Mid Term Review of the Health Sector Strategic Plan IV 2015 -2020

Thematic Report
COMMUNITY SYSTEM
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Thematic Report
COMMUNITY SYSTEM
Mutalemwa Prince Pius
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<tr>
<td>AGYW</td>
<td>Adolescent Girls and Young Women</td>
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<td>BCC</td>
<td>Behaviour Change Communication</td>
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<td>BeMONC</td>
<td>Basic Emergency Obstetric and New-born Care</td>
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<td>Community Based Health Care Program</td>
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<td>Comprehensive Council Health Plan</td>
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<td>CeMNOC</td>
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<td>The Second Five Year Development Plan</td>
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<td>Home Based Care</td>
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<td>HDT</td>
<td>Health Promotion Tanzania</td>
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<td>HFGCs</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>Health Sector Strategic Plan</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>IYCF</td>
<td>Infant Young Child Feeding</td>
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<td>LTFU</td>
<td>Lost-To-Follow-Up</td>
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<td>Most at Risk Populations</td>
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<td>Mass Drug Administration</td>
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<td>MoHCDGEC</td>
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<td>MTR</td>
<td>Mid-Term Review</td>
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<td>NCDs</td>
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<td>NTD</td>
<td>Neglected Tropical Disease Control Program</td>
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<td>PHSDP</td>
<td>Primary Health Services Development Programme</td>
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<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
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<td>PoLAG</td>
<td>President’s Office – Regional Administration and Local Government</td>
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<td>Abbreviation</td>
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<td>REC</td>
<td>Reaching Every Child</td>
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<td>RHMTs</td>
<td>Regional Health Management Teams</td>
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<td>RMNCAH</td>
<td>Reproductive, Maternal, New-born, Child and Adolescent Health</td>
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<td>Standard Operating Procedures</td>
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<td>Strength, Weakness, Opportunities and Challenges</td>
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<td>TANACDA</td>
<td>Tanzania Non-Communicable Disease Alliance</td>
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<td>Tuberculosis</td>
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<td>TCCP</td>
<td>Tanzania Capacity and Communication Project</td>
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<td>Tanzania Communication and Development Centre</td>
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<td>Tanzania Police Female Network</td>
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<td>Timed and Targeted Counseling</td>
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<td>Voluntary Counseling and Testing</td>
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<td>Village Health Committees</td>
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<td>Water, Sanitation and Hygiene</td>
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<td>WDC</td>
<td>Ward Health Committees</td>
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<td>WHO</td>
<td>World Health Organization</td>
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1 Introduction
This is an assessment of community health and implementation update citing the existing community interventions and experiences on the health service deliveries. It is both review of health service delivery documents and extract of community health systems related issues from reports of eight visited regions. The report focuses on three key areas of Community Health, Health Promotion and Non-Communicable Diseases (NCDs). These areas were itemised on the following strategic directions itemised below and further to specific issues.

1. Community Health.
   **Strategic Direction:** Revitalising Community Based Health Care, increasingly supported by professional Community Health Workers, will ensure that essential health promotion, health protection and prevention activities are addressed in partnership with communities and with a high rate of return on investments. The Community-based health programme aims to reduce the pressure on facility-based care through enhancing healthy living at households, in schools, work places and other levels.

2. Health Promotion
   **Strategic Direction:** Invest in health promotion interventions that give emphasis to multi-sectoral approaches in addressing the preventable causes of disease, disability and premature deaths in all population groups throughout the course of life.

3. Non-Communicable Diseases
   **Strategic Direction:** The country will focus on community-based prevention, health promotion, screening and early treatment as well as rehabilitation. Activities will be integrated in health services and not as new vertical programme.

Purpose
The purpose was to back up the MTR core team on the status of community health services delivery in the country. The focus was on the extent to which the essential health services were being delivered to be accessed by the populations targeted. This looked into the realization of community health services in relation to the sector’s policies and programs. The present assignment used the following techniques in attempt to acquire the reported information:

1. The desk review involved obtaining documents related to health services, (published articles, surveys, research, plans, guideline and policy and other written reports) from various sources. A careful collection and review of these documents provided overall introductory insights, facts, policies and systems on community health services in Tanzania

2. There were group discussions with members of Regional Health Management Teams, Council Health Management Teams, Health Facility Governing Committees and Regional Referral Hospital Management Reviewing, analysing and synthesising existing data sources addressing key areas on community health.
2 Strategic Directions and Specific Issues

2.1 Strategic Direction 1: Community health

Community health refers to the health status of a defined group of people, or community, and the actions and conditions that protect and improve the health of the community. Those individuals who make up a community live in a somewhat same area under the same general regulations, norms, values, and organizations. The actions and conditions that protect and improve community or population health can be organized into three areas: health promotion, health protection, and health services. The Government of Tanzanian intended to develop a cadre of Community Health Workers (CHWs) that are well-trained and equipped to address basic health needs at the community level for improved community health in terms of prevention, care and treatment. The engagement of government was important in order to develop a harmonized curriculum and a nationally recognized, accredited program for this cadre.

In a move to establish the evidence MUHAS examined CHW training programs and their curricula, determined areas of commonalities and distinctive differences among the different curricula with a view to identify categories tied to CHW cadres for subsequent validation under the National Council for Technical Education (NACTE). It also developed a policy advocacy strategy and plan for accreditation of CHW training within the broader context of Health Systems Strengthening efforts in Tanzania.

In this report MUHAS concluded that the role of CHWs can be optimized to serve as a valuable addition to human resources for health, helping to achieve universal coverage and that the current national human resource gap estimated at 65%, with a large percentage of this gap existing at the dispensary and village level in rural areas, “task shifting” of primary care functions from professional health workers to community health workers is considered to be a means to improving the health of millions quickly and at reasonable cost.

In line with the above, the MoHCDGEC developed the The Community-Based Health Programme Implementation Design (CBHP-ID) building on builds on the National CBHP Policy Guidelines (2014) and the National Costed Community-Based Health Programme Strategic Plan 2015–2020. The programme design also includes actions for formalization and integration of

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4 Community Health Workers’ Training and Deployment in Tanzania: A review of PEPFAR funded programs (Killewo J et al 2012)
the new CHW cadre into the national health system. This was meant to guide operationalization in Tanzania so that it is functional and sustainable in improving community health and social welfare.

The CBHP service package (page 11) consists of activities derived from the National Essential Health Package (NEHP) organized according to four public health needs: health promotion services, preventive services, curative services and rehabilitative services. These activities constitute a minimum service package, responsive to the common health problems at the community level, facilitated by the CHW in close coordination with other service providers. They cover the major NEHP service categories, such as reproductive, maternal, neonatal, child and adolescent health (RMNCAH); HIV and AIDS malaria; TB and leprosy; and neglected tropical diseases (NTDs). Social welfare elements cut across most CBHP services, while monitoring and data management support quality provision of services listed.

The National Community Based Health Care Strategic Plan (NCBHCHP 2014-2020) calls for strengthening community involvement and participation to improve health. It is anticipated that this strategy will contribute to a more coordinated implementation and improved community health services when communities are empowered and hence capable of sustaining their own health. This has to consider the already established reality that communities rarely contribute meaningfully to the planning and conduct of CBHC activities in their environs, which in turn undermines the sense of community ownership and initiative behind them (National Costed Community Based Health Program Strategic Plan 2015 – 2020. Furthermore, it will facilitate concrete and effective community actions in setting priorities, making decisions, planning, implementing, monitoring and evaluating strategies and interventions with the objective of attaining better health.

Community Health Workers and specific challenges

According to the World Health Organization, CHWs health workers are needed to compliment healthcare services provided by health facilities. However, there are challenges associated with CHWs: inadequate incentives; poor motivation; drop outs and lack of scheme of services for this cadre (WHO 2006). CHWs are needed because facilities are often far away, people are reluctant to use them, or they are over-crowded. CHWs have a broad range of work environments and expectations. Some CHWs have only a few days of training, while others have six months or even more of training. Some CHW cadres are paid, others work as volunteers. Some have a wide array of tasks and responsibilities, and others have a narrowly defined scope of work. Some have close interaction with health staff based in facilities and others operate far away and function in a very independent manner.

2.1.1 Community health management

Through Decentralization by Devolution (D by D) Policy, community members are envisioned to exercise their democracy through a bottom-up approach. Lower level government consists of two major organs of governance at the village level, village assembly and Village Council. The
Ward Development Committee (WDC) is responsible for coordinating development activities and planning at the Ward level and linking with the district level.

According to the National Community-Based Health Programme Design (2017-22), the Village Health Committees are the first step towards community orientation of health care services and for making health a people’s movement. Community health services are to be owned and controlled through a local mechanism that allows a community to influence the operation or use of services and to enjoy the resulting benefits.

In a move to empower local communities on health issues, three organs are in place, namely Health Facility Governing Committees, Ward Health Committees and Village Health Committees. However, there are overlapping roles of these bodies and also obstacles to meeting the people they serve. For instance, HFGCs, WHCs and VHCs do not have direct relationship with members of the communities and are unable to call meetings to discuss health issues. Such meetings have to be convened by Ward and Village leaders if “Health” as one of the Agenda has to be discussed.

Other issues that limit the fluent performance are:

- Absence of meeting and transport allowances and other kind of motivations (for VHCs/WHCs) means that the Committee members’ willingness to spare their time to attend the meeting and/or do some duties assigned is automatically or impliedly lowered.
- Members of such specific committees do not have any training on their roles and responsibilities and also expected relationships with other committees, including suggestions on how to engage in a collaborative action.

2.1.2 Community based interventions

Tuberculosis care and treatment

TB care and treatment had previously faced challenges that are all based in the communities, these have included delays by patients in seeking care when TB symptoms appear, passive participation of the community in TB care and control, stigma associated with TB and HIV and poor adherence to anti-TB regimens, leading to an increased threat of TB drug-resistant. In attempting to address this problem the National Tuberculosis and Leprosy Control Programme


(NTLP) introduced a community TB care approach to involve communities and former TB patients across the country to improve early TB care-seeking and treatment adherence, increase community awareness around TB symptoms and signs, and mitigate TB stigma. Community TB care has included activities that promote effective communication, community empowerment, and participation where communities are empowerment to take appropriate actions to address community TB burden, reduced congestion in health care facilities, thus reducing the workload of facility-based health care workers and raising the quality of interactions between health care workers and patients.

**Involvement of CHWs on HIV and TB services**

CHWs perform multiple functions and interventions, including referring community members for HIV testing, linking them to care, accompanying them to clinic appointments, providing psychosocial support and making referrals to other services. At the community level CHVs follow up of patients needing continuum of care, advocacy and participation in public education, nutrition promotion and counselling. The evidence indicates that a well-implemented community health workforce can improve health seeking behaviors and provide low-cost interventions for common maternal and child health issues, while enabling improvements in the continuum of care. Immediate data indicate that TB case detection rates in 2018 were well below target (50%). TB notification rates declined until 2015 but increased since from 128 to 140 (Analytical report). This is not necessarily due to an increase in TB cases but could be due to improvements in case detection and this may probably be due to the engagement of CHW and their linkages to the suspected TB cases in their respective communities.

**Involvement of CHWs and CDDs in drug administration**

Mass Drug Administration (MDA) is a public health intervention that is implemented by the through CHWs and CDDs who are from the very respective communities. The NTD Master Strategic Plan (2007-2017), highlights the that success of MDA was due to the engagement of communities, empowering communities, engaging implementers and broader system effects. Community and health systems changes were triggered, such that the inherent value of community involvement and empowerment could be internalized by communities and health workers, leading to a more receptive health system. CHWs and CDDs conduct census for entire population of their areas, determine the population eligible for treatment and number of drugs required. CHWs are responsible for implementing the MDA, compiling registers and submitting them to the front line health facilities within their catchment areas hence relieving frontline health facility workers the resultant burden.

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7 https://ntlp.go.tz/other-activities/community-tb-care/

8 One Million Community Health Workers Technical Task Force Report; (2011) The Earth Institute, Columbia University

9 Strategic Master Plan for the Neglected Tropical Disease Program (2012-2017)
In the Ivermectin distribution for the treatment of onchocerciasis for instance, Community and health systems changes were triggered, such that the inherent value of community involvement and empowerment could be internalized by communities and health workers. This led to a more receptive health system as CHWs at community levels were readily available and supportive of the process. CHWs were also available to simple malaria interventions such as distribution of ITN in the households, educating users on the importance of ITNs, limiting alternative use of the ITNs given that the Insecticide-treated nets are a critical preventive intervention for malaria control.

The Analytical report also indicated positive increase of the coverage for NTD control. For instance; the prevalence of trachoma has declined markedly from 2014 to 2018. Furthermore, number of trachoma endemic districts has declined from 60 in 2013 to 8 districts in 2018. Trachoma mass drug administration (MDA) coverage declined from 2013 to 2016. However, since 2017 the coverage has significantly improved to above 80%.

- The number of lymphatic filariasis endemic districts has declined from 119 districts in 2013 to 24 districts in 2018. Since 2013 the lymphatic filariasis coverage has been above the threshold (range was 70% to 84%).
- Onchocerciasis MDA coverage has improved over the years to 100% in 2018.
- Schistosomiasis MDA using Praziquantel is applied in all 185 councils and has steadily increased from 2013 to 2018.
- Soil transmitted helminthiases MDA coverage using Albendazole in during 2014-2018 has remained higher than 74%.

Although that may not be attributed the work done by CDDs and CHWs, but their efficiency in the NTD control is ahistorical and also acknowledged.

WASH Program at the Community level

According to the World Health Organization, the primary impact of WASH promotion is on health, and of all health impact. The most significant is probably the prevention of communicable diseases such as diarrhoea among community members. Experience has shown that sustained improvement in access to sanitation and sustained changes in hygienic behaviours requires an appropriate enabling environment and multi-sectoral approach that involve stakeholders from policy, financial management sectors both at the community and national levels.

In other sources it has emerged that communities are more sensitized to mobilize resources to address WASH problems at schools than at health facilities. One way to improve and sustain


11 ANALYTICAL REPORT TO INFORM THE TANZANIA HEALTH SECTOR STRATEGIC PLAN

WASH interventions at health facilities is to mobilize communities to contribute in the construction and maintenance of WASH infrastructure in health facilities so as to build community ownership of such facilities. Community Owned Water Supply Organizations (COWSOS) were identified as important grassroots initiative organizations to mobilize resources and maintain WASH infrastructure at the health facilities.

One of the best practice of RHMTs is to oversee all CHMTs on the implementation of ongoing National Sanitation Campaign in order to increase coverage of household with improved latrine as well as the general inspection and follow-up of construction and use of improved latrine by each household in every community. The target for 2020 was that 70% of the population should live in households with access to improved drinking water sources. According to the household surveys, the proportion of population (based on the number of people in each type of household) using improved drinking water sources increased from 51% in the TDHS 2010, and 56% in census 2012 to 59% in TDHS 2015/16 and 60% in the TMIS\(^{13}\). The increase is gradual, and too slow to reach the HSSP IV target for 2020.

The urban rural differences remained large: in 2015/16 87% of urban and 49.0% of rural population had access to improved drinking water. Furthermore, the increase in the rural areas from 2010 to 2015/16 was smaller than for the urban areas, widening the gap. Use of improved non-shared toilet facilities has increased from 13% in 2010 to 20% in 2015/16 and further to 24% in TMIS 2017. This was still short of the HSSP IV target for 2020 (30%). There were significant disparities in water and sanitation between rural and urban populations. Only 16% of the rural population has access to improved toilet facilities (not shared), compared to 42% of the urban population in TMIS 2017. The increase in the rural areas since 2011/12 is strong with a doubling of the population with access to improved sanitary facilities.

In some areas, local and international efforts based in the communities have been observed. Health facilities provide community initiated health education regarding water and sanitation which is done in community level meetings. This is because use of toilet facilities especially in rural areas is extremely low and CHWs may play a significant role in raising it.

**RMNCAH services at the community level**

The National Communication Strategy for Maternal, New-born and Child Health provides a framework that guides the development and implementation of a variety of communication interventions that will contribute towards accelerated reduction of maternal, New-born and child deaths. *The document admits that community involvement and participation is vital, as it contribute in improving MNCH through ensuring that, the family members are well informed about all issues of MNCH.* Other critical challenges in reducing maternal, newborn and child morbidity and mortality comprise two categories non health system factors-inadequate community involvement and participation in planning, implementation, monitoring

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\(^{13}\) ANALYTICAL REPORT TO INFORM THE TANZANIA HEALTH SECTOR STRATEGIC PLAN 2015/2016 – 2019/2020 (HSSP IV) (Draft August 2019)
and evaluation of health services, some social cultural beliefs and practices, gender inequality, weak educational sector and poor health seeking behavior.
Many community members had limited knowledge of child nutrition, feeding frequency, growth monitoring, and supplements thus resulting to higher levels of stunting, moderate and severe nutrition.

**Illustration of community action on RMNCAH**

Uturo village in Mbarali district, Mbeya region has been leading a community initiative for increasing utilization of maternal and childhood services. The initiative has achieved impressive results in terms of increasing utilization of MNCH services and ultimately reducing neonatal and maternal mortality to zero in the district. The community led action was initiated by the head of the Uturo village dispensary with the main intervention elements of; house to house registration (of pregnant/lactating mothers, neonates and under five children), establishing a women mobilizing group called ‘Commando’ and sensitizing village leadership. This has been ongoing for years and for that particular community, maternal death is “a taboo”. Uturo experience shows the power of community empowerment and strengthened systems for expansion of access to essential health services at the community level driven and managed by the community itself. The lesson to learn is that the power of the community is key to dealing with maternal mortality.

According to the UNICEF Annual Report 2016, Tanzania, UNICEF has been supporting Reproductive Maternal and New-born Child Health (RMNCH) community model in 10 villages in Mbarali. Key implementers of this model are Community Health Workers (CHWs) under supervision of health facility staff. The CHWs operate at household and community levels using designated counselling cards. The CHWs compile monthly and quarterly reports and submit to respective health facilities. The remarkable achievement of Uturo village has drawn an attention from the Government, UNICEF and different donors.

**Community level nutrition services**

Malnutrition is becoming the health problem contributing to NCDs and also reducing working capacity. There is inadequate implementation of guidelines at the community levels of maternal, infant and young child feeding, management of acute malnutrition, control of micronutrient deficiencies, health eating and lifestyle issues. Community members have low levels of awareness on nutrition matters and general health food intakes. There is a National Multisectoral Nutrition Action Plan (NMNAP) that reflects Tanzania’s commitment to addressing the unacceptably high levels of malnutrition and translates into a single comprehensive national plan the nutrition relevant national, regional and international.

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14 URT; National Nutrition Survey (2014)
commitments that Tanzania has made. There is an overreaching multi-sectoral approach strategies some of these focus on Community-centres capacity development (CCCD). The aim is to improve human, institutional, organizational and functional capacity for nutrition to ensure efficient and effective Multisectoral and multi-stakeholder collaboration focusing at the community level.

As per NMNAP, Chronic malnutrition is attributed to a combination of factors, including maternal malnutrition, inadequate infant feeding practices, low quality of health care, and poor hygiene. Thus effectively addressing the challenge of malnutrition may help interrupt the vicious cycle of malnutrition-disease-poverty-inequality now and future generations if a At Ward level however, nutrition interventions are still viewed as belonging to health and there is less assimilation as Multisectoral. This should not be surprising as stunting awareness has been observed to be less at sub-districts (Wards and Villages) compared to higher levels.

Field visits revealed the NMNAP was being addressed in terms of putting in place Regional Action Plans consequently followed by District plans, all of which are Multisectoral, but a critical gap is noticeable at Ward level. It was encouraging to observe in a district that stunting intervention campaign in villages in collaboration with CONSENUT was going on with male involvement to balance labour distribution per day, a measure which was bound to free mother’s time for child feeding; first 1000 days’ focus includes engagement of men.

There is an evidence of the increasing burden of non-communicable diseases, an inevitable trend as the battle against infectious diseases is successful and risk factors for NCDs are on the rise, but this will require further data and analysis in preparation of the HSSP V. For almost all indicators there are persistent inequalities between urban and rural populations, the poorest and richest households and between regions, and there is only limited evidence of reductions. Appropriate targeting of councils and regions, as well as the poorest populations, based on reliable data is needed to reduce inequalities and make major progress towards universal health care.

Among the key findings of the report are as follows:

- Overall, NBS estimates that there are about 350,000- 400,000 deaths in 2018. Therefore, the hospital deaths cover only 10% of all deaths, and 90% of deaths occur in the community. The hospital data provide an incomplete picture, as the majority of deaths occur in the community and no cause of death is registered.
- The percent of women with community-based health insurance increased from 2.1% to 4.4% and for men from 2.7% to 4.6%. The HSSP target of 80% coverage with community-based health insurance was by far not met. The same data is also available from the HP+ Policy Brief which goes on proposing a Single National Insurance Scheme in Tanzania.

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16 ANALYTICAL REPORT TO INFORM THE TANZANIA HEALTH SECTOR STRATEGIC PLAN 2015/2016 – 2019/2020 (HSSP IV)
17 ACTUARIAL STUDY OF THE PROPOSED SINGLE NATIONAL HEALTH INSURANCE SCHEME IN TANZANIA: Summary Brief
November 2017
given that Health insurance coverage, across all schemes, has remained about 15–16 percent in Tanzania in recent years.\textsuperscript{18}

Summary of key issues for MTR:

- CHWs can be optimized to serve as a valuable addition to human resources for health, helping to achieve universal coverage and that the current national human resource gap.
- The CHWs undertake simple health interventions at community level which are largely preventive medicine and health promotion.
- In easing the involvement of communities, three organs are in place, namely Health Facility Governing Committees, Ward Health Committees and Village Health Committees.
- Community members are mobilized to take charge of local based interventions, example for NTDs they are responsible for selecting drug distributors, deciding where and when to take drugs.
- Community involvement and participation is vital, as it contribute in improving MNCH through ensuring that, the family members are well informed about all issues of MNCH.
- Communities are more sensitized to mobilize resources to address WASH problems at schools than at health facilities.
- Sustained improvement in access to sanitation and sustained changes in hygienic behaviours requires an appropriate enabling environment and multi-sectoral approach that involve stakeholders from policy, financial management sectors both at the community and national levels.
- Local and international efforts based in the communities have been observed. Health facilities provide community initiated health education regarding water and sanitation which is done in community level meetings.
- Promotion of effective communication among community members leads community empowerment, and participation where communities are empowerment to take appropriate actions to address their health needs (NCBHCHP 2014-2020).
- The percent of women with community-based health insurance increased from 2.1% to 4.4% and for men from 2.7% to 4.6%. The HSSP target of 80% coverage with community-based health insurance was by far not met

2.2 **Strategic Direction 2: Health promotion**

This strategic direction on Health Promotion points to the importance of community participation and ownership as a key to promoting the primary health care service delivery. It further maintains the necessity of enhancing behaviour change for informed health choices and action. Health Promotion therefore is vital for community based health care services whereas it enhance community involvement and participation in various health activities at that level.

Operationally, health promotion is a combination of educational and social efforts designed to help people take greater control of and improve their health. In the other round, Health promotion is the process of improving and protecting the health of the public, including individuals, populations, and communities. Health promotion and disease prevention can be achieved through planned activities and programs that are designed to improve population health outcomes\(^\text{19}\). Health promotion has been advocated as a way of increasing community awareness and raise their participation in public health matters.

The MoHCDGEC has the vision of ensuring better coordination of advocacy, social and behavioural change communication across different initiatives, programmes and interventions. It has Health Promotion Policy Guideline and Strategy, guidelines on specific areas for Health promotion and Standard Operating Procedures for SBCC. A Community Based Health Promotion Risk communication Strategy, rumour tracking tool and community messages mapping tool were also developed. The National Costed CBHP Strategic Plan (2015-2020) which built upon the Policy Guidelines to further define program priorities and objectives, including specific strategies for management and coordination; formalizing CHWs; strengthening institutional capacity, resource mobilization and management, and advocacy; and promoting gender equity, human rights, and sustainability and 3). National CBHP Implementation Design 2016 that provides key strategies for the program’s scope, coordination, governance, implementation, rollout, and monitoring and evaluation. Available promotive activities focus on behaviour change and aim at avoiding the emergence and establishment of the social, economic, and cultural patterns of living that are known to contribute to an elevated risk of diseases.

Currently Social and Behavior Change Communication (SBCC) is attained through collaborating with Implementing Partners’ support. Through intense collaboration with the District Health Services TWG the SBCC intent shall attain closer monitoring of its operational aspects within the CCHP process for countrywide coverage.

\(^{19}\) Community health promotion programs, Fincham S Soc Sci Med. 1993 DOI: 10.1016/0277-9536(92)90020-q
The MMAM (2007-2017) sees health education and promotion as a means of increasing individual and community participation in health action. Its implementation involves health education, advocacy, social and community mobilization, information, education and communication, mediation and lobbying. The aim is to empower the community for health improvement. Health promotion and education which is one of the main strategies of promoting health seeking behaviour of the community will be given priority. Capacity building of the communities and individuals to get involved in health promotion and education activities at all levels will be enhanced.

Effective community engagement was a key running methodical theme and approach to advance health promotion interventions through the formulated policy guide, the strategy and the implementation design. Close consultations with PO-RALG have been ongoing regarding implementation and resource implications of formalized CHWs. MOHCDGEC leadership collaboration with PO-PSM, NACTE, Development Partners and NGOs on this community engagement initiative has been exemplary in terms of consultations in favor of integration and critical considerations on sustainability.

Other developments include a health communication resources center is in place with an Audio-visual studio, printing unit, Social media accounts, and a Health Promotion Digital Platform engaging social and mass media to reach the public with educative and correctional messages more efficiently and with effective interaction in the population.

**Mass media campaigns and community outreach**

The role of the mass media in promoting positive norms is highly rated. Media has the capacity to reach masses of people simultaneously (e.g. Radio, television, cell phones, and newspapers) targeting large and diverse audiences rather than specific groups or communities; although there are exceptions\(^\text{20}\) (e.g. special programs on the radio targeting a specific segment of audiences; SMS campaigns targeting specific segments of people who register to receive messages).

Elsewhere, Media having capacity to reach masses of people simultaneously (e.g. Radio, television, cell phones, and newspapers). Mass media usually target large and diverse audiences rather than specific groups or communities; although there are exceptions (e.g. special programs on the radio targeting a specific audience segment; SMS campaigns targeting specific segments who register to receive messages) (page 11).

There has been a plan, for instance, on the nutrition community health communication principles of reach, frequency, and message salience, placing particular emphasis on cultural relevance and gender equality to develop the Social Behavioral Communication Change (SBCC) on infant and young child feeding (IYCF) program has been used to influence the behavioral change. It is through that program where local community health workers and volunteers are supported to meet with caregivers either in a group setting such as a care group or to go to the

\(^{20}\) National Nutrition Social and Behavior Change Communication (2013/18)
doorstep of households and engage directly with household members. To do this, the vast cadre of community health workers and other community agents are engaged and equipped with knowledge and skills for behavior change\textsuperscript{21}.

**Strategic Communication Approach:**

The nutrition community uses the communication principles of reach, frequency, and message salience, placing particular emphasis on cultural relevance and gender equality to develop the Social Behavioral Communication Change IYCF (infant and young child feeding) program.

**Reach:** Since IYCF practices occur in the private domain (in the household) the national SBCC program intends to reach every household, giving priority to those households with women of reproductive age and young children. While mass media will be used, the national program will support local community health workers and volunteers to meet with caregivers either in a group setting such as a care group or to go to the doorstep of households and engage directly with household members. To do this, the vast cadre of community health workers and other community agents must be engaged and equipped with knowledge and skills for behavior change (page 71).

**Community IEC and peer education ASRH**

In many communities across the visited districts there were adequate and appropriate IEC/BCC messages and materials that are specific for adolescent health issues and needs. Furthermore, many health facilities have set aside each last Saturdays of the months or week-ends where community-based platforms such youth clubs are used by adolescents to discuss issues pertaining sexual and reproductive health. At their age also, media outreach including radio and text messaging and institution-based interventions, mobile phone information sharing has been very significant among adolescents among them as they have been sharing text messages wherever they are in their communities.

On MNCH and HIV; community involvement plays a very key role for the success of MNCH/HIV/AIDS integrated services. Communities have a significant influence on norms that determine the utilization of services. Communities can also provide resources for integration process. The following actions regarding communities are a pre requisite for successful MNCH/HIV service integration\textsuperscript{22}:

- The RCHS and NACP shall jointly work together to create an environment to support MNCH/HIV service integration at the community level;
- The MoHCDGEC shall establish a common cadre of community workers to cater for MNCH and HIV integration;
- The MoHCDGEC shall develop training curricula for community-based workers to cover MNCH and HIV keeping integration in mind;

\textsuperscript{21} National Nutrition Social and Behavior Change Communication (2013/18)

\textsuperscript{22} The National Operational Guidelines for Integration of Maternal, New-born, Child Health, and HIV/AIDS Services in Tanzania
• The MoHCDGEC in collaboration with partners shall hold capacity building/training of community workers including content about MNCH or HIV, as appropriate;
• The MoHCDGEC shall develop joint community-based IEC/BCC materials so as to include both MNCH and HIV messages;
• MoHCDGEC shall create an integrated referral system, integrated job aids, and an integrated monitoring tool for community workers; MoHCDGEC in collaboration with partners shall standardize the motivational package for community-based workers and create a mechanism for sustainable way of motivating CHW;
• MoHCDGEC shall create a mechanism to ensure constant availability of logistical support and commodities for community workers including working gears and tools to CHW

Summary of key issues for MTR
• Apart from having the National Standards for Communication and the National Centre for Health Communication, implementation of health promotion at community level are uncoordinated and often community directed, Community involvement and participation in Health promotion planning, monitoring and evaluation is weak and if any NOT sustainable.
• In many communities across the visited districts there were adequate and appropriate IEC/BCC messages and materials that are specific for adolescent health issues and needs.
• The MoHCDGEC has the vision of ensuring better coordination of advocacy, social and behavioural change communication across different initiatives, programmes and interventions.
• The MMAM views health education and promotion as a tool for increase individual and community participation in health action.
• BCCs, IECs and Mass Media are the main interventions for health promotion at the community levels where people are empowered to take “health action”.
• Use of e-health applications in Health Promotion is inevitable, moreover there are still many areas which are yet to reached by the Networks hence not benefiting from the planned interventions.
• Community health volunteers or community health workers were said to be active in their areas and are involved in vaccination campaigns, health promotion activities and link persons between communities to health facilities.
• Many health facilities have set aside each last Saturdays of the months or week-ends where community-based platforms such youth clubs are used by adolescents to discuss issues pertaining sexual and reproductive health.
2.3 **Strategic Direction 3: Non Communicable Diseases**

The country plans to strategically focus on community-based prevention, health promotion, screening, early treatment and rehabilitation of NCDs.

2.3.1 **Community level NCD activities and plans**
Between 2016 and 2018, the Tanzania Non-Communicable Disease Alliance (TANCDA) has been implementing the Project under a collaborative coordination by the MoHCDGEC and PO-RALG among other activities was prioritize capacity development in primary health facilities and awareness in communities. A small number of community members to have ever been screened for NCDs, including diabetes, cancer, asthma/COPD, heart diseases and hypertension and their risk factors. This has called in the plan of the National NCDs phase II Program which is expected:

- to train facility staff at all health centres and some dispensaries and community health workers (CHWs).
- Community NCDs attained knowledge will remain and be transferred to each other by the community themselves.
- The CHWs will be empowered to enable them support the health care system by participating in the screening and then referring the detected NCDs cases to the higher health facility levels.
- The trained NCDs staff and Journalists NCDs Forum members are expected to continue providing NCDs education in the community.
- Awareness creation will also continue through using free airtime provided by both local and national radios and TVs.

2.3.2 **Specific community NCD issues at the community level**
- **Relevance:** Although NCDs issues are prioritized in the national strategic and action plan for 2016 – 2020 and in the Health Sector Strategic Plan - July 2015 – June 2020, there is *NCDs knowledge gap of a missed opportunity of NCDs early detection in the communities concerned*
- **Effectiveness:** There are fund raising resource to support the implementation of NCD including community NCDs awareness creation, community based screening and capacity building and empowering of staff at PHC levels
- **Effect/Impact:** The presence of TANCDA has acknowledged to increase community knowledge which has resulted increase and this has influence health seeking behaviour as a results more people were detected this lead to the increase in number of clinics offering NCDs service and increase number of days for operating the clinic.
The only community NCD issues deployed health education with regard to lifestyle. There is health education provided with regard to alcohol, smoking, road safety and prevention of injuries done as they educate people on injuries and motorcycle accidents. There are first aid services are available and in some cases CHWs help identifying and referring “suspected” NCD cases to health facilities.

There is an opportunity for critical re-examination of behavioural oriented factors contributing to malnutrition and appropriate interventions to address them for improved nutrition status of the community and the nation at large. This is provided through guiding principles that may lead to better community nutrition and these imperatively classified as "Continuous Advocacy for Nutrition Social and Behavior Change is Important"\(^{23}\).

Summary of key issues for MTR

- There is a national strategy that recognises community participation and ownership as the key primary prevention of the NCDs through limiting the incidence and controlling causes and risk factors.
- A booklet for general public education on NCDs has been produced by the Tanzania Non-Communicable Disease Alliance (TANCDA) and currently been utilized as resource material as well as distributed at events that address NCDs.
- NCD medications (particularly Diabetes Mellitus and Hypertension) are available in many health facilities,
- NCD is also prioritised parallel to other health needs like Maternal Health, Neonatal survival, HIV, Malaria and TB.
- There are community based outreach services focusing on prevention, counselling or health education with regard to lifestyles, alcohol, smoking, diet, physical exercise, road safety, hypertension, diabetes treatment and prevention.
- There is inadequate implementation of guidelines at the community levels of maternal, infant and young child feeding, management of acute malnutrition, control of micronutrient deficiencies, health eating and lifestyle issues. Community members have low levels of awareness on nutrition matters and general health food intake.

\(^{23}\) National Nutrition Social and Behavior Change Communication (2013/18)
3 Cross Cutting Issues

Cross-cutting issues require action across multiple sectors. In seeking to promote an enabling environment for health, it is important to devise appropriate policies and practices to address barriers to health service scale-up, access, quality, and use.

3.1 Equity and quality

According to WHO, attaining UHC entails equitable access and use of quality services by all those that need it, be it preventive, curative or palliative care. In order to fully realize this, all aspects of health services provision must be attended to. As Tanzania strives to attain universal access to quality health services, several issues that include the health sector itself and other socio determinants of health that affect public health have to be looked at.

As the ADDO program has taken off for instance, many have recognized the potential of these shops to not only increase access to essential medicines, but also to serve as a platform for community-based public health interventions; for example, a child health training module for dispensers includes danger signs of pneumonia in children and the appropriate action (co-trimoxazole treatment or referral), depending on the situation presented. Other programs currently being integrated include tuberculosis case identification and referrals and reproductive health commodities and services (*AHPSR Flagship Report 2014 – Medicines in Health Systems*).

3.1.1 Availability

Availability of drugs and outreach health services to the community is moderate and in other hard to reach areas such services are not available. In most cases, the mostly available community services are mere health education on how to protect oneself from malaria, HIV, counselling and education on malnutrition, caring for infants and child health. In general, there are no services for special people with special needs such as those with disabilities, health services for children, women and aged people are not accessed, no special/practical attention the elderly. Findings from the fields visits illustrate that efforts by the Government to avail health for all as stipulated in the Policies and Guidelines have not reached many parts of the population. Even those communities that are reached they remain with high concerns on stable access and quality issues which are of high importance to poor and vulnerable people.

3.1.2 Accessibility

There are challenges of reaching communities in hard to reach areas. Furthermore, in numbers, presence of health facilities in communities does not necessarily translate into the accessibility and usage of health. Due to various reasons available facilities have been inaccessible to certain people. According to the feedback obtained from the field visits, among the reasons hindering the facility visits by clients were geographical inaccessibility where remote communities are on the disadvantage side, fare and transport costs to reach the facilities as well as people’s inability to afford some medical services.
The community level emergency transport systems, the referral system has serious challenges including limited number of ambulances; unreliable logistics and communication system; and low community based facilitated referral system. Basing on that deficiency and what was actually found during the field visits, it is crucial for health stakeholders to consider measures that will ensure the sustainability, efficacy and reliability of community based transport system.

3.2 Public Private Partnership

Evidence from the field visits have shown that the district level coordinate PPP fora at lower levels where they meet not less than once per year. Members are formed from both public and private sector at particular community, village/ward authorities etc. The updating of the PPP forum at all levels is annually discussed by the members.

In almost all visited HFs/CHMTs/RHMTs there is high multi-sectoral collaboration (Government, private, voluntary and non-profit groups, intending to improve the health of populations). All districts/regions have PPP coordinators linking public and private sectors.

There are however bottlenecks where many PPP focal persons are trained/specialized on PPPs thus lacking sustainability of the existing multi sectoral collaborations. They are also not capacitated (financially) to identify suitable areas for partnerships, conduct feasibility studies, facilitate establishments, monitor and evaluate.

3.2.1 PPP Implementation at decentralised level: Comprehensive Council Health Plan

- It has to be approved by the Council Health Services Board (CHSB), which consists of community representatives, officers from other departments, and representatives from the private sector.
- The Regional Health Management Teams approve the CCHPs and forwards these to national level. The PoRALG together with the MoHCDGEC assesses the CCHPs and gives final approval, before funds can be disbursed to the local authorities.
- The services of all providers have to be considered including public and parastatal providers, FBOs, private self-financing providers, NGOs, community-based initiatives for health promotion, traditional and alternative medicine providers

Availability of drugs and outreach health services to the community is moderate and in other hard to reach areas such services are not available. II 2015-2020 that is implemented as a component of the HSSP IV (2015-2020). This strategic plan is to use the same institutional arrangements so as to ensure harmonisation and alignment with implementation of the HSSP IV. The organisational structures responsible for implementing the health sector strategic plans includes several public institutions, non-government stakeholders at central, regional and district levels and the community.

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24 MMAM (2007/17)
3.3 Gender

Recent institutional reforms in government point to promising paths toward responding to and preventing GBV. For example, each Ministry has a gender focal point, and the Ministry of Community Development, Gender, and Children initiated efforts to train the focal points on ways to mainstream gender in their Ministry work plans and budgets. Also noteworthy, the Police Force, under its institutional reforms makes the police more accessible to the community and more responsive to the community’s needs. Out of this initiative, the Tanzania Police Female Network (TPFNet) was created, and with it came the creation of gender desks to respond to cases of GBV at police stations.

As per Analytical report however, “…………..the health facility reporting on GBV has been quite incomplete, and it is difficult to conduct a statistical analysis of current data in DHIS2. By 2018, reporting was much more complete than in the initial years and most regions reported at least some data. Based on these data 49% of all GBV involved women, a rather surprising statistic, given that GBV is mostly directed towards the “weaker sex”. Perhaps health clinic visits associated with male violence were also reported. Physical violence was 38% of all GBV, sexual violence 5%. Much needs to be done if reliable statistics on GBV (and VAC) are to be generated by health facilities, as currently these numbers cannot be trusted........”

It recommends 1) an in-depth assessment of what health workers are recording and, 2) what women are reporting in health facilities to improve the data collection on GBV and VAC in health facilities.

Summary of key issues for MTR:

- Availability of drugs and outreach health services to the community is moderate and in other hard to reach areas such services are not available.
- Many communities in remote/hard to reach areas have been inaccessible hence lacking essential health services.
- Staff behaviours have limited community members’ health facility visits and hence leading to their alternative approaches.
- PPP is recognised in health services delivery down from the community to the operational levels.
- There have been also various community based initiatives on the prevention of violence against women, adolescents and children.
4 Reflections from Strategic Objectives

**Strategic Objective 1:** The health and social services sector will achieve objectively measurable quality improvement of primary health care services, delivering a package of essential services in communities and health facilities.

**Reflection**

Improvements in health care delivery require a deliberate focus on quality of health services, which involves providing effective, safe, people-centered care that is timely, equitable, integrated and efficient. Primary health care services have been designed so that all people in a defined target population are covered, i.e. the sick and the healthy, all income groups and all social groups. This is also a view of the World Health Organization.

The MoHCDGEC has strived to achieving high quality health services by making sure such services are effective, safe, centred on the patient’s needs and given in a timely fashion. However, measurable improvements in the quality improvement of primary health care services may be achieved if there is community support, staff responsiveness to capacity building, technical support and effective management.

In almost every facility there is an HFGC, there are WHCs and VHCs in each ward and village respectively, there are also responsive CHWs in almost all vicinities. It is now a high time that all these are enabled to be very effective and functional.

It is suggestive that quality improvement needs to be a continuous cycle and requires an investment in people, processes, infrastructure, equipment, and materials. Required also is periodic evaluations and feedback for sustainable improvement. Reviews, field visits and validation meetings have indicated that increased community engagement at the primary level, MoHCDGEC and PoLAG support and commitment in the establishment of sustainable structures and processes, is required for improving quality of health care eventually leading to strengthening the country’s health system. Improvements in quality health services must lead to improved health status and well-being, for all citizens, without discrimination.

**Strategic Objective 2:** The health and social welfare sector will improve equitable access to services in the country by focusing on geographic areas with higher disease burdens and by focusing on vulnerable groups in the population with higher risks.

**Reflection**

The MoHCDGEC maintains that by Policy and in paper there should be dispensaries in villages, Health Centre in Wards, district hospitals, Regional referral hospitals and lastly Consultancy and Specialized Hospitals. However, availability may not necessarily mean accessibility the latter is attributed to distant areas where people live versus facilities’ locations hence people have to
incur transport costs, ability of the clients to pay for the services and also in various cases unavailability of certain services that clients may require.

In general, some assessments have shown that services cannot yet ensure that people from the most vulnerable groups identified in HSSP IV have equitable and adequate access to services which are appropriate for them. The issues that particularly vulnerable people have about services are similar to those expressed by other poor and disadvantaged people – but the negative experiences of particularly vulnerable people are especially intense and, sometimes, painful. In many ways, all poor and socially vulnerable people feel even more vulnerable when interacting with the health services.

**Available and safe:** Health services are to be equitably located within acceptable reach of all clients. This may mean that considerable reconsideration of investment is necessary to ensure that geographical disparities are addressed and that isolated areas – previously neglected – receive services or are reliably linked into them.

On the other side, there are however some measures targeting addressing issues of equitable availability of health services and among these are attention to gender equity, VGG and VAC, male involvement in specific services such as RCH, application of the Waivers and Exemptions, expanding already available outreach, specific attention to the Most at Risk and other Vulnerable populations. Addressing all these efforts may at most lead to a more systematic availability of health services.

There is a great heterogeneity amongst people who are poor and vulnerable. In order to remove barriers to gender-sensitive and equitable access to health and well-being, the range of Social Determinants of Health needs to be understood. The full social context (geography, socio-economy, politics, culture etc.) affects possibilities for equity, and affects different people in different ways.

**Strategic Objective 3:** The health and social welfare sector will achieve active community partnership through intensified interactions with the population for improvement of health and social wellbeing.

**Reflection:**
Active involved community partnerships (AICPs) are essential to co-create implementation infrastructure and translate evidence into real-world practice. This is done (and can also be applicable in our setting) when the following are done: (1) relationship-building; (2) addressing system barriers; (3) establishing culturally relevant supports and services; (4) meaningful involvement in implementation; and (5) ongoing communication and feedback for continuous

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25 Community perspective study on Health Services experience: A study to inform Mid Term review HSSP III by Sheena Crawford and Prince Mutalemwa

26 United Republic of Tanzania, MOHSW (2009) National Guidelines for Improving Quality of Care, Support, and Protection for Most Vulnerable Children in Tanzania
improvement. In public health however, collaborative partnerships attempt to improve conditions and outcomes related to the health and well-being of entire communities. When the focus is a community, those affected may include people who share a common place, such as a rural community or an urban neighborhood, or an experience, such as being a child or living in poverty. The intensified relations include taking aboard community health needs and plans, and communities act as catalysts for respective community change. As such, there are both top-down lead by experts and bottom-up where community needs lead the procedure.

**Strategic Objective 4**: The health and social welfare sector will achieve a higher rate of return on investment by applying modern management methods and engaging in innovative partnerships.

**Reflections**
Application of modern health technology is currently a typical feature of the healthcare system. This has always been used unconsciously on a daily basis for example through mobile phone apps, MRI, CT-Scan, telemedicine, point of care tests and others. Health Management Information System (HMIS) is facility-based system within the MoHCDGEC. Different programs have developed their own systems of data collection at community level. The data from these activities are collected in locally prepared registers and it is difficult to harmonize those data with facility based HMIS. Therefore, there is an urgent need to streamline HMIS framework at health facility and program levels, such that health related information collected in the community through the HMIS village register by PMO-RALG, can be used to compliment facility data.

**Monitoring and Evaluation**
Monitoring and evaluation of community interventions is a process through which communities measure the quantity and quality of community based health activities. Monitoring provides ongoing information on how well the program is doing while evaluation shows the impact of the program or intervention overall. Research helps to highlight problems, showing the associations and magnitude and suggest potential solutions.

**Community Based Health Component of HMIS**: Community health indicators are not adequately reported through the current facility based reporting system. This limits the various levels in planning and decision making processes. As a result, some vertical programs have devised alternative systems to collect community data to ease their reporting and management. It is therefore important to strengthen the community based HMIS, and also monitor use of HMIS for quality assurance, supportive supervision, case co-management, and community surveillance and program evaluation during training practicum.

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27 Active involved community partnerships: co-creating implementation infrastructure for getting to and sustaining social impact (Transl Behav Med. 2017 Sep; 7(3): 467–477 Renée I. Boothroyd)
Additionally, incorporate pilot HMIS tools and indicators into training curriculum and pilot during facility and community based practical sessions.

**Strategic Objective 5:** To address the social determinants of health, the health and social welfare sector will collaborate with other sectors, and advocate for the inclusion of health promoting and health protecting measures in other sectors’ policies and strategies.

**Reflection**

The health and social welfare sector need to engage multi sectoral collaboration to establish policies that positively influence social and economic conditions and those that support changes in individual behaviour. Further, improve health for large numbers of people in ways that can be sustained over time. Improving the conditions in which we live, learn, work, and play and the quality of our relationships will create a healthier population, society, and workforce. Other important socio issues that if well addressed in the policies and guidelines the health promotion may thereby bear fruitful results include access to health care services, availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities and social norms and attitudes (e.g., discrimination, racism, and distrust of health services and the providers). The most important issue to be clearly considered is that Multisectoral collaboration is a managed process in response to a challenge or opportunity

The World Health Organization in this case points out that improving health is clearly articulated in SDG 3 (Ensure healthy lives and wellbeing for all at all ages), it also comes through in the other SDGs. However, collaboration within the health sector itself can be a challenge and working with other sectors perhaps even more so. What, therefore, are the priorities when it comes to Multisectoral collaboration for health? What are the key priorities for policymakers in particular? Which key gaps have been highlighted in the health sector?

Community based health interventions obviously require multi sectoral collaborations in their control. Malaria, WASH, HIV/AIDS, disease outbreaks and preparedness, Food and Nutrition, food and zoonotic disease, Dengue, Ebola etc. would call for different sectors in their control likewise the NCDs and NTDs. Even the issue of CHWs requires the MoHCDGEC and Paralog to work together in processing their recruitment, formalization and even retaining them. As pointed out in the Service Delivery report, “Inter-ministerial meetings of Permanent Secretaries and Local Government Councils already provide platforms that are usually optimized for the intersectoral health agendas”.

27
5 SWOC Analysis

The table below illustrates key strengths, opportunities, weaknesses and challenges in the Community health thematic area.

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Opportunities</th>
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<tbody>
<tr>
<td>• Presence of supportive government documents advocating the need of CHWs and the systems eg CBHC, CBHP, NCCBHPSP</td>
<td>• CHWs capable of health services interventions when properly oriented and/or trained</td>
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<tr>
<td>• Presence and availability of CHWs in the respective communities</td>
<td>• Presence of local and foreign supported interventions in the community health services</td>
</tr>
<tr>
<td>• Community involvement, engagement and participation in health care delivery services</td>
<td>• CHWs may serve as alternatives amid the HRH crisis reducing the workload of facility-based health care workers</td>
</tr>
<tr>
<td>• Availability of adequate and appropriate IEC/BCC messages and materials in communities</td>
<td>• Raised interactions between health care workers, communities and patients (the facility –community network on some disease programs is in place.</td>
</tr>
<tr>
<td>• Existence of community based functional structures (HFGCs, WHCs and VHCs)</td>
<td>• Presence of active community outreach services</td>
</tr>
<tr>
<td>• CHWs’ effectiveness in in delivering HP and education messages with simple and targeted audiences</td>
<td>• Presence/availability of Mass Media in most of the communities that can aid airing the HP/HE issues</td>
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<tr>
<td>• Majority people are reached by various health interventions</td>
<td>• Willingness and ability of community implementers to deliver multiple interventions</td>
</tr>
<tr>
<td>• Presence of Public Private Partnership personnel, advocacy and documents supporting it</td>
<td>• Many regional and district hospitals provide Diagnosis and Treatment for hypertension and diabetes and prevention services through health education.</td>
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<table>
<thead>
<tr>
<th>Weaknesses</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Low community awareness on the basic facts about modern Contraceptives</td>
<td>• inadequate community involvement and participation in planning, implementation, monitoring and evaluation of health services</td>
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<tr>
<td>• Community not aware of their rights and obligation in Family Planning</td>
<td>• CHWs: inadequate incentives; poor motivation; drop outs and lack of scheme of services</td>
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<tr>
<td>• Low awareness on reproductive system functions and pregnancy risks.</td>
<td>• The increasing burden of non-communicable diseases</td>
</tr>
<tr>
<td>• Lack of training to community implementers leading to low efficiency</td>
<td>• Few people still not reached by health services (eg KVPs and those in hard to reach areas)</td>
</tr>
<tr>
<td>• Limited knowledge of child nutrition,</td>
<td></td>
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feeding frequency, growth monitoring, and supplements resulting to higher levels of stunting, moderate and severe nutrition

- Uncoordinated delivery of IEC/BCC messages and materials to communities
- No NCD screening among community members thus leading to continued episodes of the NCDs,

- Most school based adolescent health programs are not linked to the community interventions
- Some members (HFGCs, VHWs and WHCs) are not oriented on their roles and responsibilities
- Funds for running health facilities stumbles its neat performance (age transport costs and sitting allowance).
- Availability of drugs and outreach health services to the community is moderate and in other hard to reach areas such services are not available.
- Lack of functional community based Multisectoral approach on health issues
- Weak health infrastructure and absence of community based referral system
- Many community members had limited knowledge of child nutrition, feeding frequency, growth monitoring, and supplements thus resulting to higher levels of stunting, moderate and severe nutrition
6 Recommendations

6.1 Short term recommendations:

1. Strengthen community based advocacy and communication in order to raise awareness on health related issues among community members.
2. Strengthen community participation (especially men) on RAMNCAH services in general.
3. There should be a multi-sectoral planning of health issues (nutrition, water, environment) at the implementation level (LG).
4. Successful community based interventions should be scaled up important for improving health of the general population.
5. The Ministry of Health should ensure that facilities have essential drugs and hence restore the lost confidence on the HFs by patients.
6. There should be frequent community health education/promotion on based food and nutrition in order to change the already deteriorating life styles leading to NCDs.
7. Political commitment is necessary to enable communities to explore possibilities for solving their nutritional problems and translate perceived possibilities into action programs.
8. It is important to maximize the use of locally available mass media since they maximize reaches in the intervention areas.
9. NCDs community awareness and screening activities should clearly be earmarked during those and then continued to be monitored and evaluated on their performance special days (such as Mwenge and other locally organized days).
10. It is there recommended that NCDs capacity building at district and regional levels and health management teams at those levels should treat NCDs as an important public health problem needing immediate response and attention.
11. Support community-based programs to provide information and counseling on optimal and appropriate complementary feeding practices.
12. There is a need to strengthen inter- and intra- collaborations between and among the WHCs and VHCs in order to ensure that they do not generate distrust among the community members.
13. Formalise links of HFGCs with the LGAs, as further step in Decentralisation by Devolution.
14. Formalise roles and responsibilities of committees. Clarify roles and build capacity of members to perform them as required.
15. Enhance integration of health issues in the social services and community development agenda at ward and village level, especially in view of the Health in All Policies Approach.
16. Incorporate pilot HMIS tools and indicators into training curriculum and pilot during facility and community based practical sessions.

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17. Integrate relevant CBHP HMIS data into integrated disease surveillance, response and case management systems including community-based surveillance.
18. Develop a community level data management, reporting and program evaluation capacity.
19. There should be better guidance on engagement of partners in community-based services and integration in planning and management for enhancing effectiveness.
20. Local authorities and HFs within the catchment areas, should ensure communities have access to the necessary information on the implications, rights and responsibilities of participatory health promotion.

6.2 Long term recommendations

1. MOHCDGEC, PO-RALG and stakeholders have to redevelop a feasible CBHC programme, that is costed and within the political and economic disposition of the country.
2. Strengthen training of community based information, education and communication (IEC) programmes among the CHWs so as to fortify their knowledgeable link to health service facilities.
3. Health promotion and behavioural change communication require coordination and more guidance under guidance of the Health Promotion/Education Unit especially in production and dissemination of materials.
4. Reach many adolescents and youths in school via School Health Programs and Youth Clubs to address sensitive issues in this target group who in turn may deliver same messages to respective communities.
5. The MOHCDGEC and PO-RALG need to allocate additional budgets for NCDs short course training in order to equip more of the frontline staff and CHWs with sufficient knowledge on, and skills to manage, NCDs.
6. The MOHCDGEC should coordinate development, distribution and use of operational guidelines on participatory health promotion planning and implementation. The guidelines should contain separate sections for community, practitioners and other stakeholders.
7. Community based health interventions require multi sectoral collaborations in their control. From the side of the health sector further investments in collaboration with LGAs in community development activities (eg Good governance and adequate coordination of Multisectoral nutrition work at all levels)