTION
2. SITUATION ANALYSIS
3. REVIEW OF RESOURCE AVAILABILITY
4. PRIORITY PROBLEMS
5. OBJECTIVES, TARGETS AND PLANNED INTERVENTIONS
6. PLAN OF OPERATIONS/ACTION
7. MONITORING PERFORMANCE INDICATORS AND TARGETS
8. ASSUMPTIONS AND RISKS

4.4.0 FIRST PAGES

These first pages include:

- Table of content
- List of members of the planning team
- Acknowledgement
- Acronyms
- Executive summary
- Part 1: Review of the implementation of the last year's plan
- Part 2: Summary of the new plan
- Main Budget Summary
- Specific Budget Summary for Basket Funds (see annex 1)
- Budget Summary for allowances and Fuel (see annex 2)

How to structure the Executive Summary?

The Executive summary should be divided in two parts

Part 1. Review of the implementation of the last year's plan

This review should briefly answer the following questions:

Have the planned objectives been achieved, in general?

What are the reasons that main objectives have not been achieved and main activities have not been carried out?

To what extent has the allocated money has been spent?

Note: All this information should be available in the annual report.

Part 2. Summary of the new plan

It should be written clearly and comprehensively because many readers want to pick up only the essential information. It should answer the following questions:

What are the main problems?

How the CHMT will cope with these problems (main objectives, main activities)?
Have the unachieved objectives of last year been addressed again in this year's plan?

Note: The Executive Summary should not exceed 2 pages!

Main budget summary

List in a table all sources of financing and the allocated amount.

The Council Director or his/her representative should sign the Executive Summary and the Main Budget Summary.

4.4.1 INTRODUCTION

Advice: Chapter 1 is written for someone who doesn't know anything about your **council**, but who is interested in its problems. Therefore much information, which is mentioned in the CCHP of the last years, can be mentioned again. Perhaps chapter 1 of last years CCHP needs only the minor revision?

This chapter should includes

- Purpose of the CCHP
- Reference documents
- Planning techniques, logistical support

4.4.2 SITUATION ANALYSIS

This is a process of analysing and interpreting health system information and orients it to curative and preventive health problems and needs.

District Profile

- Map of the district with all health facilities
- Geography: nature, climate, season
- Administration: borders, structures (list of division etc.),
- Transport and communication; roads, road conditions, electricity, phone/fax, e-mail
- Water supply,
- Socio-economical: ethnic groups, main economical activities, employment situation, gender, education (literacy rate), water born diseases, others
- Population: total, per division, important population groups, vital statistics (pop. growth, TFR, birth rate, mortality rate, urban-rural distribution,

Use also the following table:

Table 1: Important Indicators

Total population	
Growth rate	
Births in.. (4.6%)	
Children< 1 year (4.0%)	
Children <5 years (21%)	
Women: 15 – 49 (18%)	
Maternal Mortality (countrywide)*	
Under Five Mortality (countrywide)*	

* Figures to be found in the DHS of Tanzania

Health problems

Morbidity statistics: Proposed format:

Table 2: Main OPD Diagnoses (to be included in table D5.5)

Diagnosis	<5 years	5+ years		Total	Diagnosis	<5 years	5+ years		Total
		M	F				M	F	
Malaria					Genital discharge				
ARI					Genital ulcer				
Diarrhoeal disease					Other STD				
Intestinal worms					PID				
Pneumonia					Anaemias				
Eye					PEM				
Ear					TB				
Skin					Leprosy				
Cardiovascular disorders					Other diagnosis				
					Total diagnoses				

Comments:

Mortality statistics: Proposed Format:

Table 3: In Patient Admissions and Deaths per Diagnosis (to be calculated from F005 – Section 7b)

Diagnosis	<5 years		5+ years				Total		CFR in %
	Admission	Deaths	Admission		Deaths		Admission	Deaths	
			M	F	M	F			
ARI									
Diarrhoeal diseases									
Malaria severe, complicated									

Diagnosis	<5 years		5+ years				Total		CFR in %
	Admission	Deaths	Admission		Deaths		Admission	Deaths	
			M	F	M	F			
Malaria uncomplicated									
Tuberculosis									
Anemia									
Pneumonia									
PID									
Complications of pregnancy									
Bites									
Burns									
Poisoning									
Clinical AIDS (hosp only)									
Cardiovascular Diseases (hosp only)									
Fractures (hosp only)									
Other diagnosis									
Total diagnoses									

Comments:

Outbreaks, emergencies: Proposed format

Table 4: Notifiable Diseases

Diagnosis	<5 years	5+ years	Total
Acute Flaccid Paralysis			
Cholera			
Dysentery			
Relapsing Fever			
Measles			
Meningitis			
Neonatal Tetanus			
Plague			
Rabid Animal Bite			
Rabies			
Typhoid			

Comment:

Note: AIDS has to be mentioned among the top priorities and has not to be hidden under other diseases.

Table 5: Important Primary Indicators of Health Status

Indicator	How to calculate the indicator	Figure for last year
Maternal mortality in all HF	Nr of maternal deaths in all HF Total live births	
Infant mortality rate in all HF	Nr of death < 1 year in all HF Total live births	
Under Five Mortality in all HF	Nr of death < 5 years in all HF Total Nr of children < 5 years	

Be aware that the above indicators are underreported because deaths outside the HF are not taken into account.

Existing Health Services

List of all (!) health facilities by type, level and ownership
 Information on the geographical accessibility
 Physical state, equipment

The following table should be used:

Table 6: HF, their Catchments Area and their Physical State

HF (Name)	Type	Ownership	Total population	Population < 5 km *	Physical state**
			(Sum)	(Sum)	

* If reliable figures are not available, even estimation is helpful

** Use the following classification

A = good

B = minor rehabilitation needed

C = major rehabilitation needed

Advice:

1. Please add up the total of column “total population” and Population < 5 km. Only when these two figures are compared can you know how many people in your district are not yet covered by HFs.
2. Classify “C” all health facilities for which later rehabilitation

The following MTUHA Indicators should be mentioned for the last two years

Table 7: Important MTUHA Indicators

Indicator	Year	Year.....
OPD attendances (persons attending) (in %)		
ANC new attendance rate (in %)		
ANC clients receiving TT2+ (in %)		
DTP3 immunization < 1 year (in %)		
Couple Year Protection (in %)		
Number of TB cases diagnosed in the last 12 months		
Number of malaria cases		
Proportion of births attended by skilled attendants		
Cesarean Sections per expected births (in %)		
Proportion of FSB among reported births (in %)		
Severe malnutrition rate (in %)		
Proportion of low birth weight (in %)		

In addition describe:

- Training institutions in the district
- Other institutions, initiatives and programmes in the district (e.g.MEUSTA etc)

Community involvement

Short description of the community activities related to the following issues
 Activities concerning the establishment of a CHSB
 Health promotion activities e.g. water supply, toilets, refuse collection, disposals, drying racks and other IEC-activities
 CORPs, VHW / TBA activities, CBD
 Activities of the Health Committees (HIV/AIDS, Malaria, Cholera, etc....)
 Other initiatives: financing schemes as CHF, etc.
 Participation in process of development of Council Health Plans

4.4.3 REVIEW OF RESOURCE AVAILABILITY

4.4.3.1 Manpower

List of all staffs

According to the "Staffing Levels for Health Facilities/Institutions", three different lists should be elaborated according to the following format:

Table 8: CHMT (Example)

Type of personnel	Requirement **	Staff available		Overstaffing / Understaffing
		(F)	(M)	
Medical Doctor	1	1		0
Ass. Med. Off.	4		2	- 2
Nursing Officer	5	7	1	+ 3
Sum	10	5	6	+1

Table 9: Council Hospital (example)

Type of personnel	Requirement **	Staff available	Overstaffing / Understaffing
Medical Doctor	1	1	0
Ass. Med. Off.	4	2	- 2
Nursing Officer	5	8	+ 3
Sum	10	11	+1

Table 10: HC / Dispensaries (Example)

Type of personnel	Requirement **	Staff available	Overstaffing / Understaffing
Medical Doctor	1	1	0
Ass. Med. Off.	4	2	- 2
Nursing Officer	5	8	+ 3
Sum	10	11	+1

Advice: After having filled in this table, the different columns should be added up and a short comment should be given indicating the qualification mix and gender difference per facility to assist interpretation of these figures.

4.4.3.2 Material / Equipment/ Drugs/ Supplies

Information should be given on material and drug supply in the last year. Main problems should be identified and a list of essential equipment (X-Ray, ultrasound, autoclave, etc.) provided in the last year should be established.

Table 11: Overview on the Condition of Essential Medical Equipment

Name of Health Facility	Item	Quantity	Status / condition	Comment

Concerning the transport system, a table with the following format should be worked out:

Table 12: Vehicles and their use (from F002 and Council Transport Officer)

	Registration number	Usage for what purpose	Condition	Mileage	Comments

Please work out the following table:

Funds received last year and funds allocated for the planning period: proposed format:

Table 13: The Different Sources of Financing

Source of financing	Received /collected last year	Allocated for the planning period
Block/council grants: Personal emoluments (P.E.)		
Other charges (O.C.)		
Council own resources: Recurrent costs		
Development budget		
Council basket grants:		
Vertical programs: RBM		
NACP		
Etc.		
Capitalization of drugs		
Cost sharing		
Hospital		
Other HF		
Community Health Fund		
NGO: MEUSTA, World		
World Vision		
Etc.		
National Health Insurance		
Other donors: GTZ,		
JICA		
Ireland AID,		
Etc,		

4.4.4 PRIORITY PROBLEMS

4.4.4.1 Primary health problems

In Tanzania three tools are well developed to give us hints for priority setting

- Essential Health Package (EHP)
- Burden of disease concept
- Council Performance Indicators ([Annex 3 and 4](#))

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

The burden of disease concept has identified seven interventions, which are the most cost effective and which have a measurable impact on mortality. These seven interventions are

1. Integrated Management of childhood illnesses (IMCI)
2. Case management and prevention for acute febrile illnesses (AFI) including malaria / Insecticide treated nets (ITN) for prevention of malaria
3. Safe Motherhood Initiative / Intermittent Presumptive Therapy (IPT) for malaria in pregnancy
4. STI Syndromic Management
5. Expanded Programme for Immunisation (EPI)
6. Essential Drug Programme (EDP), TB-DOTS
7. Injury care

If the planned activities focus on one of these interventions one can be sure to have chosen a priority area

For each council a set of about 30 indicators is established. Please, refer to [annex 3](#). The Planning team should address by the planned activities those indicators, which are not satisfying. (E.g. low vaccination coverage, low coverage of professionally assisted deliveries etc).

4.4.4.2 Structure and Management Related Problems

Beside the health problems, reflected in the EHP, the seven interventions for the burden of disease concept and in the indicator set, it might help the planning team to look deeper into the following topics:

Infrastructure and equipment shortcomings

Based on the table 11 a list should be elaborated with medical equipment needed

Based on the table 6 a list should be elaborated with rehabilitation work needed

Problems concerning the efficiency of the referral system including transport and communication

Problems concerning management

it should be outlined which shortcomings in management skills hamper the management of the council. Which skills are needed (e.g. supervision skills, computer training etc)?

It should be mentioned whether supervision activities were conducted properly. Comment, why supervision was not done as planned and plan activities to respond to that.

4.4.5 OBJECTIVES, TARGETS AND PLANNED INTERVENTIONS

Situation analysis and priority setting done in the previous chapters are mainly based on:

- Analysis of the MTUHA data
- Council Indicators assessment
- Burden of disease concept

There are a large number of problems, which we want to address with the CCHP. To make sure that the CCHP helps to solve the identified problems, it is crucial to link the planned objectives and activities to the findings of the above mentioned data sources.

Chapter 5 describes how to do this and is therefore the most important and the most time consuming step in the planning process.

Before coming to the details, it should be stressed, that planning teams should not omit those activities which don't require financial recourses, but which are important to provide services of quality. (Example: support supervision of a MO for his/her council hospital.) If planning is finished and the plan shows only activities whose implementation needs funds, the quality of the plan is doubtful.

4.4.5.1 Composition of the Council Planning Team

According to Module 4: "Planning and Implementation for District Health Services, Second Version, 2001", the following members compose the team:

- District Planning Officer / or his technical representative (chairperson)
- District Medical Officer (secretary)
- Other members of the CHMT/ co-opted members
- Representative of the private Sector
- Representative of NGO's
- Representative of Community Development Department
- Faith based service providers (religious organizations, voluntary agencies)
- One Member of the RHMT/RS (should be knowledgeable about planning procedures)

N.B.: The composition of the planning team should depend on the specific health problems of the district, interlinked problems like nutrition, TB-control etc.

4.4.5.2 Preparation for Planning / Logistics

The establishment of the CCHP is the most important task the CHMT/planning team has to fulfill during the year. A CCHP of high quality doesn't guaranty quality of services, but a CCHP of poor quality makes good quality of services nearly impossible. Therefore the CHMT/planning team should be aware of the crucial responsibility, which it bears to make the planning process successful. Some recommendations follow:

- Allocations from all possible sources should be known before planning.
- Select a venue, which allows the team to work without disturbance
- The number of the planning team should not exceed 12 members
- Members should be invited timely (2 weeks in advance)
- Persons who cannot commit themselves for the whole planning period (7 – 10 days) should not be invited.
- The logistics (blackboards, draft – paper, markers, calculators etc.) should be in place

Sufficient copies of the last year' plan should be available or the chapter 1 – 3 should already been drafted by a smaller team, because often there will be only minor changes compared to the previous year

A computer literate secretary/member of the planning team can facilitate the whole process tremendously

Pre-planning meetings with all stakeholders in the health sector should be considered and stakeholders should be encouraged to commit themselves to the financial and technical resources they want to allocate to the council health services.

4.4.5.3 Objectives

There are different planning approaches and certain terms are used in a different way. Therefore it is crucial to have a common understanding of these terms. The following definitions are taken from the “National District Health Planning Guidelines”

“Objectives define the ultimate achievements one wishes to obtain with a given input and process. Objectives must be stated in quantitative, i.e. measurable terms. They must be specific, reasonable attainable under given constrains of resources, management capacity and in the ecological setting, and achievable within the specified period of time”

The guidelines make a difference between “**Long term objectives**” and “**Short-term objectives**”, also called “**sub objectives**”

All kind of objectives have to be **SMART. This means**

Specific:	State clearly what should be expected
Measurable:	Can be quantified
Attainable:	Feasible given the constraints of resources, management capacity and environmental setting
Relevant:	Fits with general health policy (EHP), relates to the problem
Time bound:	Achievable within specified period of time

The following example is quoted:

<p><u>Long term objective:</u> Maternal mortality shall be reduced from the current 300 / 100.000 to 250 / 100.000 within 5 years.</p> <p><u>Short-term objectives (sub objectives)</u></p> <ul style="list-style-type: none">• All pregnant women in all villages advised and referred to ante natal services at the end of the year• Eighty percent of women delivering in the villages assisted by a trained personnel at the end of the year

This example is **SMART**

Long term objective:

Maternal mortality (**specific**) shall be reduced (**attainable, relevant**) from the current 300 / 100.000 to 250 / 100.000 (**measurable**) within 5 years (**time bound**)

Short-term objectives (sub objectives)

All pregnant women in all villages (**specific, measurable**) advised and referred to ante natal services (**relevant, attainable**) at the end of the year (**time bound**)

Eighty percent of women (**measurable**) delivering in the villages (**specific**) assisted by a trained personnel (**relevant, attainable**) at the end of the year (**time bound**)

To make this step an easy but successful exercise the following hints should be taken into consideration:

- It is strongly advised to do first target setting. Use the findings of annex --, last but one column “actual achievement”. Put these figures into column No 3 “Baseline information”. In the column “Expected output” determine the targets you expect to achieve by December of the planning year.
- The best way to formulate sound long/medium and short-term objectives is to go through the priority areas and the interventions of the annex -- (Essential Health Package). So you make sure, that essential areas are not omitted.
- Long-term objectives are broken down in short term objectives (sub objectives). This short term objectives will help us to define the respective activities and to budget them.
- To visualise these different steps, we advised you to prepare black boards, flip charts with the following format and to formulate the problems and objectives according to the following examples:

Table 14: An Example of formulating Long Term/ Short Term Objectives and Activities in Relation to the Stated Problems

Problem	Long term objective	Short term objective	Activities	Priority area (EHP)	Area of Intervention (EHP)
The number of professionally assisted deliveries is too low	The number of professionally assisted deliveries increased from 20% to 50% by Dec. 2008	1. To equip maternity ward according to the national standard by Dec. 2004	1. Make inventory of available equipments	Reproductive and Child Health	Obstetric care
			2. Procure required equipments	Reproductive and Child Health	Obstetric care
			3. Distribute equipment to the labour ward	Reproductive and Child Health	Obstetric care
		2. All communities are informed about the advantages of professionally assisted deliveries within one year			

Explanations

Problem: List here all priority problems you identified during the priority setting discussion in the planning team

Long-term objective: Define an objective in regard to the problem, which can be reached in 5-10 years time

Short-term objective: Define here one or more objectives that can be achieved in 1 year's time

Activities: Determine activities by which the short-term objectives can be reached.

Priority area: Write here for each activity the priority area according the essential health package (EHP)

Area of intervention: write here the intervention area, which you find under the respective priority area in the EHP

This table should be typed by the secretary and be part of the CCHP.

Table 15: Cost analysis of activities / Budgeting

After having completed the above exercise, you dispose at a long list of short-term objectives (sub objectives), which you want to reach in the planning period. Consequently, a lot of activities can already be defined; other will be added during the planning exercise, for which you should use the following format:

Table 15: Master table/ cost analysis

Cost Centre: 1 Ceiling: 2 % = 3 Tsh

Priority area: 4

Intervention	No	Activity	Inputs	Unit costs	Total Unit cost	Total activity cost	When	By whom	Source of Financing	Allowances	Fuel Transport	Training	Rehabilitation
5	6		8	9	10	11	12		14	15		17	18
		7						13			16		

Note: It is difficult to put all columns on one paper, use two soft boards with flip chart paper!

Explanations:

1. Cost Centre: There are 6 cost centres. Write the cost Centre you are planning for!

2. Ceiling: Concerning “Basket grants” and "Block Grants", to each cost centre a certain percentage range is allocated (see annex 5). Write the percentage range here! For other sources of financing (council own resources, cost sharing money....) there is no need to fill in this box, because ceilings don't apply.

3. Multiply this percentage range with the total available budget and write the amount here (Example: total budget: 200.000.000 Tsh, to the cost Centre “hospital” 25% - 35% are allocated: $200.000.000 \text{ Tsh} \times 0,25 = 50.000.000 \text{ Tsh}$ / $200.000.000 \times 0,35 = 70.000.000$) Consequently for the cost centers "Hospital" from 50.000.000 to 70.000.000 Tsh can be spend.

4. Priority area: See annex 4: There are 6 priority areas
 - Reproductive and Child Health
 - Communicable Disease Control
 - Non – Communicable Disease Control
 - Treatment and care of other common diseases of local priority
 - Community Health Promotion and Disease Prevention
 - Organizational structures and institutional arrangementsWrite the priority area, which you plan for!

5. Intervention: According to annex 4 (EHP)

6. No: Each activity has to be numbered. The same number has to be kept in all other tables and report (Operational Plan, in the report tables...). To keep the same number is crucial, because numbering the same activities differently in different tables leads to confusion

7. Activity: Put here the activities defined in table 15. If during the planning session additional activities have been identified, add them to table 15, too.

8. Inputs try to break down activities as much as possible. Sometimes, however, it is difficult to do so. Example: Rehabilitation of a dispensary. In this case it is advised to estimate the costs per unit and to multiply the costs by the number of facilities you want to rehabilitate.
9. Unit costs: Write the unit costs. Example:
 Allowances for 20 participants in a 2 days workshop: $20 \times 2 \times 15000$
 B.P. machines: 2 per 5 HC $2 \times 5 \times 80.000$
10. Total unit cost Write total unit costs! Taking our examples: $600.000 (20 \times 2 \times 15000)$
 $800.000 (2 \times 5 \times 80.000)$
11. Total activity cost Add the total costs per activity, for example the total cost for a workshop/training and write it here!
12. When: Write when the activity will be conducted! Example: I. Quarter, II. Quarter
13. By whom: Write the responsible for the respective activity! Example: DMO, DMCHC, etc...
14. Source of financing: It may be possible that the same activity is funded by different sources. In this case, mention in this box all sources of financing and their respective share.
15. Allowances: Check the activity, if allowances are needed, write the amount here! Note: Allowances for training activities, which you will finance by block grants, have to be reported fewer than 17
16. Fuel/Transport: Check the intervention, if fuel or transport costs are needed, if yes write the amount here!
17. Training cost: This column is only needed if you plan for the block grants. For basket grants training cost are included under 15 allowances
18. Rehabilitation: If the activity deals with rehabilitation, report the respective costs in this column.

Table 16: Example: Training, which will be financed by block grants

Cost Centre: Hospital

Ceiling: 25% - 35% = 50.000.000 - 70.000.000 Tsh

Priority area: Reproductive and Child Health

Intervention	No	Activity	Inputs	Unit costs			Total Unit cost	Total activity	When	By whom	Allowances	Fuel	Training	Rehabilitation
Obstetric care	1	Organize a 3 days Partogramme training for 30 participants and 4 facilitators	Venue:	3	1	15000	45.000	2.053.000	March	MCHC			2.053.000	
			Allowances:											
			- Participants:	3	30	15000	1.350.000							
			- Facilitators:	3	4	20000	240.000							
			- Driver	1	4	5000	20.000							
			Transport: bus tickets 30 x 2000	1	30	2000	60.000							
			Fuel:	3	20	600	36.000							
			Stationary	1	1	200000	200.000							
			Tea / Bites	3	34	1000	102.000							

After having finished the planning, the content of the flip chart papers should be typed by the secretary. He / her should use the following format, which is entitled “Cost analysis of activities / Budgeting”.

If possible, it is highly recommended to use for this table an EXCEL spreadsheet

Table 17: Cost Analysis of Activities / Budgeting

Cost Centre	Priority area	Intervention	No	Activity	Details	Unit costs	Total Unit cost	Total activity

Explanations:

1: Section/ Level/ cost Centre Write Hospital, Community etc

2: Intervention: Write intervention (identical with the column “Intervention” in “Cost analysis of activities / Budgeting”)

3: No The numbering of activities has to be the same as in the cost analysis table

4: Activities Write activities (identical with the column “Activities” in “Cost analysis of activities / Budgeting”)

5: Output / Indicators: Write the expected output, you defined in Annex 3.
Whenever no indicator is available for a planned activity, define indicators by yourselves! These indicators should be independent from the activities. They also have to be SMART (specific, measurable, attainable, relevant, time-bound)

Example: Activity:” to train 40 health workers in partograph use”

Good indicator: In 80% of all HF (measurable) with maternity ward the partographs are correctly used (specific, relevant, attainable) by the end of the year (time bound)

Bad indicator: 40 health workers are trained

Define indicators only for the most important activities!

6: Time frame: Indicate the quarter when the activity is going to be carried out.

7/8/9/10/11/12: Write the respective amount per activity in the respective column!

13: Responsible person: Indicate the person responsible for the implementation of the identified activity.

4.4.7 MONITORING OF PERFORMANCE INDICATORS AND TARGETS

The implementation of the Council Health Plan has to be followed by appropriate monitoring tools. This is very often a cumbersome exercise requiring a lot of additional resources. Therefore the MoH/PORALG has opted for an alternative approach by determining a set of about 30 indicators, for which each district sets its own targets. This exercise is part of priority setting and has to be done at this phase. Refer to annex 3. As baseline information you should use the data from annex 3 column “actual achievements” of the previous year.

In the column “Expected outputs” the targets set by the planning team should be indicated.

You should be aware that annex 3 (completely filled in) is compulsory part of the CCHP and of the annual report, without which the CCHP and later the annual report will not be approved.

4.4.8 ASSUMPTIONS AND RISKS

Don't neglect this chapter. If for any reason you will not be able to conduct the activities of your plan, you can always refer to the assumptions and risks, you mentioned under this chapter. These assumptions may concern:

- Financial resources and their availability
- National health policy and realisation of the Health sector reform
- Availability of Health personnel
- Supply with drugs and equipment
- Emergencies, outbreaks
- Availability of Technical Assistance

4.5 Illustrations of how the computer can facilitate the elaboration of the CCHP?

The computer can considerably facilitate your work, all CHMT are using already the computer, at least in order to type the different chapters and to put them in a nice format. But the computer has many other advantages:

It allows you to use some elements of the last year plan, to update them and use them again.

By using EXCEL spreadsheets you can easily calculate different items. Example:

Have the ceilings for allowances and fuel been respected?

Have the ceilings for the different cost centres been respected?

How much money has been spent for the different cost centres?

All figures for annex Nr. 1 and 2 can be taken from the above-mentioned spreadsheet, so that these annexes are easy to establish

But you should respect the following hints:

Your secretary should be computer skilled, if not the work may take longer than without computer.

Use only one computer system, it makes no sense to write one part with a Macintosh computer and other parts with a computer with MICROSOFT software. Converting problems may come up and cause problems.

If EXCEL is not available on your computer, you can also add up figures by WINWORDS, but only if you use the following formats for figures: 1000000, 1,000,000

If your secretary faces any problem it is better to get advice from experienced people within the council or at the regional level.

Back up always your files

4.6 Illustrations on how to write Financial and technical reports

4.6.1 Introduction

Councils and CHMTs are required each financial year to prepare a comprehensive council health plan, whose activities are implemented in order to offer to the Tanzanian people qualitative acceptable and accessible services. The implementation of the plan has to be followed up very closely by the CHMTs through regular formative supervisions, a high performance HMIS which provides vital health data in time and last but not least regular reporting to the regional and national health authorities.

The importance of reporting in a timely manner cannot be emphasized strongly enough. Reporting in time and using the appropriate format is an important precondition for receiving the next funding installments for the implementation of the Plan.

Therefore this section explains how to write sound reports, which fulfill requirements of the MoH/ PORALG, BFC and other related bodies or departments. These reports will facilitate tasks at all levels.

- Report writing is a valid tool to monitor performance (technical and financial)
- Timely approved reports will ensure continuous funding for the councils so that the entire CCHP can be implemented according to the planned time schedule
- Sound reports are a prerequisite for MoH/PORALG to dispose further transfer of money to the council account
- Approved reports assist making sound decisions on how to continue the entire basket financing process and promote accountability

4.6.2 Overview on the report system

CHMTs have to produce altogether four quarterly financial reports and two semiannual technical reports. These reports will be cumulative, that means that the fourth quarterly financial report and the second semiannual technical reports are considered as the annual report for the planning period. Furthermore it is evident that the second quarterly financial report and the first semiannual technical reports should be compiled in one document. This applies also to the fourth quarterly financial report and the second semiannual technical reports, which become the main part of the annual report.

The DMO is responsible person who should initiate draft of all reports submit it to the RS for scrutiny and the final version to the Council Director for approval.

4.6.3 The technical report

The technical report is a holistic report on the technical performance of the council against the Council Health Plan. It should not be excessively burdensome to produce but should summarize the critical data required for the councils to manage the health service and allow the Council and Regional Secretariat to monitor that performance

The outline format of the report only two parts:

1. Overview
2. Technical Report (table)

The overview gives a comprehensive summary. This summary should contain

- Comprehensive appraisals whether the activities planned for the respective 6 months were implemented. In case of serious time delay for implementation a substantial explanation should be given
- The different sources of funds and the respective amount allocated/received in the respective quarter
- A summary of expenditures per cost center

The box below gives an example how Section 1 might be structured:

Lindi town Council is among Local authorities under reform programme – phase one- eligible for Health Basket funds with effect from July 2000.

Basket funds were only allocated by end of July, so only 5 months were left to conduct the activities of the first 6 months. This explains a certain delay in regard to our planning. It has to be stressed however, that all routine activities (supervision, drug supply) could be conducted and other planned activities could either be terminated or at least started.

We received the basket grants on July 31, so we started to conduct basket grant related activities from August 1. In total we received in the first two quarter of the financial year the following funds

Council health Basket Grant	Tsh	6.623.600
Block Grants	Tsh	27.331.836
Others	nil	
Total funds	Tsh	33.955.436

The following funds were expended to date for the cost center:

District Hospital	Tsh	1.165.000
Council Health Department	Tsh	21.124.987
Health Center	Tsh	3.000.000
Dispensaries	Tsh	3.323.920
Total payments	Tsh	28.613.908
Balance by March 31:	Tsh	5.341.529

The remaining money will be spent in the following 6 months.

Yours truly,
(Signature DMO)

Format for the Technical Report

It consists of a filled in table with the following format.

Table 19: Council Health Plan Semiannual Technical Progress Report

REGION		COUNCIL...		PERIOD.....	
1	2	3	4	5	6
Level or cost center	Number of activity	Planned Activities	Status of implementation	Achievements in %	Comments constraints

Prepared by: (Name)	<input type="text"/>	Title	<input type="text" value="Health Secretary"/>	Signature	<input type="text"/>	Date	<input type="text"/>
Checked by: (Name)	<input type="text"/>	Title	<input type="text" value="Council Planning Officer"/>	Signature	<input type="text"/>	Date	<input type="text"/>
Checked by: (Name)	<input type="text"/>	Title	<input type="text" value="DMO/MOH"/>	Signature	<input type="text"/>	Date	<input type="text"/>
Authorized by: (Name)	<input type="text"/>	Title	<input type="text" value="Council Director"/>	Signature	<input type="text"/>	Date	<input type="text"/>
Confirmed by: (Name)	<input type="text"/>	Title	<input type="text" value="RMO"/>	Signature	<input type="text"/>	Date	<input type="text"/>

Explanations

- Column 1: Fill in the respective cost centre
- Column 2: Write down the same number of activity as it appears in the plan of operation section of the CCHP.
- Column 3: Write down the activity as they appear in the CCHP.
- Column 4: Make a short statement on the status of actual implementation e.g. 20 Health providers out of the targeted 25 have been trained.
- Column 5: Estimate/calculate in percentage to which extent the activity has been implemented.
- Column 6: To be filled only if there are particular observations.
E.g. Additional fund available, activity insufficiently implemented.

Note: Because all reports are cumulative, the second semiannual report contains all information of the first one, too.

4.6.4 Six Monthly (bi-annual) Financial Report and Technical reports for Comprehensive Council Health Plan

The biannual financial and technical report has to be prepared 6 monthly. It consists of

- a) 6 monthly Technical implementation status report as shown on table 19 on page 59 of this guidelines.
- b) 6 monthly Health Sector Recurrent Accounting Return Form as shown in annex 5 and should be accompanied with the bank reconciliation statements, bank statements and certificate of the bank
- c) 6 monthly Technical and Financial Joint Report For Comprehensive Council Health Plan in according to the format below.

Table 20: BI-ANNUAL TECHNICAL AND FINANCIAL JOINT REPORT FOR COMPREHENSIVE COUNCIL HEALTH PLAN

COUNCIL:

QUARTER ENDING: 2

Level Cost Center	No	Planned activities by Cost Centers	Achievements in %	IMPLEMENTATION STATUS (FINANCIAL)							Actual Expenditure this Quarter							Remarks Variance	
				Quarter allocations															
				Block Grant	Basket	Council	*Cost sharing	** Receipt in Kind	Others	Total	Block Grant	Basket	Council	*Cost sharing	** Receipt in Kind	Others	Total Exp		
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	
CHMT																			
CH/DDH																			
HC/Disp																			
Community																			
VAH/Un alloc																			
Total																			

Prepared by Name Title Signature Date:

Checked by Name Title Signature Date:

Checked by Name Title Signature Date:

Authorized by Name Title Signature Date:

Confirmed by Name Title Signature Date:

* Includes user fees, CHF and Capitalization/Drug Revolving Fund

** Includes the value of drugs, medical supplies, equipment, yellow and blue kits supplied by MSD and donor donations

Explanation:

Column 1 to 4:	Copy from CCHP (cost analysis)
Columns 5 to 10:	Put in the figures for the respective activities as in the plan of operation.
Column 11:	Write the total amount from column 5 to 10
Column 12-17:	Write the amount of money spent per activity.
Column 18:	Write the total amount from column 12 to 17.
Column 19:	Write the difference between column 11 and 18

Two important reminders

- 1. The table should be prepared in Excel to facilitate easy and accurate mathematical operations.**
- 2. The reports are cumulative, therefore the second quarterly financial report contains the information of the first, the third the information of the first and second and the fourth, which is part of the annual report, contains all information of the three preceding quarters**

b) The Health Sector Recurrent Accounting Return Form has to be also filled in by the district treasurer.

Furthermore the following documents have to be attached to each quarterly report

- Bank statement
- Bank reconciliation statement
- Certificate of the Bank

4.6.5 Elaboration of the annual report

In July of each year an annual report for the period July to June of the last financial year will be produced which consists of

- An overview (compare overview for the technical report)
 - The second semiannual technical cumulative report
 - The fourth quarter financial cumulative report
 - Assessment of the short-term objectives identified in the CCHP. Use the following simple table

Example

Objective	Comment
Vaccination coverage for all vaccinations raised from 60% to 80% by end of 2003	The coverage at the end of the year was 75%. One of the reason that 80% was not reached is the fact, that some vaccines have been out of stock for some weeks.

- Assessment of the Council health indicators.

After having filled in column 3 of the “Council Health Performance Indicators” which is called “base line information” and 4, called “expected output” now this table has to be completed by filling in column 5 “actual achievement”

4.6.6 Deadlines

First quarterly financial report	October, 31
Second quarterly financial report	January, 31
Third quarterly financial report	April, 30
Fourth quarterly financial report	July, 31
First semiannual technical report	January, 31
Second semiannual technical report	July, 31
Annual report	September,30

4.7 Self assessment Tool to Evaluate the Quality of the Established CCHP

The following table helps the planning team to do a self-assessment of the CCHP. It is advisable to use this tool in order to check the plan and to improve it, if necessary.

Criterion	How to measure?	How to score	Max.
Comprehensiveness of the plan	Look if all 6 priorities of the EHP are taken into account	5 or 6 = 1 4 and less = 0	1
	All available sources of funds are laid down, explanations are given.	All mentioned = 1 Funds omitted = 0	1
Composition of the planning team	Representatives of the private sector participated in the planning?	Yes = 1 No = 0	1
Content and Quality of the Executive summary	Both parts of the Executive Summary are in the plan and contain the needed information (refer to prototype)	Both parts = 2 One part = 1 No summary = 0	2
Is there a clear purpose of the CCHP?		Yes = 1 No = 0	1
Map of the district with all health facilities available	-----	Yes = 1 No = 0	1
Catchments area of all facilities in the district known	Verify whether in table 6, the population < 5 km is added up	Yes = 1 No = 0	1
General comment on staff situation in the district is available	After table 11 a general statement on the situation of the staff should be given	Yes = 1 No = 0	1
Essential Health Package (EHP):	On the respective intervention at least the following percentages of basket grant should be spent		0
- Case management and prevention for acute febrile illnesses (AFI) including malaria / Insecticide treated nets (ITN) for prevention of malaria	5%	> 4 % = 2 1 - 4% = 1 0- 0,9% = 0	2
- Safe motherhood initiative	3%	3% or more = 2 1-2,9% = 1 0,0 - 0,9% = 0	2
- STI Syndromic Management	3%	3% or more = 2 1-2,9% = 1 0,0 - 0,9% = 0	2

Criterion	How to measure?	How to score	Max.
- Expanded Programme for Immunisation (EPI), Immunisation	5%	> 4 % = 2 1 - 4% = 1 0- 0,9% = 0	2
- HIV/AIDS related activities	5%	> 4 % = 2 1 - 4% = 1 0- 0,9% = 0	2
- Integrated Management of childhood illnesses (IMCI)	5%	> 4 % = 2 1 - 4% = 1 0- 0,9% = 0	2
Non costing activities reflected	Find at least 5 non costing activities in the plan	5 or more = 2 1 - 4 = 1 0 = 0	2
Are the stated objectives SMART?	Look at all objectives of the plan. The total number is the denominator. The nominator is the total number of objectives, which are SMART. Multiply the fraction x 8	Example: In a plan 12 objectives are listed out of which 8 are SMART: $8/12 \times 8 = 5$	8
Are the calculations correct?	Select randomly 20 calculation operations in table "cost analysis" and check them	All correct: = 3 15 - 19 = 2 10 - 14 = 1 < 10 = 0	3
Are the activity numbers consistent in the different tables	The numbering in table "cost analysis" has to be identical with the numbering in the "plan of operation"	Yes = 3 No = 0	3
Adherence to the ceilings	Check this for the items allowances, fuel, minor rehabilitation	Adhere to all three = 3 Adhere to two = 2 Adhere to one = 1 0 = 0	3
Total			40

CHAPTER 5: REHABILITATION STRATEGY FOR HEALTH CENTRES AND DISPENSARIES AND FUNDING MECHANISM TO BE APPLIED TO FACILITATE REHABILITATION

5.1 Objective

The objective of the Rehabilitation strategy for Health Centres and Dispensaries is to improve health service delivery through rehabilitation and maintenance of these primary health facilities and provision of medical equipment with community participation. The rehabilitation package will consist of; building's rehabilitation, supplementary equipment supply to ensure congruence among services provided and equipment, supply of furniture to meet basic requirements in each facility and infection control.

5.2 Resource Allocation

The Government and the development Partners have agreed to establish a Joint Rehabilitation Fund (JRF) to be financed from the US\$ Holding Account. Funds from the Joint Rehabilitation Fund Account will be utilized to finance rehabilitation of health care facilities (Health centres and Dispensaries) and provision of supplementary equipment and furniture for all the primary health care facilities in the country. The Health Basket Fund Committee (BFC) will approve and release funds to councils on the basis of the comprehensive council health plans, which will incorporate rehabilitation plans. Resource allocation to the respective councils will be determined using allocation criteria as approved by the BFC from time to time. For the time being this will depend on:

- Number of facilities (health centres/dispensaries) to be rehabilitated.
- Under five mortality rate (BOD)
- Poverty rate
- Formation of health facility committees.

Inclusion of districts in the rehabilitation plan will be done on a rolling basis. Districts that have received substantial support for rehabilitation of its health facilities in the past five years will receive lowest priority while those, which have the highest poverty rates, will first be considered. Each district will get its allocation depending on the number of health facilities and a rehabilitation unit rate applicable to that particular region.

5.3 Flow of Funds

Development partners will deposit funds into the US\$ Holding Account in the Bank of Tanzania and thereafter channel the financing for rehabilitation activities to the Joint Rehabilitation Fund Account to be opened and maintained by Ministry of Finance (MoF). The Ministry of Finance will channel funds from JRF to the Council's Account No. 6 under a separate account heading. The Council will then transfer funds into bank accounts opened by each Health Facility Committee (HFC) exclusively for the implementation of the rehabilitation activities in three tranches of 40%, 30% and 30%. The second tranche will only be released upon the HRC accounting for at least 70% of the previous tranche. Similarly disbursement of the third tranche is contingent upon the HFC accounting 70% of the second tranche and 100% of the first release. Signatories for approval of the expenditure from the facility account will be the HFC chairman and the Village Government Chairman.

5.4 Management of Funds

At the central level, PORALG/MoH will coordinate the approval, release and the disbursement of the funds from the JRF account to the Council's account no. six.

At the Council level, the Director, the DMO, the Treasurer with assistance from the Council engineer will manage and release funds from account no. 6 to the facility accounts.

The HFC Chairman and the Village Government Chairman will manage funds received at the facility level. The council engineer will certify Works for payment. The Facility manager/in charge, who is also the secretary to the facility committee, will oversee the day-to-day implementation of rehabilitation activities.

Since most of the works will be contracted out, procurement of works and goods shall be carried out in accordance with the Public Procurement Act 2001 and the Local Government Procurement regulations 2003.

5.5 Monitoring and supervision

The Health Facility committee will report physical and financial expenditure on rehabilitation account to the Council Health Management Team (CHMT) on a monthly basis using a simple format designed by PORALG/MoH (see Annex 5.1 to this chapter). Councils will collate the information on physical/financial received from the facility level into quarterly reports and submit them to RAS for vetting. RAS will assess the council reports received and submit them to PORALG; copy to MoH with their recommendations and comments. PORALG will consolidate all the reports received and submit them to BFC.

With respect to the works progress, quality and expenditure will be properly recorded and reporting to the districts shall coincide with contractor's payments.

At Council level, receipts of rehabilitation fund will be reported on a separate Development Accounting Return Form similar to Annex 5 of this document. A simplified format is shown as Annex 5.2 to this report. The form shall be supported by a bank statement, certificate and bank reconciliation report. Physical implementation of the works will be reported on semi-annual basis on a separate form similar to the consolidated technical and financial report for the Comprehensive Health plans as shown on page 64 of this guideline to include cost centre, planned activities by cost centres, achievement in percentages, actual expenditure and remarks. A simplified format is shown on annex 5.3

5.6 Community Participation

To ensure sustainability and sense of ownership, the communities using the health facilities (health centre/dispensary) will participate in the planning, implementation and monitoring of the rehabilitation works. The communities will be required to contribute in cash or in kind at least 15% of the cost of rehabilitation works.

5.7 Auditing

The existing government laid down technical and financial auditing procedures and regulations will govern. However, in order to ensure cost efficiency and improved quality of work, an independent auditing firm will be contracted to carry out technical audits of randomly selected project in all districts receiving funds under the scheme.

LIST OF ANNEXES

- ANNEX 1: BUDGET SUMMARY FOR COUNCIL HEALTH BASKET GRANTS**
- ANNEX 2: A) BUDGET SUMMARY FOR ALLOWANCES AND FUEL FOR BASKET GRANTS**
- ANNEX 2: B) BUDGET SUMMARY FOR ALLOWANCES, FUEL AND TRAINING FOR BLOCK GRANTS**
- ANNEX 3: COUNCIL HEALTH PERFORMANCE INDICATORS**
- ANNEX 4: EXPLANATORY NOTES ON HOW TO FILL IN THE PERFORMANCE INDICATORS**
- ANNEX 5: HEALTH SECTOR RECURRENT ACCOUNTING RETURN**

Annex 1: BUDGET SUMMARY FOR COUNCIL HEALTH BASKET GRANTS FOR THE YEAR ... PLANNED INTERVENTIONS AS PER COST CENTRES

PRIORITY AREA	INTERVENTIONS (Examples)	CHMT/CHSB	Council Hospital/DDH	HC	Dispensaries	COMMUNITY	VAH/ (UN-ALLOCATED)	TOTAL COST
Reproductive and Child Health	1.1 Reproductive Health							
	1.2 Improve Child Health							
Communicable Disease Control	2.1 Roll – back Malaria initiative							
	2.2 Multisectoral STD/HIV/AIDS Strategy							
	2.3 Disease Surveillance							
	2.4 EPI							
	2.5 TB & Leprosy							
	2.6 Other Council Specific disease							
Community Health Promotion and Disease prevention	3.1 Water Hygiene and Sanitation							
Administration	4.1 Establish/strengthen Organization Structural & Arrangements							
	Actual budget							
	Percentage							
	Budget Allocated/ceiling							
	Percentage							

This matrix is to assess if the Council Health Plans is in conformity with the health planning guide and ceilings set for each cost centre

Annex 2 A:

BUDGET SUMMARY FOR ALLOWANCES AND FUEL FOR BASKET GRANTS FOR THE YEAR.....

ITEM	Total amount allocated for Basket Grants	Amount ALLOCATED By the Planning Team for allowances and Fuel ..	Percentage	ALLOCATED BUDGET CEILING OF BASKET GRANTS	PERCENTAGE	VARIANCE IN PERCENTAGE	REMARKS
1. Allowances					25%		
2. Fuel					20%		

THIS TABLE IS USED TO COMPARE ACTUAL BUDGET/PERCENTAGE COMPARED WITH ALLOCATED BUDGET and allowed ceilings percentage and variance in percentage.

Annex 2 B: BUDGET SUMMARY FOR ALLOWANCE, FUEL AND TRAINING FOR BLOCK GRANTS FOR THE YEAR.....

ITEM	Total amount allocated for Basket Grants	Amount ALLOCATED By the Planning Team for allowances and Fuel ..	Percentage	ALLOCATED BUDGET CEILING OF BASKET GRANTS	PERCENTAGE	VARIANCE IN PERCENTAGE	REMARKS
1. Allowances					25%		
2. Fuel					20%		
3. Training					10%		

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

Annex 3: COUNCIL HEALTH PERFORMANCE INDICATORS

MOH/PORALG Council Health Guide	Council Minimum Health Standards	COUNCIL	COUNCIL	COUNCIL	
OBJECTIVE	DATA TO BE COLLECTED/ PERFORMANCE INDICATORS	BASELINE INFORMATION (JAN – DEC of PREVIOUS YEAR)	EXPECTED OUTPUT AT THE END OF THE PLANNING YEAR	ACTUAL ACHIEVEMENT (DEC.....)	REMARKS
<p>Improve Reproductive Health Care</p>	<p>proportion of clients attending for purposes of: ANC Deliveries Post delivery complication Postnatal Care</p> <p>(a) Proportion of women of child bearing age using family planning method (b) Proportion of clients receiving family planning by method: (i) Pills (ii) Injection (iii) IUD (iv) Condom (v) Natural</p> <p>Proportion of women of child bearing age attending ANC clinic receiving Tetanus Toxoid Immunization</p> <p>(a) Proportion of under five children attending under five clinic.</p>				

MOH/MRALG Council Health Guide	Council Minimum Health Standards	COUNCIL	COUNCIL	COUNCIL	
OBJECTIVE	DATA TO BE COLLECTED/ PERFORMANCE INDICATORS	BASELINE INFORMATION (JAN YEAR)	EXPECTED OUTPUT (DEC. YEAR.....)	ACTUAL ACHIEVEMENT (DEC.....)	REMARKS
<p>Improve malaria case management</p> <p>Improve STD care management and HIV new transmission.</p> <p>Improve TB/Leprosy care management and disease transmission</p>	<p>(b) Proportion of under five children with a body weight less than 60%</p> <p>proportion of children under one year immunized against Measles Polio BCG DPT3</p> <p>6) a) Proportion of malaria cases for under 5 years b) Proportion of malaria cases above 5 years</p> <p>a. a) Proportion of death due to malaria under 5 years b) Proportion of death due to malaria above 5 years.</p> <p>8) a) Proportion of population infected with STDs b) Proportion of blood donors tested HIV positive</p> <p>9) (a) Proportion of TB cases completed treatment (b) Proportion of Leprosy cases completed treatment</p>				

MOH/PORALG Council Health Guide	Council Minimum Health Standards	COUNCIL	COUNCIL	COUNCIL	REMARKS
OBJECTIVE	DATA TO BE COLLECTED/ PERFORMANCE INDICATORS	BASELINE INFORMATION (JAN. 2000	EXPECTED OUTPUT (DEC. 2000	ACTUAL ACHIEVEMENT (DEC.2000)	REMARKS
Strengthen disease Surveillance and case Management of specific Epidemic diseases	10) Proportion of treated cases of Cholera/ meningitis who died				
Improve non- Communicable disease Cases management	11) (a) Proportion of patients diagnosed with the following non communicable diseases i) Hypertension ii) Trauma/injuries iii) Mental disorders iv) Neoplasms v) Diabetes (b) Proportion of deaths due to i) Hypertension ii) Trauma/injuries iii) Mental disorders iv) Neoplasms v) Diabetes				

MOH/PORALG Council Health Guide	Council Minimum Health Standards	COUNCIL	COUNCIL	COUNCIL	REMARKS
OBJECTIVE	DATA TO BE COLLECTED/ PERFORMANCE INDICATORS	BASELINE INFORMATION (JAN. 2000	EXPECTED OUTPUT (DEC. 2000	ACTUAL ACHIEVEMENT (DEC.2000)	REMARKS
<p>Improve availability Drug/medical supplies Laboratory reagents and Vaccines</p> <p>Improve financial Management system.</p>	<p>12) Proportion of health facilities by level with constant supply of drugs/medical supplies vaccines and Laboratory reagents:</p> <ul style="list-style-type: none"> a) Hospital b) Health Centre c) Dispensary <p>13) Respect/Adherence to ceilings stipulated in the DHP guidelines:</p> <ul style="list-style-type: none"> a) Hospital b) Health Centre c) Dispensary 				

MOH/PORALG Council Health Guide	Council Minimum Health Standards	COUNCIL	COUNCIL	COUNCIL	REMARKS
OBJECTIVE	DATA TO BE COLLECTED/ PERFORMANCE INDICATORS	BASELINE INFORMATION (JAN. 2000	EXPECTED OUTPUT (DEC. 2000	ACTUAL ACHIEVEMENT (DEC.2000)	REMARKS
<p>Improve human resource For health in terms of Number, professional Mix at all levels.</p> <p>Improve control of Communicable diseases</p> <p>Ensure facilities are in good state of repair.</p> <p>Improve Health facilities Utilization rate at all levels.</p>	<p>14) Proportion of trained personnel per level actually available compared to thee national minimum standards:</p> <p>a) Hospital b) Health Centre c) Dispensary</p> <p>15) Proportion of health personnel who have undertaken short term training:</p> <p>a) Hospital b) Health Centre c) Dispensary</p> <p>16) Proportion of facilities supervised by DHMT</p> <p>a) Hospital b) Health Centre c) Dispensary</p> <p>17) (a) Proportion of households with acceptable toilets, refuse bins/refuse bin or pit and access to safe water (b) Proportion of HF with JEV Materials</p> <p>18) Proportion of facilities in good state of repair:</p> <p>a) Hospital b) Health Centre c) Dispensary</p> <p>19) Proportion facility with bed occupancy rate of 60% and above:</p> <p>a) Hospital b) Health Centre c) Dispensary</p>				

Annex 4: EXPLANATORY NOTES ON HOW TO FILL IN THE PERFORMANCE INDICATORS

Indicator	Source of data	Instruction
<p>Proportion of clients attending for purposes of ANC Deliveries Post delivery complication Postnatal care</p>	<p>MTUHA D5.3 part 3 MTUHA D5.3 part 9 MTUHA D5.3 part 9 MTUHA D5.3 part 3 MTUHA D5.4 part 3</p>	<p>No of ANC clients (at least one visit) a) Total population x 0.046 Total deliveries* b) Total population x 0.046 * Deliveries in HF, and registered deliveries by TBA Total of post delivery complications acc. To MTUHA * c) Total of registered deliveries * Post delivery complications according MTUHA, D5.7 part 9: - Post partum Hemorrhage Retained placenta 3rd degree tear - Other complications Deaths Postnatal clients d) Total of registered deliveries</p>
<p>2 a) Proportion of women in childbearing age using family planning methods</p>	<p>MTUHA D5.3</p>	<p>Total current users a)..... Total population x 0.18 b) No of women using pills Pills:..... Total current users No. of women using injections Inj:..... Total current users.....</p>

Indicator	Source of data	Instruction
		No. of women using IUCD IUD: Total current users No of couples using condoms Condom: Total current users No of couples using natural methods Natural: Total current users
3) Proportion of women attending ANC clinic receiving Tetanus Toxoid immunization	MTUHA D4.6, part 7	ANC clients receiving TT2+ Total ANC clients
3 (a) Proportion of under five children attending under five clinic b) Proportion of under five children with a body weight less than 60%	MTUHA D4.6, part 7	Children <5 years registered in <5 clinic a) Total children 5 years Children < 5 years with body weight <60% b) Total children < 5 years weighted
5) Proportion of children under one year immunized against	MTUHA D4.5, part 7	Children vaccinated against measles Measles: Total children <1 year Children vaccinated against polio Polio: Total children <1 year BCG vaccinated children BCG: Total children <1 year Children vaccinated against DPT DPT3: Total children < 1 year

Indicator	Source of data	Instruction
<p>6. (a) Proportion of malaria cases for under 5 years</p> <p>b) Proportion of malaria cases above 5 years</p>	<p>MTUHA 5.5, part 4-8</p>	<p>OPD children < 5 years with diagnosis malaria Total children < 5 years</p> <p>OPD patients with diagnosis malaria > 5 years b)..... Total population > 5 years</p>
<p>7. (a) Proportion of deaths due to malaria under 5 years</p> <p>(b) Proportion of deaths due to malaria above 5 years</p>		<p>No. of patients with malaria died <5 years a) Total No. of malaria patients < 5 years</p> <p>No. of patients with malaria died > 5 years b) Total No. of malaria patients > 5 years</p>
<p>8. (a) Proportion of population infected with STDs</p>	<p>MTUHA D0005, part 9, page 88</p>	<p>Total patients diagnosed with STD STD:..... Total population</p> <p>No. of blood donors tested HIV positive HIV pos: Total of blood donors tested</p>
<p>9. (a) Proportion of TB cases completed treatment</p> <p>(b) Proportion of Leprosy cases completed treatment</p>	<p>MTUHA, D5.14</p>	<p>a) Tuberculosis patients completing treatment = Cohort initiating treatment- (Total of “failure” + out of control” + “Transfer)</p> <p>b) Leprosy patients completing treatment = Cohort initiating treatment- (Total of “failure” + out of control” + “Transfer)</p>

ANNEX 5¹ – HEALTH SECTOR RECURRENT
ACCOUNTING RETURN

Schedule A – Summary

Council Quarter Ending / /

	A Current Quarter TSH	B Year to Date TSH	C Budget YTD TSH
B1 Cash Book Bal. at Start of Period	<input type="text"/>		
Amount Received			
R1 Block Grants	<input type="text"/>	<input type="text"/>	<input type="text"/>
R2 Basket Funding	<input type="text"/>	<input type="text"/>	<input type="text"/>
R3 Council Funding	<input type="text"/>	<input type="text"/>	<input type="text"/>
R4 Other Funding	<input type="text"/>	<input type="text"/>	<input type="text"/>
R5 Receipts in Kind	<input type="text"/>	<input type="text"/>	<input type="text"/>
R6 Cost Sharing	<input type="text"/>	<input type="text"/>	<input type="text"/>
R7 Total Received	<input type="text"/>	<input type="text"/>	<input type="text"/>
R8 Total Funds Available	<input type="text"/>	<input type="text"/>	<input type="text"/>
Payments			
S1 Council Health Department	<input type="text"/>	<input type="text"/>	<input type="text"/>
S2 Council/CDH Hospital Costs	<input type="text"/>	<input type="text"/>	<input type="text"/>
S3 Urban Health Centre Costs	<input type="text"/>	<input type="text"/>	<input type="text"/>
S4 Rural Health Centre Costs	<input type="text"/>	<input type="text"/>	<input type="text"/>
S5 Dispensary Costs	<input type="text"/>	<input type="text"/>	<input type="text"/>
S6 Community Initiatives	<input type="text"/>	<input type="text"/>	<input type="text"/>
S7 Total Payments for Period	<input type="text"/>	<input type="text"/>	<input type="text"/>
B2 Cash Book Bal. at the End of the Period	<input type="text"/>		

Prepared by:	Name	<input type="text"/>	Date	<input type="text"/>
		Council Treasury		
Checked by:	Name	<input type="text"/>	Date	<input type="text"/>
		DMO/MoH		
Authorized by:	Name	<input type="text"/>	Date	<input type="text"/>
		Council Director		
Confirmed by:	Name	<input type="text"/>	Date	<input type="text"/>
		Regional Accountant		

**HEALTH SECTOR RECURRENT ACCOUNTING RETURNS
of 2**

Schedule B1

Council

Quarter

	A Current Quarter TZS	B Year to Date TZS	C Budget YTD TZS
<u>Council Health Department</u>			
P1	Salaries and Wages		
P2	Other Payroll Costs		
P3	Allowances		
P4	Vehicle Running Costs		
P5	Office Running Costs		
P6	Others: (Specify)		
P7			
P8	Total DMO		
<u>Council/CDH Hospital Costs</u>			
P9	Salaries and Wages		
P10	Other Payroll Costs		
P11	Allowances		
P12	Hospital Running Costs		
P13	Medical Supplies		
P14	In-Patient Costs		
P15	Food Costs		
P16	Repairs and Maintenance		
P17	Other: Specify		
P18	Total Council Hospital Costs		
<u>Urban Health Centre Costs</u>			
P19	Salaries and Wages		
P20	Other Payroll Costs		
P21	Allowances		

P22	Health Running Costs			
P23	Medical Supplies			
P24	In-Patient Costs			
P25	Repairs and Maintenance			
P26	Other: Specify			
P27	Total Urban Health Centre Costs			

**HEALTH SECTOR RECURRENT ACCOUNTING RETURNS
of 2**

Schedule B2

Council

Quarter

Ref		A Current Quarter TZS	B Year to Date TZS	C Budget YTD TZS
	Rural Health Centre			
P28	Salaries and Wages			
P29	Other Payroll Costs			
P30	Allowances			
P31	Health Centre Running Costs			
P32	Medical Supplies			
P33	In-Patient Costs			
P34	Food Costs			
P35	Repairs and Maintenance			
P36	Other: Specify			
P37	Total Rural Health Centre Costs			
	Dispensary Costs			
P38	Salaries and Wages			
P39	Other Payroll Costs			
P40	Allowances			
P41	Hospital Running Costs			
P42	Medical Supplies			
P43	In-Patient Costs			
P44	Food Costs			
P45	Repairs and Maintenance			

P46	Other: Specify			
P47	Total Rural Health Centre Costs			
Community Initiatives				
P48	Salaries and Wages			
P49	Other Payroll Costs			
P50	Allowances			
P51	Hospital Running Costs			
P52	Medical Supplies			
P53	Total			
P54	Grand Total			

HEALTH SECTOR RECURRENT ACCOUNTING RETURNS

Schedule C

Council

Quarter:

		Current Quarter	Year to Date	Budget YTD
		TZS	TZS	TZS
Summary of Personnel Emoluments and Allowances				
T1	Total Salaries and Wages			
T2	Total Other Payroll Costs			
T3	Total Allowances			
T4	Total Other Charges			

Health Sector Accounting Return – Notes for Guidance

These notes are intended to assist Council Staff in completing the Health Sector accounting Return. The return should include **Recurrent receipts and payments only**. Returns should be made within four weeks of the end of the quarter. Returns should be made to the Regional Administrative Secretary, who should be the first point of contact in the case of any question on the content of the return.

<u>Page</u>	<u>Box Reference</u>	<u>Comments</u>
1	Column A	In this column, actual receipts and payments for the quarter should be entered.
	Column B	Enter the cumulative receipts and payments for the Year to Date.
	Column C	Enter the cumulative budget figures as appear in the approved Council Health Plan. Any variation from this should be accompanied by the appropriate Council minute authorizing a virement.
1	B1	Enter the balance on the Account number 6 at the beginning of the quarter. For all quarters after the first quarter, this should be exactly the same as the closing balance – box B2 in the previous quarters return. This return should be accompanied by a copy of the bank reconciliation statement which must agree with the cashbook and the balance in this box.
	B1	The amount of Block grant received in the current quarter.
	R2	Total Basket grant received in the current quarter
	R3	The amount of funds transferred from the Councils General Account to fund Health expenditure
	R4	Any other funds received, for example any funds intended for recurrent expenditure from donors, NGO's.
	R5	Receipts in kind are receipts, which are not paid in money, but include such things as drugs and medical supplies, vaccines laboratory reagents, medical equipment and general supplies. Such Items will have to be valued. This entry should have a corresponding entry under the Payments section of this return in the appropriate box.
	R6	Cost sharing includes receipts from fees, CHF, DRF, NHIF etc. and charges for health services. These receipts should be paid directly into the Number 6 Account.
	R7	Enter the total of boxes R1 to R6
	R8	Enter the total funds available, opening cash book balance plus total receipts
	S1	This is the total of all payments made and charged to the Council Health Department and should equal the total in box P8 on page 2.
	S2	This is the total of all payments made and charged to the Council/CD Hospital and should equal the total in box P18 on page 2
	S3	This is the total of all payments made and charged to the Urban Health Centres and should equal the total in box P29 on page 2.
	S4	This is the total of all payments made and charged to the Rural Health Centre costs and should equal the total in box P37 on page 3.
	S5	This is the total of all payments made and charged to Dispensary costs and should equal the total in box P47 on page 3.
	S7	Total of boxes S1 – S6
	B2	Enter the cashbook balance at the end of the period. This should equal box B1+Box R7 – Box S6.

<u>Page</u>	<u>Box Reference</u>	<u>Comments</u>
	P1 –P7	Costs relating to the Council Health Department should be entered according to the classifications given. Where there are any costs which do not fall into the given classifications, they should be described and entered into Box P7. This should include all costs of the council Health Department, Council Health Management Team activities, and Health Board Expenses where Health Board exist.
	P1	Enter the salaries expenditure on health management and administration.
	P2	Enter the costs of NSSF contributions.
	P3	Enter all allowances paid to COUNCIL MEDICAL OFFICER staff, which is not correctly chargeable to any of the other cost centres.
	P4	Enter the fuel, vehicle maintenance, insurance costs of vehicles run by the DMOs office. Drivers salaries and associated costs should be entered under salaries.
	P5	Office running costs include: stationery, telephones, utilities and any other costs associated with running the office.
	P8	Total Boxes P1 to P8. Enter this figure in box S1
	P9 – P17	Costs which are incurred in the running of the Council/CD Hospital should be entered according to the classifications given. Where there are any costs which do not fall into the given classifications, they should be described and entered into box P17.
	P12	Hospital Running costs includes all utilities and supplies (such as cleaning materials) incurred in the day to day running of the hospital)
	P 18	Total Boxes P9 to P17. Enter this figure in box S2
	P19 – P27	Costs incurred in running Urban Health Centres should be entered according to the classifications given. Where there is no Urban Health Centre, enter zeros in the total box – Box P 29. Where there are any costs which do not fall into the given classifications, they should be described and entered into box P27.
	P28	Total Boxes P19 to P27. Enter this figure in box S3
	P28 – P36	Costs incurred in running Rural Health Centres should be entered according to the classifications given. Where there are any costs which do not fall into the given classifications, they should be described and entered into box P36
	P37	Total Boxes P28 to P36. Enter this figure in box S4
	P38 – P46	Costs incurred in running dispensaries should be entered according to the classifications given. Where there are any costs which do not fall into the given classifications, they should be described and entered into box P46.
	P47	Total Boxes P38-46
	T1	Add Boxes P1 +P9 +P28+P38, enter total
	T2	Add Boxes P2 +P10+P21+P29+P39 enter total This total of Allowances should not exceed MOH Guidelines.
	T4	Add Boxes containing all costs except salaries and wages, other payroll costs and allowances.