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Micro planning in the implementation of community-based health programmes: Lessons from vaccination services in Geita and Morogoro Districts, Tanzania

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Abstract

Background: Microplanning is an important tool that health workers can use to ensure that immunization services reach every community. Through community participation, microplanning helped the health facility and communities to identify priority interventions, to address barriers, and to develop work plans with feasible solutions. Since 2017, Tanzania has implemented micro-planning projects in poorly performing districts as a comprehensive approach to addressing Equity in immunization.

Objective: The study explored the benefits and challenges of the implementation of microplanning in community-based health programs in vaccination services in Tanzania.

Methods: This study employed a qualitative case study. In-depth interviews were used to obtain information from 22 key actors in the micro-planning process at the district, health facility and Community levels.

Results: The study identified benefits of micro planning including engagement of stakeholders from the district to the community level and the creation of a sense of ownership of the Reach Every Child strategy at the community level. The study also revealed barriers to microplanning including delayed disbursement of funds to health facilities and the critical shortage of human resources for health.

Conclusion: the implementation of microplanning at the health facility level has shown evidence of the theory of change indicating the paradigm shift from district dominant planning process to the involvement of local actors.

Keywords: Microplanning, community participation, Immunization services and community health workers, Tanzania.

Introduction

Following the Alma Ata Declaration in 1978 of Health for All by the Year 2000, it was envisaged that the community members could take a leading role in planning their health development issues ("World Health Organization. (1978). Declaration of Alma-Ata.,"). On the contrary, community participation in the planning and management of the provision of health services in many countries including Tanzania has remained minimal. In Tanzania, since the early 1990s, following the fourth generation of health sector reforms, the Government through the Ministry responsible for Health has been reforming the health sector to address several shortfalls including the limited community participation in health planning (Hingora, 1994; Tidemand & Msami, 2010). Generally, the Health Sector Reforms (HSR) focus on addressing challenges that led to inadequacy in the provision of health services to the community.

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The HSR has decentralized the provision of health services to the Local Government Authorities (LGAs). Among others, decentralization aimed to enhance effective community participation in the planning, implementation, monitoring, and evaluation of health services (Ministry of Health and Social Welfare, 2008). Specifically, decentralization of management of health services aimed at motivating and engaging communities in the development of health plans through identification, analysis and prioritization of their local problems and their appropriate solutions. Furthermore, decentralization aimed at empowering the communities in decision-making over their own health needs and control of resources. The decentralization focused on using a bottom-up planning approach through community participating and initiating the health planning process to promote ownership and commitment to solving community health problems for equitable access to health services for all (Ministry of Health and Social Welfare, 2008).

One of the strategies to promote community participation in planning is microplanning. Micro-planning involves defining and identification of clients and how to reach them, how many of them should be targeted for services in the area, and how frequently quality services are provided and are developed by all stakeholders at each level including community members (World Health Organization, 2017).

In 2017 the ministry responsible for health in Tanzania in collaboration with UNICEF implemented the Reach Every Child (REC) micro plan. The REC approach focused on addressing immunization by identifying the unreached children and where they reside – and devising a mechanism for reaching them. The key tool for the implementation of the REC approach is community micro-planning. The latter was developed through an interactive and consultative process with the effective engagement of community members. In this approach, community members are believed to be aware of the obstacles and challenges to immunization equity and coverage. Therefore, it is believed that the community can provide relevant information to inform the micro-plan. This approach uses the REC Microplan tool, which health facility (HF) workers in collaboration with community representatives use to ensure that health plans such as immunization services reach every community. Through community participation, microplanning is applied to identify priority interventions, address barriers, and develop work plans with feasible solutions.

Since 2017, Tanzania has implemented micro-planning projects in poorly performing districts as a comprehensive approach to address Equity in immunization by ensuring that every child is reached for immunization services. Through microplanning, it was planned to develop a comprehensive REC/EQUITY micro plan for addressing Maternal and child intervention that is linked with the community in 15 immunizations' low performing districts. In the Reaching Every Child (REC/EQUITY) strategy, the health facility and surrounding communities have to ensure that there are plans in place whereby all children in a specified community are immunized against vaccine-preventable diseases (UNICEF, 2018). This strategy is in line with the fact that every child has a right to be vaccinated. It is focused on reaching unvaccinated children through immunization services to protect them against preventable diseases in the community. However, since the introduction of this initiative, no lessons were documented. This study was an attempt to fill this gap using a case study of the micro-planning of vaccination services in Geita and Morogoro districts in Tanzania.

Micro-planning with Community linkage framework

This study (paper) follows the micro-planning with a community linkage framework ("World Health Organization. (1978). The framework is based on the fact that improvement of health service provision is dependent on the extent to which the community participates in the process of health planning. For

instance, it is believed that most of the deaths are due to poor health-seeking behavior and poor utilization of health services among community members. The microplanning exercise must follow outlined procedures when identifying priority interventions and communities, addressing barriers, and developing work plans with feasible solutions(UNICEF, 2018). Three groups of people actively participate in microplanning exercise: the facility health workers, community health workers and representatives from the community through health facility governing committees. The health facility workers perform a leading role in the planning process and they form a technical part of the planning team. Community health workers and health facility governing committees bring in the community perspective in the plan. During the implementation, community health workers use a defaulter tracing tool (My Village, My Home) for tracing defaulted children. Once identified, they are required to conduct physical visits in the communities and household levels to ensure that these children receive vaccination services. Furthermore, during the outreach session, CHW mobilizes a community for services in terms of the identification of children that require childcare interventions and women who require maternal care interventions. Following the identification of unvaccinated children, they participate in setting priority actions to be implemented during the subsequent financial year.

Methods

Study design

This was an exploratory qualitative case study that aimed to document lessons following the implementation of microplanning in community-based health programs in vaccination services in two selected districts. Microplanning of vaccination services was studied as a case in understanding how the community is involved in developing and implementing the plans. This design enabled the research team to explore contextual issues regarding micro-planning at the community level. A case study design was found relevant as micro-planning is a complex phenomenon involving social processes (Yin, 2009).

Study context

Tanzania operates a decentralized health care system whereby health services provision is organized in a pyramid of three levels. The three levels are (i) the Primary health care system that comprises the district hospital/s, Council Health Management Team, health centres at the ward level, dispensaries at the village/Street level, and outreach services at the community level. (ii) The secondary level comprises the regional and regional referral hospitals and Regional Health Management Team and (iii) The tertiary level that comprises the Zonal hospitals, specialized hospitals and National hospitals. The Ministry of Health oversees the provision of health services in the whole country. The provision of vaccination services is done at all levels with close supervision at the National level. Importantly, most of the vaccines for children are provided at the postnatal clinics with some outreach services in some places based on resources available and need for such services.

Sampling strategy

This assessment was conducted in Geita District Council (DC) in the Geita region and Morogoro DC in Morogoro region. These councils were purposively selected because they are implementing micro planning at the district and community levels. Geita DC is one of five districts of Geita Region located in the North West part of Tanzania. The district has one district hospital, four (4) health centres and 39 dispensaries. Two facilities that are implementing REC at Geita DC were randomly selected for this assessment. Morogoro DC is one of the seven districts in Morogoro region. Morogoro DC has a total of 391 health facilities (15 hospitals, 42 health centers and 334 dispensaries. In Morogoro DC, two

health facilities were conveniently selected due to geographical proximity and seasonal limitations that made remote facilities inaccessible.

Twelve and ten key informants were purposefully recruited in Geita and Morogoro Districts respectively. These included officers from the district, health facility and community levels dealing with immunization and vaccination. At the district level, participants included the District Medical Officer (DMO), District Reproductive and Child Health Coordinators (DRCHCO), District Health Secretary and District Immunization and Vaccination Officer (DIVO). At the facility level, the In-charge of the health facility and Reproductive and Child Health Coordinator were included in the study, whereas at the community level, CHWs, Village Executive Officer and members of the facility governing committees were included in the study.

Data Collection

Data were collected through key informant interviews and document reviews. The interviews were considered the best method of data collection as they involved one-on-one interaction with key participants from different levels who are well informed about micro-planning at the facility level. Additionally, the interviews were complemented with documents' review, which helped to provide more evidence on how micro-planning is being conducted at the facility level. The guides consisted of broad questions on the implementation process of microplanning while reflecting on its benefits and challenges. The interviews took place in the office of the respective key informant or village offices, which provided adequate privacy. The interviews were audio-recorded and privacy was ensured during the process. Document reviews involved reading the district and facility reports on microplanning to identify achievements and challenges encountered through the use of microplanning.

Data analysis

All audio recorded interviews were transcribed verbatim and translated from Kiswahili into English before analysis. We used a thematic data analysis approach, which applies inductive reasoning. Emerging themes across a sample of transcripts were identified and validated by three researchers before conducting a line-by-line analysis. The use of an inductive approach sought to ensure that the emerging themes were strongly linked to the data, rather than being imposed by the researcher(Attride-Stirling, 2001; Thomas & Harden, 2008). The audio-recorded interviews were transcribed and translated from Kiswahili to English. All transcripts were reviewed by the first, second and third authors to assess validity of the data and become familiar with the data. The first and second author analyzed data manually in three steps: line-by-line coding of transcripts in which emerging concepts were developed; examination and interpretation of codes into descriptive themes; and condensation of descriptive themes into more abstract analytical themes. The third and fourth authors reviewed the generated themes to ensure they reflected what was found from the interviews and were not constructed by the coders. Our study reporting follows the consolidated criteria for reporting qualitative research (COREQ), which recognizes and addresses the importance of the study design, research team, sample size, and analysis and study findings (Tong, Sainsbury, & Craig, 2007).

Ethics and consent

The Muhimbili University of Health and Allied Sciences Institutional Research and Publications Committee granted ethical clearance with reference number ' DA.282/298/01.C/' to conduct the study. Permission to conduct the study was sought from the authorities at the regional, district, ward, village and lower-level health facilities. The research team-maintained confidentiality by gathering data without names or unique identifiers attached to the data or known to the researcher. Each study

participant was informed of his/her right to decline participation outright or to withdraw from the study at any stage of the research without any consequences. All study participants who agreed to participate in the study were requested to sign a consent form before interviewing them.

Findings

A total of 22 key informants were interviewed. Of the 22 interviewed study participants, 10 were aged between 35 and 45 years, and 13 were female. On the other hand, nine of the study participants had a secondary level of education while seven had a primary level of education and six had college/University level of education. Among the interviewed people, five were CHWs whereas four were clinical officers, two were medical officers and four were nurses. Three broader categories illustrating the roles of key actors, benefits and challenges of the implementation of microplanning at the community health system level in Morogoro DC and Geita DC were generated.

The role of key actors in micro planning

This category was attributed to three themes: the role of community level actors, the roles of Health facility level actors and the roles of district level actors.

The role of community level actors

Almost all interviewed study participants at the community, health facility and district levels reported that through CHWs and the representatives of the community in the facility governing committees, the community play important several roles during the development, implementation and monitoring of the health plans at the community level. These roles include participation in the identification of community health needs including communities with unvaccinated children; use of community leaders and CHWs to sensitize and mobilize community to uptake health services, carry out outreach services through CHWs and participate in the actual preparation of micro plans as shown in the following quotes.

> *At the community level, we participate in mobilizing the community members to take their children for vaccines, …but we also take part in carrying outreach services…. The governing committee is also responsible for monitoring the use of drugs and other supplies in our facility and they are very keen on this task (KI-Geita DC)*

Another respondent said

The community has a representative in the facility governing committee who is involved in preparing the community health plans (KI - Morogoro DC).

The role of key actors in micro planning at the health facility level

The findings show that at the facility level, those in-charge of health facilities and other health workers participate in the development of micro plans in several ways. They mentioned the key roles at the facility level to include among others: Provision of Technical Support in the identification of community health needs or problems and priorities; preparation of health plans and budget for the facility and surrounding communities and participation in the implementation and monitoring of the micro-plans as supported by the following quotes.

> *As experts, we are expected to provide technical support when developing micro plans and I think our health workers had been performing good work in this process (KI – Geita DC).*

> *We (health workers) are supposed to be at the forefront in micro planning as we were trained by the district experts on how to do it, so we must provide all the required support to show the way… (KI-Morogoro - DC)*

The role of key actors in micro planning at the district level

It was revealed from the study findings that the district level actors are responsible for the training of lower-level health workers on preparation of micro plans and provision of technical guidance and support to HFGCs & CHWs during the planning process.

> *We are responsible for the training of health workers at the health centres and dispensaries to build their capacity to prepare and implement micro plans in collaboration with community members (KI – Geita DC).*

Furthermore, it was reported that the district level actors play an important supervisory role to ensure that there is the smooth implementation of the community health plans as per developed micro plans. This was remarked on by one of the following study participants:

> *As you know, in each health centre and dispensary there is a patron or matron whose main responsibility is to supervise the implementation of micro plans… and we are required to provide facility reports during the CHMT meetings (KI – Geita DC)*

Benefits of micro planning

In this category, six themes were generated; Microplanning has been a participatory process, it is a process engaging all levels from the district to the community, it Involves multiple stakeholders at the community level, it entails working together for a common goal, it has created a sense of ownership of the REC strategy at the community level, and it has enhanced decentralization of the planning and decision making to the health facility.

Microplanning as a participatory process

Respondents narrated that one of the benefits of conducting micro-planning is that it is a participatory exercise since it brings together and engages different stakeholders in planning. For instance, when the health facility management teams plan, they invite community leaders especially village chairpersons, health facility governing committee chairperson, one member of the facility governing committee and the CHWs affiliated with the respective health facility. Thus, micro-planning engages people from the grassroots level, as they are the ones who know the health needs and priorities of their communities.

> *'..when we plan, nowadays we invite representatives from the communities such as village chairperson, members of the health facility governing committee and also community health workers to be part of the planning team' (KI – Geita DC).*

Micro planning is a process engaging all levels from the district to the community

Respondents reported that health plans prepared under micro planning exercise engage all levels of health care services provision from the community, and dispensary to district level. They added that the planning exercise includes representatives of the community. The exercise starts at the district level whereby CHMT communicates guidelines (priority areas and budget ceiling) to the in-charges of HF.

The priority areas are the same as those used in preparing the Comprehensive Council Health Plans (CCHPs). Micro plan exercises involve respective HF staff, CHMT representatives, members of Health

Management Teams (HMTs), community leaders and teachers from nearby schools. From the analysis based on the reviewed documents and interviewed study participants, the planning team conducted micro-planning at the facility level using a five-stage process. First, the microplanning team identifies the key priority areas to be included in the microplanning; second, the team identifies the health problems facing the communities, third, they analyze the root causes of the problems; fourth, the team identifies the interventions to address the problems and fifth, they identify the actions including the resources required for implementing the identified interventions. It was also reported that the CHMT representatives oversee if the whole planning process conforms to the CCHP guidelines.

> *Each member of the CHMT is given a health facility to be a patron or matron to oversee the health facility and guide it during the exercise of micro planning. CHMT member has the role of providing technical and administrative support to the facility (KI – Geita DC)*

The microplanning team members reported that all health facility plans are presented in CHMT before being fed into local government budget software known as Plan Rep. PlanRep is a planning and reporting database used by Local Government Authorities (LGAs). This software data base is designed to incorporate the Strategic Plan, revenue projection, budgets, money received, and track expenditure of the LGAs. A review of documents indicates that micro-planning is a tool used in Reach Every Child (REC) strategy whereby health workers identify health problems at the HF and its catchment communities as well as possible solutions to address them.

Involvement of multiple stakeholders in the implementation of the micro-plans at the community level

At the implementation level, study respondents reported that implementation of micro plans is now done by multiple stakeholders at the community level. for instance, sensitization on vaccination is not only done by the government or the village leaders and CHWs, it has now extended to other stakeholders including religious leaders who play a key role in sensitizing parents to take their children for immunizations. Religious leaders have been involved in advocacy programs; this has made vaccination campaigns a common community agenda. One of the respondents expressed the following:

> *'We identify all influential people in the community including the religious leaders… so when one goes to church or the mosque or anywhere s/he worships, the language of taking children for vaccination is heard. Such practice has transformed the vaccination agenda to be a community agenda rather than health workers' agenda as it used to be. (KI-Morogoro DC)*

The Micro planning process has created a sense of ownership of the REC strategy at the community level

The involvement of community members in developing health plans for their areas through facility governing committees and participating in implementing them has created a sense of community ownership of the plans. The study findings have shown that in the past period, the communities were not aware of the health plans since they were developed by the higher-level authority including CHMTs without much involvement at the grassroots level. During the implementation of REC strategies including outreach services, it was noted that the village leadership actively participate in mobilizing parents to bring their children for vaccination because they own these plans as they were involved from the beginning in developing them. This was clarified by our study participants:

> *'Microplanning has facilitated the implementation of REC strategies such as immunization of children because communities through their leaders own the plans since they were part and parcel of the team which developed such plans' (KI-Morogoro DC).*

Furthermore, the study participants said that increasing ownership of the health plans, this situation has increased utilization of vaccination services by the communities.

When a priest or any religious leader asks you to visit a health facility to seek health services, you will go because you trust him (KI-Morogoro DC)

Another respondent had this to say:

Nowadays many parents bring their children to outreach services for taking vaccines because vaccination has now become a community agenda (KI-Geita DC).

Microplanning has enhanced decentralization of the planning and decision-making to the health facility and community level.

Before the introduction of microplanning and Direct Health facility Financing (DHFF), the CHMT was responsible for developing health facility plans and incorporating them into Comprehensive Council Health Plan (CCHP) with little contribution from the health facilities. Findings from this study have revealed that microplanning has paved a way for the health facility management team in collaboration Facility governing committee to prepare their plans based on local needs and priorities. This was evidenced by the following information from one of the study participants.

'Community now they know what is going on at the facility because they are involved in the planning and supervision of the implementation of the plans' (KI-Geita DC)

Challenges encountered in implementing the microplanning

Even though micro planning has several benefits, most of the respondents reported that its implementation faces several challenges. These challenges are illustrated in five themes. These include; a lack of training for all health managers on microplanning, delayed disbursement of funds to the health facilities, Seasonal migration of some communities, pressure to use REC funds for other activities and a critical shortage of human resources for health.

Lack of training on micro planning for some health managers

The study findings revealed that not all health managers at district and health facility levels were trained on micro-planning. For instance, some of the interviewed heads of health facilities who oversee the implementation of all activities in the facility were not trained and therefore not aware of micro-planning. In addition, those who were trained did not bring feedback to Health Facility Management Teams and other healthcare workers, making it difficult to have smooth continuity in the implementation of micro planning in case trained members are not present during the micro planning process.

'Generally, we are making all the attempts to develop our health facility plans but we have not been exposed to any training on planning, maybe the training was conducted for those working at the council level… we request to be given a special course on planning so that we can competently develop our plans' (KI-Morogoro DC)

Delayed disbursement of funds to the health facilities

In-charges of the health facilities reported that there is a delay in disbursement of funds from the central government to the health facilities, which delays the implementation of various RMNCH services including immunization. For instance, for health workers to conduct outreach services, they need to have means of transport to reach some of the remote areas. In most cases, they use a motorcycle, which needs fuel and money for maintenance. When funds are delayed, the outreach services cannot be implemented as planned. The health facility in-charges gave an example that according to the annual plans, facilities are supposed to receive funds every quarter, however, they did not receive funds for quarter two (covering October to December 2018) and quarter three (covering January to March 2019) and they were now in quarter four (covering April to June 2019).

Lack of reliability/assurance in receiving funds quarterly disrupts the implementation of all health facility plans including outreach services.

> *The main challenge is delay in reimbursement of funds from the central government to implement the planned activities. This challenge has greatly affected the implementation of the planned REC activities. For instance, we cannot conduct outreach activities if there is no money for covering transport cost as most of the villages where outreach activities are conducted are located far away from the facility (KI- Geita).*

Seasonal migration of some communities

From the interviews, we were informed that, during farming season, most families concentrate on agricultural activities and thus go interior for farming. The latter keep them at a distance from the health facilities and thus set aside little time in seeking health services. Therefore, more education is required to increase awareness and the importance of vaccination as well as the disadvantages of children who are not vaccinated.

> *A few families especially livestock keepers practice nomadic life where they sometimes move from one village to another to seek fresh pastures on which to graze. It is difficult to come up with clear micro plans for such kinds of families regarding vaccinations of their children (KI-Geita DC).*

Pressure to use REC funds for other activities

Interviewed study participants remarked that political will is required for the successful implementation of REC as it can be a facilitating or hindering factor in reaching out to every child. They cited an example where councillors wanted to reallocate funds allocated for REC to finance other activities in the district. Such kind of political pressure may hinder the implementation of REC strategy.

> *The councillors come here and require money designated for REC to be used for their supervision visits to health facilities, it is a challenge…You refuse, they corner you (KI-Moro DC)*

The pressure to use funds for other activities shows that there was low involvement of political leaders in the design and implementation of microplanning. Interviewed CHMT members reported the importance of creating awareness among politicians including councillors about the new interventions such as microplanning for them to support their implementation.

> *'Awareness creation campaign, especially for councilors, is important for them to understand the importance of microplanning and their roles in the planning and implementation of health plans at the community level' (KI-Morogoro DC)*

Critical shortage of human resources for health

Shortage of staff was reported as one of the major challenges facing the implementation of outreach services in some of the health facilities. The interviewed health workers raised a concern that the provision of health services must continue every day regardless of the scheduling of the outreach services in some of the areas. Therefore, because of the few staff allocated to the health facilities, sometimes they fail to divide among themselves so that a few can conduct outreach services and others remain at the facility to continue with service delivery. This challenge is worse in health facilities with 2 to 3 staff. Sometimes they fail to do so especially when some of the staff are preoccupied with other activities including participation in meetings or seminars somewhere else.

> *'Although we have good plans for improving vaccination coverage, in health facilities where there are two to three staff, it is a challenge to conduct outreach services because health services must be provided every day with exception of weekends, they cannot close the facility and go for outreach services' (KI- Geita).*

Discussion

This article explored the benefits and challenges of the implementation of microplanning in two districts of Tanzania. It is important to acknowledge that in the past one-decade microplanning tool has gained popularity in health care services planning including those targeting to address reproductive and maternal health challenges in many parts of the world as it encourages health facilities and surrounding communities to use their local data to identify existing problems and develop micro-plans that will address their problems (ADRA Japan/Nepal, 2015; USAID, 2016; World Health Organization, 2017). The findings of this assessment have revealed that microplanning implementation is organized in five stages, from the identification of the key priority areas, identification of the existing and pressing community health problems, analyzing the root causes of the problems; identification of the potential interventions to address the problems and deciding which priority actions should be implemented to address the problem using the available the resources. This type of organization in community planning is similar to the organization of microplanning implementation as found in other countries like in Uganda (USAID, 2016).

The participatory approach employed by the districts in developing and implementing micro planning as revealed by the findings of this study has evidenced the theory of change, that is the paradigm shift from district dominated planning process to the involvement of local actors such as health facility management teams and community leaders, which in turns gives hope of the likelihood of sustainability of micro planning intervention (Fig 1). For any health intervention to yield impacts, issues related to sustaining the activities of the intervention need to be considered from the early stages of implementation (Sondaal et al., 2019; Walugembe, Sibbald, Le Ber, Kothari, & systems, 2019). Engaging community leaders in the implementation of micro planning as revealed in this study adds to the likelihood of owning the intervention and thus increases chances of performance as revealed in other places (Haldane et al., 2019). Furthermore, evidence from this study has shown that microplanning has enhanced the engagement of different stakeholders not only in planning for local health needs but also during the implementation of outreach services.

Community and religious leaders as well as CHWs have been actively involved in the creation of awareness about the importance of children's immunization, thus helping to mobilize people to reach every child for vaccinations. In Uganda, different stakeholders including civil society organizations were engaged at different points in the process of microplanning including mobilization of resources at the health facility and the provision of routine immunization services, particularly for outreach is effectively done (USAID, 2016).

Related to the use of the participatory approach in developing plans microplanning has proved to be a tool for enhancing decentralization of the planning and decision-making to the health facility and community level. The decisions on what to include in the plans and when the plans will be implemented and the associated budget are now discussed and agreed upon at the facility/community level. As reported in previous studies, in Tanzania, health facilities and the community at the grassroots level had limited power in planning and deciding on health service delivery given the fact that District level authority through Council Health Management teams guided and dominated the whole process of planning (Frumence, Nyamhanga, Mwangu, & Hurtig, 2013).

Lachapelle (2008) reports that a sense of community ownership in development occurs when people have a voice and they can influence decisions over their affairs. In this study, the involvement of community-level stakeholders such as village leaders, CHWs, and religious leaders has shown that the microplanning process created a sense of ownership of the REC strategy at the community level. This implies that when key stakeholders at the community level are involved in the planning and implementation of the local health plans such as children immunization through different strategies including outreach services, the community feels that they own such plans and they are ready to

support and participate in its implementation. A study done in Ghana (Kweku, 2020) on Community-Based Health Planning and Services reported some level of apathy among the community members towards their services, which was largely caused by the fact that the communities did not view such plans as their own as they did not participate in developing them and therefore did not want to participate in implementing them.

Furthermore, in this study, findings showed that micro planning has enabled different stakeholders in the health sector to work together for a common goal and that this spirit of togetherness has contributed to the achievement of REC strategy, especially in the mobilization of parents to vaccinate their children. This is in line with the education microplanning toolkit which states categorically that microplanning is a management tool to enable people to plan together and direct available resources, aspirations and efforts at all levels towards the achievement of common goal (Chang, Huong, Kennedy, & Tsui, 2014). The theory of change resulting from this study (Fig 1) illustrates that all key stakeholders in microplanning from the district to the community level are all working towards achieving the common goal of increasing the utilization of vaccination services by the communities.

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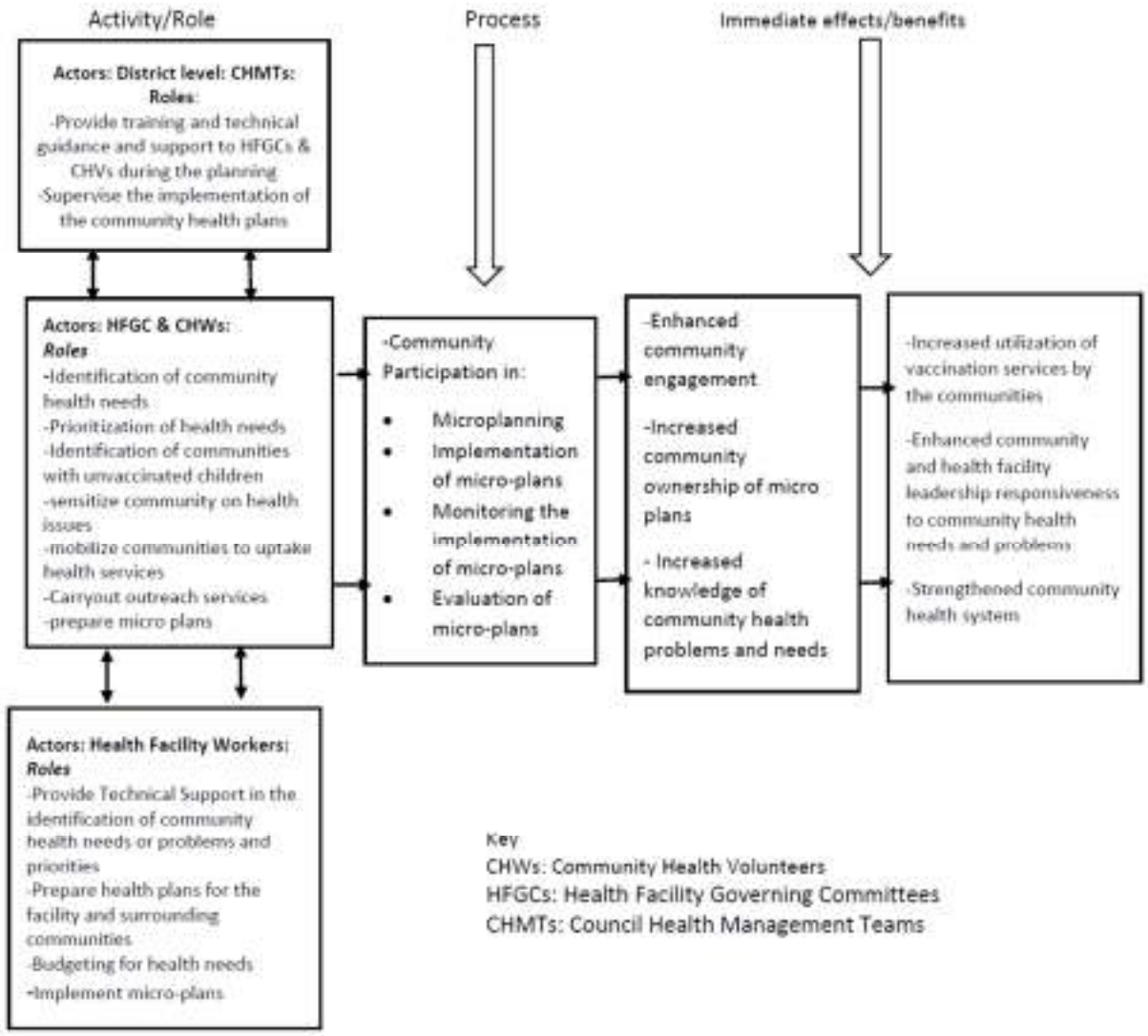

Figure 1. Theory of change for the implementation of community health system micro-plans

Despite the reported benefits of microplanning, this study has revealed several challenges that impede the sustainability of these benefits. Although training on how to use micro planning was done at the district and lower levels, not all district and lower-level health managers were trained. Training all health managers at the district level is important in ensuring that all health managers own the agenda and thus move it together (Knight, Patterson, Dawson, Brown, & Psychology, 2017). Abdul (2015) states that when the organization introduces a new intervention, members who will be responsible for implementing it must be exposed to training that will impart them with new knowledge, skills, and attitudes to enable them successfully implement the intervention. When the employees are not well trained and prepared on how to implement the new intervention, the organization is likely to fail to achieve the desired objectives of the intervention.

As from previous studies done in Tanzania (Berman, 1995; Mæstad, 2006; Sirili, Kiwara, Gasto, Goicolea, & Hurtig, 2017), this study revealed a critical shortage of health workers, which has partly constrained the implementation of microplanning. Furthermore, a critical shortage of health workers

is not unique to Tanzania but rather a regional and global challenge (World Health Organization, 2013). To ensure that micro planning for other health interventions succeed, the shortage of health workers must be addressed by not only recruiting competent and qualified healthcare workers but also ensuring the available health workers are retained.

Political pressure to use REC funds for implementing other activities as revealed in this study is not unique to REC intervention rather it is a cross-cutting challenge that affects many interventions in the districts. The latter is like what was documented in another study by Sirili et al on the retention of doctors, where political leaders were quoted to be a push factor for the doctors to leave the rural districts (Sirili et al., 2018). It is imperative that efforts of improving microplanning implementation also focus on ensuring that political leaders are on the same page of understanding with the other stakeholders involved.

Delayed disbursement of funds to the health facilities as revealed in this study contradicts the fact that the country is now implementing a direct health facility financing strategy where funds are directly taken to the health facilities (Kapologwe et al., 2019). The same challenge is also hindering the implementation of planned health activities at the district level in Tanzania (Frumence, Nyamhanga, Mwangu, & Hurtig, 2014; Frumence et al., 2013). One of the major challenges in the implementation of many health interventions in Tanzania is the termed chronic underfunding of the health sector (Frumence et al., 2013; Ministry of Health and Social Welfare, 2009). Both central and local governments need to address the chronic challenge of inadequate funding and delayed disbursement of funds to create an enabling environment for lower-level plans to be implemented successfully.

Strengths and limitations of the study

The strengths of this study emanate from two major factors. The data collection period was prolonged to allow the research team enough time for reflections between the data collection period and a preliminary analysis that guided the subsequent data collection where necessary, and the peer-debriefing sessions involving a multidisciplinary research team guided the final data analysis.

This study has one main limitation, which is the busy working schedule of the District Medical Officer (DMO), District Reproductive and Child Health Coordinators (DRCHCO) and In-charge of health facilities who were overwhelmed with administrative duties and a large number of patients respectively. However, to ensure that all key informants were interviewed, the research team asked for interview appointments even during weekend days or late hours in the evening. Even though the findings of this study were collected from a limited sample of key informants from two districts, we believe that the insights gained from this study are reflective of other districts which have a poor implementation of REC strategy in Tanzania. This is because the implementation of the REC strategy does not differ between health facilities and LGAs, implying that information generated from our study respondents may represent the benefits and challenges of the implementation of microplanning in the intervention districts.

Conclusions

This assessment has revealed that implementation of micro planning has introduced a paradigm shift as illustrated in the theory of change in which community members are involved in the planning and implementation of REC activities. Although micro-planning is still in its infancy stage, it shows promise of success in improving the Reproductive, Maternal, Newborn, and Child Health services in low-performing districts in Tanzania. However, several reported challenges including shortage of health workers, delayed disbursement of funds and reallocation of REC funds for other activities need to be addressed to ensure smooth implementation of micro planning. It is recommended that the ministry

of health and other stakeholders invest more efforts to build capacity for health workers on the appropriate use of REC microplanning tools to develop sound and comprehensive facility micro-plans.

Competing Interest

The authors declare that they have no competing interests.

Authors' contributions

GF, SN and AM conceived the study. GF and SN participated in the design of the study. GF, SN and LPS participated in the data collection. GF and SN analyzed the data. GF wrote the first draft of the manuscript. SN, LSP, AM and CJ reviewed the manuscript. All authors reviewed and approved the final manuscript.

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