THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH

NATIONAL OPERATIONAL GUIDELINE FOR COMMUNITY-BASED HEALTH SERVICES, 2021

Towards Sustainable Community Health and Social Welfare Services
Leaving No One Behind

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FOREWORD

Community-based health care services has a long history in Tanzania, dating back to the year 1967 where Arusha declaration spearheaded by Hon. Mwalimu Julius K. Nyerere, the first President of the United Republic of Tanzania and furthered through the Alma Atta declaration of 1978. Community health care has been deeply rooted in Tanzania's health system. Over the years, a wide range of community-based health programmes and initiatives have been carried out throughout the country, addressing critical health issues such as maternal, child and neonatal health, HIV and AIDS, Nutrition, Malaria, Tuberculosis and adolescent sexual and reproductive health. Community Based Health Programmes have often lacked sufficient coordination and have been programme-specific, donor-dependent and hence unsustainable.

This Operational Guideline for Community-Based Health Services (CBHS) in line with the CBHS Policy Guideline map an integrated and coordinated national approach to community-based health services in Tanzania. The approach builds on and furthers national priorities for decentralization, community empowerment and strengthened systems for expansion of access to essential health services at the village level and below. The operational guideline provides critical information on the creation of a sustainable Community Health Worker (CHV) cadre. This will help in expanding access to services in communities and serving as a critical bridge between individuals and health care services at all levels.

The development of this document has been done in a participatory and inclusive approach. Technical staff members from both Ministries (MOHCDGEC and PORALG) had a series of meetings where deliverables were presented to respective ministerial forums and finally to all key stakeholders to gather comments and inputs. It clearly articulates procedures for CHV nomination, training, incentive package and the services that CHVs will provide, based on national priority health objectives to ensure that the Tanzanian population has access to essential health care services.

In addition, this guideline provides guidance on CBHS governance, implementation in councils and communities and outlines a clear monitoring and evaluation framework. This operational guideline therefore provides a roadmap for initiating, implementation and sustaining community-based health service delivery in Tanzania. The Tanzanian Government, calls for strong collaboration and effective coordination among all programmes,

development partners and all other stakeholders to facilitate the implementation of the CBHS as a fundamental approach to ensuring high quality and equitable health services to all Tanzanians.

Prof. Abel Makubi
Permanent Secretary

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Specifically the MOHCDGEC wishes to recognize the contributions of programme experts from the Health Promotion Section and Members of the Technical Advisory Committee (TAC).

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Dr. Aifello Sichalwe
Chief Medical Officer

Glossary of Terms

Term	Description
Accreditation	A form of qualification or individual registration awarded by a professional or regulatory organization that confirms an individual or institution as fit to practice.
Advocacy	A combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health programme/initiative (WHO, 1998).
Burden of disease	A measurement of the gap between a population's current health and the optimal state in which people attain full life expectancy without suffering major ill health (WHO, 2006).
Child abuse	A form of physical, sexual or emotional maltreatment or neglect of a child below the age of 18 years (according to the Child Act of 2009).
Child exploitation	The act of using a minor child for profit, labour, sexual gratification, or some other personal or financial advantage
Child neglect	A form of child abuse in which there is deficit in meeting a child's basic needs by a parent, guardian or caregiver, including the failure to provide adequate supervision, health care, clothing or housing, as well as other physical, emotional, social, educational and safety needs
Collaboration	Collaboration is the practice of two or more people working together to achieve a common aim.
Community	A group of people, based on common value and norms, who live within a defined geographic area and share a common language, culture or values
Community Based Health Services	Services provided by people who spend a substantial part of their working time outside a health facility, discharging their services at the individual, family or community level
Community development	A process in which community members come together to take collective action and generate solutions to common problems. Community well-being (economic, social, environmental and cultural) often evolves from this type of collective action taken at a grassroots level. Community development draws on existing human and material resources in the community to enhance self-help and social support and to develop flexible systems for strengthening public participation in and direction of health matters (WHO, 2009). Community development ranges from small initiatives within a small group to large initiatives that involve the broader community. Community development usually involves the use of participatory approaches and methodology.
Community Health Worker	A person providing Health and Social Welfare services outside a health facility, discharging their services at the individual, family or community level

Term	Description
Continuum of care	An integrated system of care that guides and tracks patients over time through a comprehensive array of health services spanning all levels of intensity of care (Evashwick, 1989). A continuum of care is achieved through a combination of well-defined strategies and intervention packages to improve health and social well-being through home- and facility-based services throughout the lifecycle of a health or social welfare issue.
Direct Health Facility Financing	Direct Health Facility Financing is one of the disbursement approaches within the health-financing component of the health system and one of the approaches to facilitate fiscal decentralization. Evolving evidence indicates that DHFF is linked to improvements in efficient use of resources and promoting accountability.
Health	A state of complete physical, spiritual, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1946) In the context of health promotion, health has been considered less as an abstract state and more as a means to an end. In this sense, health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities.
Health behaviour	Any activity undertaken by an individual, regardless of actual or perceived health status, for the purpose of promoting, protecting or maintaining health, whether or not such behaviour is objectively effective towards that end (WHO, 1998).
Health communication	A key strategy to inform the public about health concerns and maintain important health issues on the public agenda. The use of the mass and multimedia and other technological innovations to disseminate useful health information to increase public awareness of specific aspects of individual and collective health, as well as the importance of health in development (WHO, 1998).
Health development	The process of continuous, progressive improvement of the health status of individuals and groups in a population, best achieved through health systems strengthening (WHO, 1998).
Health education	Comprises consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge and developing life skills that are conducive to individual and group health (WHO, 1998).
Health promotion	The process of enabling people to increase control over the determinants of health and thereby improve their health. The goal of health promotion practice is to provide and maintain conditions that make it possible for people to make healthy choices and facilitate environmental conditions that support healthy behaviours. Health promotion represents a comprehensive social

Term	Description
	and political process that embraces actions directed at strengthening the skills and capabilities of individuals and action to change social, environmental and economic conditions and alleviate their impact on public and individual health (WHO, 2005).
Kitongoji	A subdivision of a village in rural areas that forms the lowest level of the local government system in Tanzania.
Mtaa	A subdivision of a ward that forms the lowest level of the Local government system in urban areas in Tanzania. In the local government hierarchy, mtaa (In urban area) is equivalent to a village in a rural area.
Public health	The science of protecting and improving the health of families and communities through promotion of healthy lifestyles, research for disease and injury prevention and detection and control of infectious diseases.
Qualified, skilled and committed community health worker	A person who volunteers to serve as a Community Health Worker and has successfully completed a three-month training programme approved by the Government for provision of health and social welfare services at the community level.
Social determinants of health	The circumstances, in which people are born, grow up, live, work and age and the systems put in place to deal with illness.
Social services	A range of public services provided by the government, private, profit and non-profit organizations. These public services aim to create organizations that are more effective, and build stronger communities and promote equality and opportunity.
Social welfare services	The services designed to promote and ensure the well-being of the vulnerable and marginalized groups.

Abbreviations

ABC	Abstinence, Being faithful, Condom use
AIDS	Acquired Immunodeficiency Syndrome
ALu	Artemether/Lumefantrine
ART	Antiretroviral Therapy
CBHP	Community-Based Health Care Programme
CBHP-ID	Community-Based Health Programme Implementation Design
CBO	Community-Based Organization
CCHP	Council Comprehensive Health Plan
CD	Communicable Disease
CE	Continuing Education
CHA	Community Health Agent
CHMT	Council Health Management Team
CHV	Community Health Worker
COPD	Chronic Obstructive Pulmonary Disease
CTC	Care and Treatment Clinic
CWD	Children with Disabilities
DHIS	District Health Information System
DHFF	Direct Health Facility Financing
DHR	Department of Human Resources
DMO	District Medical Officer
DOTS	Directly Observed Treatment, Short Course
eIDSR	Electronic Integrated Disease Surveillance and Response
FBO	Faith-Based Organization
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPS	Health Promotion Section
HPV	Human Papilloma Viruses
HRHIS	Human Resources for Health Information System
HSSP IV	Health Sector Strategic Plan IV
HTC	HIV Testing and Counselling
HTI	Health Training Institute
ICCM	Integrated Community Case Management
IDSR	International Disease Surveillance and Response
IEC	Information, Education and Communication
IPT	Intermittent Preventive Therapy
IPTP	Intermittent Preventive Therapy in Pregnancy
JD	Job Description
LGA	Local Government Authority
LLIN	Long-Lasting Insecticide-Treated Net
LTF	Lost to Follow-Up
M&E	Monitoring and Evaluation
MA	Medical Attendant

MEO	Mtaa Executive Officer
MDA	Ministries, Departments and Agencies
MDR-TB	Multidrug-Resistant Tuberculosis
MMAM	*Mpango wa Maendeleo wa Afya ya Msingi*
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MRDT	Malaria Rapid Diagnostic Test
MTUHA	*Mfumo wa Taarifa za Uendeshaji Huduma za Afya*
MUAC	Mid-Upper Arm Circumference
MUHAS	Muhimbili University of Health and Allied Sciences
MVC	Most Vulnerable Children
NACS	Nutritional Assessment Counselling and Support
NACTE	National Accreditation Council for Technical Education
NCD	Non-communicable Disease
NEHP	National Essential Health Package
NGO	Non-Governmental Organization
NTD	Neglected Tropical Diseases
ORS	Oral Rehydration Solution
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother-To-Child Transmission
PO-RALG	President's Office – Regional Administration and Local Government
POPSM	President's Office of Public Service Management
PPP	Public–Private Partnership
PSW	Para-Social Worker
QA	Quality Assurance
QI	Quality Improvement
RCH	Reproductive and Child Health
RHMT	Regional Health Management Team
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
SARA	Service Availability and Readiness Assessment
SRHS	Sexual/Reproductive Health Services
TB	Tuberculosis
THBS	Tanzanian Household Budget Survey
TIIS	Training Institutions Information System
TOT	Training of Trainers
TSPA	Tanzanian Service Provision Assessment
USAID	United States Agency for International Development
VAC	Violence Against Children
VEO	Village Executive Officer
VHC	Village Health Committee

VHND	Village Health and Nutrition Day
VMAC	Village Multi-sectoral AIDS Committee
VSSC	Village Social Services Committee
WASH	Water, Sanitation and Hygiene
WCPC	Woman and Child Protection Committee
WDC	Ward Development Committee
WEHO	Ward Environmental Health Officer
WEO	Ward Executive Officer
WHO	World Health Organization
WMAC	Ward Multi-sectoral AIDS Committee
SWASH	School Water Sanitation and Hygiene

EXECUTIVE SUMMARY

One of the key approaches to achieving universal health coverage is the effective use of Community Health Volunteers (CHVs), to increase linkages and household-level access to high-quality health services. In Tanzania, the MOHCDGEC is committed to formalizing the CHV cadre. Although there are several CHV initiatives in place, most of these focus on a selective area of health in the community and are donor dependent. This calls for a standardized and generic CHV approach that will be useful in all communities and taking into consideration cultural and socioeconomic diversity across the country. The kind of CHV addressed through this guideline is driven by insights gained from several community-based initiatives implemented in Tanzania. This operational guideline therefore provides guidance on how best Tanzania can implement a successful and sustainable CBHS in general and services in particular by setting grounds on how to identify, select and train CHVs, service delivery package mode of service delivery, job description and scope of work,, supportive supervision and monitoring and evaluation (M & E).

The National Operational Guideline for Community-Based Health Services is an updated version of the formerly Community-Based Health Programme Implementation Design (CBHP-ID) which was developed to build on the National CBHP Policy Guidelines (2014) developed by the MOHCDGEC. The main addition in these guidelines that distinguishes it from the former is the significant review of CHVs training modality, deployment, supervision, motivation and incentives.

There shall be at least one CHV in each Kitongoji and one CHV Supervisor at the village level. The nomination process shall start with the VEO/MEO advertising the vacant positions and applicants will be screened and nominated through community involvement and participation. The CHVs will be trained using the approved national training package and certified to serve as CHVs. They will work on voluntary basis but will be eligible for financial and non-financial incentives.

The CBHP service package consists of activities derived from the National Essential Health Interventions Package (NEHIP) organized according to health promotion services, preventive services and rehabilitative services. These activities constitute a minimum service package, responsive to the common health problems at the community level. They cover the major NEHIP service categories, such as reproductive, maternal, neonatal, child and adolescent health (RMNCAH); HIV and AIDS; malaria; TB

and leprosy; and neglected tropical diseases (NTDs) and Social welfare services.

The MOHCDGEC shall bear full responsibility for overall strategic direction and policy, as well as laws, regulations, rules relating to CBHS implementation and provision of technical support during implementation. In the context of decentralization, the President's Office, Regional Administration and Local Government (PO-RALG) shall be responsible for overseeing implementation of these strategies at the Local Government Authority (LGA) level and for integration into the region and district plans. The CBHS shall be managed by the Health Promotion Section (HPS) in close collaboration with other departments and programmes within the MOHCDGEC and Local Government (PORALG). The CBHS operational guideline has defined the role and responsibilities for implementation of CBHS at all levels.

Each region and council shall have a Health Promotion Coordinator (HPC) who will be responsible in overseeing CBHS. To ensure effective implementation of the CBHS, the CHMT shall incorporate and manage it within the existing administrative system, with necessary adjustments.

The CHVs will engage, network, collaborate and cooperate with other players to identify entry points at the community level. CHVs shall apply participatory planning approaches in providing CBH Services guided by the defined service package.

The Monitoring and Evaluation (M&E) system will operate using a bottom-up/top-down participatory approach (bottom-up for reporting and feedback purposes and top-down for feedback). It will involve capturing community-level data that is generated through CBHS activities to be analysed, discussed and used to inform community-, ward- and district-level community health work plans, progress, challenges and reviews. Data collection tools and reporting and management processes have been designed to integrate with existing information systems that are already in use, such as the health management information system (HMIS) and DHIS-2.

1.0: INTRODUCTION

1.1. Background:

Tanzania has made impressive gains in health development, as witnessed in reduced child and infant mortality, reduced stunting, reduction in HIV prevalence and modest declines in maternal and neonatal mortality. However, there is also an upsurge of emerging and re-emerging health issues including disease outbreaks and non-communicable diseases (NCDs). The country is facing a demographic transition with rapid population growth, urbanization and all these need to be taken into consideration when planning for health services delivery. In addition, there is a limitation with regard per capita financing of health services, leading to limited, and in many cases inequitable, access to health and social welfare services.

Despite the increase in the coverage of health services, few Tanzanians, specifically those in rural areas, have limited access to health services. This is due to social determinants of health, such as low income and education levels, unhealthy practices and critical shortages of human resources for health, particularly at the primary health care (PHC) level. Addressing these determinants is difficult without community involvement and participation. It is for this reason that the contribution of CHVs is increasingly being recognized as essential to expand access and provide essential health services. Experiences from various community-based initiatives in the country has informed the revision of both the Policy and Operational Guidelines in order to increase sustainable community involvement, participation and ownership.

The CBHS shall therefore respond to these barriers by empowering communities to understand and demand their rights to health services and facilitated linkages to the health facilities. Experiences from Tanzania and elsewhere have demonstrated that trained and supported CHVs are effective in providing essential health services at the household and at the community level.

This Operational Guideline provides updated information and guidance needed for implementation of the community-based health services. It operationalizes the Policy Guideline for Community-Based Health Services (2020), which has been updated to be in line with the National Health Policy (2020). It introduces operationalization of volunteer CHVs; increase community involvement, participation and ownership; and integrates social welfare services in community-based services. For other

Community based services like physiotherapy, nursing care, rehabilitation services just to mention a few, specific standard operational procedures shall be developed to complement this guideline when need arises. Thus, this Operational Guideline replaces the National Community-Based Health Programme – Implementation Design (CBHP-ID) 2017.

This guideline provide essential information needed to guide all stakeholders responsible for overseeing, facilitating, managing and implementing community health interventions at all levels to ensure consistency, adherence to standards, quality and sustainability.

1.2. Vision and Mission of the CBHS Policy Guideline:

The vision and mission of Policy Guidelines for community-based health care services is:

Vision: To have 'communities with improved health and social well-being that contribute to socioeconomic development of individuals, families, their communities and the nation',

Mission: To 'empower communities and build capacity through sustainable and gender-sensitive community-based health services that respond to health needs'.

1.3. Objectives of the CBHS Operational Guideline

In order to realize the vision and mission of the CBHS policy guidelines, the objectives of the Operational guideline are as follows:

1. To specify procedures for identification, nomination, selection, training and motivation of CHVs to deliver community based health services.
2. To elaborate the integrated service delivery package for Community Health Volunteer and health professionals working at the community and procedures for enhancing integration of the into all levels of the health systems.
3. To describe the community systems and governance structures for smooth operationalization of Community Based Health Services.
4. To elaborate enabling environments and mechanisms for increasing community participation, ownership and sustainability of CBHS.
5. To outline the procedures for monitoring and evaluating community health services.

1.4. Guiding Principles:

In line with the National Health Policy, the following principles will be respected during the implementation of the CBHP as elaborated in the programme policy and operational guidelines:

1. **Community participation and ownership:** Effectiveness and sustainability of the CBHS will be enhanced through Community participation and involvement in all stages from nomination of CHVs, service delivery, monitoring and evaluation of community and social welfare activities.

2. **Complementarity** of roles between CHVs and multilevel partnerships will help in optimizing resources to ensure optimum working environment for service provision.

3. **Social inclusion of vulnerable and special groups:** Concrete and deliberate way to address equity aspects and access with regard to gender, religion, ethnicity, equality, poverty and other social characteristics, for groups that face the risk of marginalization.

4. **Continuum of care;** integrated system of care shall be provided to guides and tracks patients over time through a comprehensive array of health services spanning all levels of intensity of care.

5. **Integration:** CBHS shall assure an optimal combination of service packages that benefits clients and providers in terms of efficiency and synergistic effects through better coordination.

6. **Evidence-based approach:** CBHS planning and implementation shall be guided by reliable and evidence-based data.

7. **Transparency and accountability:** CBHS planning and implementation shall follow all aspects of good governance; accountability and transparency

8. **Sustainability** of the CBHS shall be attained through the participation of stakeholders and communities and pooling of resources under the framework of the local government system as well as optimizing innovations.

9. **Confidentiality:** Maintaining client information and ensuring only authorized person/institution has access to the information. A service provider must also seek a client's consent before discussing or sharing any information with other people.

1.5. The CBHS's Specific Contributions to Health Policy Objectives

The CBHS has been developed to implement the objectives of the Policy Guideline of community-based health Services that contribute to the objectives of the National Health Policy as follows:

1. Introduction of volunteer CHVs trained with approved standardized training packages and coordinated within existing structures to deliver high-quality community-based health care services will facilitate attainment of universally accessible and sustainable PHC services and strengthen community participation in health development.

2. Use of existing community systems and structures for resource mobilization, management and accountability will support proper utilization of domestic and external resources for health services.

3. Implementation of the CBHS service package shall contribute directly to the reduction of disease burden, improved nutrition outcomes, better control of communicable diseases (CDs) and NCDs, improved coverage of Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCAH) and social welfare services including effective responses to gender-based violence (GBV), violence against children (VAC) and services to elderly and people with disabilities.

4. Strengthening the capacity of systems and structures for delivery and coordination of CBH services at all levels and use of participatory approaches by communities shall ensure standardization of human resources, training, service delivery, supportive supervision and M&E of health services.

5. Strengthening of community participation, involvement and ownership, allocation of adequate resources, public–private partnership (PPP) and prioritization of CBH services in CCHP will enhance integration and sustainability of community-based health care services.

6. Inter-sectoral collaboration to address crosscutting issues will ensure integration of gender, human rights and services for people with disabilities, elderly and other vulnerable groups into CBH services.

1.6. Key components of community based health policy guidelines.

Success of the CBHS depends on clearly defined operational procedures. The guideline has six main implementation components derived from specified guideline objectives. To operationalize Community-Based Health Services as stated in the policy guidelines of 2020; proper elaboration and implementation framework is needed. The main key components in this implementation guideline are illustrated in figure 1 and each component is described in sections 2 through 6 of this document.

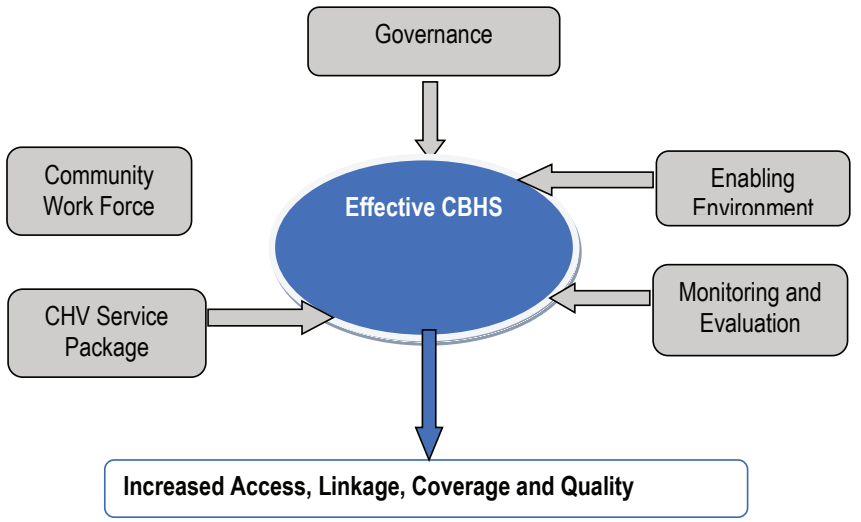

Figure 1: Components of CBHS Operational Guidelines

2.0. COMMUNITY HEALTH SERVICES WORKFORCE

The CBHS workforce encompasses all key players across the different levels of the health system. This section covers essential human resource development and management for the workforce that shall deliver the health and social welfare services at the community level. The target is those who will be entrusted to deliver the community-based health care service package. These human resources at community level have been identified by different names over time and in different settings such as village health workers (VHW), community health agents (CHA), Village Health Volunteers (VHV) or community health volunteers (CHV) and Community Case Workers (CCWs). Based on this guideline, the community health volunteers, male or female, providing community-based health and social welfare services at the community level will be called Community Health Volunteer (CHVs) or Wahudumu wa Afya-Jamii (WAJA) wa Kujitolea in Kiswahili language. All existing cadres of CHVs have the opportunity to be included in the CBHS as long as they meet the criteria for selection and are selected by their communities to play that role. The CHVs will be defined into two groups (Licenced Community Health Professional and None Licenced CHVs)

There shall be at least one CHV in each Kitongoji and 2 in each Mtaa. In addition, there shall be one CHV Supervisor at the village level nominated by the village government.

Where there are licenced Health professionals residing in the village, and who are willing to provide community health services on voluntary basis, they can be certified to perform specific roles as approved by the in-charge of a nearby health facility and the respective council. These are professional health personnel registered by their Councils, willing and have met all the criteria to work in the community.

The following sections describe how CHVs will be nominated (identified, screened, interviewed and selected), trained and motivated.

2.1. Community Health Volunteer Nomination:

The CHVs shall originate and be based in the community they serve. Table 1 shows the minimum qualifications for candidates to be nominated as CHVs.

Table 1: Minimum Criteria for Nomination of CHVs (Shall include but not limited to).
Community Health Volunteer • Readiness to do volunteer work • Must be a resident and currently residing in the *Kitongoji* for at least 3 years • Must have completed at least primary school education, including being able to read and write • Must be familiar with local language, culture and social norms • Must be morally and culturally well accepted by the community • Must have no record of child abuse, mistreatment or any other unlawful conducts • Must be committed, hardworking and with a passion to serve the community • Must be trustworthy and able to keep client information confidential • Priority must be given to those experienced in community-based health and social welfare services. **Licenced Health Professional** • Readiness to do volunteer work • Must be a resident and currently residing in the *Kitongoji* for at least 3 years • Must be morally and culturally well accepted by the community • Must have no record of child abuse, mistreatment or any other unlawful conducts • Must be committed, hardworking and with a passion to serve the community • Must be trustworthy and able to keep client information confidential

The nomination process shall start with orientation session at different levels including RS (RHMTs), LGA (CHMTs), Ward (WEOs), Village/Mtaa (VEO/MEO) and Health Facility (In-charge). The orientation session shall focus on mode of advertisement, identification, shortlisting and approval of the eligible candidates who meet the required criteria. In addition, the session shall take on board details on Operational Guideline, Coordination structure and role of each level in nomination and operationalization of CBHSW Services through CHVs.

Thereafter, the VEO/MEO shall advertise the vacant CHV positions through notices posted in public places (village government office, health facility, school, market places). In addition, the Kitongoji chairpersons shall announce the vacancies by word of mouth and encourage suitable candidates to apply. In urban areas, the chairperson of the local government - Mtaa and their assistants (Wajumbe) will play these roles. All existing community volunteers including CCWs shall have an opportunity to apply and be included in the nomination process if they meet the criteria. A deadline of at least two weeks shall be given for all applications to be received by the VEO or MEO known as Afisa Mtendaji..

The VEO/MEO shall submit the names to the Village/Mtaa Social Services Committee (VSSC) for deliberation and recommending the proposed candidates to the Village Council. The Village Council is given the

mandate to nominate the selected candidates presented to the Village/ Mtaa Assembly. In order to improve efficiency, the Village/Mtaa Council may delegate its role to the VSSC. In that case, the VSSC shall approve the nomination on behalf of the Village/Mtaa Council in lieu of convening a village assembly.

2.2. CHVs Screening and Selection

Within one week after the application deadline, the Village/Mtaa Executive Officers (VEO/MEO) shall pass the names of the applicants to the Village Health Committee (VHC) for initial screening and short listing of qualified applicants. The VEO/MEO shall invite the chairpersons/Wajumbe of each Kitongoji/Mtaa in the village/Mtaa to participate in the VHC meetings to observe and contribute to the screening and shortlisting process. The VHC or Mtaa Health Committee (MHC) shall display the shortlisted names in public in all Kitongoji/Mtaa for 7 days before final approval in presence of Health facility Governing Committee for endorsement. Selection will be done by voting and taking the majority members rule.

2.3. CHVs Training and Certification:

Following nomination, the CHVs will be trained on community-based health and social welfare services. The CHVs will be trained using on-the-job training and mentorship approach as elaborated in Table 2. Only CHVs trained using the approved national training package and certified can serve as CHVs. Training will be conducted by national trainers..

Table 1: Training Approach

- To ensure quality, a three-month CHV training programme based on the approved standard training package developed by the Ministry of Health, Community Development, Gender, Elderly and Children will be given in three blocks of one month (30 days) each.
- On the job training, mentoring and coaching will be conducted using national facilitators.
- Up to 30% of the training can be done online using m-health when facilitators are convinced that selected CHVs have facilities to allow online training and acquisition of knowledge and skills can be assessed.
- The MoHCDGEC will give certificate of attendance after each training block and later on final certificate after completion of Six Modules, which are elaborated in this chapter. Practice of certain services will only be allowed to certify CHVs who are listed in the national CHV database.
- Short courses and updates given by specific programmes will be recorded in a pocket booklet provided to the CHV and should be signed by trainers.
- To ensure quality of trainings of CHV, the MoHCDGEC in collaboration with the PO-RALG will coordinate all trainings done at Regional and Local Government authority. Coordinators shall ensure that training is conducted to the appropriate participants using the appropriate methods and contents.

CHV training package is described under section 3.4, the facilitators and participants' course material has been developed by the MoHCDGEC to facilitate training.

2.4. Training package for CHVs and Licensed Community health professionals

The Government has developed a standardized training package for CHVs that will ensure delivery of integrated health and social welfare services at community level. The CHV Training Package is organized in seven modules that are in line with the Integrated Community-Based Service Package through module 1 to 7.

Licenced community health care providers will receive training packages outlined for CHV and will be trained on basic curative service based on their qualifications to enable them to perform such as provision basic curative services. Therefore, they will be taken through module 7. The modules will be updated by the MoHCDGEC as required. Currently are outlined as follows.

2.4.1 MODULE 1 – Basics of Health Promotion for Community Health Volunteer:

This module has six sub-modules: (a) Planning for health promotion at community level; (b) Familiarizing with the health needs and problems of a community; (c) Tools used in communicating community health information; (d) Promoting social and behavioural change communication at community level; (e) Providing good customer services to clients; (f) Promoting quality assurance in health service delivery. Upon completion of this module, participants are expected to be able to influence the community behaviour change towards health promotion and in particular the CHVs shall be able to plan for health promotion services at community level, elicit the health needs and problems of a community, select appropriate tools for communicating community health information and apply concepts of M&E in carrying out community health services.

2.4.2 MODULE 2 – Reproductive, Maternal, New-Born, Child and Adolescent Health:

This is a stand-alone module for RMNCAH and has five sub-modules that address essential health needs and problems of men and women at reproductive age, new-borns, children and adolescents. The sub-modules including promoting appropriate use of reproductive and maternal, new-born, child and adolescent health services and family planning services.

Upon completion of this module, participants are expected to apply concepts of reproductive, maternal, new-born, child and adolescent health in promoting health in the community as per country context.

2.4.3 MODULE 3 – Prevention and Control of Communicable Diseases:
This module equips the CHVs with ability to apply concepts of providing preventive and control measures of communicable and related health conditions. After completing this module, the CHV shall be able to do the following:

- Understands concepts of communicable diseases and apply appropriate health promotion principles for preventions of diseases of public health importance. These diseases includes Human Immunodeficiency Virus (HIV) /AIDS; Malaria; Tuberculosis and Leprosy; Neglected Tropical Diseases; Priority notifiable CDs including outbreaks;
- Apply and promote appropriate preventive measures of environmental health, water, hygiene and sanitation to control of CDs.

2.4.4 MODULE 4 – Prevention and Control of Non-Communicable Diseases:
This module comprises sections that address essential needs and problems of the community for prevention and control measures of NCDs in the community. The CHV will be able to apply fundamental concepts of prevention and control of eye, oral and dental conditions, diet-related NCDs, physical injuries and trauma in a community.

2.4.5 MODULE 5 – Prevention and Control of Malnutrition in a Community:
This module has several units that address essential needs and problems of the community with regard to measures to prevent and control malnutrition in the community. Upon completion of this module, CHVs shall be able to do the following:

- Promote maternal, infant, young child and adolescent nutrition in a community;
- Use the 1000 days kit in preventing childhood stunting and reducing maternal anaemia;
- Apply concepts of Integrated Management of Acute Malnutrition in managing acute malnutrition in a community;
- Promote nutrition to people subjected to vulnerable circumstances
- Promote appropriate dietary intake and physical exercises for better health of the community.

2.4.6 MODULE 6 – Fundamentals of Social Welfare Practice for Community Health Volunteer:

This is a standalone module comprising of ten sub modules namely, (a) Foundation of Childs Rights, Child Protection and GBV, (b) Roles and Responsibilities of Community Health Volunteer in Case Management, (c) Identification, Registration and Management of Case Progress, (d) Assessment Practices, (e) Developing a Care Plan (f) Providing Support and Services, (g) Provision of Referrals and Follow-Up to the MVC, (h) Closure of Service Case, (i) Working with Adolescents and Elderly, (j) and Working with Persons with disabilities, and (k) Facing Challenges. Upon completion of this module, participants are expected to be able to explain concepts of child's rights, protection and gender based violence; describe the national integrated case management system; manage gender based violence; conduct assessment to children with needs; provide care and support to identified cases; provide adolescent-friendly health services, and overcome challenges that might face CHVs.

2.4.7 Module 7: Basic Curative Services:

This is a standalone module for licenced health professional. It comprises skills for provision of basic curative services mainly Community Integrated Management of Childhood Illness (cIMC)), these services include assessment, classification of disease and provision of appropriate basic treatment referral. Conditions may include Pneumonia with Amoxicillin DT, Malaria with use of mRDT and ACT, Diarrhoea with use of ORS and Zinc, Rapid HIV tests, Screen for severe acute malnutrition using MUAC and keep record that should be submitted to the nearby health facility.

2.5. CHV's incentives and motivation

CHVs shall serve their communities on a voluntary basis and shall enter into a binding volunteer agreement with the Village/Mtaa to serve the said community for at least five years. In order to sustain the volunteer spirit and to recognize their efforts, the CHVs will be eligible to be provided with performance-based financial and non-financial incentives or in kind payment/exemption from duties that are deemed necessary by the community whenever possible. Various forms of incentives are encouraged, and they can be national planned incentive approaches or locally designated which should be coordinated by the Government.

The MOHCDGEC and PO-RALG have devised national workforce volunteer's guidelines 2021, to guide volunteers' financial incentives package, which includes:

a) A basic stipend that will be provided to all CHVs based on availability of funds, this guidelines will be used in setting payment standards.
b) In addition, a performance-based payment that incorporates CHV performance against agreed indicators, targets will be devised. Performance indicators and targets should be reviewed periodically and adjusted as needed, as CHV service package and responsibilities change. In order to be objective, only performance indicators derived from community-based and facility data included in the DHIS-2 and community Score Card that are influenced by the work of CHVs will be used to measure CHV performance.
c) Non-financial Incentives
There will be non-financial incentives to motivate the CHVs following their good performance. These may include but not limited to: Provision of iCHF membership, Exemptions for some community activities, letters/certificates of appreciation for good performance and others according to local contexts.

To avoid double standards on CHVs incentives, the MOHCDGEC shall coordinate a review and standardize CHVs incentives if need arise. CHVs will receive similar financial incentives or performance-based incentives measured by the same metrics or indicators according to their scope of practice.

Any financial incentives intended for CHVs provided by the LGA or partners must be channelled through Direct Health Facility Financing (DHFF) or through Government system. Direct Health Facility Financing is one of the disbursement approaches within the health-financing component of the health system that facilitate fiscal decentralization. Direct Health Facility Financing represents a payment and disbursement mechanism where mobilized funds are disbursed directly to the health facility from any funding source or the government treasury without going through any other channel. The objective is to improve efficiency, accountability, transparency, and autonomy and service delivery while also adhering to the financial guidelines, regulations, and laws. At this point, DHFF is envisaged to set a foundation and platform for resource mobilization, utilization, and accountability for committed resources at the PHC facility level. As part of the DHFF implementation arrangement, the facility is required to prepare a budget and plan that undergoes rigorous scrutiny. Once responsible authorities approve the plan, in this case the HFGC, spending by facilities will not be subject to pre-approval by the District

Council. There is a requisite for a certain level of approval for the set financial threshold by the District Executive Director (DED). As part of financial accountability and compliance mechanisms, all PHC facilities will be subject to audits by the Internal Auditor General (IAG) and the National Audit Office as per Public Act Number 11 of 2008.

The Village/Mtaa social services committee of the Village/Mtaa where the CHV is working will decide provision of non - financial incentives to any CHV by the Village/Mtaa.

3.0: SERVICE PACKAGE FOR COMMUNITY HEALTH VOLUNTEER

3.1: CHV'S SERVICE PACKAGE

The service package describes tasks to be carried out by the CHVs as part of their routine activities. The service package has been developed based on the training package to ensure that CHVs have knowledge, skills and capacity to provide the specified services. These services shall be provided by CHVs as per need and priority as they are often the first point of contact for the community and provide the linkage to the health system to ensure the continuum of care. These services cover the following areas (Table 3):

Table 1: CHV Service Package

Health Promotion ● Health needs and problems of a community ● Health communication ● Social and behaviour change communication ● School health interventions ● Promotion through IEC and Audio visual materials **Health promotion and demand creation for health services on the following areas** ● **RMNCAH** Reproductive health and family planning ● Environmental Health, Water Hygiene and Sanitation ● Maternal health (ANC, labour, delivery and postnatal care) ● New-born care ● Child health ● Adolescent health **Nutrition** ● Maternal, infant, young child and adolescent nutrition ● Childhood stunting and reducing maternal anaemia ● Severe acute malnutrition (SAM) ● Nutrition for vulnerable individuals and groups	**Communicable Diseases** ● HIV and AIDS ● Malaria ● TB and leprosy ● NTDs ● Emerging and re-emerging diseases ● Epidemic and notifiable diseases **NCDs** Mental health disorders Emerging diseases and outbreaks Physical injury and trauma Oral health Eye care **Social welfare services, including:** ● Gender-based violence (GBV) and violence against children (VAC) ● Gender mainstreaming ● Child protection ● Vulnerable populations such as extremely poor families and people with disabilities ● Health and welfare of the elderly ● Most vulnerable children **Basic Curative Services:** *To be carried out by licenced and registered health professionals willing and recognised to work in the community. In critical condition where access to the health facility is inevitable accredited and licenced community health professionals' in additional to other community tasks they will be allowed to perform basic curative services as outlined here. • Integrated Community Case Management (iCCM Assess, classify and provide treatment for:

	• *Pneumonia* – Amoxicillin DT • *Malaria* – mRDT and ACT • *Diarrhoea* – ORS and Zinc • *Rapid HIV tests and refer to CTC* and; • Screen for severe acute malnutrition using MUAC.

The services provided by the CHVs respond to most of the public health needs of the communities in Tanzania and follow a sequence from promotion through disease prevention and rehabilitation to palliative care. Annexure 1 provides a detailed description of the service package.

3.2. CHVs Mode of Service delivery

CHVs will deliver interventions specified in the integrated community-based service delivery package through various modalities including household visits, community gatherings, special planned meetings, Village/Mtaa health days, Village/Mtaa health nutrition days and during national campaigns. The mode of delivery may differ depending on rural or urban setting, availability of transport, communication and other resources. Since communities are empowered to address health and social welfare issues in their localities, mode of delivery of services will be a result of the participatory' planning, implementation and local financing of community-based health care needs to address issues of high priority in their area.

Although households and communities shall be the focus of service delivery by CHVs, close linkage with health facilities will be needed to ensure the continuum of care from community to health facility and vice versa. This will be achieved through having one CHVs supervisor to be a member of Health Facility Governing Committee (HFGC). In addition, the health facility will provide space and forum for CHVs in a particular village or villages served by the facility to meet on a monthly basis and exchange information, experience and solutions to challenges observed in their work. In addition, the health facilities will provide an opportunity for the CHVs and village leaders to share technical and administrative updates and instructions. In addition, these monthly meetings will serve as avenues for providing refresher training and feedback on performance.

In order to extend their reach and address specific challenges, CHVs in each Kitongoji shall establish, orient and support peer groups to address health related issues in the area including RMHCAH, multisectoral nutrition issues, HIV and AIDS, adolescent health and youth matters and issues of

the disabled or elderly. The mode of service delivery will be organized as follows (Table 4):

Table 4: Model of Service Delivery

- *Kitongoji/Mtaa* will be the focus of community-based service delivery.
- VEO will be the administrative supervisor.
- Health facilities will provide technical support in collaboration with certified licenced health professional in the village
- In villages without Health Facilities, CHVs will receive technical support from health facilities located in the nearby villages
- There will be at least one CHV for each *Kitongoji/Mtaa*
- Each CHV will formulate peer groups to support his/her functions at the *Kitongoji/Mtaa*. *These may include the following*:
    1) MNCH matters *(members consisting of adult females and males)*
    2) Nutrition matters *(members consisting of adult males and females)*
    3) Adolescent and youth matters *(members consisting of youths)*
    4) Chronic diseases and conditions *(members consisting of formerly and or currently affected people - PLHIV, PLWD, TB and HBC)*
    5) Matters including GBV, VAC, orphans and destitute *(members consisting of adults and youth)*
- Each peer group will have 3 to 5 members, all on volunteer basis.
- CHVs will work from a stationed location (VEO's Office) and in gatherings, except in some specific cases where they will conduct home visits.
- Peer groups will conduct home visits and participate in other community work while being supervised by CHVs.

3.3 CHV Job description and Scope of Practice

3.3.1 Job description

The CHV job description (JDs) will be developed by the MoHCDGEC to show the roles and responsibilities of the CHVs. The roles will reflect the multiple health and social welfare needs of the community. The JDs will be matched with the competencies from the CHVS training modules, the CHV service package and experience of people working with the CHVs, amongst other activities, CHVs shall

- Mobilize, motivate and organize communities to participate in CBHS activities;
- Determine eligibility and enrol individuals in health insurance plans;
- Create connections between vulnerable populations and make linkage to health care system;
- Collect data and relay information to stakeholders to inform programs and policies;
- Provide informal counselling, health screenings, and referrals;
- Build community capacity to address health issues;
- Address social determinants of health;
- Educate healthcare providers and stakeholders about community

health needs;
- Provide culturally appropriate health education on topics related to chronic disease prevention, physical activity, and nutrition;
- Advocate for underserved individuals or communities to receive services and resources to address health needs;
- Interpersonal and relationship-building; and
- Outreach and iCHF enrolment.

3.3.2 Scope of Practice:

CHVs will be required to respect village bylaws and conditions governing health practices specified by the Government. The conditions shall bind the CHV to a confidentiality and privacy and shall specify the terms and conditions for the volunteer services, job description, reporting arrangements and scope of practice. On the other hand, the community, who are the recipients of the services, will have provided informed consent by approving their nomination in formal meetings of the Kitongoji or village. However, an individual or household may opt out from the service provided by CHVs as long as it does not affect the public health of the community at large.

Tanzania has a long-standing experience in licensing or certifying professionals, but there are unique considerations when creating a system for regulating CHVs. This is because they are volunteers, not belonging to a specific cadre, performing a variety of roles in a range of settings and they come from diverse educational and experiential backgrounds. In most cases, CHVs are chosen because of their connection with communities. In fact, CHVs and other stakeholders in the field have recognized that the primary source of a CHV's expertise and therefore the most essential CHV quality is the CHV's "connection to the community served". The same assets, which make someone particularly well suited to be a CHV may also create barriers to achieving certification or licensure. For example, differently defined by-laws and training levels may make certification or licensure itself difficult. Both nomination and education need to be provided in formats that are easily available and understandable to all types of adult learners. Although this demonstrates the need for the community members to include CHVs in the process of creating a training or certification system, these considerations make core competency attainment impracticable. An additional issue to consider in developing certification processes is that some of the most qualified CHVs may have non-traditional backgrounds.

One way to navigate this challenge is to allow local communities/villages to use by-laws rather than implementing blanket requirements or policies from the national level because there may be more room for flexibility and individuation based on the needs of the population served. Thus, in this approach to ensure CHVs practice stays within their scope of practice and attain high-quality service provision, the following shall apply (Table 4):

Table 5: Regulation of CHVs Practice

- Existing local village by-laws and other government regulations will be applied to regulate CHV conducts, However, the MOHCDGEC will develop a guide to support specific villages to regulate CHV practices if need arises.
- The MOHCDGEC shall develop working modalities of CHV and Voluntary community health professional to guide decision-making at all levels.

3.4. CHV Identity and Working Tools:

The CHVs certified by the MOHCDGEC will be provided with unique uniforms and working tools (See Box 3) to facilitate their recognition in the community. Experience from neighbouring countries as well as from many community health initiatives in Tanzania and other countries show that CHVs are identified by the project-specific dressing codes, particularly T-shirts. The MOHCDGEC has designed a standard CHV uniform for easy of recognition, promoting ownership and respect within and outside the community. The selected uniform is of blue colour with reflectors a unisex sleeveless jacket bearing the Government and Health Promotion Services branded logos. In addition, CHVs will be provided with a volunteer ID card, which will have the following information:

- Government logo
- First, second and surname of the CHV
- Name of the Kitongoji and Village in which they work
- CHV number linked to the National or Voting or Driving ID number of the holder (in lieu of photo)
- Date of issue (and date of expiry); and
- a unique CHV number
- Signature of ID issuer of the respective council

For the CHVs to perform their roles as expected, a standardized list of minimum essential working tools and equipment shall be provided. The supply shall be organized by health facility in-charge based on available resources and the utilization rate. The list of working tools and equipment shall include items listed in Table 6 in the next section.

Table 6: Minimum Essential working Tools and Equipment for CHVS	
1) Thermometer 2) Timer 3) Solar torch 4) Gumboots 5) Umbrella 6) Soap 7) First aid kit	8) Mid-upper arm circumference (MUAC) measuring tape 9) Registers and forms 10) Job aids (SOPs, flip charts, manuals, visuals illustrations, SBCC materials, etc.) 11) Backpack 12) Simple PPE during outbreaks 13) Motor cycle

3.5. CHV Referral Procedures:

Referrals from the community to the health facility are essential to enhance access to services, save lives and ensure continuum of care particularly in rural areas. Improvements in referral can be achieved by strengthening communication and feedback between CHVs, supervisors and health professionals based in the health facilities. This will help the CHVs and their supervisors to better understand the barriers the community faces in going to the health facilities when referred and collaboratively help the community members to overcome them. The following referral approach shall be applied (Table 7):

Table 7: Referral Procedures to be Used by CHVs
● CHVs will identify cases that require referral at household level and during VHNDs. ● CHVs will refer such cases to the closest health facility that provides technical supportive supervision, be it dispensary or health centre. ● Cases that require social welfare attention (e.g. GBV and VAC) may be referred to other points of care depending on their nature and the legal system. ● CHVs will use designated referral form to fill in details justifying the need for referral. ● Depending on the circumstances, the CHVs may accompany the patient referred to the health facility. ● Receiving facility shall provide feedback to CHV on the outcome of the referred patient. ● CHV will keep record of all patients referred using the specific tools provided for record keeping. ● CHVs will use national community-level standard referral forms to refer clients.

4.0. COMMUNITY SYSTEMS AND GOVERNANCE STRUCTURES:

The principles of effective governance include efficiency and effective leadership supported by clear oversight and regulatory frameworks, timely actions, shared values, transparency, responsiveness to the needs of the communities, accountability, respect for human rights and free flow of information. This section describes the organization, management and coordination of the CBHS.

4.1. Governance and Operational structure

For CBHS governance to be effective, clear guidelines and standards, need to be set for all levels. All stakeholders and key players shall commit to good governance. The MOHCDGEC, through the Department of Preventive Services – Health Promotion Section, shall be responsible for overall strategic, technical guidance, quality and policy directions and shall oversee implementation of the CBHS. PORALG shall be responsible for facilitating implementation of community-based health care services through the decentralized local governance structures and integration of these services into all priority areas of Council Comprehensive Health Plans (CCHPs). The following actions are necessary for ensuring robust CBHS governance at national, regional, district council and community levels

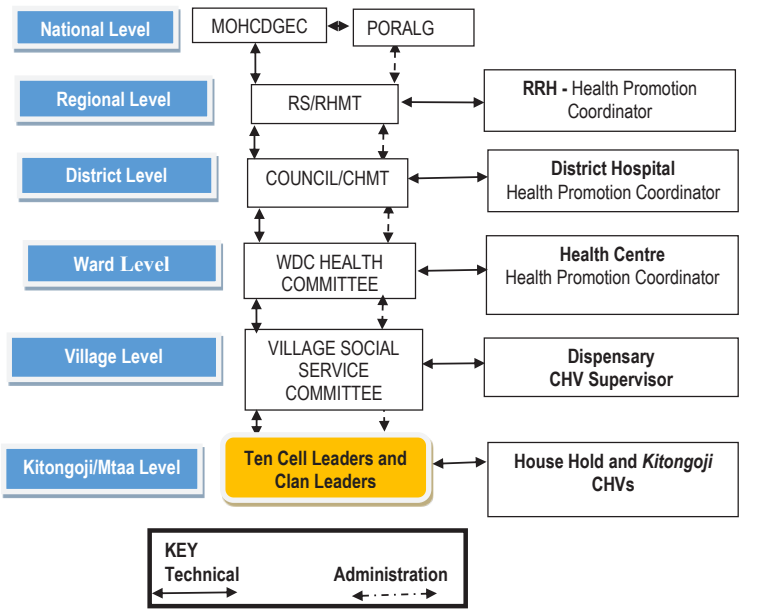

Figure 2: Key Operational Structure of CBHS

4.2. Roles and Responsibilities at each level of operation

4.2.1 National Level

1. Determine the strategic direction, detect and correct undesirable trends and distortions in CBHS planning and implementation through regular discussions with the Technical Advisory Committee of CBHS/HPS, as well as supervising, reviewing monitoring, evaluation and operational research findings.
2. Integrate the CBHS agenda into a relevant technical working group to enhance joint planning and implementation.
3. Facilitate integration of the CBHS workforce into the existing PO-RALG human resources management system through provision of supportive guidelines.
4. Delineate the roles and responsibilities of CBHS coordinators at national, regional and council levels and CHV supervisors at facility and community levels.
5. Develop an advocacy plan for the inclusion of CBHS activities into CCHPs and other LGA development plans.
6. Provide strategic direction for implementation of the CBHS.
7. Monitor and evaluate activities to ensure that the CBHS meets populations' needs and contributes to desired results.
8. Update policy guidelines, plans and regulations.
9. Develop a CBHS resource mobilization plan within government and across other stakeholders and development partners.
10. Coordinate partnerships and multisectoral collaboration and promote accountability.
11. Establish and maintain a system for knowledge management. Incorporate community health services into the national Quality Assurance (QA) system.

4.2.2 Regional Level

1. Provide technical and advisory support to LGAs, including review of CCHPs.
2. Supervise implementation of the CBHS.
3. Provide clear roles and responsibilities for the regional Health Promotion Coordinator.

4.2.3 Council Level

1. Clarify council CBHS coordinators (CHP Coordinator?) roles and responsibilities and the support to be provided by the CHMT.
2. Strengthen council leadership to support CBHS effectively.
3. Implement the PPP mechanism in support of the CBHS.

4. Ensure availability of adequate and coordinated funding for, using the sector-wide approach.
5. Coordinate implementation procedures and mechanisms for monitoring, financial management, procurement and expenditures related to the CBHS.
6. Put in place a strengthened formal coordination mechanism involving all relevant stakeholders (such as public, faith-based, private, community-based, civic and civil society organizations) in the CBHP, in which all members participate as equals.
7. Form and manage CBHP partnerships using protocols adopted and/or adapted from a national template.
8. Implement a charter, developed nationally, for regulating the relationship between communities and health facilities.

Specific actions to be implemented by CHMTs

1. **Policy Adoption:** The CHMT shall adapt national policy guidelines, tools and protocols into the existing structure, including the CCHP, ensuring that the CBHS is addressed with due prioritization, in accordance with the resources available, by ensuring adequate supplies and budget.

2. **Planning:** CBHS activities stipulated in the CBHS Policy and strategic plan shall be incorporated in the CCHPs for implementation, bearing in mind the core principle of sustainability through participation and use of local resources. To assure local ownership and sustainability aspects, the planning process shall start from Village/Mtaa level and move to ward and council levels. The council shall play a supportive role to enable participatory planning, implementation and evaluation of the CBHS by respective communities in the context of the council planning process.

3. **Budgeting:** The CHMT shall propose a budget for the council that will facilitate and run the CBHS activities in the council. The budget shall include costs for CHV motivation and incentives, supplies and training components. Each year, the CBHS coordinator shall provide an estimate of needs in terms of human resources and funds to run the services.

4. **Coordination:** The DMO shall be responsible for providing supervisory roles for CBHS as part of his/her overall council health management responsibilities. The CMT and CBHS coordinator

shall ensure effective engagement of civil societies, NGOs, FBOs and other implementing partners undertaking community-based health initiatives in CBHS planning and budgeting processes. The functions of the coordinators are clearly defined here:

4.2.4. Roles and Responsibilities of Health Promotion Coordinators:

The Health Promotion Coordinator (HPCo) is a member of the council technical committee, in which the coordinator will provide guidance on CBHS. The coordinator will also be responsible for reporting CBHS issues to the CHMT. Additional functions are as follows:

Table 8: Roles and Responsibilities of Health Promotion Coordinator

● Coordinating CBHS activities at council level ● Mapping out CBHS actors/stakeholders in the council ● Organizing and orienting ward-level actors to support Villages/Mtaa in community assessments/reviews and participatory planning for the CBHS ● Conducting meetings to jointly allocate resources by area at LGA level, with a goal of achieving integrated programme implementation ● Supervising CBHS implementers and how they support CHVs administratively and technically ● Managing CBHS-related data such as compiling, analysing, providing feedback and reporting to CHMT, as well as uploading in the District Health Information System (DHIS 2). ● Organizing Training-of-Trainers (TOT) events to build local council capacity for CBHS implementation. The council coordinator shall request support from the region to access TOT facilitators capacitated as a national pool of trainers.	● Coordinating planning, implementation and M&E of the CBHP in the local government council ● Spearheading recruitment, training and deployment of CHVs ● Compiling data and reports from the CHV to identify performance gaps and areas for improvement and to analyse and give feedback to facility supervisor and CHVs ● Conducting targeted supportive supervision once in every quarter to monitor implementation of various community activities done by CHVs ● Ensuring that all supplies required by CHVs are budgeted for each year and that they are available and given to CHVs in a timely manner upon their request ● Supporting CHVs in system linkages for community, facility, council and national initiatives and programmes in which CHVs can be involved.

4.2.5 Ward Level

1. Supervise development and implementation of village health plans.
2. Support village governments to mobilize resources for the CBHS.
3. Coordinate CBHS activities at ward level – i.e., management of disease outbreaks, social protection issues, etc.
4. Approve nominees for the CHV positions; compile and submit the list of applicants to the council.
5 Support Villages/Mtaa to organize Village Health and Nutrition Days.

4.2.6 Village Level

The national CBHS policy guidelines state that CBH services are to be owned and controlled through a local mechanism that allows a community to influence the operation or use of services and to enjoy the resulting benefits. Such a mechanism shall allow external funding to be channelled to strengthen service delivery through existing systems and structures, and hence create an opportunity for the services to be sustained across generations. The village government shall be responsible for developing and implementing a CHV accountability mechanism. In order to achieve good governance, communities shall do the following:

1. Nomination of CHVs
2. Ensure that CHVs participate actively in village meetings.
3. Direct CHVs to report to the VEO issues related to client satisfaction and community rights to high-quality health care.
4. Mobilize resources for supporting the CBHS in a transparent way.
5. Mobilize resources for implementing Village Health, Social Welfare and Nutrition Days
6. Coordinate local civic and social organizations' inputs into the CBHS.
7. Adopt and/or adapt national-level regulations, laws and guidelines to support communities as stipulated in the National Health Policy.
8. Promote community health care financing for the CBHS.
9. Ensure effective sharing of information between community, ward and facility.
10. Actively participate in community diagnosis and generate a CBHS plan for the village that shall feed into the Ward Development Plan. The elements of the plan included in the Ward Development Plan and the CCHP shall be the basis for performance accountability and transparency.
11. Ensure that a managerial and technical supervisory system is in place and operational.
12. Oversees equity in service provision by CHV and ensure respect for human rights is in place.

4.2.6.1 Role of VSSCs and other village structures

VSSCs are responsible for orientation of the communities on health care services and for advocating all community members to understand that health is a joint responsibility. The VSSC will facilitate activities to address the health needs of the entire village, with the help of health facility in-charge. VSSCs will play an important role in planning and monitoring health care services delivery in the village. The CHVs shall utilize the VSSC and the multisectoral committees listed earlier for participatory planning and health promotion actions.

- The CHVs shall utilize the VSSC and the multisectoral committees listed earlier for participatory planning and health promotion actions.
- The CHV shall receive administrative support from the VEO and receive technical support from the health facility in-charge and other health based at the ward level such as the Ward Environmental Health Assistant/Officer and Assigned Officer.

4.2.7 Role of the Village/Mtaa Executive Officer

The CHV shall receive administrative support from the VEO and receive technical support from the health facility in-charge and other health and social based at the ward level and assigned Officer. The VEO shall on behalf of the community, do the following:

Table 9: Role of the Village/Mtaa Executive Officer

• Participate in the orientation sessions for nomination of CHVs candidates. • Participate in the nomination and recommendation of CHV trainees. • To supervise CHVs from *Vitongoji* within VEO's jurisdiction area. • Work in collaboration with the facility in-charge to oversee the implementation and coordination of CBHS activities; • Remind the CHVs on matters of follow-up drawn from the resolutions of Village/Mtaa government meetings; • Monitor and report issues related to client satisfaction, community rights, and quality of care to VHCs;	• Provide leadership in transparent resource mobilization to support the Village/Mtaa CBHS plan; • Advocate for community health care financing, as promoted by the CHVs; • Oversee organization of Village Health and Nutrition Days; • Ensure coordination between CHVs activities in the community; • Coordinate all stakeholders engaging CHVs in the village • The VEO is responsible for coordination of all Community Health Volunteer in the village in close coordination with health facility and other existing community structures

4.2.8. Responsibilities of the Health Facility:

The incharge of the health facility will be the direct technical supervisor of all CHVs providing services in the villages served by the health facility. The Health facility shall timely provide emergency care to referrals from the community and shall be points of refill for CHVs supplies and equipment, as requested by them. Once every month, all CHVs in the village(s) served by the health facility will meet to present progress reports, share experience and address challenges faced. The health facility in-charge will use the opportunity to provide updates, refresher training on specific issues and feedback on performance.

The following are the roles of the health facility in-charge in assisting CHVs to perform their roles and responsibilities:

1. To create awareness in the village about services available in the health facility and their health entitlements;
2. To develop a village health plan based on community priorities and link it to the council;
3. To maintain a village health register and health information board and calendar;
4. To analyse key issues and problems pertaining to village-level health and nutrition activities and provide feedback to relevant levels of government and officials most appropriate to a given issue;
5. To assist in implementing Village Health, Social welfare and Nutrition Days;
6. To create and maintain good working relations with the CHVs and the community at large in order to facilitate provision of quality community based health services; and
7. Maintain adequate stock of working tools, materials and supplies for use by all CHVs working in the villages served by the health facility.

4.2.9. Roles and Responsibilities of CHV supervisor at Village Level:

Supervise the activities of Community Health Volunteer (CHVs) and provide them with adequate coaching and support to ensure the quality of their work and the accuracy of their monthly reports.

Table 10 Role of CHV Supervisor at Village level	
• Work in close collaboration with the VEO and Dispensary Incharge • Supervise the activities of Community Health Volunteer (CHVs) and provide them with adequate coaching and support to ensure the quality of their work and the accuracy of their monthly reports. • Provides overall supervision of community-based activities in his/her catchment area. • Ensures high quality and timely implementation of community-based activities by the CHVs in his/her catchment area. • Builds and maintains strong cooperation with VEO and Facility incharge to keep them informed and actively involved in community health activities. • Builds and ensures strong partnership with health facilities in his/her catchment area • Ensures safe and accurate use/storage of working kits/tools provided. • During supervisory visits, evaluates CHVs' performance, provides feedback, and agrees on recommendations to solve problems and improve CHV performance. • Attends WDC and health facility meetings in her/his catchment area whenever they happen. • Ensures quality review of the reports provided by CHVs.	• Maps the location of all CHVs in catchment area and maintains a register to track those who have received training. • Establishes a monthly work plan and calendar of supervision activities and shares it with health facilities and the CHVs in his/her catchment area. • With CHV supervisor, introduces self to health facilities. Makes sure that health facilities have the name and mobile phone number for CHVs and supervisors to improve referral of patients for community-based support. • Conducts at least one supervision visit every day to observe a support group, a visit to a community group, a home visit, or some other behaviour change activity. • Ensures supervision of each CHV under his/her responsibility every month. • During supervisory visits, supports CHVs to plan their monthly activities • Compiles monthly supervision forms at each supervision visit. 10. Collects monthly activity reports from each CHV under his/her responsibility every month. • Submits monthly reports to the Health Facility Incharge; consolidating information from the monthly activity report compiled by all CHVs under his/her supervision.

4.2.10. Roles of Other key Stakeholders

1. **Health Training and Research Institutions:** Human resource development and CE, operational research on governance issues and sharing of findings and experiences

2. **Development Partners and Implementing Partners:** Providing financial resources and technical support for implementation

3. **Civil Society Organizations:** Advocacy on accountability and efficiency in implementation

4. **Private Sector:** Supporting implementation of the CBHS though PPPs

5. **Professional Bodies:** Supporting QA, efficient implementation, M&E and standards

6. **Health Facility Governing Committees and the Council Health Board:** Oversight on coordination, transparency in resource allocation and spending comparisons between health facilities and CBHS plans, providing a community voice for health.

7. **Indigenous and Social Platforms:** Use of social networks, indigenous channels of communication (sociocultural events, weddings, funerals, religious gatherings, specific ceremonies, community radios, commemoration days) and positive sociocultural values as avenues for addressing specific health problems or promotional themes.

4.2.11 . Roles and responsibilities of CHVs at the community

Beyond the services provided by the CHVs at household and individual level, CHVs will have responsibilities within the community.

4.2.11.1 Roles and responsibilities of CHVs at the community

Community Assessment

Data collection: Participatory methods shall be utilized to generate local evidence to influence planning and implementation. Information/data needed include

- Common diseases per season
- Number of deaths by age group
- Geographical features, boundaries of Kitongoji, accessibility
- Distribution of resources
- Distribution of health problems
- Participatory problem analysis and solutions generation based on evidence
- Reporting results of above to the health facility in-charge
- Identify gaps in community health services and report to the health facility in-charge

Community Planning

The CHV shall take responsibility for CBHS planning at the Kitongoji level, in collaboration with Village/Mtaa leadership, health staff at the health facility, community representatives and extension agents at the ward level. The Kitongoji leaders shall constitute a local CBHS planning team, which shall work according to planning guidelines to be developed. Prioritized activities are discussed and sequenced logically. Planning and implementation elements include

a. Translating community health issues into activity planning
b. Combining individual Kitongoji plans into a comprehensive Village/Mtaa plan
c. Linking activity plan to the council plan through the health facility in-charge
d. Planning activities in line with CHMT performance indicators
e. Feedback plans to the community and dispensary/facility in-charge, who will share the plan with the VHC. The CHVs will identify other health and welfare related peer groups and facilitate cooperation to plan and coordinate communal interventions and initiatives that promote healthy living and welfare at the community level. other CHVs duties are elaborated in the CHVs Job description

4.2.11.2. CHV Role in Village Social Services Committee (VSSC):

CHVs will provide technical input to the VSSC. This will be done by sharing reports on performed activities through the health facility in-charge. The health facility in-charge is the member of the VSSC, representing the CHVs and other health officers in the village. The CHVs reports will also be presented to the Health Facility Governing Committee through CHV supervisor to provide updates on health issues that need close linkage between the health facility and the community through interface meetings. The CHVs shall utilize the VSSC and the multisectoral committees listed earlier for participatory planning and health promotion actions.

4.3 Management of CBHS

These policy guidelines emphasize the importance of proper management of the CBHS within the sector at national, regional, council and community levels. CBHS implementation is well facilitated when interventions are built into existing systems. In this regard, the following domains present opportunities for management of CBHS in existing systems.

4.3.1 Services: The CHV service package shall be in accordance with section 3.1 of these guidelines.

4.3.2 Referrals and linkages:

The councils shall implement a set of referral system and tools for CHVs. Tools will accommodate referrals to government health facilities and to other community support services and providers, such as social welfare, legal services and other social services. QA/QI guidelines shall be updated to cover the quality of CHV service provision. A system shall be put in place to ensure effective referral in terms of timeliness and appropriateness. This shall include client satisfaction monitoring and use of an appropriate referral tracking tool and interactive techniques during supervision. The CBHS coordinators shall ensure implementation of community-based QA/QI processes.

The dispensary shall support and supervise the CHVs in health service provision, health promotion, and preventive services. The dispensary shall also support and supervise data collection and feedback to CHVs and provide a link with the HMIS through the District HMIS Office and CBHSCBHSW coordinator. The dispensary shall provide technical guidance for participatory planning of CBHS activities in the respective community. The dispensary shall support and carry out capacity-building interventions, with guidance and leadership from the ward and council (details of these services in Appendix 2).

4.3.3 Logistics, supplies and support:

The HFMT and CHMT shall estimate, depending on the government budget, CHV supply needs, including first Aid kits, equipment, protective clothing, mobile phones and bicycles.

4.3.4 Recording and reporting:

CHV reporting elements for the CBHS shall be in accordance with the set National M&E format, as described in Chapter 6. The CHMT shall ensure that CHVs and other community service providers use national M&E standard recording and reporting forms and that information is integrated into the council reporting system and DHIS-2. The CHMT shall ensure that the capacity is in place for data collection and use.

4.3.5 Monitoring and Evaluation:

The LGA shall be guided by the indicators elaborated in Chapter 6 to conduct a programme of M&E. Using participatory approaches, the CBHS council coordinators shall facilitate setting of programme targets according to the policy and strategic plan and local feasibility.

4.3.6 Knowledge management:

The council, CHVs and facilities shall adopt and adapt information generation, knowledge management and programme support communication mechanisms for the CBHS. CHVs and VHCs shall participate in information generation and knowledge management according to guidelines for improving services at village level.

The CBOs and NGOs active in the community shall liaise with the council HPC coordinator on how to integrate their initiatives in order to safeguard effective allocation of resources, smooth coordination of CHV activities and thus keep sustainability issues on track

4.4. CBHS management cycle:

At the council level, the HPC coordinator shall apply the 'Five Steps' approach to manage the CBHS activities (Figure 5):

1. **Step 1:** The HPC coordinator shall collect preliminary information on available CBHS resources to enable councils to plan CBHS activities. This shall include information on the following:
    - o The number of qualified CHVs they can expect for the year, so that their salaries, materials and supplies are included in the financial year budget.
    - o CBHS stakeholders, their operating areas, conditions, procedures and the participatory methods they use.
    - o The LGA shall capacitate wards and Villages/Mtaa to undertake community diagnosis and identify gaps.

2. **Step 2:** Orient council stakeholders for consensus building on values, principles, funding, programme objectives, targets and commitment.

3. **Step 3:** The CBHS coordinators, in collaboration with CHMTs, shall use participatory approaches to inform planning and budgeting of CBHS activities. Plans developed by the villages and wards shall be compiled into one CBHS plan for a given council.

4. **Step 4:** The CBHS coordinator shall seek consensus on planned CBHS activities, get the plans authorized, ensure they are included in the CCHP as part of the annual planning cycle and ensure they are implemented.

5. **Step 5:** To inform the following year's planning, a review/ appraisal of implementation of the current year's plan shall require a well-designed M&E mechanism in place at the council.

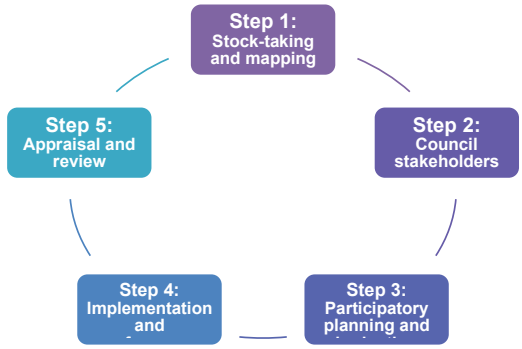

Figure 3: Council Health CBHS Management Cycle

5.0. ENABLING ENVIRONMENTS AND COMMUNITY PARTICIPATION.

Financial and material support (both domestic and external) are crucial to the success and sustainability of CBH&SW services. According to the National Health Policy 2007, the Government shall prioritize allocation of resources for PHC services, both at central government through the medium term expenditure framework (MTEF) and local government levels through the Comprehensive Council Plan (CCP), the Comprehensive Council Health Plans (CCHP) and Health Facility Plans. Due to the limited resources available to address a long list of priorities additional funds ought to be mobilized and allocated for the CBHS.

5.1 Resource mobilization and allocation:

The Government will work with development partners to fill the resources gap through general budget support, health-based pooled funding and direct to project. In addition, the government will mobilize resources from non-traditional donors such as private philanthropic foundations and the private sector. In order to harmonize and optimize use of resources, the GOT shall put in place systems and structures to guide resource mobilization from domestic and external sources, and ensure proper management of funds geared to support community-based health care services.

CBHS activities shall be included in the CCHP and Health facility plans. There are multiple sources of funding for CCHP and Health Facility Plans such as Health Basket Fund, Direct to Project Funds, Block Grants, Council Own Source and health facility revenues from user fees, NHIF and iCHF. Funds for implementation of the Health facility plans are channelled through DHFF approach to health facility bank accounts. This presents an opportunity for health facilities to earmark in their plans a proportion of those funds for CBH services. Allocation of these funds for the functioning of CBHS will add value to Government health expenditure and ensure sustainability of CBHS. Various opportunities within the government, private and community organizations and structures are recommended to support community initiatives. Such opportunities include but are not limited to the following.

5.1.1 Health insurance schemes:

The .CHVs will have a role to mobilize communities to enrol in the iCHF and NHIF. This provides an opportunity for the NHIF and iCHF to increase membership enrolment and collections of funds without much investment

in the workforce used to promote enrolment. Hence, the CHVs are doing the job that NHIF would incur higher expenses if it had recruited staff for that purpose. It then becomes important that a proportion of the facility reimbursements from NHIF be allocated to facilitate CBHS at the village level. In addition, the NHIF can allocate additional funds for villages and health facilities to support CHVs and CBH services.

5.1.2 Public–Private partnerships

A proportion of voluntary financial contributions and in-kind from private sector, individuals, companies, NGOs and CSOs can be channelled through DHFF to support CBHS activities.

5.1.3 Contributions from community initiatives:

Villages can establish community-based health funding through a variety of innovative ideas such as fund raising during social mobilization events such as Village Health and Nutrition Day or introduce community health-based microfinance initiatives. A proportion of contributions can be allocated for the functioning and sustenance of CBHS activities.

5.1.4 Intersectoral Collaboration

Health and social well-being of people are affected by diverse social determinants of health (SDH), which are conditions in which people are born, grow, work, live and age with, and the wider set of forces and systems shaping the conditions of daily life. The Health sector cannot achieve their goals without involvement, participation and collaboration with other sectors responsible for these SDH. Therefore, the National Health Policy 2020 has placed increasing focus on Health-in-All-Policies approach, where all sectors take the responsibility of addressing SDH under their jurisdiction.

In this regard, the Prime Minister's Office (PMO) responsible for government coordination and planning has already taken an initiative to improve coordination to address SDH through an intersectoral approach. The PMO in collaboration with MOHCDGEC and all relevant sector ministries has conducted a thorough review of related key sectors policies, identifying existing opportunities for synergies with a view to formulate a joint work plan. This joint work plan has facilitated the development of a common result accountability framework towards a robust and complementary health strategy and a realistic intersectoral collaboration. Since intersectoral coordination is done at the PMO level, these guidelines will refer to the guidance from the PMO that will be issued from time to time instead of issuing specific policy guidelines for this area.

5.2. Optimization of resources allocated for community-based health activities:

The GOT shall establish an accountability mechanism for the community-based health care initiatives implemented at different levels in order to optimize utilization of existing resources and attract additional resources. Specifically, the MOHCDGEC will prepare standard operating procedures for guiding implementing partners, private sector and LGAs in prioritizing coverage to underfunded areas, use of existing systems and structure for allocation, expenditure and reporting of funds spent and by considering a resources allocation formula as stipulated in the CCHP guidelines. In particular, this will include the following:

Guidance to Development Partners and Private sectors on the utilization of existing government systems and structures including Direct Health Facility Financing System (DHFF) to ensure established initiatives are sustainable:

- To include all activities funded by implementing partners in HFP and CCHP
- To utilize DHIS-2 and community-based registers.
- To utilize the Facility Financial Accounting and Reporting system (FFARS) for accountability of resources spent in health facilities.
- Integrated community-based service package and mode of delivery.
- With regard to direct to project funds which pass through implementing partners MOHCDGEC will devise a mechanism to ensure that before mobilising funds partners should communicate with the Government and obtain support in writing for proposed activities, this will ensure alignment of government national priorities and avoid duplication of efforts.

5.3. Support and strengthen Community Capacity:

5.3.1 Community Integrated supportive supervision

The Tanzania Human Resource for Health (HRH) Strategy underlines the need for supportive supervision to ensure compliance with standards and quality of care in health service provision. The HRH strategy states that “the key role of the leadership of the health sector at all levels is to ensure a health care environment in which the health workforce is valued and supported and has the opportunity to develop while providing high quality care” (MOHSW, 2016). In the context of this guide, supportive supervision shall derive its meaning from this strategy description and will include not only a performance management and administrative tool, but also a mechanism of personal and developmental support to CHVs.

To ensure effective CBH services, supportive supervision will provide the opportunity to identify CHVs in need of follow-up training, on-job mentoring or coaching to improve performance and solve other systemic problems that contribute to quality of care and support. The supervisors shall use the National Integrated Supportive Supervision checklist. Supervision will be performed by the CHMT (including the council Health promotion coordinator) and the health facility in-charge of a nearby health facility where technically the CHV reports. In situations where the health facility in-charge is unable to supervise the CHVS, he/she can appoint a staff in the health facility or any other licensed health professional residing in the community and willing to be a supervisor of the CHVs working in the village where he/she is residing.

In this approach, supportive supervision for CHVs will be conducted as per national community supportive supervision guide. Box 8 presents key components found in the national Supportive supervision for community health Services:

Table11:Key Components of Supportive Supervision of CHVs

- The Village Executive Officer (VEO) will supervise CHVs administratively.
- CHVs will be technically supervised by the in-charge of the health facility within the village or in the nearby health facility. Where this cannot be done, the facility incharge can appoint one employee from the health facility or a licensed health professional residing in the community and willing to work as a community volunteer.
- A national guide for Supportive supervision will be developed to support systematic supervision.

Continuing training:	The mentoring aspect that contributes to the up skilling of the CHV, which can occur during an individual supervision visit, or the needs for which are identified by the supervisor.
Equipment and supplies:	Equipment and supplies are typically checked during supervision visits.
Individual performance evaluation:	Individual performance evaluation or appraisal processes are informed by the supervision reports and data submitted.
Motivation	May be given based on performance that may be informed by the supervision and reporting data. For example Opportunity for advancement such as further training or promotion based on good performance
Documentation and information management:	Supervision is typically the point at which the quality of data entered into the HMIS registers/electronic appliances is checked.
Linkages to the health systems:	The key manner in which CHVs are linked to health facility staff is by building (a) a friendly mentoring relationship between them and individual health technicians in the facility and (b) a sense of accountability by the facility staff for supervision of CHVs providing services in the community.
Community involvement:	Community recognition of the work of CHVs that could be fed into the supervision processes

5.3.2. Community participatory approaches

To effectively enable the achievement of CBHS objectives, activities shall be based on a participatory approach. People learn best when they practise what they have resolved to act on, compared with when they are simply instructed to do what health agents prescribe. Active, participatory learning ensures that knowledge and skills are integrated into the social structure by communities, resulting in continuity and sustainability of CBHS.

Participatory methodology enables the community to get a comprehensive understanding of their problems, the causes of the problems and what needs to be done to address the problems. Methods such as the Community Score Card, Community Diagnosis, Participatory Rapid Appraisal, and Participatory Action Research, Rapid Assessment Procedures and Participatory Learning and Action tools have been shown to be effective in generating local evidence to guide problem identification and analysis.

5.3.3. CHVs entry to the communities

The CBHP will engage, network, collaborate and cooperate with other players to identify entry points at the community level. Three common approaches are as follows:

1. Settings, which can be prayer venues, primary and pre-primary schools, secondary schools, colleges, prenatal and child health clinics, social clubs and associations, households, open markets, public meetings and Village/Mtaa and ward development planning sessions, and faith-based organization (FBO) venues.

2. Health Issues (priority health problems): Common preventable conditions such as HIV, TB, malaria, malnutrition, helminth infestations, diarrhoeal diseases, NCDs, GBV, VAC and use of available services, such as those for immunization and reproductive health, to be determined through the participatory assessment at baseline. NCDs are increasingly an important entry point. Outbreaks of emerging diseases can also serve as CBHP entry points.

3. Population groups, which can be age-based categories, such as prenatal women and new-born babies; children under the age of 5 years; pre-primary, primary school and secondary school pupils; adolescents and youth in or out of college; adult men and women; the elderly; most vulnerable groups (MVC, adolescent

girls and young women, key populations, women of childbearing age, the elderly, pregnant women, PLHIV, people with disabilities, people suffering from chronic conditions); and people in difficult circumstances (street children, people living in slum areas, people in war areas and people facing emergency situations).

Table 12 :CHV Guide to Community Entry :
Understand the administrative structure and where to report;
Map key influential people to drive the agenda;
Map key social structures such as markets, clubs this are target groups for message dissemination they can also drive the agenda.
What are the key social structures this will save as message delivery channels e.g. markets….., Conduct mapping of barriers tor CBHS
Conduct mapping of *Vitongoji*n the village and number of village households
Develop a plan and share with the nearby health facility and VEO

5.3.4 Participatory Planning

Under the leadership of the VEOs, health facility supervisors, VHCs, assigned officers and village leaders shall support CHVs to network with other stake holders and shall jointly facilitate participatory assessment, data collection, analysis and use for planning and other decision-making. Currently deployed CHVs and CBHS coordinators shall be capacitated on data analysis and use in developing bottom-up plans using bottleneck analysis. The CHVs shall be provided working space at the VGO for storing working tools, records, materials and supplies under lock and key.

6.0. MONITORING, EVALUATION

The monitoring and evaluation of community health interventions is an important element in ensuring effective service delivery. Success of M&E basically depends on availability of valid information.

The goal of M&E is to generate key information that drives result-based management to improve quality of services and strengthen planning at all levels. Information generated through routine M&E of the CBHS should empower decision-makers to review and use the data to improve performance.

In this adapted approach, a separate and an overall M&E plan for CBHS is provided. However, for CHV specific activities, Box 11 provides guidance for monitoring data collection and reporting that the CHVs will follow.

Table 13: Data Collection and Reporting
• CHVs will be provided with a National HMIS data collection tool, which is a replica of MTUHA Book 3. • The collected data will be reported using HMIS reporting forms (MTUHA Book 10) at facility level. • The MTUHA data collection tools and reporting forms will be digitized in a format that can be used in mobile tools such as smart phones and tablets. • Processing of data will be conducted using the DHIS2 at district level. • Feedback shall be provided to the CHVs by health facility in-charge regarding the quality, analysis and utilization of the data submitted. • Referrals from community level to health facility and vice versa will be done using the standardized referral form.

The community-based M&E system will use the participatory approach and will involve capturing community-level data that is generated through CBHS activities to be analysed, discussed and used to inform community-level interventions for health plans at village, ward, health Facility, and council levels. Tools for data collection, reporting and management processes are designed and integrated with National Health Information Systems (HMIS).

6.1 Monitoring

Information system

CBHS data will be collected by CHVs in the community, but also through CBHS coordinators (health promotion coordinators?) and supportive supervisors. The programme will use the community data registry (MTUHA Book No. 3), which has been modified to capture community-

level data. Community health data will be routinely collected by the CHVs during household visits and community activities, using MTUHA Book No. 3 and then summarized into monthly summary data reporting tools (MTUHA Book no. 10) at the Health facility level. The register and monthly summary data reporting tool will link with online reporting forms in the DHIS2 database for entry at the council HMIS office or at the health facility where data are directly entered in the DHIS-2 at the facility level. As technology becomes available, the CHVs will collect data using mobile applications (use of m-health approach) through recommended gadgets such as tablets, PDAs and smart phones, in line with the MOHCDGEC's e-Health strategy.

The CBHP coordinator and CHMT will ensure constant availability of registers and data collection tools and that there is proper documentation using data management guidelines developed by MOHCDGEC.

Data flow

Data collection tools will be kept at the health facility where the CHVs report. On a daily basis, the CHV will pick a data collection tool (MTUHA Book No 3) as his/her working tool when planning to conduct community activities. On a monthly basis, the facility in-charge will be responsible for compiling all the summary reports from MTUHA Book 3 and transferring them to the MTUHA Book No 10, ready for entry in the web-based system (HMIS/DHIS-2) or submit to the council for entry to the HMIS/DHIS-2. All community-based data should be readily available at the facility for compilation before the 5th of every month. Facility in-charge may assign any staff (facility staff or selected CHV) to compile data under his/her supervision. Data entry in the DHIS-2 should be done before the 15th of every month as per National Health data flow protocol. Where technology is available, the health facility in-charge or the CHV will enter data directly into the database. All these data will be available at the facility for use by the community (VEO, WEO and all other data use points at the community).

Other Data Source

CBHS monitoring shall make use of information systems already in use for health and human resource management to collect CBHP data. These routine data collection systems include

1. Health Management Information System (HMIS/DHIS-2)
2. Electronic Integrated Disease Surveillance and Response (eIDSR)
3. Care and Treatment Clinic (CTC2) Database

Routine monitoring will also use available data from periodic surveys to set benchmarks to track progress and to provide population statistics to assist in calculating monitoring indicators. These periodic surveys include

1. Integrated Supportive Supervision (ISS)
2. Service Availability and Readiness Assessment (SARA)
3. Tanzania Service Provision Assessment (TSPA)
4. Tanzania Demographic and Health Survey (TDHS)
5. National Population Census (NPC)
6. Tanzanian Household Budget Survey (THBS)
7. Tanzania HIV Indicator Survey (THIS)
8. Other National Indicator Surveys

Indicators

Monitoring of CBHS will measure performance indicators (Quantitative and Qualitative) including inputs, outputs, outcomes and impact indicators. Indicators are linked to M&E programme framework found on strategic plans. These indicators are set against targets that link the CBHS objectives to measurable results that will be monitored throughout the implementation period and beyond.

Monitoring System

Monitoring is an ongoing assessment of processes, outputs and outcomes intervention/activities. Routine monitoring will use tools and procedures for the ongoing collection, management, analysis, dissemination and review of data to inform implementation and planning decisions at village, ward, council, regional and national levels. The CBHS progress will be monitored with a set of indicators that link to the specific and health outcome objectives. Also, CBHS will use different approaches in monitoring such as using community score card tool.

Capacity Building and Training

CHVs receive training on data collection, management, reporting and basic analysis. The CHMT, HP Coordinator (CBHS) coordinators and supervisors will support CHVs in routine data quality assessments to address data discrepancies and ensure that community staff maintain skills in data management. Health facility supervisors will oversee the incoming reports from CHVs for completeness, accuracy, compilation and provide on-the-job training for CHVs as required.

Data Quality Assurance

Data quality assurance is a process of profiling and cleaning data to identify inconsistencies and make corrections to collected data in order to ensure that CBHS is capturing data that closely resembles reality. On the other hand, Data Quality Assurance is the process, which ensures that data collected meet the required standards. In order to ensure that data generated by CHVs are of sufficient quality, data checks and verification will be done by the health facility in-charge before submission to the council. The CHMT will regularly provide feedback and support to the health facility staff and the CHVs to ensure that high-quality data are generated.

Confidentiality of Health Information

It is the responsibility of the Facility in-charge to store and manage MTUHA Book Nos. 3 and 10 to ensure that protected and sensitive health information is kept safe and secure. However, while working at the community conducting community activities, CHVs will be held accountable. All registers and reporting books will be stored in a locked box or cupboard at the health facility, as other HIMS books, which is the CHV's operational office. Digital data will be reported and stored on password-protected devices and software with closed user groups and encrypted files. Authorized staff will use credentials to access the information. Where necessary, patient and household-level records will be de-identified by using unique number identifiers or letter codes. For HIV patients, ID numbers will be kept in the CTC at the facility to reduce duplication of reporting and enhance integration.

Data Analysis and Use

In line with the participatory approach to CBHS management and the decentralized health system in Tanzania, basic analysis, interpretation and use will happen at each level. This will be used to inform CBHS planning and promote data-driven decisions at community, ward, council and national levels. CHVs and CBHS coordinators will be required to perform basic data analysis of CBHS performance using data from monthly and quarterly reports to perform trend analysis and track performance and use findings for work planning.

Dissemination and Feedback

Dissemination of results and feedback will be done at village, ward, council and regional health committee meetings. The regional medical officers and DMOs will be responsible for disseminating CBHS reports in

their respective technical meetings, including primary health committee meetings. The health facility in-charge will be responsible for dissemination and feedback at village primary health committee meetings to the VEO and CHVs under their supervision.

Results will also be made available to the broader stakeholder base through briefs, technical workgroup meetings, workshops and conferences, social media and online via the HPS webpage.

6.2 Evaluation

Effective evaluation is a systematic way to account for investment and activities of the initiative and provide useful, ethical and scientifically sound evidence of the initiative effectiveness. This can be used to identify areas for improvement that will inform policy, strategy adjustments and operational decisions.

The proposed evaluations will inform the MOHCDGEC, PO-RALG, councils and villages when making annual planning, as well as in decision making.

Two approaches to programme evaluation will be carried out: internal evaluation, and operations research. Annual internal reviews will focus on outputs and outcomes, based on available data generated through the services provided or existing surveys. The programme shall use operational research to identify gaps and opportunities in community health services. Communities and councils are encouraged to conduct their own assessments to evaluate community health services at the local level.

Internal Evaluations

Internal output and outcome evaluation will assess the contribution of the CBHP to the health system through access, quality and coverage of health services to the community. Internal evaluation should be conducted annually at each level. Areas of investigation for internal review include the training of CHVs, integration of the CBHP into health systems at the council level, deployment of CHVs into communities, coverage of households and populations and contribution to health outcome of community.

Operations and Implementation Research

It can be anticipated that the CBHS will encounter significant operational challenges as the new approach is adapted and integrated into the health

system. These challenges will occur in all aspects as new mechanisms for management, coordination and communication are put in place, task-sharing practices are employed, and health care is extended from the facility into the community. Operational and implementation research will inform MOHCDGEC and PO-RALG decisions on how best to implement the CBHS in order achieve its objectives. CBHS-related operational and implementation research will be done following existing national research guidelines as illustrated in Figure 6 below.

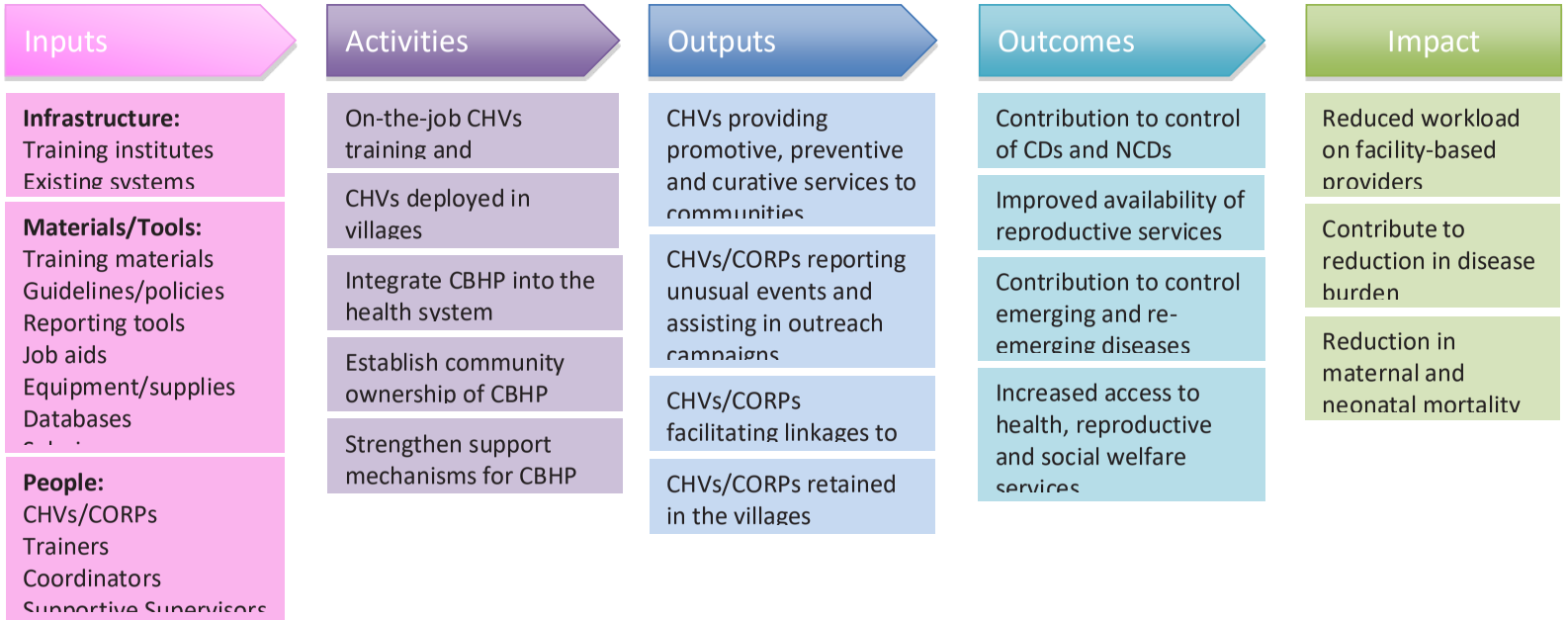

Figure 4: CBHS Theory of Change

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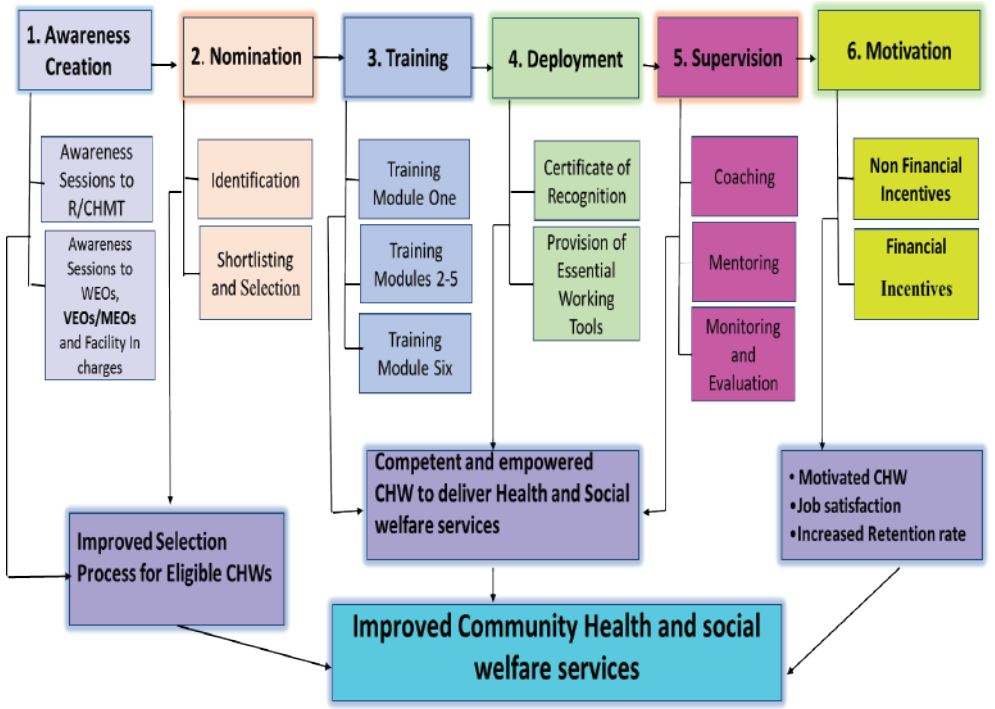
APPENDICES

Appendix I: The interrelationships of the basic steps of operationalization of CBHS Guide



Appendix 1: CBHSW Minimum Service Package

NEHP Category	Continuum of Care Category	Community-Based Health Services
RMNCAH	**Promotive Services**	**Maternal and New-born**
		i. Family planning ii. Early booking for antenatal care iii. Early HIV testing and own sero-status iv. Regular attendance to antenatal care, at least four visits v. Individual birth preparedness plan vi. Optimal maternal nutrition vii. Facility-based delivery viii. Regular postnatal care for mother and neonate ix. Importance of birth registration x. Immediate RCH clinic attendance for newborns born at home xi. Male involvement in RCH interventions, including attending for their own health xii. Exclusive breastfeeding for the first 6 months xiii. Promote adherence to the use of ARV to exposed infants born from HIV-positive mothers for the first 6 weeks post-delivery xiv. Promote skin-to-skin contact (kangaroo mother care)
		Children (Under 5)
		i. Optimal child feeding practices (frequency, variety, quantity and quality for age groups) ii. Children's regular attendance to the under-5 clinic and for growth monitoring, immunization, vitamin A supplementation and deworming iii. Awareness to identify danger signs for life-threatening conditions iv. Promote adherence to the use of long-term medications – e.g. antiretroviral therapy (ART)
		Children (School Age)
		i. Attendance at school health campaigns ii. School-based health screening and recordkeeping iii. School health clubs iv. Healthy eating, lifestyle and positive behaviour towards health (demote unhealthy snacks and drinks, promote physical activities, school gardening, increase awareness of unhealthy behaviour such as smoking, alcohol intake, abstinence on sex-related activities) v. Promotion of comprehensive sexuality education (CSE) vi. Personal hygiene

NEHP Category	Continuum of Care Category	Community-Based Health Services
		vii. Menstruation hygiene viii. Promote vaccination, including for human papilloma virus (HPV).
		Adolescents
		i. Healthy lifestyles – e.g. nutrition, physical exercise, hygiene and continuous learning ii. Promotion of CSE iii. Life skills, abstinence/safe sex and avoidance of substance abuse – e.g. smoking, alcohol iv. Early health-care-seeking behaviour v. Awareness of family planning methods vi. Knowledge of one's own sero-status and HIV treatment and care (HTC) vii. Disclosure of sero-status to trusted people for support and treatment adherence viii. Awareness of reproductive cancers (cervical, prostate and breast cancers) and promote vaccination for HPV and attendance at cancer-prevention campaigns ix. Peer-group formation for education among adolescents and youths and promote access to adolescent- and youth-friendly services x. Adherence to treatment for chronic illnesses among adolescents
	Preventive Services	**Maternal**
		i. Assist in organizing and participating in outreach campaigns. ii. Distribute contraceptives to clients who have chosen male or female condoms, oral contraceptive pills, emergency contraceptive pills and calendar 'cycle beads'; refer for other methods. iii. Educate households with pregnant women on birth preparedness, including having all the necessary commodities. iv. Educate pregnant women on postpartum and neonatal hygiene.
		Newborn
		i. Initiation of breastfeeding within 1 hour of birth ii. Educate parents and caregivers on ways to prevent sepsis and infections, including umbilical cord, eye, ear and skin care. iii. Encourage exclusive breastfeeding for 6 months. iv. Ensure immunizations as per guidelines. v. Educate the family on prevention of newborn exposure to smoke.

NEHP Category	Continuum of Care Category	Community-Based Health Services
		Refer difficult cases to the health facility.
		Children (Under 5)
		i. Identify children who missed clinic attendance – e.g. immunizations, growth monitoring, prevention of mother-to-child transmission (PMTCT), early infant diagnosis of HIV and refills for any chronic condition – and retain them in care through effective referral back. ii. Screen for CDs and NCDs using the national screening tool. iii. Promote HIV testing among household members of a family with people living with HIV (PLHIV) or tuberculosis (TB)/HIV. iv. Educate to prevent traditional harmful practices – e.g. uvulectomy, female genital mutilation.
		Children (School Age)
		i. Assist in organizing and participate in school health campaigns. ii. Participate in school health programmes at community level – e.g. environmental health and water, sanitation and hygiene (WASH) activities. iii. Menstrual hygiene
		Adolescents
		i. Identify family planning needs among adolescents and provide services according to their unique needs – e.g. abstinence, condoms, cycle beads and emergency contraceptives and refer for other methods. ii. Early identification and treatment of sexually transmitted infections.
	Basic Curative Services	**Maternal**
		i. Identification of early danger signs during pregnancy and neonates and refer effectively for delivery and other services.
		Neonates
		i. Identify sick newborns and refer to the health facility.
		Children (Under 5)
		i. Recognize danger signs of acute respiratory infection, provide first dose of amoxicillin and refer effectively to the facility for management. ii. Support families to provide home management of the sick child such as completion of dose, feeding and extra fluid. iii.

NEHP Category	Continuum of Care Category	Community-Based Health Services
		iv.
	Rehabilitative Services	**Maternal, Newborn, Children and Adolescents** i. Identify women with fistulae and facilitate effective referral. ii. Identify children with physical disabilities (e.g. clubfoot, cleft palate) and/or intellectual disabilities (e.g. retardation) and mental disorders and refer to clinic, welfare services or relevant CBOs using existing mechanisms (e.g. council directory of health and social welfare services). iii. Facilitate self-care and support to families with children who have congenital disorders – e.g. Down's syndrome, sickle cell anaemia, albinism; refer effectively to clinic, social welfare or CBO for follow-up.
	Palliative Care Services	i. Support palliation at household level for those in need (such as psychosocial support).
HIV		i. HIV prevention and treatment awareness; abstinence, be faithful, condom use (ABC); HIV testing services; treatment adherence; PMTCT; voluntary medical male circumcision ii. Access to HIV testing services among high-risk and vulnerable populations through house-to-house visits, index case testing and attending events with special groups iii. Facilitate the formation of psychosocial peer support groups and other peer-led groups for prevention and treatment (teen groups, community adherence groups, youth treatment clubs). iv. Proper food diversification by encouraging small-scale gardening and keeping small animals among PLHIV v. Voluntary medical male circumcision among young males and adults vi. Voluntary medical male circumcision among young males and adults vii. Importance of HIV status disclosure viii. HIV status disclosure among children ix. Become a member of the village most vulnerable child team x. Dispense condoms (male and female). xi. Create community awareness on the availability of post-exposure prophylaxis (PEP)

NEHP Category	Continuum of Care Category	Community-Based Health Services
		in the facilities in cases such as rape or other means of possible HIV exposure. xii. TB among PLHIV/TB among PLHIV their families, including children, if needed, using the community TB screening tool. xiii. Compile the list of HIV clients from the clinic and community sources who require follow-up (missed appointment, lost to follow-up [LTF] and adherence) for further support to return to care and treatment. xiv. Refer known HIV patients with deteriorating conditions to the health facility Care and Treatment Clinic (CTC) for further assessments and management. xv. Support patients with co-infections to adhere to both ART and TB treatment and support home-based TB DOTS. xvi. Support households with HIV-exposed or infected children and adolescents on management and care (e.g. disclosure, adherence, retention in care, ART storage and support from guardians/parents).
	Palliative Care Services	i. Support palliation at household level for those PLHIV in need.
	Data and Statistics	i. Collect and submit data for HIV and TB services provided in *Mfumo wa Taarifa za Uendeshaji Huduma za Afya* (MTUHA) Book No.
TB and Leprosy	**Promotive services**	i. screening tool and collect and transport sputum specimen whenever necessary. ii. Conduct community education on TB prevention and treatment awareness. iii. Formation and continuation of support groups (ex-TB patients and leprosy self-care groups) iv. HIV testing amongst TB patients
		i. Regular and proper (IPT) among TB index contacts, children and PLHIV without TB infection/disease Use TB

NEHP Category	Continuum of Care Category	Community-Based Health Services
	Preventive Services	ii. Educate on TB preventive practices (cough hygiene, ventilation, avoid overcrowding, early diagnosis). iii. Create community awareness on leprosy prevention and treatment. iv. Screen for TB in the household with TB/multidrug-resistant TB (MDR-TB) index case based on the list from the facility. v. Refer all the children under 5 living with TB patients for TB investigation and initiation of IPT.
	Curative Services	i. Patients with to the nearest health facility for assessment. ii. Support patients and treatment supporters during TB treatment with home-based DOTS. iii. Follow up on sputum examination results during and after DOT treatment to all bacteriologically confirmed patients. iv. Identify TB treatment side effects and refer to the
	Rehabilitative Services	i. TB groups and leprosy self-care groups to perform their tasks.
	Services	i. Conduct community education on prevention of NTDs (onchocerciasis, lymphatic filariasis, trachoma, schistosomiasis, soil-transmitted helminths and other worms). ii. Create awareness on the need for treatment of NTDs. iii. Promote health-seeking behaviour among NTD patients.
NTDs	**Preventive Services**	i. Educate the community on face washing (trachoma), destruction of mosquito breeding sites (lymphatic filariasis) and avoid unnecessary visits to fast-running rivers (onchocerciasis). ii. Encourage wearing of gumboots to avoid soil-transmitted worms and schistosomiasis. iii. Discourage bathing in stagnant water. iv. Encourage use of latrines. v. Facilitate and participate in annual mass drug administration campaigns.
	Services	i. Refer effectively patients with signs and symptoms of NTD. ii. Link patients with signs and symptoms of NTDs or core-morbidity to health facilities. iii. Facilitate surgical intervention campaigns for people with testicular torsion and hydrocele.

NEHP Category	Continuum of Care Category	Community-Based Health Services
		iv. Promote foot care and exercises for patients with elephantiasis.
	Rehabilitation Services	i. Promote foot care and exercise for patients with elephantiasis. ii. Link patient with blindness due to trachoma and onchocerciasis to health facilities.
	Services	i. Create awareness of major blinding eye diseases and conditions such as cataracts, glaucoma, retinal diseases, refractive errors, infectious eye diseases and eye trauma among community members. ii. Behaviour changes leading to good eye health (proper nutrition, hygiene and periodic eye screening) iii. Distribute eye health information, education and communication (IEC) materials.
Eye Care	**Preventive Services**	i. Conduct eye health education on eye disease preventive measures including vitamin A. ii. Participate in organizing eye health outreach activities and screening campaigns such as vitamin A, screening of school children for eye diseases and mobilizing community members. iii. Educate community members on the importance of seeking proper eye health care (avoiding use of harmful traditional medicines in eyes, use of unprescribed spectacles and unprescribed eye medicines). iv. Educate community members on the importance of facility-based delivery to prevent eye infections such as ophthalmianeonatorum.
	Services	i. Identify community members with eye problems and refer them effectively. ii. Educate clients on the importance of follow-up after eye surgery. iii. Educate clients on adherence to prescribed treatment and continuum of care for chronic eye diseases such as glaucoma and diabetes.
	Rehabilitative Services	i. and community health and onward linkage to appropriate levels for rehabilitative measures. ii. Educate clients on adherence to prescribed eye rehabilitative medications or devices for continuum of care. iii. Facilitate community work participation for people with blindness.
	Services	i. Awareness of risk factors for NCDs and their prevention, such as obesity, elevated blood pressure, blood sugars and lifestyle

NEHP Category	Continuum of Care Category	Community-Based Health Services
		ii. Healthy lifestyle such as being free from substance use and engaging in physical activities and school physical education
Sickle cell diseases, trauma and injuries, substance abuse, obesity and mental disorders	**Preventive Services**	i. Identify early sign of possible complications of NCDs – e.g. blindness and gangrene foot, psychological impairment. ii. Educate family members to support patients with chronic illness to adhere to medications – e.g. mental disorders, diabetes and other NCDs. iii. Periodic screening for blood sugar, blood pressure, blood lipids and reproductive cancers iv. Universal health insurance coverage and exemptions where applicable v. Educate the community with correct information on diseases to reduce stigma associated with conditions.
	Services	i. Identify patients with early signs of NCDs and provide effective referral to the facility ii. Provide first aid services for health emergencies. iii. Sensitize the community on tertiary prevention referral to appropriate health facility – e.g. coma patients, gangrenous extremities, severe mental disorders.
	Rehabilitation Services	iii. Awareness of risk factors for NCDs and their prevention, such as obesity, elevated blood pressure, blood sugars and lifestyle i. Support and provide home-based rehabilitative and palliative care. ii. Identify the social welfare needs and provide psychosocial support and link to relevant rehabilitative services if needs arise – e.g. spiritual needs, legal and social welfare services.
	Services	i. health the community regarding IDSR-related disease. ii. Participate in the control of disease outbreaks such as cholera, watery and bloody diarrhoea and epidemics, loss of consciousness, fevers and convulsions. iii. Mobilize the community to allocate resources for handling emergencies – e.g. transport funds, rented vehicle.

NEHP Category	Continuum of Care Category	Community-Based Health Services
Epidemiology and Disease Control	**Preventive Services**	i. Mobilize the community to participate in early identification of eIDSR-related diseases and other public health events. ii. Report early signs of and health
	Services	i. Participate in the early response/management of disease outbreaks – e.g. cholera, bacilli dysentery and other WASH-related diseases. ii. Facilitate early transfer of patients with highly infectious diseases, such as Ebola, to the nearest health facility and village leadership. iii. Participate in emergency case management delivery – e.g. for cholera or Ebola.
	Promotive Services	i. Create awareness of use of helmets, protective goggles, life jackets and gloves. ii. Promote understanding. iii. Provision and use of safe environments, such as playgrounds and recreational areas
Physical Injury	**Preventive Services**	i. Educate households on home-based safety such as proper storage and disposal of sharps, medicines, cooking gas and oil and proper covering of septic tanks and other holes. ii. Educate on proper storage of food and other tempting items to avoid dangers of childhood injuries/trauma. iii. Educate the community on the importance of guidance to vulnerable groups, such as children, the elderly, people with disabilities and mentally ill persons, during physical activities. iv. Educate the community to avoid discrimination against elderly people and people with disabilities due to myths and misconceptions. v. Educate the community on the importance of periodic maintenance of motor vehicles, motorbikes and bicycles for safety. vi. Educate the community on ensuring safety at the workplace. vii. Educate the community on proper handling of patients with injuries.
	Curative Services	viii. Perform basic first aid and take patients to the nearest health facility.
	Rehabilitative Services	i. to adherence to recommended home-based rehabilitation following physical injury. ii. Link people with disabilities caused by injuries to access assistive devices.

NEHP Category	Continuum of Care Category	Community-Based Health Services
		iii. Conduct psychosocial support meetings for people who have experienced traumatic events.
		i. Healthy eating for maintenance of good health throughout the life cycle ii. Appropriate infant and young child feeding practices iii. Use of fortified food and iodised salts iv. Iron and folic acid to pregnant and lactating women v. Food diversification by encouraging small-scale gardening and keeping small animals vi. Conduct nutrition education sessions. vii. Distribute social and behavioural change communication materials on nutrition. viii. Maintenance of ideal body weight
Nutrition	**Preventive**	i. Screen for acute malnutrition using anthropometric measurement tape (MUAC, length and weight) and refer severe acute malnutrition. ii. Participate in provision of vitamin A capsules and deworming tablets. iii. Provide dietary counselling for obese patients. iv. Conduct regular nutritional assessment counselling and support (NACS) at households and refer accordingly. v. Proper feeding during first 1000 days (2 years) of life
		i. Reduction of calorie intake among obese people ii. Screen and refer all severely malnourished children to the nearest health facility and follow up on the progress.
	Promotive Services	i. Healthy eating for maintenance of good health throughout the life cycle ii. Appropriate infant and young child feeding practices iii. Use of fortified food and iodised salts iv. Iron and folic acid to pregnant and lactating women v. Conduct nutrition education sessions. vi. Distribute social and behavioural change communication materials on nutrition. vii. Reduction of sugar-added drinks (all sodas and all processed juices) among infants, children and youth

NEHP Category	Continuum of Care Category	Community-Based Health Services
Nutrition, Oral Health and Dental Care	**Preventive Services**	i. Educate community groups and individuals on identification of early signs of dental caries, especially in schoolchildren. ii. Identify families and individuals with oral health problems. iii. Educate the community on 'sweet day' – i.e. eating sugar only once a week. iv. Dispel, through education, the myth related to uvulectomy and removal of plastic teeth (*ukataji wa vimeo na meno ya plastiki*). vi. Educate the community on identification of early signs of oral cancer. Screen for acute malnutrition using anthropometric measurement tape (MUAC, length and weight) and refer severe/acute malnutrition. vii. Participate in provision of vitamin A capsules and deworming tablets. viii. Provide dietary counselling for obese patients. v. Proper feeding for first 1000 days (2 years) of life
	Curative Services	iii. Ensure adherence to prescribed nutritional supplements, regular NACS among patients and refer according to their nutritional status. i. Screen and refer all severely malnourished children with dental caries and link them with services. ii. Identify people with dental malalignment to the nearest health facility and link them with services. iii. Identify people with dental anomaly, such as cleft palate and cleft lip, and link with services. iv. Follow up with all clients who have received oral and dental care on the progress.
	Rehabilitative Services	i. Brushing teeth at least twice a day, in the morning and at bedtime ii. Link patients to clinics for artificial teeth.
	Preventive Services	**Community**. . . .*wavimeo na meno ya plastiki*....
	Preventive Services	i. Identify oral health care needs using questionnaires and visual inspections. ii. Identify children with dental caries and link them with services. iii. Identify people with dental malalignment and link them with services. iv. Identify people with dental anomaly, such as cleft palate and cleft lip, and link with services.

NEHP Category	Continuum of Care Category	Community-Based Health Services
		i. Follow up with all clients who have received oral and dental care for progress.
		School **i.** Promote the formulation of School Water Sanitation and Hygiene (SWASH) clubs. ii. Insist on the construction of latrines with consideration to special groups (pupils with disabilities and changing rooms for female pupils). iii. Promote hygiene practices – e.g. hand washing after visiting toilets and at all crucial times – and wearing of shoes. iv. Menstruation hygiene facilities
		Community i. Participate in organizing disinfection and fumigation. ii. Conduct sensitization to prevent contamination of water sources.
Environmental Health, Hygiene and Sanitation	**Preventive Services**	i. Male and youth involvement to address gender inequalities ii. Participatory decision-making on health-related issues of household water treatment, safe storage and use. iii. Positive attitude towards adolescent girls/boys and young women on health rights iv. Promote awareness of gender equity and equality. v. Create awareness about GBV and VAC.
		i. Create awareness within the community on the use of (SWASH) clubs. ii. Insist on the construction of latrines with consideration to special groups (pupils with disabilities and changing rooms for female pupils). iii. Hand washing after visiting toilets and at all crucial times and wearing of shoes. iv. Educate the community on the availability of GBV and VAC services in the community. v. Educate the community on the consequences of GBV and VAC and the importance of reporting to service providers in the community. vi. Educate the community on gender roles and responsibilities and gender equity/equality.
		vii. Identify victims and survivors of GBV and VAC in the community and link them to appropriate

NEHP Category	Continuum of Care Category	Community-Based Health Services
		services – e.g. Health Services (PEP, contraceptive services, forensic evidence collection) legal services and psychosocial support.
	Promotive Services	viii. Male and youth involvement to address gender inequalities ix. Participatory decision-making on health-related issues at household level x. Positive attitude towards adolescent girls/boys and young women on health rights xi. Gender equity and equality xii. Create awareness within the community on the dangers of discrimination and rights to health information and interventions. i. Awareness on child protection activities and structures that will protect a child from abuse, violence and neglect in the communities; e.g. formation of children's clubs, education on the rights of the child and protection systems ii. Traditional practices that are in the best interest of the child – e.g. traditional positive parenting iii. Involvement of children and their families in addressing child abuse and VAC issues in communities iv. Identify out-of-school children and report to the Social Welfare Officer.
Child Protection	**Preventive Services**	i. Educate the community on the availability of GBV and VAC services for VAC and child abuse victims/survivors in the community. ii. Educate the community on the consequences of GBV and VAC and child abuse and the importance of reporting to service providers in the community. iii. Support child protection teams in the community. iv. Educate the community to prevent harmful traditional practices towards children. v. Conduct household visits to identify and assess needs of the most vulnerable children (MVC) (orphans, children with disabilities [CWD], children heading households/young carers, children with HIV and AIDS and other terminal illnesses etc.). vi. Identify victims of child abuse and VAC in the community. vii. Become a member in a village child protection team

NEHP Category	Continuum of Care Category	Community-Based Health Services
	Curative Services	i. Identify victims and survivors of GBV and VAC in the community. ii. Provide linkages and referrals to appropriate services for MVC (orphans, CWD, children heading households/young carers, children with HIV and AIDS and other terminal illnesses, etc.), survivors of child abuse and VAC. iii. Provide psychosocial support to MVCs and survivors of child abuse and VAC.
	Promotive Services	i. Awareness on child protection activities and structures that will protect a child from abuse, violence and neglect in the communities; e.g. formation of children's clubs, education on the rights of the child and protection systems ii. Traditional practices that are in the best interest of the child – e.g. traditional positive parenting. iii. Involvement of children and their families in addressing child abuse and VAC issues in communities iv. Identify existing community-owned support systems – e.g. churches, mosques – and report to the Social Welfare Officer.
Vulnerable – Poor Families	**Preventive Services**	i. Educate the community on the availability of social welfare services for VAC and child abuse victims/survivors in the community. ii. Educate the community on the consequences of VAC and child abuse and the importance of reporting to service providers in the community, community-owned support systems. iii. Identify most vulnerable families and individuals in need of social welfare assistance through household visits. Support child protection teams in the community. iv. Educate the community to prevent harmful traditional practices towards children. v. Conduct household visits to identify and assess needs of the most vulnerable children (MVC) (orphans, children with disabilities [CWD], children heading households/young carers, children with HIV and AIDS and other terminal illnesses etc.). vi. Identify victims of child abuse and VAC in the community. vii. Become a member of the village MVC protection team.

NEHP Category	Continuum of Care Category	Community-Based Health Services
	Curative Services	i. Link vulnerable poor families and individuals in the community. ii. Provide linkages and referrals to social welfare services for MVC (orphans, CWD, children heading households/young carers, children with HIV and AIDS and other terminal illnesses, etc.), survivors of child abuse and VAC. iii. Provide psychosocial support to MVCs and survivors of child abuse and VAC.
	Promotive Services	i. Promote healthy lifestyles for the elderly, such as exercise and healthy eating. ii. Promote screening for NCDs such as diabetes and cardiovascular disease. iii. Create awareness on CDs such as TB and HIV and AIDS because most elderly people are carers for orphans and the sick. iv. Sensitize the community on age-related health problems. v. Promote acceptable traditional 'safety nets' (social network) for care and protection of the elderly. vi. Conduct household visits for follow-up on old people.
Health of Elderly People	**Preventive Services**	i. Link survivors of GBV to appropriate services. ii. Educate the community on the consequences of outdated cultural norms and practices that victimise older people, such as killing of women with red eyes and the right to inherit property. iii. Create awareness on the availability of social protection and health services for MVC/families in the community. iv. Educate the community on the importance of community-owned support systems. v. Identify most vulnerable families and individuals in need of social welfare assistance in the community through household visits.
	Curative Services	i. Link vulnerable poor families and individuals in the community to social welfare services. ii. Provide psychosocial support to vulnerable poor families.
	Rehabilitative Services	i. Promote healthy lifestyles for the establishment of recreation groups and healthy eating.

NEHP Category	Continuum of Care Category	Community-Based Health Services
		vii. Promote screening for NCDs such as diabetes and cardiovascular disease. ii. Create awareness on CDs such as TB and HIV and AIDS because most elderly people are carers for orphans and the sick. iii. Sensitize the community on age-related health problems. iv. Promote acceptable traditional 'safety nets' (social network) for care and protection of the elderly. v. Conduct household visits for follow-up on old people at elderly homes. vi. Facilitate availability of recreation centres for the elderly in the community vii. Support elderly to access health exemption services. viii. Support revitalization and functioning of the elderly councils.
	Resource Mobilization	i. Mobilize and facilitate effective emergency referrals. ii. Facilitate the mobilization of resources for response to appropriate services. iii. Create awareness on the availability of social protection and health services for older people.
	Curative Services	iii. Identify older people and link them to services.
	Rehabilitative Services	ix. Facilitate the establishment of recreation groups and areas for elderly people in the community. x. Refer all destitute elderly people to elderly homes.
	Resource Mobilization	iv. Mobilize and facilitate effective emergency referrals. v. Facilitate the mobilization of resources for response to the emergencies.
Administrative and QA Resource Mobilization Mobilize effective emergency referrals. Facilitate the mobilization of resources for response to	**Supervision Mechanisms**	i. Develop own work plan to guide implementation of assigned tasks in the community. ii. Use checklists to track all tasks done. iii. Report to the supervisor regularly according to established mechanisms.
	Data, Statistics and Reporting	i. Enter data on community and household activities into MTUHA Book No. 3. ii. Report risks or hazards that may contribute to accidents in the community.

NEHP Category	Continuum of Care Category	Community-Based Health Services
the emergencies. **Administrative and QA**		iii. Record and report all births and deaths that happen in the community to the nearest health facility. iv. Record and report any unusual events, accidents, traumas or other reportable events using Community Diagnosis guidelines to the nearest health facility and village executive. v. Record and report all cases identified, services offered and treatments dispensed through CHV services. vi. Record and report all referrals and linkages. vii. Prepare and submit monthly reports on health-related issues to village leadership, VHC and Ward Executive Officer (WEO).

Appendix 2: Roles and Responsibilities of other CBHSW Stakeholders

Level	Responsibilities
Community Health Volunteers	i. Routine data collection and event-based reporting using paper registers and health tools. ii. Maintain CHV register, generate monthly reports and deliver to facility supervisor or CBHP coordinator for entry into DHIS2. iii. Review own data to assess achievement of tasks outlined in the action plan and identify disease trends in the village. iv. Develop activity plans each quarter with supervisor, set targets for service provision. v. Receive feedback from the ward PHC committee on technical components of the CBHP. vi. Ensure that high-quality records and monthly reports are completed and correctly stored. vii. Report to VEO on administrative tasks related to the CBHP. viii. Attend village meetings to discuss challenges and receive updates from the village government. ix. Assist in organizing Village Health and Nutrition Days
Parent Health Facility (Clinical Supervisor)	i. Ensure the quality of CHV reporting forms. ii. Provide the intermediate step for reporting and review between the CHV and the facility. iii. Prepare and review monthly reports to monitor performance of activities outlined in the activity plan. iv. Develop quarterly activity plans with the CHV and set targets for service provision. v. Receive feedback from the ward PHC committee on technical components of the CBHP.
Village Government (VEO)	i. Attend village meetings to discuss administrative issues. i. Support the CHVs/CHVs in administrative processes at the village level. i. Organize Village Health and Nutrition Days v. Report and receive feedback from the WEO on administrative issues. v. Ensure the quality and completeness of reports.
Ward PHC Committees (Supportive Supervisor)	i. Work with VHCs to develop activity plans and set targets for CHV service provision each quarter. ii. Receive feedback from Council PHC Committee and reports from the VHCs. iii. Provide technical support to the VHCs in planning and monitoring CHV activities. iv. Provide regular feedback to the CHVs/CHVs during supervision visits and quarterly review meetings.
Ward Development Committees (WDC)	i. Receive reports on CBHP administrative activities from the VEO via the WDC. ii. Compile reports from the ward for discussion and reporting to the council. iii. A representative of the WDC shall report to the council on ward CBHP administrative tasks and feed updates back to the WDC.

Level	Responsibilities
Council PHC Committees (CBHP Coordinator)	i. Analyse and generate reports on CBHP data. ii. Ensure dissemination of reports to relevant stakeholders. iii. Review and approve activity plans for CHV activities in the council that have been generated at the ward and village levels. iv. Receive, review and discuss reports from the supportive supervisors and wards in their council to provide support to ward PCH committees on implementing and improving programme activities according to the annual plans. v. Review council-level programme performance data that is entered in the national HMIS (DHIS2). vi. Provide technical support to the ward PHCs in conducting participatory planning and monitoring of technical programme activities. vii. Conduct a quarterly programme review meeting at the council level.
Councils (District Executive Director)	i. Collect and analyse data and compile quarterly reports from CHV supervision visits on CBHP administrative tasks and report to council for inclusion in the CCHP. ii. Receive and review reports from the WDCs on the performance of administrative activities in the wards. iii. Receive, review and discuss reports from the supportive supervisors and WDCs in their council to plan and provide support to improve programme administrative activities. iv. A representative of the council will report on administrative features of the CBHP to the Regional Authority.
Regional PHC Committees	i. Receive and review quarterly reports from the council PHCs. i. Review programme performance data quarterly as they are entered in the national HMIS database. i. Provide support on implementing and improving programme activities according to the council-level annual plans. v. Incorporate CHV activities into semi-annual performance assessment of councils in the region.
Regional Authorities	i. Receive and review reports from the council for planning of administrative activities at the regional level. ii. Support the councils in their area in planning and implementing administrative tasks related to the CBHP. iii. Report regional-level administrative results to the PO-RALG, respond to feedback and update the councils.
National CBHP	i. Receive and review quarterly reports from the regional PHCs. ii. Conduct monthly meetings at the national level to discuss technical issues related to CHV operations. iii. Provide technical support and provide feedback to regional and council PHCs through annual meetings.
PO-RALG	i. Collect, analyse and review annually reported data from regional authorities, in addition to data from national administrative databases.

Level	Responsibilities
	ii. Conduct annual meetings to review and discuss programme administration to revise policies and strategies for the CBHP. iii. Disseminate results of the annual review process and national analysis to regional authorities.

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