ADVANCING PARTNERS & COMMUNITIES

COMMUNITY HEALTH SYSTEMS CATALOG COUNTRY PROFILE: TANZANIA

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JSI RESEARCH & TRAINING INSTITUTE, INC.
1616 Fort Myer Drive, 16th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
Email: info@advancingpartners.org
Web: advancingpartners.org

ACRONYMS

APC	Advancing Partners & Communities
CBHP	Community-Based Health Program
CHMT	council health management team
CHS	community health system
CHW	community health worker
DHIS	district health information system
FP	family planning
HPS	Health Promotion Service
IUD	intrauterine device
MMAM	Mpango wa Maendeleo wa Afya ya Msingi (Primary Health Service Development Program)
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
NACTE	National Accreditation Council for Technical Education
NGO	nongovernmental organization
PHC	primary health care
PO-RALG	President's Office of Regional Administration and Local Government
RHMT	regional health management team
TB	tuberculosis
USAID	Unites States Agency for International Development
WASH	water, sanitation, and hygiene
VDC	village development committee
VHC	village health committee
WDC	ward development committee

INTRODUCTION

This Community Health Systems (CHS) Catalog country profile is the 2016 update of a landscape assessment that was originally conducted by the Advancing Partners & Communities (APC) project in 2014. The CHS Catalog focuses on 25 countries deemed priority by the United States Agency for International Development's (USAID) Office of Population and Reproductive Health, and includes specific attention to family planning (FP), a core focus of the APC project.

The update comes as many countries are investing in efforts to support the Sustainable Development Goals and to achieve universal health coverage while modifying policies and strategies to better align and scale up their community health systems.

The purpose of the CHS Catalog is to provide the most up-to-date information available on community health systems based on existing policies and related documentation in the 25 countries. Hence, it does not necessarily capture the realities of policy implementation or service delivery on the ground. APC has made efforts to standardize the information across country profiles, however, content between countries may vary due to the availability and quality of the data obtained from policy documents.

Countries use a wide variety of terminology to describe health workers at the community level. The CHS Catalog uses the general term "community health provider" and refers to specific titles adopted by each respective country as deemed appropriate.

The CHS Catalog provides information on 136 interventions delivered at the community level for reproductive, maternal, newborn, and child health; nutrition; selected infectious diseases; and water, sanitation, and hygiene (WASH). This country profile presents a sample of priority interventions (see Table 6 in the Service Delivery section) delivered by community health providers and for which information is available.

APC regularly updates these profiles and welcomes input from colleagues. If you have comments or additional information, please send them to info@advancingpartners.org.

TANZANIA COMMUNITY HEALTH OVERVIEW

Over the past 50 years, Tanzania has focused on improving community-level health services as a key component of overall health systems strengthening. In the 1970s, the country expanded primary health care (PHC) services at the grassroots level by expanding frontline health facilities and training village health workers to conduct community outreach. While the country emphasized vertical programming in the 1990s, the Millennium Declaration prompted health sector reforms, including a revised national health policy to accommodate community-based health services and more integrated programs.

In 2007, in response to rapid population growth and poor health sector performance, the Mpango wa Maendeleo ya Afya ya Msingi (MMAM)—the primary health service development program—aimed to improve access to basic health care and empower communities to take charge of their own health. Specifically, MMAM intended to expand and better support the health workforce by improving motivation, training, and retention; strengthening district health services by creating more facilities; promoting health care-seeking; and reducing maternal and child mortality.

Under the recently developed Community-based Health Program, Tanzania created the CHW cadre to formalize and harmonize health worker efforts under a single program.

In the early 2010s, the Ministry of Health, Community Development, Gender, the Elderly, and Children (MOHCDGEC) and the President's Office for Regional Administration and Local Government (PO-RALG) began planning the Community-based Health Program (CBHP) to address the lack of coordination, standardization, monitoring, supervision, and support across a range of community health programs operating at the local level. The CBHP centers on Tanzania's first officially recognized and standardized community health worker (CHW) cadre, and the services that they deliver, which are derived from the 2013 *National Essential Health Care Interventions Package – Tanzania (NEHCIP)*. Village health committees (VHCs) oversee and closely collaborate with CHWs.

Table 1. Community Health Quick Stats

Main community health policies/strategies	*Primary Health Services Development Programme (MMAM) 2007–2017*	*National Essential Health Care Interventions Package – Tanzania*	*Community-Based Health Program (CBHP) Policy Guidelines*	*Health Sector Strategic Plan IV*	*CBHP Costed Strategic Plan (2015–2020)*	*CBHP Implementation Design*
Last updated	2007	2013	2014	2015	2015	2017
Number of community health provider cadres	1 main cadre: Community health worker (CHW)					
Recommended number of community health providers	24,886 CHWs					
Estimated number of community health providers	*Information not available in policy.*					
Recommended ratio of community health providers to beneficiaries	2 CHWs: 1 rural village or urban street					
Community-level data collection	Yes					
Levels of management of community-level service delivery	National, regional, district, ward, local/village					
Key community health program(s)	CBHP; MMAM					

The MOHCDGEC oversees the CBHP while the PO-RALG is chiefly responsible for its implementation. Nongovernmental organizations (NGOs), donors, and other partners support CBHP planning and implementation at all levels, including goal- and objective-setting, resource mobilization, and information-sharing. Once fully implemented, the program will operate in rural, urban, and peri-urban areas using a combination of funding sources, including the national government, district-level actors international donors, and NGOs. Additionally, the CBHP encourages communities to support the program through direct labor, materials, and funds. Cross-sectoral by design, the program is linked to the education sector, which supports CHW training processes, as well as the private sector to support program implementation, with the first cohort of CHWs to be trained by mid-2017.

Table 2. Key Health Indicators, Tanzania

Total population[1]	54.2 m
Rural population[1]	70%
Total expenditure on health per capita (current US$)[2]	$52
Total fertility rate[3]	5.2
Unmet need for contraception[3]	22.1%
Contraceptive prevalence rate (modern methods for married women 15-49 years)[3]	32.0%
Maternal mortality ratio[4]	398
Neonatal, infant, and under 5 mortality rates[3]	25 / 43 / 67
Percentage of births delivered by a skilled provider[3]	63.7%
Percentage of children under 5 years moderately or severely stunted[3]	34%
HIV prevalence rate[5]	4.7%

[1]PRB 2016; [2]World Bank 2016; [3]MOHCDGEC, NBS, OCGS, and ICF 2016; [4]World Health Organization 2015; [5]UNAIDS 2015.

Three main policy documents guide the CBHP. The *National CBHP Policy Guidelines* provides context for the program, outlines its vision and components, and delineates a framework through which the program should be organized and implemented. The *National Costed CBHP Strategic Plan* builds upon the *Guidelines* to further define program priorities and objectives, including specific strategies for management and coordination; formalizing CHWs; strengthening institutional capacity, resource mobilization and management, and advocacy; and promoting gender equity, human rights, and sustainability. Finally, the *National CBHP Implementation Design* provides key strategies for the program's scope, coordination, governance, implementation, rollout, and monitoring and evaluation.

In addition to these documents, the country's fourth *Health Sector Strategic Plan* guides service delivery, including at the community level. An overarching health strategy, the MOHCDGEC developed the plan to guide the continued transformation of the health sector and improve the quality of PHC.

Together, Tanzania's policies provide guidance about a wide range of health areas, including FP, tuberculosis (TB), and HIV and AIDS. They also describe the role of CHWs and the systems and processes that support them, including recruitment, deployment, supervision, retention, incentives, and referrals.

Overall, community health guidance is comprehensive. However, because the different CBHP documents were developed over the course of several years, guidance sometimes varies. For example, the *CBHP Implementation Design* reflects slight inconsistencies from earlier documents on the roles and responsibilities of some health system actors, including community groups.

Gender is a key priority of the Ministry and therefore is heavily integrated into all recent policies and strategies. The *CBHP Policy Guidelines*, for example, emphasize gender awareness and sensitivity during planning, implementation, and dialogue about health matters pertaining to CBHP services. The document also acknowledges gender inequality as a barrier to health care and socioeconomic growth and development, and includes a policy statement to ensure that the CBHP addresses gender equity, women's empowerment, and constructive male involvement in promoting community health services.

LEADERSHIP AND GOVERNANCE

Many stakeholders across national, regional, district, ward, and community levels coordinate and manage the CBHP in Tanzania. Each level has a specific role in supporting program implementation, but the roles of some stakeholders are inconsistently defined across documents. This section attempts to summarize this information.

- At the **national level**, the MOHCDGEC formulates policy, guidelines, and strategies for CBHP implementation; mobilizes resources; supports capacity building; conducts operations research; promotes multi-sectoral collaboration and accountability; and provides feedback on program progress. Within the MOHCDGEC, the Health Promotion Service (HPS) manages the CBHP in coordination with the PO-RALG. The PO-RALG oversees the administrative components of CBHP implementation in districts and municipalities, including monitoring and supportive supervision. Development partners initiate and support projects in line with the CBHP; set targets; and share experiences with national authorities.

- The **regional** authority and the regional health management team (RHMT) support the district level with planning; coordination; budgetary oversight; technical support; and supervision. The RHMT reports to the MOHCDGEC, while the regional authority is responsible to the PO-RALG.

- In **districts (or municipalities)**, the council health management team (CHMT) implements the CBHP and other programs. It plans and coordinates activities; compiles and records data and submits them to the MOHCDGEC via the RHMT; and provides supportive supervision of ward and community actors. Each district or municipality has a CBHP coordinator who works with the CHMT to integrate the CBHP into the administrative system. The coordinator maps key stakeholders; organizes CHW recruitment, training, and deployment; plans CHW activities; conducts targeted CHW supervision; and manages CBHP data and uploads it to the district health information system (DHIS). District councils, which support the CBHP administratively, collect and analyze reports from the ward development committee (WDC) and incorporate CBHP information within their health and development plans. NGOs and faith-based organizations also support CBHP implementation.

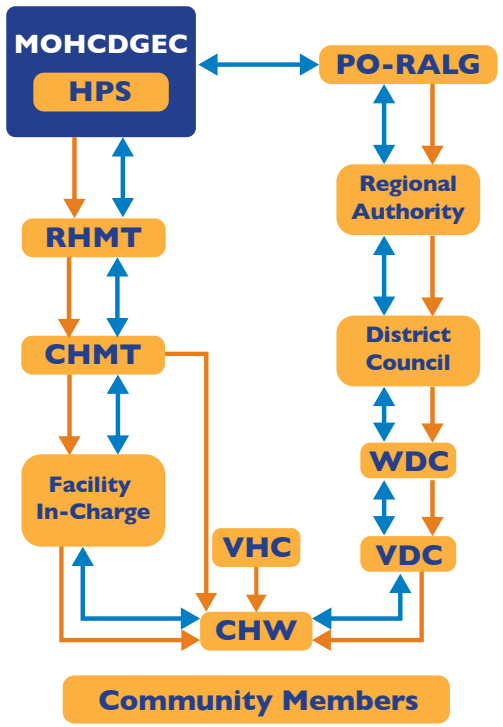
- The health facility in-charge supervises CHWs and reviews their reports at the **ward level**. The WDC supervises program implementation within its catchment area, including coordinating activities at the village level; works with the village government to develop and implement village health plans; mobilizes communities to contribute resources; and compiles reports. The WDC is a link between the village development committee (VDC) and the district council and provides administrative support to the CHW.

- At the **community leve**l, the village government and local committees, such as VHCs, participate in planning, implementation, and regular monitoring and evaluation of the CBHP in coordination with the CHMT, health facility in-charge, and CHWs; initiate sustainable financing mechanisms for program activities; and give feedback on program progress via meetings and seminars. For instance, VHCs conduct health promotion activities; develop village health plans; maintain the village health register, information board, and calendar; and keep higher-level officials apprised of local health issues. VHCs also facilitate the election of CHW candidates and support them in their routine work. CHWs provide progress reports to the WDC via the VDC.

Figure 1 summarizes Tanzania's health structure, including service delivery points, key actors, and managing bodies at each level.

Figure 1. Health System Structure

Level	Managing Administrative Body	Service Delivery Point	Key Actors and Their Relationships*
National	MOHCDGEC PO-RALG	Referral Hospital Specialized Hospital	
Regional	RHMT Regional Authority	Regional Hospital	
District	CHMT District Council	District Hospital	
Ward	Facility In-Charge WDC	Rural Health Center	
Community	VHC VDC	Dispensary CHW	



*NGOs and development partners provide support at all levels and work in close collaboration with the government in community health planning and implementation.

Supervision
Flow of community-level data

HUMAN RESOURCES FOR HEALTH

While community health providers have been working as volunteers in Tanzania for decades, they have operated under various, often uncoordinated programs, sometimes with a narrow scope in specific health areas, such as HIV and AIDS or FP. Under the CBHP, the country aims to officially recognize and harmonize the CHW role under a single program within the health system, train them on a standard, more comprehensive package of services, and pay them a salary. CHWs are expected to work in collaboration with other informal community health provider cadres in the country, but guidance does not specify the structure of the relationship.

Within their catchment area, defined either as a rural village or a subsection of a city called a 'street,' CHWs will work in pairs to identify opportunities and obstacles for health access and use in their communities; implement community health interventions during household visits; manage commodities and supplies; collaborate with village and ward government as well as community groups; collect, analyze, and report data to the health facility in-charge; and conduct community-based surveillance. The specific health and social welfare areas in which they provide services are outlined in the Service Delivery section.

Table 3 provides an overview of CHWs.

Table 3. Community Health Provider Overview

	CHWs
Number in country	*Information not available in policy*
Target number	24,886
Coverage ratios and areas	2 CHWs (1 male and 1 female) : 1 rural village or urban street Operate in urban, rural and peri-urban areas.
Health system linkage	CHWs are an officially recognized cadre trained to provide a package of services derived from the NEHCIP using a standardized training program and curriculum. CHWs receive government salaries and are linked to health facilities, such as dispensaries.
Supervision	CHWs are supervised by health facility in-charges. Ward-level actors, such as officers for social welfare, health, community development, or agriculture, may also provide support. The CHMT, RHMT, and the CBHP coordinator may also conduct periodic supportive supervision, which may include mentorship, coaching, and data quality assurance. Local authorities, such as village leadership, the VHC, VDC, and WDC, may provide additional oversight to CHWs. Peer supervision is also encouraged.
Accessing clients	On foot Bicycle
Selection criteria	Minimum of a Form IV education[1] Resident of the locality At least 18 years of age Approved by the village assembly/VHC Undergo a 1-year training
Selection process	The Department of Human Resources within the MOHCDGEC and the National Accreditation Council for Technical Education (NACTE) advertise for the CHW training. They send the posting to the PO-RALG and districts/municipalities to advertise, and the NACTE also puts it on its website. CHWs must secure a nomination from their communities before they apply, a process which the VHC oversees. Qualified applicants are then assigned to health training institutes within their localities. They are expected to finance their own training except where scholarships are available. Scholarship recipients must sign agreements with their villages indicating that they will return to serve there for a minimum of three years upon graduation. Once the training is complete, CHWs receive an employment contract detailing their job descriptions and employment conditions, and the health facility in-charge orients them to their roles and responsibilities.
Training	Training is approximately 1 year. The curriculum includes classroom-based and practical components and will be regularly reviewed. CHWs receive job aids and on-the-job training, organized by the MOHCDGEC and partners.

Table 3. Community Health Provider Overview

	CHWs
Curriculum	*Curriculum for Basic Technician Certificate in Community Health (NTA Level 4)* (2015). This curriculum is designed to train a general 'health aide' category, which can become a social work aide, a medical attendant, or a CHW. It includes modules on infection prevention and control; basic life support skills; management of health care facility environment; citizenship and gender; management information systems; disease prevention and control; community-based reproductive, maternal, and child health services; health promotion; fundamentals of social work practice; home-based care; entrepreneurship and life skills; and 'managing the deceased' at the health facility and in the community.
Incentives and remuneration	CHWs will receive salaries equivalent to approximately $143 US per month[2] from the government as well as per diems and a benefits package. Nonfinancial incentives may include formal social recognition for their work at public events and opportunities for career advancement, such as promotion to a senior CHW position and pathways to earn further qualifications through a continuing education plan. CHWs may also receive supplies and equipment to ensure performance, such as bicycles; umbrellas; backpacks; boots; raincoats; uniforms; mobile phones; flashlights; and identification cards. A combination of the MOHCDGEC, district actors, NGOs, and the community may provide nonfinancial incentives.

[1] Form IV is equivalent to a secondary education in Tanzania.
[2] This figure corresponds to an annual salary of 3,840,000 Tanzanian shillings budgeted per CHW in the *National CBHP Strategic Plan*.

HEALTH INFORMATION SYSTEMS

Under the CBHP, CHWs collect data using household registers, stock management forms, and other simplified health management information system (HMIS) tools designed for the program. The CHMT is responsible for ensuring standardization of data forms.

CHWs complete monthly reports and send them to health facility in-charges and village authorities like the VDC. Data then moves up through health system; the in-charge compiles CHW-collected data and sends it to the HMIS focal person of the CHMT, who enters it into the relevant HMISs, including the DHIS and the human resources information system. From there, the RHMT may access the data from all the councils within its jurisdiction, and passes reports up to the HPS within the MOHCDGEC.

With regard to the administrative system, the village government and/or VDC sends CHW activity reports to the WDC, which passes information to the district council. The district council sends information to the regional authority, which then transmits it to the PO-RALG. The MOHCDGEC and PO-RALG share data with NACTE and the Ministry of Education.

Each level of the system is expected to share data for feedback purposes. For instance, CHWs are to share health information with communities and households during regular formal sessions.

The blue arrows in Figure 1 show the data flow across Tanzania's health system.

Table 4. Selected Medicines and Products Included in the *Standard Treatment Guidelines and National Medicines List for Mainland Tanzania* (2007)[1]

Category		Medicine / Product
FP	☐	CycleBeads®
	☑	Condoms
	☑	Emergency contraceptive pills
	☑	Implants
	☑	Injectable contraceptives
	☑	IUDs
	☑	Oral contraceptive pills
Maternal health	☐	Calcium supplements
	☑	Iron/folate
	☑	Misoprostol
	☑	Oxytocin
	☑	Tetanus toxoid
Newborn and child health	☑	Chlorhexidine
	☑	Cotrimoxazole
	☑	Injectable gentamicin
	☑	Injectable penicillin
	☑	Oral amoxicillin
	☑	Tetanus immunoglobulin
	☑	Vitamin K
HIV and TB	☑	Antiretrovirals
	☑	Isoniazid (for preventive therapy)
Diarrhea	☑	Oral rehydration salts
	☑	Zinc
Malaria	☑	Artemisinin combination therapy
	☐	Insecticide-treated nets
	☑	Paracetamol
	☐	Rapid diagnostic tests
Nutrition	☑	Albendazole
	☑	Mebendazole
	☐	Ready-to-use supplementary food
	☐	Ready-to-use therapeutic food
	☑	Vitamin A

HEALTH SUPPLY MANAGEMENT

CHWs are expected to keep a stock of supplies that clients can access at any time of day. They may go to their designated health facility/dispensary to refill stock as needed. Health facilities obtain medical supplies from the Medical Stores Department of the MOHCDGEC. The CHMT is responsible for estimating the supplies that CHWs will need, including essential medicines, test kits, bandages, equipment, protective clothing, and bicycles.

1 While there is a 2013 version of Tanzania's *Standard Treatment Guidelines and Essential Medicines List*, the version available does not include the essential medicines list.

While details are not available about how CHWs dispose of medical waste, an outline of their training curriculum indicates they should follow infection prevention and control guidelines.

Policies do not specify how CHWs may obtain backup supplies in the case of a stockout.

Information about selected medicines and products included in the *Standard Treatment Guidelines and National Medicines List for Mainland Tanzania* is provided in Table 4.

SERVICE DELIVERY

Tanzania's main service delivery package is the NEHCIP, which was last updated in 2013. It includes primary and referral services listed by age group. The CBHP service package that CHWs deliver is a subsection of the NEHCIP. It comprises both health and social welfare interventions, including reproductive, maternal, newborn, child, and adolescent health; HIV and AIDS; malaria; TB and leprosy; neglected tropical diseases; non-communicable diseases; mental health disorders; emerging diseases and outbreaks; physical injury and trauma; nutrition; oral health; eye care; WASH; gender-based violence prevention; gender mainstreaming; child protection; vulnerable people such as poor families and people with disabilities; and elderly health.

Table 5 indicates the modes through which clinical services, health promotion, and community mobilization should take place at the community level.

CHWs refer clients to the health facility with which they are associated, usually a dispensary, for services they cannot provide. Because of Tanzania's multidisciplinary approach to health and social services, CHWs may also refer clients to para-social workers, legal services, and NGO providers as appropriate.

Referrals are tracked through a system using quality assurance indicators. Health workers are supposed to counter-refer clients to CHWs.

Table 5. Modes of Service Delivery

Service	Mode
Clinical services	Door-to-door
	Periodic outreach at fixed points
	Provider's home
	Health posts or other facilities
	Special campaigns
Health education	Door-to-door
	Health posts or other facilities
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups
	Schools
	Prayer venues
	Open-air markets
Community mobilization	Health posts or other facilities
	In conjunction with other periodic outreach services
	Community meetings
	Mothers' or other ongoing groups

The CHW scope of work covers a range of health and non-health areas, due in part to the MOHCDGEC's integration with gender, development, and other sectors.

Using FP as an example, CHWs may provide clients with CycleBeads® condoms, oral contraceptive pills, emergency contraceptive pills, and information on lactational amenorrhea method, the Standard Days Method, and other fertility awareness methods. They may refer clients to:

- **Dispensaries** for injectable contraceptives; intrauterine devices (IUDs); and any of the methods that the CHWs may provide.
- **Health centers** for implants and any of the other methods available at dispensaries.
- **Hospitals** for permanent methods and any of the other methods available at health centers.

Table 6 provides details about selected interventions delivered by CHWs in the following health areas: FP, maternal health, newborn care, child health and nutrition, TB, HIV and AIDS, malaria, and WASH.

Table 6. Selected Interventions, Products, and Services

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
FP	Condoms	CHW	CHW	CHW	CHW
	CycleBeads®	CHW	CHW	CHW	CHW
	Emergency contraceptive pills	CHW	CHW	CHW	CHW
	Implants	CHW	No	CHW	CHW
	Injectable contraceptives	CHW	No	CHW	CHW
	IUDs	CHW	No	CHW	CHW
	Lactational amenorrhea method	CHW		CHW	CHW
	Oral contraceptive pills	CHW	CHW	CHW	CHW
	Other fertility awareness methods	CHW		CHW	CHW
	Permanent methods	CHW	No	CHW	CHW
	Standard Days Method	CHW		CHW	CHW
Maternal health	Birth preparedness plan	CHW	CHW	CHW	CHW
	Iron/folate for pregnant women[l]	CHW	CHW	CHW	CHW
	Nutrition/dietary practices during pregnancy	CHW		CHW	CHW
	Oxytocin or misoprostol for postpartum hemorrhage	Unspecified	No	Unspecified	Unspecified
	Recognition of danger signs during pregnancy	CHW	CHW	CHW	CHW
	Recognition of danger signs in mothers during postnatal period	CHW	CHW	CHW	CHW
Newborn care	Care seeking based on signs of illness	CHW			CHW
	Chlorhexidine use	Unspecified	No	Unspecified	Unspecified
	Managing breastfeeding problems (breast health, perceptions of insufficient breast milk, etc.)	Unspecified		Unspecified	Unspecified
	Nutrition/dietary practices during lactation	Unspecified		Unspecified	Unspecified
	Postnatal care	CHW	Unspecified	CHW	CHW
	Recognition of danger signs in newborns	CHW	CHW	CHW	CHW

Subtopic	Interventions, products, and services	Information, education, and/or counseling	Administration and/or provision	Referral	Follow-up
Child health and nutrition	Community integrated management of childhood illness	CHW	CHW	CHW	CHW
	De-worming medication (albendazole, mebendazole, etc.) for children 1–5 years[2]	CHW	CHW	CHW	CHW
	Exclusive breastfeeding for first 6 months	CHW		CHW	CHW
	Immunization of children	CHW	No	CHW	CHW
	Vitamin A supplementation for children 6–59 months	CHW	CHW	CHW	CHW
HIV and TB	Community treatment adherence support, including directly observed therapy	CHW	CHW	CHW	CHW
	Contact tracing of people suspected of being exposed to TB	CHW	CHW	CHW	CHW
	HIV testing	CHW	No	CHW	CHW
	HIV treatment support	CHW	CHW	CHW	CHW
Malaria	Artemisinin combination therapy	CHW	CHW	CHW	CHW
	Long-lasting insecticide-treated nets	CHW	CHW	CHW	CHW
	Rapid diagnostic testing for malaria	CHW	CHW[3]	CHW	CHW
WASH	Community-led total sanitation	Unspecified	Unspecified		
	Hand washing with soap	CHW			
	Household point-of-use water treatment	CHW			
	Oral rehydration salts[4]	CHW	CHW	CHW	CHW

[1] CHWs may also provide iron/folate to lactating women.
[2] CHWs may also provide de-worming medication to the general population.
[3] CHWs may not conduct rapid diagnostic tests if patients have severe malaria symptoms; instead, they must immediately refer them to a health facility for management.
[4] CHWs may give oral rehydration salts only to children under 5 years.

KEY POLICIES AND STRATEGIES

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ADVANCING PARTNERS & COMMUNITIES
JSI RESEARCH & TRAINING INSTITUTE, INC.

1616 Fort Myer Drive, 16th Floor
Arlington, VA 22209 USA
Phone: 703-528-7474
Fax: 703-528-7480
Web: advancingpartners.org