

DRAFT "1 REVISED"

THE UNITED REPUBLIC OF TANZANIA



MINISTRY OF HEALTH AND SOCIAL WELFARE

NATIONAL
GUIDELINES FOR IMPLEMENTATION OF
COMMUNITY BASED HEALTH INITIATIVES

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TABLE OF CONTENTS

ABBREVIATIONS.....	5
FOREWORD.....	6
1.1 BACKGROUND INFORMATION.....	10
1.2 DEFINITION OF CBHI CONCEPT.....	13
2.0 GUIDELINES ON COMMUNITY BASED HEALTH INITIATIVES IN TANZANIA.....	14
2.1 VISION.....	14
2.2 MISSION.....	14
2.3 GOAL.....	14
2.4 OBJECTIVES.....	14
3.0 MAJOR CBHI STRATEGIES AT VARIOUS LEVELS.... Error! Bookmark not defined.	
4.1 Household.....	15
4.4 Ward.....	16
4.5 District.....	16
4.6 Region.....	16
4.7 National.....	16
5.0 COMMUNITY BASED HIMS.....	23
5.1 Linking Community and Facility Based Information Systems.....	23
5.1.1 Ways to link Communities and Facility based Information.....	23
5.1.1.1 <i>Establishing Contact between Health Facility and Community</i>	23
5.1.1.2 Community based data collection and storage.....	23
5.1.1.3 Data aggregation and dissemination.....	23
5.1.1.4 Utilization of Community Based Information by a health facility.....	24
5.2 Types of Health Information to be collected in the community by category and source.....	25
5.3 Training in Community Based information System.....	27
6.0 PLANNING FOR COMMUNITY BASED HEALTH INITIATIVES.....	28
6.1 The Planning Process.....	28
6.2 Implementation of CBHI Activities.....	29
6.3 Monitoring and Evaluation.....	29
7.0 COMMUNITY INVOLVEMENT AND PARTICIPATION.....	29
7.1 Definition of the concept.....	29
7.2 Community Empowerment.....	30
7.3 Initiating Community Based Health Interventions.....	30
8.0 COMMUNITY BASED RESOURCE MOBILIZATION.....	31
8.1 Options for Resource Mobilization for CBHI.....	31
8.1.1 Internal/Community Sources of Revenue for CBHI.....	31
8.1.2 Other Options.....	31
8.1.3 Maximizing use of local resources.....	32
8.1.4 Sectoral collaboration.....	32
8.2 Sustaining Resource Base and Management.....	32
9.0 Community Based Human Resource FOR CBHI.....	33
9.1 Human Resource Needs Assessment.....	33
9.2 Capacity Building for CBHI Trainers.....	33
9.3 Selection Criteria for the TOTs /Trainers.....	34

9.4	Training Guides	34
9.5	Training Duration	34
9.6	Training Manual	34
10.0	COMMUNITY BASED HEALTH SERVICE DELIVERY PACKAGE.....	35
10.2	Community Health Worker’s Kit	37
10.3	Community Based Service Provider.....	38
11.0	HUMAN RIGHTS FOR HEALTH	38
12.0	COMMUNITY BASED COMMUNICATION	39
12.1	Strategies for Effective Communication.....	39
	The Strategies for effective community based communication include:	39
12.2	Communication Channels:	39
13.0	OPERATIONAL RESEARCH (OR)	40
13.1	Operational Research at Community Level	40
13.2	Capacity of CMTs/CHMTs to conduct Operational Research.....	40
13.3	Key Areas of Research in CBHI	40
14.0	SUSTAINABILITY OF COMMUNITY BASED HEALTH INNITIATIVES ...	41

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ADDO	Accredited Drug Dispensing Outlet
ARI	Acute Respiratory Infection
BCC	Behaviour Change Communication
CBDAs	Community Based Distributors Agency
CBHC	Community Based Health Care
CBHI	Community Based Health Initiatives
CBHWs	Community Based Health Workers
CBMIS	Community Based Management Information System
CBLSS	Community Based Life saving skills
CBOs	Community Based Organizations
CCHP	Comprehensive Council Health Plan
CHBG	Council Health Basket Grant
CHF	Community Health Fund
CHSB	Council health services board
CHMTs	Council Health Management Teams
CMT	Council Management Team
CORPs	Community Own Resource People
DOTs	Direct Observed treatment
DHMT	District Health Management Teams
ESRF	
FGCs	Facility Governing Committees
FP	Family Planning
HIMS	Health Management Information System
HIV	Human Immunodeficiency Virus
HSRs	Health Sector Reforms
HSR	Health System Research
IEC	Information Education and Communication
IMCI	Integrated Management of Childhood Illnesses
ITNs	Insecticide Treated Nets
ITMs	Insecticide treated materials
MoFEA	Ministry of Finance and economic affairs
MoHSW	Ministry of Health and Social Welfare
MSPH	Muhimbili School of Public Health
MUHAS	Muhimbili University of Health and allied Sciences
MTUHA	Mfumo wa Taarifa za Utekelezaji wa Huduma za Afya
MMR	Maternal Mortality Ratio
NGOs	Non-Governmental Organizations
NIMR	National Institute for Medical Research
OR	Operational Research
O&OD	Opportunities and Obstacles to Development
PHAST	Participatory Hygiene and Sanitation Transformation
PHEs	
PLWHA	PEOPLE LIVING WITH HIV/AIDS
PHC	Primary Health Care
PAR	Participatory Action Research
PMORALG	Prime minister's Office, Regional Administration and Local Government

PRA	Participatory Rural Appraisal
STI	Sexually Transmitted Infections
TFNC	Tanzania Food and Nutrition centre
TH	Traditional Healer
TOTs	Trainers of Trainers
AA A	Assessment Analysis and Action
VEO	Village Executive Officer
PNC	POST NATAL CARE
VHD	Village Health Day
VHWs	Village Health Workers
VPDs	Vaccine Preventable Diseases
WDC	Ward Development Committee
UDSM	University of Dar es salaam
WEC	Ward Education Coordinator
WEO	Ward Executive Officer

FOREWORD

The Government of Tanzania through the Ministry of Health and SOCIAL WELFARE, is currently engaged in implementing the Health Sector Reform (HSR) throughout the country. The HSR addresses numerous short falls that resulted into inadequate health services provision to the community. One such shortfall is that the community does not participate fully in health development issues. Nevertheless, since the Alma Ata Declaration of Health for All by the Year 2000, the community was expected to take an upper hand in their own health development issues with a positive attitude towards a health action. Despite these efforts, the results attained on health status improvement of the population have been minimal.

The HSR has therefore adopted decentralization of health services to the Local Government Authorities (LGAs) as a yardstick towards effective planning, implementation, monitoring and evaluation of health services. Thus decentralization to the District aims at the following:

- Motivating and involving communities towards a positive health action and development by making them participate in their problem identification, analysis, prioritization and finding relevant solutions to the problems:
- Empowering the community in making decisions, having authority and commitment over their own health issues and active control of resources as well as the resource allocation process;
- Participating and initiating the health planning process with emphasis on “bottom-up planning approach”:
- Promoting a sense of ownership and commitment to solve health problems by the community within the contention that health is a basis for human rights for every individual; and
- Ensuring that the whole population equitably accesses health services.

The PHC Guidelines updated in 1992; became a means through which community activities in health care would be promoted and achieved. Substantive achievements have been realized, but the review and updating of the current National Guideline aims at focusing on community based health initiatives in the context and perspective of the HSR. Thus these Guidelines on the Implementation of Community Based Initiatives are meant to provide general principles for the operation of the Council Health Management Teams (CHMTs) in directing and advising the implementation of Community Based Health Initiatives (CBHIs). The Guidelines emphasize on key areas especially on Community Based Management of resource mobilization, use of Community Based Health Management Information System (CBHMIS), Human resource management at the community, provision of essential health service package, community based communication strategy, coordination and linkage for health initiatives at various levels but more at household and community levels.

The Guidelines also provide a complementary link between the Primary Health Care needs and requirements of the HSR for the overall improvement of health service delivery in the country. Also, its preparation has been generally guided by the Tanzania Development Vision 2025. This approach is in line with health sector decentralization fiscal policy.

Implementation of Health Sector activities at community level is expected to contribute towards the achievement of the Millennium Development Goals (MDGs) in reducing Infant Mortality Rates (IMR) and Maternal Mortality Rates (MMR). Furthermore, HIV/AIDS infections can be reduced or halted. These interventions are inline with MDG 4,5 and 6 respectively.

It is my conviction that these guidelines will make another milestone in scaling up implementation by the communities taking up an active role in fighting against disease, ignorance and poverty. All partners in health service delivery need combined efforts to achieve better outcomes.

It is my understanding that the leaders and the communities will take this opportunity to enlist a difference in the course of implementing the community initiated activities . Also other stakeholders will find the Guideline useful tool to achieve the intended objectives.

WILSON C. MUKAMA
Permanent Secretary

1.0 INTRODUCTION

Tanzania has spearheaded the health for all spirit and approach in health since independence, expanding basic health services reaching 3000 health centres and dispensaries distributed in the 8500 villages all over the country. Thus, equity in health care *is* an important component of the Health Policy adopted after independence. The health facilities distribution in the country reflects the focus of the health system, which espoused principles of equity in access as well as self-reliance. Additionally, the government policy in health emphasised access through community participation, and intersectoral collaboration. Health for all was included in the government manifesto at independence expressing commitment to universal access to basic health care. The Arusha Declaration in 1967 strengthened the commitment, making health care to be free for all, emphasising self-reliance and self-determination. However, to date health for all has not been realised.

Currently, 93% and 72% of the population respectively, live within 10km and 5 km from a health facility. As a result of this policy, health status of Tanzanians has improved considerably as shown by the drop in infant mortality rate from 162 per 1000 live births in 1967 to 88 in 1996. However, these gains are currently challenged by the high prevalence of HIV/AIDS, the level of poverty and the debt burden facing the country. All these issues should be addressed at the policy level in pursuing improvement of quality services and accessibility. (UP DATE DATA)

Primary Health Care (PHC) was adopted by the Government as the main strategy for health service implementation emphasising community participation and overall community development with the Village Health Workers (VHWs) as the key service providers at the community level. Evaluation of the programme carried out in 1988 resulted into the introduction of CBHI approach. This aimed at improving health care services, putting more emphasis on community participation, intersectoral collaboration, use of available resources and appropriate technologies. In 1992, the PHC strategy document was produced. The document advocates the involvement of all sectors and profound political commitment. However, implementation of Community Based approach remained patchy and mostly donor dependent.

The Guidelines are therefore an attempt to ensure that CBHI becomes securely embedded into the implementation of reforms in Tanzania. In essence, the core principles of the reforms are devolution of power to the grassroots, integrated approach to care and service provision, building *health* care systems on local resources / financing, strengthening the capacity and involving people in the processes of health service provision and health status improvement. All these are common to CBHI as well as the reforms. Therefore, the Health Sector Reform (HSR) can be *more* successful if CBHI is an essential part of it.

The Guidelines are an attempt to bring together experiences of many years from a number of districts and communities as examples that can be applied in implementing CBHI nationwide. The term Community Based Health Initiatives is used to emphasize the notion of multiplicity and integration of actions that can be undertaken by individuals, families and communities towards health improvement that may not be part of the formal health care system.

From June 1996, the government of Tanzania embarked on a Local Government Reform (LGR). The reform aims at strengthening the local government for social development, public service provision and facilitation of issues of national importance such as education, health, water, roads and agriculture. The Reform is designed to strengthen the local government systems through devolution of power to plan and manage expenditure in the delivery of services to the community from central to the local government. The reform aims at increasing the involvement of the public in decision making in all aspects of development.

One of the principles of the Reform program is the financial decentralisation. This principle empowers councils to collect local taxes and obligates the central government to supply local government with adequate and unconditional block grants. This principle also allows local government to pass their own budgets reflecting their own priorities. Based on this principle, the local government must ensure that mandatory expenditure required for the attainment of national standards in the development initiatives, are being implemented as guided by the Sectoral Ministries.

The other principle of the LGR program is administrative decentralization. The principle involves de-linking local government staff from their respective ministries. This principle makes them accountable to the local councils that will have the power to hire and fire.

Thus the role of the central government vis-à-vis local council will be changed into a system of inter-government relations with the central government having the overriding powers within the framework of the constitution. In this relation, Sectoral Ministries have changed their role and functions to become policy-making, supportive and capacity building, monitoring, regulatory and quality assurance bodies. Regulatory roles include, among other things, legal control and audit. All the documents, including planning/budgeting guidelines related to the LGR, emphasise on the need and importance of true participatory planning. Thus the LGR, is a powerful vehicle for participatory planning as will be evident in the subsequent sections and chapters.

1.1 BACKGROUND INFORMATION

The first Guidelines on Community Based Health Care Initiatives in Tanzania were developed in 1995 to foster implementation of Community Based Health Care activities. During that time, the thrust of the key health messages was embodied in the PHC strategy, which was a response to the Global Goal of Health for All by the year 2000. Community Based Health Care was a means towards achieving good health status by way of involving the people in taking an active and dynamic action towards a health action in identifying their own health problems, and taking appropriate action in solving them. However, since 1995, a number of health development changes have taken place.

The Ministry of Health is currently involved in implementing the Health Sector Reforms for overall improvement in the quality of health services. Both the HSR and PHC have been advocating better health for the people through the people's own active initiative and involvement. PHC principles were on equity, self-reliance, community involvement and participation. On the other hand, HSR expands those principles through decentralization to give more power to the people by way of determining their own health needs and priorities, making appropriate decision on course of action, being involved in the development of health plans, having an authority, power to control resources and resource allocations for improvement of peoples' socio-economic status. Under the Health Sector Reform, the Community is a key partner in the provision of health services in the overall health development. Thus the people are being empowered to make decisions regarding their own health development issues through the Facility Governing Committees and Council Health service Boards.

The HSR community initiatives are financed according to the new Resource Allocation Formulae (RAF) whereby 5-10% of the available Council basket funds, are earmarked to finance Community Initiated activities annually. Other sources of funds include; their own generation, council and other partners within the respective community.

While PHC defines services by way of 10 elements including Education on prevention of health problems, Treatment of minor illnesses Food and Nutrition, Housing, Water and Sanitation, Immunization against preventable diseases, Maternal and Child Health, Family Planning, Control of locally endemic diseases, Provision of essential drugs and supplies Mental and Oral Health. HSR categorizes these, services in minimum essential health service delivery packages. In this context, Community Based service delivery packages are referred to health education promotion on environmental sanitation, hygiene, Reproductive and Child health. Others are STI/HIV/AIDS, Malaria, nutrition etc. health status monitoring, mobilization for immunization, referral, distribution and sales of commodities like ITMs and contraceptives. These specific filtered service delivery packages are targeting to the community level from the MoH Policy which states that the Tanzanian basic health package will cover the following:

Reproductive and Child Health Services

- Safe mother hood
- Ante-natal care
- Intra-natal

- prenatal conditions
- Post natal care
- Gynaecology- STI/HIV
- Family Planning
- Integrated Management of Childhood Illnesses (IMCI)
- Adolescence sexual and reproductive health
- Reproductive health cancers.
- School health
- Immunizations
- Nutritional disorders

Communicable Disease Control:

- Malaria
- Diarrhoea diseases
- TB/Leprosy
- HIV/AIDS/STIs
- Epidemics
- Cholera
- Meningitis
- Measles
- Polio
- Rabies
- Plague

Emerging and re emerging diseases

- Avian influenza
- Ebola
- Rift valley fever etc

Neglected tropical diseases(NTDs)

- trachoma
- Onchocerciasis
- Schistosomiasis/STH
- Lymphatic filariasis
- Trypanosomiasis etc

Non-Communicable Diseases Control

- Cardiovascular diseases
- Diabetes
- Neoplasms
- Injuries/Trauma
- Mental illness
- Nutritional Disorders

Other common diseases of local priorities within the Council

e.g Eye diseases,
Oral conditions
,neonatal tetanus
anaemia etc.

Community Health Promotion and Disease Prevention

- Information Education and Communication (IEC)
- Water
- Hygiene
- Sanitation

Establish/Strengthen Organisational Structures and Institutional Capacities for Improved Health service Management at all levels

- Establishment of Council Health Service Boards and Facility Governing Committees
- Preventive Maintenance/Rehabilitation/Repair of facilities and equipment
- Improved employment of Skilled and Committed Staff at all levels.
- Ensuring availability of minimum infrastructure, equipment, drugs, vaccines and supplies.
- Supportive Supervision and Inspection

This package has to be incorporated into Comprehensive Council Health Plans (CCHPs) to enable LGAs to properly utilize available scarce resources. Similarly, the community should incorporate the filtered health service packages targeted at community level, into the community-based health plans as one of the priority problem areas requiring feasible and cost effective interventions.

The rationale behind the development of the cost effective essential clinical and public health packages is that, despite the close correlation between budget allocation and the burden of disease, resources have, to a larger extent, not been targeted towards the most cost effective interventions. It is therefore imperative for a package of both public health

measures and clinical service that are highly cost-effective and help to solve major health problems to be identified.

Ideally, the services delivered in the package should meet the following criteria:

- Address major health problems;
- Have a significant impact on the health status;
- Address prevention and promotion as well as curative;
- Be cost effective; and
- Improve equity and respond to the demands of the population.

It is important to note that the service package to be delivered at the household and community levels by various village based health workers, is consistent with the National Essential Health Package which is based on the studies of the burden of diseases in Tanzania.

The National Health Policy aims at improving the health and well-being of all Tanzanians with a focus on the most *at risk*, and hard to reach areas to encourage the health system to be more responsive to the needs of the people. The Policy therefore will achieve the goal through selective highly cost effective service package interventions likely to result into tangible health improvement in the population. The Guidelines intend to mobilize communities towards their active and dynamic involvement and participation in implementing the intervention in order to contribute towards their own health and socio-economic development.

1.2 Definition of CBHI concept

The community based health initiatives, are a *summation of* community activities undertaken by individuals and families aimed at promoting and improving the health and well-being of the respective community and socio-economic development of the country.

Included in the community based health initiatives, are activities like effective participation in the construction and rehabilitation of health facilities, establish mechanism to provide meals for primary school children, establishment of mechanisms to prevent unwanted pregnancies, staff housing and in environmental sanitation, identifying sources of income, construction of latrines, protection of sources of water supply, caring of orphans, vulnerable children and elderly, prevention of mental and physical disabilities. Personal hygiene and participation in immunization activities (routine and campaigns). Furthermore, in case of high risk and complicated pregnancies, for example, it is the community's initiative to decide *how to transfer (transport)* such case to a higher level health facility.

2.0 GUIDELINES ON COMMUNITY BASED HEALTH INITIATIVES IN TANZANIA

2.1 Vision

To have communities actively and effectively involved and enabled to increase control over their environment in order to improve their own health and development.

2.2 Mission

Having communities able to assess, analyze, plan, implement, and manage health and health-related development issues for a sustainable socio-economic development by the year 2020

2.3 Goal

Tanzanian communities improve their health status through implementation of CBHI

2.4 Objectives

The communities based health care initiatives, are the mainstay through which communities take an active role in health and health-related development issues and contribute effectively to the country's *poverty reduction programme and* socio-economic development. The initiatives target the major priority health and health-related problems and execute proposed minimum essential health interventions to *meet the MDG targets*. The major objectives of Community Based Health Initiatives are therefore to:-

2.4.1 Mobilize the community to take-up greater responsibilities in identification of their health development problems through a decentralized health service delivery system;

2.4.2 Provide guidance to communities on self-identification of locally available resources *including participating in cost-sharing payment programmes* in solving their health and health-related problems;

2.4.3. Develop community capacity for planning, implementation, monitoring and evaluation of community-based activities *and reflect these in the comprehensive council Health Plans for funding*

2.4.4 Promote integrated approach in implementing community based health intervention, *(taking on board other stake holders)*.

3.0 ORGANIZATION STRUCTURE

For effective implementation of CBHI, it is crucial for a clear organizational structure with well-defined roles and responsibilities of all actors at all levels *to be* developed and made available for use. CBHI is operationalized within the existing Government Structures (i.e. administration, planning, budget allocation etc) in order to avoid parallel structures and promote provision of integrated health services.

3.1 Household

The household consists of individuals under the household head. Members of the households/families are the primary targets and implementers of CBHI. They are responsible for their day-to-day upkeep of the household affairs as well as participating in community-organized activities. They have contacts with the community based workers and the formal health system where they seek and utilize health services. This forms the first level of care universally available at all households.

3.2 Hamlet

The Hamlet chairperson is the overall coordinator and overseer of CBHI at the hamlet level. She/he is a link between the Village Government and household/families within the Hamlet. *S/he* is responsible for community resources and social mobilization for implementation of CBHI and reports to the Village Government. Community health workers within the Hamlet, report to the chairperson on their day-to-day activities. The Hamlet leader is responsible for preparing an implementation report for discussion, decision-making and actions.

3.3 Village

The Village Council through the Village Executive Officer (VEO) is responsible for coordinating CBHI within the Village. In order to ensure effective implementation of CBHI, the VEO should work in close collaboration with *the* respective extension workers, CBHW and other CORPs. *Will report* to the Village Chairperson and the Ward Executive Officer. The CBHW in the Village should report on their day-to-day activities to the Village Executive Officer and are accountable to their respective communities. VEO is responsible for preparing the implementation report to be presented to Village Government for discussion, decision-making and actions. Then, the agreed report will be submitted to WEO.

3.4 Ward

The Ward Development committee(WDC) is the overseer of all health and development activities in the ward. All extension workers (including health staff) within the Ward provide technical support at the level. They are also responsible for facilitating and implementing CBHI in their respective wards. After the WDC discussion, the WEO compiles the implementation report of the Villages in the Ward and submits it to the district.

3.5 District

At the District/Council level, the organization and management of the CBHI *are* integrated within the *Health Sector* and Local Government reform framework. The CMT and CHMT should provide technical support including planning, implementation, monitoring and supervision of community initiated development at lower levels. Equally important they are responsible for scrutinizing, presenting lower level plans to the Council Health Service Boards and Full Council for approval. The Districts should seek technical support from the Regions, Zones and Central levels.

3.6 Region

In planning, budgeting, monitoring and supervision, the Regions in collaboration with the MoH zonal training centres provide technical support to Districts. They translate Policies and guidelines.

3.7 National

The National level formulates and reviews the National Health Policy, Guidelines and Quality Standards. Other roles include advocacy and capacity building through training, supervision, monitoring and evaluation.

Partnership should be encouraged to enable different sectors such as Health, Education, Agriculture, Social Welfare and Community Development, NGO's, CBO's and Voluntary agencies to work together. This will optimize utilization of available resources. The MoHSW through Prime Minister's Office Regional Administration and Local Government facilitates this process.

4.0 MAJOR CBHI STRATEGIES AT VARIOUS LEVELS

Level	Strategies
Household /Family	<ul style="list-style-type: none"> • Awareness rising on rights for health. • Awareness rising on control and elimination of neglected tropical diseases. • Awareness rising on the cause, control and prevention of diseases with emphasis on STI/HIV/AIDS, TB and Malaria. • Ensuring rational gender decision-making. • Health eating and Life style. • Contribution to cost sharing programmes eg. CHF (Mfuko wa Afya ya Jamii) • Fight against Malaria by Vector Control through abortion of breeding sites (fukia mashimo na vifuu vya nazi) • Promote early health seeking behaviour including maternal care and referral • Family life education. <ul style="list-style-type: none"> - Proper child up bringing • Promoting <ul style="list-style-type: none"> - Community IMCI with emphasis on 17 key household practices. - Proper attendance to immunization services - The use of ITMs to reduce Malaria infection. - The use of safe water and improved environmental management, sanitation and personal hygiene by all households. - Households' food security - Improved housing condition - Proper resource mobilization and utilization - The promotion and use of appropriate local technologies by households.
Hamlet (Kitongoji)	<ul style="list-style-type: none"> • Community sensitization, mobilization and organization. • Health education and promotion. • Identification and protection of water sources. • Training of CBHC actors on skills and communication methods towards enabling household to undertake their roles as aforesaid. • Malaria issues • NTDs issues

	<ul style="list-style-type: none"> • <i>STI/HIV/AIDS</i> • <i>Tb issues</i> • <i>Immunisation issues</i> • <i>Cost-sharing issues</i> • <i>Health eating and Life styles</i> • Promoting safe delivery • Ensuring adequate promotion of community IMCI (with emphasis on 17 key household practices) • Ensure rational gender decision-making • Ensuring rights for health. • Identifying and discouraging risk behaviours for getting unwanted pregnancies
Village/Mtaa	<ul style="list-style-type: none"> • Community mobilization and organization. • Motivation to community based health care workers • Follow ups and records keeping • Promotion of ownership of health services in the community • Support of immunisation services • Contribute for primary school meals • Mobilization for health care financing • Inter-sectoral collaboration and co-ordination. • Provision and protection of water sources. • Participatory assessment and planning. • Strengthening community health services delivery system. • Promoting hygiene and sanitation (PHAST). • Vector Control Activities • emergency preparedness including control and elimination of NTDs • Promoting safe delivery through pregnancy monitoring, establishment and use of maternity waiting homes and timely referral of obstetric emergencies.(Community based life saving skills) • Priority setting and participatory planning (O&OD process). • Identification and promotion of utilization of locally available resources. • Integration of vertical programmes. • Ensure promotion of community IMCI (with emphasis on 17 key household practices..) • Ensuring rights for health.

	<ul style="list-style-type: none"> • Signing working agreement between CBHW and the village government. • Promote Community labour based rehabilitation and construction of health facility and staff houses. • School Health Promotion.
Ward	<ul style="list-style-type: none"> • Support, provision and protection of water sources at village level. • Initiating and strengthening community based information system. • Support Community labour based rehabilitation and construction of health facility and staff houses. • Providing technical support to villages. • Capacity building to villages/Mtaa • Training CBHWs, CORPs, Village and Hamlet leaders on community IMCI (17 household practices). • Training and conducting social mobilization and sensitisation on rights for health to all communities. • Mobilization and sensitization on the NTDs • Emergency preparedness including control and elimination of NTDs • Provide security for health infrastructure, equipment and supplies • Set motivation strategy for CBHW. • Facilitate working agreement between the CBHW and the village government • Facilitate planning process implementation and monitoring of activities at village level.

Districts/Councils	<ul style="list-style-type: none"> • Comprehensive Councils Health planning • Support implementation of essential health intervention package. • Supervision, monitoring and evaluation • Disease surveillance, emergency preparedness including control and elimination of NTDs. • Provide feedback to lower levels. • Identification and increased utilization of existing community organizations. • Capacity development to Ward/Village/Mtaa on clean and safe water supply, sanitation through PHAST. • Advocate and Train Ward Extension staff, teachers and leaders on community IMCI with emphasis to 17key household practices and NTDs and other health issues. • Train health teachers on issues related to health in schools • Facilitate monitoring & evaluation of NGOs activities in the District/Council • Facilitate community participatory planning /O&OD process. • Support, provision and protection of water sources at village level. • Support community based rehabilitation services. • Strengthening operational research on CBHI. • Providing technical and material support. • Co-ordinate and link CBHI activities supported by development partners/NGOs/CBO. • Capacity development to Wards/Villages on rights for health. • Support Community Initiatives on Construction of Infrastructure. • Set strategy for CBHW motivation
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Region	<p>The region being the operating arm of the Central Govt. links with the Councils in implementing the following strategies:</p> <ul style="list-style-type: none"> • Coordinating and interpreting the National Health Policy and other related Health Sector policies, guideline and directives. • Coordinate and link the Ngo/partiners working in the region • Operational research. • Capacity building to districts/Councils on safe water supplies and sanitation through PHAST. • Capacity development to district / council on disease surveillance, emergency preparedness including control and elimination of NTDs • Quality assurance and Control. • Monitoring and evaluation. • Providing technical support. • Capacity development to districts/Councils on rights for health. • Facilitate networking among different partners in health
National	<ul style="list-style-type: none"> • Formulating and reviewing the CBHI guidelines inline with the National Health Policy. • Capacity development to Regions and Districts/Councils for participatory needs assessment and planning. • Multisectoral and donor coordination in health. • Resource allocation. • Ensuring that CBHI management information system is part of HMIS. • Monitoring policy implementation. • Ensuring equity of health services. • Quality assurance and Control. • Providing technical support and feedback. • Advocate for community health issues.

5.0 COMMUNITY BASED HEALTH MANAGEMENT INFORMATION SYSTEM

The Community Based Health Management Information system refers to information gathered, analysed and used by the community and other levels for planning, monitoring and decision making process with regard to CBHI. The System enables the community to make a follow-up on the progress of implementation of planned activities and determine their success and constraints in achieving their objectives. Communities are advised to Use Community Based Health Management Information System In capturing information for planning, monitoring and decision making

5.1 Linking Community and Facility Based Information Systems

Community Information System should be linked with the HMIS which operate in health facilities in order to make reports more Comprehensive and adequate.

5.2 Ways to link Communities and Facility based Information

5.2.1 Establishing Contact between Health Facility and Community

Community Based Health Workers (VHWs, TBAs, **PHEs** CBDAs, THs and any other CORPs) are responsible for collecting data at Community level within their respective service areas in relation to their roles. CBHWs supervisors from health facilities should visit respective service areas, provide technical support and collect reports from CBHWs .This data and report should be presented and discussed at village PHC/Social Services Committees on monthly basis and utilized for decision making.

5.2.2 Community based data collection and storage

Key community resource teams should be identified in a participatory approach for orientation on importance of data collection, analysis, storage and utilization and thereafter collaborate with community based health workers in the implementation of this activity. The Health Facilities, CHMT and Council should facilitate the process.

5.2.3 Data aggregation

The facility in-charge aggregates and collates data obtained from the Village PHC Committees and health facilities of the respective Villages with assistance from other health facility workers.

5.2.5 Utilization of the Information, dissemination and feedback mechanism.

Health facility in-charge should use the information as a basis for discussion during the review and planning of Village and Ward Development Committee meetings. He/she is supposed to provide immediate feedback to CBHWs during supportive supervisory visits and other avenues.

CBHWs, Village and Ward leaders, should use *the given* information to monitor progress of community-planned activities at different levels:

Village level:

- a) The CBHW in collaboration with VEO and Hamlet leaders should use the data for monitoring and identifying households in need of special attention.
- b) Feedback to the community should be given routinely during household visits and Hamlet/Village community meetings.
- c) Hamlet leaders should report to VEO while CBHWs do the same to both VEO and health facility in-charge in the respective Ward,
- d) Information should be used when discussing progress on implementation of activities and in appraising performance of key actors in the Village.

Ward Level:

- a) Health facility in-charge in collaboration with the *Ward* Committee members, shall analyse, interpret and prepare data to be utilized by the Ward Development Committee meetings.
- b) The Village should be provided with feedback through representation of VEO in the Ward level meetings.
- c) Health facility in-charge shall be responsible for promoting utilization of data for planning, implementation, monitoring and evaluation of health development activities.

District level:

- a) The CHMT in collaboration with heads of sectors shall analyse and interpret data from the Ward level for District use.
- b) The information shall be used by sectoral officials during supervision and for discussions in the CMT and Council meetings.
- c) The whole process of planning, implementation, monitoring and evaluation depending on the level of operation shall involve CHMT, NGOs, donors, religious groups, FBOs companies, and individuals.

5.3 Types of Health Information to be collected in the community by category and source

Category	Types of data	Collection/Source
Demographic	<ul style="list-style-type: none"> • Population by age and sex • Births and deaths (with cause) • Migration in and out 	<ul style="list-style-type: none"> • Village/Hamlet Register • Birth and Death Register • Village register.
Nutrition	<ul style="list-style-type: none"> • Under one year registered weight for age • One to five years registered weight for age • Moderate and Severe Malnutrition 	<ul style="list-style-type: none"> • Under fives Register
Immunization	<ul style="list-style-type: none"> • Under one year registered, vaccinated children against BCG, DPT-HB, Polio3, Measles. • Women protected against Tetanus with at least 3 TTs. 	<ul style="list-style-type: none"> • Under fives Register • Household survey/ Visit form • National Immunization Day Register <ul style="list-style-type: none"> • MTUHA tally sheet • Community register
Reproductive and Child Health (RCH)	<ul style="list-style-type: none"> • ANC visits, risk factors, ANC Referrals, • Deliveries, referrals during delivery, complications, mother and child outcome, deaths and causes. • Child health data including child abuse • New and current Family Planning clients • IEC/BCC. • 17 key house hold practices(c-IMCI) 	<ul style="list-style-type: none"> • ANC Register • Delivery Register • Maternal Audit Report • Police data register • Family Planning Register • Household/catchment area survey form • Follow up forms

Health status	<ul style="list-style-type: none"> • Under fives with fever, diarrhoea, measles, chest tightness, HIV/AIDS, HMIS report from health facilities. 	<ul style="list-style-type: none"> • Household survey/visit form
Environmental Sanitation /Water	<ul style="list-style-type: none"> • Permanent latrines, Permanent houses, safe waste disposal methods, safe water sources, utensil drying racks and garbage pits 	<ul style="list-style-type: none"> • Household Survey / Visit form.
School Health promotion	<ul style="list-style-type: none"> • Total pupils by gender • Latrine pit ratio • First aid kits • Accessible toilets for pupils/teachers with disability • Provision of school meal • Total pupils with pregnancy • School drop outs • Water supply and sources. <p>(other information as detailed in the indicated forms)</p>	<ul style="list-style-type: none"> • Pupil health card • Pupil health monitoring form.
Social Economic	<ul style="list-style-type: none"> • Number of orphans, people with disability, aged, poor, alcohol and drug addicts and street children exempted. 	<ul style="list-style-type: none"> • Household / Visit form
Eye care	<ul style="list-style-type: none"> • Population with eye problem such as Trachoma, Cataract 	<ul style="list-style-type: none"> • Household cards. • Latrine Inventory forms
Dental Care	<ul style="list-style-type: none"> • Community members with dental problem 	<ul style="list-style-type: none"> • Household/School health cards
Mental health Care	<ul style="list-style-type: none"> • Mental ill Health • Mentally challenged children • Epileptic children 	<ul style="list-style-type: none"> • Household mental health data
NTDs	<ul style="list-style-type: none"> • Total population • People treated • Number of people eligible and non eligible • Drug summary 	<ul style="list-style-type: none"> • Sub and village treatment register

ADDO	<ul style="list-style-type: none"> • The number of ADDO • Conditions/diseases referred to a health facility • Number of patients / clients managed at the ADDO 	<ul style="list-style-type: none"> • ADDO register • Referral note
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5.8 Training package for TOT/CBHI(refer to curriculum)

The CMT/CHMT shall strengthen the capacity for participatory approach by training key actors on Data Collection, analysis, presentation, use and storage. The CMT shall sensitize authorities at District, Ward and Village levels on the importance of information in planning, decision-making and data ownership. This ensures sustainability of the system. Training in Community Based System should ensure that the monitoring and evaluation component, provides improved quality and coverage of data required.

6.0 PLANNING FOR COMMUNITY BASED HEALTH INITIATIVES

Community Based Health Initiatives (CBHIs), are the domain of the health care that should be owned by the community with some support from technical resource people. Its planning should be interactive and participatory. As such the community assumes the central role in making decisions on their priority problems and solutions. This process increases capacity of the community to practice evidence-based planning. Bottom-up planning should be promoted for CBHI for effective implementation of interventions. There should be adequate sensitisation, mobilization and organization of the communities and their support structures with clear responsibilities and authority. The community should participate and be involved in all stages of planning and implementation, monitoring and evaluation of community health initiatives.

6.1 The Planning Process

The Government has reversed the planning process from top-down to bottom –up because the community is the lowest level in the planning process. The major administrative structures in the community are the Villages under the Village Council. To effect to this planning process, the Government has developed a Participatory Community planning methodology known as the Opportunities and Obstacles to Development (O&OD). This methodology uses the targets and objectives of the Tanzanian Development Vision 2025. In so doing, planning at the Community level is holistic in the since that it is multi-sectoral. O&OD manuals have been prepared by PORALG which is facilitating the LGAs to institutionalize the methodology. LGAs which have not rolled out the O&OD can *continue to* use other participatory techniques such as Participatory Rural Appraisal (PRA) and Assessment Analysis and Action (AAA).

The Planning process inputs into community awareness for health need assessment, situation analysis, priority setting and preparation of respective Village Plan. The draft Village draft plan prepared is submitted to the WDC for comment and technical inputs before being approved by the Village Assembly. The approved plan is then submitted to the LGA, discussed by the CMT before being submitted to the Council Standing Committees through the respective Sectoral Boards. The draft CCHPs are then submitted to the Regional Consultative Committee (RCC) for technical inputs before approval by the Councils .The approved CCHP is submitted to PORALG, MoH and Ministry of Finance (MoF) for necessary action.

6.2 Implementation of CBHI Activities

Once the plans have been approved feedback is provided to respective levels (Region, District, Ward, Village) on what has been approved for implementation. It is the responsibility and accountability of the community to make sure that the activities are implemented as planned. Equally important, it is the responsibility of other stakeholders (Ward, District, CBOs, NGOs) to timely provide the necessary support to the respective community for effective implementation of their plans.

6.3 Monitoring and Evaluation

Monitoring and evaluation ought to be participatory. The community should be guided to take control of activities. To facilitate this, there should be regular collection and analysis of relevant programme management information. Feedback should always be given to the community for monitoring progress and be used for re-planning programme activities. In monitoring and evaluation, the already set indicators should be used in determining the achievements *and* failures of the expected outputs.

7.0 COMMUNITY INVOLVEMENT AND PARTICIPATION

7.1 Definition of the concept

Community involvement and participation, is a social process whereby the community is empowered to take responsibility of identifying, analysing, prioritising and solving its problems. The community should have authority and control over its resources, management and ownership for health and development activities. Communities are the backbone of the community-based health initiatives. The health problems including diseases, pregnancy-related conditions, natural disasters and many other conditions such as unsafe and inadequate water, *shortage* of food supply, *poor school infrastructure and education*, are a major concern for misery surrounding the people in the country.

Implementation of the Health Sector activities at the Community level, contributes towards the achievement of the Millennium Development Goals (MDGs) including reduction of under five Mortality Rates and Maternal Mortality Ratio (MMRs) and HIV/AIDS infection. These Interventions are in line with MDG 4, 5 and 6 respectively and their implementation can result into the following benefits:

- a) Immunisation rates under one year old children, will be maintained at above 80% and transmission of Infectious diseases like Measles will be controlled;
- b) Death rates of mothers will be reduced;
- c) The Community will protect itself from Communicable Diseases and epidemics.
- d) More time will be spent on production of food and cash crops through gainful employment;
- e) Women will be economically empowered.

The CBHWs and extension workers should guide the community to take control of activities and resources to overcome their problems. Communities should take part and be involved in all stages of planning, implementation, monitoring and evaluation of programmes and be responsible for initiatives beneficial to them. Their involvement and participation is key to the success of the health interventions and development activities.

7.2 Community Empowerment

Community empowerment is a process of enabling the community to make decisions and take appropriate actions on matters affecting them. The process involves the transfer of knowledge from technical personnel to community resource persons and individuals at the household level, enhancing capacity for resource generation and management at household level; devolution of powers and authority to make decision to the lowest functional organs through democratic processes. The communities should be able to:

- a) Take control of the development process;
- b) Make decisions on priority problems *and possible solutions*;**
- c) Identify available resources and plan for more resource generation to enhance an improved resource base at household level,
- d) Facilitate provision of specific education and sensitisation programmes;
- e) Initiate interventions independent of external support;
- f) Make contacts with partners for technical support and resource mobilization while, at the same time, retaining control over the use of resources; and
- g) Work out mechanisms for accountability of resources and delineation of responsibilities for implementation of activities.

7.3 Initiating Community Based Health Interventions

(Need to be expanded as the problem has been on how to initiate the process?) We need to bring every body on board the CBHI to sustain our efforts on community development.

The Community based health interventions, should be under the control of communities with some support from the technical people. The CHMT in collaboration with community leaders and other stakeholders should identify:

- Groups to be involved in initiating a CBHI ;
- Existing capacities for facilitating implementation of activities;
- Available resources;
- Existing initiated investment in health e.g. infrastructure and equipment;
- Main bottlenecks in health improvement;
- Community organizational structures for making decisions and solutions.

7.4 Sensitization for CBHI initiation

The CHMT should sensitise and educate the community on the importance of initiating CBHI in their respective villages using various communication channels.

On their part, the CHMTs should build capacity of community leaders and extension workers on I.E.C. techniques for continuation and sustainability of the sensitization and education to the community on health, health-related and other social conditions/problems.

8.0 COMMUNITY BASED RESOURCE MOBILIZATION

Resource mobilization for activities can be divided into two categories mainly internal including labour, materials and Community Health Fund at one hand and external support. However, the main source of financing community-planned activities has been through the budget line which caused under funding of the community-planned activities. Therefore, there is a need to seek for additional resources from Internal and external sources.

External contributions are helpful to reinforce efforts by the communities. The external support can be in the form of expertise (human), equipment, material or financial. Such support should therefore complement community efforts and be directed towards initiatives that enhance the power of the community for resource generation and self-reliance.

8.1 Options for Resource Mobilization for CBHI

8.1.1 Internal/Community Sources of Revenue for CBHI

- Initiate, implement and sustain income-generating activities in the community by using simple improved techniques.
- Establish a revolving fund for drugs, equipment, and supplies.
- Collected revenue from sales of commodities such as ITMs
- Revenue collected from miscellaneous sources.
- Cost-sharing including User fees, National Health Insurance Fund (NHIF) and Community Health Fund (CHF). There are four guidelines elaborating the CHF scheme in areas of; concepts and Objectives, Establishment of the Fund, Training and Planning.

8.1.2 Other Options

- Donor assistance:
- Government subventions
- Private sector
- Faith based Organisations.
- CBOs and other partners e.g NGOs

- Voluntary contributions (financial/material) from community members such as communal labour, payments in kind, time at meetings and service delivery e.g Village Health Day.
- Health Basket funding allocation using new Resource Allocation Formulae (NRAF).

8.1.3 Maximizing use of local resources

- Communities should consider building on existing initiatives that may require minimal inputs to achieve greater improvement in health status.
- Recognizing and utilizing the local available resources in the communities such as expertise, materials, finance and assets like indigenous knowledge in transport and medicine.
- Recognizing individual /family/household initiatives to their own health improvement, a beneficial /better practice to be emulated.

8.1.4 Sectoral collaboration

It is important to note that improvement in health at the community level as experienced by councils with CBHI activities is far beyond the Health Sector. This includes economic empowerment and transformation, enhancing access to the means of production and marketing. Some of the interventions might include:

- Strengthening the economic capacity of Households through professionally managed credit schemes;
- Encouraging use of special talents and better technologies to reduce workload and increase productivity;
- Development by the councils of expert extension workers and equitably deploying them to ensure successful implementation of planned activities; and
- Establishing strong linkages to the on-going poverty alleviation initiatives.

8.2 Sustaining Resource Base and Management

Whereas communities have resources to initiate and implement CBHI, CHMTs should provide Technical assistance through the established channels for the community to be able to develop, manage and maintain the available resources. Communities should be in control of their funds and determine mode of utilization that includes deciding on remuneration of different Community Based actors.

Possible ways of Sustaining Resource base as support to CBHI include:

8.2.1 Technical, Material and Financial support

Communities to be provided continuously with necessary support from higher levels to gradually become innovative and scale down dependency to local or external assistance.

8.2.2 Revenue collection

Local Governments should increase their capacity to collect revenue and make appropriate use for CBHI activities.

8.2.3 Accountability

Ensuring accountability of resources through transparent mechanisms e.g meetings, auditing and feedback to Village Assemblies.

8.2.4 Performance appraisal

CHMTs/CMTs to develop performance based reward system for better performing communities;

9.0 Community Based Human Resource FOR CBHI

Human resource is an important component in addressing and promoting Community Based Health Initiatives. The availability of adequate competent community based actors at various levels, promotes effective implementation of CBHI activities.

Multipurpose workers who are able to provide the essential service package at the household and community, should serve CBHIs in combining the current functions of VHWs ,CBDs, CBDAs. However, TBAs and THs, should continue to provide services according to their respective community needs. Therefore, they should be trained and supported for such a multipurpose role. The communities should be responsible in selecting the appropriate CBHWs according to the agreed selection criteria, local needs and also be accountable to determine the way and type of motivation.

9.1 Human Resource Needs Assessment

Prior to the implementation of the CBHI, there is a need to conduct CBH need assessment in order to determine the actual human resource available and gaps at various levels. The assessment and capacity building plan, can be developed to suit various levels (for the community, Hamlet, Village/Mtaa, Ward, District and Region).

9.2 Capacity Building for CBHI Training of trainers and the CBHI actors

In order to implement effective CBHI, there is a need of having competent actors with adequate knowledge and skills to be attained through training and updates on CBHI issues. There should be a core multisectoral team of trainers charged with the responsibility of training the Ward trainers.

The national level in collaboration with the zone and regional level teams has to facilitate capacity development of the District teams of trainers. The Ward trainers drawn from various sectors working within their respective Wards, with regular technical and financing support from the Districts, should train the Community Based Health Workers in their respective Wards. The training should take place in respective Wards or Divisions; preferably, the training should be residential. In equipping the CBHWs with the knowledge and Skills, the Essential health package becomes part of an integrated community based health services for better performance.

9.3 Selection Criteria for the TOTs /Trainers/

Training of Trainers (TOTs) team at District and Ward level should consist of four to five technical staff from all health-related sectors with special consideration on Water, Education, Agriculture, Community Development and Livestock Development. At the Ward level, the selection should consider the available extension staff.

9.4 Selection criteria for CBHI actors

- Community member
- At least primary school education
- Accepted by the community
- Age not below 18 years
- Gender balance
- Ability to express her/himself
- committed

9.5 Training Guides

A training guide for the TOT's and CBHW's, should be used to train the resource people at respective levels and address:

- Components in the National Package of Essential Health Interventions;
- Communication strategy, which contains advocacy, social community mobilization and interactive/participatory communication;
- Community based management information system, including data collection and storage, analysis, interpretation and utilization; and
- Planning for community based health initiatives.

9.6 Training Duration

The training duration should be as follows:

- Two weeks for District TOTs;
- Three weeks for Ward TOT; and
- Two months for CBHWs
- One week refresher training each after two years.

9.7 Training Manual

There are three manual developed for training CBIs

- CBHW Manual
- CBHW TOT manual

10.0 COMMUNITY BASED SERVICE DELIVERY PACKAGE

The essential health package is an integrated collection of cost effective interventions that address the main common diseases, injuries and risk factors. The criteria for choosing components in the health package, is the size of the burden caused by a particular disease/disease condition i.e the total amount of life lost in all causes, whether from premature mortality or from some degree of disability over a given period of time. Studies conducted to determine the essential health package for Tanzania, found the following disease condition account for the highest mortality and morbidity among Tanzanians:

Reproductive health problems

- Maternal health problems (obstetric emergencies and abortions);
- HIV/AIDS/STI emphasising HIV prevention through community based communication methodologies.

Child health problems

- Malaria;
- HIV/AIDS
- Diarrhoeal diseases;
- Acute Respiratory Infections (ARI);
- Nutritional disorders
- Immunizable diseases.

10.1 Services to be delivered at community Level

Based on the results of the Adult Morbidity and Mortality Programme (AMMP) studies, the conditions identified are those in which the CBHI could make most significant contribution towards improvement of the health and well-being of Tanzanians. At the community level, the elements of care emphasize on effective communication strategy aimed at behaviour change, access to safe water and basic care.

The justifications for selecting these interventions are:

- Ability to address the major health problems;
- Having the most significant impact on health status at affordable cost at the community level;
- Improving equity thus making health and well-being a possibility for all Tanzanians;
- Can be coordinated with mutually re-forcing interventions at the community level;
- Building on existing initiatives which have shown to be effective in reducing overall burden of disease in the community;
- Can be provided effectively and safely by Community Based Health Workers (CBHWs);
- Can be incorporated into the community based participatory planning process based on available resources; and
- Medical wastes management e.g. Construction of incinerators.

Services to be delivered by a CBHW include:

General services:

- Health education and promotion on environmental sanitation *personal hygiene*, safe water supply, housing, and nutrition;
- Monitoring of child growth health status;
- Promote use of standard latrines ;
- Distribution of contraceptives;
- Selling of ITMs
- Distribution of NTDs drugs
- Advising pregnant women regarding ANC attendance delivery and PNC,FP, CBLSS;
- Referring high risk pregnant mothers and other indicative clients to health facilities;
- Treatment of minor illnesses;
- Health status monitoring

- Update under-five community register

Services regarding HIV/AIDS/TB by the community and its agents including CBOs.

- Information Education, Communication (IEC);
- Prevention;
- Care and treatment;

In the fight against HIV/AIDS infection, the community is the centre of action while households and Individuals are the main recipient of care and services.

Key activities at community level include:

- Co-ordination of care and input by community committees:
- Community Involvement and education in caring for patients and affected households:
- Support to service providers as advised by the CHSB and or FGCs
- Support to the affected persons psychologically, spiritually, nutritionally, economically and culturally;
- Arrange for home and nursing care, promotion of personal hygiene, nutrition, palliation and education while strictly observing community norms;
- Support and encouragement to those who have started treatment regime under Anti-Retroviral Therapy;
- Encourage PLHA to form their own social support groups
- Mobilisation of resources from own sources, Council budget, NGOs, Partners, Charity Organizations etc; and
- Training of community service providers.

Information about tools on HIV/AIDS can be obtained from:

- Guidelines for Home Based Care in Tanzania;
- Course Plan for training Community Home Based Care Providers;
- Trainers Guide for Home Based Care Providers: and
- Guideline for community home based care

10.2 Community Health Worker's Kit

The trained multipurpose CBHW should be provided with working tools for better performance. These includes:

- First Aid Kit;
- Home Based HIV/AIDS Kit;
- Family Planning commodities (contraceptives);
- A bicycle;

- IEC and other health promotional materials for social marketing.
- Drugs for MDAs for disease elimination and control
- Data collection and reporting tools

The actual content of the Kit should be worked out by the CHMT. The Village Government is fully responsible for the management of the First Aid Kit including regular replenishment of drugs and supplies.

10.3 Community Based Service Provider

A multipurpose worker able to provide the essential service package at the household and community level is recruited. Due to the current combined functions of VHWs, CBDs, CBDAs and Peer Educators, they should be trained and supported for such multi-purpose role. This may not be very rational approach, and will be counter productive,

11.0 HUMAN RIGHTS FOR HEALTH

Human rights for health are tools to empower those who are not in a position to assert and protect their rights in health. The necessity to protect members of the community, who are unable to protect their rights, hardly needs explaining. What needs to be explained is that the most vulnerable groups of the society *are* children, pregnant women, people with disability, orphans and the aged.

The objective of rights for health in the context of CBHCI is to enable CBHWs, community leaders and communities as a whole to understand and acknowledge the rights for health and reasons for deprivation. Community members should be able to identify and discuss the main challenges and find solutions. Equally important, they should analyse and get answers for:

- The roles and responsibilities of each individual, family, community, government, NGOs/CBOs, religious bodies, and development partners.
- Causes of ill health
- How power-relationship with regard to resource utilization and decision-making can be discussed.

It is the responsibility of the Districts/Councils, Ward and Village/Mtaa to create and raise the awareness on rights for health to every member of the community. This entails ensuring accessibility to essential health care package with special attention to the marginalized and disadvantaged groups. Communities, through participatory processes, should therefore assess their situation, analyse and find solutions to address the existing problems.

12.0 COMMUNITY BASED COMMUNICATION

Community Based Communication Strategy is essential in guiding health education activities at the household, community and district levels. As a hub of the community based health services, it facilitates the transfer of knowledge and skills on health matters between individuals and families so as to make informed choices and decisions for behavioural change. It also creates demand for better health services, mutual understanding and trust among key actors within the community.

12.1 Strategies for Effective Communication

The Strategies for effective community based communication include:

Advocacy:

Advocacy is a means of communication which focuses on policy and decision making process to influence support or action on CBHI applicable at all levels.

Social mobilization

This is a process which serves to influence the community to take action or support initiatives

Interactive/participatory communication for CBHI

This is a means of communication that focuses on imparting specific knowledge and skills towards positive change of behaviour and attitudes.

12.2 Communication Channels:

Cultural Communication:

This is a type of communication, which applies traditional means of delivering health messages to community members or groups. It includes traditional dance, drummer, poems and songs. CMT should promote, support and provide the correct health messages to be delivered through traditional means of communication.

Print media

This includes newspapers, pamphlets, posters, leaflets, booklets, etc.

Electronic media:

This channel encompasses Radio/Radio calls, Television, Video, Telephone, Fax, E-mails and Public Address System.

These communication channels can be used at individual, family/household, Hamlet/Village, Ward, District, Regional, Zonal and National levels.

13.0 OPERATIONAL RESEARCH (OR)

13.1 Operational Research at Community Level

Participatory Operational Research on health issues has extensively been conducted but utilization has to a larger extent been uncoordinated and limited. Research methodologies should be encouraged at the community level to promote participation in identifying problems and providing solutions. There are several research methodologies but the following are participatory in nature:

- Community theatre; and
- Participatory techniques including PRA, AAA, PAR

13.2 Capacity of CMTs/CHMTs to conduct Operational Research

Capacity of CMT/CHMTs to conduct coordinates and promote utilization of OR in the management of CBHI is increased. They have to conduct OR by involving extension staff including communities and provide feedback in a simple language. Research findings enable communities to identify problems and take appropriate action for their development.

13.3 Key Areas of Research in CBHI

These include:

- Community financing and management;
- Community participation;
- The roles of different community groups in the implementation of CBHI; and
- Issues related to Community Health Workers motivation and incentives.
- The poor and disadvantaged groups in the community who need support.

Operational Research for CBHI should be embedded in the community and District Health Plans. National institutions like the UDSM, MUHAS, MSPH, ESRF, TFNC, NIMR and the MoHSW - Health Systems Research (HSR) Unit should be involved in the planning and execution of the Operational Research activities. Research findings should be effectively disseminated to relevant institutions for decision making and planning and for problem solving at the locality.

14.0 SUSTAINABILITY OF COMMUNITY BASED HEALTH INITIATIVES

Sustainability of community based health initiatives will mainly depend on the degree of household participation, appropriate decision-making and ownership. Fully empowered communities are able to identify own and external resources. The latter resources are meant to complement the former while focusing towards self-reliance. In implementing CBHI, inter-sectoral collaboration and approach should be encouraged to maximize resource utilization and therefore outcome maximization.

Community organization

Effective and efficient implementation of CBHI requires a community that has authority in decision making. Community leaders must be strengthened to assume effective control and support of community-Initiated projects or activities. While responsibilities for implementing must involve community members, the latter should have authority to make decisions on the use and control of resources.