

## Report of the Stakeholders' Meeting on Community Health Workers' Initiatives

**'Exploring sustainable ways for promoting Community Health in Tanzania'**



Oceanic Bay Hotel, Bagamoyo, Coast Region  
August 30-31, 2012



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# Stakeholders' Meeting on Community Health Workers' Initiatives

Oceanic Bay Hotel, Bagamoyo, Coast Region  
August 30-31, 2012

**Funded by:**

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**Organized and Coordinated by:**

*The Health Education Unit of the Ministry of Health and Social Welfare in collaboration with  
WHO, UNICEF, Jhpiego, FHI360, and AMREF*

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## **List of Acronyms and Abbreviations**

AIDS	-	Acquired Immune deficiency Syndrome
ALAT	-	Association of Local Authorities of Tanzania
AMREF	-	African Medical Research Foundation
ANC	-	Antenatal Care
ART	-	Antiretroviral Treatment
CBD	-	Community Based Distributor
CBO	-	Community-based Organization
CCHP	-	Council Comprehensive Health Plan
CHAI	-	Clinton HIV/AIDS Initiative
CHAs	-	Community health Agents
CHBC	-	Community Home Based Care
CHBCPs	-	Community Home Based Care Providers
CHEWs	-	Community Health Extension Workers
CHF	-	Community Health Fund
CHMT	-	Council Health Management Team
CHWs	-	Community Health Workers (CHWs)
CMO	-	Chief Medical Officer
CORPs	-	Community Resource Persons
CSOs	-	Civil Society Organizations
CSPD	-	Child Survival Protection and Development
CSR	-	Corporate Social Responsibility
DMO	-	District Medical Officer
DPs	-	Development Partners
DPS	-	Director of Preventive Services
DSS	-	Demographic and Social Surveillance
FANC	-	Focused Antenatal Care
FHI	-	Family Health International
FHI	-	Family Health International
FP	-	Family Planning

HBC	-	Home Based Care
HBCT	-	Home Based Care Treatment
HIV	-	Human Immunodeficiency Virus
HMIS	-	Health Management Information System
HRD	-	Human Resource Development
HSSP	-	Health Sector Strategic Plan
ICT	-	Information Communication Technology
IHI	-	Ifakara Institute of Health
IMCI	-	Integrated Management of Childhood Illnesses
INGOs	-	International NGOs
LGA	-	Local Government Authorities
LGAs	-	Local Government Authorities
MAISHA	-	Mother And Infant Safe Health Alive
MDAs	-	Ministries, Departments and Agencies
MDGs	-	Millennium Development Goals
MMAM	-	Kiswahili acronym for 'Primary Health Care Development Programme'
MNCM	-	Maternal, Newborn, Child Health
MoHSW	-	Ministry of Health and Social Welfare
MUHAS	-	Muhimbili University of Health and Allied Sciences
MVCs	-	Most Vulnerable Children
NACP	-	National AIDS Control Programme
NGOs	-	Non Governmental Organizations
OVCs	-	Orphans and Vulnerable Children
PEPFAR	-	President's Emergency Fund for AIDS Relief
PHC	-	Primary Health Care
PLWHA	-	People Living with HIV and AIDS
PMORALG	-	Prime Ministers' Office Regional Administration and Local Government
PMTCT	-	Prevention of Mother to Children Transmission (of HIV)
PNC	-	Post Natal Care
PPP	-	Public Private Partnership

PSW	-	Para-social Workers
RCH	-	Reproductive and Child Health
RCHS	-	Reproductive Child Health Section
SOPs	-	Standard Operating Procedures
SWAp	-	Sector Wide Approach
TASAF	-	Tanzania Social Action Fund
TBAs	-	Traditional Birth Attendants
TFCHWI	-	Task Force CHW initiatives
TRCS	-	Tanzania Red Cross Society
TWG	-	Technical Working Group
USAID	-	United States Agency for International Development
VEO	-	Village Executive Officer
VHW	-	Village Health Worker
WHO	-	World Health Organization

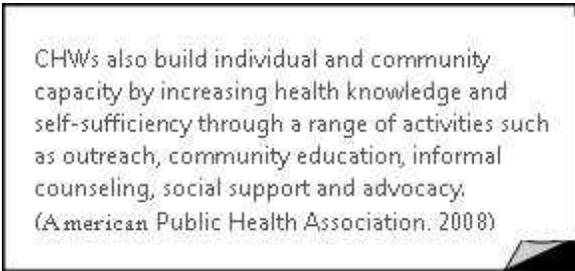
## Section One: Executive Summary

### *Context and Rationale*

Community Health Workers (CHWs) is not a new concept; it has been in existence for almost 50 years with countless experiences realized through a variety of approaches. A number of countries in the world, especially resource-strained countries, have recognized the use of CHWs as a fairly efficient strategy to deal with the growing shortage of human resources for health (HRH) which can destabilize a country's health delivery system. There have also been several studies funded by different organizations that confirm the viability and effectiveness of CHW programmes.

Tanzania adopted the Alma Ata Declaration which identified CHWs as one of the foundation stones of comprehensive Primary Health Care (PHC), and since the early 1980s, it has used the PHC approach to re-orient health services with a deliberate effort to decentralize health care delivery to the district level and beyond. The emphasis is on the provision of primary care at health facilities, outreach health services and other services. The enhancement of community participation and overall community development, with the aid of community based health workers, commonly known as Village Health Workers (VHWs) who worked in close collaboration with the then 'Ten-Cell leaders' was also a key feature of the said approach.

Currently, the roles and activities of this group of health aides are extremely varied within and across programmes. In some initiatives CHWs perform a wide range of different kinds of tasks that can either be preventive, curative and/or developmental, while in others, they perform specific activities. Their recruitment, training and remuneration also differ greatly. What is commonly acknowledged, however, is the fact that CHWs can make an important contribution to the health and well-being of their respective communities because of their good understanding of the community they serve. This is particularly so with regard to improving access to and coverage of basic health care services, where



CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy. (American Public Health Association, 2008)

they serve as an important link/intermediary between health and other social services and the community. Significant evidence exists to substantiate that the work of CHWs can lead to improved health outcomes, especially in maternal and child health, and more recently HIV/AIDS programmes.

### *The CHW Stakeholders' Meeting*

It is in light of the above, that the Ministry of Health and Social Welfare (MoHSW), in consultation with some development partners, initiated a consultative process to explore sustainable ways of promoting CHWs' Initiatives in Tanzania drawing on experiences of different programmes in the country. The process began with a mapping exercise to document different programme initiatives that use CHWs in order to establish where they operate from and what approaches they use to recruit, reward and retain CHWs. The 2-day Stakeholders' Meeting that was held at the Oceanic Bay Hotel in Bagamoyo on the 30<sup>th</sup> and 31<sup>st</sup> of August, 2012 was part of that process.

### *Objectives of the meeting*

The objectives of the CHW Stakeholders' meeting were presented by a member of the Task Force, Helen Semu who informed the audience that the meeting aimed at soliciting ideas on how to promote community health through community health workers, in a sustainable, affordable and effective way in line with policy guidance from the PHC Development Programme, or as it is popularly known by its Kiswahili acronym, 'MMAM', as well as the 3<sup>rd</sup> Health Sector Strategic Plan (HSSP III).

Specifically, she said, the meeting objectives were to:

1. Communicate information on CHW programmes that are being implemented in the country;
2. Share findings from current studies on policy options and the implementation and training of CHWs and experiences from a selection of CHW initiatives implemented in Tanzania;
3. Discuss and propose a common nomenclature for CHWs and a sustainable reward system;
4. Recommend a coordinating mechanism for stakeholders working with CHWs;
5. Develop options for national guidance from the Prime Ministers' Office – Regional Administration and Local Government (PMO-RALG) and the Ministry of Health and Social Welfare (MoHSW) at national, regional and council levels;
6. Agree on a common vision for the operationalization of Community Health activities within Local Government Authorities (LGAs);
7. Come up with a consultative framework for continuous exchange of lessons learned between Government, NGOs/CBOs and other development partners.

### *Participants*

More than eighty people (*see Annex A*) with a wide spectrum of representatives from Government, the UN family, local and international NGOs (INGOs), research and academic institutions and Civil Society Organizations (CSOs) attended the meeting. Functionally, there was a good mix of public service specialists, human resource development experts, policy developers, medical doctors, community specialists, trainers, researchers and academicians, and strategic planners. The organizers of the meeting also invited two CHWs (male and female) to share first hand their experiences as CHWs.

### *Process and Methodology*

The meeting was structured to accommodate a mix of methodologies. These included plenary and small group sessions and the use of both English and Kiswahili to ensure open and uninhibited discussions across board. It was facilitated by Dr. Elihuruma Nangawe.

The first day was spent taking stock of what exists and started with official opening remarks by the Head of the Health Education Unit of the Ministry of Health and Social Welfare, Dr. Geoffrey Kiangi who spoke on behalf of the Chief Medical Officer followed by a keynote address that provided a historical overview of community health initiatives in the country. Thereafter a series of presentations were delivered starting with findings from the mapping exercise mentioned earlier and other key presentations that set the stage for rigorous discussion on the different approaches used to implement CHW initiatives in the country.

The entire second day was used to draw a road map for the MoHSW as it explores affordable and sustainable ways to revamp existing community health initiatives that are implemented using community based health workers. This was done in small working groups organized around specific themes, and ended with an 'open space' session whereby a selected group of Panelists shared their final words on the way forward, before the Guest of Honour closed the meeting with his own insights. The deliberations of the first day provided the basis of analysis as participants brainstormed on what needs to be done to make CHW initiatives in Tanzania more efficient and effective.

#### *Salient issues from the discussions*

Many insightful ideas surfaced as experiences on CHW initiatives were shared. Participants identified best practices, analyzed challenges and proposed essential capacity enhancement areas that can shape and/or sharpen CHW initiatives in line with the national health priorities. Discussions at the meeting also brought out experiences of many years from various partners and stakeholders, with clear suggestions on how to improve and strengthen community based health care and support into a holistic, responsive, coordinated and sustainable way.

Findings from a recent research study that were part of the discussions at the meeting revealed that despite the strong network of health facilities, access is still a problem with limited outreach to communities and households, specifically for emergency referrals – in other words, there is a huge disconnect between households and the formal health system. The shortage of trained HRH exacerbates the problem, making the provision of community-based healthcare a challenge.

Participants had an undisputed agreement on the role of community-based health providers/CHWs in improving access to health care services for under-served communities. They were also in agreement that this valuable group of health auxiliaries is not a cheap option for the health sector to realize its goals, in that while CHWs can help to achieve universal coverage of basic health services, their identification and selection, training and placement need to be harmonized and streamlined into existing systems. They also need to be given some form of compensation for their efforts firstly to keep them motivated and secondly in order to ensure continuity of the services that they provide.

Recently, there has been a strong push to officially recognize CHWs as a cadre since they serve as a critical link between communities and the health delivery system not to mention the growing shortage of HRH. This was one of the hot topics which generated a long debate as participants discussed the issue of CHW recruitment and selection, the requisite/desired level of education, their roles and activities including whether they should be generalist or specialist, and their retention. In general participants felt that just like any other human resource, CHWs should be carefully selected, properly trained and remunerated, and continuously supported for them to be effective. Their roles and activities should also be clearly stipulated. And to make them more accountable they should be firmly rooted in and be answerable to the communities within which they live and work.

All of the above aspects are closely tied together and have a direct impact on the sustainability of CHW initiatives. Participants identified a number of opportunities that could be explored with regard to CHW compensation and reward systems and different remuneration modalities for remunerating CHWs for their work. One suggestion was to take advantage of the streamlining of Government accounts under the District Executive Director (DED), for example, encouraging Local Government Authorities (LGSAs)

to establish a specific budget code to support community initiatives in the Council Comprehensive Health Plans (CCHPs) and/or exploring the possibility of using money from Community Health Funds (CHF), cost-recovery arrangements in health facilities, direct contributions from communities that can afford and support from the private sector particularly mining and other large companies, as part of their Corporate Social Responsibility (CSR). The issue of volunteerism was not particularly attractive for various reasons including doubts whether it is possible for a person to volunteer and yet provide quality and sustainable services. An alternative option in form of performance based remuneration was more favourable.

As a longer term strategy, the meeting recommended rigorous policy advocacy for the accreditation of CHW training and their formal deployment in the country and the harmonization of this accreditation programme that will be recognized nationally and available for multiple donor support. Participants also recommended use of a common nomenclature used internationally and a review of the minimum level of education to secondary education (Form IV) so that CHWs can be better able to grasp issues on the one hand and on the other to ensure their career growth and development. To facilitate this, the meeting recommended the development of a standardized curricula and materials packages for different categories of CHWs, a shift of emphasis from facility-centered to community -based health care services that will enable the provision of comprehensive health services all the way to grassroots level and a multi-level coordination structure with sub-committees at national, regional and district level. The coordination role of the government from central to local level must be clearly defined.

Finally, to ensure that the momentum gained from the consultation process does not wane after the stakeholders' meeting, participants recommended that the Task Force that coordinated the process leading up to the Stakeholders' Meeting be expanded to include members from other key units and departments within Government and continue consultations with individuals, institutions and relevant groups of stakeholders to tap into their experiences and feed these experiences back into the process. The main outputs realized during the two-day CHW Stakeholders' Meeting are presented in Box 1 below.

**Box 1: Outputs of the CHW Stakeholders' Meeting**

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1. A report on the Mapping Exercise on CHW Initiatives in the country;
2. A list of lessons learned from current studies on policy options, implementation and training of CHWs and experiences from a selection of CHW initiatives implemented in Tanzania;
3. Proposals on a nomenclature for CHWs and an affordable and sustainable reward system;
4. Recommendations on a coordinating mechanism for stakeholders working with CHWs;
5. Options for national guidance on CHW initiatives from the PMO-RALG and the MoHSW at all levels;
6. Proposals for a common vision for the operationalization of Community Health activities within Local Government Authorities (LGAs); and
7. Suggestions on a consultative framework for continuous exchange of lessons learned between Government, Non-governmental and Community-based Organizations (NGOs & CBOs) and other development partners.

### *The Report*

The report of the CHW Stakeholders' Meeting contains a detailed account of the different sessions. *Section Two* focuses on the opening session; *Section Three* contains summaries of the different presentations delivered in plenary with a sub-section on key issues raised during discussions after the presentations and *Section Four* is an overview of group deliberations on specific topical issues. *Section Five* provides highlights of key issues and major conclusions and suggestions on the way forward and *Section Six* concludes with key messages from the closing session.

The report is a valuable reference for the Task Force as it coordinates the consultative process and a record of experiences and lessons in implementing CHWs programmes in Tanzania.

## Section Two: The Opening Session

### 2.1 Welcome Remarks by the Moderator

The meeting started with a short remark by the Moderator who welcomed participants and introduced them by their respective groups to the Guest of Honor, noting the rich assortment of individuals at the meeting. He also acknowledged and commended efforts of a Task Force composed of representatives from the Ministry of Health's Health Education Unit and a select group of partner organizations that coordinated all the preparations leading to the Stakeholders' meeting. He then invited the Acting Director of Preventive Services to welcome the Guest of Honor to officiate the meeting.

### 2.2 Remarks by Acting Director of Preventive Services

Before inviting the Guest of Honor, the Acting Director of Preventive Services, Dr. Peter Mmbuji explained that the Ministry has involved stakeholders implementing CHW initiatives in the country in designing the road map for CHW work in Tanzania in order to tap into their experiences and learn from best practices. He apologized for the absence of the Chief Medical Officer who had been earmarked to do the official opening and invited the Head of the Health Education Unit, Dr. Geoffrey Kiangi to deliver the opening speech.

### 2.3 - Opening Remarks by the Head of the Health Education Unit of the Ministry of Health and Social Welfare, Dr. Geoffrey Kiangi

Speaking on behalf of the Chief Medical Officer who was supposed to deliver the opening remarks Dr. Geoffrey Kiangi (in picture) warmly welcomed partners in community health workers' initiatives in the country and thanked them for accepting the invitation. He explained that the context of the meeting was in line with the National Health Policies which are pivotal to the implementation of priority health interventions in our country and expressed his anticipation of their active participation and commitment in making the meeting a success.



He described the meeting as historic in that it was the first meeting of its kind in Tanzania that brought together various partners and stakeholders who have vast experiences in providing community based health services. He hoped that the outcomes that would be generated from the meeting would also be historic and would pave the way for a community health worker approach that will be holistic and responsive to the needs of Tanzanian communities particularly at household and family levels. Dr. Kiangi touched on the main objective of the meeting which he said was to reflect and harness the riches of the past, build on existing strengths and attend to emerging challenges in order to move community based health services in Tanzania forward, in an effective, coordinated and sustainable manner.

Walking down memory lane, he recalled the Alma-Ata Declaration of 1978 on Primary Health Care that recognized Primary Health Care as a foundation to the attainment of the level of health with the primary goal of enabling all people in the world to lead socially and economically productive and satisfying lives. Inherent in this Declaration, he said, was the goal of Health for All (HFA) whose main goal revolves around the principles of equity and social justice in health which are still valid today and continue to drive efforts in health development.

Participants were informed that the establishment of the Community Based Health Care (CBHC) support unit that is mandated to coordinate and oversee the development of national policy guidelines, strategies and implementation of community based health related interventions, was part of the Government's efforts to reorient health services and focus them on preventive services and primary care at lower level health facilities at district level. The first National guidelines on CBH initiatives were developed in 1995. They aimed at fostering the implementation of CBHC activities and empowering communities to take charge of initiatives that will promote public health, reduce morbidity and mortality among children, adolescents and adults and enhance community participation, involvement and ownership of these joint efforts. These guidelines were also designed to foster the spirit of self-reliance in resource mobilization and problem solving.

Community Own Resource Persons (CORPs) were identified as key allies in the provision of health services within the scope of the PHC approach as witnessed with the introduction of village health workers (VHWs) who were expected to carry out key elements of PHC including, education for prevention of health problems, treatment of minor illnesses, food and nutrition, housing, water and sanitation, immunization against preventable diseases, maternal and child health, family planning, control of locally endemic diseases, provision of essential drugs and supplies and mental and oral health. The Health Sector Reforms that Tanzania embarked on categorized such services as an essential package of health services delivery at community level.

Taking about challenges in strengthening the health care system, the Guest of Honour singled out the challenge of human resources for health, which he said were not sufficient to ensure effective and equitable delivery of quality essential health services and to facilitate the provision of general health services and the achievement of the health Millennium Development Goals (MDGs). He cited the World Health Report 2006 which argues that community health workers have the potential to be part of the solution to the human resource for health crisis that is looming in Tanzania especially in hard to reach areas.

Dr. Kiangi informed the audience that Tanzania, like many other countries in the world, is in the process of revitalizing its primary health care delivery system and strengthening the overall public health infrastructure. This necessitates a shift from individual, hospital-centered practice to community/village-based health care services for providing comprehensive, coordinated health services under the leadership of village government committees and supervision and coordination of facility governing bodies.

This requires adequate preparation of the workforce to meet expected changes in the health system and to support primary health care delivery. He acknowledged the shortage of facility based health care providers and pointed out the need to increase and strengthen community/village health workers who can provide an essential link between primary health facilities and the communities, as strategized in

the MMAM and HSSP-III. However, he cautioned that the engagement of communities in health development requires vigorous community mobilization for them to fully participate in the process and for CHWs to act as “change agents” as they “educate and empower” their fellow community members.

To this end, Dr. Kiangi strongly advocated for a paradigm shift in the provision of health care services whereby the roles of primary health care providers should be viewed through the lens of health promotion and disease prevention in the community. He emphasized the need for people in the community to be part of the process as they seek solutions to their health problems, something that he said can only happen if they are enabled to make informed health decisions. At the same time, CHWs need to be equipped with the necessary and adequate know-how and tools to capacitate them to deal with community health problems efficiently and effectively. This calls for a common understanding among stakeholders and partners.

He concluded his remarks by expressing his confidence in the expertise of stakeholders' at the meeting which he believed would help to 'loosen the knot around community based health services' and help to build a solid foundation for the success of this important initiative.

With those brief remarks he declared the meeting officially opened.

## **Section Three: Highlights of the Plenary Presentations**

In this session, findings from recent and/or on-going studies on CHW training and deployment were presented and experiences from selected initiatives that are being implemented with a view of enhancing the facility-community link shared. They also received feedback on results of the mapping exercise that was conducted prior to the Stakeholders' Meeting that provided an indication of who is doing what, where and how with regard to initiatives that engage CHWs. These presentations were preceded by a keynote address that provided a historical overview of the evolvement of health care delivery and a presentation on key policies and policy statements that have been guiding CHW initiatives in the country. Below are highlights of the different presentations.

### **3.1 - Keynote Address - Historical Background of Community Health Initiatives in Tanzania by Dr. Peter Mmbuji, Ag. Director of Preventive Services, Ministry of Health and Social Welfare**

The Presenter, Dr. Peter Mmbuji has a wealth of knowledge on the evolvement of the health sector in the country and has participated in the design of several key initiatives and processes aimed at making health delivery in the country more efficient and effective.

He started off his presentation by acknowledging the many definitions of a Community Health Worker and established that regardless of how a CHW is defined or described, what needs to be borne in mind is that these people are members of the communities within which they live and work and they are chosen by those communities. He then went through a litany of sequential events that led Tanzania to where it is today with regard to health delivery.

He talked about the different levels in the current health delivery system structure identifying the lowest level as the village. He explained that before independence most curative services were based in urban centres and were directed to specific groups. There were limited services to rural areas. At that time health facilities in rural areas had minimal resources and minimal equipment and medicines and human resources that existed back then were mostly 'dressers' and other preliminary service providers.

After independence in 1961, particularly after the Arusha Declaration in 1967, and in line with the first 5-year development plan of the then ruling party (the Tanganyika African National Union – TANU) improvements in health care delivery had the main objective of reaching people in the rural areas. The policy then was to have health personnel all the way down to the lowest level – the village. However, village health services then were focused mainly on curative services. Each village had a health post with 2 Village Health Workers (VHWs) who were given a short training and then continued providing services. A few years later additional cadres were introduced including rural medical aides, MCH aides and others to provide other basic health services including immunization.

In 1978 following the Alma Ata Declaration, Tanzania was among few countries that were earmarked for the implementation of the Primary Health Care strategy which brought with it 'barefoot doctors' to assist with the provision of health care to the most remote communities.

In the mid-to late 1980s the PHC strategy was implemented spearheaded by a PHC Section that was headed by an Expatriate. Family planning services were introduced in the rural areas and another cadre, the famous Community Based Distributors (CBDs) was established to facilitate the provision of these services all the way to household level.

After 2000, PHC was revitalized; the Clinical Officer cadre was established and Tanzania got into the frontline in the provision of health services, which saw the establishment of the Health Service Development Programme and the PHC Development Programme – MMAM. As we speak, every village in Tanzania has a dispensary. Dr. Mmbuji challenged participants to re-think whether there is a level below the village health service level such as Hamlets which are not officially recognized but they exist, that will help to improve efficiency in the provision of health care services. He recalled the era of 10-cell leaders (*'Mabalazi wa nyumba kumi kumi'*) who were responsible for ten households and stated that some of the government initiatives such as this one were linked to the health care system.

Coming back to the subject at hand he informed the meeting that CHWs were introduced as part of the revitalization of the PHC system and were owned by the government along with Village Executive Officers (VEOs) who are paid a salary. He stressed that as the meeting deliberates on CHWs, we also need to acknowledge other service providers, such as community mobilizers who are not health workers per se but they are providing a valuable service that facilitates the effective provision of health care services. He cited the eradication of small pox which he said was made possible because of the work of these community mobilizers. He also cited the 'Man is Health' (*'Mtu ni Afya'*) Campaign which was also very successful because of these people. With that background in mind he tasked participants to think about how we can reach every household with health education adding that the stakeholders' meeting was of great significance to the development of health in the country.

He concluded his presentation by posing a number of pertinent questions which he asked participants to ponder on as they deliberate on the concept of CHWs:

- Who should own them? Should they be owned by the village government? What are the pros and cons of such an arrangement?
- As we deliberate on the subject of CHWs, are we going to consider the educational level of these people? In the past, VHWs had to be literate; they had to know how to read and write.
- What are we going to train them in? Given the numerous developments in the health care delivery system, what curriculum can empower them to deliver effectively?
- Should they be in the pay roll or not? In the past they served on voluntary basis and were supported by the communities that appointed them. Things have changed now; the volunteering spirit is dying and the community supportive spirit not very strong.
- How should we address HIV/AIDS in the context of CHWs? What have we learned and how do we go forward?
- What about AIDS orphans, etc. how do we support them?

### 3.2 - Existing National Policies and Implementation Strategies on CHW initiatives presented by Dr. Geoffrey Kiangi

The main objective of this presentation was to share some of the policies and policy statements that can guide the development of CHW initiatives in the country. The presenter walked participants through the different policy statements highlighting key areas that guide the planning and establishment of community-based health care initiatives. He first defined the terms 'policy', 'public policy' and 'policy statement' before elaborating on the contents. Below is a summary of his presentation.

#### Definitions:

*Policy* - a "Statement of Intent", "Commitment", or "principle or rule" to guide decisions and achieve rational outcomes. It enables decision-makers to be held accountable and may apply to government, private sector organizations and groups, and/or individuals.

*Public policy* - seeks to achieve a desired goal that is considered to be in the best interest of all members of society or group of people; for example, good health, decent and affordable housing, minimal levels of poverty, low crime in society, etc.

*Policy statement* - serves to clarify intent (give an overview of the policy and why it was created); describe how a policy is administered (who the policy applies to, who has responsibility to monitor adherence to the policy); define the particulars of a policy (outline in detail how it is to be applied - Issue, Objective and policy statements)

#### Existing policy documents

Several policies have been developed including some general policies that provide overall guidance and health-specific policies that guide health-related activities.

General policies include Vision 2025; MKUKUTA III and the 5-Year Development Plans. There are also several policies that are health specific that provide guidance and elaboration on the implementation of various health-related activities. These policies are of different durations and include among others:

- **The National Health Policy (1990 and 2007):**
  - ☛ Every village in the country should have at least two Village Health Workers, one of them to concentrate on MCH activities while the other will deal with environmental sanitation (pg 9, 1990).
  - ☛ Communities have an obligation to participate in improving their own health
  - ☛ They should be involved in addressing their health problems using available local resources
  - ☛ They have to choose their own CHW who will link the community and the nearest health facility
  - ☛ Community health worker responsibilities will include health education, and assisting in relevant public health interventions (pg. 10 & 11, 1990).

- **Primary Health Services Development Plan/MMAM (2007-2017)**
  - On the National AIDS Control Programme;
    - ☛ Community Home Based Care acts as a linkage between HFs and Communities in providing basic health services at home.
    - ☛ Village governments have to mobilize resources and create a favourable environment for the implementation of the MMAM in terms of voluntary labour and materials.
  - On community IMCI, MNCH and FP;
    - ☛ Train ward and District trainers of community health workers on community IMCI and MNCH (pg 61)
    - ☛ Train community health workers on community IMCI (pg 62)
    - ☛ Train Family Planning community based distributors (pg 63)
  
- **Health Sector Strategic Plan III (2009-2015)**
  - On community ownership;
    - ☛ Community involvement and participation in health promotion, home based care for CDs and NCDs, and MNCH
    - ☛ Community participation in management of CHF
    - ☛ Collaboration between CBOs and NGOs in health services delivery
  
- **Human Resources for Health Strategic Plan (2008-2013)**
  - On Primary Health care cadres;
    - ☛ Speed up the rate of output of health workers through expanding enrolment, reduction of training duration and
    - ☛ Re-introduce Primary Health care cadres
    - ☛ HRHSP activity plan with regard to planning for a cadre of community worker (1.1.3) and developing such a cadre (3.1.3).

Other policies that touch on different aspects of community health initiatives include:

- The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania (2008-2015)
- The National Nutrition Strategy (2009 – 2015)
- The National Social Welfare Policy (in the offing)

Note:

- The 1990 Health Policy and PHSDP (2007-2017) focus on Village or Community Health Workers; whereas recent policy documents (except the PHSDP, 2007-2017) use general terms such as voluntary labour, primary care cadre, community resources, community involvement and participation.

In addition to the above policies, the following policy statements are relevant to the discussion on CHWs. They have been extracted from the Health policy, PSDP/MMAM, HSSPIII, HRH Strategic Plan and National RCH Roadmap and they talk about a number of things including:

- Communities' obligation to improve own health
- Expanded enrolment to increased output of health workers (re-introduction of PHC cadres and their training)
- Responsibilities of CHWs - improve family health practices and assist in implementation of relevant public health interventions at community level
- Community HBC to act as linkage between HFs and communities
- Resource mobilization by village governments (voluntary labor and materials)
- Collaboration between NGOs and CBOs

### 3.3 Findings from the CHW Mapping Exercise presented by Ms. BJ Humplick, Independent Consultant

The CHW mapping exercise was conducted to gather experiences of community health initiatives in the country that use CHWs with identifiers of the main characteristics in the different initiatives. The objective was to assist the MoHSW to better orient itself on who is doing what, where and how and inform on the process of developing the national community health initiative that is affordable, effective and sustainable.

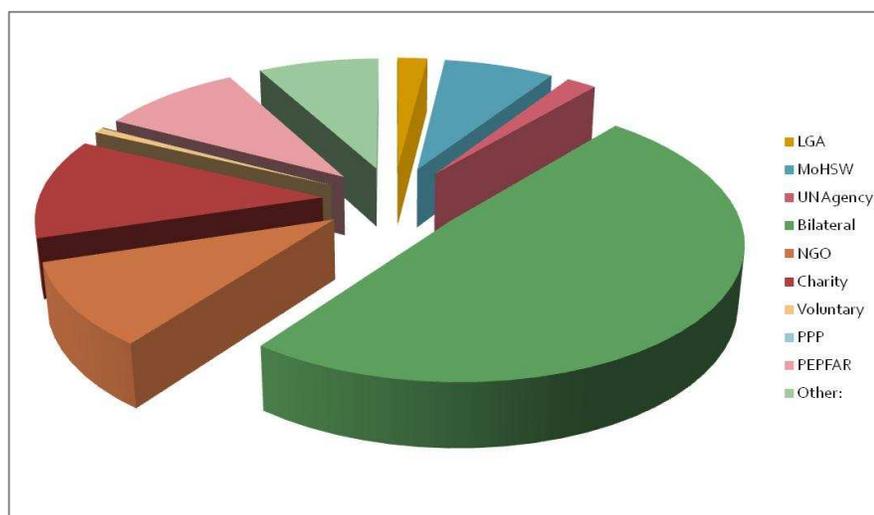
The exercise was done with the aid of a pre-designed Excel sheet with a drop down menu that was sent out to more than 50 organizations (umbrella, NGO, CBO and FBO) requesting them to share information on the type of initiatives they support or implement, the main areas of focus, the approach they use including the type of support provided to the CHWs that they work with, and where possible indicate the number of CHWs they work with. On hindsight, the Task Force realized that the drop down menu may have limited the type of responses that came forth as respondents were requested to click on the answer which most closely describes the particular characteristic of each of their initiatives, and this lost some of the specific details that could help paint a more realistic picture.

That notwithstanding, the response rate was very good as more than 100 matrixes were completed and returned from a variety of implementing agencies and the responses do shed some light on common characteristics of the different initiatives being implemented in the country.

A word of caution is necessary here in that the findings from this initial mapping exercise should not be taken as representative of the actual situation as not all stakeholders were able to respond to the matrix. However, it does provide a snapshot view of what might be out there. Below are the findings as compiled and analyzed:

#### *Funding Source:*

Bilateral funding seems to be the most common type of funding across the different initiatives followed by charity and individuals and PEPFAR supported initiatives. As can be seen from the pie chart below the biggest chunk of money is made available through bilateral arrangements.

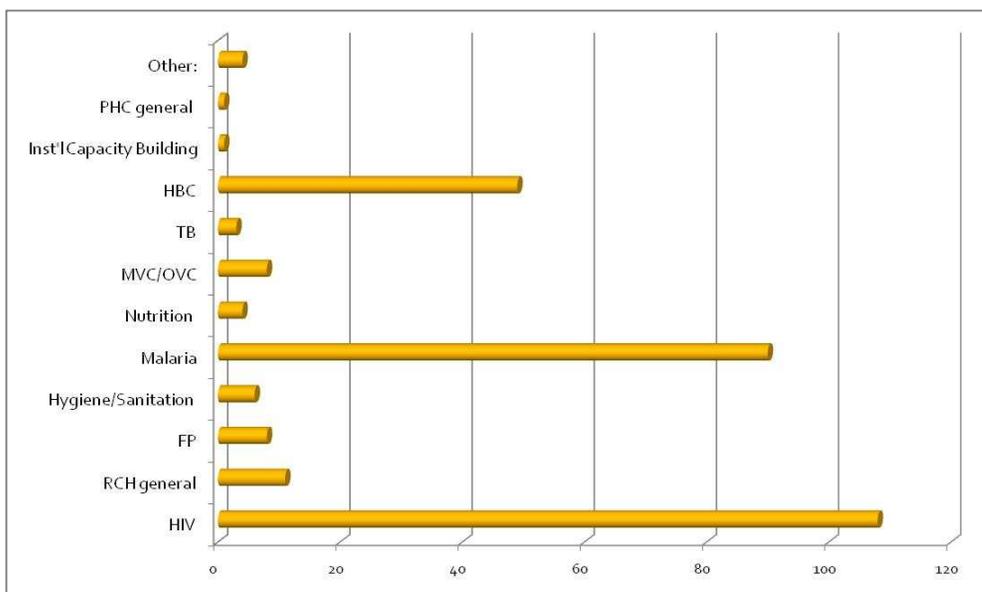


**Geographic Location:**

Most of the initiatives operate at ward followed by district level.

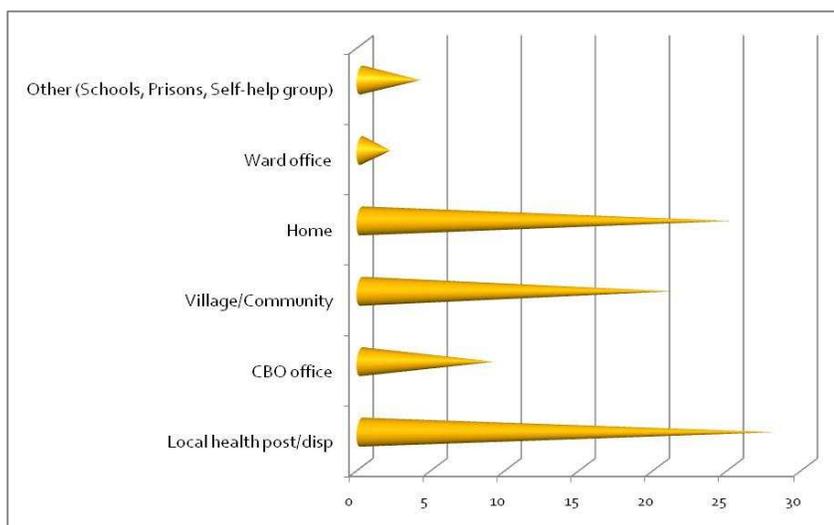
**Area of Service Delivery:**

The majority of initiatives focus on HIV/AIDS and HIV/AIDS-related services, Malaria and Home Based Care. Other initiatives that use CHWs include Reproductive and Child Health (RCH), Family Planning and Most Vulnerable Children & Orphans. Nutrition, Hygiene & Sanitation and TB initiatives were also mentioned as areas of service delivery that engage CHWs.



**Where CHWs operate from:**

The majority of CHWs are based at the local health post/dispensary, followed by those who operate at home and a few at village level. Some initiatives have been very innovative in placing their CHWs as indicated in some of the responses where schools and prison cells were mentioned as areas which CHWs operate from.

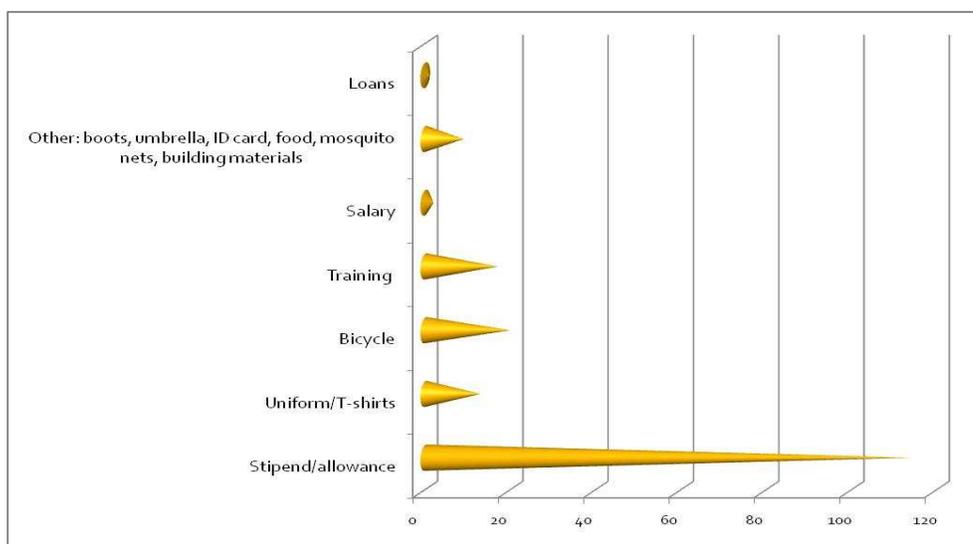


**Type of services provided:**

The provision of services, commodities and drugs was the most common type of service provided through CHWs, followed by promotion and referral services. A few stakeholders mentioned psychosocial/spiritual, protection and shelter as types of support CHWs help to provide.

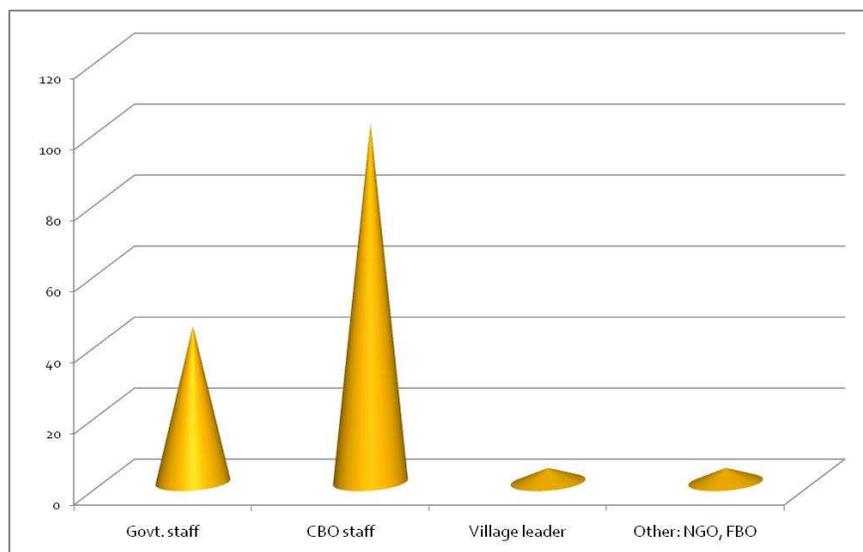
**Type of support provided to CHWs:**

A large majority of CHWs are provided with a stipend/allowance; a few get bicycles and uniforms e.g. T-Shirts and different types of training to keep them motivated.



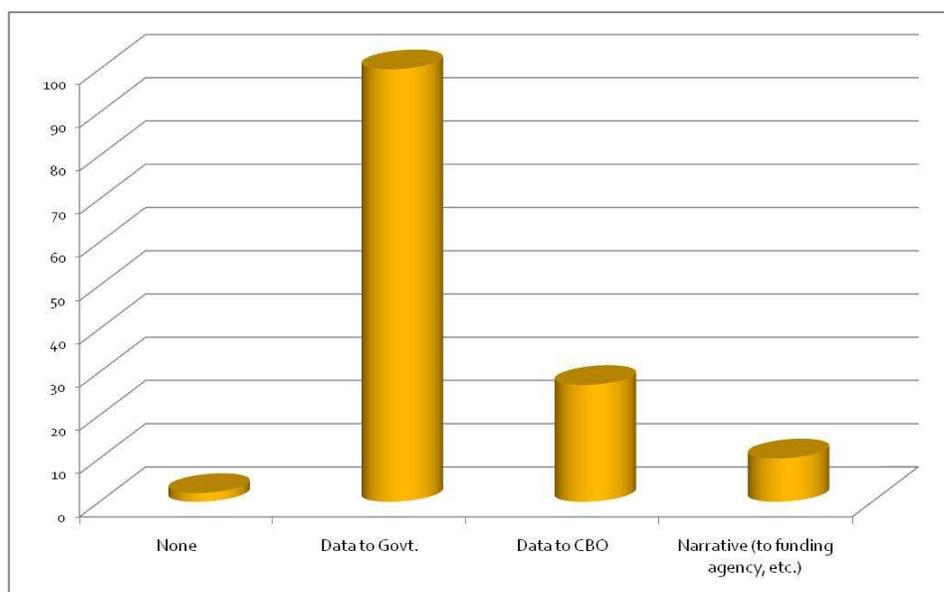
**Supervision and Coordination:**

Most of the respondents said their CHWs are supervised by CBO staff and a few by Govt. staff. Very few are supervised by village leaders.



**Reporting:**

An overwhelming majority of respondents said their CHW programmes send data to government and a few to the CBO. Some funding agencies also require narrative reports.



**No. of CHWs used by the programme:**

Not all respondents had hands-on data for this question. However programmes that engage CHWs are of varied sizes ranging from less than 50 to over 5,000 depending on the scale of the programme.

**What story do the above findings tell?**

From the responses above, there is a clear sense of ownership evidenced by the large number of CHWs that are based at grassroots level and operate from local health posts, home or village level. This is in line with the PHC Strategy which aims to decentralize health care delivery to district level and below. Another positive trend is that the coordination of most of the initiatives is done by CBOs and Government staff and reporting in terms of data flow is mostly to government with narratives to the funding agency. The government needs to have information for it to manage its programmes effectively.

There was some concern that most of the programmes are funded through bilateral arrangements with no clear phase out strategy which would shift responsibility to local authorities. Sustainability could be an issue of concern as the final objective is to transition from externally funded and owned programs to community /civil society owned programs with a realistic government coordination role. Another area of concern is the remuneration of these CHWs. The provision of a stipend/allowance could be a motivating factor for the CHWs but there is a need to develop a strategy to sustain such a system after the project comes to an end. Aiming for community-driven approaches whereby communities take up the responsibility of rewarding CHWs might provide better hope in this regard.

In terms of area of service delivery, having more initiatives providing HIV and AIDS-related services and Malaria is not reason for concern as both AIDS and malaria are among the top 10 killer diseases in the country. However, there is a need to ensure that all key areas are covered including Reproductive and Child Health (RCH), Family Planning (FP), Nutrition and others. Such balancing can only be done after an in-depth mapping exercise is conducted country-wide that will provide a baseline for CHW initiatives and help to identify gaps in terms of coverage – both geographical and service delivery.

One of the main advantages of using CHWs is their potential role as a link between the communities and the service provided, in this case health care. CHWs can reach large numbers of people with information and services all the way down to household level as they extend the continuum of care where health services end. Well planned and executed CHW initiatives can go a long way in realizing the goal of health for all.

### 3.4 Testimonies of CHWs

In this session, participants to the Stakeholders' Meeting were able to hear first hand narratives of life as a CHW in Tanzania from two CHWs who had been invited to the meeting to share their experiences and respond to questions from the audience. The Task Force that organized the Stakeholders' Meeting managed to identify and invite two CHWs (one female and one male) who have been providing services in their communities for many years. Their testimonies helped to give a human face to the discussions on CHWs. Following below is their testimony of how they were selected, what they do, how they are remunerated, what motivates them to stay, the challenges that they face in their work and recommendations for improvement of CHW initiatives.



#### Testimony 1: Salma Chuma

##### How she was selected

Salma Chuma (in picture) lives in Soga village in Kibaha rural district. She was selected as a CHW in a General Village Assembly meeting in 1993 and tasked with a set of activities which by then included educating her community on various health related issues and preparing reports on epidemics, such as diarrhea and cholera. She reports to the village government and to the village dispensary. She is a primary school leaver.

##### Role and Activities

As years went by and more partners came on board she got involved in other activities and started providing services under different programmes. For example, she performs several tasks under the Child Survival Protection and Development (CSPD) programme supported by UNICEF; she works as a Community Based Distributor (CBD) of family planning methods and is engaged in Demographic and Social Surveillance (DSS) exercises. She also works with the Family Health International (FHI) supported 'Tunajali' programme.

Her current activities have expanded to include visits to patients suffering from chronic illnesses such as AIDS, Cancer, Diabetes, Heart complications and TB; promotion of exclusive breastfeeding; distribution of various support items including school uniforms and other materials; psychosocial support to vulnerable children and dispensing medicine for treatment of common ailments (aspirin, panadol, etc.).

##### Training

She has received training in various areas conducted by different programmes in the areas of Home Based Care, psychosocial support; income generation and other basic skills required for the type of work she is supposed to do. She works from 2-4pm every day and her salary ranges between 30,000/= and 35,000/= per month depending on the programme that engages her services.

## Accomplishments

Through her work, she has noticed a number of successes that have motivated and reinforced her commitment. Among the most significant are the reduction of maternal and newborn mortality rates and reduced incidences of environmental and water-borne diseases. On a personal level, working as a CHW has increased her confidence as she is well known in the village by all age groups, she has traveled to different regions for demonstrations of different skills, such as making toys using locally available materials.

## Challenges & Recommendations

Lack of working tools and the distance she has to cover to provide services are among the major challenges she faces. There are 5 hamlets in her village and she has to walk long distances to reach those communities. She sometimes struggles with lack of cooperation from some community members who refuse to cooperate because of the monetary compensation she gets.

Salma's recommendations were centered on the challenges listed above. She requested that NGOs that use CHWs should consider providing them with bicycles to facilitate their work. She also talked about additional funds for photocopying some of the tools she uses in her work, e.g. data forms. Currently she requests the village government to support her but there is no formal system to ensure that this support is always provided and/or sustainable. Her last request was for a higher allowance because of the expectations that some of her clients (community members) have of her. She is often asked for money by patients whom she visits at home during her home based rounds, particularly in referral cases where the referred patient asks her for bus fare or money for medicine, etc.

## Testimony 2: Ramadhani Kondo

### His role and activities

Ramadhani Kondo (pictured on the right) is also a primary school leaver who works as a CHW in Lukenge village in Kibaha rural. He did not tell the audience how he was selected; he went straight on to talk about what he does. His main activity is to educate communities about epidemics. He works from 12 noon - 3pm on weekends.



### Training

He has been trained by the Ministry of Health and various other organizations in several areas including home based care, psychosocial training for children, malnutrition, counseling on HIV and Sexually Transmitted Infections (STIs) and health services for children.

## **Accomplishments**

Through his work, communities are more aware of the importance of environmental sanitation specifically the construction and use of latrines. There is an increase in facility-attended births and the use of family planning methods. More women are aware of the importance of breastfeeding and parents and caretakers can now identify when their child is in danger by reading/interpreting the child's growth card. HIV prevention efforts are going well and there is a reduction of stigma against PLHWAs. Personally, the community has confidence in his leadership ability as they appointed him as Chairperson of the Tanzania Social Action Fund (TASAF) in his village.

## **Challenges**

Ramadhani's main challenge is reaching community members during the farming season (cultivation and harvest period) as most communities shift to their distant farms and it is difficult to follow them up. He also has to deal with some people's resistance to change. Some believe in traditional and customary taboos and are adamant to adopt modern ways or methods. Others simply don't understand some of the health promotional messages that are being imparted. For example, he sometimes gets resistance during cholera epidemics when he advises food vendors to shut down their food business until the environment is safe. He also feels that he is not sufficiently compensated for the work he does.

## **Recommendations**

He would like to be employed by the Government. He feels that the work that he does is similar to the work of a health assistant or health officer and he is doing it very well.

## **Question and Answer Session that followed the testimonies**

After the CHWs had given their testimonies the Moderator invited questions from the audience for clarification and also to get more information on areas that they did not dwell on in their testimonies. Information gathered from their testimonies and the responses they gave during the question and answer session was later used during the group work session reported in Section Four of this report. Below are the actual questions and answers from the session.

*Qn: You mentioned that you would like to be paid a higher allowance; how much do you think will suffice?*

Ans: I would like to be paid the minimum wage paid to public servants.

*Qn: How much time do you need to work in order to be more effective?*

Ans: I can work for the entire day if I am being paid the minimum wage.

*Qn: If you are paid the minimum wage and you are ready to work for 8 hours how will you provide services to families during the farming season when they are in their farms?*

Ans: The farms are within the community and the cultivation/harvest period is very short so there still is an opportunity to reach them.

*Qn: Are there any efforts to teach other community members to play similar roles in your community?*

Ans: I work with Integrated Management of Childhood Illnesses (IMCI) volunteers; I educate them in their respective groups. I also work with out of school youth by involving them in what I do and they help disseminate the education in their communities.

*Qn: How do you plan your work?*

Ans: The community identifies which families I should visit and then I visit them at their homes. When I'm through I request for a follow up visit and we set a date.

*Qn: Do you go from house to house in these two hours or do you gather people together to provide the education?*

Ans: I gather people together and provide group education

*Qn: Do you only work with organizations that pay you?*

Ans: Initially I did not receive any payment. I offered my services as a volunteer. It is only recently that I started receiving an allowance. I am willing to work regardless of whether I get paid.

*Qn: Do you get paid if you attend courses (i.e. in addition to the 35,000/=)?*

Ans: It depends on who is providing the training. For example, an HBC course takes 3 weeks and I get paid 480,000/= for the entire duration.

*Qn: How frequently do you go for training?*

Ans: As CHWs we are recognized by the community so in most cases whatever training comes up, be it in CBD, HBC, CHBC we get appointed as a way of keeping us motivated.

*Qn: What are your boundaries of authority/responsibility; for example, is it your responsibility to tell people to shut down their businesses during an epidemic?*

Ans: Health officers are based at ward level so they request CHWs who are closer to the communities to assist them in informing communities about health dangers during an epidemic. We do our work with permission from the village government.

*Qn: Do you think it is important to have specific areas of operation for each CHW? Or can it be better to multi-task?*

Ans: There are 2 CHWs in each village and each one is assigned a set of tasks to perform.

*Qn: You have been taught a lot of things, what do you mostly follow up on and what do you report on?*

Ans: We report on actual happenings at household and community level. If a household member has a certain problem then it would be recorded in that month's report.

### **3.5 CHW Rewarding options and Nomenclature <sup>1</sup> - presented by Dr. Serafina Mkuwa**

The presentation on CHW rewarding options and Nomenclature was the first in a set of 3 key presentations that touched upon policy issues from CHW studies. The presenter, Dr. Serafina Mkuwa shared findings from a study on training of the CHW cadre in existing CHW programs highlighting nomenclature and rewarding options for CHWs. Below is an overview of her presentation.

#### ***Huge variations***

The existing CHW programmes in the country vary greatly in terms of geographical coverage, approaches used in the training (curricula and materials), duration of training and the area of focus. There is a heavy bias in HIV-related training. The only common factor is that in all the training programs offered, the selection of CHWs to be trained always involved communities and literacy was among the main criteria for the selection.

#### **Generalist vs. Specialist CHWs**

There are two distinct types of community based health personnel; those that perform a set of varied tasks (Generalist) and those that provide perform specific tasks (Specialist) with different nomenclature used to describe them. What is noticeable is that regardless of the classification, all the terms used connect them with a grassroots locale (village/community or rural) and health-related activities. Among the popular names used are 'community health' aides, 'community health agents', 'community health guides', 'community health' auxiliaries, 'community health volunteers' and 'community/village health' workers. On the other hand, CHWs that are recruited for specific programs (specialist), e.g. HIV, RCH, Orphans and Vulnerable Children (OVCs), Home Based Care (HBC), etc., are identifiable by the type of services they provide but the locale is not always mentioned, hence names such as 'home based care providers', 'community based distributors', 'peer HIV educators', 'lay counselors', 'life skills trainers', 'traditional birth attendants', 'parasocial workers' and other such terms.

There are merits and demerits of both categories in that while Generalist CHWs are more holistic and respond to a wide range of family needs, they are difficult to monitor and to show impact, often overloaded with too many tasks and require longer training to grasp the different health aspects. There are also issues regarding the quality of the services they provide because they do too much. Specialist CHWs on the other hand are easier to monitor and show impact, it is easy to maintain quality because they have a minimal set of tasks and easier to attract funding; however, they are not responsive to all community needs and their activities are often donor driven.

#### ***Policy frameworks and Policy Direction***

There are two key national policy frameworks that are supportive of CHWs initiatives. The first one is the Primary Health Care Services Development Plan (PHCSD) of 2007 (MMAM) which talks about the establishment of CHWs with specific targets for training them within a specific time frame (6000 CHWs to be trained in a span of 10 years) to address specific areas (maternal and newborn care). The second one is the National RCH Roadmap which relies on CHWs to improve family health practices, monitor

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<sup>1</sup> extracted from a study titled "Training of CHW cadre in Tanzania" by Drs. R. Shoo and A. Mzige

implementation at community level and involve communities. However, there is no mention of the strategies to be used.

Existing policy documents do not provide much direction as there isn't much mention of CHWs in the key national policy documents. The Human Resources Development policy and strategy talks about reintroducing community health cadres but does not specifically talk about CHWs. It only mentions Clinical Assistants and Grade B Nurses. The National health policy is also not explicit about CHWs although subsequent strategic plans recognize the importance of this cadre of health workers. What is clearly lacking in both of these documents is mention of a coordinating mechanism of the different vertical initiatives.

In terms of legal recognition, while villages are legally recognized by the government Act that established them in July 1975 there is no formal representation of 'health' in the village committee neither is the village based health extension worker recognized. It is hoped that the Village Act will be reviewed during the process of developing the new Constitution

### ***Conflicting messages about their importance***

CHWs are not officially recognized in the public service as a cadre and are not legally recognized as part of Community Based Resource persons but they are regarded as useful by implementing partners and are often said to be a complementary option in areas with shortages of human resources and as a useful link with communities and reliable informant of what is happening at community level.

### ***Rewarding CHWs***

Evaluations of different approaches used to reward CHWs do not present a positive picture about using volunteerism in the provision of community based health services. Volunteerism is said to be unsustainable or unproductive. The force of this argument is backed by evidence of a number of volunteers who show a lack of motivation to do their job or drop out of the programme altogether.

Some countries in Africa including Malawi and Ethiopia have fully integrated CHWs in the health system as paid workers. Others such as South Africa pay them a fixed monthly salary of R1,000.00 which is

equivalent to about USD 150. There is yet another category of CHWs, as established by a recent study conducted by MUHAS, who work on voluntary basis but they receive cash rewards for their performance and to support their basic needs. Such cash payments vary widely and range from Tshs. 10,000/= to 75,000/= a month although when asked the study participants proposed a range between Shs. 50,000 and 300,000/= a month. Countries that reward their CHWs have recognized their role and are willing to invest in their development and sustenance.

In Ethiopia, paid community based health workers helped to achieve substantial scale up of Antiretroviral Treatment (ART) and HIV Treatment and Care (HTC), moving from 900 patients on ART in 2005 to more than 150,000 by 2008.

### ***Incentives and disincentives***

Aside from salaries, CHWs also receive other cash rewards including transport and meal allowances and non-monetary rewards in the form of items such as basic supplies such as notebooks and pens, bicycles, raincoats, umbrellas, carry bags, flashlights and soap. Other non-monetary rewards for CHWs that serve as incentives include recognition and respect by the community and by health professionals; acquisition of valuable skills; personal growth and development; peer support and membership to CHW Associations; status within the community which sometimes gains them preferential treatment; flexible and minimal hours and most importantly the feeling that they are part of the health system. However, they do face some situations that are a disincentive to them and lead to attrition. Those who receive monetary rewards are sometimes paid inconsistently and at times the tangible incentives change. Those who receive non-monetary rewards complain of inadequate supervision, not getting adequate refresher training, excessive demands on their time and lack of respect from the health facility in their locality.

Communities on the other hand are motivated to select CHWs when they notice visible changes in the health status of community members e.g. as a result of successful referrals that help to prevent avoidable deaths, or when they are better able to protect themselves and prevent diseases from the health information that they received from CHWs. But they get de-motivated by the unclear roles and expectations of these CHWs (prevention vs. curative) especially in areas with shortages of health personnel; inappropriate behaviour among CHWs and by their lack of attention to community needs.

### ***Existing rewarding opportunities***

The study on CHW training identified a number of rewarding opportunities that can be utilized for CHWs, with specific suggestions on mechanisms that can be used. For example, the study recommends the inclusion of CHW initiatives in Council plans by utilizing Code E07 in Rural Councils and B16 in Urban Councils. Apparently, 5-10% of the council funding is supposed to go to such initiatives but the excuse given is that community health work should be voluntary. Other opportunities for rewarding CHWs through existing systems include the CHF, cost recovery in health facilities, direct contributions from communities that can afford, direct support from the private sector including setting up a social responsibility fund for mining Companies in Tanzania, and support from private foundations and charities.

The presenter ended with suggestions for the way forward and a set of questions that provide food for thought as participants continue to think through the process. See bulleted list below:

### ***Suggestions on the way forward:***

- Revision of the existing Health Policy and government Act to spell out the role of this cadre at village level and prioritize the implementation of these policies.
- Establish a formal reward system for CHWs
- Formally recruit and remunerate CHWs through the Local Government structure.
- Encourage LGAs to sponsor CHWs for training and remuneration.
- Recognize CHWs as formal health extension workers serving a facilitation role.
- The CHW career development program should provide opportunities that allow several entry points for existing capable CHWs for them to grow.

**Food for thought:**

1. What are the best options to harmonize the various existing names and functions of the CHWs?
2. What would you advise the government regarding the inclusion of CHWs in existing policies?
3. What strategies should be used to compensate CHWs for their efforts and for sustainability?

*Community Health Workers are a lifeline for hundreds of thousands of people who would otherwise not have access to health care.*

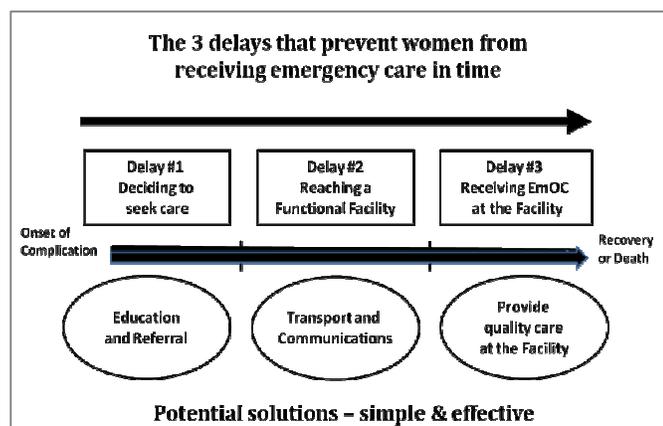
### 3.6 Multitasking, Cost-effectiveness & Sustainability<sup>2</sup> presented by Dr. A. Hingora

The research project through which issues about multitasking, cost effectiveness and sustainability were studied is a trial project of Tanzania's MMAM designed to generate evidence for guiding sustainable health systems development and strengthening links between communities and health systems in order to accelerate progress towards achieving Millennium Development Goals (MDGs) 4 & 5. It combined qualitative process evaluation with a statistically randomized controlled experiment comprising treatment and comparison villages. The project intervention shifts the focus of services from static facility-based approach to Community Health Agents (CHA). It was also part of a trial to clarify contextual factors that enable or hinder the intervention and affect health care services availability, accessibility, utilization, quality, affordability and equity. The project is titled CONNECT as it tries to address the huge disconnect between households and the formal health system which MMAM aims to address. The assumption is that "Where there is a functional health system CHAs can add value through community based service delivery". The role of CHAs is to prevent the 1<sup>st</sup> delay through education and referrals hence facilitating access to emergency care in time.

#### The Setting

The CONNECT project was implemented on the following premise:

- Unacceptably high maternal and newborn death rates which impact on the achievement of MDGs 4 and 5.
- A shortage of a trained health workforce that hinders the provision of community-based healthcare.
- Numerous community based health workers/volunteers who are single tasked, trained through vertical programs, who have been abandoned or were highly frustrated and unsupported and decided to drop out or engage in other activities to make a living.
- Poor access to health facilities and limited outreach to communities and households despite the strong network of health facilities.
- Huge challenges with emergency referrals.



#### Cost-effectiveness

The CONNECT trial project aimed to improve access to and extend the range of MNCH services through community-based care and referral systems; improve the quality of services through relevantly appropriate and people-centered care; improve information on community health status and needs; and increase the efficiency of the health system through multi task-shifting to CHAs. The theory that guided the trial is that a formally trained and paid multitasking CHW providing community based services and emergency referrals will impact on access to RCH services and save infant lives.

<sup>2</sup> extracted from findings of a Randomized Cluster Controlled Trial titled "Introducing Community Health Agents (CHAs) to facilitate the household to health facility continuum to accelerate progress towards achievement of MDGs 4 and 5"

**Multitasking:**

The basic roles and responsibilities of the CHA are to provide a package of health services in the community including, education, promotion, prevention, risk identification, early management and referral activities and to connect people across the household to the facility. This person is a secondary school leaver residing in the village/ community within which they work; selected by the community at a full Village Council Meeting to ensure that s/he is acceptable by and answerable to the community. They report to and their activities are monitored and supported by the village authority and technically by a health staff from a nearby health facility.

Below is a core package of a range of tasks that this person is expected to perform:

- Improve household and community practices and capacity in the area of MNMCM
- Enhance community-based case management of childhood /other illnesses
- General RCH including ANC, FP including refills, medicines and supplies, facility delivery, PNC, improve organization of work from community-level up, including timely referrals (maternal and newborn emergencies)
- Organize/mobilize communities for CHF and identify households with food insecurity and family members at risk, affected by or with disabilities
- Data collection, analysis and presentation of routine h/hold and service data, village register and the transmission of information to health facilities
- Improve household and community practices and capacity mainly MNMCM
- Enhance community-based case management of childhood and other illnesses
- Strengthen the health system by providing a link with villages to facilitate accessibility of information and services

**Sustainability:**

The trial project used WHO's Health Systems Development Interventions model which necessitates working within/through existing health and administrative structures to ensure sustainability, local ownership and cost-effectiveness. In this model, the CHA is a focal person within the CHMT. The model also engages national stakeholders in the development of CHA curriculum and support systems and establishes feedback loops with stakeholders at different levels – national, regional and international. The strengthened connections between communities and the system help to generate evidence to guide the development of sustainable health systems. Further efforts towards sustainability include initial discussions on the operationalization of CHWs in the MMAM policy and the utilization of CONNECT experiences during the designing the national model.

**Key Conclusions:**

The CONNECT trial project worked towards generating evidence and the national recognition & formal integration of paid CHAs into health system in Tanzania. The evaluation of the project focused on a number of areas including CHA effect on infant and child health and nutrition, newborn and child mortality; key outcomes including service utilization/coverage, improved health behavior, increased equity, decreased social cost for health and health seeking behaviours; service delivery and quality; outputs, health systems inputs/processes and cost-effectiveness analysis.

Preliminary observations reveal a sense of fatigue among communities for people who just collect data and do not tell them why such data is being collected and how the data can be used to improve the situation. The study also revealed that there is a ready workforce in the village waiting to be used and that the Village Council has total ownership of the process. Also, because CHAs multitask, they can better respond to the different community needs. They are well accepted and can be very effective. They are operationalizing the community component of IMCI very effectively.

CHAs have also proved to be extremely useful in community data collection, use and mobilization for outreach services from static facilities in the areas of HIV counseling, condom distribution, facility FP initiation and community refills, facility deliveries, early diagnosis, management and early referrals and reducing cases with complications at facilities (dehydration, fevers, pneumonia, injuries). They get invited to various village meetings to report, share and discuss the data they collect and the data is used for the operationalization of community Health Management Information System (HMIS).

Community emergency referrals begin from community level and can help to prevent maternal and newborn deaths. However, static health facilities need to be functional for CHAs to be of any value to the health system otherwise, as the CONNECT project observed, it can lead to “reverse referrals phenomenon” whereby dispensaries and health centres refer patients to CHAs. The project provided CHAs with mobile phones which they use to refer patients, advice, train, report on outbreaks and transfer and timely data in an effective and efficient manner,

*“Essential health services cannot be provided by people working on a voluntary basis if they are to be sustainable. While volunteers can make a valuable contribution on a short-term or part-time basis, training health workers should receive adequate wages and/or other appropriate and commensurate incentives”. WHO, 2008*

### **3.7 Competencies and Accreditation<sup>3</sup> – Presented by Prof. Japhet Killewo**

One of the over-arching goals of the Tanzanian health system is to accelerate the reduction of Maternal, Newborn and Child deaths which can be effectively done by developing a cadre of CHWs that is well-trained and equipped to address basic HIV/AIDS needs at the community level. CHWs have been identified as a valuable addition to the pool of HRH that can help to achieve universal coverage of HIV services, particularly in developing countries.

This noble goal can be attained by establishing clearly defined categories of the CHW cadre(s); with comparable scopes of work and training curricula. To this end, the government must be engaged in the development of a harmonized curriculum and nationally recognized and accredited program for CHWs that will eventually attract multiple partners to support their training and deployment.

In its efforts to assist the government to harmonize and standardize systems and processes, CDC Tanzania funded a study on the training and deployment of CHWs to enhance their recognition and effectiveness. The study aimed at reviewing existing curricula of PEPFAR-funded CHW programs in order to develop recommendations towards defining homogeneous cadres of CHWs as well as a set of standardized teaching materials that would constitute recognized curricula for different categories of CHWs. It also sought to examine CHW training programs to define distinct cadres of CHWs based on consumer perspectives; determine areas of commonalities and distinctive differences among the different curricula so as to identify categories of CHW cadres that can be validated and accredited; and to develop a policy advocacy strategy and plan for the accreditation of CHW training and their formal deployment in Tanzania.

Through the use of semi-structured questionnaires about CHW programs, the curricula were administered to PEPFAR partner organizations supporting CHWs and analyzed using grounded-theory methods to identify similarities, differences and gaps in outreach and content. In addition, an in-depth literature review was conducted to explore the impact of models that engage volunteers. Six regions in Tanzania Mainland, and Zanzibar were involved in the study. Below is summary of the findings as they related to issues of competencies and accreditation.

#### ***Competencies***

Results of the analysis identified a total of 8 distinctive categories of CHWs of which 7 were specifically engaged in HIV-related work. The same categories listed in the previous study on CHW training were identified namely; HBC providers; Community Based Distributors for both RCH and HIV education and supplies, para-social workers and counselors for MVC/OVCs, Peer HIV Educators, Lay Counselors, Life Skill Trainers and TBAs.

#### ***Accreditation***

As far as training is concerned, even though HBC, CBD and PSW programs utilized government standard curricula there are some variations and/or gaps in the training content in the area of basic anatomy, maternal and child health care, HIV treatment adherence and common opportunistic infections.

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<sup>3</sup> Extracted from a study on "Training and Deployment of CHWs: creating homogenous cadres of CHWs to enhance recognition and effectiveness"; A review of PEPFAR funded HIV programmes

Curricula in the remaining CHW categories (Peer educators & counsellors, MNCH providers, TBAs etc.) varied greatly in content, methodology of recruitment, training and deployment, length of training and refresher courses and assessment of trainees.

One common feature was noted in that ALL programs employ a model of permanent volunteerism which leaves a lot to be desired because while it might create hope for the volunteers, their retention is not guaranteed. There is no career path for CHWs and they are not integrated at the facility level since facilities do not have a supervisory role to play over them. Such a model is also driven by donor priorities.

***Recommendations on the way forward:***

Cadres:

The study recommended the combining of several categories of CHWs whose tasks are somewhat related to create a new cadre called 'Community Health Extension Workers' (CHEWs). This cadre would combine HBC, CBD, Community Maternal, Newborn, Child Health (MNCH) Coordinators into one new cadre to be called Community Health Extension Worker (CHEW) cadre.

Para-social Workers, Peer Educators and Peer Counselors to remain in their distinct categories as their services are very provide value added HIV/AIDS related support.

Curricula:

As per the combined categories above, there should be a corresponding combined HBC/CBD/MNCH curriculum that should be developed using existing modules to create a comprehensive curriculum that addresses all issues including HIV/AIDS, primary health care and sexual and reproductive health to support the CHEW cadre.

Sustainability:

CHWs should be paid a standard wage consistent with the government minimum wage scales with a clearly defined career ladder.

All maternal, newborn and child health programs operating in Tanzania should assess the feasibility of incorporating the different MNCH curricula into the new CHEW cadre and the care provided by CHEWs should be expanded to include safe and sterile home birth/deliveries.

Supervision:

Supportive supervision of CHWs at the facility level should be strengthened by including supervision skills training in the training modules for clinical officers and nurses working at dispensary and health center levels.

Recognition:

To enhance recognition and career development of CHEWs, the minimum education level should be raised to Form IV.

**Critical issues to be taken into consideration:**

- Clinical officers or clinical assistants are not trained to supervise CHWs. Their training curriculum does not contain modules for supervising CHWs. Need to find ways to ensure effective supervision of CHWs.
- What arrangement would be feasible for bearing the costs for the training and deployment of CHWs in Tanzania? How can such an arrangement be sustained?

### **3.8 Experiences of CHWs working in Reproductive and Child Health – Presented by Dr. Chrisostom Lipingu**

This presentation was meant to serve as a model of CHW programs in Tanzania on the implementation of an integrated facility-community approach. The program is funded by USAID through Jhpiego-MAISHA, which stands for Mother And Infant Safe Health Alive. The main strategy used in this model is the provision of education no Focused Antenatal Care (FANC), malaria prevention, infant feeding, PMTCT, cervical cancer and other critical areas under RCH through CHWs. The intervention is implemented in 4 regions and education is also provided using modern technology (mobile phones) at facility and community level. The CHWs engaged are selected by community and village leaders using exiting national guidelines. These selected CHWs and their supervisors under a 3-week and 2-week training programme respectively.

#### ***Tools and resources***

A set of five different types of resources including National guidelines and learning Resource package have been developed, four of these have been translated into Kiswahili and pre-tested with 25 trainers. They include an integrated community MNCH trainers' guide, CHW reference and supervisor guide and some job aids. Also developed are national guidelines on integrated community MNCH which have been printed and are awaiting signature.

#### ***Achievements***

So far the program has achieved the following:

- Conducted a needs assessment in 8 villages in Morogoro and dissemination meeting
- Worked with MoHSW to develop materials
- Pretested materials by training 25 Trainers and using CHWs at the village level
- Conducted advocacy meetings at regional, districts and community level.

#### ***Challenges:***

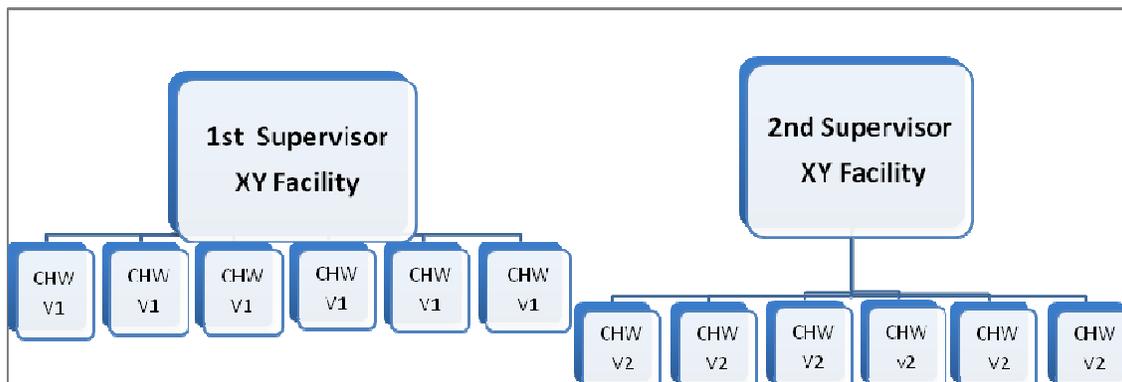
- One of the main challenges that this program faced, is the presence of multiple partners on the ground (at community level) working in the area of PMTCT, MNH and FP
- The program is also very complex as it involves various units within the MoHSW as such it requires consensus building and collaboration with 4 different units at the RCHS

#### ***Key Findings about the Model:***

The integrated MNCH is a viable strategy in facilitating communities to manage their own health. However, it requires joint efforts among the different partners. It is also necessary to incorporate a motivation mechanism at the design stage to facilitate the realization of the intended outcomes. Another finding which sheds light on the deployment of CHWs is that the number of CHWs trained should determine the catchment area to be covered.

**Future plans:**

Plans are underway to start training in five districts in Morogoro. Two CHW supervisors in each facility will be trained in the cascade supervision model and everyone will supervise one village with 6 CHWs each. After the training, each facility will cover 2 villages. See illustrated model below.

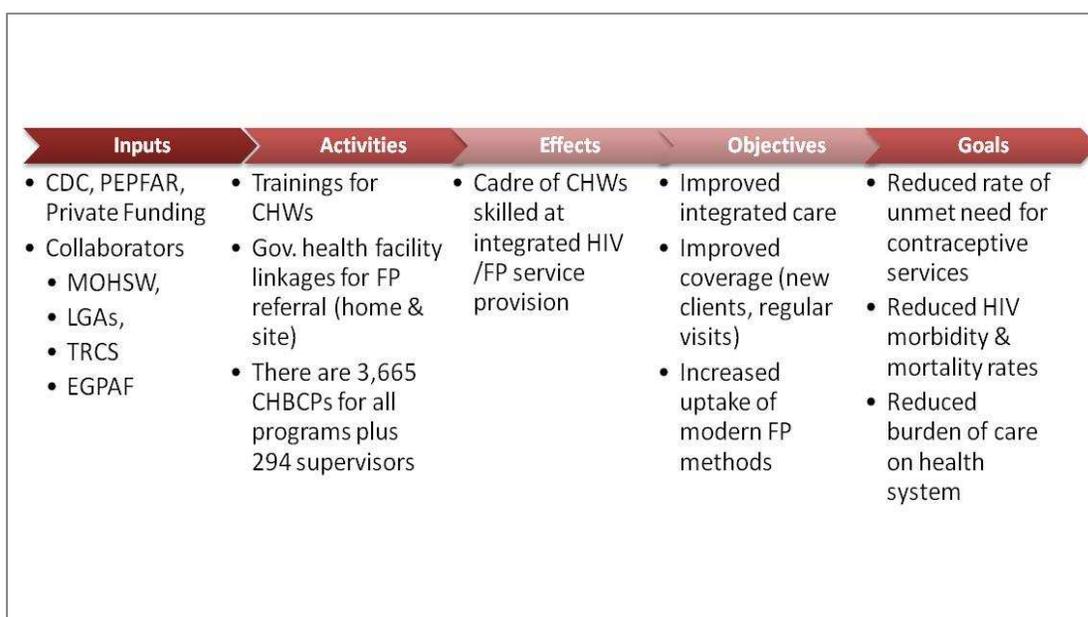


**Food for thought:**

The Presenter challenged participants to think about the role of policy makers in ensuring sustainability of CHWs; how CHWs should be motivated and whether the integrated model for training and service delivery could be used by other partners, and if so how.

### 3.9 Experiences of CHWs working in HIV and FP – Presented by Dr. Pasiens Mapunda

This presentation was another case study on integrated services but this time in the area of Family Planning and HIV. It was based on a collaborative effort between the Ministry of Health (NACP & RCHS), Tanzania Red Cross Society (TRCS), PEPFAR and Pathfinder. The rationale for integration of HIV and FP was based on the fact that PLWHAs on ART increasingly desire access to contraceptive services; there is a highly unmet need for contraceptives in the general population with multiple barriers to FP access including distance, quality, misconceptions, facility-level human resource shortage and stock-outs. There are also large networks of community-based health workers for HIV established through PEPFAR. The idea was to find ways to leverage CHBC providers to provide contraceptive and other health services. The FP/HIV TWG has a key role in this intervention. The illustration below provides a snapshot view of how the project is organized and implemented with clear objectives and goals.



#### **Achievements:**

##### **HIV:**

- Over 36,158 PLWHAs have been supported with HBC services
- More than 86,265 referrals made, including 17,789 for FP; some CHWs are purely CBDs they do not perform and HBC work.
- 180,356 people tested and counseled for HIV thro HBCT services.

The above achievements confirm the following:

- HIV and FP services can be integrated at the community level through community providers offering a broad range of contraceptive methods.
- Integrated programmes provide an effective platform for increasing service availability in the general population as well as for PLWHAs.
- Community health workers can be trained to provide HIV support services alongside FP counseling and referrals and can be involved in contraceptive distribution.
- Counseling for FP from a trusted community source can result in a method choice that reflects the fertility desires of the client and effectively links the client to the service that can provide the method she wants.

**Future plans:**

- Further absorption of HBC providers to integrated services in Dar es Salaam (245 providers)
- A total of over 2,000 CHBCPs will start working on the new project (LIFE PROJECT) after receiving training on National Data collection tools. This Project will cover regions such as Tabora, Mwanza, Pwani and Zanzibar.
- Pathfinder International and its collaborators has also absorbed 327 CHBCPs recently from Mild May and ELCT. They will start working from September 2012 after completion of training on data collections tools.
- Training to improve contraceptive counseling for PLWHAs, especially those on ART
- Focus on PMTCT clients to counsel for post-partum FP and HIV-free, well spaced and timed births too.
- Continued advocacy for more HIV funding in Tanzania to be used for FP programming.
- Integrate community-based response to S/GBV to address gender inequalities

### **3.10 Key Issues from Plenary Discussion following presentations**

This section contains an array of issues that were raised during the different plenary sessions. Most of them were picked and used during the group work session (see Section Four) which is exactly what was intended. By design the Task Force arranged all presentations on the first day so that as much information as possible was generated. This information was then reviewed and used to come up with draft proposals and recommendations on various aspects. No analysis of the issues has been attempted. They have just been clustered into different themes or areas and presented as they came up.

#### ***On National Policies:***

- Several meetings have been held during which policies were shared; where are these policies? Have they been disseminated widely enough? How many NGOs are aware of these policies?

#### ***On Governance:***

- Working in silos - there is a tendency for some government departments and ministries that are involved in similar or the same issues to not talk to each other and in cases of crises they keep passing the buck and/or the blame to each other.
- There is a historical explanation for the existing inter-ministerial and interdepartmental relationships. Initially, the PHC strategy was chaired by the District Commissioner and Regional Commissioner at district and regional level respectively and health activities were coordinated by a multi-departmental committee. The liberalization of PHC should not overlook the human factor. A sense of collaboration and cooperation needs to be cultivated and team spirit revived.

#### ***CHWs cadre – what does it include?***

- Are paralegal or para-social workers CHWs? Some programs use them to do work that is done by CHWs in other programs. Is there a need to upgrade them to CHWs?

#### ***CHW compensation:***

- Is the government read to pay them?
- Using which mechanism? Is it affordable? For how long?
- Alternative option is to find people who are willing to volunteer with minimal incentives.
- We should not reinvent the wheel. Existing national policy guidelines, specifically the CCHP guidelines state clearly that CHWs should be given monetary compensation but there are not terms of reference on how much they should be paid and the mechanism for paying – e.g. allowance, salary, etc. We need to have clear terms of reference to avoid multiplicity; but the TOR should depend on the locality and the activity being performed

#### ***Think globally but act locally:***

- The discussions should focus on actual implementation so that at the end of this meeting we can suggest to the MoHSW what can be done.

**PPP:**

- Nothing has been said about PPP arrangements for rewarding CHWs. What does the policy say with regard to CHWs?
- Needs to be encouraged and become more visible
- It is a public service department initiative
- The Government support of PPP is crystal clear in the representation to the stakeholders' meeting

**Interlinkages:**

- Village government is the first point of contact and VHVs/CHWs are based at the village/community level and are within the village government. Other health workers at dispensary level; it is important to establish linkages between staff working in the village and those at the health facility.

**Standardization of rewarding mechanisms for CHWs:**

- Differential treatment; CHWs get their supplies and instructions from the dispensary. Some are on payroll and other are volunteering

**CHW supervision:**

- Does the dispensary supervise CHWs?
- How effective is this supervision?

**Putting Social welfare on the map:**

- Matters concerning social welfare keep being kept on the back burner. Just like the Department of Social Welfare keeps being shifted from one Ministry to another social welfare matters do not seem to be taken with the seriousness with which they deserve. This has been going on since independence. For example, how are community workers in the social welfare sector recognized? Importance of social welfare was recognized in 1993 when cost-sharing was introduced. The department was instrumental in identifying community members who qualify for exemption.
- There are very few social welfare personnel at the district level; most of them are working with NGOs.
- The social determinants of health are multi-sectoral and multi-disciplinary. The government is looking for ways to work together. Currently, there is social welfare officer position at district level as part of the harmonization and streamlining process.
- Coordinators of OVC/MVC counselors and social workers need to be clarified since they work in the same community but are coordinated differently
- MVC coordinators, para-social workers and community justice facilitators are not coordinated by the district, rather by the district social welfare office

**Costed Plan of Action for MVS:**

- Not mentioned – still a new document at the MoHSW; working tools are still being developed
- Need to review all documents that shed light of what needs to be done – extensive review is necessary

***Integration of PHC strategy:***

- All types of implementation mechanisms, e.g. vertical interventions, consortiums, etc. need to be considered as we work towards strengthening the health system.
- Different programs go down to the community with different demands – need coordinated efforts not to overwhelm these CHWs. If we are not careful we might find ourselves relieving our burden to the CHWs.
- We need to learn to work together with other sectors. It is not only about integration but the principles as well.

***CHWs sustainability – what is the problem?***

- They are not paid that is why the program is non-sustainable
- They are doing a lot. They were an important link with the dispensaries and between different teams

***Need to think outside the box:***

- Health might be simple but it is very complicated. Vertical components will always exist. We need technical inputs at technical level but we need to implement horizontally.

***Documentation of experiences to capture best practices and lessons learned:***

- There is a tendency to re-invent the wheel because we don't have a habit of documenting our best practices.
- Tanzania has very rich experiences; it was once recognized the entire world because we could provide services all the way to the grassroots level. We are losing this. Now there is total confusion because whoever pays more gets more cooperation.

***Need to identify best approach for achieving better health outcomes:***

- The preventive approach to health care and the emergency component is crucial
- We also need to balance between clinical facility health care and promotive and preventive health care. We have approximately 23 Million people to be served by a mere 50,000 CHWs!

***Need to borrow a leaf from successful programs, e.g. Nepal***

- Even though money is an important factor, the issue of ownership is even more important
- Things are not happening that is why we are discussing this issue today
- Need to think of how to create a linkage between the local level and central level. The challenge is that the different key ministries are operating at different levels; recruitment is done by a different ministry (PMORALG), training and supervision at another (MoHSW), and financing at yet another (MoF). There has got to be confusion.
- Need to work together to come up with complementary rather than conflicting strategies. Need to develop advocacy plan to get the MoF to understand the important of this initiative and then find the best way to identify critical minimum activities, decide how they should be implemented and then cost them.
- In order to be on the same page, we need to harmonize different processes and develop user-friendly versions of key guidelines and disseminate them.

**Availability of policy documents at local government:**

- The ministry frequently produces and disseminates various documents to all regions and districts and does orientation on how to use the documents
- Tanzanians do not have a reading culture so a lot of this effort goes to waste
- We need to change our perception of things.

**We lost our boat somewhere along the line – who is to blame?**

- In the 1980s we used to have a very strong PHC system; very well organized from national to district level
- There were committees at regional, district, ward and village levels
- Villages were in charge of raising money to pay CHW/VHWs
- Facility health workers supervised VHWs
- As time went on things changed donors began paying some of the workers while others were not being paid. Programs that could not pay lost their VHWs; others were employed by NGOs and the leadership at district level became slack
- Different nomenclature came in and derailed the chances of sustainability. The Ministry kept shifting direction

**Importance of the referral chain:**

- If the referral chain is not functioning a lot is lost
- There is a huge disconnect between the system and the households
- CHWs are basically giving added value to the system – if the health system is not functioning CHWs are useless. They need the support of a functioning system

**Information flow up and down to influence decision making**

- The HMIS works against the laws of physics “everything that goes up must come down “but with the HMIS it remains up!
- Information (data) is useless if it cannot be used for planning and informed decision making

**Go modern with ICT:**

- Referrals and reporting could be simplified if CHWs were given mobile phones to ease communication. Some phone companies e.g. Airtel have very attractive packages that are not very costly when compared to the advantages. Need to explore these

**Referral system with feedback**

- Non-existent in this country, yet!
- Need to established a feedback mechanism up and down (back and forth) the referral chain
- CHWs need to know what information to pass on during referral, e.g. what tests were done, what action was taken, etc.
- Communication between referring and receiving points is very crucial
- Facility staff now being trained to become clinical advisers’ helps to reduce a lot of complications by taking the appropriate step before referring a case to a higher level.

**Moving from specific to more generalized**

- Initially the center of gravity was the newborn, hence emphasis on RCH
- There are more serious cases from pregnant women and children emerging and the urgency has shifted to IMCI
- CHW training needs to incorporate such shifts

**Legal recognition of CHW:**

- Once CHWs are legalized at national level it will trickle down to the LGA level.
- You cannot be employed by the government if your scheme has not been approved by Public Service.

**Community mobilization to embrace CHW initiatives:**

- Develop mechanism to empower communities to own CHWs
- Sensitize them so that they can support the intervention and sustain it

**Incentives for CHWs:**

- Monetary and non-monetary (bicycles, etc.)
- Training is an incentive; they get paid allowances but also their social status is elevated through their expanded knowledge

**Volunteerism**

- We cannot do away with it completely
- However, we cannot rely on volunteers to deliver a package of services without any remuneration and then expect quality or accountability
- Volunteerism is neither sustainable nor productive. For example testimonies of CHWs show that they lose motivation if they are not supported to meet some of the individual and family needs. In the past people could work on voluntary basis nowadays that spirit is dead.
- Still a need to consider volunteerism - it can work!

**Training**

- Different programmes using different approaches – have different entry requirements for training and the duration differs for the same type of training
- Need clarity on this so that we can harmonize. What is the view of the MOHSW on this?

**Financing options available**

- Government is streamlining accounts under the DEDs
- Other options such as CHIF and other funding schemes that can pay two CHWs per village should be explored

**Lack of clear roles and responsibilities:**

- Conflict of interest between CHWs and health assistants
- Need to come up with something that is doable by the government.

**Level of education of CHWs**

- Need to move with the times
- All other government employees including drivers have to have secondary school education. If CHWs are to be paid as a public servant this is a condition that must be fulfilled. We now have a secondary school in every ward so it is possible to attract young energetic and committed people to serve their communities as CHWs
- Even among CHWs there is a desire to advance career-wise. CHWs who gave their testimonies expressed their wish to get more education so that they can qualify for employment in the government
- On the other hand it could be risky to train this level; they might shift to urban centers after being trained.

## Section Four: Highlights of Group Work Session

The premise for this session was a list of issues captured during the previous sessions which needed further discussion. Prior to the meeting the Task Force in consultation with the different presenters had identified key themes in line with the outputs of the meeting around which participants would have in-depth discussions to come up with concise recommendations on the way forward in that regard. Three main themes were identified: policy and systems strengthening; implementation and operationalization of CHW initiatives, including financing, single/multi-tasking and sustainability and training of CHWs, including the required competencies and standards. The information that was generated on the first day of the meeting including the testimonies from the CHWs provided a lot of material to guide the group discussions.

The discussion took place in small mixed groups of between 8 and 10 people formed on the basis of interest. Three sets of questions developed from the material generated from the presentations and plenary discussions on the first day were put on 3 separate flipchart stands and placed outside the meeting room. Participants were invited to sign up for a group of their interest and when in their groups they responded to a set of questions around the above mentioned themes and later shared in plenary. The deliberations below include additional suggestions from the plenary.

### 4.1 Policy and Systems Strengthening

The group that worked on this theme was required to come up with recommendations on the following:

- A preferred nomenclature for CHW s in Tanzania;
- Financing options for sustained CHW initiatives which are acceptable and feasible;
- Optimal coordination and harmonization mechanisms of the various CHW initiatives focused on family and community needs at national and council level.

#### ***Nomenclature:***

The majority (16 out of 21) of the members of the group opted for '***Community Health Workers***' as the most fitting nomenclature because it is internationally recognized, it is already used in national policy documents and it is commonly used elsewhere. They further argued that this cadre provides services from household level and that using Village Health Worker does not entirely connote representation of the grassroots level.

Other suggestions for a nomenclature for this group included '*Community Health and Social Worker*' to include the social welfare aspect; '*Community Health Extension Worker*' as they are called by other Ministries, e.g. Agriculture and '*Community Health Agent*' since they support /facilitate the provision of basic primary health care.

***Financing options for acceptable, feasible and sustainable CHW initiatives:***

There was unquestionable agreement that CHWs should be remunerated through a formal mechanism. They argued that given the number of villages in the country which is estimated at 12,000 and the policy instruction that each village should have 2 CHWs there is a need to have a mechanism to remunerate this workforce because projects come and go. In this regard, they proposed that CHW be established as a new cadre whose incumbents should have a minimum educational level of Form IV plus training. There also needs to be a formal standardized system for their training, deployment and retention. In the interim, we should continue working with the current CHW who are primary school leavers.

As a long-term plan it was proposed that all related costs for the recruitment, training, deployment and retention of CHWs should be incorporated in the Council Comprehensive Health Plans as it is well documented in the CCHP guidelines of 2011. Once this system is up and running, having a community health worker on board should be a pre-requisite for the approval of Council plans. Other options suggested included using funds generated from different schemes including the CHF which was found to be promising in terms of sustainability since the community has a say on the use of funds and they contribute into the fund and the National Health Insurance Fund (NHIF) and upcoming Social Health Insurance Scheme (SHIS). Individual partner support should be coordinated.

***Optimal coordination and harmonization mechanisms of the various CHW initiatives at national and council level:***

Since this is an area that needs further consultation, the group suggested that the issue of coordination and harmonization mechanisms be tabled at the TC SWAp and suggested that there is no need to reinvent the wheel. TWG No. 12 is already in place and it should be engaged instead of using a national steering committee. It should have open membership picked from any of the relevant ministries.

The MoHSW should be the 'Coordinator General' of this process which will require the strengthening of the CBHC Unit in order for it to better serve its coordination role. The involvement of the PMO-RALG was strongly recommended since the LGAs that will eventually assume responsibility for this initiative are under its jurisdiction; however, there is a need to explore financing options for the PMORALG to participate in coordination meetings. Nevertheless, coordination MUST be at government level to ensure that resources are not duplicated.

Operationally it was recommended that there be a multi-level coordination structure with sub-committees at national, regional and district level. At district level, the DMO will appoint the CHW Coordinator from the CBHC unit. The group also felt the need to review the national CHW guidelines to include a chapter on 'coordination' that will guide the process.

***Consultative framework:***

The group recommended using the TC SWAp for continuous guidance on policies, strategies and guidelines which is a responsibility of TWG No. 12 of the TC SWAp.

## 4.2 Implementation and Operationalization

The group that worked on this theme was required to come up with recommendations on a set of tasks for the CHWs, criteria for their recruitment, deployment and retention and how they can be effectively supervised in way that will ensure optimal community involvement and ensure quality delivery. They were also required to recommend the way forward for government, partners and communities on the stated objectives. This is what they proposed:

### ***Set of tasks for a CHW and whether they should be comprehensive or selective:***

Given that there are only 2 CHWs per village and as confirmed by the testimonies of the CHWs at the meeting, the group recommended that the tasks to be performed by CHWs should be comprehensive and they should be expected to multitask. For certain services, e.g. HIV/AIDS there is need for specific tasks but generally the allocation of tasks should be guided by the principle that says *"the closer you are to the community the less specialized you should be"*. This means that community based health workers should be able to perform a variety of tasks in accordance with the specific needs of the communities within which they live and work.

The range of services that CHWs are expected to perform include sanitation, water, disease prevention and health promotion, nutrition, referrals, reporting, community mobilization, basic curative palliation and most importantly data collection which will provide a basis for further planning and strategy development.

### ***Criteria for recruitment, deployment and retention of CHWs:***

#### Recruitment:

The group recommended that while we should continue using CHW with primary education, new recruitment should preferably be of form four leavers with additional relevant qualifications and experience. This recommendations ties in with previous discussion about the developments in health care delivery and their ability to grasp the different concepts as well as their career path and growth.

Their selection should continue to be done by the communities themselves according to a set and mutually agreed criteria. Once selected, the candidates should be interviewed by a mixed panel of interviewers consisting of representatives from the funding agency, selected community members and supervisors from the nearby health facility.

#### Deployment:

CHWs should be deployed by a formal contract with accompanying job description, equipped with essential tools and supplies. There should also be a formal schedule for training. This will enhance their recognition both in the communities they serve as well as in within the government system.

#### Retention:

A retention system that ensures the provision of incentives (monetary and non-monetary) on the basis of performance and workload should be designed with a basic monetary remuneration of at least 30 percent of the current minimum wage. It is not a full time job as confirmed by the testimonies of the CHWs. The system of using volunteers will continue to complement the formally recruited cadre of CHWs.

#### Supervision:

The group discussed the supervision of CHWs in detail and came up with clear recommendations on who should supervise them and how they should be supervised. Supervision was seen at two levels; according to arrangements of the respective locale and at a technical level. At the locale they proposed that the Village Executive Officer (VEO) should appoint a person from the Village Social Services Committee to assume a supervisory role and advised that the paymaster should be an administrative officer in the said committee. From the technical side, supervision should be done by the person responsible for supervising community health activities based at the nearby facility (dispensary or health centre).

As regards the 'how, the group recommended that Standard Operating Procedures (SOPs) for supervision should be developed and adhered to.

### **4.3 Training of CHWs including the required competencies and standards:**

The group that dealt with training, competencies and standards was required to propose an essential package of roles, skills and competences for CHWs in Tanzania and recommend essential elements and standards for a training program for CHWs.

#### ***Essential package of roles, skills and competences:***

The group started by categorizing health services into major categories and then identified the major roles of a CHW in each category of health service. Four main categories of health services and one general one were identified. Below is a summary of the respective roles for each category.

*Health promotion* – this will require the CHW to educate, follow up, sensitize, distribute education materials, refer patients, counsel and support them. Organization and mobilization of communities and networking are key functions under this category.

*Prevention* – this mainly involves problem identification and notification of health problems and the distribution of preventive supplies (condoms, printed materials, etc.).

*Care and treatment* – entails first aid support, referrals, follow up on treatment compliance and home visits.

*Rehabilitation* – involves the provision of psychosocial support, identification of people with special needs e.g. disabled, MVC/OVCs and the chronically/terminally ill, follow up and referrals.

*Cross cutting services* - these include the documentation of issues that can be used to monitor and evaluation services, use of data for planning community interventions and birth and death registration.

As far as skills and competencies are concerned, a CHW needs to have good interpersonal communication, the requisite technical skills and the ability to apply the knowledge and skills to effectively perform all of the roles described above. Meanwhile, the Steering Committee at national level should continue discussion on how to improve training curricula, position training institutions, output of the training and the scaling up plan.

***Essential elements and standards for a training program for CHWs:***

The basic elements of a CHW training programme were discussed in length and the group proposed that CHW training should be residential, competence based, interactive and demonstrative. It should also use nationally recognized curricula and consist of a combination of theoretical and practical skills. There should also be refresher training after a set period of time.

As for the standards the group felt that there should be a clearly defined level of entry, qualified facilitators and formally recognized training periods and stages. The question of using accredited institutions to conduct the training was also suggested although this might involve further consultation and dialogue at different levels.

***Recommendations on a set of tasks for a CHW in order to meet the need of the families and communities:***

In their deliberations, the group went as far as listing the advantages and disadvantages of having a comprehensive set of tasks and argued that while comprehensive tasks may be cost-effective, support integration of services, address multiple tasks and help to simplify supervision, there is a danger of overloading CHWs who would then require longer training periods that can be more expensive. They also cautioned that it may eventually lead to higher rates of attrition due to burnout.

***General Concerns:***

During the plenary discussion that followed the group presentation, some participants were wary about the danger of prescribing too much as some activities tend to be left out. It was therefore advised that while it is critical for the central level to guide the process, we should avoid encroaching on the mandate of the DMOs and other officials at district level. Some flexibility should be allowed during implementation based on the actual situation on the ground. It was also recommended that the planning function be left to the planning team whose capacity needs to be enhanced for it to plan well and all sources of funds (grants, Health basket funds, cost sharing, etc.) should be used in line with priorities in the guideline.

A certain degree of skepticism was also expressed about whether it was possible to get form IV leavers who are interested in serving in their communities on a semi-voluntary basis. However it was argued that if such positions are sufficiently advertised there are quite a few form IV leavers in the communities who have no formal employment who can take up the offer. The key emphasis is on the candidate's residency in the respective community hence use of the term 'preferably' and the provision for the alternative qualification of having the relevant experience. A lot of training has

gone into training existing CHWs who are recognized by their communities and have a lot of experience in community mobilization and education so they will continue to be used. But more and more community members with higher levels of education will be encouraged to serve as CHWs.

The composition of the CHMT also came up in the discussion with a feeling that there is a need to add a social welfare coordinator to the team. Further discussion on the issue however advised that due to the current HR crisis it might not be possible to do that at this point since even other cadres, e.g. the Nutritionist that had been included before no longer exists for the same reason.

On remuneration, participants felt that it was not possible to mention exact figures that CHWs should be paid until an agreement has been reached on the scope of work (specific tasks and working schedule) for the proposed cadre of CHWs. A lot of things need to be sorted out including the varying needs of CHWs in remote districts who have to work for longer hours due to distance from one household to another, age and other such considerations. All these factors need to be taken into consideration and there might be a need to carry out time-task allocation studies on some existing CHWs to find out how much time they spend doing CHW work. This will shed light on a workable mechanism.

#### **4.4 The Way Forward**

The way forward was a constant thought throughout the meeting. The Task Force was taking note of key issues that emerged from the discussions that need to be included as part of the way forward; participants deliberated on it in their group discussions; and a group of Panelists including some of the Presenters and other participants who have been involved in various health initiatives in the country shared their views in a moderated session at the end of the group presentations. The Panelists with the organizations they represent indicated in parenthesis included Dr. Geoffrey Kiangi (Health Education Unit/MoHSW), Dr. Faustine Njau (World Health Organization), Dr. Eric van Praag (Family Health International 360), Prof. Japhet Killewo (Muhimbili Health and Allied Sciences), Dr. Athumani Hingora (Ifakara Health Research Institute) and Dr. Serafina Mkuwa (African Medical Research Foundation). The major question being addressed was "What should be the strategic next step?"

Below is a bulleted list that summarizes the different thoughts, ideas and suggestions that came out of the above mentioned processes grouped into themes.

##### ***Moment of truth!***

- Tanzania used to be the first and pioneer country in Primary Health Care 30 years ago; we need to regain in the communities what we have lost. To do so, we need to ensure that PHC policies translate into practice.
- CHWs, being the preferred title for this community cadre, are essential if we want to revitalize PHC and to meet all basic health needs of individuals, households and communities in both rural and urban areas. However, they can only function and make a difference if the health system is functioning and capacitated to fulfill their facilitating role.
- All stakeholders attending this meeting expressed their will and commitment to be ready to jump in and participate to complement our different comparative advantages.

**Immediate next steps:**

- The Task Force CHW initiatives (TFCHWI), initiated by the Health Promotion Unit and sanctioned by the CMO coordinated the process so far but should be formalized by MOHSW and its specific role (Scope of Work) identified to be able to coordinate the promotion of CHW initiatives process within MOHSW in a focused manner. It should be answerable to a higher authority at the MoHSW.
- The TFCHWI to elaborate and propose detailed steps/actions from the broad suggestions of this meeting and future deliberations and present them to the relevant authorities in MOHSW, PMORALG and partners.
- The TFCHWI to develop an outline of options for improved coordination within MOHSW and between PMORALG, MOHSW and other relevant ministries at national and council levels.

**Issues that need to be considered during the process of harmonizing and operationalizing CHW initiatives:**

- Take into consideration realities on the ground reflecting people's health needs in prevention, care, support and emerging health issues
- Identify individual needs in relation to community needs for Primary Health care including RCH, HIV and other life threatening conditions
- Focus should be at the household level; health care provision cannot begin at the facilities
- The role of local government authorities is crucial. While the technical guidance lies with the Ministry of Health, we should work towards getting the support and participation of LGAs
- Need the support of other stakeholders and development partners in planning, funding and technical assistance
- The general direction/guidance should come from the central level Ministries however the community health coordinators within the CHMT should assume a leading role in planning and guiding CHWs initiatives at community level and needs support from their DMOs, CHMTs and LGAs.
- Social Welfare will need to be integrated into PHC but may need a separate cadre working in close collaboration with CHWs such as the para social workers currently being trained.

**Operational actions (mid-and longer-term):**

- Establish an advocacy framework to influence LGAs to utilize first and foremost available budget lines within CCHPs to support CHW initiatives and in addition proactive exploration of sustainable options like community insurance schemes like CHF, PPP initiatives, TASAF and other community financing options as well as partner support options. As much as possible, use the Association of Local Authorities of Tanzania (ALAT) as a platform for advocating CHW initiatives. This will help to develop a common vision for the operationalization of community health activities within LGAs.
- Work towards making CHW a cadre that is recognized and included in national policies and strategies but complementary to public civil servants
- Elevate and capacitate the CBHC Unit within the ministry to a level where it can perform its coordinating role more effectively. This is a very crucial one to avoid the silo way of working to support CHW initiatives through special programs such as HIV HBC, FP RHC etc.

**Hard facts:**

- The final decision lies with the government, specifically the MoHSW; the duty of stakeholders is to promote the decision making process and advocate for quality improvement.
- We are operating in a resource- constrained environment we should not expect all that has been proposed to be accommodated. Resource identification needs to be done using new opportunities within Government, NGOs and private sector.
- The MoHSW is in transition; it has undergone a series of crises in the last 6-8 months, now is the moment to facilitate change.
- Structures are not as functional as they should. Rural communities are worse off; supplies and trained human resources do not get there. Therefore we should not make more demands on community health workers while they lack basic common supplies and medicines
- We should avoid raising expectations too high; It will take a decade to create a critical mass of CHWs, curriculum development needs to reflect current comprehensive needs which are dynamic and training takes time but needs to be short and practical with inbuilt coaching and supervision afterwards.

**Additional comments from the audience:**

- Need to expand the consultation to include PMORALG, more CHWs, more people from community level and other implementing partners.
- The Task Force that will work to influence the MoHSW should seek a mandate from the DPS, CMO and the management of the MoHSW. One suggestion is to use the Technical Working Group for Health Promotion (TWG – HP) which has the advantage of having government, civil society and donors around the same table. This way, development partners can bring the issues to the DCG group. Health meetings of development partners can be another platform that can be used to share what is going on and will help to create a momentum on the DP side. The power of the TWG should not be underestimated – issues head by senior management are likely to be taken as priority.
- The momentum gained from the process leading to and including the Stakeholders' meeting should be carried into the TWG.
- The high level exchanges are a sign that we are ready for action. We need to move at the same pace and broaden the involvement and participation of more people
- Partners now know the issues at hand they must not go back to the things that have been disqualified at the meeting, instead they should start mainstreaming the current thinking into the things they are doing while waiting for the formal cadre to be put in place.
- No need to wait for available resources; when Government and development partners see that something can achieve sustainable results resources will flow. More pilot studies to measure and show this are needed.
- Need to think of ways to take on board other partners including social security funds, health insurance, private companies and public corporations that are approachable
- We should not limit ourselves to the only a few studies if possible each organization should have a pilot and share experiences. Wherever possible collaboration with government and development partners can be sought. This is a heavy undertaking it needs a lot of support way beyond the health sector because it will touch all aspects.
- Need to start thinking of advocacy strategies and think of immediate strategies such as informing and involving the Health and Social Services Committee of the Parliament, and

convene a follow up stakeholders' forum to get feedback on the implementation of the recommendations of the meeting after one year.

Finally, one participant suggested an innovative way to remember important things during the review process by using the letter 'C' which represents among other things:

1. **Coverage** (how many CHWs do we actually need?)
2. **Coordination** (by whom? At what level? How?)
3. **Collaboration** (between who and who and in what?)
4. **Commitment** (whose – political, financial, personal, champions?)
5. **Capacity development** (in which area? financial, technical, systems, programme management)
6. **Compliance** (how do we make sure things are done in a transparent and accountable way?)
7. **Cost** e.g. CCHP and alternatives (where is the budget coming from?)
8. **Challenges/Constraints** (what are they? How do we deal with them?)

## Section Five: Summary and Conclusion

The rationale for today's renewed focus on the use of CHWs is based on universal recognition of the service needs at grassroots level that are not met by existing health services, particularly in remote and underserved communities. The increased needs created by HIV/AIDS and the worsening health worker shortages make the choice to use CHWs almost non-existent. This group of community based auxiliaries can be groomed into a reliable workforce that can be used to deliver basic health services within homes and communities and to assist health professionals with their tasks. They provide a critical link between the community and formal health services in all aspects of health development which in turn provides an opportunity to increase the effectiveness of promotive, preventive, curative and rehabilitative services. More importantly, CHW initiatives can contribute towards the enhancement of community management and ownership of health-related programmes.

The issue of governance is crucial in the revitalization process because experience has shown that where there has been good leadership community based programmes have thrived. The government through the MoHSW has the lead role in the process; as such CBHC services must be accountable to the people and to the government.

The Ministry has always been clear on how to undertake CBHC, however revitalization provides an opportunity and to some extent a challenge for communities to plan their health and actualize health interventions of a priority nature in their setting. The role of other stakeholders is to facilitate and support communities by ensuring that these interventions are supported and sustained. This includes taking stock of existing services to ensure an equal geographical distribution of services. A lot of groundwork needs to be done to advocate for a favorable policy environment before systems and processes are developed. All the ideas that were generated at the meeting need to be reviewed and carefully analyzed to come up with holistic, affordable and sustainable mechanisms for the identification, selection, recruitment, deployment and remuneration of CHWs.

The CHW Stakeholders' Meeting was resounding success! It was a ground breaking meeting whose recourse will be felt far and wide. It managed to sensitize the highest level of officials of the MoHSW all the way down to programme implementers as evidenced by the bold suggestions on how to address some of the implementation challenges that came to light. Stakeholders revisited what is being done and helped to identify ways to translate some of the policy issues into action, not to mention reaching a common understanding on how things should be. A lot was said as people with diverse experiences shared their thoughts and beliefs. The passion was unquestionable, which is rare in meetings with government. The head of the Health Education Unit of the Ministry of Health and Social Welfare, Dr. Kiangi was commended for "*acting more like a colleague than an official from the Ministry*" which helped a lot in making the stakeholders' meeting a success.

Immediately after the Stakeholders' Meeting the deliberations will be shared with key officials in the MoHSW including the Chief Medical Officer and Director of Preventive Services to ignite action. Participants all left the meeting with a feeling that a new journey in a more focused direction has begun and resolved not to go back to things as usual anymore.

## Section Six: The Closing Session

Speaking on behalf of his colleagues at the Ministry of Health and Social Welfare, the Head of the Health Education Unit, Dr. Kiangi acknowledged the participation of representatives from the different stakeholders groups and expressed how moved he was with the commendable job that was done at the meeting, which he believed will make a difference.

He also extended the Chief Medical Officers appreciation for their participation and contributions that helped to realize the set meeting objectives. Talking about the different roles in the process of revitalizing PHC, he described the MoHSW as the 'mid-fielder' who acts as an intermediary between many players including the 'defenders' (regulatory authorities and other bodies that ensure quality assurance) and the 'strikers' (the actual implementers of the initiatives including NGOs/CBOs/FBOs through CHWs). He added that all actors and partners on board need to be coordinated to make a joint headway in pursuing a demanding and delicate exercise so as to arrive at our intended destination.

Reiterating the importance of revitalizing PHC he cited the adage "*Prevention is better than cure*" and emphasized the importance of community involvement, urging participants to think critically about what exactly that means in their day to day life. He continued to muse about the fact that health is something you cannot give to anyone and so it must be preserved and protected at all costs. The generation of health, he said, is a shared enterprise that needs investments in human capital, monetary resources and time and because it is shared we have to work together as technocrats and pioneers of the field of health while consulting and engaging a wider audience and allies who are interested in health promotion and preservation. He also talked about making better and more effective investments to make a difference.

He ended his remarks by wishing participants the best in their undertakings and promised them that the MoHSW will keep in touch and keep them informed of developments.

## Annex A: List of participants to the Stakeholders' Meeting

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## Annex B: Meeting Schedule

### Day one

Time	Topic	Responsible
08:30 – 09:00	<b>Registration</b>	<b>Secretariat</b>
09:00 – 09:15	Introduction (presenters, facilitators, task force group, invited guests: government and related institutions, UN agencies, NGOs)	<b>Dr. Nangawe Moderator</b>
09:15 – 09:20	Introduction of the guest of honor	<b>Dr. Mmbuji Ag DPS</b>
09:20 – 09:40	Official opening	<b>Dr. G. Kiangi HPES</b>
09:40 – 09:50	Objectives and outcomes of the meeting	<b>Dr. Kiangi AD HPES</b>
09:50 – 10:10	Key note: Historical background of Community Health Work initiatives in Tanzania	<b>Dr. Mmbuji Ag DPS</b>
<b>10.10 -10.40</b>	<b>Refreshments</b>	<b>All</b>
<b>Session one Existing policies for CHWs in Tanzania</b>		
10:45 – 11:15	MMAM, HSSP III and HRH Implementation strategies from national documents	<b>Dr. Kiangi HPES</b>
11:15 – 11:25	Questions for clarification	<b>Dr. Nangawe Moderator</b>
<b>Session two Initiatives of Community Based Health Workers: Mapping of who does what, where and how</b>		
11:30 – 12:00	Findings from the responses received from a CHW mapping exercise	<b>BJ Humplick Documentalist</b>
12:00 – 12:10	Testimonies from two CHWs	<b>Dr. Nangawe Moderator</b>
12:10 – 12:20	Questions for clarification	<b>Dr. E. Nangawe Moderator</b>
<b>Session three Policy issues from CHW studies</b>		
12:20 – 12:35	Rewarding options and nomenclature from “Training of CHW Cadre in Tanzania by Drs R. Shoo and A. Mzige	<b>Dr. Serafina Mkuwa AMREF</b>
12:35 – 12:45	Questions for clarification	<b>Dr. Nangawe Moderator</b>
<b>Session four Implementation issues from CHW studies</b>		
12:45 – 13:00	Multitasking, Cost-effectiveness and Sustainability from CONNECT study	<b>Dr. A. Hingora IHI</b>
13:00 – 13:10	Questions for clarification	<b>Dr. Nangawe Moderator</b>
<b>13:10 -14.00</b>	<b>Lunch</b>	<b>All</b>
<b>Session five Training, competencies and standards for CHW studies</b>		
14:00 – 14:15	Competencies and accreditation from: “CHW: Training and Deployment in Tanzania, a review”	<b>Prof. J. Killewo MUHAS</b>
14:15 – 14:25	Questions for clarification	<b>Dr. Nangawe Moderator</b>

<b>Session six</b> <b>Examples from ongoing projects working with CHW</b>		
14:30 – 14:45	Experience from CHW working on Reproductive and Child Health	<b>Dr. C. Lipingu Jhpiego</b>
14:45 – 15:00	Experience from CHW working on HIV HBC and FP	<b>Dr. P. Mapunda Pathfinder</b>
15:00 – 15:15	Questions for clarification	<b>Dr. Nangawe Moderator</b>
15:20 – 15:30	<b>Refreshments</b>	<b>All</b>
<b>Session seven</b> <b>Group assignments in breakout sessions</b>		
15:30 – 17:00	<b>Group 1:</b> Policy strengthening: coordination, rewards, nomenclature, roles MOHSW, LGA, CSOs <b>Group 2:</b> Implementation strengthening: financing, single/multitasking, sustainability <b>Group 3:</b> Training, competencies and standards	<b>Dr. Serafina</b> <b>Dr. Hingora</b> <b>Prof. Killewo</b>

## Day two

Time	Topic	Responsible
08:00 – 08:45	Registration	<b>Secretariat</b>
08:45 – 09:00	Summary of previous day's work	<b>BJ Humplick Consultant</b>
09:00 – 10:00	Group work (continued, prepare slides)	<b>Dr. Serafina</b> <b>Dr. Hingora</b> <b>Prof. Killewo</b>
<b>10:00 – 10:30</b>	<b>Tea break</b>	<b>All</b>
<b>Session Eight</b> <b>Plenary Presentations from group work</b>		
10:30 – 12:00	Findings and recommendations	Group 1 - 3
12:00 – 13:00	Plenary Discussion and Summary	<b>Dr. Nangawe Moderator</b>
<b>13:00 – 14:00</b>	<b>Lunch</b>	<b>All</b>
<b>Session Nine</b> <b>Way forward in National Coordination</b>		
14:00 – 15:00	A moderated session with all Presenters and experts in community health work to discuss way forward	<b>MoHSW</b>
15:00 – 15:15	Closing	<b>Dr. Kiangi HPES</b>
15:15 – 15.45	<b>Refreshments</b>	<b>All</b>

## **Annex C: Evaluation of the Meeting**

There was no time for a formal evaluation at the end of the meeting, however participants had an opportunity to provide feedback at the end of the first day and this is what came up:

### ***What they found useful:***

- Ongoing Research studies and their findings
- CHWs historical background
- The various models of CHWs
- Experiences of people implementing on the ground including CHWs testimonies
- MOHSW policy statements on CHWs
- Well prepared, analytical and informative presentations
- The spirit of openness
- Their involvement in the designing the process
- Lively debates and rich discussion
- Knowing that systematic remuneration of CHWs widely accepted now and their motivation, education background are being proposed
- Presentations clearly articulated III; focused
- The Moderator's ability to manage the group
- Organization of the meeting
- The presentations especially of the IHI CONNECT project
- Opportunities to hear both sides of issues
- Experience sharing

### ***Areas that could be improved in future meetings***

- Meeting room – chairs too heavy and too crowded; room too big
- Duration of meeting – too short
- Time allocation and management (long presentations; late arrival and commencement of sessions; too many questions allowed and winding discussion – stories
- Need more time for discussion
- Prefer to hear from other CHWs who do not have an incentive (e.g. from another region)
- Handouts of presentations to be distributed for reference
- More discussions on the way forward – action items