A PROPOSED FRAMEWORK FOR THE IMPLEMENTATION OF COMMUNITY BASED HEALTH INITIATIVES (CBHI) IN THE CONTEXT OF REFORMS IN TANZANIA

Enabling households and communities to take effective action for the improvement of their own health and development.

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EXECUTIVE SUMMARY

A team of 10 local and one external consultants was contracted to review the implementation of CBHI in Tanzania. The objective of the review was to develop a framework for the implementation of CBHI in the districts; in the wake of Health and Local Government Reforms.

Specifically, the team set out to review:

1 Community Based Management of CBHC (Situation analysis, Planning, Implementation, Monitoring, Evaluation, and Feedback)
2 Community Based Health Information Systems
3 Community Based Resource mobilization
4 Community Based Human resource management
5 Community Based provision of the essential health service package
6 Community Based Communication Strategy for Health development and behavior change
7 Community Based Coordination and linkage for health initiatives.

In the course of the review, the team visited 11 districts with the aim of identifying best practice in Community Based Health Initiatives (CBHI) in Tanzania. Lessons derived from district experiences were to be included in this framework so as to guide the scaling up of this approach throughout the country, as a key element of the Health Sector Reform (HSR) process.

Information gathering was undertaken through desk review, key informant interviews, and group discussions as well as observation of ongoing activities at National, District, Ward and Village levels. Visits were made to a total of 11 Districts (and 40 villages, 21 Wards). A second visit was paid to two Districts to validate the findings and assess relevance of strategic actions suggested by the team. Key informants and groups interviewed included: District Management Team (DMT), District Health Management Team (DHMT), Ward Development Committee (WDC) members, Village Chairpersons and Executive Officers, Kitongoji Chairpersons, other Village leaders and ordinary community people at Village Assemblies.

In general, the Review Team found that CBHI implemented in whole Districts over a long period of time were associated with a series of indicators of improved health status, household health behaviour, and community services.

In Mufindi District, for example, quarterly pregnancy monitoring reports submission increased from 72% to 88%. Maternal Mortality dropped from 900/100,000 in 1991 to 397 in 1993. Child mortality from 107/1000 to 90/1000 live births. Immunization coverage reached 92% in 1990 and stabilized at 80% from 1994 to date. Family Planning acceptance has reached 75% in some villages. Severe malnutrition had gone down from an average of 7 to 1 case per quarter in one of the villages visited. The number of houses constructed using permanent materials had also increased eight-fold during the project

period indicating the possibility of an improving economic base. Access to water sources had improved to the level of 80% of households having access to safe water within 30 minutes walk. The villages visited had not experienced an outbreak of cholera for the past three years. In addition, roads to the villages had been improved and maintained in good condition.

There was increased proportion of women in Village committees reaching up to one third (8 / 20) in some of the villages. These achievements were attributed to the use of participatory approach in planning and implementation of CBHI.

The review team made the following conclusions, observations and recommendations:

1. Community Based Participatory Situation Analysis, Planning and Management

Key findings:

The team found adequate capacity for the management of CBHI as part of the District Health System, in accordance with the Ministry of Health guidelines, in most of the Districts visited. Efforts had been made to forge linkages with the ongoing local Government reform process. In some Districts there was evidence of capacity at Ward level to facilitate community based planning using participatory reflective methodologies and tools (e.g., the "triple A" other PRA methods, as well as the logical framework). The planning process starts with small groups at the hamlet level, these are collated and approved at a village assembly before they are compiled at the Ward level and transmitted to the District level. At the District Planning Unit the District Planning Officer (DPLO) compiles the Ward Plans into the draft District Master Plan. The health elements in the plan are conveyed to the DHMT for compilation into the District Health Plan. Both the District Master Plan and the District Health Plan go through the appropriate approval processes and resource allocation. From there feedback is given to the concerned parties for implementation to commence.

In some of the districts, the villagers confirmed that the planning process is regular, participatory and bottom up. Technical extension personnel participate in planning meetings at all levels, to provide technical input and advice. All sectors are involved and stakeholders were involved. However the plans seemed to be biased towards physical structures (roads, buildings, etc.), and did not make adequate use of data collected at the village level. The villagers demonstrated effective mechanisms for resolving conflicts to generate consensus. The teams were shown impressive village plans and evidence of implementation and monitoring of progress.

Strategic actions:

There is enough evidence regarding participatory management of CBHI in Tanzania to justify making it the preferred approach throughout the country. This process would require capacity building at all levels for evidence based

participatory integrated bottom up planning, implementation and management of CBHI, through training, as well as an operational policy framework and provision of tools. The coordination role of the DPLO is crucial, as it enables the process to be implemented as a regular approach to planning tied to the reform efforts across sectors.

The initial introduction of this process in a District would require a top to bottom awareness process, starting with the District Commissioner, the District Executive Director, and all the related Sector Heads. The DED takes ultimate responsibility for the implementation process assisted by the DPLO, District Community Officer (CDO) and the District CBHC Coordinator.

2. Community Based Health Information Systems

Key findings:

The Community Based Information System (CBIS) was relatively inadequate with regard to systematized data collection, processing and usage. Different agents that were neither adequately co-ordinated nor linked to the management of the programs collected a lot of data in different ways. Much of the information was collected and shared around the Village Health Days, which were held at least once every 3 months. Otherwise routine reporting and record keeping were the main information activities observed at the village level. Reports are sent both to the local health facility and to the Village and Ward Executive officers. There is a dual channel of information flow up to the District level. There is no formal feedback mechanism but verbal interactive sharing of information takes place at meetings or at the Village Health Day where instant feedback is received and fed into decision making.

Strategic actions:

There is an urgent need to streamline the information system and to build capacity for its management through a careful design, training, development of instruments and supervision. It should be built into the framework for participatory management of CBHI as well as ensure better linkages between the community information system and MTUHA data at village, ward and district levels. The Village Health Days should be recognized as special days for sharing information based on service and assessment data. This should lead to recognition of excellence in performance and adjustment of detailed plans of action to ensure progress towards targets. They should be Days of celebration of progress.

3. Community Based Resource Mobilization

Key findings:

There were good examples of revenue generation like the Community Health Fund (CHF), facility cost sharing, and revenue collection from taxes as well as fines based on local by-laws. These funds which are managed at the local level have greatly improved

quality of service. The financing of education is more secure because of earmarked funds from the development levy retained at the Village level. The financial resources are complemented by the contributions of labour, time, and other inputs, particularly around the Village Health Days, enabling the direct involvement of most villagers in health improvement activities. Often there was direct payment for services rendered by the Health Worker (e.g. mothers paying per child weighed).

Buying and selling essential drugs developing into a revolving fund to replenish the kit. There were also experience with buying and selling preventive and promotive materials like family planning commodities; providing an initial service delivery package / equipment which is then paid for and owned by the worker as a local entrepreneur. The worker becomes self employed.

Examples of private enterprises were also witnessed (Insecticide Treated Nets, Water supply, garbage collection and clean toilets in public places).

Additionally, schools are major entry-points for health action (child to child and child to parent), which are available in all the villages.

Strategic actions:

The potential for revenue generation at the local level could be maximized if the Councils strengthened their capacity for revenue collection at all levels. People's confidence to pay taxes would be improved if the plan/budgeting/controls processes were transparent and accountability to the taxpayers ensured. As for Education Community Based Health Initiatives (CBHI) could benefit from earmarked percentage from the development levy retained at the village level. This money could be used to support the work of the VHWs and to establish First Aid kits. It would be up to the local CHF Boards to decide on their contribution towards CBHI activities.

Other resources to maximize for CBHI include:

- **voluntary and communal work for health**
- **private enterprise development, both health and non- health related, regulated by the local government to benefit community health**
- **Schools as entry points for health and development engaged more deliberately in health acti through clubs, festivals, services and curricular review to ensure coverage of essential health information.**

4. Community Based Human Resource Management

Key findings:

The categories include Village Health Workers (VHWs), Community Based Distribution Agents (CBDAs), Traditional birth attendants (TBAs), Peer Educators and Village AIDS counselors. There are also persons who are traditionally trained, e.g. Traditional Healers (THs). In addition, there are many other agents for health in all Districts visited, e.g., teachers supporting child to child and child to parent health efforts; religious workers involved in counseling; Village leaders and officers as well as extension workers. In

some Districts the TBAs and VHWs had improved antenatal care and pregnancy follow-up considerably.

The team noted that the training of various categories of workers differed from district to district, based on the interests of the supporting agencies. In general, refresher courses were rare and irregular, in spite of the provisions of the national guidelines. Workload also varied widely with no clear accountability mechanisms. In the same way their rewards ranged from recognition, payment for their levy by the Village Government or exemption from communal labour, to in kind gifts and cash payments. There was no established supervision mechanism.

In some Districts the VHWs were multipurpose in function, combining the functions of TBAs and CBDAs. In other Districts the opposite was true, having a multiple of workers with different functions, incentives and support, often based on the supporting agency. A general rather specialised TBA was preferred because the problems they deal with at the Village level tend to be integrated and multidimensional and should be dealt with in an integrated manner. However they were also the most externally trained, managed and recognised of all the Village Based Workers with high expectations for regular remuneration, often not commensurate with the time spent nor productivity by them. They were often not recognised as the responsibility of the local government. Most Villages visited had enthusiastic local leaders engaged in integrated development functions of their village. In some Villages they were supported by a team of experienced extension personnel and resource persons trained as animators for participatory development.

Strategic actions:

It would be necessary to reform the human resource at the community level and have the community decide what they want to accomplish in health, who they suggest should do it and how such people should be supported by way of incentives, based on their own village priorities and resources. CBHWs should be appointed and deployed by Village Government (with contracts specifying tasks, workload, area of responsibility and support, based on Village plan and budget), 2 per Hamlet suggested, male and female. This would ensure that VHWs are internally recruited and accountable like other local officials.

Given the rapidly worsening situation of HIV affecting the youth more than other age groups, it is reasonable to suggest that VHW include HIV/AIDS education as a priority. This role should go beyond the traditional health education approach to include interactive techniques that are effective in changing behaviour. The role of the DHMT is to train the workers once they have been selected and tasked by the Village Government. It would simplify matters for the Villages if these workers were multipurpose in function to cover all the essential health package but with emphasis on prevention and promotion. Continuing education and options for growth would add to the incentive package that would motivate CBHWs. The Villagers' suggestion to have an average of two VHWs (man and woman) per Kitongoji, who are able to cater for all the essential health service needs at

household level, is reasonable. They would need to include the costs in their plans and budgets.

It is necessary to harmonise curricula for the training of managers, trainers and community workers as well as the training methods. Managers and trainers should be trained for their role in CBHI. The materials available for the training of Trainers (TOTs) and Facilitators (TOFs) would be appropriate, with some adjustments to suit local situations.

In addition to CBHWs, other Village leaders and other extension personnel, religious workers, teachers who are strategically placed for health promotion should be assigned specified roles by their Villages (included in job descriptions), based on village plan.

5. Community Based Service Delivery Package

Key findings:

The following are the services currently provided at the houschold and Village level:

Actor	Service provided
VHW	Health education and promotion on: environmental sanitation, hygiene, family planning, nutrition, STI/HIV/AIDS, malaria and ITNs, etc. Health status monitoring of: child growth, pregnancies, latrine coverage, etc. Mobilisation for: immunisation, Village Health Days Distribution and sales of commodities: ITNs, contraceptives Referral: high risk and complicated pregnancies Health care: some treatment of minor ailments, conduct normal deliveries (by some female VHWs)
TBAs	Health care: Conduct normal deliveries, post-natal care Health education: advise pregnant women on preparation for delivery, attendance at ANC, PNC, family planning, STI/HIV/AIDS Referral of: high risk pregnant women
CBDAs	Health education on: family planning and contraceptives, STI/HIV/AIDS and counseling Distribution and sales of: contraceptives Referral of: clients needing care beyond their capacity to provide. Some carry out VHW activities.

The services currently provided at the village level cover the areas included in the national essential health package that can be undertaken by the Village Based Health Workers (Reproductive and Child Health, Communicable Disease Control and Health promotion, water / sanitation). There is inadequate agreement as to whether and how much curative work the VHW should carry out. Another area of debate is whether one type of worker, the VHW, can cater for the whole of the essential service package to permit effective integrated care rather than fragmented services.

Strategic actions:

The service delivery package issues would best be resolved at the Community level within the participatory planning process where problems are identified and how they can be solved within the resources available. The CBHI coordinator can facilitate a process to negotiate best interventions for each Village situation during the planning process. However the team considers the provision of First Aid kits for villages that are far from a facility, to be important. However the contents of such a kit would need to be decided by the DHMT in consultation with the Villagers.

In general the service delivery package at the household and village levels should focus on preventive and simple curative/referral elements of:

- **Reproductive and child health care including HIV/AIDS, Nutrition, and IMCI**
- **Control of communicable diseases particularly malaria, Vaccine Preventable Diseases (VPDs), Diarrhoeal Diseases**
- **Health promotion, water and sanitation.**

6. Community Based Communication Strategy

Key findings:

Among the more effective behaviour change strategies seen in the districts were participatory interactive methods carried out by inter-sectoral animation teams at various levels. In addition there were popular theatre and other traditional approaches like use of drum and gong (*kijembe* and *kengele*) method. The Community Based Health Workers (CBHWs) were involved extensively with health education as well as counseling during home visits, clinics, general meetings and Village Health Days. The use of print or electronic media was limited.

The team underscored the need for a coherent communication strategy for CBHI which is embedded into the CBHI planning and management initiatives, built into the Community Based planned training and educational activities. The strategy should focus on behavior change at the household level but supported by advocacy and social mobilization. The strategy should maximize the use of traditional and multi-sectoral channels as opportunities to affect behaviour change. It will also need to build on the bottom-up process of clarifying communication content, audiences, channels, and material support needs. Of special consideration would be youth directed communication mechanisms that aim at behaviour change rather than only providing information and acquisition of knowledge.

improved health status, household health seeking behavior, as well as community services and health responsibility (annex 3).
The team recommends consideration of the following revised and specific vision for the CBHI: *"Communities actively and effectively involved and enabled to increase control over their environment in order to improve their own health and development."*

1.3.1 Community Based Participatory situation analysis and planning:

The team found adequate capacity for the management of CBHI as part of the District Health Systems, in accordance with the Ministry of Health guidelines, in most of the Districts visited. In some Districts there was evidence of capacity at Ward level to facilitate community based planning using participatory reflective methodologies and tools (e.g., the triple A, other PRA methods, as well as the logical framework). The planning process starts at the village level, gets collated at the Ward level and gets transmitted to the District level for compilation into the District Master Plan as well as the District Health Plan. This process is led by the District Planning Officer (DPLO) with technical assistance from the Sectoral Ministries (Health, Education, Agriculture, Water and Community Development, Women and Children Affairs).

The villagers in some of the districts confirmed that the planning process is regular, participatory and bottom up. It starts with interest groups at the level of the hamlet (Kitongoji), collated at the village assembly before forwarding to the district level through the Ward Development Committee (WDC). Technical extension personnel participate in planning meetings at all levels, to provide technical input and advice. All sectors are involved. However the plans seemed to be biased towards physical structures (roads, buildings, etc.), and did not make use of any data collected at the village level. There were examples of problems solved at the lowest possible level, through the planning process, utilizing local resources available to them. The villagers demonstrated effective mechanisms for resolving conflicts to generate consensus.

The team concluded that there is enough evidence regarding participatory management of CBHI in Tanzania to justify making it the preferred approach throughout the country. This process would require capacity building at all levels for evidence based participatory integrated bottom up planning, implementation and management of CBHI, through training, as well as an operational policy framework and provision of tools. The coordination role of the DPLO was supported in all the districts visited. This will enable the process to be implemented as a regular approach to planning. At the moment it appears to be ad-hoc and dependent on external resources.

1.3.2 Community Based Health Information Systems

In some communities Village Health Workers (VHWs) and Government Officials collected data using village registers and other local instruments. However, there was lack of harmony in handling, processing and using data/information. Much of the information was collected and shared around the Village Health Days, which tend to be held at least every 3 months. Otherwise routine reporting and record keeping are the main

information activities at the village level. Information is gathered and passed on to some other level and not adequately used at the level at which it is collected and by those who collect it. There were few examples of well functioning health information systems beyond the facilities.

Some respondents complained of too many channels of communicating the information, often influenced by the donors, and with different and unrelated tools used in the same communities. The village register is a good tool but it covers only population. Each village will need additional information based on their activity plans.

There is urgent need to streamline the health information system and to build capacity for its management through a careful design, training, development of instruments and supervision. It should be built into the framework for participatory management of CBHI. There is also a need to ensure better linkages between the community information system and MTUHA system at village, ward and district levels.

1.3.3 Community Based Resource mobilization

Good examples of revenue generation for community based initiatives were seen. The sources included the Community Health Fund (CHF), facility cost-sharing, and revenue collection from taxes as well as fines based on local by-laws. These resources are complemented by the contribution of labour, time, and other inputs, particularly around the Village Health Days, enabling the direct involvement of most villagers in health improvement activities.

There is a need to earmark a specific percentage of village development levy to Community Based Health activities. This could be used to purchase and replenish the drug kit and support VHW activities. CBHI expenses can most effectively be funded by a specified percentage of the retained development levy, as is the case with education. Regarding the use of CHF in financing CBHI, the members can only make the decisions. CBHI expenses can funded more appropriately by the Village Government a specified percentage of the retained development levy, as is the case for education.

1.3.4 Community Based Human resource management

The categories include Village Health Workers (VHWs), Community Based Distribution Agents (CBDAs), Traditional birth attendants (TBAs), Village AIDS counselors, etc. There are also persons who are traditionally or informally trained, e.g., Traditional Healers (THs), and many more TBAs. In addition, there are many other agents for health in all Districts visited, e.g., teachers supporting child to child, and child to parent health efforts.

The team noted that the training of various categories of workers differed from one district to the next and even sometimes within one District, based on the agencies responsible for the training. In general, refresher courses were rare and irregular, in spite of the provisions of the national guidelines. Workload also varied widely from 3 to 8 days a month with no clear accountability mechanisms. In the same way their rewards were in the form of recognition, payment of levy by the Village Government or exemption from communal labour, in kind gifts and cash payments.

There is a need to reform the human resource at the community level and have the community decide what they want to accomplish in health, by what activities, by whom, and how such people should be supported by way of incentives, based on their own village priorities and resources. There is need to integrate functions of CBHWs but together with better-defined scope, roles and workload. CBHWs need training and incentives. It was suggested that the one or two VHWs (man and woman) take care of a Kitongoji.

1.3.5 Community Based Service delivery package

The service package delivered at the household and community levels by various village based health workers are consistent with the national essential health package health workers which is based on the disease burden studies in Tanzania. These services are shown below:

Actor	Service
VHW	Health education and promotion on: environmental sanitation, hygiene, family planning, nutrition, STI/HIV/AIDS, malaria and ITNs, etc. Health status monitoring of: child growth, pregnancies, latrine coverage, etc. Mobilisation for: immunisation, Village Health Days Distribution and sales of commodities: ITNs, contraceptives Referral: high risk and complicated pregnancies Health care: Treatment of minor ailments (some female VHWs conduct normal deliveries)
TBAs	Health care: Conduct normal deliveries, post-natal care Health education: advise pregnant women on preparation for delivery, attendance at ANC, PNC, family planning, STI/HIV/AIDS Referral of: high risk pregnant women
CBDA	Health education on: family planning and contraceptives, STI/HIV/AIDS and counseling Distribution and sales of: contraceptives Referral of: clients needing care beyond her capacity to provide. Some carry out VHW activities.

It was noted that most of the functions of the Community Based Health Workers (CBHWs). The DHMTs generally feel that VHW kit tends t divert the attention of the VHWs away from preventive activities. They recommend that the focus of CBHI should be preventive except in special situations and circumstances where there are no facilities. Additionally the DHMTs feel that combining the functions of the VHWs, CBDAs, and Peer Educators is a must and not an option in CBHI. The core provider in the village is the VHW; the others complement the work of the VHW. These additional cadres were

created by donors and often the DHMT is faced with the problem of what to do with them when the donor funding ends. They are specifically trained for their functions and for their relationship with the donors. Often methods and routine of work and incentives are donor specific; that brings about a lot of confusion.

CBHI would best be served by a multipurpose worker able to provide the essential service package at the household and community level, combining the current functions of VHWs, CBDAs, and Peer Motivators. Therefore they need to be trained and supported for such a multipurpose role. The Village Governments should be in a position to reject externally driven single purpose health workers that do not fit their own plan.

1.3.6 A Community Based Communication Strategy

Among the more effective behaviour change/support strategies seen in the districts were participatory interactive methods carried out by inter-sectoral animation teams at various levels. In addition there was the use of popular theatre and other traditional approaches. CBHWs were involved extensively with health education, counseling, and Village Health Days, the latter being a popular and effective forum for wide communication. The use of print or electronic media was limited.

There should be a coherent communication strategy for CBHI, which is embedded into the CBHI planning, and management initiatives, built into the Community Based planned training and educational activities. The strategy should focus on behavior change at the household level but supported by advocacy and social mobilization. The strategy should maximise the use of traditional and multi-sectoral methods as opportunities to affect behaviour change. It will also need to build on a bottom-up process of clarifying communication content, audiences, channels, and material support needs.

1.3.7 Co-ordination of efforts and building of linkages for CBHI

The reformed local government structures provide adequate organisational mechanisms for vertical as well as horizontal co-ordination and linkages necessary for effective implementation of the community based health initiative. In some districts, there are monthly partners meetings, which are voluntary and not formal. Lack of donor and NGO coordination was a major cause for concern.

In some districts the Management Teams suggested that the main coordination tool would be the District Master Plan developed in a participatory Bottom up manner. This process should include all the stakeholders like the Civil Society structures, the religious organisations being the main agency. This could be reinforced by joint awareness workshops, training and use of tools/guidelines. Such guidelines should clarify roles, responsibilities and mechanisms for joint supervisory support to the community based health initiatives in the new context. The mechanism would require focal point staff persons at District, Ward and Village levels from each of

the sectors involved. These focal staff persons could form a task force at each level, to ensure adequate support to the community based workers, using a common supervisory tool to be developed. Necessary additional by-laws may be enacted to ensure compliance.

1.4 The justification and content of the framework

It is important to emphasise that what is presented in this framework does not attempt to provide a straight jacket of guidelines that must be strictly followed by all CBHI implementors. It attempts to conform to the national planning systems in the context of the reforms. We have simply synthesised the Community Based Initiative (CBHI) practices according to the main scenarios based on the district programmes that were reviewed. The practices and principles inherent in the different scenarios have evolved through a lot of experimentation by the different programmes. This framework document is structured such that it can be of use primarily at the District level for introduction or strengthening of CBHI while also pointing out opportunities for national level support to ensure progress. Given the transitional nature of the reform process this document will need to be reviewed after 6 months to 1 year.

It can be noted that in the Seventies and Eighties the non-participatory approaches, which paid lip service to community participation, were heavily criticised because they became associated with the failure in health care provision through the public facilities and systems. As a result more bottom up or participatory approaches started to be advocated, and have now been vividly expressed in the implementation of various reforms. The efforts to break away from the top down approaches in the health area were pioneered the by non-state structures and donors that often tended to set up parallel structures alongside the local systems. This approach has delayed the scaling up of local experiences into a national program.

Whereas there are many successful Community Based Health approaches in the country, procedures that would enable health care managers to include CBHI in their regular plans and activities have not been adequately standardised. Majority of the managers and implementors are unlikely to have the necessary skills and materials. It is therefore critical that this capacity is built at the district level through training and tools development, so that all interested districts can have CBHI as part of their strategic plan and programs in health in the context of reforms. It is crucial that CBHI is integrated in the local structures and that programs do not create parallel structures or force duplication of resource demands.

This framework is based on the practical experiences of districts where CBHI has been practised for more than ten years. A number of CBHI activities implemented in some districts, originally with donor support, had been weaned from donor funding for more than ten years, and are continuing to function very well under regular health service systems wholly Government or locally supported. However, in recognition of the vastness of the country and variability of situations, what is presented in this framework is a collection of broad guidelines. More specific guideline will have to be developed to suite specific circumstances guided by the broad guidelines and existing policy

directions. The ongoing reforms provide opportunities for these innovations for health and development to become operational throughout the country, taking advantage of the policy frameworks for both the local government and health sector reforms.

While this section presents a brief overview of the concept of CBHI, the second section presents the concepts and process of participatory but evidence based planning. The third and forth sections describe the organisational structure and community based information systems, respectively. The fifth section describes the options for community based resource generation for CBHI implementation. The sixth sections provide some guidance on the management of community based human resources and the essential service package that they can provide. The seventh section summarises a community based communication strategy, recognising that such a strategy has to be embedded into all elements of CBHI. The element of co-ordination and linkages is covered under the management and governing structures for CBHI. A number of resource materials that are necessary in the implementation of CBHI are listed in annex 1.

2. COMMUNITY BASED PARTICIPATORY PLANNING CONCEPTS AND PROCESS

2.1 Introduction

This section briefly outlines the basic planning concepts and approaches in the context of community based health development. It outlines the limited advantages of the top down planning and its disadvantages. The bottom up approach commonly referred to as participatory planning in particular the Participatory Rural Appraisal (PRA) and the Assessment, Analysis and Action (A,A,A), triple "A" cycle techniques are described. Through PRA and A,A,A, techniques, the planning and implementation process options are discussed.

2.2 The main approaches to planning

Planning can be defined as a continuous process that involves making decisions or choices about alternative ways of problem solving using available resources, with the aim of achieving a particular goal. It is about choosing and prioritizing problems as well as alternative ways of solving them using the available limited resources.

In relation to CBHI there are two approaches commonly used: TOP DOWN and BOTTOM UP approaches, based on the extent of community involvement during planning, implementation, monitoring and evaluation of a programme or project. Bottom-up planning can thus be described as participatory or community based.

2.2.1 Top-down planning approach

This type of approach has been predominant in government and donor funded programmes. This non-participatory approach is seen to allow rapid, large scale spending

of budgets in accordance with pre-established timetables and therefore it gives planners an illusory feeling of control and efficiency.

Limitations of Top down approach include:

- Centrally made decisions by organizations that are remote from the community or project site.
- Planners devising technical solutions to any problems without or with minimal consideration of the well-established community social systems.
- Limited participation of stakeholders (the community) in the planning implementation, monitoring and evaluation process.
- Poor planning assumptions regarding the social and environmental factors.
- Plans are based on quantitative estimations and less on qualitative information.
- Planning and implementation following a pre-conceived project design giving little room of local initiatives, environmental changes and developments choices.

The consequences of top down approach are lack of community ownership leading to non-sustainability and failure in the implementation. It is important to note that community based planning should be linked to the district health planning and does not replace it. The linkage is based on community action priorities, which are beyond their resource capability. These elements must be picked up by the technical personnel at the ward level to feed into the District Health planning process, as explained in the organizational structures below, to be included into the district health plan.

2.2.2 Bottom-up planning approach

Community Based Initiatives by their very nature have to be planned in a participatory way. As the term implies, they are initiatives originated by the community themselves but enriched by technical resource people. Thus programmes can only be described as being community based if the community members have been fully engaged actively in the whole planning cycle: problem identification, analysis of causes, identification of alternative solutions, priority setting, implementation, monitoring and evaluation by using the available resources within their own communities. In other words planning is initiated and implemented in the community by the community itself, with the facilitation and support of technical resource persons.

Bottom-up planning approach is currently regarded as the most effective and efficient way through which the health services at community could best be addressed. This approach ascertains sustainable development change in the community through identification and use of the available resources. In this way it enhances the communities capacity and control over factors and events which influence their lives, often referred to as empowerment.

Participatory planning techniques are many; and most of them carry similar features and principles as described by different authors. Two commonly applied techniques in the country can be used in the planning process. These are, the Participatory Rural Appraisal (PRA) and the Assessment Analysis and Action techniques commonly known as the "Triple A cycle".

Participatory Rural Appraisal (PRA):

PRA is a community based planning technique, which involves active community participation in appraising, prioritizing and problem solving. There are a number of tools and techniques used in the process:

1. Review of Secondary Data: These are the available information relevant to the area or subject of the planned PRA. The data is reviewed and organised in diagrams and tables before the physical assessment process begins. Secondary data can be obtained from different information sources such as MTUHA reports, District annual reports, ward and village reports, survey etc. This data must be relevant to the area of community where PRA is to be used as it forms the background of the assessment, analysis and action process of that particular community.

2. Direct observation of objects, events, processes, relationships of people: Normally a checklist is prepared and used for systematic observation. This is conducted in the relevant community by the multidisciplinary PRA team together with the community in a systematic way where findings are recorded. It is a method of cross checking real community practices against information obtained from other sources. Some additional instruments like tapes and weighing scales may be used to quantify some of the observations such as crop production by acreage and tonnage.

3. Semi-structured interviewing which is held with individuals, key informants and groups in the general public or focussed for specific groups of people. Various techniques may be used such as brainstorming and the "but why" technique. The interviews are carried out by a team of 2 to 4 people of different disciplines who are normally guided to obtain information on the assessment, analysis and action process of the particular community. Some basic issues need to be considered when conducting an interview such as covering a wide range of various population groups, conducting the interview informally and mixing it with discussions, allowing each group member to contribute and carefully leading the discussion while considering community cultural norms and values.

4. Ranking or scoring through voting or by using a matrix table where predetermined criteria are given. This is a process whereby the community members on their own are guided by a multi-disciplinary team of staff to put problems and solutions in order of their priority or preference. Like in the semi-structured interview the process is carried out using individual members of the community, key informants, groups from the general public including specific focus groups. It is one of the

Assessment, Analysis and Action decision-making method complimenting other tools like the semi-structured interview.

5. Construction of diagrams which presents information in an understandable visual form. These can be maps, seasonal calendars, graphs etc. Diagrams are a simplified model of the reality. They are prepared by the community members under the guidance of the team of experts. This may describe different concepts or situations in that particular community which is easily understandable.

6. Innovation implementation and sustainability assessment and analysis. It is the final stage of Assessment, Analysis and Action review process which is carried out by the community itself. Through this process the community asks itself a number of questions leading to decisions and action regarding the continuation or modification of their interventions.

Advantages of PRA

- It involves continuous and intensive community participation where all segments of the population are involved.
- It uses a multidisciplinary team of experts or extension workers with different skills and backgrounds to guide the process.
- It provides on spot analysis.
- It uses a mix of techniques from a wide range of possible tools, which are combined according to the requirement needed.
- Information is collected from different sources.
- It is flexible and does not require detailed statistical analysis.
- The approach is non-hierarchical and is good for learning and understanding people's opinions, behaviours and attitudes.
- It takes the team a short time.
- It is relatively inexpensive.

Limitations of PRA

- It requires a skilled multidisciplinary team, which may be difficult to find at the community level.
- It is rapid and could be superficial, generalization may be based on too little information or too few informants and could overlook the invisible.
- Rumours, myths and gossiping may mislead the team.
- The focus appears to be on assessment, analysis and planning rather than action.

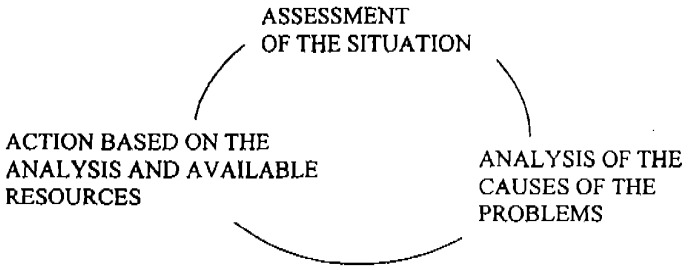
Assessment, Analysis and Action approach (A,A,A, or Triple A Cycle)

The Assessment, Analysis and Action approach, is commonly referred to as the Triple A cycle. It is based on repeated cyclical process of assessment of the existing, analysis (a search for different causes of that situation) followed by action based on the feasibility of

intervention given the resource availability within the level required. The process is facilitated by village/ward leaders and extension workers who actively involve the community in the planning, implementation, monitoring and evaluation of CBHI activities.

It starts at lowest level of decision making where resources can be allocated for use. It involves individuals, families and the community in general in collaboration with other partners - the ward and district leaders as well as other NGOs working with communities.

Fig. 1: The "Triple A" Cycle:



ASSESSMENT: Is a process of looking into the existing situation critically how it prevails within the level concerned under consideration. This could be individual, family, village, ward or district level. The aim of this critical assessment is to identify problems and thereafter be able to determine intervention needs.

Through assessment the following issues can be determined:

- Causes and circumstances – underlying problems
- Availability and adequacy of resources and capacities to undertake possible interventions
- Cases and weaknesses in the planning and implementation process.

ANALYSIS: Is a process of critically analysing the causes of the problems identified in the assessment stage. Immediate causes and underlying causes as well as basic causes are identified and prioritized based on set criteria - such as magnitude, severity, vulnerability to intervention, cost effectiveness and political/cultural will or recognition.

ACTION: Depending on the resources available and the problems prioritized, the appropriate intervention options are identified and carried out. When action is taken, reassessment and analysis also takes place (monitoring and evaluation) and further actions are sought and implemented as shown on the diagram. This technique is dynamic and repeating periodically as planned by the community, fitted in the Planning, Implementation, Monitoring and evaluation process. Because of its participatory and continuity in nature it builds community ownership in terms of accountability and responsibility from the start and therefore ensures sustainability.

The advantages and disadvantages of the Triple "A" technique

Advantages the Triple "A" technique are similar to those of PRA with the following additional ones:

- It does not necessarily require a multidisciplinary team of experts.
- It is a continuous process of reflection and action built into the planning process emphasizing action, and thus ensures community participation not only in assessment and planning but also in action for health improvement.
- It can be used at any level.
- It has no limitation of using statistical and quantitative data.

The limitations of the Triple "A" technique

Like the PRA the triple A cycle requires capacity building of all the required levels to be able to undertake Assessment, Analysis and appropriate actions. Continuous and regular technical support is needed during the initial stages. It is important, however to note that for participatory based planning and implementation to continue working effectively, it involves a process which may go through different stages or levels of participation as shown on the following table.

On table 1 below is a summary of typologies that are possible in the use of participatory methods, ranging from manipulation to self-mobilization. A successful process should lead to self-mobilization.

Table 1 Types of Participatory Planning

Type of Planning	Characteristics
1. Manipulative	Participation is simply a pretence
2.Passive participation	People participate by being told what has been decided or has already happened. Information is owned only by external professionals.
3. Participation for consultation	People participate by being consulted or by answering questions. No room for shared decision making between the stakeholder and the professionals. People's needs and priorities are ignored.
4. Participation for material incentives	People participate in 'work for food' arrangements. They may also participate for cash, or other materials incentives. The activities and the participation end when the material incentives stop.
5. Functional participation	Participation is seen by the external agencies as a means to achieve project goal, especially reduced costs. People may participate by forming groups to meet predetermined project objectives.
6. Interactive participation	People participate in joint analysis, which leads to action plans and the formation of strengthening of local groups, or institutions that determine how available resources are used. Learning methods are used to seek multiple viewpoints.
7. Self mobilisation	People participate by taking initiatives independent of external institutions. They develop contacts with external institutions for resources and technical advice but retain control over resources usage.

Thus, it is possible to describe various levels of participation in a community based planning process as shown on table 2 below.

Table 2: Levels of Community Participation

LEVELS	CHARACTERISTICS OF PARTICIPATION
I. Increase of User Response (Elementary level)	• Programme contact and details worked out by non-community members. • People mobilised to use available services e.g. epidemic control, vertical programmes.
II. Community Collaboration	• There is some development of community skills and solicitation of community input, but minimal. • The programme content is also worked outside the community. • Community invited to respond at some stage of the planning especially on how to implement a preplanned programme. • Has elements of community participation but does not really accommodate community needs and priorities.
III. Community decision / involvement	• There is some local needs assessment and community decision to participate. • Community starts to build and develop their capacity in terms of the planning process. • Self community diagnosis starts taking place.
IV. Community Empowerment	• Community assumes control of the development process. • People take initiatives independent of external institutions. • Contacts with partners are made for technical advice and resource assistance but retain control over the use of resources. • The questions WHAT, WHY, HOW, WHO and WHEN are raised and worked out by the community itself.

Source: Were, M.; Challenge of Capacity Building at Community levels, 1990 [adapted by T. Barton 2000]

In order to make Community Based Health planning an effective process the following conditions should be met:-

- All members of the community should have the possibility to be involved in the whole process.
- There should be gender balance and inclusiveness in the participation of marginalised groups: the elderly, the youth, the most at risk groups, school children etc.
- Intersectoral and partners collaboration to permit integrated planning.
- Control of the process by the community while involving all the stakeholders e.g. the Village Government, the Ward leadership, the District leadership and the partners.

It is important to note that community based planning should be linked to the district health planning, it does not replace it. The key linkage is through the community action priorities, which are beyond the resource capability of the Village. These elements must be picked up by the technical personnel at the Ward level to feed into the District Health planning process as displayed in the organizational structure, figure 1 below.

2.2.3 The relationship between the triple "A" cycle and PRA

It should be pointed out that the two methods complement each other. While PRA is basically designed as a research appraisal technique of learning from, and with the community as they investigate, analyze and evaluate constraints and opportunities to enable them make informed and timely decisions, triple "A" cycle ensures that the process is a self-driven by the community. The repeating reflection action process in

triple "A" maintains momentum towards continuous improvement. This is in recognition of the fact that biological and social factors influencing a given situation or problem are not static but changes constantly. Hence there is a need for reassessment, analysis and improved action. In this way the cyclic technique serves more as an implementation rather than simply than a planning tool. Many of the districts implementing CBHI commonly use triple "A" technique.

Introducing CBHI into a District

District authorities are important starting points because of their crucial role in the implementation of programs, CBHI being no exception. It is therefore critical that awareness, support and capacity are built at the district level so that the district authorities not only realise their roles but also have the capacities to carry out their functions in facilitating community based development. The District Planning Unit under the responsibility of the DED is crucial in co-ordinating development initiatives in the district (CBHI being a key one) to avoid the current trend of setting up parallel systems for every project.

Training is critical for CBHI in order to build capacity to a reasonable level. It is important to train the whole cross section of stakeholders in the district on the principles and strategies of CBHI, particularly on participatory planning and management of community based initiatives.
The training process should develop **multi-disciplinary district teams of** facilitators where they do hot already exist. Already there are districts that have built strong animation teams to do a basic training on participatory approaches. This process should be organized in a systematic manner to build capacities for participatory methodologies at the regional, district, ward and village levels. Even if spearheaded by the DHMT the office of the DED, DPLO, and CDO, should always be involved.

The process starts with the training of District level managers as facilitators. These facilitators train and supervise the Ward level Trainers who in turn train the Community Based Workers and leaders. Program planning and implementation should be built into the training process, as trainees actually undertake assignments as part of the "on the job" training exercises. The steps are summarized in the box below.

Box 1: Four steps in Introducing CBHI: the experience of a District

1. An experienced CBHI manager is identified and or deployed to support the DHMT / DMT in the CBHI process. If the expert is external then a local counterpart (CBHI Co-ordinator) is assigned to work with the expert manager. The local counterpart undergoes an accelerated training course to build confidence and speed up uptake of new skills on the job.
2. CBHI awareness workshops for the District Heads of Departments, leaders and decision-makers, to explain CBHI and to get their inputs into its content to produce a framework plan for the district. Workshop elects a taskforce consisting of the DED, DEO, DALDO, DMMO, and DMO, with DSDWCO as Chair. They meet at least twice a year to review progress of implementation. Later the task force may establish a quarterly meeting of stakeholders and implementers strategically timed to take advantage of the Village Health Days.
3. Training of a multi-sectoral animation team at the District and Ward levels, together with awareness process at the Ward, Village and Hamlet levels as the practical exercises for trainees. Regularised awareness process is then built into the "triple A cycle" This becomes a continuous repeating activity that drives CBHI activities. The strengthening of the village structures to ensure effectiveness is a crucial element of this step. CBHI should be built into existing legal structures.
4. The participatory planning, monitoring, evaluation and feedback with built in peer review elements e.g. hold joint Quarterly review meetings of neighbouring Districts. Process to make maximum usage of the Community Based Information system, explained in section 4 of this framework, based on the actual plan and intervention package decided upon.

2.3 A Framework for Participatory Planning

2.4.1 The Planning Process

Community Based Health Initiative (CBHI) is the domain of health care, which should be under the total control of the community with some support from the technical resource people. Its planning should be interactive, see table 2. As such, the community should take the center stage in making decisions on their priority problems, available resources and solutions and to drive the planning process. This process increases the capacity of the community to control their environment through effective evidence based planning, action, evaluation and feedback. To accomplish this there is need for community education, sensitization and mobilization to get the process going and maintained. This is consistent with the Health Sector, Local Government Reforms and Restructuring of Regional Administration, which among other things require meaningful involvement of the communities. The crucial question is how does the bottom up link with the top down planning processes.

Many districts are already operating the CBHI whose plans are either incorporated in the District Health Plans or in the District Master Plans. Although such plans reflect CBHI components, the respective communities may not have been involved in determining the priorities and interventions. Where they were involved, the scope, extent and quality of their involvement may vary from one place to another. This framework is intended to guide the district team in the process of facilitating participatory planning to ensure adequate community involvement in planning, implementing, monitoring and evaluating CBHI.

A major assumption made in proposing this framework is the availability of capacity for participatory planning in all Districts interested in implementing CBHI. Where this is not true then the first step would be to develop such a capacity for participatory planning, management and sustainable development at local government levels (Districts, Wards and Villages) either through recruitment or training. The operationalisation of a truly district participatory planning is critical for a successful implementation of CBHI because it brings together all the stakeholders in development and thus ensures community consensus regarding and ownership of development initiatives.

The community is the lowest level in the planning process. The major administrative structures are the hamlets, which are under the leadership of Hamlet Chairpersons and the Village Governments, which are under the leadership of the Village Executive Officers (VEOs). Both the structures should play a leading role in the planning process since it is the community level, which determines what should go into the district plan. The following, therefore, are the steps involved at community level:

Step 1: Awareness Creation

Community awareness creation is the first step in participatory /bottom up planning. The PRA and the AAA techniques should be used to:

- Sensitise the community on health problems and needs prevailing in their surroundings
- Enable the community to identify and analyse problems and needs
- Assist the community to prioritise the identified needs
- Assist the community to make suggestions on the solutions to the problems.

This process should start at the hamlets where the Hamlet Chairperson will co-ordinate the awareness creation activity. The Chairperson should ensure that all the hamlets are involved in the process. The objective is to have hamlets that are **well informed** and that **can articulate** health problems and needs prevailing in their households.

Step2: Community assessment

Community assessment is the next step in participatory planning. This involves:

- analysis and identification of critical health issues to be included in the plan
- determination of required resources to address the identified health issues.

Participants are asked to mention the focal health problems, i.e., to describe what they consider to be the most serious health issues that should be included in the plan. This should be done through **village assemblies**. Technical assistance from the higher levels, preferably the Community Development Officer should be used to assess the health situation, needs and problems, set priorities and suggest possible solutions to the identified problems. CBOs and NGOs, which operate in the respective community, can be invited to participate in the exercise. The Village Executive Officer (VEO) is

responsible for the process at the village level but should be supported by the CDO and CBHI Coordinator.

In the district where the CBHI programme is in operation, the existing planning models will have to be reviewed in order to find out whether or not they are bottom-up. The information will have to be collated and gaps in the planning process established. A multi-sectoral review team from related sector ministries could carry out the review. The reasons for the non-functioning approaches should be established in order to scale up good planning models and experiences as well as introducing the bottom-up process.

At this stage, the objective is to use participatory approaches to come out with a list of priorities and suggestions on how to handle the identified health issues.

Step 3: Community Planning

The hamlet (Kitongoji) is further sub-divided into Focus Groups like women, youth etc who come up with plans that are merged into Kitongoji plans. These plans are then presented to and negotiated at the village assembly, which brings together all the Kitongoji plans into one village plan. When the list of the priorities has been formulated the next step is to put these priorities into a **Village Draft Plan**. The key players at this level are:

- Village Executive Officer – coordinating the process
- Committees to the Village Government (Finance and Planning Committee, Social Services Committee and Defence and Security Committee)
- Hamlet leaders
- NGOs and CBOs (as invitees)
- Technical assistance from the Community Development Officer.

This group should:

- consolidate the lists of the identified problems and suggested problems
- prioritise them further
- concretise them into a **draft plan**.

The draft plan will include all the problems identified by the community so that in the end there is an **integrated Village Draft Plan.** The basic components of a plan include objectives, activities, inputs, outputs, outcomes and verifiable indicators, see annex 5 for details.

Step 4: Negotiating consensus and commitment at the village level

When the Draft plan is ready, it should be sent back to the community for discussion and acceptance. The purpose is to solicit village consensus and commitment to the plan. The **village assembly** seems to be the most appropriate forum through which consensus can be sought. The objective is to produce a plan, which is acceptable to the community facilitated by the VEO. As such, villagers should:

- be given enough time to discuss the draft plan.
- ensure that their priorities have been addressed
- ensure that the special, vulnerable individuals and households have been taken care of in the draft plan.
- discuss resource implications and the means to mobilise them
- discuss and agree on the roles and responsibilities of the different community groups in the implementation of the plan

When community is satisfied about the draft plan, the Village Development Committee consisting of the Village Executive Officer and the three Committees finalises the plan using the agreed upon log frame. This becomes the **integrated Village Plan.** The plan should then be submitted to the Ward Office for further processing.

Step 5: Ward Level Planning

The integrated Village Plan is submitted to the Ward Development Committee (WDC) which comprises the Ward Executive Officer (WEO) Village Executive Officers, Village Chairpersons, Ward Education Co-ordinator (WEC) various extension officers and NGOs. The WDC is vested with the role of overseeing the overall development of the respective ward, facilitated by WEO assisted by extension workers. On receiving the draft plan the WEO should organise the WDC meeting to:

- receive the presentations of the draft village plans by the VEOs
- collate the Village Plans
- review them in relation to resource implications, village capacity and technical support required to implement the plans.
- consolidate the village plans into one entity.

The ward-level technicians should know the resource availability and practicality of the priorities for them to guide the communities into realistic plan. Since the Community Development Workers are well trained in the techniques of involving people, they may have to lead the planning process at the ward level. When the WDC is satisfied with the presentations and discussions, the WDC should consolidate the drafts into one entity and forwards it to the district as the **integrated Ward Plan**.

Step 6: District Planning

Consolidation of Ward plans

The integrated Ward Plans are submitted to the District Planning Officer (DPLO) who co-ordinates planning at the district level. The DPLO is assisted by other professionals from other sectors, forming a technical team. The DPLO with his/her team should:

- DPLO separates the integrated Ward plan into sectoral components e.g., health, water, education, etc and forward them to the sectoral heads for review. The health component is sent to the DHMT for review and District Health draft plan preparation.
- The draft District Health plan is reviewed and forwarded to the DHB, where it exists, and then forwarded to the Social Services Committee.

- The Sectoral draft plans (District Health Plan included) are collated by the DPLO into the District Master Plan
- The District Master Plan is sent to the District Management Team for review and comments.

Box 2 Experience of a District in Development of CBHI village plans

The entry point for developing village plans is the hamlet (Kitongoji), collated into Village plans. The team developing the village plans comprises of members of the village government, selected community groups and ward extension personnel. The stages are summarized as:

- CBHI seminars are conducted for village governments, prominent elders, councilors, Ward leaders etc. The focus of the seminars is on the identification of problems in the Ward using PRA methods to identify and prioritize them as well as possible actions and resource requirements. CBHI is explained in relation to the outcomes.
- Training of village government and selected villagers by experienced animators (facilitators)
- Kitongoji meeting convened and planning sub-groups formed.
- Each group has a trained facilitator, identifies problems in their Kitongoji
- Kitongoji problems are compiled and discussed by village government
- Appropriate village standing committee (e.g. Social welfare and self-reliance Committee for CBHI) discusses the synthesized problems and come up with a village plan with a budget.
- The village plans discussed in the village assembly
- The village leaders are given feedback and implementation proceeds
- Regular reviews conducted during Village Health Days, Village Government quarterly and other committee meetings.

Reviews and approval

The plans go through an approval process. While the plans are taking the formal approval process, copies are directly submitted to the program for selection of projects from the village plans that fall within its remit for support. The selection of projects in the village plans to be supported by the program funds is guided by representatives of the District Council.

Following this selection, the outcome is feedback to Village Assemblies of the concerned villages. The village plans are then formally submitted to the Ward Development Committee. This committee is made up of the counselor (as chairperson), ward executive officer (as secretary), the village chairmen in the ward, all the village executive officers, extension staff in the ward, NGOs and religious leaders). The Village plans are compiled into a Ward plan and passed to the District Council. The WDC does not reject any of the items contained in the village plans since they would have been involved in the whole process of the development of the plans.

From the District Management Team, the District Executive Director should submit the District Master Plan the Regional Consultative Committee (RCC) which should review it in the context of existing national policies and guidelines. From the RCC, the plan should be submitted to the Full Council for deliberation. The Council approves the

activities that are within the District resource capability, and pass on the rest to the Central Government and donor partners. From the Full Council the District Master Plan is submitted to the Regional Secretary and finally to Treasury for inclusion in overall national plan

It is important that the different levels be given feedback on the plans so that they know what has been approved/not approved and the budget implications.

The District Health Plan

Many districts are now operationalising District Health Plans, which consolidates the more detailed ward plans. This seems to be a requirement in the districts which have **District Health Boards** and are required to present such plans to the respective boards and/or funding agencies, These districts should maintain the plans as separate entities to be used in the implementation stage. District Health Plans are prepared by the DHMT. In the process, the DHMT should take cognisance of community priorities and concerns. Other stakeholders including donors and NGOs should be involved in the development of the District Health Plans.

2.4.2 An overview of the Planning Cycle

It is important that district participatory planning is approached systematically. Luckily the basic structure for participatory planning in Tanzania is in place. The local government reform policy and the planning procedures provide conductive environment for instituonalization of the participatory planning process. What remains to be done is to effectively build in the experience of the best practices in participatory planning into this system.

Community, ward and district plans should follow the established planning cycle in order to ensure that their plans reach the national level in time to be considered along with other plans, particularly for the elements that require national resource allocation.

Guidelines for budgets based on grants/subventions funding from the Central Government are issued by the Ministry of Regional Administration and Local Government after consultations with sector Ministries for policy issues. These guidelines provide the framework for both investment as well as recurrent planning and budgeting and give highlights on various indicators.

After receiving the guidelines the regions brief their local authorities on the technical requirements for the process following various changes in the budgeting process and planning (i.e. from Annual Plans, Rolling plan and forward budget, performance budgeting and now mid-term framework). In total, the process and activities are expected to last for about 38 weeks up to the stage where the budget is submitted to the Economic and Finance Committee of the Parliament.

District and Urban Councils are obliged to elaborate development and sector plans coordinated with the budget. Their development plans must be:

- Comprehensive i.e. covering all sectors
- Include the financial implications
- Take lower levels plans into consideration
- Take central government development objectives into consideration.

From the experience which exists already, the CBHI planning process can be fully integrated into the procedures laid down in the Local Government planning framework as shown on the table 3 below.

Table 3: Summary of the activities and time frame for CBHI planning process

Activity	*Responsibility*	Timing
i) Ministry issue guidelines for Local authorities to prepare 'O & OD' report	MRALG	May (1wk)
ii) Region briefs all local Council Directors on the technical requirements for the process	Regional secretariat	May (1wk)
iii) The facilitates a participatory community process in the identification of opportunities for strategic action through the following steps:	Ward animation team led by CDO and WEO	June-July (8wk)
♦ Ward team holds Village assembly for CBHI awareness creation	Ward Animation team, CDO and CBHI facilitator	
♦ Team facilitates assessment, analysis, priority setting at Kitongoji level (working with groups)	Kitongoji Chairperson and Ward Team/trainer	
♦ Village leaders hold Village Assembly for negotiation, consensus and commitment	Village Chair, VEO, Ward Team/CBHI facilitator	
♦ Ward Development Committee Collate village plans to Ward plans	WDC, WEO, CDO	
♦ Ward plans collated into draft District Master plan and relevant technical elements sent to respective sector Departments (including Health)	DPLO, Heads of Departments, Boards (DHB, where existing)	
♦ Sector plans sent to Boards (including DHB) then to Standing Committees ♦ Final sectoral plan submitted to respective ministries (District Health Plans to the MoH)	DPLO / DHMT/DMO	
iv) Draft District Master Plan/sector plans sent to RCC	DED/DPLO	Aug. (1wks)
v) Technical briefing with RAS, and Regional Secretariat	DED, DPLO	Sept. (1wks)
vi) Submission of the draft O & OD to the Regional Consultative Committee	DED, DPLO	Oct. (1wks)
vii) Each Council Director finalises his/her Councils O & OD analysis as part of its Annual Report and Service Improvement Plan (ARSIP)/Performance Budget for submission to the full Council	DED, DPLO	Nov. (2wks)
viii) Each Council's approved O & OD report is submitted to RAS	Full Council	Dec.–Jan. (1wk)

ix)	Each RAS prepares consolidated report for submission to Treasury, copied to MRALG	RAS	Dec-Jan (2wks)
x)	MRALG sits with each RAS at budget scrutiny sessions to support RAS's resource bid per next year.	MRALG and RAS	Feb.– March (2wks)

Box 3: The Village Health Day (VHD), a driving force for participatory CBHI management

The Village Health Day (VHD) is a special earmarked day by the members of the community in a village where all of them together get mobilized and involved in health promotion by conducting specific activities based on their master plan. The day is organized and coordinated by the village government and is conducted on monthly or quarterly basis depending on need. The functions of the VHD include:

- Review of progress in the implementation of the Village Health Plan through the triple "A" cycle process, by the community members working in appropriate groups. They assess their performance and identify gaps, weaknesses, problems. They analyze causes and take the appropriate action for improvement. This may include revision of plans and adjustment of targets.
- Essential health services are provided according to the essential package by CBHWs in collaboration with Health Facility workers and some members of the village government. The package include monitoring for health of vulnerable groups e.g. Children growth monitoring, pregnancy monitoring, follow up on sanitation issues at household level, ITN sales promotion, health education as counseling of special groups on HIV/AIDS, including condom sales promotion etc.
- Health Information and Communication among members through meetings and interactive methods based on planned priorities, and a theme for the day.
- Data collection based on an established community based information system and on spot analysis by CBHWs together with village leaders. Feedback is given to the community members as well as to the Ward and Health Facility.
- Resource mobilization in terms of labour, time, expertise etc. for health development at the community level.
- Community members recognize best performers in the households and individual members and celebrate success.

2.4.3 Financing District Plans

The main source of financing District Plans is the District annual recurrent and developmental budget. Since the District budget is often under-funded some community planned activities which require funding from outside the community may not be supported from the District budget. Therefore there is always the need to seek additional funds from other sources of grants or donations. At the moment DHMTs have access to funds earmarked for community initiatives. Criteria for supporting community initiatives by the DHMT is found in annex 4. This is alternative source of financing innovative CBHI activities. The DHMT should support the community concerned to translate their plans into a proposal to request these funds. An outline for such a proposal, see annex 5 may be used in developing such a proposal and may also be useful in judging which

communities to be funded. Since such funds are also limited there should be criteria for selecting the initiatives for priority support. The following criteria are suggested for consideration of the DHMTs:

- The proposal is derived from the village plan developed through a participatory process (verifiable by the Village Plan), processed through the approval system.
- Evidence of a sound financial management system, operating a bank account with four category A and B signatories and an accounts clerk able to keep village books of accounts.
- The magnitude of the problem to be addressed and technical effectiveness of the proposed interventions in addressing the problems.
- Evidence of feasibility in terms of local capacity to undertake the intervention suggested (skills, experience, materials etc).
- Evidence that the requested input completes the task or sets up a sustainable revolving fund for sustained effective action.
- Evidence of local investment, requested funding only topping up community efforts.
- Falls under the Essential Health Intervention Package
- Evidence of sound monitoring and supervision possibilities, continued support based on progress.
- Evidence of inclusiveness in process and targets (particularly the most vulnerable members of the community).

3. ORGANIZATIONAL STRUCTURES FOR SUPPORTING AND COORDINATING CBHI

This section presents the governing and management structures showing how CBHI is situated within the official structures. The organizational arrangement is presented showing the chain of support, coordination lines and linkages to the rest of the state and non state systems (see Fig. 1).

3.1 Organizational levels and functions

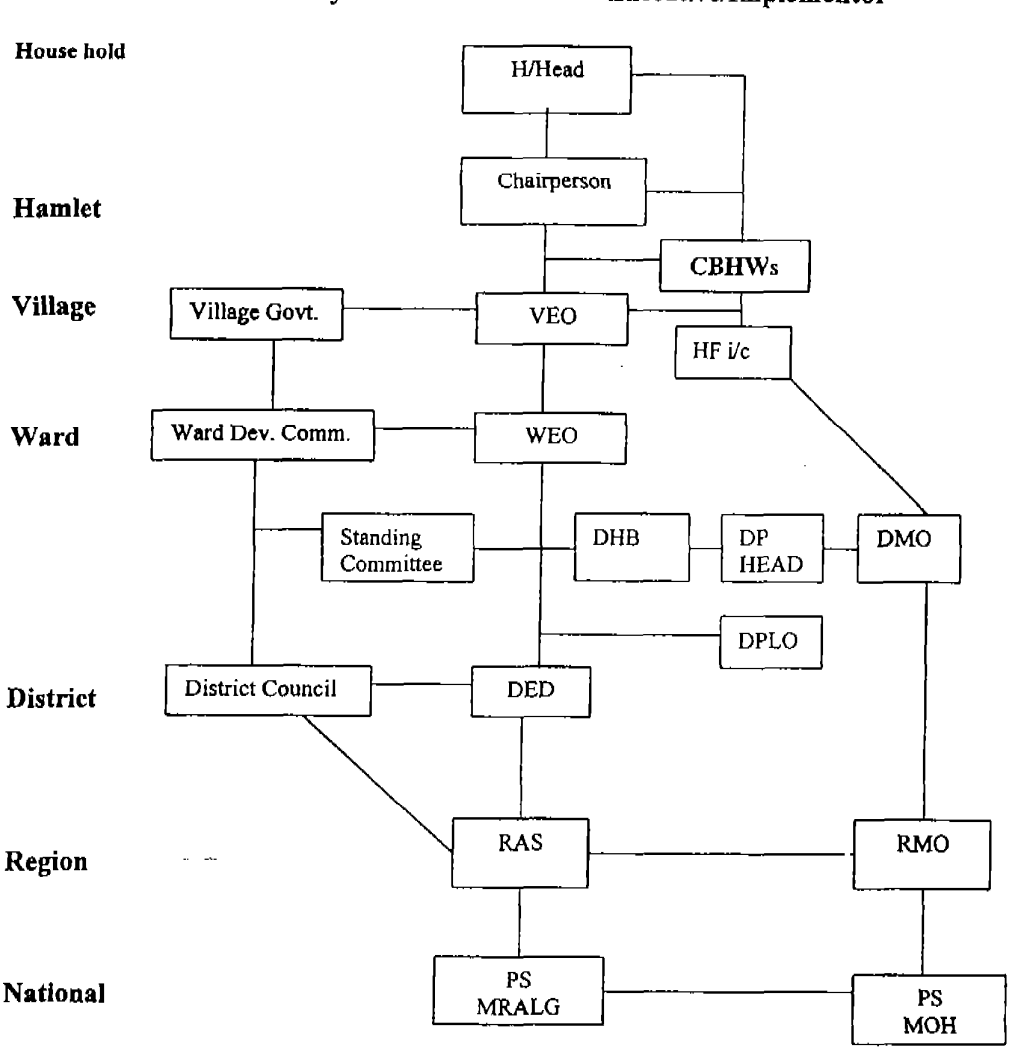
3.1.1 House Hold Level

The person in-charge of the household and the house hold members are the target implementors of CBHI. They are responsible for their day to day up keeping of the household affairs as well as participating in Community Organised activities. They have contacts with the Community Based Workers (CBHWs), and the formal system where they seek services. CBHI is the first level of care universally available to all households.

3.1.2 Hamlet (Kitongoji) Level.

The Hamlet Chairperson is the overall coordinator of CBH initiatives at the hamlet level. S/He links between the village Government and the Households within the hamlet. Mobilizes Community resources for implementing CBH Initiatives and reports to the VEO and Village Government.

Fig.1 **The Organizational structure for CBHI**



KEY

VEO	Village Executive Officer	WEO	Ward Executive Officer
CBHWHs	Community Based Health Workers	MOH	Ministry of Health
DED	District Executive Director	DMO	District Medical Officer
DPLO	District Planning Officer	DHB	District Health Board

RAS	Regional Administrative Secretary	**RMO**	Reg. Medical Officer
MRALG	Ministry of Reg. Admin. & Local Govt.	**PS**	Permanent Secretary

Partners are involved at all levels, particularly if they participate in the planning process.

3.1.3 Village level

The Village Executive Officer (VEO) is responsible for coordinating CBH initiative at the Community level. In order to ensure effective implementation, the VEO should work in close collaboration with the extension workers and report to the Village committees, the Village Government, and Ward Executive Officer.

Apart from the VEO and the Village Committees, CBHWs are responsible for implementing specific health activities in the Community. These are the Village Health Workers (VHWs), Traditional Birth Attendants (TBAs) and any other trained or untrained person with duties assigned by the village leaders or self determined which contribute to achievement of the Community goals. An animation team can be formed to facilitate implementation of CBHI activities. Members of the team can be drawn from the various social groups found in the village.

3.1.4 Ward Level.

At the Ward Level the Ward Executive Officer is the overall coordinator of Community Based Health Initiatives within the Ward. The extension and health workers working within the same ward offer technical support at the ward level. They are responsible in facilitating implementation of Community Based Health initiatives in their respective ward. Specific roles be assigned by the Ward Executive Officer, the Ward Development Committee and Sectoral Heads. The extension workers work closely with the Village Government and relevant committees at the village level to ensure effective implementation of the initiative. An animation team can be formed drawing members from the committee members, extension workers and other influential people in the respective villages to spearhead the introduction of CBHI in the ward.

Ward development committee – main tasks are to:

- Ensure the implementation of decisions and policies of the district council.
- Ensure the implementation of all development schemes in the ward.
- Supervise and coordinate the implementation of district council projects and programmes in the ward.
- Promote cooperative activities.
- Collates and discusses village government development plans and forwards these to the district council together with plans proposed by the Ward Development Committee itself.

- Proposes by laws to the village government and/or district council.

3.1.5 District Level

The organisation and management of Community Based Health Initiatives will be integrated in the existing district Health system structure /local Government structure.
The district Management team offers technical support for planning implementing monitoring in development activities in the district. The team is co-ordinated by the District Planning Officer who co-ordinates inputs from all sectors involved including private and NGOs. The DPLO reports to the DED and to the relevant council Committees.

3.1.6 Co-ordination and Linkages

The government role in regulation should include setting standards and regulating compliance with those standards.

Intersectoral collaboration should be transformed to intersectoral recognition and promotion of levels of partnership in facilitating community based transformation in the domains of health and development. Partnership would enable Health, Education, Agriculture, Social Welfare and Development plus NGOs and the Private sector to move together if each has their contribution planned, budgeted, recognised and rewarded. This could be facilitated by the Ministry of Regional Administration and Local government or a training institution for Community Based Health and Development. The DPLO should play a co-ordinating cum regulatory role.

The initial process of introducing and planning of CBHI in a district should involve all the relevant sectors at all levels. The process should start at community level to avoid the top down approach. This is crucial for sustainability as it is at this point where the question of ownership, accountability and responsibility is declared and defined. The community should be empowered through information education and advocacy aimed at building their capacity in the planning and implementation process.

NGOs and Community Based Organisations should be encouraged and motivated to undertake activities to support CBHI. The district management team should list NGOs and CBOs in the district, study their policies and functional objectives, strategies and functional frame to facilitate collaboration and co-ordination of their activities with the district. NGOs and CBOs involved in CBHI should be incorporated in the planning process in order for them to integrate activities in the district plans. Special forum to discuss various partners inputs in the CBHI plans can be initiated to avoid duplication of resources and ensure equity.

4. COMMUNITY BASED MANAGEMENT INFORMATION SYSTEM

4.1 Introduction

Community Based Management Information System refers to information required, gathered and used by the community for planning, monitoring and decision making with regard to Community Based Initiatives. The system enables the community to follow-up on the progress of planned activities to determine their success in achieving their objectives. Timely changes can therefore be made based on evidence, to ensure achievement of the objectives. This section presents a brief description of a framework for community based information system for monitoring and evaluation of CBHI. A number of suggested tools are annexed (annex 6) at the end of the document for use at the District and Community levels.

Data is critical in planning. But data collection, management and utilisation are lacking in many of the programs reviewed. Those which collect data, use a variety of data collection methods like routine recording / reporting of events, holistic studies, baseline surveys and PRA etc. Most of them, however, do not use the information they have information in their planning process. It should be possible to collect the required data and keep it in simple cards with different data sets, at the village level. Where possible, at the district level, the data in the cards could be computerised into a district database.

An effective community based information system should have the following characteristics:-

- At the lowest level the system should be owned and managed by the community. This can be achieved through participation in the developing the system from data collection to the use of generated information. This element should be built into the participatory planning process, described in the second section above.
- The information collected should have direct relevance to village based plans developed by the villagers, as described above. Additional information required by the district health system should be part of the facility based system.
- The information system should be a tool for decision making and planing and not an end in itself.
- The system should be based on the administrative structure and organisational set-up of the villages. Thus an integrated information system will function better in a decentralised integrated governed system.
- Information system should be built on the existing strength and opportunities. It is much easier to introduce a modified village register that a completely new one. Ideally the community based workers who collect the information should be involved in developing the tools for information gathering.
- The system should be linked with the facility based information system. Data from the community synchronised with technical data from the facilities will result into a comprehensive picture for decision making and planning.

4.2 Data collection

The type of data to be collected will depend on the objectives of the plans. The same methods and venues for making decisions on priority activities at the planning stage should be used to decide on data requirement. There is however a need for consistency on the type of data to be collected, definitions and levels of aggregation on some of the data to enable higher level authority to make use of the data in planning and decision making.

When deciding on the basic minimum data-set to be collected by the village government, caution should be exercised, due to the enormous data requirement by sectoral ministries. The MRALG should take up the challenge to coordinate sectoral ministries in deciding the minimum data-set that will be included in the village register. As a stating point, it is proposed that village register should contain demographic data, since it cuts across the various sectoral data requirement. However, few columns should be spared for collection of data that is of local interest. A proposed village register is shown in annex 6.

Table 4: Types of data that can be collected from the community, by category and source:-

CATEGORY	Types of data	*Collection/Source
Demographic	• Population by age and sex • Births and Deaths (with cause) • Migration in and out	-Village/Hamlet Register -Birth and Death Register
Nutrition	• Underfive registered, weighed • Moderate and severe malnutrition	Underfive Register
Immunization	• Under one year registered, vaccinated against BCG, DPT3, Polio Measles, Fully Immunised Children • Women protected against tetanus	-Underfive Register -Household survey/visit form
Maternal Care	• ANC visits, Risk factors, ANC Referrals, • Deliveries, Referrals during delivery, Complications, Mother and child outcome, Deaths and causes • Postnatal attendance, Complications, Referrals • New and Current Family Planning users by method	-ANC Register -Delivery Register -Family Planning Register
Health status	• Underfive with fever, diarrhoea, measles, chest tightness	Household survey/visit form
Environmental sanitation/Water	• Permanent latrines, Permanent houses, Clean environment, access to safe water sources, utensil drying rack, Refuse bin/pit	Household survey/visit form
School	• School visits, Pupils screened on disease conditions, class one enrollment by gender, drop-outs by gender	School visit form

	and cause	
Social Economic	• Orphans, Disabled, street kids, exempted households/people	Household visit form

*Note: For logistic reasons and ensuring cost-effectiveness some of the registers may need to be combined. Although printed registers are preferable because they ensure consistency in recording, exercise/note books may be advantageous because of local availability at a price that may be more affordable by the community.

Morbidity and Mortality data

A special mention need to be made on collection of morbidity and mortality data due to following facts:

- The need for technical expertise in the collection, analyses and interpretation of mortality and morbidity data.
- Birth and death registration is not reinforced, especially in rural areas.
- Intervention strategies as part of national essential health package, targets some disease conditions that will need to be monitored from the community.
- Government administrative infrastructure take root from the village/hamlet level. This offers an opportunity for collecting demographic data that includes mortality

In addition to recording deaths in the village registers, hamlet/village leaders can assist the registrar of birth and deaths and also as informers of deaths that occurs in their respective villages/hamlets. Birth and death registration should be enforced by providing incentives for the community to report and hamlet leaders to record and report. Penalties and legal measures can also be instituted to ensure prompt reporting. Village/hamlet leaders may report deaths to the nearby facility. Facility workers may need to be trained on verbal autopsy. With some modifications, that will render the system affordable to the district, the AMMP experience on conducting verbal autopsy can be adapted.

At the higher level where there is more technical and resource capacity, other methods of data collection should be considered. Several method for data collection exist. The choice of which method to use will depend on the type of data required, frequency, coverage (sample/whole population), capability (skills) and capacity (staff, equipment, stationary and finance). These methods includes:

- Routine data collection system
- Sentinel Surveillance
- Surveys
- Supervision reports
- Scientific Research

Table 5 Information gathering methods by advantages and disadvantages

Method	Advantages	Disadvantages
Routine data collection system	Output covers wide area in a short period Relatively high investment costs but low maintenance costs Allows continuous and close monitoring Applicable to the area and topic of interest	Add an extra work to HFWs Data quality relatively low Difficult to measure quality Cannot be detailed because if detailed becomes more intricate for
Supervision reports	Low cost because it is conducted as part of the supervision itself Can be relatively more detailed Can measure quality of services Quality relatively high Subject matter focussed	Data collectors relatively more educated
Periodic surveys	May cover a wide geographical area through sampling Quality very high Subject matter more focussed	Relatively expensive Infrequent Limited information
Scientific research		Most expensive Limited information output Outputs sporadic

4.3 Data Analysis

Data analyses at all levels of data collection is necessary so as to ensure prompt action. Data analyses will enable service providers and leaders at various levels to identify specific areas and groups that needs special attention. Analyses will also reveal progress in the implementation of agreed interventions and be able to change strategies where necessary.

Data analyses requires a level of skills in calculus depending on the depth of analyses. Given the low level of arithmetic skills at the community level, there is a need for employing simple analytical procedures. Complex analyses should be done at higher level where technical capacity is available and feedback to the lower level.

For the purpose of comparison totals, averages and percentages can easily be calculated by key actors at community levels since most of them have completed primary school. Despite this background education, it is true that some of them may still need a close support to be able to perform these analyses. Extension officers located in the respective communities should be able to give the necessary support.

Analyses will be done on the basis of indicators. Simple analyses can be done at community level using selected indicators. Indicators are markers of progress towards set objectives. During the planning process, indicators should be developed/identified for each objective. The type and source of data/information required to measure the indicator

needs to be determined. For each objective there could be five types of indicators. These can be classified as follows:

Category of indicator	Characteristics	Example/s
Input	Refers to resource availed in attaining the objective (human, finance, material, time)	Percent of budget that was spent on immunization
Process	Refers to amount of work done in reaching the objective. Measures activities.	Number of immunisation outreach visits made
Output	Refers to completed tasks as a result of the processes	Number of children vaccinated
Outcome	Measures intermediate objectives; that can be ascribed directly to the specific interventions.	Percent of children fully immunized in the community
Impact	Assesses the long term goals; that may be attained as a result of a combination of efforts/changes that may necessarily be a result of a specific intervention.	-Incidence of immunicable diseases -Reduction of IMR -Increase life expectancy

Decision on the number of indicators to be used for each particular objective will depend, among other things, on the level of implementation/monitoring. At the lower level, where close monitoring in terms of frequency and depth, of implementation of activities is required; input, process and output indicators are most important. At the higher level, where information is required for macro level planning and policy/guidelines formulation; output and outcome indicators are most valuable. Thus the lower level may need a wider range of indicators than the higher level. Key actors at each level should have the mandate to develop/identify indicators to monitor and evaluate specific objectives as dictated by plan of action and their ability to collect such data. However, for the sake of uniformity and consistency, that is necessary for monitoring and evaluation at higher level, a basic package of indicators need to be defined at higher level, in a cascade manner, and adopted at the lower level. This will ensure flexibility in the system that allows lower level to determine their own indicators without undermining higher level interests.

4.4 Presentation of Information

It is important that information is presented in a format that can easily be understood by the intended audience. Increasing the ability of the community and key actors to understand the presented information will have a directly effect of improving participation of the people in decision making; since they will be making informed choices. People with less skills in calculus abhors collection of numbers. It is therefore necessary, especially at the lower level, to present data in figurative and pictorial forms. Should tables be found necessary, then it should be the simple two by two tables. Unfortunately, this is the level that even skills for preparation of figurative presentation of data are comparatively lower. Technical officers working at the lower level should

assist actors at lower level in preparing pictorial formatted information. With computer technology becoming more affordable, districts that have capacity for producing a state-of-the-art presentations using modern graphic, pictorial and mapping softwares should share outputs with the lower level implementors.

4.5 Information Utilization

Reports presented in a user-friendly format can be distributed to members of the various committees before scheduled meeting date. This will enable them to digest the information and be able to contribute effectively during discussions. Where resource availability is a problem, such as shortages of stationery, information can be presented on flip charts and posted on the meeting room/conference hall. In case of assemblies information can be posted in popularly visited places e.g. churches, mosques, market places. Verbal presentation of information is the last resort where all methods are impossible.

LEVEL	MEETINGS
Community	Hamlet/household meetings Village assemblies Informal meeting/gathering e.g. religious, attending drama, ngoma, rallies Village Health Days
Village	Village Government meeting Social Services Committee meeting Security & Defence Committee meeting Finance and Planning Committee meeting
Ward	Ward Development Committee meeting Special Committees meetings
District	District Full Council meeting District Management Team meetings Specific Committees meetings Sectoral specific meetings e.g. DHMT meeting

number of households per hamlet is few or the CBHWs/hamlet leaders are un-trainable, analyses should be done at the village level by the VEO with the assistance from other members of Village Government.

Data utilisation

Locally adapted targets should be set at ward or district level to enable the community to assess their progress. Data should be used by CBHWs to make followup on specific households that may need special attention. In order to make full use of data collected, CBHWs/Hamlet leaders should share information among themselves on a person to person basis or through a data-base to be situated at the Village Government office. Feedback to the community should be given routinely during household visits and during hamlet/village community meetings. While hamlet leaders will report to VEO only; CBHWs will report both to the VEO and health facility incharge in the respective ward.

4.6.2 Opportunity for data collection and use during Village Health Days (VHDs)

VHDs are special days earmarked by the village for conducting specific health and health related activities. These services includes monitoring the health of vulnerable groups in the community, such as underfives and pregnant women; health education and counselling to people with special problems; environmental sanitation; and improving water sources. All activities are conducted once a month whereby community is mobilised to to ensure full participation.

Therefore, VHDs offers a unique opportunity for data collection, analyses and immediate feedback to the community. Data collected on these days will be reported to the village government and health facility separately or incorporated into the monthly reports.

Village Level

Data Collection

At the village level, VEO is responsible for planning, implemention, monitoring and evaluation of development activities and should therefore keep a record of all important data/information in the village. CBHWs and hamlet leaders' reports will be the source of information for the VEO to compile village data This will provide a comprehensive picture to the village government. Technical information, such as disease pattern in the village, will be obtained through feedback from the WEO to whom, health facility incharge reports.

Data Analyses

In analysing data, VEO will be assisted in data analyses by village committee leaders. Each committee will calculate relevant indicators and present them in a simplified format during specific committee and Village Government meetings.

Data Utilisation

Information will be used when discussing progress on implementation of activities in the village and in appraissing the performance of key actors in the village. In addition, information will be used to inform the community on the situation of the village when setting priorities for intervention during village assembly meetings. Feedback on progress of implementation will also be given to the community during these meetings. Members of households will also get feedback from hamlet leaders who represents them during Village Government meetings. VEOs will report to the WEO quarterly so as to coincide with the quarterly Ward Development Committee meetings. This will ensure effective use of information.

Ward Level

Data Collection

At the ward level, WEO is responsible for planning, implementing, monitoring and evaluating development activities. Therefore, WEO will aggregate data from reports sent in by the VEOs. WEO will also collate data from extension workers.

Data analyses and use

With assistance from ward committee leaders, data will be analysed, interpreted and prepared ready to be used in the committee and Ward Development Committee meetings. Feedback to the village will be ensured through representation by VEOs in the ward level meetings.

Role of Health Facility

Health facility incharge will receive reports from CBHWs either on individual basis or in a collated form through the VHW. HF incharge will aggregate data obtained from CBHWs of the constituent villages with the assistance from other health facility workers and collate with facility data. Through data sharing with other extension officers and the WEO in the ward, HF incharge will be able to obtain important data such as demographic, water, and education. Data will be used in the supervision of CBHWs; identification of vulnerable communities in the ward; targeting outreach services; and deciding on appropriate health education lessons. HF incharge will use information as a basis for discussion during specific committees and Ward Development Committee meetings. Immediate feedback will be given to CBHWs during supportive supervision. Currently, HF incharges are not obliged to send routine reports to the WEO. **Policy/Guidelines changes will be required for the HF incharge to report to WEO.**

This will enhance accountability and facilitate information gathering and utilization for the benefit of the community.

District Level

Data Collection

WEOs will report to the DEDs office at the district. The DPLO, under the DED, will be responsible in aggregating data from the wards. Depending on the capacity at the district, aggregation of data should be by village if data processing is done using computer; and by ward if manual. Other methods of data collection can be used at the district level where better technical and resource capacity are available. Data can be collected using sentinel surveillance, special surveys and scientific research methods. Assistance from higher level can be sought. Data can also be obtained from local institutions such as hospitals, research centres and secondary schools. These information should be compiled at the DPLO's office.

Data Analyses and Utilisation

Sectoral heads, including the DMO, will assist the DPLO's office in data analyses, presentation and interpretation. Information will be used by sectoral officials during supervision; and for discussion during committee, DMT and District Council meetings. District Health Board and CHF Board will need these information for decision making and planning.

Role of Partners

Partners includes NGOs, donors, religious groups, companies, individuals etc. Majority of them have a wide experience in implementing CBHI in the country. It is important for them to be involved in the whole process of planning, implementation, monitoring and evaluation depending on the level they are operating. In this way partners will be able to obtain the necessary information. Many partners have an adequate capacity for data analyses, presentation and interpretation that can be used by the local leadership.

4.7 Implementing Community Based HIS (CBHIS)

Advocacy and Training

Strengthening capacity for participatory approach in the data collections, analyses and use is required to enable the community to participate. High and low level authorities will need to be sensitised on the importance of information in planning and decision making and data ownership. This will ensure sustainability of the system. They should also be made aware of other sources of data in the district and higher level that can be of use to them. Key actors will need to be trained on data collection, analysis, presentation and use. Training on information system should be integrated into other training to make it more cost-effective.

Logistics

Plans for introducing the system, where it does not exist, and modifications for improvement, where the system exists need to be made. The district should determine the team that will spearhead the introduction/changes, time schedule and source of funding. Funds will be required for advocacy, training and stationery (including provision of initial registers).

5. COMMUNITY BASED RESOURCE MOBILISATION FOR HEALTH

It can be acknowledged that what is required to improve health beyond the health facilities in many of the districts that have implemented the CBHI approach successfully is largely outside the Health Sector. This includes economic empowerment and transformation, enhancing access to the means of production and to marketing. These are the main bottlenecks to health improvement. For this reason the CBHI must be adequately broad and integrated to permit interventions that will make a difference in the wellbeing of people. Some of these interventions would include enacting and enforcing by-laws to ensure access to quality care, enhanced economic productivity, and regulation of the private sector by the Village Councils. Strengthening the economic capacity of the households through professionally managed credit schemes to support local enterprise development, expanding production and marketing. CBHI should have strong linkages to the ongoing poverty alleviation initiatives in which a number of districts are involved. In addition there are special funds in the Vice Presidents Office for the the support of Community Based Initiatives (e.g. MASAF).

This section describes a number of options for resource development at the village level for CBHI, based on examples existing in some of the districts.

5.1 Recognising and building on existing resources

There are many initiatives in which people are engaged for their livelihood and for which they have built immense experience and technical know-how. Unfortunately, such initiatives are often ignored by development workers who tend to introduce new ideas and initiatives for which no experience or skill may exist in the community. It is crucial that an economic initiative is built on existing capacities and just on needs. The process of community based resource mobilization should include identification of existing capacities, assets, investments in health and development that are already changing the lives of people and build on these without overwhelming or displacing the people and their efforts. This element can be built into the participatory approach adopted by the respective community. Recognizing what people are already doing and achieving in their health improvement could be the key to a successful resource mobilization initiative. Lots of resources are already invested in health at the household and community levels. If these were recognized and built on, a great deal could be achieved in a sustainable way. Any external funding should complement community efforts and should be directed towards initiatives that enhance the power of the community for resource generation and self-reliance.

The use of local resources to improve health and quality of life is unlimited but unrecognized such as indigenous knowledge in transport, medicine and other items. An external facilitator should always seek to start with existing community initiatives and build on these towards desired directions. An initiative built on existing efforts may require minimal inputs to achieve greater improvement in health status. External

animators should look for entry-points to hook new ideas. This would ensure compatibility of new ideas and thus avoid rejection.

5.2 Options for Resource Generation

Some of the effective and creative current resources being used for supporting community based health care and development activities include:

- Retention of percentage of the revenue collected by the village.
- Donor assistance in form of matching grant or topping up.
- Revenue collected through cost sharing and sales of commodities such as insect treated nets (ITNs) and drugs.
- Government subventions
- Revenue collected from miscellaneous sources at village level (e.g. levies on meat roasters, charcoal burning, local brews, etc.)
- Full cost recovery (BAMAKO initiatives)
- Community Health Funds
- Cost sharing.

Additional sources of funds can be identified by the community to enhance financing of CBHI. Some of these sources include:

- Income generating activities and sale of commodities using commercial techniques to make them efficient and effective
- Central Government.
- Community based organization and partners
- Community members contributions
- Full cost recovery at the health facility contributing a percentage to CBHI
- Donors/Agents (External funds).

The community through their government should be in control of the funds which are mobilized by themselves towards community based activities. They should decide on mode of utilization of these funds, including decisions on remuneration of different actors. For example the Village Governments together with community members could to establish a revolving fund for drugs, equipment and supplies to ensure effectiveness of their CBHWs.

5.3 Handling Donor supported CBHI

Funding (seed money) may be needed even for CBHI but must be applied carefully to facilitate and establish sustainable elements that can be relied on. Otherwise creation of dependency also creates dead projects when funding ceases. In addition, there is the problem of setting up programs with parallel structures to the local systems. When managing donor funded CBHI projects the following key issues should be observed:

- The program budget should be integrated into that of the councils budgets'.

- Projects should be managed at the district level with a small backstopping from the regional secretarial level.
- Staff operating under the project should be directly under the district authority
- There is a tendency of donor programs to provide topping-up allowances that cannot be sustained by the district councils during their integration into the local government systems. This frustrates staff and reduces their work morale when the system stops. Thus where topping up of staff salaries is practised, it should be gradually scaled down towards complete removal. Other performance based reward systems should be worked out with the DMT.

5.4 Community Based Human Resources including communal labour and service provision

Human resource is the greatest of resources present in all villages. Mobilized and organized they can make substantial contribution through communal labor, payments in kind, time at meetings, service delivery, to name but a few. The Village Health Day has emerged as a powerful idea around which voluntary contributions towards health improvement could be maximized.

The traditional healers and birth attendants are the most common sources of private health care at the community level. They can be part of the public private mix at the community level with continuing training and updating by an appropriate team. In addition there are drug sellers and other non-formal service providers at the village level. The government could play a strong regulatory role on behalf of the users.

5.5 The need for stronger financial bases and management systems in the districts

The majority of districts lack a solid financial base. This is because prior to the local government reform, most of the regular sources of revenue were controlled by the central government. This system weakened the financial resource base for the local government. It is important that Local Governments increase their capacity at various levels to collect revenue. Loopholes for corruption and embezzlement of funds must be completely sealed. This being done, will enhance the credibility of the council and improve the morale and commitment of staff and their electorates. The council will also be able to hold regular meetings to pass plans and budgets and to review progress on the implementation of programmes. Regular meetings are also essential for ensuring accountability.

6. HUMAN RESOURCES DEVELOPMENT AND MANAGEMENT

Human resource is a very vital component in addressing Community Based Health Initiatives (CBHI). The scope of CBHI activities for implementation by actors at various levels should be as comprehensive and inclusive as possible. Roles and responsibilities needs to be defined for various actors at different levels as elucidated below:

6.1 Human Resource needs for CBHI

6.1.1 Household Level

Household is a group of people feeding from a common pot. Single headed family can also be recognized as a household. The main care giver who undertakes several CBHI activities at this level is the mother, assisted by other members of the household.

Their main responsibilities include:

- Ensuring that members of the households have adequate and sustainable access to income derived from production labor and/or other sources to enable households meet their basic needs.
- Ensure that individuals belonging to a household are able to identify, prevent and manage risks posed to their health, supported by appropriate health technologies, community norms and systems, institutions and public policies.
- Ensure that there is sustainable access to a quantitatively adequate and qualitatively appropriate dietary intake, personal care and the proper health and sanitation to maintain the biological condition of the members of the household.
- Ensure that there is adequate access to and proper utilization of safe drinking water and sanitation services to the household.
- Performance of life activities including feeding, provide shelter and food production.

6.1.2 Community Level

At this level, actors are village/community leaders, (VEO, Village Government), economic groups; including women and youth groups, teachers, traditional practitioners (traditional healers and traditional birth attendants, etc.). The VEO should be the CBHI coordinator, linking health action with the rest of the developmental initiatives in the village.

The Community Based Health Workers (CBHWs) are members of the community, selected by the community and trained by the extension workers as community motivators and/or providers of general or specific services.

The categories of Community Based Health Workers (CBHWs) available at this level include:

Trained Community Based Health Workers

- Integrated Village Health Workers
- Birth Attendants (BAs)

Functions of the Village Health Workers

- Health promotion and education (e.g. on environmental sanitation, hygiene, family planning, malaria and mobilization for immunization).
- Promotion of good nutrition messages for various groups i.e. infant and young children, pregnant and lactating women and others.
- Preparation and coordination of village health days.
- Health status monitoring (e.g. growth, pregnancy).
- Communication on HIV/STD/STI
- Provision of Family Planning education and services
- Distribution and/or sales of commodities (e.g. contraceptives, ITNs, Micronutrients.)
- Referring cases (e.g. high risk pregnancies).
- Treating minor ailments.
- Conducting normal deliveries (especially female village health workers and trained TBAs).
- Keeping records and reporting.

Traditional or Informally Trained

- Traditional Healers
- Traditional Birth Attendants

Functions of the trained birth attendants

- Conduct normal deliveries
- Refer high risk pregnant women
- Advise pregnant women on preparation for delivery, attendance at anti-natal care, safe motherhood and post-natal care.
- Family planning advice
- HIV/AIDS and STI education
- Family Planning education
- Distribution of family planning commodities
- Keep records of users

Functions of the traditional healers

- Treat illnesses (e.g. convulsions, infertility, mental illness, snake-bites, treat patients self-referred from medical facilities)
- Refer patients to health facilities
- Counseling
- Community education

Other supporting actors

Other non-formal providers include religious counselors, peer educators, drama groups and agents involved in various health related activities.

Functions of the Community Leaders

Community leaders are the hub/link of all socio-economic activities undertaken in the villages. Their functions include:

- Participation in community health including; setting community norms, cultural behaviour, festivities and celebrations.
- Decision making systems and environmental health related activities including water to humans and animals, fishing and crop husbandry.

6.1.3 Ward Level

Supportive human resources at this level for community based activities include among others:

- Ward Development Committee
- Ward Executive Officer (WEO)
- Extension field workers (e.g. Agriculture, livestock, community development and health)
- Other actors (NGOs, religious organizations)

Functions of human resources at Ward Level

- Participation in community health and development activities.
- Provision of essential services to the community (medical/health, education, advice on food production and livestock rearing)
- Extension work
- Collate/organize community plans
- Technical supervision
- Mobilize funds for CHF
- Administration

6.1.4 District Level

Administration and management of social services in the district is rendered by the following district support system are:-

- Full Council
- District Executive Director
- District Management Team (Heads of Departments e.g. DPLO, DCDO, DALDO etc.)
- District Health Management Team
- Other players (Donor community, NGOs, CBOs, etc.)

Functions

- Administration and management of social services in the District as part of the implementation of Government policies, including education, medical/health, community development, roads and communications and general administration.
- Integration of ward plans to district plans
- Technical support
- Budget and accountability

6.2 Internal and External Relationships influencing the work of CBHW

Communities have multiple problems and many agencies are trying to assist in solving these problems. Often these agencies are addressing in single problem areas. They may also be using different approaches to the same problem in the same community. Sometimes there is duplication of effort and even wastage of resources. In order to maximize on benefits to the community and minimize own resources, there is need for adequate collaboration between institutions and agencies implementing CBHI and development, and for proper coordination of their activities in the communities.

While it is the responsibility of the health sector to provide comprehensive health care, this cannot be fully achieved without the involvement of other sectors like agriculture, education, community development, national planning, water, NGO's etc.

6.2.1 Process of selection

The community is the backbone of the community health and development. Their involvement and participation in selecting community based workers is the key in success of community based health care and development activities. The community should be assisted in identifying CBHWs. This should be done by:

- Community involvement, negotiation and participation.

- Negotiation on the workload of CBHWs:
- Availability of the CBHWs in the village
- Expectations of their tasks and the expectations of the community from CBHWs
- Confidentiality on daily practice
- Recognition and support

Selection Criteria

Community based workers are members of the community that are already engaged in some community work, accepted, recognized and trusted by the community. Some of them may need to have their knowledge and skills improved (e.g. traditional birth attendants, traditional healers, women and youth group leaders, key members of the village government etc.).

The following list should serve as a guideline only, local communities can modify this to suit their needs. The following elements are considered important:

Acceptability	-should be selected by villagers, should be cooperative, approachable and an example to others.
Personal qualities	-should be a respectable and committed person of mature and preferably with leadership qualities.
Membership	- should be a resident in the village with a home, a farm and respected person.
Literacy	- should be able to read and write Kiswahili.
Others	-should demonstrate previous related activity e.g. TBA, THs, Retired health personnel.

6.2.2 Community Based Workers Workload, Productivity, Reporting Lines and Rewards

- The workload for community based workers in the villages varies from one cadre to another. The general picture is that the workload is not too much for the community based workers. Their number in the village is proposed to be 2 workers (one male and one female) per hamlet (Kitongoji) depending on the capacity for the village to support them. The female worker may also perform the roles of the trained birth attendant.
- Community based workers have a great potential for helping to improve or change health conditions in their communities. They are therefore agents of change in their communities.
- Community based workers are administratively be accountable to the Village Government. They will prepare and submit their performance reports to the Village Government and a copy sent to the health facilities.
- All Village Governments should find possible ways of motivating their community based workers. Rewards should be raised through voluntary contributions, income generating activities, exemption from development

levy, communal labour and by establishing revolving funds and contribution in kind. Other incentives should be involvement in sale of commodities (e.g. drugs, nets, family planning, commodities etc.), recognition and exemption from fee for services. Currently Community Health Fund (CHF) have committees at the Ward but not at the Village level. There is no clear involvement of the Village Government with CHF. Additionally, the use of the fund appears to be Health facility based. Since the contribution is optional and intended to benefit those who have contributed it, it is unlikely that the contributors would allow its use to finance community based health activities in general, like financing the VHWs and first aid kits. In any case such a decision would have to be made district by district and cannot be generalized. If decisions are forced on them it may adversely affect the rate of enrolment on the CHF. In the current situation of HIV/AIDS pandemic, VHWs responsibilities should include communication on HIV/AIDS as an area of special emphasis.

6.2.3 Supervision of Community Based Workers

The District Medical Officer will provide technical support to community based health workers through the Dispensary and Health Centre. Dispensary or Health Centre staff will visit them to guide and support them in the activities by using a supervisory checklist.

The Village Government may see to it that they carry out their activities according to their working plans. In this way, they can spend more time on preventive and promotive activities. In addition they will have spare time to carry out their personal social and economic activities. They will administratively be accountable to the Village Government.

6.3 Training

6.3.1 Assessing Learning Needs

Awareness of members of the communities is vital in effective implementation of CBHI. While this is clear, its implementation is a task that is not easy. Before initiating CBHI preparation of all those involved is crucial. Two groups of people can be identified in this regard. Programme Managers and extension workers on the one hand and community based health workers on the other.

6.3.2 Training Curricula for Community Based Workers (Integrated VHWs, CBDAs and Village Leaders)

The training of community based workers bear a relationship to what is actually happening in the community regarding health, and must consist of curative, preventive and promotive community based activities. To have an effective training, community based workers trainers must first introduce the PHC/CBHI concept carefully in the villages. Time should be spent on dialogue with the communities or village government on the importance of community based health workers of what they should expect from them and what role the community is expected to play in the programme.

The contents of the curriculum topic could be:

- Participatory Community Based approach in health care management (planning, implementation, monitoring and evaluation)
- Food production, growth and nutrition
- Water, sanitation and personal hygiene
- Control of communicable disease
- Reproductive and Child health/Immunisation
- HIV/AIDS/STI
- Management of home accidents and common diseases
- Income generating activities
- Record keeping and report making
- Evaluation and indicators
- Family planning

Extension workers and Managers are technical personnel in various field from various departments and sectors who are working in the communities and administrative and management capacity in various programmes and projects. They have to be re-oriented in skills and knowledge such as:

- Concepts, Principles, Strategies and approaches in community based health and development
- Teaching methodology relevant to helping adults learn.
- Management skills particularly relating to information collection, analysis, interpretation, reporting and use.

6.3.3 Training Program

It has been noted that sensitization of members of the communities is paramount in effective implementation of CBHI activities. While this is clear, its implementation is not easy. Before starting a programme of community education, preparation of all those involved is necessary. Those who will be involved are the Trainers/Supervisors and Integrated Village Health Workers (VHWs and CBDAs).

Contents of training of Village Health Workers Course

- Concepts of Primary Health Care and Community Based Health Initiative (PHC/CBHI) and the series of health and disease.
- The process of community entry for CBHI activities
- Communication skills and methods in helping adults learn (i.e. appropriate skills for adult education and community mobilization for action on health and development).
- Basic first aid and simple recognition and management of common diseases.
- Methods of information collection, reporting and utilization of information.
- Use of Assessment, Analysis, Action process in planning (Triple "A" cycle)
- Nutrition education include promotion of exclusive breast-feeding and optimal complementation, preventing stunting (growth monitoring) as well as specific deficiencies.
- Anti-natal care, post-natal care, delivery, family planning and counseling.
- HIV/AIDS/STI

Trainers / Supervisors

- These are the extension workers drawn from various sectors (i.e. multi sectoral) working in the community on health and health related development activities.
- They should be selected from among extension workers at the most peripheral points - usually at ward level such as dispensaries, health centres, schools, agriculture and Community Development.

Responsibilities of Trainers

- Help with needs assessments, prioritization, planning, communication,
- development, monitoring and supervision.
- Give technical support to the community.
- Help the community to improve the performance in health and health related
- activities e.g. environmental sanitation.
- They are community changing agents, helping the community to change from ineffective to more effective methods of promoting health and development.
- They are trainers and supervisors of the CORPs.
- They are trainers of the Trainers of the Communities (TOC)

Contents of the Trainers' Course

- Concepts of primary health care and community based health initiative (PHC/CBHI) and the basis of health and disease.
- The success of community entry for CBHI related activities
- Communication skills and methods relevant in helping adults learn (i.e. appropriate skills for adult education and community mobilization for action for health and development)

- ♦ Basic project planning, management, organization, supervision, monitoring and evaluation and feedback, using the PRA "triple A cycle" approaches.
- ♦ Collection, processing, reporting and use of information.

Facilitators/Managers

- These are the Managers of the sections at the district level.
- They are members of District Health Management Team and District Management Team.

Responsibilities of the Facilitators

- Training and supervision of trainers of CORPs
- Coordinates planning and management of community programmes for improving the health and socio-economic status of the communities.
- Participate in planning
- Liaise with DPLO, DHMT.
- Technical support to ward level trainers and supervision
- Be part of technical team coordinating communication efforts from district level
- Accountability in area of responsibility according to guidelines.
- Advocacy

Content of Facilitators' course

- ♦ Concepts of public health care and community based health care and the basis of health and disease
- ♦ The process of community entry for CBHI related activities
- ♦ Communication skills and methods relevant in helping adults learn (i.e. appropriate skills for adult education and community mobilization for action for health and development)
- ♦ Management skills including planning, management, organization, supervision, monitoring and evaluation, feedback and re-planning.
- ♦ Management information system
- ♦ Advocacy.

6.3.4 Training Procedures and Tools

Venue for Training

The community based workers should be trained in the community and they (communities) be involved in supporting the organization and management of the training, including providing resources for the training. Their training should emphasize on preventive and promotive health and community development activities.

Duration of Training

This will differ from community to community and from season to season. The duration of training is proposed to last for a maximum of 2 months followed by refresher courses of at least one week once every year and close continuous supervision.

7. COMMUNITY BASED SERVICE PACKAGE

7.1 Selecting the essential health package at the Community level

The criterion for choosing components in the package at all levels is the size of the burden caused by a particular disease, injury or risk factor. The burden of disease is the total amount of health life lost, to all causes, whether from premature mortality or from some degree of disability over a given period of time. The burden of disease estimated at any moment reflects the amount of health care already provided to the population, as well as the effects of all other actions which protect or damage health. Studies to determine the essential health package for Tanzania found the following disease conditions to cause the highest mortality and morbidity among Tanzanians, but which can be addressed effectively through the Community Based Health Initiatives:

Reproductive Health Problems

- Maternal Health Problems (obstetric emergencies and abortions)
- HIV/AIDS/STI – emphsising HIV prevention through community based communication methodologies.

Child Health

- Malaria
- Diarrhoeal Diseases
- Acute Respiratory Infections (ARI)
- Nutritional deficiencies
- Immunisable diseases

Based on the results of the AMMP studies, the above conditions are identified as conditions in which the CBHI could make most significant contribution to the improvement of the health and wellbeing of Tanzanians. At the community level the elements of care emphasize effective communication strategy aimed at behavior change, access to safe water, access to basic care in regular emergencies and sanitation. The justification for selecting these interventions are:

- ability to address the major health problems.
- having the most significant impact on health status at affordable costs at the community level.
- improve equity making health and well being a possibility for all Tanzanians.
- can be co-odinated with mutually reinforcing interventions at the community level.
- building on existing initiatives that are in place at the community level and have shown to be effective in reducing overall burden of disease.
- can be provided effectively and safely by Community Based Workers.
- can be incorporated into the integrated community based participatory planning process, based on resources available for action.

The essential package is an integrated collection of cost effective interventions that address the main diseases, injuries and risk factors, plus diagnostic and health care services to satisfy the demand for treatment of common symptoms and illnesses. Thus the proposed package is a menu which is close to being non-negotiable but which would be subject to reflection by the Community Based structures through the participatory planning, monitoring and evaluation processes that are to be strengthened in the context of the ongoing reforms. Several interventions that can be implemented at the community have been proposed in annex 10. A Cost effectiveness considerations should be an integral part of the planning process, as emphasized in the feasibility analysis step in planning, through the "triple A" technique, while ensuring that current scientific knowledge and evidence are translated into action at the community level, making service providers at all levels accountable to the service consumers in financial as well as performance terms.

The Ministry of Health has provided a planning framework for districts (The District Health Planning Guidelines), which attempt to give exhaustive and detailed guidance on all technical aspects of the services. These guidelines are meant to facilitate a co-ordinated and integrated approach to planning in the districts. Other guidelines include the Planning Guide for Local Authorities. Both of these do not include the Community Based element which is the focus of this framework.

The interventions in a package should be clustered together in the process of service provision at the village level, and provided by the VHW. Cost effectiveness is achieved through synergism between treatment and prevention activities, and joint production costs and improved use of the resources through the screening of patients at the first level of care, assuring that a small share of high risk cases can be recognized and referred to hospital.

7.2 The sustainability of the Community Based Activities for Health and Development

Community Based Health Initiatives should be implemented in such a way as to ensure that there is sustainability of the results by establishing continuity in the implementation part of the programme. To achieve this, the communities should identify ways and means for initiating and financing their own community based health care and development activities. Some of the options for sustainability may be:

- Creating opportunities for community members to increase their own individual income and thus be able to take effective health actions, and be able to make financial contributions towards health activities.
- For communities to control funds generated by themselves for community based health activities.

- Village Governments to use some of the revenue retained by the village for community health related activities including remuneration of community based health workers and first aid kits.
- Awareness raising workshops to promote self-reliance and reduce the dependency syndrome
- Contribution of labour.
- Contribution of time.
- Continuing education/refresher courses.

7.4 The Basic Working Tools and Supplies in CBHI (Kits)

The trained community based health workers could be supplied with working tools in order to assist them implement various preventive activities and treating minor ailments. These include first aid kits, delivery kits, family planning commodities and bicycles. The contents of the kit is meant to be preventive rather than curative. The actual content should be worked out within the district in consultation with the communities (see annex 2 for a suggested list).

CBHI should encourage prevention than cure in many areas. Community may be involved in selling preventive material in order to prevent communicable or non-communicable disease.

These could include:

- Sale of ITNs
- Sale of Condom
- Sale of drugs e.g. antimalarials, antihelminths

8. COMMUNICATION STRATEGY FOR COMMUNITY BASED HEALTH INITIATIVE (CBHI)

8.1 Strategic Communication as a concept.

Strategic Communication in CBHI can be defined as a purposive symbolic interchange of CBHI issues or ideas, among key stakeholders and actors, resulting in an understanding and (in most cases) agreement on Community Based Health Development.

As a purposive undertaking, Communication for Community Based Health Initiative has to be designed to achieve some expected end points or objectives in community health activities. The interchange of symbols could be verbal but sometimes it could be non-verbal expressions.

8.2 Importance of Strategic Communication

Often planning efforts for developing community health services do not include communication for health. A community based communication strategy is, however, essential in guiding health education activities at household, community and district levels.

There are at least **four** main reasons why strategic communication is increasingly becoming a hub of community based health services. **Firstly**, communication creates knowledge that can enable people to learn about health matters so as to make informed choices. Access to such information, leading to acquisition of health knowledge, is considered to be a basic human right.

Secondly, strategic communication is important in community based health services as it encourages behavioural change. Communication interventions directed to individuals and the community, through interpersonal communication, mass and folk media can influence people to learn and acquire new habits. Under normal circumstances however, behaviour change hardly occurs in the absence of communication.

Thirdly strategic communication can create demand for better health services. A health literate community is more likely to demand and make use of high quality health services. In the same vein, community as a provider to its own needs can respond by increasing or improving supply of high quality community based services.

Finally, Strategic communication can create mutual understanding and trust among key actors within the framework of community based health activities. When such a situation is realized communication encourages coordination among key stakeholders and consequently creating a conducive environment for sustainable community health services.

8.3 Rationale for Communication Strategy for CBHI.

During the field visits to the sampled districts it was more apparent that participatory and interactive methods conducted by intersectoral teams were among the more effective strategies for awareness creation and behaviour change. Similarly, the day to day interpersonal communication at household and community levels were commonly used. However, communication on CBHI either through CBHWs or between community members appeared to be done on an ad-hoc basis, for example, health campaign in response to an epidemic like cholera.

In the ongoing Health Sector Reforms the Health Education section and Community Based Health Care Support Unit, have as one of their main tasks, a responsibility of developing guidelines on strategic communication; and to support the DHMTs to undertake Community Based Health activities within their District Health Plans on permanent basis.

Presently however, reforms in the health sector are still at their infancy; and districts do not have adequate capabilities (knowledge and skills) for developing, implementing, monitoring and evaluating CBH communication activities.

It seems also that there is no coherent communication plan for Village, Ward and District levels; and communication for health appears to be an ad hoc phenomenon. Moreover, community health workers have no guidelines for implementing health education activities. This situation could partly be explained by inadequate participation of villagers in planning for communication for their own health.

Planning, designing and implementing a comprehensive communication intervention [based, for instance on triple "A" Cycle and the P-Process for CBH initiatives, is likely to encourage positive health seeking behaviour among individuals, families and communities; and hasten stakeholders' willingness, collaboration and support for CBHI at village, ward and district levels.

Currently, leadership, policy and resource issues and support for CBHWs are inadequately addressed in the communication process. It appears, from the health education activities implemented by the CBHWs, that imparting knowledge was the end in itself rather than being a means to achieve change of behaviour.

8.4 Strategies and Objectives for Effective Communication

Generally, approaches for communication are categorized into three main areas. These strategies include advocacy, social or community mobilization and interactive or participatory communication. Each of these categories has its main objectives although such objectives are, to a greater extent, intertwined and do overlap. The approaches are intended to guide on communication activities. Table 6 summarizes the strategies, main objectives, advantages and limitations of each approach.

Table 6: *Strategies, Main purpose(s), Advantage(s) and Limitation(s)*

Strategy	Main purpose	Advantages	Limitations
Advocacy for CBHI	Focuses attention on policy and decision making process to influence support or action on CBHI at village, ward, district and national levels	Addresses leadership, policy and social or community mobilization issues	Limited use in influencing individual or group behavior.
Social / Community mobilization for CBHI	Engage society/Community interest and willingness to participate and/or support CBHI activities	Hastens social or community mobilization and creation of alliances. Addresses cultural issues and rumor mongering and may hasten support for CBHWs.	Limited use in influencing individual or group behavior
Interactive/Participatory communicati on for CBHI	Intends to impart specific skills, knowledge about and attitudes towards CBHI among partners, group/category to influence their actions/ behavior	Useful in influencing individual or group behavior. Addresses cultural issues and rumor mongering and may hasten support for CBHWs	Limited use in dealing with leadership, policy issues and social or community mobilization.

There are a number of issues under CBHI which require to be addressed through communication. Ideally, however, communication of activities may be geared towards the main public health problems elaborated in the Essential Health Package. The list of topics below (Table 7) provides only a glimpse of what appears to be a more complicated phenomenon. Table 8 rates the utility of each strategy by the communication problem to be addressed. The ratings are expected to provide readers/users with optional approaches when addressing a given communication gap as revealed in the present CBHI review.

Table 7: Some Areas and Issues that need to be addressed through Communication

Some Areas And Issues for Communication	Administrative levels		
	Community	Ward	District
Stakeholders analysis	+	+	+
Leadership Issues	+	+	+
Policy & Resources Issues	+	+	+
Communication skills	+	+	+
Dealing with roumors			
Negative Cultural values/Norms	+	+	+
Behavior change and Support	+	+	+
Indigenous communication methods	+	—	–
Service package and reward system	+	—	–
Support for CORPS	+	+	+

KEY: + Applicable
– Not applicable

Table 8: Rating the Approaches/Strategies for CBH Communication by problems to be addressed

Some Communication Issue/gap to be addressed	Approaches/Strategies for CBH Communication		
	Advocacy	Social Mobilization	Interactive Communication at community & Household level
Leadership Issues	+++	+	+
Policy & Resources Issues	+++	++	+
Cultural values/Norms	+	++	+++
Behavior change and Support	++	+++	+++
Support for CORPS	++	+++	++

KEY:

+++ Very Strong
++ Strong
+ Weak

8.5: Behaviour Change Models/Theories

Several models behaviour of have been developed and applied in different settings. In general, these models purport that behaviour is learned and could be influenced or altered through effective means of communication. Such models include the Social Cognitive Theory, the Health Belief Model, Behaviour Change and Support Model and Steps to Behaviour Change Model.

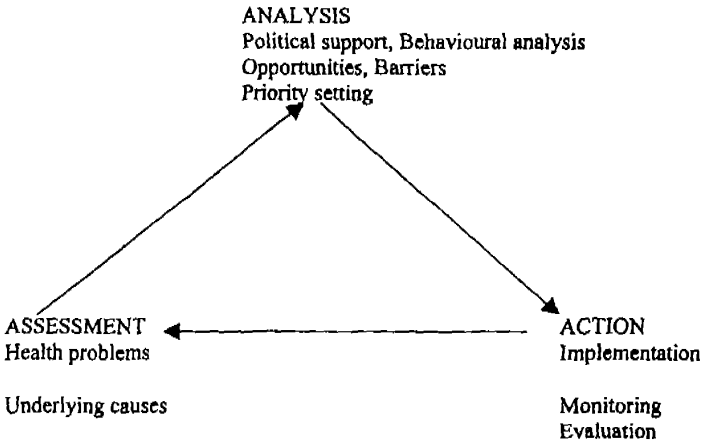
The first two models are highly philosophical and may appear complicated for use in CBHI activities. The later two models are simple and easy to comprehend. Over the years scientific evidence has accumulated regarding the usefulness of the two later models. These models have been tested, refined and applied in communication interventions in family planning and HIV/AIDS in different settings. Therefore, we recommend them for use in developing and implementing CBHI interventions in our country. Table 9 summarizes the main elements in each of the recommended behaviour change models.

Table 9: Main elements for Steps to Behaviour Change and Support Model, and Behaviour Change Model.

Elements for Steps to Behaviour Change Model	Elements for Steps to Behaviour Change and Support Model
Awareness (being sensitized)	Sensitization (awareness raising)
Knowledge (understanding, comprehension)	Personalizing of risk (specific knowledge for individuals)
Approval (acceptance, endorsement)	Skills development (experiential practice)
Intention (willingness to act)	Resource support (provide necessary materials)
Practice/ Behaviour (action)	Maintain behaviour (sustained behaviour change)
Advocacy (support for the intervention)	

8.6 Developing a CBH Communication Plan

There are several techniques such as the P-Process, the Participatory Rural Appraisal and the Triple "A" Cycle through which the process of strategizing health communication at village, ward, and district levels could be accomplished. The triple "A" cycle which is a simplified interactive planning technique, could be applied in planning health and/or health-related communication activities at the aforesaid administrative levels of service delivery. A diagrammatic presentation of the triple "A" cycle as applied in developing a communication strategy is shown below.



The first step in developing a communication plan is to Assess the health or health related problems of the people. In addition, any ongoing communication activities at village, ward or district levels have to be analyzed. The purpose of these analyses is to enable household members and villagers to, first of all, identify their health and health related problems. In this process villagers and other community members are involved in identifying and prioritizing health problems for which solutions have to be sought. Table 10 provides a logical matrix for Communication Strategies, Objectives, Participant groups, Channels/Methods and expected CBHI achievements. Annex 9 is a tool that can be used for data collection for baseline educational needs assessment.

Table 10: Logical Framework for Strategic Communication for Community Based Health Services

Strategy	Objective(s)	Participant group(s)/ Target Audience	Channels/Methods	Expected Output/ Outcome
Advocacy	To increase awareness and political will /support and Resource allocation for CBH activities	Opinion and Religious leaders, Central and Local Government Officials, Political leaders, NGOs, International Agencies, CBOs.	Mass media group, group discussion, meetings, popular theatre.	Policy changes in favour of CBHI, Increased political will/support. Increased resource allocation for CBHI
Social/Community Mobilization	To increase community awareness, willingness, participation and for support CBHI	Villagers, NGOs, CBOs, Women and Youth groups, Professional groups, MOH, Local Government Leaders, Mass media and Folk media.	Radio, TV, newspapers and meetings, Village Assembly, Seminars, Workshops, popular theatre.	Alliance formation. Organization support, Multisectoral collaboration, Increased Community willingness to participate/support CBHI, Increased service utilization.
Interactive / Participatory Communication	To impart health knowledge, Influence attitudes, values and individual or group behaviour.	Mass media, Folk media, Groups, Women , Men, Parents and Individuals	Face to face communication, folk media.	Increased awareness, Improved knowledge, Approval/support, practices/behaviour change and advocacy for CBHI. Increased demand for services, reduction in morbidity and mortality.

Analysis is the next step in developing communication interventions based on the triple "A" cycle. This process tries to identify the underlying Social-cultural causes of the identified health or health-related problem. It entails analysis of demographic, social and economic factors that shape peoples' behaviour. The process also addresses opportunities for strategic communication at household, community, district and national levels. At this stage, possible communication approaches, methods, channels, agents, materials and support for CBHI communication including indigenous methods and practices, are explored and validated. Table 11 shows some key steps for a simplified process of developing participatory communication intervention.

Table 11: Logical framework for developing a Participatory Health Communication Strategy

Objective	Activities/ Sub-activities	Inputs	Who to be involved	Suggested Indicators
To conduct participatory needs assessment for CBHI Communication	Plan the appraisal, prepare tools, collect data, collate data and prepare report/plan	Technical team, funds, Villagers	Technical team, DHMTs, Ward and Village leaders, CBHWs and villagers	Tools developed, Appraisal conducted, Report/plan prepared
Develop a CBHI Communication Strategy and Tools	Prepare communication strategy and tools	Technical team, funds	Technical team, NGOs, DHMTs, Ward and Village leaders, CBHWs	Communication plan and tools drafted
To pretest/Refine CBH Communication Strategy / Tools	Pretest and refine communication strategy and tools	Technical team, funds	Technical team, NGOs DHMTs, Ward and Village leaders, CBHWs	Communication plan and tools tested and refined. Report prepared
To Produce/ Distribute CBH Communication Strategy /Tools	CBH Communication Strategy and Tools produced and distributed	Technical support and funds	MOH, MRALG, DHMTs, Ward and Village leaders, CBHWs	CBH Communication Strategy and Tools produced and distributed

8.7: Monitoring and Evaluation of CBH Communication Activities

The third step in developing a Communication Strategy based on the Triple "A" Cycle is Action. Members together with other key actors and partners, implement, monitor and evaluate health activities at their villages. Table 12 presents the main elements of the Health Communication interventions.

Table 12: Logical framework for implementing Participatory Communication Intervention

Objective	Activities/ Sub-activities	Inputs	Timefra me	Who to be involved	Suggested Indicators
To orient DHMTs, DMTs, NGOs Ward and Village CBHWs on Communication strategy /Tools.	Conduct orientation workshops, seminars	Technical team and funds	To be estimate d	MOH, MRALG, DHMTs, Ward and Village leaders, CBHWs	DHMTs, DMTs, NGOs Ward and Village leaders, CBHWs familiarized on Communication strategy and Tools.
To implement CBHI Communication	Distribute IEC materials/tools and disseminate messages at all levels	Funds, Key actors	To be determin ed	MRALG, DHMTs, Ward and Village leaders, CBHWs, mass and folk media	IEC materials/ messages/ tools distributed/ Disseminated to participant groups
To conduct monitoring of CBHI communication activities	Plan CBHI monitoring, Develop checklist/tools for monitoring CBH communication activities	Funds, Key actors	To be determin ed	MOH, MRALG, DHMTs, Ward and Village leaders, CBHWs	Number of IEC materials produced, disseminated, number of radio programmes broadcasted, supervision visits made, meetings held etc.
To conduct evaluation for CBHI communication activities	Plan evaluation communication activities, Develop checklist/tools for evaluation	Funds, Key actors	To be determin ed	MOH, MRALG, DHMTs, Ward and Village leaders, CBHWs	Change in KAP/B, in demand political will, in social support, in demand and use of services to improve health status

8.8 Implementation of CBHI Communication

Training

Training and acquisition of appropriate skills for communication to CBHWs are important ingredients for successful implementation of CBHI. The following table indicates the level and the type of training needs for the communication strategy.

Table 13: Training needs for Communication strategy for CBHI

LEVEL	*TARGET*	INPUTS	OUTCOME
District	• DMT • DHMT • Mult-Sectoral Teams	• Skills in conducting Advocacy, and social mobilization activities • Skills in conducting relevant research using "PRA" and Triple "AAA" cycle. • Skills in analysing writing and disseminating information. • Capacity building through internal and external support. • Communication tool kit (annex 7) • Guidelines for effective counseling (annex 8)	• Increased competence in designing and conducting advocacy and social mobilization activities by using appropriate research tools.
Ward	• WEO • WDC • Extension Workers • Teachers	• Skills in conducting Advocacy and Social mobilization activities • Communication tool kit (annex 7) • Guidelines for effective counseling (annex 8)	• Increased competence in designing and conducting advocacy and social mobilization activities by using appropriate research tools. • Gaining skills in conducting small groups discussions. • Gaining skills in analysing data and writing up a report
Village	• VEO • CORPS • Facility Based Health Workers • Extension Workers	• Skills in conducting interpersonal communication. • Skills in conducting mobilization activities. • Skills in conducting communication through small focused group discussion. • Technical support, district, ward. • Technical knowledge in Life Skills. • SHOWeD • Communication tool kit (annex 7) • Guidelines for effective counseling (annex 8)	• Increased competence in conducting interpersonal communication. • Gaining skills in conducting small group discussion. • Gaining skills in data analysis and report writing. • Empowerment in Life Skills.

8.9 CBHI Communication Interventions (Programme Dissemination)

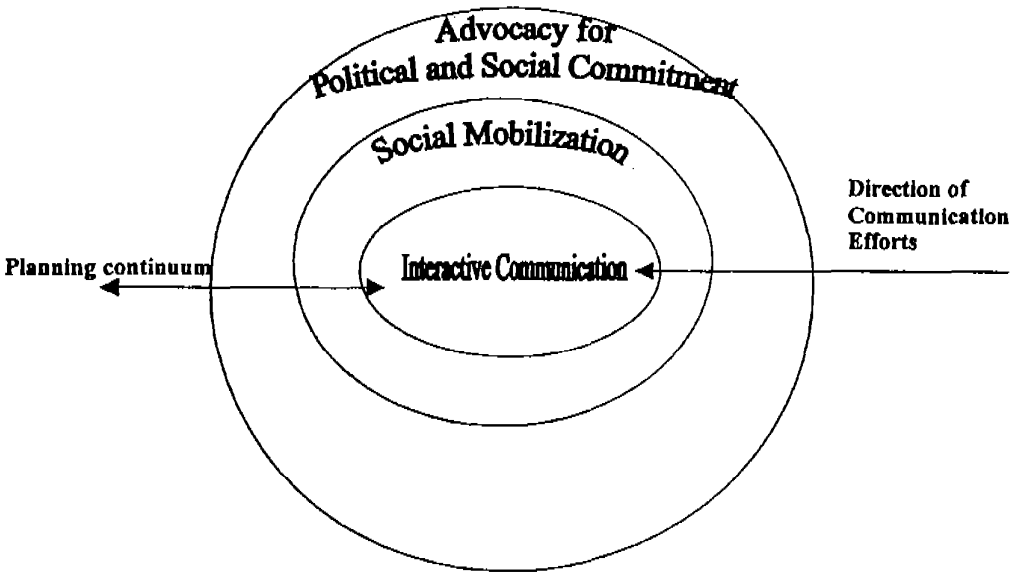
Implementation of a communication strategy, otherwise referred to as programme dissemination, is usually preceded by a thorough baseline educational needs assessment. The data collected is collated, analysed and interpreted in terms of how it relates or it explains the level of knowledge, attitude, believes and practices of a given health problem in a community. This process is regarded as behavioural analysis. It provides for indigenous explanatory models on underlying causal factors of a given health problem or condition.

Interpretation of the behavioural data vis-à-vis the scientific explanation provides a premise for designing, pretesting and refining the communication material or messages. Dissemination of materials and messages is guided by the educational needs of the audience and the targeted groups. The following Table summarises communication strategies that can be used to support CBHI: -

Examples of Communication Strategies that can be used to Support CBHI

Level	**Strategy**	**Agents**	**outcome**
• Household • Hamlet • Community	Interpersonal communication and radio hamlet/household meetings - Village assemblies - Village committees - Extension services - Village health days - Popular theatre folk media - School systems - Religious institutions - Health facilities - Use of traditional drum, kengele, kijembe - Media.	Household members/CBHWs Village leaders + VEO Extension workers Religious leaders School teacher Radio stations	• Increased awareness on CBHI (Information. Communication, education) • Targeting desired behavioural changes. • Stimulating dialogue on CBHI • Delivery of relevant information packages from the district and ward levels. • Initiating CBHI activities leading to community mobilization and participation of the people.
Ward	Regular official meetings - Extension services - School system - Electronic media, - Radio	BAMAKA, WEO Extension workers Teachers (Inspectors) Radio stations	• Plan and coordinate CBHI • Implement CBHI guidelines and policies • Supervise and monitor CBHI
District	- Advocacy - Routine meetings - Cascading system - Print, electronic media - Multi-sectoral meetings - NGO coordination meetings	- DC, DMT, DPLO, DHMT, DED, DAS, DMO, DEO, NGOs, WAMMA, Animator (Multisectoral task group/teams)	• Enlist support on CBHI • Plan, collate and implement and coordinate CBHI • Supervise and monitor CBHI • Develop policies and guidelines for CBHI. • Support/participation in CBHI.

Figure 3: An Illustration of the direction of communication efforts and linkage of approaches



Legend: Communication efforts should be directed to the community and household levels.

Annex 1: A list of Resource Materials for Developing and Managing CBHI Activities

1. Participatory planning guidelines (PRA, Triple A, PAR), Planning guidelines
2. Psycho-social methods (LePSA, SHOWeD), for behaviour change and adult education
3. Model for Community Dialogue based on modifies "Triple A" technique
4. Training manuals for community based health workers.
5. Training Curricula for various categories.
6. Supervision checklist.
7. Guidelines for the management of the Community health fund.
8. National package of essential health interventions in Tanzania.
9. Guidelines for cost sharing and user charges.
10. The Health Sector Reform Program of Work and Plan of Action.
11. Guidelines for nutritional supplement.
12. National Plan of Action for Nutrition.
13. Guidelines for traditional birth attendants.
14. Guidelines for communication strategy
15. Indicators for Community Based Information System
16. Training Manuals prepared for VHWs, Trainers and Facilitators
17. CBHI Communication Kit for integrated VHWs

Annex 2: The Community Based Health Workers' Drugs, Supplies and Tool Kits

For the Village Health Worker (VHW):

1. Interactive Health Education kit (UNICEF, MOH)
2. Analgesics
   - Aspirin
   - Paracetamol
3. Antihelmintics
   - Mebendazole
4. Antimalarials
   - Chloroquine
5. Ophthalmological preparations
   - TCL Eye ointment 1%
6. Dermatological preparations
   - BBE
   - Whitefield ointment
7. Oral Rehydration Salts
8. Disinfectants and antiseptics
   - GV
   - Tincture iodine
9. Cotton Gauze
10. Bandages
11. Forceps
    - Dressing forceps - 2
    - Straight scissors - 1
    - Kidney dish - 1
    - Gally-pot - 1
12. Clinical thermometer - 1
13. Torch (flash light) and dry cells - 1

<u>Delivery kit (some to be supplied by the users*)</u>

1. Flash light - 1
2. *Sheeting plastic - 2
3. *Umbilical cord ligatures - 1
4. *Blades - 5 packets
5. Kidney dish - 1
6. Bowl sponge - 1
7. Scale 25 Kg - 1
8. Bag for above equipment - 1

Annex 3: Significant CBHI Practices Identified During the Review

Theme	Issue/example	Where	Why important
Needs assessment	Community identification of problems, prioritising and planning Participatory method to identify community problems Community centred assessment (plus analysis and action) through PRA/PLA tools	Iringa, Mufindi, Kilombero	Local capacity for problem identification, prioritisation, tools available
	Tying the programme to DPLO worked for stakeholder involvement in mobilising	Mufindi	Central role of DPLO / Local government in reformed CBHC
	District planning office supplying forms, registers. VHW buys own notebook and pen	Iringa, Mufindi, Morogoro	Sustainable information gathering tools
Resource mobilisation	Community IGA - planted trees, raising rabbits, have ox-carts	Mufindi	Helping women
Ownership	Water scheme	Morogoro Kilombero	Fund-raising for sustainability, local management
VHW Workload	VHW input maximised around village health days (otherwise 3 to 8 days a month)	Kilombero, Iringa, Mufindi	Intensified engagement every 1 to 3 months yet appears adequate
CBHC impact	No cholera since VHWs there in the past three years; latrine coverage increased	Dodoma	Tangible impact of CBHC
	Maternal mortality down, FP up, ANC 100%; local perceptions plus independent study confirms	Mufindi . Iringa	CBHC long enough (15 years) and large enough for tangible impacts
	Family planning acceptance increased	Morogoro	Tangible impact of CBHC
Start-up	Introducing CBHC; funded by AMREF – TZ technical assistant, situated in DHMT, with counterpart (CHN)	Kilombero	District based and responsible system
	CBHC start up	Kilombero, Sanje	Community level start-up, shared between villages
	CBHC start up	Mufindi	CBO/local NGO involved as facilitator
Equity	Gender representation in leadership balanced	Mufindi	Changes happening
	Female leadership	Mufindi, Iringa, Kilombero	Effective of female leadership confirmed
	Loan-barter scheme	Kalabo (Uganda)	Reaching poor households
	Exemption plan, registered the poor HHs, elderly, handicapped	Dodoma	VEO involved in identifying vulnerable HHs

	AIDS programme, identifying the orphans, vulnerable persons and HHs	Iringa	Link to community worker, VHWs as counsellors
Client/HH records	High risk card with star (*)for TBA to identify and refer	Iringa, Mufindi	Works for low literates, rating by trained HW
	Health "passports", some linked to CHF arrangements	Zambia	Community sensitised to CBHC, saw need for records
	VHW assist growth monitoring and immunisation sessions, write on card	Iringa, Mufindi	Knowledge by VHW
	Three colour card for growth monitoring	Iringa, Mufindi	Help VHW and mother to interpret
Policy link	Adherence to policy guidelines while planning and implementing CBHC activities	All Districts	Provides uniformity, with variations
	Fired VHW, and selected replacement	Mufindi	Local ownership
	Village policies and sanctions (fines)	Mufindi	Local structure, ownership
	Fines for not having healthy HH, rewards for healthy children	Rufiji, Dodoma	Is helping change behaviour
Capacity Building through Training	Refresher courses conducted by some donors, e.g., UMATI	Morogoro	Performed as guidelines required
	Training of CHWs on donor interests, e.g., CARE, HESAWA, OXFAM	*Kwimba*	*Brings about confusion (Worst practice)*
	The Naisinyai cattle dip; immunisation coverage	Arusha	TBAs and women acquiring skills and knowledge; increased engagement in health and development
	Training pyramid/cascade by AMREF – District facilitators to trainers to community	Kilombero	Training linked to implementation
	Training CBWs at multi-purpose training centre (ward level)	Iringa Rural	Training within the community
	TBA/MCHA working side by side	Iringa, Kahama	Informal, but effective feedback, not called 'supervision'
	VHW trained originally for 6 months, now trained for three months – 2 months residential, full time, and 1 month supervised practice TBA trained for 30 days at 1-2 hrs/day	All Districts	Workers trained in all Districts but inconsistency is worst practice
	Traditional healers – some informally trained, some have formal training organised by DHMT and CBHC co-ordinator	Kilombero, Mufindi	Need to keep the THs practice current in the light of new situations
	Village based training of TBAs with village labour assisting	Iringa	Training in location; more local ownership
	Project Concern – Jigger project, selected by community	Ludewa	Good local supervision and co-ordination
	CBDAs supervised by extension health worker from health facility	Mufindi	Example of the needed technical support

	UMATI supervising CBDAs	Morogoro	Value of supervision; community 'volunteers' also help to supervise
	Village government following up VHWs	Dodoma	Comm. Based supervision
Supplies, including kits	The use of "zero-kit"; developed by DMO/DHMT – first aid, minor ailments, wounds, worms, malaria, eye problems	Kahama, Iringa, Kwimba	More relevant to the area, sustainable, good supervision, documented use
	Mothers replacing stock in TBA kit, for own use	Iringa, Mufindi Morogoro, Kwimba	Sustainable, minor expense for families / family responsibility, similar in traditional system
	ITN sales and distribution	Kilombero	Private sector involvement
	CBDA kit, project for FP and deworming	Morogogo	Integrating functions
	The village drug revolving fund for "first aid drug kit"	Kahama, Kwimba	Village sustained drug kit is possible
Co-ordination	Co-ordination of key partners at district level	Iringa, Mufindi	Good co-ordination by local government
	The co-ordination between DHMT and NGOs/donors , and other players	Dodoma Rural, Mufindi	Co-ordination and linkages facilitated by District Council
	Co-ordination of PIME by DPLO	Mufindi	Approach which enables integrated planning and action
	Support given to the VHWs by the staff at the health facility level	All districts with VHWs	Supervisory activities occur but not called supervision
	Presence of district CBHC co-ordinators	Mufindi, Iringa	System in place to ensure CBHC initiatives
	Enhanced multi-sectoral support to CBHC	Kilombero	District down to ward to village
	Use of multi-sectoral approach in implementing CBHC, e.g., teachers, other extension workers in supervision	Iringa, Kilombero	Ward and village; including health in other activities
	Leadership for health – good example involving political wing	Mufindi	Importance of involving DED and politicians
Community information system	Data collection while marking the village health days	Iringa, Mufindi, Rufiji	Use of Village Health days for monitoring action
	Community based growth monitoring for children under five years	Iringa, Mufindi	Sustained health intervention
	Health facility worker doing follow-up to CIS information; initiated by DHMT, some support from TEHIP	Morogoro	Role of VHW in data collection
	Community based (SMI) pregnancy monitoring	Iringa, Mufindi	Sustained essential intervention through CBHC
	VHW has summary form for growth monitoring for nutrition	Iringa, Mufindi	VHW able to monitor health status

	Use of MTUHA booklets in collecting information, *but none at community level*	All Districts visited	Base set but gap to be filled
	The dual information flow: through VEO to DED, and through facility to DMO	Iinga, Mufindi	Engaging both the technical and political leadership
	Village health days practice	Iringa, Mufindi	Generates a lot of information in a village
	Schools health screening and feedback of results to parents and teachers and pupils – C→P→community action; a health club	Dodoma	Sharing, use of information, continuing process
	Collection of various health related data during village health days in some villages	Iringa, Mufindi	Effective use of Health Days
	Use of sticks and stones in counting deliveries by TBAs	Iringa, Mufindi	Works with non/low literates
	Village health data information to village government where they adjust quarterly action plan	Mufindi	Systematising local data collection and use
	Pictorial recording system	Kwimba	Ease of use by low literates
	Village registers	All except Kahama	A data gathering tool to be maximised
Implementation	CSPD – UNICEF – introduction, then handed over to the district; partner relationship with community to implement	Iringa , Mufindi	Funded project long enough and capacity built for sustainability
	Housing, road, environmental sanitation, water, community quarterly monitoring, community fund and local use	Mufindi	Bottom up approach in implementing activities
Planning	Involvement of communities in participatory planning: HHs, Gp., Kitongoji, Village, Ward, District , Using AAA, PRA	Iringa, Mufindi, Morogoro, Rufiji,	Good example of integrated participatory planning, lead to District Master plan
	Ward and district councillor take active interest	Dodoma	Ward and District level support ensured
	Training and supervision for planning process by DPLO, CBHC co-ordinator	Dodoma, Mufindi	Effective capacity building for integrated participatory planning
	Village plan and budget/report is a means of accountability	Mufindi	Community based /accountability / management capacity
Village health days	Normal practice, done routinely	Iringa, Mufindi	Excellent idea for people's participation
	As minimum requirement for voluntary action	Iringa, Mufindi	Innovation for sustained voluntarism
Integrated roles and persons	Integrated CBHC activities, CBDA / VHW	Iringa, Kahama	Each provides integrated care
	Some integration of VHW/CBDAs and THs	Ilala, Iringa, Mufindi	Needed for integrated action

Integrated roles of VHWs (in SMI, STI/HIV/AIDS, sanitation...)	Mufindi, Iringa	"
Linking immunisation with child growth monitoring clinics	Mufindi, Iringa	Making Growth monitoring more worthwhile/usable
Circumcisers engaged in sexual education	Kilombero	Traditional resources for communication
The use of various forms in communication, e.g., traditional means and modern means	Morogoro, Dodoma	Building communication on existing popular activities
Use of religious gatherings to disseminate health information	Morogoro, Dodoma	"
A glimpse on the reflections of "Jando/Unyago" – THs socialising boys in sexual matters	Kilombero	"
Change of ritual sex cleansing using chiefs in Chikankata	Zambia	"
Design of health education using indigenous knowledge and indigenous cultural practitioners	Kahama	Importance of building on indigenous knowledge
Tools and participatory methods of message development available	Kilombero, Iringa, Mufindi	Means to enhance ownership of messages

Annex 4: Criteria for the Selection of Community Based Initiatives for Support by the District Earmarked Funds

One of the areas for district health sector financing under the sector POW is the Community Initiative Support. The districts may be allocated funds earmarked to support community initiative on health promotion. The following criteria could be used by the DHMT to assess community proposals for funding:

- That the proposal is developed from the approved village plan formulated through the participatory bottom-up approach.
- That the village has a sound resource base and financial management system, with adequate accountability checks and balances.
- That the proposal includes evidence for magnitude of the problem to be addressed and effectiveness of suggested interventions.
- That the proposal focuses on essential health intervention package.
- That the community has invested in the initiative and needs topping up funds to complete the project or to set up a sustainable revolving fund.
- That the proposal clearly defines how the project will be monitored.
- That the marginalised population groups e.g. the poor elderly people, orphans, disabled, street kids woman and children are given priority.
- That the proposal is within the planning cycle

Annex 5: Outline of a Community Based Proposal

TITLE:

This is a heading statement, which explains on what the proposal is all about.

EXECUTIVE SUMMARY:

This is summary of objectives and major activities to be performed. How, by, who and when. Resources required and ways of monitoring.

INTRODUCTION OR BACKGROUND INFORMATION:

This section describes the village by providing basic information on location, geographical features, demographic data and the social cultural profile including how people participate in community based initiatives.

SITUATION ANALYSIS:

This section identifies the common health problems and discussed their causes morbidity and mortality figure if available they should be included. Secondary problems underlying poor health are also discussed. The problem to be addressed is analysed and described in depth. Existing routine health services, which operate at the community, are also described here. Successes and shortcomings or gaps are also outlined. Resource availability and requirement are also outlined.

JUSTIFICATION:

Based on the objectives and interventions to be developed a justification to the undertaking is made showing how the intervention will benefit the community and improve their health.

PLAN OF ACTION:

A plan of action is written using a logical framework matrix table where various element and stages of the planed activities are put in logical and sequential order where they can be visualised.

A sample plan of action logical framework will include the following elements:

Objectives: these are statements, which describe the intended outcomes towards which the plan will contribute. An objective should be SMART (Specific, Measurable, Achievable. Realistic and Time bound) and should be stated for each selected priority.

Activities: these are the actions, works or tasks to be performed by the staff and others involved in the implementation of the plan. These should be target oriented in that they are tasks to be performed in order to produce the plan outputs. This requires that all the essential activities necessary to produce the anticipated outputs be included and should be contributing directly to the intended outputs.

Inputs: these refer to all resources to be used in the implementation of the plan in terms of the funds, personnel, materials, services etc. as provided by the central government, local government, donor, NGOs etc. The total inputs must realistically reflect what is necessary in order to produce the intended outputs. As such the inputs should be directly related to the specified activities and that they are necessary and sufficient conditions to undertake the planned activities. They should also be precise and verifiable in terms of quantity and quality.

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Outputs: these are the results, which can be guaranteed by the plan as a consequence of the activities and inputs. It is important that all essential outputs are included and that only the outputs, which can be guaranteed by the plan, are defined. They should also be precise and verifiable.

Indicators: these are descriptions of the performance standards to be reached in order to achieve the objectives. They reflect the changes directly and indirectly sought by the plan. Information is needed to verify the indicators and this can be generated by the plan itself or through surveys, in-depth studies etc. In any case, the indicators must be specific in terms of quantity, quality, time, location and target group. The means of verification should be available including statistics, observation records, etc., and that the information is generated at a reasonable cost, relevant as a measurement of the achievement of objectives, reliable and up-to-date and well stored.

An example of plan of action logical framework can be as follows:

MALARIA INTERVENTION PLAN OF ACTION FOR BAHATI VILLAGE

Problem	Objective	Activity	Date Commence	Date Finish	Input	Output	Indicators	Responsible
High Morbidity due to Malaria	To reduce Malaria morbidity from 200 to 100 by the end of the year.	Supply 500 ITNS through health facilities and open market	1/3/00	1/4/01	ITNs Traders H/Workers Community	300 HHs purchased ITNs 3000 households trained how to use ITNs	300 households using ITNs	Villages H/Workers VHW VEO WEO

BUDGET:

This is a process of translating inputs and activities into monitoring terms in order to identify financial requirement for the plan implementation. Like the logical framework for the action plan, matrix table indicating activities against cost estimates and source of funding is prepared.

An example of budget matrix.

Activity	Cost Analysis	Source of Funding		
		Community	District Council	Donor
1. Train 300 household members in using ITN	Trainers 2 x Lunch All. Tsh. 2000 x 4 days = 16,000	16,000/=	-	-
2. Purchase 300 ITN and stock them at H/facility and two existing shops.	300 mosquito nets x Tsh. 3500 = 1,050,000	-	1,050,000	-

Annex 6: Data Collection Instruments and Indicators

INTRODUCTION

The primary level for data collection will be the community. Data will be collected by Community Based Health Workers in the course of giving services in the village. Demographic data will be collected by the VEO with the assistance from the hamlet leader. It is important to know that while some of the data may be relevant at the community level, especially those pertaining to resource input and monitoring activities taking place at the village, some of the data will be required at the higher level for strategic planning and decision making. A minimum basic set of data that need to be collected at the community level is shown in the main text. In this annex various tools for data collection and examples of relevant indicators are described by level of implementation. The data set and the indicators are by no means exhaustive, but serve as a menu for actors at the various levels to select and into which additional data requirement can be included.

DATA COLLECTION INSTRUMENTS

The following are examples of registers that can be used to collect data at the community level. The registers are by no means exhaustive. They can be modified to allow for additional information that will need to be collected by the community itself. Therefore, in most cases it is the basic minimum of data that may be required countrywide that has been cited.

VILLAGE REGISTER HAMLET

S.No	Name	Sex	Date o Birth	Educa tion level	Date Emigration	Date Immigration	Date of Death	Cause of death		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)

It is important to register every person in the village for the following reasons: -

- To enable village government and the higher level to followup/track demographic trends
- To enable village government and higher level plan for resource mobilization and utilization
  It is from the number of people in the village that the Government can know the number of people expected to contribute through taxation hence the amount of money expected.
- In the provision of services the number of people in the village will guide leaders on how to deploy resources in order to accomplish objectives in the most efficient way.
- Through the register, the current number and potential voters can be known. This will enable village leadership to monitor participation in the various elections.

The register will be filled in by the Village Executive Officer. VEO will be assisted by the hamlet chairpersons who are more closer to the people and therefore in a better place to inform the VEO on the occurrence of births, death and immigration. After the initial registration of every person in the village; this will be followed with a regular updating of register.

It is advisable to have the registers for each hamlet and age group. The proposed age groups are 0-4 years, 5-17 years and 18 years and above. The underfive register will be useful in followup child health thus may include aspects of vaccination. The 5 to 17 year register may be used to followup educational issues while the 18 and above register may be used to followup on levy and elections.

How to fill in the register:

Column 1: Serial number is filled in as new member of village comes in through immigrating or birth starting from zero. The number is not deleted upon the demise of the person.

Column 2: Three full names of the person should be recorded starting with maiden name, middle and finally surname.

Column 3: For those who cannot remember Date of birth special events can be used to trace the year of birth.

Column 4: Level of education could be primary, secondary, high school, graduate or postgraduate. Record 'Adult education' if has not attended school but knows how to read and write in Kiswahili.

Column 5: Occupation of the person can be farmer, businessman or teacher. If more than one occupation e.g. businessmen and farmer, write the occupation which take most of the persons time and that which the person relies more for his/her daily living.

Column 6: Date when the person first came into the village. For those who came before the register is introduced this column should be left blank.
Column 7: Date when the person left the village to settle somewhere else.
Column 8: Date of death. The cause of death in column 9 can be obtained either from record obtained from a health facility or symptoms narrated by a relative.
Column 10,11,12: Is left blank for the village leaders to include data that is relevant for the village.

ANTENATAL REGISTER

First page for every client:

FIRST VISIT OF PREGNANCY								REATTENDANCE AND RISK FACTORS DETECTED												TT VACCINATION
Date	Name	GRAV	PAR	ALIVE	Booking age in weeks	EDD	Risk detected	Put a tick for each reattendance. Use symbols shown below to enter risk factors detected during reattendance.												
								Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
																				1 2 3 4 5
1	3	4	5	6	7	8	9	10												11

Note: Ab = abortion, and Cs = Caesarean Section, A = Anaemia, O = Oedema, H = High blood pressure, P = Proteinuria, U = Failure to increase weight, D = Antepartum haemorrhage, M = abnormal lie.

Column (1), the date of the first visit during pregnancy.
Column (2), the identification number. Record number from the antenatal card given at the clinic.
Columns (3), name of the client.
Column (4), Gravidity. Write the number of pregnancy the women has had, including abortions.
Column (5), Parity. Write the number of deliveries the women has had, including still births.
Column (6), Alive. Record the number of children the women has had and are still alive.
Column (7), Booking age in weeks. This is the number of weeks from the time the women had her last normal menstruation (counted from the day she menstruation). Weeks are recorded in a fraction of 40 e.g., 18/40.
Column (8), EDD. Record the date the women is expected to deliver.
Column (9), maternal risks. Record risk factors detected on the first visit. Maternal risks that may be detected includes having more than 5 pregnancy, age below above 35 years, height les than 150 cm, three or more consecutive abortions, history of caesarian section in the previous pregnancies.
Column (10), Reattendances and risk factors. Each re-attendance of a client should be recorded in this column with a (✓) under the correct month. If the woman pr with any of the following risk factors, instead of the tick the abbreviation should be written under the month of the visit. Abbreviations are Anaemia (A), Oeden High blood pressure (H), Proteinuria (P), Failure to increase weight (U), Antepartum haemorrhage (D), and Abnormal lie (M).
Column (11), TT vaccination. Circle the number of tetanus toxoid vaccination already given.
Column (12), Comments. Write any advice given to the women. This can be referral for delivery at hospital, family planning educatior

DELIVERY REGISTER

Del Date	Serial Num	Name	Name of Hamlet/Head HH	Age	Gra vida	Para	Pregnancy Outcome			Mother final status		Live birth information				Still Birth information	Deliver by
							Abort ion	Type of deliver y	Complic ations during delivery	Wel l	*Die d	Sex	Wt	Complications	Final status		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)		(12)	(13)	(14)	(15)	(16)	(17)

Column (1), Delivery Date. The date that the women delivered.
Column (2), Serial Number. The serial number starts with "001" each year.
Column (3), Name of the woman.
Column (4), Name of and hamlet head of household that woman resides.
Column (5), Age. The age of the woman. Use special historical events to estimate the age if not known.
Column (6), Gravida of the woman. This is the number of times the woman has been pregnant including the current pregnancy.
Column (7), Para of the woman. This is the number of previous deliveries.
Column (8), Put a tick if pregnancy outcome is abortion. By definition, the time point used to differentiate between a miscarriage/abortion and a still birth is 28 gestation. If no abortion enter dashes (---).
Column (9), Type of delivery. Write if delivery was normal. If not, then the reason for it being not normal is written, for example, "Premature", "Prolonged la "Breech".
Column (10), Complications during delivery. Write complications of the mother. These could be post-partum haemorrhage, retained placenta, 3rd degree tear, etc.
Column (11), Mother's final status. Write either "well" or "died". If died record the cause of death.
Column (12, 13,), Live birth information. A birth is defined as a live birth if the newborn breathes independently after birth. If there is a live birth, then the s weight in kilograms are recorded.
Column (14), Complications are written briefly, such as "premature". "congenital deformity".
Column (15), The final status of the child can be 'well' or 'died'. If died, indicate if within 24 hours or after.
Column (16), Still birth Information. A birth is defined as a still birth if the gestation period is at least 28 weeks, and the newborn does not breathe independentl birth. If a delivery resulted in a still birth, write FSB if skin was intact and MSB if broken skin. If the skin is broken. If outcome was not a stillbirth enter dashes (–
Column (16), Name of the person who conducted the delivery.

UNDERFIVE REGISTER

Name of Hamlet Nam

INFORMATION TO RECORD AT FIRST CONTACT					DPT 1 date	DPT 2 date	DPT 3 date	Polio 1 date	Polio 2 date	Polio 3 date	Measles Immunisation Date	Vit A at 9 months	Vit A at 1 months
Date	ID No.	Birth date	BCG date	Child's name									
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)

Column (1), the date of first contact.
Column (2), the identification number from the MCH road to health card.
Column (3), the date of birth. If possible try to get the day and month of birth. This is easier to get if the child comes to the clinic only a few days after birth. Encourage the mothers in your health facility to bring their children immediately. You should also take the opportunity to do a post-natal check on the mother, and find out if she is having any problems with breastfeeding.
Column (4), the date that BCG was given
Column (5) the name of the child.
Column (6,7,8) the dates that the DPT 1, 2 and 3 were given.
Column (9,10,11), the date that the Polio 1, 2 and 3 were given.
Column (12), the date that the Measles vaccine was given.
Column (13,14,15), the dates when the first, second and third doses of vitamin A were given.

VILLAGE HEALTH DAY TALLY SHEET Date _____

TALLY ALL CHILD VISITS

OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO
Sum =

TALLY ALL ANTENATAL VISITS

OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO
Sum =

TALLY ALL POSTNATAL VISITS

OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO
Sum =

TALLY CHILDREN ACCORDING TO WEIGHT FOR AGE:-

RED(Less than 60% WA)	GREY (60% - 80% WA)	GREEN (Greater than 80% WA)
OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO	OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO	OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO
Sum =	Sum =	Sum =

DISEASE DATA

FEVER	DIARRHOEA	COUGH AND CHEST TIGHTNESS
OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO	OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO	OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO OOOOOOOOOO
Sum =	Sum =	Sum =

Tally sheet is for tallying child, pregnant, postdelivery women attendances during village health days. If there are no VHDs in the village, the form can still be used during home visits by the VHW. It is also used for tallying the weights of the children in three categories; Red if the child is severely malnourished, Grey if moderately malnourished and Green if nutritional status is good. This record will assist the VHW in monitoring their nutritional status of the children and give immediate feedback to the parents. In addition, tally of three major diseases conditions can be done and these are Fever, Diarrhoea, Cough and Chest tightness. Disease conditions is obtained by asking the parent who brought the child whether the child has suffered from any of the conditions. This will help to monitor control of diseases, give health education on prevention and advice on best approach to take should the child happen to suffer again from the same condition.

Family planning register

Date	Client Name	Client Number Yr	Num	FP method	Contraceptive Dispensed at this Visit (Units) Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Complaints client/comm
(1)	(2)	(3)			(5)												

**Units: Pills = cycle, Condom = piece, Foam tablets = tube, Jelly = tube*

Column (1), Date. Write the date when the client was registered that year.
Column (2), Client name. Write the name of the client.
Column (3), Client number. Write the client's identification number that is written on her/his Client Card.
Column (4), Client type. Put a tick (√) under the correct type of client. **New** clients are those who have never accepted a contraceptive before ANYWHERE at any tim **All others** are those who have accepted a contraceptive in the past. **All others** include those continuing without interruption and those returning after a period of no contraception, and those accepting a contraceptive at different place.
Column (5), Contraceptive dispensed at this visit. For each visit, write the amount of the contraceptive given to the client
Column (6), Comments. Record in this column any special circumstances for the client, especially complaints. This will assist in determining the important health issu associated with contraception.

Treatment Register

Da te	Serial No.	Name	Name of Head of Household	Age	Sex	Major symptoms and duration	Treatment/Advice	Ne
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	

The register will be used in villages where First Drug Kit is available. The register will be filled in by the VHWs to register all patient treated by him/her.

Column (1): Date when the patient was attended
Column (2), Serial Number. Start with number 1 each month. Each attendance gets one number.
Column (3), the name of the patient.
Column (4), the name of head of household where the patient currently lives.

Column (5), the age of the patient. If the patient is under the age of one year, record the age in months out of a possible twelve. For example, a five month old patient would be written as "5/12". A neonatal child is recorded in days.
Column (6), the sex of the patient. Make a circle around 'M' for male or 'F' for female.
Column (7), major symptoms and duration. Enter the major symptoms as narrated by the patient.
Column (8), the treatment or advice.
Column (9), New patient: is the one being trated for that condtion for the first time.
Column (10), Reattendance: is a patient who returns for repeat treatment with the same disease episode.
Column (11), Referral is a patient who is adviced to seek further medical attention at a health facility.

COMMUNITY BASED DATA BOOK

Community Based Data Book is a boook that will be used by the VHWs to record important data/information in the village. Thhis will include names of hamlet/village leaders, Communitty Based Workers and influential people. It will also include an annual calender of events scheduled to take place in the village such as VHDs, village assemblies and village government meeting. The book will be used to record data received from other CBHWs, village government and other sources. Information obtained from the aggregation of various data collected by the VHW will also be entered in this book. VHWs are resouceful persons that can be used as informers of births and deaths in the village. This book will be used to record incidences of births and deaths in the village and also as a tool for counterchecking and comparison with birth and registration done by the VEO to ensure that no vital event is missed. VHW will have a separate book to record day to day issues during household and school visits. Format for this book is shown in the last table.

The tables are arranged to accomodate data/information collected for three year. Tables for data aggregation contain variables that are compatible with that collected at health facilities through MTUHA. This will enable users to derive a maximum benefit from the community based data as well as facility based data.

SECTION 1: BACKGROUND INFORMATION

Names of village government leaders/influential people

Name	Position	Indicate Years Active		
		Yr ___	Yr ___	Yr ___

Names of Community Owned Resource Persons (TBAs, CBDAs, TH, Peer educators etc)

Name	Function	Hamlet

Dates Reports were received from CBHWs

Trained TBAs	Yr ___				Yr ___				Yr___			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

Calender of Village major events and VHWs activities

Event/Activity (meeting, HH visits, school visit)	Qtr ___			Qtr ___			Qtr ___			Qtr ___		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

3. Results of quarterly child weighing

Estimate of children under five Year 1 _____ Year 2 _____ Year 3 _____

Date	Number registered	Number weighed	Number 60-80% WA	Number <60% WA	Number not growing	Number behind in imm
Q1 Year ____						
Q2 Year ____						

4. Reports from trained TBAs

Name of trained TBA	Deliveries	Live births	Still births		Livebirth deaths	Maternal Deaths
			FSB	MSB		
TOTAL						

FSB = Fresh still birth
MSB = Macerated still birth

5. Reports on contraception

		Year ____				Year ____				Year ____			
		Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Qtr 1	Qtr 2	Qtr 3	Qtr 4
New clients	Pills												
	Condoms												
	Foam tablets												
	Jelly												
	Other_____												
Current Users	Pills												
	Condoms												
	Foam tablets												
	Jelly												
	Other_____												
Units*	Pills												
	Condoms												
	Foam tablets												
	Jelly												
	Other_____												

** Units are as follows:- Pills = cycle, Condom = piece, Foam tablets = tube, Jelly = tube*

HOUSEHOLD/COMMUNITY VISITS RECORD BOOK

Date	Name of Head of Household	Description: Findings, Activities done, Advice/Recommendations given and date for next visit

INDICATORS

DEVELOPING INDICATORS TO MONITOR AND EVALUATE CBHI

HOUSEHOLD LEVEL

OBJECTIVES/ACTIVITIES/DECISIONS	HH DATA/INDICATORS	VILLAGE/WARD INDICATORS	DISTRICT INDICATOR
Keep livestock	Number of cows, goats, sheep in the HH Number of cows, goats and sheep slaughtered in the HH Number of cows, goats and sheep sold by HH	Number of cows, goats, sheep in the village Amount of Revenue collected from selling and slaughtering livestock	Livestock Per capita Revenue generated from livestock se District Per capita income
Enroll children to school	Children aged 7 years and enrolled to school Children of all gender attend to school throughout the year	Percent of children aged 7 and above enrolled to school by gender Number of desks made Number of dropouts by gender Number of pupils per classroom	Percent of children aged 7 years and school by gender Percent of schools that have adequate Average number of pupils per teache Average number of pupils per classr
Build permanent houses	Family has a house made of cement/burned bricks, corrugated iron roof and cemented floor	Number of permanent houses in the village	Percent of people in the district living house
Build permanent latrine and use them	Family has a latrine with a walled pit, washable floor, superstructure with a door and roof.	Number of HH with an acceptable latrine	Percent of people using latrines
Get access to safe water source	Family has at least 20 litres (a bucket) of water per person/daily within 400 metres	Number of safe water sources in the village Number of HH within 400 metres to a safe water source	Percent of population living within 4 safe water source Number of water projects in the distr Percent of district budget used to sup
Boil water	Family drinks boiled water	Number of children reported to have had diarrhoea in the past three months	Rate of diarrhoeal diseases CFR due to diarrhoea Number of cholera/dysentery epidem
		Number of Households that have utensil	

Build utensil drying rack	Household has a utensil drying rack	drying rack	—
Dig a pit for solid waste/acquire a dust bin	Household has a waste pit/dust bin	Number of Households with a pit/dust bin for solid waste disposal	-----
Clean surroundings	Surroundings have no scattered litter, overflowing water and tall grass	Number of households found to have clean surroundings in the last survey/VHD	---
Participate in village health day	Family attends village health days	Number of VHD in a year Percent of underfives attending VHDs Number of Maternal deaths in a year Number of underfive deaths in a year	Percent of villages observing VHDs Rate of severe and moderate malnutrit Maternal Mortality Rate Underfive Mortality Rate
Attend hamlet/village meetings/assemblies	Family attends hamlet/village meetings/assemblies	Number of village assembly meetings held Percent of villagers attending VA by gender and age groups	Percent of villages reporting to have c quarter Percent of villages that had an accepta determined locally) representation of i aged people
Use iodated salt	Family uses iodated salt	——	Percent of people with goitre
Pay medical bills	Family enrolls into CHF/HI or has cash to pay when a member falls sick	Number of HH enrolled with CHF Number of people exempted from paying medical services	Percent of HH joined CHF Percent of population exempted from medical services Percent contribution of CHF and user budget
Medical consultation	A sick member is sent to the nearest health facility		Percent of population using HF Percent of deaths occurring at home w medical facility
Use Insecticide Treated Nets	All members of HH sleeps under an ITN	Percent of underfives reported to have had fever in the past three months	Rate of malaria/fever
Support orphans	Head of HH ensures support to orphan relatives	Number of orphans in the village Number of orphans supported by the village government by type of support	Percent of orphans supported by type
Acquire enough land for cultivation	Family has enough land to cultivate food and cash crops	Number of households in need of food support Number of acres cultivated by type of crop Total income from selling food/cask crops	Proportion of arable land that is cultiv Per capita income Production of food and cash crops by
Plan family size and spacing	Family has children spaced not less than two years	Percent of childbearing women using modern family planning by methods	Current users of family planning by m Total population

Produce adequate food for the family	Family produces enough food to last for at least the whole year.	Percent of households with enough food to last the whole year	Number of villages that need food su amount of food required
Share household workload	Each member of HH has a part to play in HH work	----	----
Take child for vaccination	Children are fully vaccinated before attaining the age of one year	Percent of underfives vaccinated by antigen Number of children reported to have had measles in the past three months	Percent underfives vaccinated by anti Rate of immunicable diseases in the c

ADDITIONAL INDICATOR AT THE VILLAGE AND WARD LEVEL

OBJECTIVE/ACTIVITY/DECISION	DATA/INDICATOR
Develop village plan	A written village plan document before a specified date
Support CBH activities	Number of supervision visit Number of months VHWs was paid promptly Percent of fund planned for CBH activites that was actually spent on CBH activities
Register births and deaths	Number of deaths and births registered
Improved heath care delivery system	Percent of villagers using health facility in a year
Follow-up on immunisation dropouts	Proportion of dropout visited at home, Proportion of immunisation dropouts
Follow-up on malnourished children	Proportion of severely and moderately malnourished underfives Proportion of severely and malnourished underfives visited at home
Identify and support orphans	Number of orphans in the village by cause Number of orphans obtain assistance on school fees
Follow-up on households that have no latrines	Proportion of HH followedup for lack of latrines Proportion of HH built latrines this year Proportion of HH fined for lack of latrine
Promote use of condoms	Number of condom sold in the village
Take actions against non-compliant	Proportion of non-compliant people by action taken against them
Advocate CBHI	Number of advocacy meetings held Proportion of HH attending CBHI activities voluntarily
Promote income generating activities	Proportion of HH engage in one or more IGA
Facilitate resource mobilization	Percent contribution from the community /village government to the village annual budget
Provide health education to the communities	Number of health education sessions conducted during village assembles in a year
Pregnancy monitoring and risk identification	Proportion of pregnant women attending ANC/VHDs Percent of pregnant women found to be at risk Percent of referred at risk women who actually reported to the HF
Control harmful practices eg. FGM,	Enaction of village by-law against FGM Percent of FGM reported cases that were punished according the by-law
Access to quality health care	Proportion of population leaving within 5 kilometres from a health facility

ADDITIONAL INDICATORS AT DISTRICT LEVEL

OBJECTIVES/ACTIVITIES/DECISIONS	DATA/INDICATOR
Ensure community participation in planning and implementation of CBHI activities	Number of villages/wards that used participatory method in developing annual plans Percent of district budget contributed through community contributions Number of self help projects in the district in a year
Provide technical support in planning, implementation, monitoring and evaluation of CBHI	Number of advocacy meetings/workshops on CBHI plans conducted in a year Number of supervision visits conducted by CBHI core team Percent of reports received within the prescribe period
Train ward and village key actors	Number of ward/village leaders trained in a year
Attend district level meetings	Number of quarterly meetings held in time, Percent of attendance to quarterly meetings
Develop district health plan and master plan	A district health and master plans produced in time
Set by-laws to have a percent of levy retained at village level	A by-law enacted
Design and introduce drug kit to villages that are far from health facilities	Percent of village that are more than 5 kilometres from a health facility that have First Drug Kit.

Annex 7: Communication Tool Kit for CBHWs

Category	Objective	Suggested tools and Contents	methods/approach
1. Integrated Village Health Worker (VHW, CBDAs]	Assessment of community health problems and needs i.e. malaria, sanitation water, measles, diarrheas, HIV/AIDS, nutrition, family planning, etc. To educate clients on need for early treatment, referral systems, HIV/AIDS, etc.	Posters (Pictorial with relevant information) - What have you seen. - What is the main problem - Does it happen in your situation (if yes give examples) - Why does it happen. - What can be done about it, and by whom. - How can we measure and evaluate achievements. -CBDA kit with pictorial relevant information. - Descriptive information on different methods.	Participatory • Triple AAA cycle • PRA • Lepsa • Demonstration • Face to face • Brainstorming • Small focussed group discussion • Demonstration • Interpersonal • Life skills
2. TBAs	To educate pregnant mothers on safe delivery practices	TBAs Kit - Descriptive information on safe and unsafe delivery practice. - Pictorial information on reproductive physiological complications.	Participatory • Brainstorming • Small focused group discussion • Demonstration • Interpersonal
3. Traditiona l Healers	To educate clients on need for early treatment, referral systems, HIV/AIDS, etc.	-Face to face discussions -Health learning materials (Posters, leaflets, booklets)	Participatory • Interpersonal • Small group discussion • Demonstration

Annex 8: Community Based Health Initiatives: Communication Systems and Strategies

GUIDELINE FOR EFFECTIVE COUNSELLING

Effective Counselling includes three key characteristics:

1. Empathy – putting oneself in the other person's place.
2. Respect – for the feelings and attitudes of the other person.
3. Honesty – when dealing with concerns, questions and feelings of other person.

The goal of, for example, a family planning counseling is to enable clients to make a free and informed choice among the available FP methods.

In order to achieve effective communication the counselor should do the following:

1. Greet client in a friendly and helpful way. Build rapport.
2. Ask clients about themselves for example about their family planning needs, their reason for coming to the FP clinic, what do they already know.
3. Collect factual information as well as learn what the client feeling. Try to explore where the client is along the behavioural change continuum.
4. Allow the client to do most of the talking.
5. Encourage questions. Repeat what clients says to help reinforce comprehension by both counselor and client. Use non-threatening words.
6. Tell clients about available family planning methods or other health options, provide an overview of accurate information by using real examples or clear pictures of the methods.
7. Help clients to make an informed choice i.e. to decide which method best suits them.
8. Explain in detail how the chosen method or health option works, including the advantages and side effects and how to deal with the side effects.
9. Check to make sure clients completely understand your explanation.
10. Return visits should be planned – follow-up visits are important for checking that the method is being used correctly and that the client is satisfied.

Important non-verbal behaviours

1. Make the client feel comfortable by sitting so that your head is on the same level as the client.
2. Become sincerely interested in what the client has to say by:
3. Listening attentively
4. Establish eye contact with the client.
5. Make the client feel that you have time.

Annex 9: Guidelines for Conducting Focused Group Discussions

Group Interview

Definition

'Group Interviews bring together small numbers of people to discuss topics on the research agenda ..... The task of group interviewer – frequently called a "moderator" or "facilitator" – is not to conduct individual interviews simultaneously but to facilitate a comprehensive exchange of views in which all participants are able to "speak their minds" and respond to the ideas of others.

Preparation

The sample of people participating in a group interview is usually a purposive one (e.g. women, men, group of professionals, pupils).
The interviewers have to be trained, because they play the crucial part in the discussion. It is their role to stimulate the discussion, to listen what is being said, and to keep group dynamics under control. They should not act as a teacher or evaluator.
Depending on the openness of the discussion, either a structure has to be defined or only some key points.

Process

Usually between eight and 12 people attend a group interview which lasts on average one to one-and-a-half hours. In a village context it is often difficult to restrict the number and to exclude people willing to participate.

The discussion should be held in a place where every participant can feel comfortable. In a structured group interview the interviewer poses the questions in a given order and in the same way as they were formulated beforehand. In a more unstructured discussion the interviewer only gives incentives to stimulate the discussion and the discussion process evolves freely.
The researchers should work in a pair: one person conducts the interview while the other observes the discussion.

Recording and analysis

Discussion may be tape-recorded and portions of the tapes later transcribed. This procedure is not always possible, because, for example, the participants do not want to be recorded, or tape-recorders are not available. In these cases the interviewer should try to keep as much information in mind as possible and record it afterwards to avoid disrupting the discussion process and giving the participants the feeling of being examined. If it does not have an impact on the process of the interview itself, the observer may instead take notes during the discussion.

If the interviewer writes a protocol immediately after the discussion, s/he usually still has the important points of discussion in mind. If this protocol and the notes of the observer are put together, a fairly accurate written document of the interview can be obtained. Another way of recording can be to make a tape recording immediately after the interview. In this case, someone (perhaps the designer of the whole study) would ask the interviewer to repeat the course of the discussion and at the same time tape-record what is being said.

Analysing the data may be very difficult. The disadvantage of tape-recording procedure is that it takes a lot of time to analyse the tapes. Often it is more appropriate to take notes during or afterwards and liit the recording to main points. The information obtained should be analysed according to categories developed beforehand or after the discussion have taken place.

Strengths/weaknesses

Group interviews are often used in combination with other techniques to counter-check information. Group interviews have several advantages: they can give access to a large body of information (usually from the common sense of the population interviewed) in a relatively short period of time; they can be used for mutual checking; they can produce rapid information on changes; they can be used for sensitive types of information on changes; they can be used for sensitive types of information (whereas people a feeling of security); and they have a built-in self-correcting mechanism, because if one person puts across too favourable a picture of a situation, another group participant can give a more realistic view.

On the other hand, results can be seriously misleading if the interviewer is believed by the group to have the power to make decisions or introduce sanctions, or when strong hierarchical structures within the group of participants exist. If the interviewer is not trained to control group dynamics, the discussion process can easily get out a hand, leaving the interviewer in an unsolvable situation: for example, group processes can lead to aggression between group members, which can result in a serious conflict.

There are also difficulties in recording and analysis because of the huge amount of data that may be obtained.

Annex 9 b: Focus-group interview

Definition

A focus-group interview is a special type of group-interview in which a small group discusses a subject freely and spontaneously, guided by a facilitator who has a theme ('the focus') in mind considered important for the investigation. This focus is not revealed to the participants.

Focus-group interviews are especially helpful for gaining insight into people's perceptions, attitudes, opinions, behaviour and experiences. They can also help to assess the acceptance of concepts, the acceptance of messages, how information is being passed on and where incentives or resistances lie.

They stimulate 'discussion among respondents. Responses are not forced out of each group member, as they usually are in individual survey questionnaires; rather they are spontaneous, and uninhibited. In African villages, where the "palaver" "Baraza" is a community activity, focus-group interviews are a viable method of data collection.

Preparation

- preparation of discussion guidelines
- training of the facilitator
- information of authorities concerned
- invitation of the participants (one week to one day before)
- preparation of the place of the interview.

The discussion guidelines should be very short; five to ten questions are sufficient and these should include questions that lead to the focus of the investigation. This does not mean that the questions are to be put in a pre-established order. Flexibility is more important than following the logic of the guidelines. The number of questions should be limited so that ideally the facilitator can keep them in mind, without referring to a paper.

Composition of the groups

- 6 to10 participants of the same sex and similar age
- participants of similar social and family background

- participation is absolutely voluntary
- the interview is held in a neutral place (in respect of the subject discussed)
- the facilitator is neutral
- an observer takes notes on the discussion process.

The selection of participants should be made at random. Using pre-existing groups (women's group, group of traders, youth groups, members of a parents' association, etc.) can be difficult because hierarchical structures may exist which are undetected by the facilitator and hinder free exchange.

Process

As a first step, the facilitator introduces himself and explains briefly in general terms the purpose and rules of the meeting (without naming the focus). Then all participants introduce themselves. To start the discussion, everybody expresses his view on a general question in order to make the participants relax and become used to speaking in front of a group and to show them that every person's contribution is important. It also gives the facilitator a first impression of the group.

Afterwards, the facilitator should try to guide the group to the focus so that all the attitudes, beliefs, and feelings related to the subject emerge.
In the end, the facilitator gives a short summary and encourages the participants to correct him or her, if s/he did not get the ideas right. This allows the facilitator to rest any conclusions and it gives the participants an overview of what has happened.

Recording and analysis

- tape recorder
- discussion protocol
- protocol of the observer

A tape-recorded protocol of the discussion is probably the most valuable source for analysis. On the other hand, it needs a lot of time for transcription afterwards. Especially when the language of the interview is not understood by the research team, or when time is scarce, another method proved its value for rapid appraisals. Directly after the group discussion and his/her impressions on the group dynamics and the emotions shown. This 'summary' is tape-recorded and serves as a 'discussion protocol'. The observer pays attention to what is said, how it is said, and how the participants react to certain statements s/he should note down especially those points that created agreement, disagreement and emotional involvement. If the end of the discussion.

Shortly after the group-discussion the facilitator, the observer and the members of the research team meet to discuss their impressions and conclusions.

Analysis of discussion protocols by computer has been tried by Willms, who codified units of the text and then counted them and their combinations.

Strengths/weaknesses

- Unforeseen ideas may arise
- the thinking pattern of group members is expressed.
- dynamics within the group develop and show points of specian interest, points of strong emotional involvement.
- contradictory opinions and feelings may be articulated.
- analysis of data demands time and an appropriate framework
- how the interview is conducted strongly influences the result.
- only people willing to verbalize their opinion participate
- not representative and only partially quantifiable (semi-quantitative method)

Annex 10: Summary of Possible Interventions at the Community Level

Health condition	**Community Level**
NUTRITIONAL DISORDERS	♦ Information and education to women, families, pupils and communities on nutrition ♦ Recognition of nutrition faltering and action ♦ Breast feeding support groups ♦ Growth monitoring and promotion including pupil health screening ♦ Micro-nutrient supplement (Iron and Vitamin A supplements) ♦ Monitoring of salt iodination ♦ Appropriate feeding during and after illness ♦ De-worming ♦ School feeding
ARI	♦ Information and Education to families and communities on early recognition of diseases & danger signs ♦ Home care ♦ Early care seeking
DIARHOEA	♦ Information and Education ♦ Prevention (PHAST) ♦ Home based care – food, fluids including ORS, breast feeding ♦ Early care seeking
PERINATAL	♦ Information and Education to women families and communities about: ♦ The needs of pregnant women including maternal nutrition ♦ Danger signs and appropriate action including transportation for emergencies ♦ Birth preparedness, including local transport for emergencies ♦ Early care seeking for pregnant women and neonates ♦ Attending antenatal clinics ♦ Safe delivery of the Neonates ♦ Maternal nutrition ♦ Malaria control in pregnancy ♦ Early identification of problems and referral
IMMUNIZABLE DISEASES	♦ Information and Education to women, families and communities about importance of immunizing against six killer diseases (diphtheria, pertussis, tetanus, measles, polio and tuberculosis) ♦ Reporting of disease to Health Authorities (measles, neonatal tetanus, AFP/Cases) ♦ Community participation in Immunisation activities ♦ Advocacy for immunisation of pupils to parents, teachers and communities ♦ Information and education to women, families and communities about the importance of Hepatitis B infection and need to vaccinate.

MALARIA	♦ Health education and information ♦ Use of insecticide treated nets (ITNs) ♦ Home based care ♦ School Health Education on malaria prevention ♦ Sustainable source reduction ♦ Use of chemoprophylaxis to pregnant women ♦ Early recognition of malaria including danger signs: ♦ Use of oral anti-malarias ♦ Treated insecticide bed nets ♦ Early care seeking
ANAEMIA	♦ Information and education to women, families, schools and communities on different maternal condition and action to take ♦ Identification and referral of risk pregnancies ♦ Promote use of insecticide treated nets, prophylaxis and adherence to treatment ♦ Provision of multiple micronutrients accordingly (Vitamin A, iodine, iron and folic acid) ♦ **Uncomplicated deliveries**
STI/HIV/AIDS	♦ Provide counseling ♦ Information, education and communication/behaviour change communication ♦ Support for home based care ♦ IEC/BCC ♦ Support for home care ♦ 5Cs
MATERNAL HEALTH	♦ Information and education to women, families, schools and communities on different maternal condition and action to take ♦ Identification and referral of risk pregnancies ♦ Promote use of insecticide treated nets, prophylaxis and adherence to treatment ♦ Provision of multiple micronutrients accordingly (Vitamin A, iodine, iron and folic acid) ♦ **Uncomplicated deliveries**
OBSTETRIC EMERGENCIES	♦ Recognise problems/complications at early stage and seek appropriate care ♦ Perform obstetric first aid and provide safe transport
UNWANTED /ADOLESCENT PREGNANCIES	♦ Advocacy on: ♦ FGM and adolescent RH ♦ Provision of family planning methods (pills, condoms, foam tablets) and refer for long term and permanent methods (injectables, intrauterine devices, tubal ligation)

SANITATION AND HYGIENE	♦ Construction and protection of water sources ♦ Construction and maintenance of improved latrines ♦ Construction and maintenance of refuse disposal systems ♦ Construction and maintenance of waste water systems ♦ Participatory hygiene and sanitation transformation (PHAST)
IMPROVED HOUSING	♦ Construction and maintenance of improved houses for households ♦ Use of fuel-efficient stoves ♦ Cleaning of living compounds
PROMOTION OF HEALTHY LIVING/ BEHAVIOUR	♦ Peer group education on STD and eating styles/habits ♦ Organisation of sporting activities
APPROPRIATE AGRICULTURAL PRACTICES	♦ Apply appropriate farming practices
LEGISLATION AND REGULATION	♦ Review and enforce local by-laws and regulations
INCREASE PUBLIC INVESTMENT FOR HEALTH	♦ Establish community funds for health
SCHOOL HEALTH PROMOTION	♦ Advocate for school health education, health screening, immunisation and counselling of pupils ♦ Support school feeding programmes ♦ Promote water supply, latrines and sanitary facilities in schools ♦ Promote recreation, gardening and safety in schools
SECURITY AND VIOLENCE PREVENTION	♦ Advocate for security reinforcement ♦ Establish local security systems ♦ Promote household peace building, report domestic violence

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Strategic actions:

The service delivery package issues would best be resolved at the Community level within the participatory planning process where problems are identified and how they can be solved within the resources available. The CBHI coordinator can facilitate a process to negotiate best interventions for each Village situation during the planning process. However the team considers the provision of First Aid kits for villages that are far from a facility, to be important. However the contents of such a kit would need to be decided by the DHMT in consultation with the Villagers.

In general the service delivery package at the household and village levels should focus on preventive and simple curative/referral elements of:

- **Reproductive and child health care including HIV/AIDS, Nutrition, and IMCI**
- **Control of communicable diseases particularly malaria, Vaccine Preventable Diseases (VPDs), Diarrhoeal Diseases**
- **Health promotion, water and sanitation.**

6. Community Based Communication Strategy

Key findings:

Among the more effective behaviour change strategies seen in the districts were participatory interactive methods carried out by inter-sectoral animation teams at various levels. In addition there were popular theatre and other traditional approaches like use of drum and gong (*kijembe* and *kengele*) method. The Community Based Health Workers (CBHWs) were involved extensively with health education as well as counseling during home visits, clinics, general meetings and Village Health Days. The use of print or electronic media was limited.

The team underscored the need for a coherent communication strategy for CBHI which is embedded into the CBHI planning and management initiatives, built into the Community Based planned training and educational activities. The strategy should focus on behavior change at the household level but supported by advocacy and social mobilization. The strategy should maximize the use of traditional and multi-sectoral channels as opportunities to affect behaviour change. It will also need to build on the bottom-up process of clarifying communication content, audiences, channels, and material support needs. Of special consideration would be youth directed communication mechanisms that aim at behaviour change rather than only providing information and acquisition of knowledge.

7. Co-ordination of Efforts and Building of Linkages for CBHI

Key findings:

The reformed local government structures provide adequate organizational mechanisms for vertical as well as horizontal co-ordination and linkages necessary for effective implementation of the community based health initiative. In some districts, there are monthly partners meant to bring in the NGOs and donors. These meetings are voluntary and not formal. Lack of donor and NGO co-ordination remained a major concern at all levels.

Strategic actions:

Use the District Master Plan developed through the participatory bottom up process, involving all stake-holders (including NGOs and Donors), as the main tool for coordination and linkage, based on the reformed local government framework. This could be reinforced by joint awareness workshops, common training of animators, and common tools and guidelines, used by all stakeholders. Such guidelines should clarify roles, responsibilities and mechanisms for joint supervisory support to the community based health initiatives in the new context. The mechanism would require focal point staff persons at District, Ward and Village levels from each of the sectors involved. These focal staff persons could form a task force at each level, to ensure adequate support to the community based workers, using a common supervisory tool. Additional by-laws may be enacted to ensure compliance.

ABBREVIATIONS

AAA -	- Assessment Analysis and Action
AIDS	- Acquired ImmunoDeficiency Syndrome
ARI	- Acute Respiratory Infection
AMMP	- Adult Morbidity and Mortality Project
ANC	- Anti Natal Care
BA	- Birth Attendant
BCG	- Bacillus Culmate Guerin
BBE	- Benzyl Benzoate Emulsion
CBDAs	- Community Based Distribution Agents
CBOs	- Community Based Organisations
CBWs	- Community Based Workers
CBHC	- Community Based Health Care
CBH Communication	- Community Based Health Communication
CBHI	- Community Based Health Initiatives
CBHWs	- Community Based Health Workers
CDO	- Community Development Officer
CHF	- Community Health Fund
CORPS	- Community Own Resource Persons
CSPD	-Child Survival Protection and Development
DAS	- District Administrative Secretary
DALDO	- District Agricultural & Livestock Development Officer
DEO	- District Education Officer
DCDO	- District Community Development Officer
DED	- District Executive Director
DHMT	- District Health Management Team
DHB	- District Health Board
DMO	- District Medical Officer
DMT	- District Management Team
DPT	- Diphtheria Pertusis and Tetanus
DPLO	- District Planning Officer
EMAU	-Elimu ya Malezi ya Ujana
GV	- Gentian Violet
HF i/c	- Health Facility In-charge
HH	- House Hold
HFW	- Health Facility Worker
HF	- Health Facility
HIV	- Human ImmunoDeficiency Virus
IEC	- Information Education Communication
IGA	-Income Generating Activities
IMR	- Infant Mortality Rate
ITNs	- Insecticide Treated Nets
KABP	-Knowledge Attitude Behavior and Practice
KAP	-Knowledge Attitude and Practice
KINET	-Kilombero Net Project

LePSA	-Learner Centred Problem Posing Self Discovery and Action Oriented
MoH	- Ministry of Health
MRALG	- Ministry of Regional Administration and Local Government
NGOs	- Non-Governmental Organisations
O & OD	- Opportunities and Obstacles to Development
ORS	- Oral Rehydration Salt
PAR	-Participatory Action Research
PHC	- Primary Health Care
PRA	- Participatory Rural Appraisal
PTA	-Parent Teachers Association
PS	- Permanent Secretary
RCC	- Regional Consultative Committee
RMO	- Regional Medical Officer
RAS	- Regional Administrative Secretary
SHOWeD	-Showed Questions
STDs	- Sexually Transmitted Disease
STI	- Sexually Transmitted Infections
TBA	- Traditional Birth Attendants
TCL	- Tetracycline
TEHIP	- Tanzania Essential Health Intervention Project
TFR	-Total Fertility Rate
THs	- Traditional Healers
TOCs	- Trainers of Communities
TOTs	- Trainers of Trainers
TV	- Television
UNICEF	- United Nationals Children's Fund
VEO	- Village Executive Officer
VHD	- Village Health Day
VHWs	- Village Health Workers
WEO	- Ward Executive Officer
WEC	- Ward Education Coordinator
WDC	- Ward Development Committee

OUTLINE OF FRAMEWORK

1. BACKGROUND TO COMMUNITY BASED HEALTH INITIATIVE IN TANZANIA

1.1 Community Based Health Initiatives in Tanzania: the History and Concept

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 was an important component of the Health Policy adopted after independence. The health facility 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. Arusha declaration in 1967 strengthened the commitment, making health care to be free for all, emphasising self-reliance and self-determination. However, todate, 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 of services and accessibility.

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 caries 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.

This framework is 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 grass roots, integrated approach to care and service provision, building 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, Health Sector Reform (HSR) can only be successful if CBHI is an essential part of it.

The framework is 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 integratedness 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.

1.2 The local government reform; an opportunity for CBHI development

From June 1996, the government of Tanzania embarked on a local government reform. 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 local government reform 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, sector Ministries will change their role and functions into becoming policy-making, supportive and capacity building, monitoring, regulatory and quality assurance bodies. Regulatory role will, among other things, include legal control and audit. All the documents, including planning/budgeting guidelines related to the local government reform emphasise on the need and importance of true participatory planning. It will be noticed from above that the local government reform is a powerful vehicle for participatory planning as will be evident in the subsequent sections and chapters.

1.3 Summary of the findings and recommendations of the review for strategic action

The Review Team concluded that Community Based Health Initiatives adopted and implemented over a long period of time were associated with a series of indicators of

7. Co-ordination of Efforts and Building of Linkages for CBHI

Key findings:

The reformed local government structures provide adequate organizational mechanisms for vertical as well as horizontal co-ordination and linkages necessary for effective implementation of the community based health initiative. In some districts, there are monthly partners meant to bring in the NGOs and donors. These meetings are voluntary and not formal. Lack of donor and NGO co-ordination remained a major concern at all levels.

Strategic actions:

Use the District Master Plan developed through the participatory bottom up process, involving all stake-holders (including NGOs and Donors), as the main tool for coordination and linkage, based on the reformed local government framework. This could be reinforced by joint awareness workshops, common training of animators, and common tools and guidelines, used by all stakeholders. Such guidelines should clarify roles, responsibilities and mechanisms for joint supervisory support to the community based health initiatives in the new context. The mechanism would require focal point staff persons at District, Ward and Village levels from each of the sectors involved. These focal staff persons could form a task force at each level, to ensure adequate support to the community based workers, using a common supervisory tool. Additional by-laws may be enacted to ensure compliance.