THE REVOLUTIONARY GOVERNMENT OF ZANZIBAR

MINISTRY OF HEALTH

Facilitator's Manual for Training National Community Health Volunteers in Zanzibar

Zanzibar Health Promotion Unit

In Collaboration with

Training Unit

Zanzibar

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Care
AYFSRH	Adolescent and Youth Friendly Sexual and Reproductive Health
CBHP	Community Based Health Program
DHMT	District Health Management Teams
CHVs	Community Health Volunteers
CHW	Community Health Worker
CSO	Civil Society Organizations
CRALG	Coordination, Regional Administration and Local Government
DOT	Direct Observation Treatment
DPs	Development Partners
ECD	Early Childhood Development
FBO	Faith Based Organizations
HIV	Human Immunodeficiency Virus
IPs	Implementing Partners
IPC	Infection Prevention and Control
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
IYCF	Infant and Young Child Feeding
INGO	International Non-Government Organization
LMIC	Low and Middle Income Counties
LLITN	Long lasting Insecticide Treated Net
M&E	Monitoring and Evaluation
MIP	Minimum Intervention Package
MOHSWEGC	Ministry of Health, Social Welfare, Elderly Gender and Children
MPDSR	Maternal and Prenatal Death Surveillance and Response
MUAC	Mid-Upper Arm Circumference
NCD	Non Communicable Diseases
NGO	Non-Government Organizations
NTD	Neglected Tropical Diseases
PAC	Post Abortion Care
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PNC	Post-Natal Care
PORALG-SD	President's Office, Regional Administration, Local Government and Special Departments
PPFP	Post-Partum Family Planning
RCH	Reproductive and Child Health
RGoZ	Revolutionary Government of Zanzibar
SAM	Severe Acute Malnutrition
SBCC	Social and Behavioural Change Communication
SHCCs	Shehia Health Custodian Committees
TB	Tuberculosis
UHC	Universal Health Coverage
WASH	Water, Sanitation and Hygiene
WIT	Willows International Tanzania
WHO	World Health Organization
WRA	Women of Reproductive Age
ZCHS	Zanzibar Community Health Strategy

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Foreword

In 2011, Zanzibar formulated its first Community Health Strategy (ZCHS) with the main aim of 'streamlining' existing structures and creating a common framework for the coordination of the various health interventions. During the implementation of the ZCHS new opportunities emerged. The main focus by then was to improve community participation in management and running of the health system, particularly the primary health care through establishment and supporting functions of the Shehia based structures. Later on, a number of demonstrable achievements including the use of Community Health Volunteers (CHVs) to increase demand for health services (such as health facility deliveries and postnatal services) emerged. Over time, CHVs were found to have made a significant contribution in achieving positive health outcomes specifically in the area of Maternal and Child Health among the Zanzibar population.

However, the functioning of the CHVs was not well coordinated and the cadre was not formally recognized within the ZCHS and thus CHVs were not prioritized within the formal health system. Based on the need to address the above challenges and gaps, and in the process of raising and maintaining the quality of primary health care, the Ministry of Health, Social Welfare, Elderly, Gender and Children (MOHSWEGC) together with the President's Office, Regional Administration, Local Government and Special Department (PORALGSD), desirously saw the importance of addressing these programmatic and structural gaps. In order to have in place a successful implementation of the community based health program, there was a need to restructure the health system by strengthening the implementation of Primary Health Care (PHC). This was done so as to shift from an individualized, passive, curative, vertical system to a population - based, integrated, proactive model for delivery of community health services. The two ministries decided to review and update the ZCHS and outline appropriate actions to implement a revisited Community Based Health Program (CBHP) in line with the on-going decentralization of PHC.

The updated ZCHS (2019-2025) is now in place, launched and in use. The strategy is in line with up-to-date interventions, innovations and other developments that focus on improving the PHC set up as well as improving community-based services implemented by CHVs. However, the strategy will be meaningless if key players supporting the CBHP are not provided with specific working guidelines in order to standardize operations and functions related to service delivery and management of the CBHP by CHV.

The production of this **Facilitator's Training Manual for CHV** is a practical example of how the Government, in collaboration with its development and implementing partners work together to interpret the ZCHS into action and practice. The Revolutionary Government of Zanzibar is pleased in how various stakeholders, including the community, were fully engaged in the process during the course of development of the MIP. This document presents an overview of community based interventions and services that are within the scope of work and mandate of the CHV. It intends to serve as a national reference on the subject matter to promote a clear understanding of community involvement practices in Zanzibar through CHVs.

Both the MOHSWEGC and PORALGSD are delighted that the CBHP in Zanzibar is increasingly becoming structured and guided. It is a huge achievement to arrive into this stage where the ZCHS (2019-2025) is now translated into practice through various guidelines, manuals and tools that are expected to guide all key stakeholders supporting the CBHP in the country.

The two Ministries urge all stakeholders in health including our development partners to support the government efforts in ensuring the CHVs are implementing their roles and functions successfully guided by these MIPs. It remains true that the involvement of communities in the governance of the health systems is inevitable and beneficial, and that implementation of the minimum interventions will result to improvement of health promotion activities, disease prevention and improved health outcomes across the entire population in Zanzibar.

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Acknowledgments

The Revolutionary Government of Zanzibar (RGoZ), through the Ministry of Health, Social Welfare, Elderly, Gender and Children and the President's Office, Regional Administration, Local Government and Special Departments, would like to express massive appreciations to all organizations and individuals who took part and supported the development of manuals, guidelines and working tools for the Zanzibar Community Based Health Program of which one of them is this Minimum Intervention Package (MIP) for SHCCs. Many individuals and organizations devoted their time, effort and resources to ensure development of these resources is a success. Due to the essence of the community based health program, many parties were involved in different ways. As a result, the process was long and involved concerted efforts from a wide range of stakeholders. The RGoZ would like to thank all those who provided inputs in different forms including those who were involved in conducting situational analysis and needs assessment to the last stage of reviewing the and endorsing the drafts of the various tools.

The Government would like to recognize and mention a few individuals and organizations that made specific contributions to the process. Among them is Mr. Abdurahman Kwaza, from the Health Promotion Unit (HPU) of the MOHSWEGC. Mr Kwaza provided strong leadership and guidance to the process; he coordinated the process on behalf of the two ministries. The Government would also like to recognize contribution by the entire staff of the HPU, IRCHP and HMIS for their esteemed and active participation throughout the process.

At the same level of appreciation, the RGoZ is grateful to Dr. Salim Slim (DDPSHE-MOHSWEGC) for his exceptional leadership, support and guidance towards realizing these milestones. The Government would also like to thank Bi Halima Khamis, Head of Health Promotion Unit, of the MOHSWEGC who was always at hand to support and lead the HPU team and the team of consultants whenever her guidance was needed. In the same breadth, we would like to recognize and appreciate the participation and leadership of Mr. Khalid Abdalla, by then Deputy Principal Secretary-PORALGSD and the Chairman of the Steering Committee for CHS and all other senior officials from the PORALGSD who participated in this process. The support and encouragement at various stages was important for the timely completion of the assignment. In this category, the Technical Working Group (TWG) provided the instrumental and overall technical leadership of the work that led to development of these tools for Community Health Services of Zanzibar. The group draws its members from a holistic spectrum of health programs in Zanzibar together with designated representative officers from implementing Partners (IPs) and Development Partners (DPs) who support the CBHP. The Government acknowledges their efforts, technical support and appreciates their commitment in working tirelessly to ensure the working tools for CBHP, including these MIPs, in Zanzibar are in place and at their highest quality.

This work would not have been a success without a sizable technical and financial support by Willows international Tanzania (WIT). Their efforts and support were extended from proactively initiating the need for taking action in translating the ZCHS (2019-2025) into action and practice through the development of these various documents and tools to funding the entire activity and processes involved. The RGoZ therefore extends special appreciations to Dr Gokgol Turkiz (President and Chief Executive Officer of Willows International), Dr. Muhadili Shemsanga (Country Director of WIT), Mr. Paul Mchau (Finance and Administration Manager), Mr. Kahema Irema (WIT Zanzibar Program Lead), Dr. Mtumwa Kombo (WIT Technical Advisor in Zanzibar), Ms Neema Sirima (Program Coordinator), Mwanahamisi Kilongo (Administrative Officer) and the entire WIT staff for the great partnership and support. The Government would also like to thank the Global Fund for their additional technical and financial inputs during the process, which complemented the efforts by WIT.

Lastly but at the same depth and breadth, the RGoZ wishes to acknowledge the technical leadership by the team of consultants who guided all processes and activities that led to availability of the manuals, guidelines and tools including this service package for SHCC. In particular, the Government would like to thank Mr. Selemani Mbuyita who was the Lead Consultant together with his colleagues Mr. Issa Mussa, Dr. Yahya Ipuge and Dr. Emmanuel Matechi. Their hard work and commitment will forever be appreciated and constitute the land marking of the growth of CBHP of Zanzibar. Similarly, special gratitude and acknowledgment are extended to the Research Assistants who took part in conducting the situational analysis and needs assessment, which laid the important foundation for development of the manuals, guidelines and tools for the national CBHP.

To all (mentioned and not mentioned), the RGoZ remains indebted for your esteemed work and for your contribution in promoting community health services which ultimately leads to improvement of the health of the Zanzibar population.

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Chapter 1
Introduction to Community Based Health Services (CBHS)

1.1 Learning outcomes

At the end of this chapter, the training participants should understand and be able to explain:

- *Background to the development of this manual*
- *The background and rationale of having National Community Health Volunteers for delivery of community based health services in Zanzibar including;*
    - *The meaning of health services*
    - *The concept of Community Based Health Services*
    - *The meaning of health system*
    - *How is the health system of Zanzibar organized?*
    - *National Community Health Volunteer (CHV) as part of human resource in the health system*
    - *Which Health Services are CHVs expected to deliver to community?*
    - *The purpose of developing this training manual for CHVs*
    - *How is the manual organized?*
    - *The intended users of this manual.*

Facilitation plan

The overall plan of the CHV training is organized in a competence based approach. In order to fulfil this requirement, the training should start with general concepts followed by orientation of CHVs to specific competences required to meet their main roles and functions. Facilitators are advised to restrain from jumping to training the CHVs on service specific content until all types of competences are well trained. For this particular chapter:

- Apply adult learning principles as much as possible
- Involve trainees in a question-and-answer conversation to derive trainees' expectations and what they would mostly like to learn about the various concepts as outlined in the learning outcomes above
- Use the conversation to identify gaps and training needs of the trainee(s) and list them down for reference later to see if trainees' expectations have been met. Make sure that you frequently refer to cross-check if all these needs are covered when getting to the end of the training on the last day.
- After introductions and after defining the concepts from the trainees' perspectives, apply a lecture approach to orient the CHVs on the above concepts allowing questions and answers in between.

Facilitation materials

Notebook, sticky notes, flip chart, flip chart stand, marker pens, ballpoint pens, power point projector, computer/laptop

Resources

Power point facilitation slides, Minimum Intervention and service Package (MIP) for CHVs, Training Manual for CHVs, the Zanzibar Community Health Strategy (2019-2025).

Hands on activity

Innovative way of participants' self-introduction linked with presenting their training expectations.

- Ask every participant to write their full names on a small piece of paper or sticky note in capital letters.
- Ask again every participant to write what each understands about one of the concepts above and one expectation on what they would like to learn more about it.
- Ask the participants to exchange their pieces of paper with a person sitting on their right side
- Every participant should stand up and introduce his/her neighbour by reading from the piece of paper/sticky note.

Session Duration

This session should be covered in a time period of not more than 3 hours.

Facilitation site
Classroom, preferably in a U or semi-circle sitting pattern

Module 1: About this Training Manual

1.2 What is the Purpose of this Training Manual for National CHVs?

Note to Facilitators!
If time is constraining, you can skip this module! Ask trainees to read this section on their own later.

The Revolutionary Government of Zanzibar (RGoZ) is committed to strengthening its health system by ensuring that all components of the health system are appropriately strengthened and performing; and that overall it achieves its optimal performance. Inclusive is the strengthening of the Primary Health Care (PHC) of which is the level serving majority of the population. Within the PHC, the health preventive and promotion services constitute one of its uttermost important components. The Ministry of Health, Social Welfare, Elderly, Gender and Children (MOHSWEGC) as the policy maker at one hand and the President's Office, Regional Administration, Local Government and Special Departments (PORALGSD) as the implementer and provider of services at the other hand, through its Zanzibar Community Health Strategy (ZCHS) are committed to establishing community health care services at community level to provide quality and effective care and services needed by people within the communities where they live.

The ZCHS directs that delivery of the community based health services at the community level will primarily be conducted by CHVs. The World Health Organization (WHO) has recognized this cadre of health workers as the most powerful resource in empowering communities to take charge of health matters in their localities. CHVs, as a synonymous name in Zanzibar for Community Health Workers (CHW), are entrusted with the responsibility of ensuring that the strategic objective in the ZCHS (2019 -2025) of improving the provision of sustainable, equitable, effective and efficient community-based primary health services in all parts of Zanzibar is effectively fulfilled.

In their roles of providing community based health services at the community level, the Government, the IPs, the CHVs and all other stakeholders would need guidelines, manuals, protocols and other working tools. This Facilitators Training Manual for CHVs is prepared to appropriately guide the training of Community Health Volunteers in Zanzibar. It intends to impart knowledge, skills and competencies that will enable them carry out their respective roles and functions when delivering various packages of health services to the communities they serve.

1.3 How is the Manual organized?

This training manual is organized in eight (8) modules and several units under each module. The modules follow a chronological order that allows the user to incrementally grasp the content the reader moves from one chapter to another. Users are expected to follow the order of the chapters in order to comprehend the presentation of the contents. However, users can also use the different modules independently.

1.4 Who are the Intended Users of this Manual?

This manual is specifically for trainers who shall conduct training of the National CHVs. However, the resource has also been developed to be used by all key stakeholders of CBHP in Zanzibar. These include the MOHSWEGC, PORALG-SD and other related ministries supporting health programs at community level indirectly. Other users include all health programs under the MOHSWEGC, Development Partners (DPs), Universities, colleges and other training institutions, Implementing Partners (IPs) that may include International Non-Government Organizations (INGO), Non-Government Organizations (NGOs), Civil Society Organizations (CSOs), Community Based Organizations (CBOs), Faith Based organizations (FBOs)the private sector, Council Directors, District Health Management Teams (DHMT), health facility in-charges, service providers, Shehia Consultative Committees (SCCs), Shehia Health Custodian Committees (SHCCs), Councillors, Shehas, Community Health Volunteers (CHVs) and the general population.

1.5 What is a Community?

This manual is prepared for training of National Community Health Volunteers (CHVs). In this name, three connotations to the name are provided: community, health and volunteer. These three words indicate the location or workplace where this CHV will work (i.e. in the community), the kind and type of services CHV will provide (i.e. health) and the nature of his/her work (volunteering or non-paid work). Let's start by looking at what it means with "community".

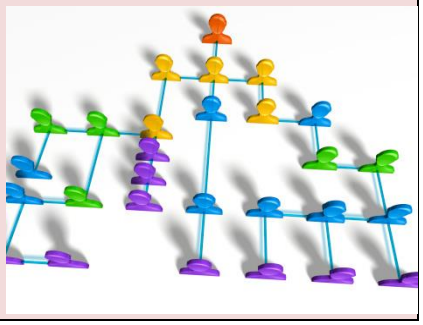
A community can simply be defined as a social unit (a group of people) with commonality such as norms, religion, values, customs, or identity living and or working in a given geographical area (e.g. a country, village, town, or neighbourhood). With the current innovative world and technological advancements, the geographical area may not be necessary as a community can equally exist in a virtual space through digital communication platforms.

Note to Facilitators!

Help the trainees to differentiate between community and society which are usually confusing terms. Use the diagram to illustrate to them that, a community is a sub-set of a society. That all of the same colour images are the communities and all images collectively constitutes a society.

Community: Group of people who live in a definite locality. Based on similarities.

Society: Group of people interrelated by their social relationships. Based on both similarities and differences.



1.6 What are Health Services?

In 1948, the World Health Organization started to use the official agreed definition of "Health". Since then, health has been defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". This definition was adopted by the International Health Conference, New York, 19th June – 22nd July 1946; signed on 22nd July 1946 by the representatives of 61 States. The definition has not been amended since 1948.

Based on this definition of health, health services (or often referred to as health care services) are defined as means of maintaining health of an individual, group of people or overall population in a state that fits the definition of health. It consists of any medical or remedial care or service, including supplies delivered in connection with the care or service that is recognized under state laws.

In order for a health system to deliver health services, it requires a collection of medical professionals, organizations, and ancillary health care workers who provide medical care to those in need. Health services are usually tailored to serving patients, families, communities, and populations. They cover emergency, preventative, rehabilitative, long-term management of illness, hospitalization, diagnostic, palliative, and home based care. In order to maintain health, health services must be accessible, of high quality, and patient-centred. Many different types of services and or care providers are necessary in order to offer successful and effective health services.

Community Based Health Services (CBHS) refer to the means through which community can attain and maintain good community health status. This can be reached by way of involving the people in taking an active and dynamic action towards maintaining their health through identification of their own health problems, needs and priorities and taking appropriate action in solving them. CBHS include a set of *selected and allowable range of services* that are provided to the community by specific *identified and trained community members* or by trained service providers through outreach program (i.e. extending facility based services at the community).

Community based health services constitute one of the components of the health system in Zanzibar.

1.7 Who is a volunteer?

The word volunteer is derived from the verb "volunteering" which literally means a willingly act of an individual or group who are freely giving time and labour for community service. A volunteer is therefore the person who offers his/her time to render her labour to serve a particular community. The National Community Health Volunteers in Zanzibar are a good example to this definition since they work to serve their Shehias and wards to deliver community based health services.

Note to facilitator!

- Engage trainees in a discussion to cite out examples of other types of community health volunteers known to them.
- Explain to them that the National CHV cadre was designed for the sake of harmonizing and standardizing the different types ad forms of health services that were being provided by the different types of volunteers in the country.

1.8 What is a Health System?

The World Health Organization describes a health system as the organization, arrangement and functioning of organizations, institutions and resources that produce actions whose primary purpose is to improve health. It entails to how the institutions, people and resources are involved in delivering health care to individuals.

Many countries have their health systems built up by six pillars, also called health system building blocks (Figure 1). Service delivery across all levels of care (specialized hospitals to community) is one of the building blocks of many health systems worldwide.

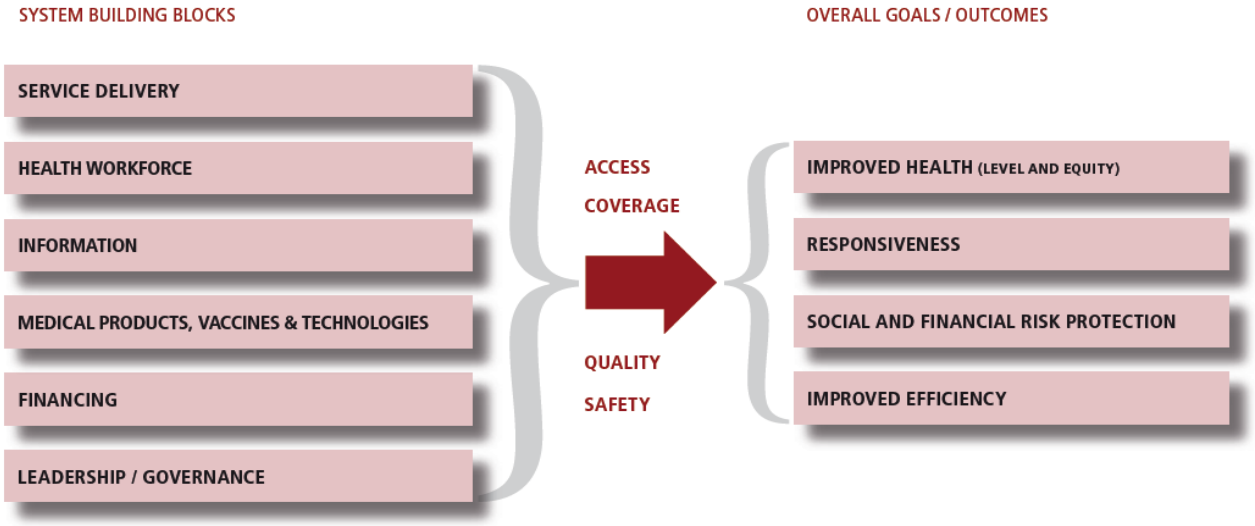


Figure 1: WHO Health System Framework

Source: World Health Organization, Geneva: WHO, 2007.

Note to Facilitators!

Show the CHVs how their roles and functions relate and contribute to each of the six health system building blocks

- **Service delivery**: they will be serving communities with basic services such as home basic care and referral to health facility
- **Health workforce**: they constitute a lineage of health service providers at the base of the health system
- **Information:** they will collect data and records to be integrated in the overall health information system
- **Medical products, vaccines and technologies**: they will participate in distribution, education, sensitization and provision of referrals
- **Financing**: they will participate in resource identification and mobilization for community health
- **Leadership/Governance**: they will constitute part of the leadership, together with the SHCC for community based health services

1.9 How is the Health System of Zanzibar Organized?

The Zanzibar Health System is hierarchal and pyramidal in nature (Figure 2). It includes all of the six building blocks which are integrated in all levels of care (from top to bottom). It consists of two arms (public and private) and it is overseen by two Ministries, the MOHSWGEC as the policy and technical overseer; and PORALG-SD as the implementation lead.

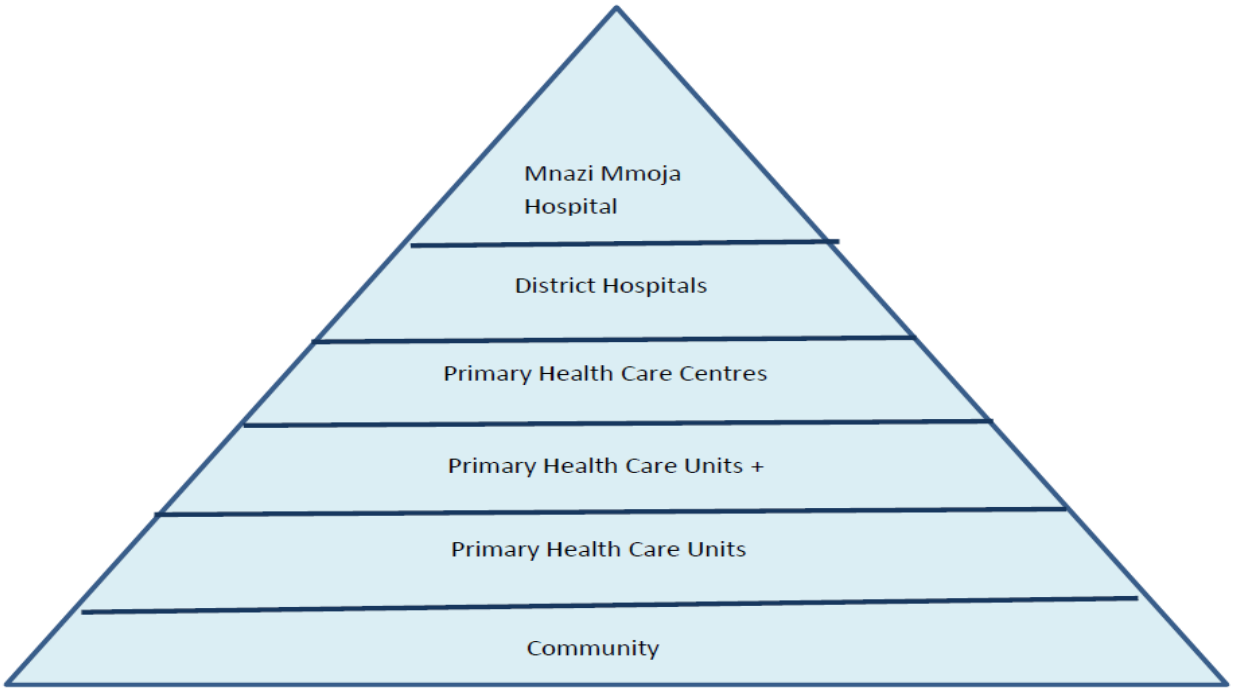


Figure 2: Zanzibar Health System Organization and Structure.

Module 3: Describing the Zanzibar Community Based Health Services

1.10 How is the Zanzibar Community Based Health Services Organized?

Note to Facilitators!

- Use flipchart to draw/sketch the lineage and lines of accountability of the Zanzibar health system as described below.
- Make sure that, CHVs see clearly how they appear and fit in the lineage.

The Zanzibar health system operations are guided by the Zanzibar Health Policy (2011) which is again translated into specific concrete components by the Zanzibar Health Sector Strategic Plan IV (2019-2024). The HSSP IV identifies and recognizes community based health services as one of the most important component of the health system. To make this recognition meaningful, a Community Health Strategy for Zanzibar (2019-2025) was developed in which a description of community based health program and services to be delivered at the community level were defined.

The organization of community health services involves a defined service package, service providers at that level, reporting and lines of accountability, demarcation and or area of service provision, supervision and linkages.

- Service providers include trained health care providers from health facilities through outreach and community health volunteers
- Reporting lines include immediate supervisor, Sheha, Shehia Health Custodian Committee, Shehia Consultative Committee, in-charge of health facility in the catchment area, the District Public Health Nurse Officer (DPHNO) and the District Health Management Team (DMT).
- Demarcation of community health services in Zanzibar is limited in the Shehia level.
- Supervision will be provided by a trained supervisor for community health services, the facility in charge of the closest health facility in the Shehia, the SHCC and DHMT.
- Community health services will be linked to health facilities as well as parallel projects run by various Implementing Partners (IPs).

1.11 Who is a National Community Health Volunteer (CHV)?

We earlier defined community, health and volunteer. The three words constitute a name of a nationally recognized cadre of auxiliary health workforce. The WHO health system framework has "Health Workforce" as one of its six building blocks. The health workforce refers to all of the people who deliver or assist in the delivery of health services, in or outside health facilities (Figure 3). Health workforce is sometimes referred to as human resource for health (HRH) and includes all people engaged in actions whose primary intent is to enhance health. Community Health Volunteers are part of the health workforce who are non-health professionals working in the health sector. They work outside the facility (in the community) but linked to health facilities.

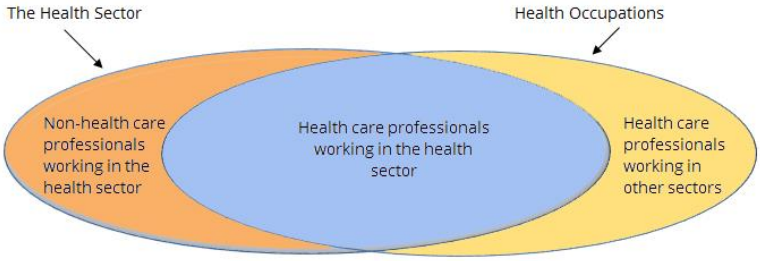


Figure 3: Dimensions of Health workforce: *Source: Centre for Health Workforce Studies (CHWS), 2020*.

1.12 Which Health Services will National CHVs deliver to community

The ZCHS (2019-2025) defines and approves set of integrated and standardized community health interventions to be implemented by CHVs in Zanzibar. The strategy makes a reference to the following broad strategic areas:

- Health promotion and need tailored education through individual and group coaching or empowerment;
- Observation of danger signs, risks, early identification of pregnancy, missed routine visits/services, and unhealthy behaviours for various programmatic services rendered at community level;
- Facility referrals including follow up, monitoring of concerns, effective and fulfilled referrals, facility discharge/counter referral to community for various programmatic areas of health services;
- Distribution of health commodities and
- Community data collection, reporting and use of digital tools.

These activities may cut across all health programs that have part of their services being delivered at community level including Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) -–of which also constitutes critical aspects such as Early Childhood Development (ECD) and nutrition. Other programs include TB and HIV/AIDS, malaria, disease outbreaks like current pandemic of Corona Virus Disease 2019 (Covid-19), neglected tropical diseases, non-communicable diseases, environmental health and water, hygiene and sanitation as well as health surveillance.

Note to facilitators!

- Provide a reference to the MIP for CHVs during this session. Use the tables describing service package as illustrated in MIP and ask trainees to make a further reference to the service package later on their own.

1.13 How Should the National CHV Start Working with the Community?

Note to facilitators!

Start this session by asking some of the CHVs who have already serviced in various communities how they started working for those communities:

- How they were introduced to Shehia leadership?
- How they were introduced to all residents in the Shehia?
- What conditions were necessary to be fulfilled before they were allowed to start their work?
- What were the first activities they did when starting working for the community?

- What should be done when interacting with an individual client or group of clients for the first time?

Communities are complex entities or structures. They comprise people with diverse attitudes and characters. They constitute formal and informal leadership structures. They comprise receptive and critical personnel as well as people of different social class, different levels of education background etc. When a CHV is assigned to work with a particular community, a standardized approach of community entry and self-introduction should be adhered to. A poor community entry approach will mean a failure before beginning your work!

1.13.1 Community Entry

Prior to starting working in the community, CHVs will have undergone several steps until they are recruited. These include their selection process, their confirmation by the leadership structures in the respective Shehia and later by the district Authorities and finally training. These initial steps will help to act as an initial introduction to the respective Shehia leaders of the coming of the CHV and their respective work that they will perform.

Despite all the initial steps, formal and official introductions must be made. It is expected that all CHVs will have a contract with the local government specifying their confirmation, their geographic boundaries of work, their roles and functions and the reporting and accountability lines. No work by CHV should commence before these formal introductions are conducted.

1.13.2 Know your community

The first thing that each CHV has to learn is to know the communities they will be working with. Despite the fact that Zanzibar can be seen as a relatively small place, there is a wide diversity of social-cultural aspects across different Shehias. Developing a Shehia profile where the population of the Shehia is provided, different social class of people are described, number of women of reproductive age are given, size of other population segments such as people with disability, youth and adolescents, under five children and others are also provided. Equally important is to know the leadership and administration structures, including the leaders and influential personalities and different stakeholders with interest to your line of work.
Note that the idea to draw CHVs from communities that they will work in was conceived as a means to increase acceptability, support, ownership and understanding of the community context and its profile.

Note to Facilitators!

- Ask some of the CHVs who had already worked for communities to explain their experience of developing a community/Shehia profile. Ask them to narrate some of the important things/features they included when developing a Shehia profile.
- Orient the trainees on the Shehia profile template (Job Aid 1)

1.13.1 Know your leaders and reporting lines

CHVs must work under the lines of accountability prescribed by the Zanzibar Community Health Strategy (2019 -2025). There shall be an immediate technical supervisor to whom a CHV should report routinely. However, all the time, CHVs should observe the Sheha leadership which will be through two entities: The Shehia Consultative Committee (SCC) and the Shehia Health Custodian Committee (SHCC). CHVs will also have a direct link with the health facility available in the catchment area. The facility in-charge and or any designated facility staff will be responsible to provide support to the CHV on a daily basis and during outreach activities at the capacity of a Supervisor to the respective CHV(s).

Note to facilitator!
Supplement your training materials by orienting the trainees on procedures for community entry using Handout 1A.

Chapter Two
Program Areas and Minimum Intervention Package for CHVs

2.1 Learning Outcomes

At the end of this chapter, the training participants should understand and be able to explain;

- *The concept of minimum intervention package*
- *The minimum intervention package designated for CHVs in Zanzibar*
- *Roles, functions and activities that CHVs are expected to perform in the community*

Facilitation plan

This chapter intends to introduce to the trainees the actual package of services that they would be delivering in the community. This is an important section because it describes the integrated service package under different sets of interventions which need to be well comprehended by all CHVs. The background of majority of CHVs will be that of "single program oriented". Facilitators should work hard to distinctly change that mentality and emphasize on the integrated nature of the service package and its inter-linkages and coordination. As usual, during facilitation of this session:

- Apply adult learning principles as much as possible,
- Involve trainees in a question-and-answer conversation for taping CHVs' own knowledge on various types of services based on their past experience.
- Follow the guidance under each sub-section to run the training. Each time, provide the lecture part as the last teaching mechanism after involving the trainees in initial discussion.

Facilitation materials

Notebook, sticky notes, flip chart, flip chart stand, marker pens, ball point pens, power point projector, computer/laptop

Resources

Power point facilitation slides, Minimum Intervention and service Package (MIP) for CHVs, Training Manual for CHVs, the Zanzibar Community Health Strategy (2019 -2025).

Hands on activity

Innovative way of participants' self-introduction linked with presenting their training expectations.

- Include a few minutes of self-reading of the broad categories of MIP
- Allow buzzing sessions after each self-reading while asking the trainees to share among themselves what they had ever done and what they hadn't done before
- Include a plenary session after every buzzing session allowing at least three trainees to explain their past experience on delivering the type of services discussed while showing which services are new to them from the MIP
- Conclude the sessions for each sub-section with a lecture presentation using you power point slides.

Session Duration

This session should be covered in a time period of not more than 3 hours.

Facilitation site

Classroom, preferably in a U or semi-circle sitting pattern

2.2 Introduction

Note to Facilitators!

You can skip this subsection 2.2 and ask trainees to read on their own later. Include the introduction as part of your opening approach to the session very briefly.

The Universal Health Coverage (UHC) guides most of the global health systems. The motto of UHC is "People Centred Health Systems and Services". This means that, services should not be provided from medical point of view or only from providers' perspectives but from the client perspectives and needs. We should, therefore, always place our clients at the centre of the planned services that we deliver.

Our clients come from the community and are among the community members. A community simply means "people in a certain geographical area (e.g. Shehia) with common interests, common culture

and socially interactive. Community members have influence on one another and this influence can affect utilization of rendered services positively or negatively. It is important that all key stakeholders (implementers, administrators, trainers, supervisors and service providers) acknowledge this importance of actively involving the community.

To-date, many simple, affordable and effective disease control measures have had limited impact on the burden of diseases due to their inadequate and inequitable distribution in poor and remote communities. Due to these limitations, the world strategically shifted health system focus to a Primary Health Care (PHC) as proposed during the Alma Ata Conference in 1978. Primary Health Care was defined by the WHO as, “essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford”

Zanzibar is well known to have a long history of successful implementation of Community Based Health Care Programme since early 1990’s. Since then, a number of ministerial health programmes have been in one time or the other establishing their own platforms and channels to reach and involve the respective targeted community sections. A number of programmes emerged including the establishment of health committees, health clubs, use of extension workers, home based care (HBC) workers, community health distributers (CBD) and community health volunteers. Most of these programs and projects are supported by donors who sometime come with interests to support specific program areas. The current efforts through this booklet is envisioning to harmonize and standardize the disintegrated implementation of the community based health program into a harmonized and well-coordinated national approach.

After a thorough consultation with various key stakeholders across all health and administrative levels in Zanzibar, and with regards to the guidance and stipulation of the ZCHS (2019-2025) the following sub-sections describe the Minimum Intervention Packages (MIP) by programmatic areas.

2.3 What is an intervention?

Note to Facilitator!

- Start this session by asking CHVs who had already worked for communities to narrate the types and nature of services they used to provide to the community. Note down all types of services that will be mentioned
- Engage the trainees to categorize the different types of services by type of health services: reproductive and maternal health, nutrition health, TB/HIV and AIDS, etc.,
- Refer to this categorization later (during the lecture session) to illustrate to the trainees the concepts of health programs, interventions and services

In this context, an intervention is defined as a carefully planned process that is intended to bring positive change resulting into a desirable outcome and or impact. The MOHSWGEC together with PORALG-SD have defined minimum interventions for CHVs. It is expected that with these well selected interventions, and through the effective training of CHVs, they will be empowered with knowledge, skills and capacity to represent the community in supporting and promoting community based health programs and activities. These interventions intend to encourage community participation as they embark onto improving their health and that of their environment.

2.4 What is Minimum Intervention and service Package (MIP)?

Minimum intervention and service package refers to a set of integrated interventions from all health programs that are designated to be provided at the community level by the CHV or other related community based service providers. Services included in the MIP have received Government approval to be implemented at community level. If IPs would like to implement extra package of service that are not included in the MIP, they will have to seek the Government approval before embarking into implementation.

2.5 What is the Minimum Intervention and service Package (MIP) for National CHVs?

There are nine sets of interventions for CHVs as defined by the MIP. These include:

1) Integrated Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH)

2) Nutrition health
3) TB/HIV and AIDS
4) Malaria
5) Environmental Health and WASH
6) Non Communicable Diseases
7) Neglected Tropical Diseases (NTDs)
8) Monitoring and evaluation
9) Cross -cutting interventions.

2.6 Description of MIP to be implemented by National CHVs

The Zanzibar Community Health Strategy (2019-2025) identifies and list the following key roles for Community Health Volunteers (Box 1)

Box 1: Roles of CHV (Source: ZCHS; 2019-2025)

1) Health promotion by creating demand for utilization of existing health services and health empowerment through structured health promotion and education;
2) Screening/recognition of danger signs, risks, missed routine visits/services, unhealthy behaviours, problems to follow up on, pregnancy;
3) Individual and group coaching and counselling;
4) Referral to facility;
5) Follow up monitoring of concerns, referrals, facility discharge/counter referral to community;
6) Prioritization of household visits with need tailored RMNCAH messages and customized follow ups to clients, especially among women of reproductive age (WRA).

These roles set the ground for defining the key functions and activities to be implemented by the CHVs. They form the basis of what CHVs will be performing to support health programs that will have activities and deliverance of services at the community level. The following sub-section provides a description of programs that will be served by CHVs through the above roles. This means that, each health program that is designing and planning to work with CHV, their scope of work should be limited within the above six roles and the consecutive defined functions and activities of CHVs as described in the Minimum Intervention and service Package (MIP) for CHVs..

2.6.1 Intervention Set 1: Integrated Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH)

The RMNCAH stands for Reproductive Health (R), Maternal Health (M), Newborn Health (N), Child Health (C) and Adolescent (A) health. Each of these components constitutes the main Key Results Areas in the RMNCAH roadmap under which specific interventions are defined. The RMNCAH services are thus a collective continuum of care across all these results areas with all the defined interventions within. It should be appreciated from this point onwards that, the continuum of care is broad and that in order to achieve efficiency and effectiveness that would lead into deliverance of quality and effective care, specialization would be required.

However, while specialization usually happens at higher level (where specialists and consultants are found) such as at regional and national hospitals, specialization tends to decrease as one goes lower in the hierarchy of the health care delivery system. At the lowest level of health care and service delivery system, (i.e. community level), specialization is completely lacking and that service providers (i.e. CHVs) are expected to learn, comprehend and deliver all interventions and services across RMNCAH. This signifies the importance of carefully selecting interventions and range of services and each intervention to be rendered by CHVs-hence the importance of Minimum Intervention and service Package (MIP) as captured in this booklet.

In consideration of stakeholders' recommendations and as guided by the ZCHS (2019-2025), the following RMNCAH interventions were recommended to be included in MIP for CHVs in Zanzibar (Table 1).

Table 1: Minimum Interventions for RMNCAH

Component of RMNCAH	S#	Key Program Areas
Reproductive Health	1	Comprehensive Family Planning for spacing or limiting
	2	Reproductive Health Related Cancers

	3	Gender and male involvement
	4	Elderly services into RMNCAH program
Maternal Health	1	ANC services (counselling, care and birth preparedness)
	2	Effective and Fulfilled Referral
	3	MNCH supplies, commodities
	4	Early identification of pregnant women
	5	PMTCT
	6	Health Facility or institutional delivery
	7	Postnatal care
	8	Post-partum FP (PPFP)
	9	Comprehensive Post-abortion care (PAC)
	10	Infection Prevention and Control including household education on Covid - 19
	11	Mothers' nutrition post delivery
Newborn Health	1	Immediate breastfeeding
	2	Baby WASH
	3	Home management of preterm and low birth weight babies
	4	Home management of sick newborn
Child Health	1	Early childhood development
	2	Management of common childhood illnesses
	3	Routine under five vaccination and Vitamin A supplementation
	4	Breastfeeding practices and services
	5	Infant and Young Child Feeding (IYCF) practices and nutrition
	6	Management of Severe Acute Malnutrition (SAM)
	7	Community and household practices
Adolescent Health	1	Adolescent and Youth Friendly Sexual and Reproductive Health (AYFSRH) including immunization and HIV services
	2	Comprehensive knowledge, skills and positive behaviours on sexuality and reproductive health
Maternal and perinatal audit		Maternal and prenatal death surveillance and response (MPDSR)

2.6.2 Intervention Set 2: Nutrition

The following interventions will comprise intervention package for nutrition (Table 2);

Table 2: List of interventions under the nutrition component

Stage		Interventions
During pregnancy	1	Healthy nutrition during pregnancy and lactation
	2	Micronutrient supplementation
Post delivery		Early initiation and exclusive breastfeeding
	4	Identify feeding problems and growth failure
	6	Feeding low-birth weight and premature babies
Infancy and childhood	1	Early recognition and referral for malnutrition (including MUAC and home growth monitoring)
	2	Minimal acceptable diet; promote optimal nutrition (complementary feeding, food diversity)
	3	Micronutrient supplementation (powder for babies after 6 months where available; children; first 3 months for mother)

2.6.3 Intervention Set 3: TB/HIV and AIDS

The TB/HIV and AIDS program will implement and follow up the following set of interventions (Table 3);

Table 3: List of interventions under the TB/HIV and AIDS program

Category		Interventions
Community based TB	1	Community active TB case-finding and referral
	2	Sputum collection, transport

interventions	3	Treatment support
	4	Tracing of patients lost to follow-up and defaulters
	5	Contact tracing for all bacteriological confirmed cases
	6	Health education and counselling
	7	Infection prevention and control
Community based HIV and AIDS interventions	1	Home based care for critically ill patients
	2	Tracing of patients lost to follow-up
	3	Health education and counselling
	4	Treatment support

2.6.4 Intervention Set 4: Malaria

Interventions at the community level for malaria program shall include:

Table 4: List of interventions under Malaria program

Category		Interventions
Malaria prevention activities	1	Malaria in pregnancy;
	2	Integrated vector control management (Use of long lasting insecticide nets (LLIN), Laval source management, Indoor spraying
	3	Social and behavioural change communication (SBCC);

2.6.5 Intervention Set 5: Environmental Health and WASH

Interventions under this programmatic area shall include:

Table 5: List of interventions under Environmental health and WASH

Category		Interventions
Environmental health	1	Prevention of water and air pollution to improve quality of water;
	2	Protection and maintenance of water sources to maintain water quantity;
WASH	1	Food safety, hygiene and need for legal enforcement of Food safety regulations;
	2	Hygiene practices to promote hand washing with soap or other agents (after defecation, after disposal of child faeces, diapers, and prior to preparing, eating and handling food) and
	3	Sanitation so as to provide or promote expanded or improved excreta disposal.
	4	Solid and liquid waste management

2.6.6 Intervention Set 6: Non Communicable Diseases

Non-communicable diseases (NCDs) are on the rise and Zanzibar is not an exception to this global trend. The most common causes of NCDs are associated with life styles and eating behaviours with little contribution of genetics and inheritance. While some of the interventions to combat NCD will be facility based, CHVs will be expected to participate in the implementation of the following interventions (Table 6) in supporting the efforts to reduce incidence and prevalence of NCDs in Zanzibar.

Table 6: Interventions for NCDs

Stage		Interventions
Infancy	1	Exclusive breastfeeding for 6 months
	2	Nutritionally adequate and safe complementary feeding
	3	Breastfeeding up to 2 years of age or beyond
Childhood and adolescence	1	Life skills education
	2	Physical activity in school and society
	3	Road traffic accidents
	4	Safe and healthy foods in schools;
	5	Restrict marketing of and access to food products high in salt/sugar/unhealthy fats
Adulthood	1	Maternal nutrition
	2	Tobacco prevention and cessation programs
	3	Availability and affordability of healthy diet
	4	Physical activity (worksites, urban design)

	5	Effective prevention and care of risks, diseases and complications

2.6.7 Intervention Set 7: Neglected Tropical Diseases (NTDs)

The World Health Organization recommends the following interventions for prevention and control of NTDs. These interventions (Table 7) can and should be implemented across all levels of the health system including the community level. The various services that the CHVs can provide to community under each of these interventions will be described in detail in chapter three. The interventions include:

Table 7: Interventions for NTDs

Intervention	Description
Innovative and intensified disease management	This includes the management of diseases that are difficult to diagnose and treat and which can, in most cases, trigger severe clinical manifestations and complications. Palliative care, which commonly takes place at household level, is an example.
Integrated Vector management	It includes safe and judicious management of public-health pesticides to achieve vector control through integrated vector management. The outdoor spray in malaria program is a good example.
Safe drinking-water, basic sanitation and hygiene services, and education	This relates to WASH program
Social behaviour change and communication (SBCC) for addressing NTD	Linked to the SBCC initiative linked to the rest of all other programs
Mass drug administration	Often through national campaigns and supported through outreach activities

2.6.8 Intervention Set 8: Monitoring and evaluation

Under the Zanzibar CBHP, CHVs participate in monitoring role especially reporting routinely on various agreed indicators (such as births and deaths, pregnancies, ANC contacts, monthly disease surveillance reports and CBHP activity and progress reports etc). They also participate in client assessments to identify social needs and problems as well as records of care, support and protection provided to households as a whole but to vulnerable groups in particular (e.g. most vulnerable children -MVCs, people with disabilities, people living with chronic illnesses and elderly). To facilitate monitoring of all these activities as well as tracking records of all services provided through the above-discussed programmatic interventions, the following key services related to M&E are in the scope of work of CHVs (Table 8):

Table 8: community based service package for M&E

Interventions	Services to be provided by CHV
Data and statistics	▪ Keeping record of all services provided based on the agreed and developed set of indicators for each program area ▪ Tracking community deaths (including maternal and neonatal) within catchment area ▪ Participate in research activities taking part in catchment areas
Community Health Information System	▪ Filling forms, (most e-forms) with information on services delivered as defined by the set of agreed indicators ▪ Uploading and synchronizing of e-filled forms to the CHIS ▪ Prioritize household visits among clients especially WRA with need tailored RMNCAH messages ▪ Providing customized clients follow up ▪ Enabling referral effectiveness and referral fulfillment among clients
Report writing, reporting and	▪ Prepare both activity and progress reports on a monthly

dissemination	and quarterly basis as directed by supervisors ▪ Prepare summaries and provide feedback to supervisors, SHCCs, SCC and community at large

2.6.9 Cross -cutting programs

Under this area, interventions shall include:

- Under this area, interventions shall include:
- Leadership and governance;
- Participatory health planning;
- Resource mobilization, and
- Rehabilitative services
- Disease and community health surveillance

Note to Facilitators!

- Take advantage of CHVs who have experience of working in the community through different programs to provide practical examples of services they used to provide in order to create a two way communication during the above session. Ask them to explain WHAT they used to do and HOW they did that!
- At the end of this session, ask the trainees to find time to read on their own the MIP for CHVs.

Chapter 3

Competences Required by CHV to Deliver Minimum Service Package

3.1 Learning Outcomes

At the end of this session, the training participants should have acquired knowledge, skills and competence on the following areas: -

1) *Health promotion and education on all services provided at the community/Shehia level to*
    a. *address unhealthy behaviours;*
    b. *promote utilization of RMNCAH services;*
    c. *promote WASH activities;*
    d. *promote good nutritional behaviours;*
    e. *Prevention of communicable and non-communicable diseases.*
2) *Individual and group coaching or empowerment for various health services especially reproductive health and youth friendly services.*
3) *Provision of basic community based services including: -*
    a. *Screening/recognition of danger signs and risks for reproductive health services and others;*
    b. *Early pregnancy identification and referral for ANC*
    c. *Rehabilitative services;*
4) *Conducting customized follow up of patients/clients who have missed routine visits/services according to treatment schedules and requirements of various health programs and services (RMNCAH, TB & HIV/AIDS, NCD, Earl Childhood Development and others); systematic household visitations; and need tailored or individualized counselling/education provision*
5) *Facilitation of effective and fulfilled referrals to facility.*
6) *Conducting research, data collection, monitoring and evaluation of all related programs and services.*
7) *Participating in cross cutting activities including: -*
    a. *Leadership and governance;*
    b. *Participatory health planning and*
    c. *Resource mobilization.*

Facilitation plan

This chapter constitute the main chapter for competence based training. It intends to impart knowledge, skills and competences that are necessary for CHVs to be able to carry out their roles ad functions. At the end of this chapter, Facilitators should ensure that we have a batch of CHVs who are competent enough to undertake delivery of the enormous integrated community based health services. Facilitators are encouraged to be self-creative in designing extra training techniques such as role plays, short exercises, brainstorming and other techniques and reduce the level of lecture approach when running sessions under this chapter. Facilitators should remember to:

- Apply adult learning principles as much as possible,
- Involve trainees in a question-and-answer conversation taping CHVs' own knowledge on various types of services based on their past experience while deriving from them the "HOW did you that" aspect when they relay their past experience.
- Mix experienced and less experienced CHVs when forming groups for group work as part of the learning technique.
- Follow the guidance under each sub-section to run the training. Each time, provide the lecture part as the last teaching mechanism after involving the trainees in initial discussion.

Facilitation materials

Notebook, sticky notes, flip chart, flip chart stand, marker pens, ball point pens, power point projector, computer/laptop.

Resources

Power point facilitation slides, Minimum Intervention and service Package (MIP) for CHVs,

Training Manual for CHVs, the Zanzibar Community Health Strategy (2019-2025).

Hands on activity

Innovative way of participants' self-introduction linked with presenting their training expectations.

- Include a few minutes of self-reading of the broad categories of MIP
- Allow buzzing sessions after each self-reading while asking the trainees to share among themselves what they had ever done and what they hadn't done before
- Include a plenary session after every buzzing session allowing at least three trainees to explain their past experience on delivering the type of services discussed while showing which services are new to them from the MIP
- Conclude the sessions for each sub-section with a lecture presentation using you power point slides.

Session Duration

This session should be covered in a time period of not more than 4 days (approx. 8 hours per day)

Facilitation site

Classroom, preferably in a U or semi-circle sitting pattern

3.2 Introduction

The national CHVs are expected to provide different types of community based health services in their respective communities. All national programs such as RMNCAH, TB and HIV/AIDS, malaria, nutrition, WASH and many others will need to utilize CHVs in reaching the communities with their package of services. As an initial package of services, the MIP for CHVs provides the minimum service package that each CHV in Zanzibar must be able to deliver. Implementing Partners who want to use CHVs to deliver extra service package beyond the MIP will be expected to orient the CHVs with knowledge on the extra interventions to be delivered.

Regardless of the type of program or intervention, and in order for the CHV to be able to serve the various health and social programs, all CHVs will be expected to have knowledge, skills and competences on the following areas;

1) Health promotion and education;
2) Screening/recognition of danger signs and risks;
3) Early pregnancy detection/identification;
4) Individual and group coaching;
5) Follow up of patients/clients with missed routine visits/services, unhealthy behaviours and emerging health problem issues in the community for immediate reporting.
6) Systematic household visitations and individualized counselling/education provision to clients
7) Effective and fulfilled referral to facility and facility discharge/counter referral to community
8) Research, data collection, follow up and monitoring and evaluation

The figure below simplifies a description and explanation of the interlink between the competences needed and the programs to be served.

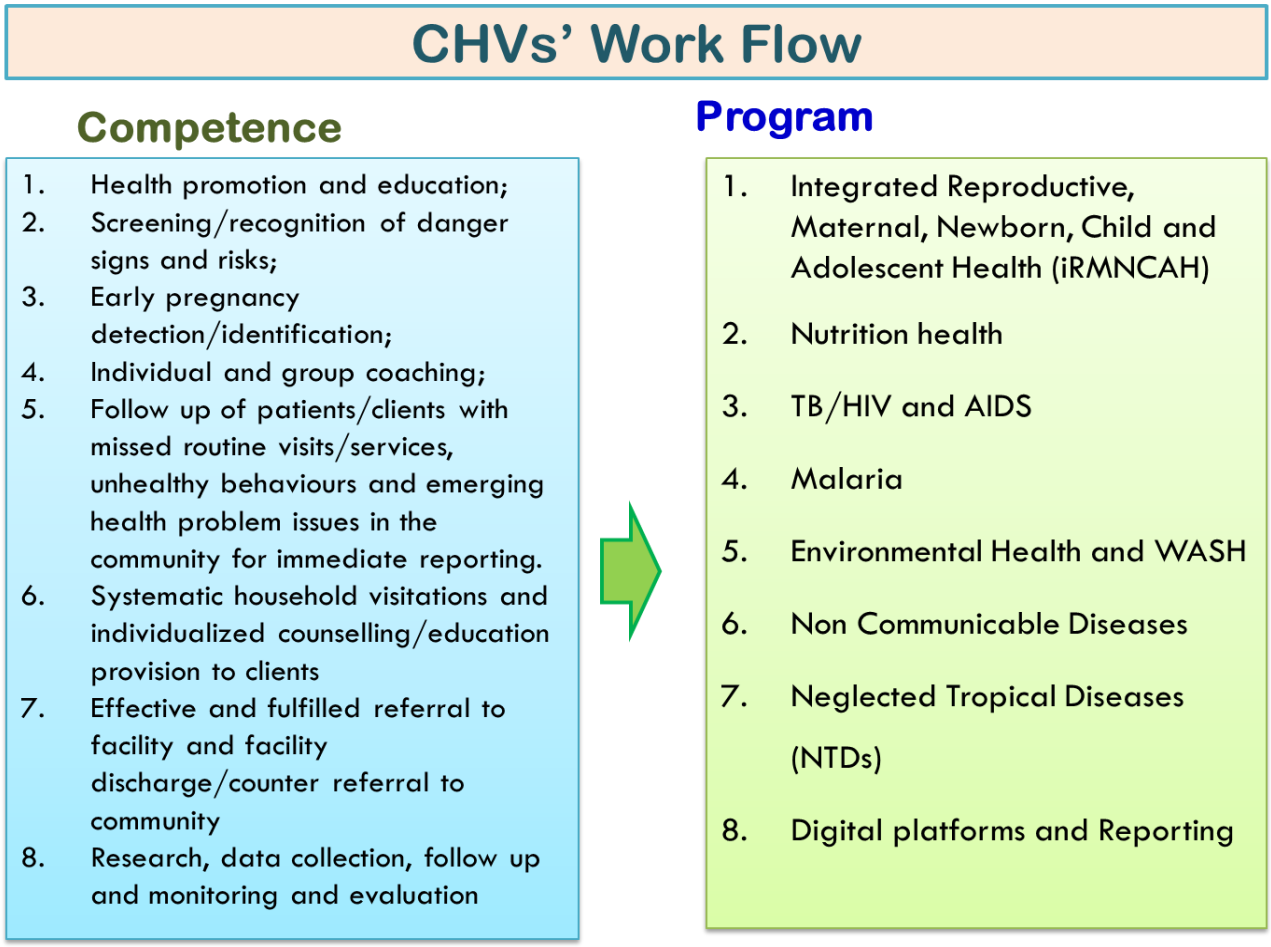


Figure 4: Inter-linkage of CHV competence and community based health programs

The following sections intend to impart knowledge, skills and competences in those eight areas above that are necessary for CHVs to deliver the respective services effectively.

3.3 What do Knowledge, Skills and Competence mean? (2 hours)

Note to Facilitators!

Start this sub-section with a plenary session that will engage trainees to appreciate the concepts of knowledge, skills and competence. You can do this by doing the following

- Ask the trainees to name out different diseases they know and their possible causes. Listen careful and correct if the cause of the disease given is not right. Explain to them that, knowing the names and the causes of the diseases they cited is an example of **knowledge**.
- Ask at least two trainees to come forward of the class and demonstrate how to provide health education to a household (consider the rest of the class as a household) regarding causes of diarrheal diseases. Ask them to structure their talk for one minute to cover important aspects of a health education session. Compare the way the various role players delivered their talk to the family - tone, voicing up, confidence, flow of the conversation etc. Ask the class based on these criteria who was more skilled among the role players. Explain to the class that this is what is meant by being **skilled**.
- Ask the role player who did the best to explain to others how he/she was able to do the previous exercise very well and how often has he/she did that before today. Listen to his/her explanation and help the rest of the class to learn how to become **competent** in their work.

3.3.1 Knowledge

Literally knowledge is a state of familiarity, awareness, or understanding of someone or something which is acquired through learning or experience. It includes understanding or familiarity of facts

(descriptive knowledge), skills (procedural knowledge), or objects (acquaintance knowledge). It can be theoretical or practical understanding of a subject.

3.3.2 Skills

The term "skills" refers to acquired expertise or born with talents that are needed in order to do a job or task. When skills are related to the job you do, they are called job skills which allow you to do a particular job effectively. When the skills are related with general life matters they are called "life skills" which help us to perform our daily routine life activities. Skills can be learned and or improved.

3.3.3 Competence

Competence is the ability that someone possesses, through learning in doing something successfully or efficiently. On the other hand, *competency* is the action of making use of competence. When we "make use the knowledge" we have and "the skills that we possess" then we are competent in what we are doing.

Module 1: Health Promotion

3.4 What is Health promotion? (2 hours)

Note to Facilitators!

- Engage trainees in a discussion to familiarize with promotion activities that they know or were involved. Start with commercial promotion which is very popular in order to get the initial understanding what a promotion activity could look like.
- Ask at least two trainees who had previously worked as CHVs if they can narrate their experience of conducting health promotion activities with specifics such as:
    - What did he/she promote about?
    - How did he/she conduct the promotion/which techniques did he/she use?
    - Who were the target audiences for their promotion activities
    - What were the challenges encountered during the promotion activity?
    - What were the overall outcome of the promotion activity
- Continue with the lecture approach after this session

The World Health Organization defines health promotion as "the process of enabling people to increase control over their health and its determinants, and thereby improve their health." In other words health promotion is all about making people aware that they are responsible for their own good health through avoidance of *unhealthy behaviours* and adaptation of *healthy behaviours* that will prevent disease spread to themselves and other individuals hence promoting good health (health as defined by WHO) in their societies.

3.4.1 Features of health promotion

Health promotion: -

- Is an educative and iterative employing different form of ways of communicating messages;
- Is a two-way communication process whereby the educator keeps learning when orienting others on planned health promotion packages;
- Leads to disease prevention as the primary objective of the process
- Is involving and engage and empower individuals and communities to choose healthy behaviours;
- Makes changes that reduce the risk of developing chronic diseases and other morbidities.
- Covers a wide range of social and environmental interventions that are designed to benefit and protect individual people's health
- Improves quality of life by addressing and preventing the root causes of ill health, not just focusing on treatment and cure.
- Health promotion involves public policy that addresses health determinants such as income, housing, food security, employment, and quality working conditions.
- Includes also promotion of health equity dedicated to social justice or human rights.

It should be noted here that, health promotion is such a wide topic and this manual does not provide a generalized and specialized health promotion education. It is designed to provide basic knowledge, skills and competence tailored to deliverance of the MIP for CHV.

3.4.2 Which services will require health promotion?

All services that have been included in the Minimum Intervention Package (MIP) for CHVs will have a component of health promotion. As thus, health promotion becomes the main role and requisite for all CHVs. Knowledge, skills and competence on how best health promotion can be conducted becomes a fundamental requirement for all CHVs.

3.5 How to conduct and an effective health promotion activity? (1 hour)

3.5.1 Requirements for conducting health education

In order to have an effective health education program or activity, the following are important requirements (Figure 5):

i. Political will and commitment for supportive context for practice.
ii. Interpersonal communication and counselling strategy
iii. Effective relationships and partnerships of and by all involved implementers and partners;
iv. Building capacity of those implementing communication (i.e. capacitating some of the community members to become peers for the rest of the community);
v. Technical package with evidence-based decision-making and practice; and a
vi. Management that oversees execution of the activity

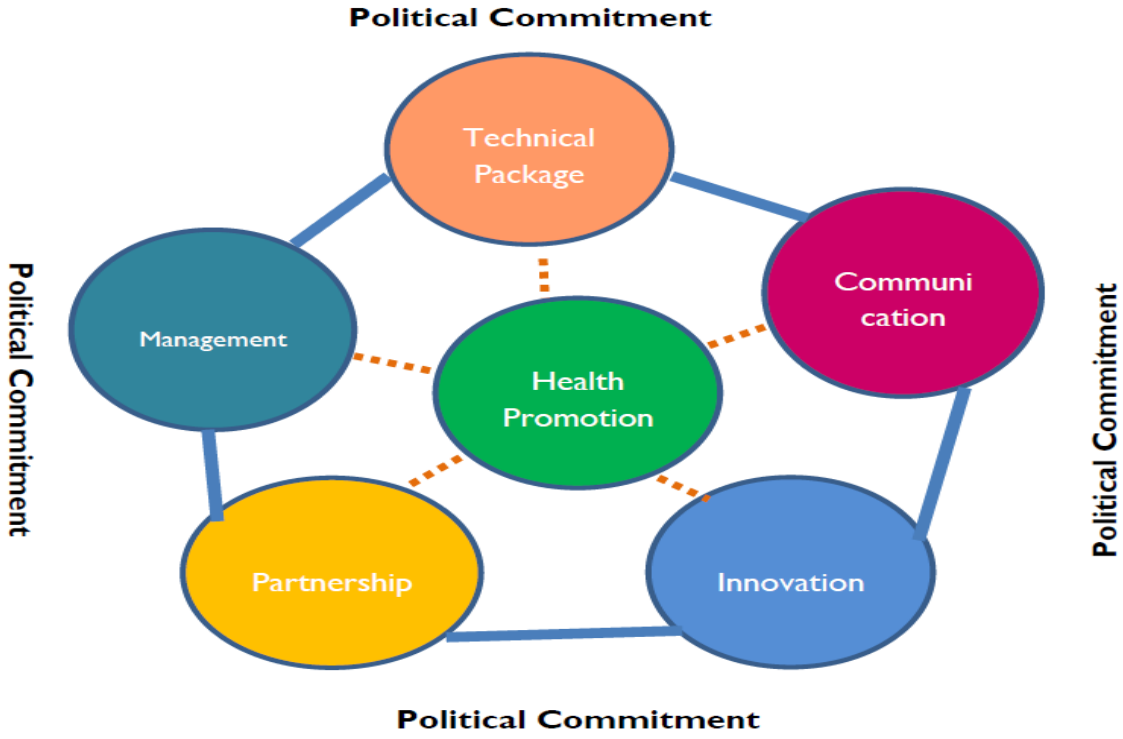


Figure 5: important components of an effective health promotion activity.

3.5.1.1 Political will and commitment for supportive context for practice

Political will means a situation whereby those with authority to make political and administrative decisions have agreed and provided approval and blessing for something to happen. In providing Community based health education, political will should be harnessed from the MOHSWGEC and its respective units, from PORALG-SD, from council administrative authorities, from Ward councils, and from Shehias. In some circumstances technical opinion from Implementing Partners (IPs) might be considered. If one or several of these key stakeholders are unwilling to approve, a health promotion activity will not be successful.

3.5.1.2 Interpersonal Communication (IPC) and Counselling strategy

Note to Facilitators!
Engage the trainees in the following exercise/activity
Ask four to five trainees to form a group.

- Ask one of them to role play as an educator and the rest as community members. Do not worry about the sex/gender mix.
- Ask the educator to ask the community members question regarding their knowledge about HIV and AIDS (causes, mode of transmission, treatment, risk behaviours to contraction of HIV etc.). All this time the educator should be facing a flip chart stand noting down what she/he hears without looking at the group members.
- Ask the group members to communicate among themselves non-verbally, by gestures or signs/symptoms showing not being satisfied with the way the educator is communicating with them.
- Ask the rest of the class what was not right in the way the educator was conducting the session?
- Ask also what did the nonverbal communication (gestures, signs and symptoms) played by the group members meant?
- How best could the session be conducted?

Continue to introduce the section using your lecture notes

Literally communication is the exchange of information between two parties i.e. sender and receiver. So for communication, one has to worry about the effective ways of communication. If information is wrongly communicated, it may not attain the intended objective. It is important therefore, when designing a communication strategy to make efforts on understanding how the sharing of information will happen.
A communication strategy is defined as the scheme or plan of how to share information. For health promotion activity, communication strategy involves the choice of the most useful messages to communicate, the target audience, the purpose and objectives of communicating the message (can be attitude and change of behaviour, alerting and saving lives etc.). It should also include methods of assessing change and success of the health promotion activity such as if number of people who have received the messages, perceived and observed change of behaviours etc.
Three types of communication strategies are known namely, virtual, verbal/audio and non-verbal.

- Virtual communication strategy includes deliverance of the messages using methods that can be seen or read. They include writings, still pictures, moving pictures and or mixed (writing with pictures etc). Example of communication materials for virtual communication include
    - Letters, newspapers, posters, leaflets, books, handouts, web-based (e.g. articles and stories on websites, phone messages, charts etc. for writings
    - Still pictures may include serialized and un-serialized posters, cartoons etc.;
    - Moving pictures may include news on TV, movies, documentaries, and others.
- Verbal communication (audio) uses voice to communicate messages. Examples include meetings, normal one-on-one conversation, news on radio, audio music, phones, voices from drums and trumpets designated to represent something such as emergency, call to the meeting etc (as used in many rural areas in Tanzania, and many others.
- Non-verbal communication means communication without voices. This is common among people with hearing disability. A complete non-verbal language has been developed and taught in schools. However, non-verbal communication is also common even among people without hearing disability. In facts, non-verbal communication constitutes the largest part of our conversation. They include ways such as shaking the head, nodding, blinking, waving the head, pointing fingers etc. Try to think of other non-verbal communication that you know or ever used and what each one meant!

3.5.1.3 How to Implement and Effective IPC and Counselling

Interpersonal communication and counselling are the cornerstones for the overall work and performance of CHVs. Interpersonal communication and counselling acumen is a prerequisite

knowledge-skill and competence set for CHVs to become successful in the rest of their wok stream. In order to become successful CHV should be able to:

- Develop a good, basic understanding of what are effective Interpersonal Communication and counselling skills CHVs must develop
- Acquire the ability to begin applying IPC and counselling skills for community based health services as defined by MIP for CHVs.

3.5.1.3.1 How can IPC be made effective?

It can be achieved through:

1) Face-to-face instead of impersonal communication
2) Two-way instead of one-waycommunication
3) Understanding context and surroundings of the client
4) Utilizing verbal and non-verbal communication
5) Utilizing verbal and non-verbal communication
6) Incorporating feedback and being an effective listener

3.5.1.3.2 Educational tools to improve communication

1) Audio-visual tools can be useful to promote easier understanding of the issues we discuss with clients!

Examples

- Flipcharts
- Posters with drawings of female and male reproductive organs
- Samples of a variety of contraceptives: pills, condom, IUD & the inserter, implants, injectables
- Pictures where possible and relevant
- Model to demonstrate how a certain item is used (example how to apply a condom for men)
- Booklets

2) Closed-ended vs open-ended questions and questionnaires

- When trying to win an obvious answer from your client and hece avoiding a lot of details that might be confusing, closed ended questions should be used. For example:
    - How many children do you have?
    - Are you married?
    - Do you have and use a latrine?
- When you need some extra information and that short answers such as "yes", "no" and or "certainly" and "not sure" may not help to explain a situation, open ended questions should be used. For example:
    - Tell me, why did you decide to have eight children?
    - How do you describe your marriage and how you and your husband decide matters of your life?
    - Why are you not using a latrine?

3.5.1.3.3 Attributes of an effective Community Health Educator

The goal of the work conducted by CHVs is to help people in the community (for example women) they serve to become fully aware of their health preferences, needs and rights and improve their own health. In reproductive health such health information to be communicated can help women decide:

- What to do to control whether or not and when to get pregnant?
- How to choose and use the appropriate birth control method
- How to achieve a healthy pregnancy and delivery
- If needed, how to access quality comprehensive post-abortion care and services.

3.5.1.3.4 How to become an effective and powerful community health educator and communicator

To be successful CHVs must:

- Possess strong internal self-motivation and desire to be a successful educator
- Ideally, the aspiration to be a successful educator should come from the person her/himself

- S/he should not be forced into the role, otherwise their commitment and dedication will not be enough to do the work and their success will be limited
- Successful educators must possess basic knowledge and understanding of the Minimum intervention package (MPI) for the 8 different health programs described in the National CHV Training Manual.

3.5.1.3.5 Attitudes of an Effective Community Health Educator

An effective community health eductor should always have a positive attitude. You mus be:

- Friendly and able to create positive relationship with clients
- Humble
- Conversationalist
- Enthusiastic
- Sympathetic and empathetic
- Encouraging
- Understanding
- Patient and accomadative.

3.5.1.4 Effective relationships and partnerships

Once a political will is obtained, there should be a well-coordinated partnership among key stakeholders who would be involved in conducting a health promotion activity. As will be shown later, for instance those promoting HIV messages might need to communicate messages that are linked to reproductive health and vice versa. If the two provide information that is inconsistent, they may cause harm and make the health promotion activity miss the point and become unsuccessful. All key stakeholders or partners need to have a unified message to avoid confusing the receiver - the community.

It is equally important to recognize that, in order for the CHVs or any person involved in provision of education or counselling to be successful in executing their roles in the community and impacting into desired behaviour changes, they must uphold the critical need for nurturing a strong bond and establishing a trusting relationship with targeted group of clients or individuals. This is highly vital particularly by considering that a CHV will be managing very sensitive programmatic health and social components and attributes such as early identification of pregnancies, HIV related clients' information, sexuality, and result-based referrals and customized follow ups among many others.

3.5.1.5 Building capacity of those conducting health promotion activity

Note to Facilitators!

- Engage the trainees in the famous "eavesdrop" game. Write a short sentence such as "in this class everyone is likely to develop diarrhoea" on a piece of paper.
- Call one trainee in front of the class and murmur to her to read the sentence on the piece of paper silently and memorize the words. Ask her/him to go to the next person in front and murmur exactly the words she just read.
- Each person who has heard the sentence/words should repeat to a next person sitting next to him/her until he last person is reached. Ask the last person to repeat what he/she was told by the last but one person loud enough for the rest of the class to hear.
- Then ask the very first person to repeat the sentence/words she/he read from the piece of paper. Compare the two versions! Ask the trainees what could be the reason for the difference!
- Explain how important for CHVs to be guided by a clear and common message when conducting health promotion/education to avoid distortion of information and hence misleading people.
- Continue with the session using your lecture notes.

Naturally, we tend to differ in the way we talk, write and communicate information to others. If everyone will be left to implement a health promotion activity using their own gifted talents, a communication strategy in the health promotion activity might be chaotic and not successful. Those

entrusted with the responsibility to conduct health promotion must possess acceptable minimum standards, of knowledge, skills and competence of delivering the messages. Beyond possessing sufficient knowledge of the content they are communicating (example, sexuality, WASH, HIV and AIDS), they should also be good speakers, good listeners and good observers. They should also be guided by standard guidelines in order to maintain commonality and consistency of the messages being delivered to the community.
Every minute you are awake, your brain is busy processing so much information at the same time. This complex information in you may hamper and reduce your ability to be a good communicator in the health promotion activity.

To be a good communicator the following qualities are needed:

1) Be conversant with the message content you want to communicate. You should familiarize it and if possible review your message before starting a communication activity.
2) Be authentic, honest, and open. Do not lie or give uncertain information.
3) Be engaging, interesting, and approachable.
4) Be a good listener: Listen actively, attentively, and understanding what is being said or asked
5) Be careful in using body language and facial expressions; some of them may mean different things in different contexts and may be offensive. Maintain good eye contact, and show empathy all the time.
6) Be careful with the language. Use the language best understood by the target audience. Use language carefully, correctly, and clearly. Avoid buzzwords, confusing jargon, and corporate speak.
7) If you have to write in order to communicate something, write appropriately, thoroughly, and in a neat readable handwriting (or if using computers, a good readable font type).
8) Be coherent and concise. Speak and write coherently, concisely, and compellingly.
9) Generally, you should be able to speak, write, present, post, reply, solicit/ask/answer questions, be interviewed, and interview others readily, easily, and effectively.

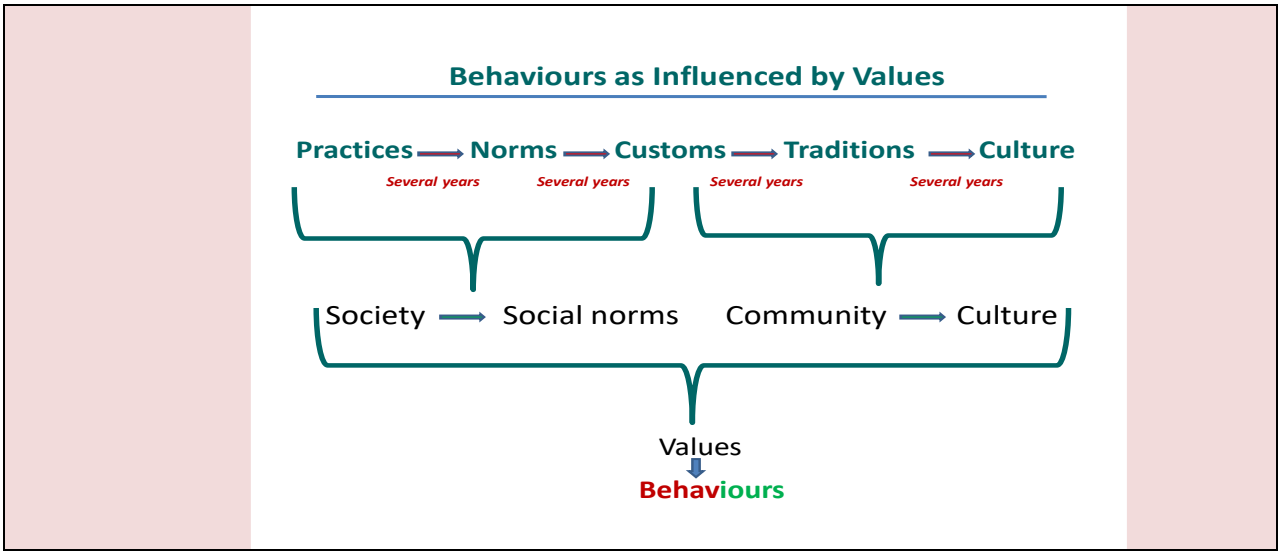
3.5.1.6 Technical package with evidence-based decision-making and practice

The first good quality of a good communicator at section 3.6.1.5 above talks about being conversant and knowledgeable of the content that you are promoting. While there is an emphasis to be knowledgeable and conversant to the content, it should also be emphasized that the content in the communication strategy should be scientifically proven, true and reliable. If the message communicated is administrative or political, it should also have been proven beyond doubt that is true and will not lead to offending Government stance. The following Units provide technical proven content of minimum intervention and service packages that CHV will be expected to promote in their respective working communities.

3.6 Social and Behavioural Change Communication (SBCC) as a Component of Health Promotion (1 hour)

Note to Facilitators!
Start this session by engaging the trainees in a discussion on how norms, customs, values and traditions influence how people live the way they live and behave.

- Use the diagram below to make trainees appreciate the length of time that it takes for our routine practices to be turned to norms, then customs and then to traditions and the values attached to them.
- Let the trainees realize that, the same length of time might be needed to change peoples' perspectives if a change in norms, customs and values - which collectively define one's behaviour need to be reversed/changed.
- Relate this with the SBCC strategy which is usually embedded in their work to promote good health behaviours to reduce health risks and development of diseases.
- Use your lecture slides to orient the trainees on this competence.



One of the most difficult task is to change people's behaviours. It is well known that most of the health problems we have today are either have their causes or their solutions in our behaviours. For example, most of the interventions for addressing health problems related to reproductive health, water, hygiene and sanitation (WASH) are targeted to behavioural change approach.

It should be noted that, behaviours are most often attached to values, which are a result of long period practice of norms and customs. One behaviour might be seen as "bad behaviour" in one society or community but upheld as behaviour of prestige in another. Taking alcohol might be a taboo in Zanzibar but a behaviour demonstrating masculinity in other societies in Tanzania. So it is important to appreciate these values when engaging communities in an effort to change their behaviours. Breaking down the values might be the first step before asking someone to drop the undesirable behaviour in question.

Social and behavioural change communication (SBCC) is an adaptable strategic use of communication approaches to promote changes in knowledge, attitudes, norms, beliefs, values and ultimately behaviours. At its core, SBCC involves coordination of messages and activities across a variety of channels to reach multiple levels of society, including the individual, the community, services and policy.

Persuasion and **Influencing** are the main drivers for conducting a successful SBCC program or activity. CHVs are expected to be able to persuade and influence community members to believe, take on, and implement a decided common goal or vision. Persuasion is simply an act or process of presenting arguments to move, motivate, or change an individual or group of people. This is one particular area of communication skills that is especially important for CHVs. CHVs may need various tools to help them understand the way that others behave, and create positive interactions when performing persuasion and influencing. Your facilitator will take your through some of these tools in the course of your training.

SBCC should be evidence-based; meaning the messages communicated must be true, reliable, tested and have proven to bring about desirable outcomes. CHVs are expected to acquire and possess the communication competence to enable them undertake this function.

Note to Facilitators!
Use handout # 2 to orient and impart knowledge and skills to the trainees to make them competent in implementing SBCC activity. Use role plays as much as possible when delivering the content as guided in the handout.

3.7 Minimum Intervention and service Packages that Include Health Promotion Activity (2 hours)

Note to facilitators!
In the following units, use your lecture slides to introduce to trainees the various intervention and service packages (by programmatic area) that require health promotion by CHVs. This should be just a quick reference to the intervention/service package as the next sections will talk in length on how to implement the actual task. Ask the trainees to read these unit notes on their own private time as well.

3.7.1 Unit 1: Integrated Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH)

3.7.1.1 Introduction

Maternal and neonatal deaths are a global issue but mostly affecting the low and middle-income countries (LMICs). It is estimated that 99% of maternal deaths occur in these countries and nearly two-thirds occur in the sub-Saharan African region. Zanzibar is not exception and is characterized with high maternal mortality with slow decline over time.
Zanzibar has shown commitment and maternal and child health is well spelt out as a major priority area within the health sector. Specific attempts have been made to address maternal and newborn health challenges through the adoption of the Safe Motherhood Initiative with the aim of reducing preventable maternal, neonatal and child deaths. Health promotion for all components of integrated Reproductive, Maternal, Newborn, Child and Adolescent health has been included to be among the key results areas. The role of CHVs in realizing this result area is paramount.

3.7.1.2 Interventions for RMNCAH included for health promotion

Service package for RMNCAH various programmatic components shall include the following (Table 9):

Table 9: Minimum Interventions and Services for RMNCAH

Component	Interventions	Services to be provided by CHV
Reproductive Health	Family Planning,	▪ Develop a plan of action for comprehensive FP service delivery in the Shehia including mapping and conducting census to establish Shehia population ▪ Provide need tailored comprehensive FP education and counselling at household level ▪ Conducting sensitization meetings with males, females, adolescent girls and boys and village leaders ▪ Conduct systematic follow ups to clients at the household level ▪ Sensitize community to attend and participate outreach services as planned ▪ Provide and facilitate referrals of clients to closest health facilities and ensure referrals are both effective and fulfilled ▪ Keep records related to FP services in the working area
	Reproductive Cancers	▪ Provide education and counselling at household level about reproductive cancers ▪ Provide and facilitate referral for patients relaying indication of potential reproductive cancers
	Gender and Male involvement& GBV	▪ Sensitize the community at household level and in meetings on the importance of male involvement in reproductive health components such as comprehensive FP, early initiation of antenatal care and health facility delivery etc. ▪ Educate and sensitize on reduction of gender based violence (GBV) for improved reproductive health
	Elderly servicers	▪ Provide accurate information, advice and link to

	into RMNCAH program	reproductive health services for the elderly ▪ Screening for indications for non-communicable diseases related to sexuality such as signs and symptoms of prostate cancers
Maternal Health	ANC services	▪ Personal hygiene and healthy behaviours ▪ Early identification of pregnancies at the community level ▪ Early recognition of danger signs ▪ Sensitize early booking and completion of ANC visits ▪ Sensitize community and promote facility delivery (skilled delivery) ▪ Educate about birth preparedness and its importance ▪ Educate community members about danger signs during pregnancy, delivery and post delivery ▪ Promote healthy behaviours during pregnancy including personal hygiene, recommended types of exercises, nutrition during pregnancy and others. ▪ Educate community about risks and dangers of use of traditional herbs/medicines ▪ Educate community on the availability of comprehensive post-abortion care (PAC)
	Referral	▪ Early detection and referral for pregnancy complications ▪ Facilitate referrals of already manifested complications during pregnancy, during delivery (in case of home delivery) and post delivery ▪ Proactively follow up to ensure referrals are effective (referral effectiveness) and fulfilled (referral fulfilment)
	MNCH supplies, commodities and medicines	▪ Sensitize compliance to use of recommended pregnancy and post-delivery supplies, commodities and medicines at community level ▪ Distribute some of the selected supplies, commodities and medicines to needy clients (such as refill of ferrous and other FP supplies) at community level ▪ Act as a resource for stock out detection to inform appropriate supply replenishment follow ups
	PMTCT/ Hepatitis B and C	▪ Linkage of couples living with HIV/AIDS with PMTCT/Hepatitis b and C services at closest health facility ▪ Tracking loss to follow up clients for PMTCT ▪ Provide education and counselling of PMTCT for exposed babies
	Postnatal care	Educate and sensitize clients and community at large on ▪ Early and continuous breast feeding ▪ PNC- for mother and baby (up to 42 days) ▪ Educate early recognition and referral of PP danger signs ▪ Special care for small babies (low birth weight and premature babies) ▪ Healthy behaviours (including exercises and hygiene) ▪ Postpartum family planning (PPFP) ▪ Immunizations ▪ Use of LLITNs ▪ Mothers' nutrition post delivery
Newborn Health	Essential newborn care package	Educate, sensitize and promote immediate breastfeeding during home visits and or in gatherings
		Educate Baby WASH practices
		Educate about Cord care for the newborn
		Educate about home management of preterm and low birth

		weight babies
		Educate early recognition of neonatal danger signs and referral
		Educate about home management of sick newborns and referral
Child Health	Early Childhood Development (ECD)	▪ Educate the community, at household and community level on the concept of early childhood development ▪ Promote early and immediate breastfeeding ▪ Identify and support maternal stress and threats to child development during pregnancy ▪ Sensitize and providing couching to promote o early stimulation during pregnancy o newborn stimulation o bonding o safety and empowerment o positive relationships; male engagement and family support o attachment o responsive and interactive parenting ▪ Identify threats to child development (e.g. milestone check, depression, child protection, positive discipline, neglect, and violence)
	Management of common childhood illnesses	▪ Educate community on use of ORS and zinc for home management of diarrheal diseases and referral of severe forms of diarrhoea. ▪ Educate community on detection and management of fevers and referral of severe forms of fevers
	Routine under-five vaccination, (supplementary immunization Activities (SIA) and Vitamin A supplementation	▪ Educate, sensitize and promote vaccination/immunization activities and services ▪ Participate and support in routine immunization, SIAs and Vitamin A supplementation campaigns ▪ Track and identify defaulters of vaccination/immunization among women and children and link back to closest health facility ▪ Keep record of defaulters and sensitized households and link to facility records and ultimately to CHIS
Adolescent Health	Adolescent and Youth Friendly Sexual and Reproductive Health (AYFSRH) including HIV services	▪ Educate adolescents (10 -19 years old) and youths (up to 24 years old) on reproductive, immunization health and sexuality (both individually and in groups) ▪ Link and promote access to youth friendly sexual and reproductive health services in a close/nearby facility ▪ Counsel and refer youth for HIV testing services and care ▪ Promote and counsel adolescence HPV vaccination
	Comprehensive knowledge, skills and positive behaviours on sexuality and reproductive health	▪ Educate, sensitize, encourage and promote best practices and good behaviours on sexuality
Maternal Audit	Maternal and prenatal death and surveillance and response	Participate in maternal and prenatal death surveillance and response (MPDSR)

3.7.1.3 Implementation of RMNCAH interventions including health promotion

Note to Facilitators!
This module is complemented by handout 3A and handout 3B that provide knowledge and service delivery orientation to CHVs. Use the handouts to orient the trainees on how to conduct health promotion for RMNCAH services described above. Use role plays and other interactive training methods as much as possible and as guided in the handouts. Ask the trainees to also read the handouts at their own time.

3.7.2 Unit 2: Nutrition

3.7.2.1 Introduction

Nutrition is a cross-cutting topic across several other programs. It is an essential component of RMNCAH as well as Non Communicable Diseases (NCD) programming. However, while some of the same details are briefly provided elsewhere in other packages, due to its importance, some of its key elements are put together here for ease of reference and packaging.

3.7.2.2 Nutritional interventions to be included for health promotion

The following interventions and services will comprise intervention and service package for nutrition that CHV will have to promote (Table 10):

Table 10: List of interventions under the nutrition component

Stage	Interventions	Services to be provided by CHV
During pregnancy	Healthy nutrition during pregnancy and lactation	Educate, sensitize and promote healthy nutrition during pregnancy and lactation based on the locally available food/dietary options
		Supply and refill micronutrient supplementation whenever is recommended
Post delivery	Breastfeeding practices and services	Educate the importance of and sensitize early initiation and exclusive breastfeeding
		Identify feeding problems and growth failure and advice accordingly
		Educate and re-supply postpartum micronutrient supplementation whenever recommended
		Educate and promote best practices for feeding low-birth weight and premature babies
Infancy and childhood	Infant and Young Child Feeding (IYCF) practices and nutrition	Conduct screening for early recognition and referral for malnutrition (including MUAC and Conduct home growth monitoring and records
		Provide education on minimal acceptable diet and promote optimal nutrition (including complementary feeding, food diversity)
		Educate and promote micronutrient supplementation (powder for babies after 6 months where available; children; first 3 months for mother)
General population	Balanced diet and eating behaviours	▪ Provide education and recommendations on minimal acceptable diet for general population, Adolescents ,the elderly and chronically ill persons ▪ Promote consumption of balance diet for optimal nutrition (including complementary feeding, food diversity)
For the elderly	Nutrition/Diet for the elderly	
For chronically ill people	Nutrition/diet for chronically ill person	

3.7.2.3 Implementation of nutrition interventions including health promotion

Note to Facilitators!
This module is complemented by handout #4 that provides knowledge and service delivery orientation to CHVs. Use the handout to orient the trainees on how to conduct health promotion for nutrition health services described above. Use role plays, illustrations and other interactive

training methods as much as possible and as guided in the handouts. Ask the trainees to also read the handout at their own private time.

3.7.3 Unit 3: TB/HIV and AIDS

3.7.3.1 Introduction

The HIV/AIDS epidemic is still a major public health problem in Zanzibar. The situation is exacerbated by the increasing co-infection with tuberculosis and other opportunistic infections. The nature of the epidemic is concentrated in the key populations whose access to health care services is constrained by stigma and discrimination associated with their social behaviours. Leprosy is another chronic disease with debilitating impacts in the population in terms of the disability and stigma it causes.

The MOHSWGEC recognizes Community Based Health Care (CBHC) as a viable strategy for delivering services along the continuum of care and reaching key populations regarded as important drivers of the HIV/AIDS epidemic. The Integrated Community Based Health Care (ICBHC) program seeks to respond to this need by emphasizing disease prevention, healthier living and expansion of the continuum of care through CHV, while strengthening linkage with health facility services.

3.7.3.2 Interventions for TB/HIV and AIDS that will require health promotion by CHV

Health promotion for TB/HIV and AIDS program will implement and follow up on the following set of interventions and services (Table 11).

Table 11: List of interventions under the TB/HIV and AIDS program

Category	Interventions	Services to be provided by CHV
Community based TB interventions	Community active TB case-finding and referral	Conduct active TB case-finding and referral in the community
	Sputum collection, transport, and fixing	Facilitate sputum collection, transport, and fixing especially during outreach
	Treatment support	Provide home based treatment support for TB patients based on national guidelines
	Tracing of patients lost to follow-up	Conduct household level patient tracing to identify lost to follow up patients linked to the closest facility records
	Health education and counselling	Provide health education (including Infection prevention and control) and counselling on TB in general among the population in the catchment area
Community based HIV and AIDS interventions	Home based care for critically ill patients	Conduct regular visits to critically ill patients and offer recommended care as per national guidelines
	Tracing of patients lost to follow-up	Conduct household level patient tracing to identify lost to follow up patients linked to the closest facility records
	Health education and counselling.	Provide health education and counselling on HIV and AIDS in general among the population in the catchment area
	Treatment support	Conduct home visit and provide care as per national guidelines including refill of ARVs for stable patients

3.7.3.3 Implementation of TB/HIV and AIDS interventions including health promotion

Note to Facilitators!
This module is complemented by handout #5A and #5B that provide knowledge and service delivery orientation to CHVs. Use the handout to orient the trainees on how to conduct health promotion for TB/HIV and AIDS services described above. Use role plays and other interactive training methods as much as possible and as guided in the handouts. Ask the trainees to also read the handout at their own time

3.7.4 Unit 4: Malaria

3.7.4.1 Introduction

Most of the countries affected by the malaria epidemic do usually develop and implement their malaria Control or Elimination Communication and Advocacy Strategies. Most of these contain three

main components namely: (i) advocacy at political, healthcare worker and community level; (ii) development and distribution of educational material on environmental and vector control, chemoprophylaxis, personal protection, signs and symptoms of malaria; and (iii) ensuring patient adherence to treatment and to collaborate with partners. For these to happen, a strong health promotion campaign is required.

Zanzibar is among the first in sub-Saharan Africa to roll out wide-scale modern control interventions that include use of artemisin in-based combination therapy (ACT), long-lasting insecticidal nets (LLINs), indoor residual spraying (IRS) and rapid diagnostic tests (RDTs). Health promotion had the largest contribution to these successes. These efforts need to be continued and sustained.

3.7.4.2 Malaria interventions that will be included for health promotion

Some of the services such as education on malaria during pregnancy and use of LLITNs are also linked to other programs especially RMNCAH. However, for the sake of packaging, here are the main and key services for interventions under the malaria program that will require health promotion (Table 12):

Table 12: Community based interventions for malaria program

Interventions	Services to be provided by CHV
Malaria in pregnancy	Conduct household visits and meetings to provide education on malaria in pregnancy and its associated dangers and risks
Use of long lasting insecticide nets (LLIN)	▪ Provide education on malaria as a whole (causes, role of mosquitoes, mode of transmission) and prevention strategies including use of LLITNs ▪ Participate in distribution of LLITNs ▪ Track use of LLITNs at household level and in the community at large
Environmental management and outdoor lavicidying	▪ Educate, sensitize and promote clean environment up-keeping as a strategy to prevent spread of malaria ▪ Collaborate with SHCCs to sensitize and mobilize special days for environment cleaning ▪ Participate in outdoor insecticide spray campaigns
Social and behavioural change communication (SBCC)	Implement social and behavioural change communication as per national guidelines and available malaria SBCC package

3.7.4.3 Implementation of Malaria interventions including health promotion

Note to Facilitators!
This module is complemented by handout #6 that provides knowledge and service delivery orientation to CHVs. Use the handout to orient the trainees on how to conduct health promotion for malaria services described above. Use role plays and other interactive training methods as much as possible and as guided in the handouts. Ask the trainees to also read the handout at their own time.

3.7.5 Unit 5: Environmental Health and WASH

3.7.5.1 Introduction

Environment is the home of humans! Humans themselves constitute part of the environment to each other. As thus, humans interact with the environment constantly and all the time! These interactions affect quality of life, years of healthy life lived, and health disparities.

The World Health Organization (WHO) defines environment, in relation to health, as *"all the physical, chemical, and biological factors external to a person, and all the related behaviors*." Environmental health consists of preventing or controlling disease, injury, and disability related to the interactions between people and their environment and among people.

There are about six dimensions (themes) that can be used to highlights and describe elements of environmental health. These include:

- Outdoor air quality;

- Surface and ground water quality;
- Toxic substances and hazardous wastes;
- Homes and communities;
- Infrastructure and surveillance and
- Global environmental health.

On the other hand, WASH stands for Water, Sanitation and Hygiene, which is a special program implemented particularly in health facilities and in communities (including at household level) by ensuring that infrastructure and practices that support water, sanitation, health care waste management, hygiene and environmental cleaning are in place. The intention is to prevent the spread of diseases within the healthcare facility and to the surrounding community.

WASH is life-saving. The spread of many diseases is perpetuated by unhygienic behaviours, practices and environments. By ensuring that the environment and our behaviours are hygienic we may divert significant disease spread. Simple practices such as hand washing with soap before and after eating or after making use of the toilets can save lives. Drinking clean and safe water is another example of a WASH intervention and practice. Your facilitator will take you through the details of WASH and how it should be effectively implemented at community level.

3.7.5.2 Interventions for environmental health and WASH included for health promotion at community level

Table 13 below summarizes service package for environmental health and WASH programs that will require health promotion.

Table 13: Community based service package for environmental health and WASH

Interventions	Services to be provided by CHV
Prevention of water and air pollution to improve quality of water	▪ Educate, sensitize and promote good up keeping of water sources and the environment as a whole ▪ Provide education on WASH and its individual components ▪ Promote behavioural change in relation to WAH best practices on use of clean and safe water, construction and use of toilets and hand washing with soap ▪ Keep records of household with sources of clean and safe water ▪ Keep record of households with and using toilets ▪ Educate communities on safety and quality of food and food relate products ▪ Notify government authorities in case of spread of foods and food related products with suspicion on their quality and safety
Protection and maintenance of water sources to maintain water quantity	
Food safety, hygiene and need for legal enforcement of Food safety regulations.	
Hygiene practices to promote hand washing with soap or other agents (after defecation, after disposal of child faeces, and prior to preparing, eating and handling food)	
Sanitation so as to provide or promote expanded or improved excreta disposal.	

3.7.5.3 Implementation of environmental health interventions and WASH including health promotion

Note to Facilitators!
This module is complemented by handout #7 that provides knowledge and service delivery orientation to CHVs. Use the handout to orient the trainees on how to conduct health promotion for environmental health and WASH services described above. Use role plays and other interactive training methods as much as possible and as guided in the handouts. Ask the trainees to also read the handout at their own time.

3.7.6 Unit 6: Non Communicable Diseases (NCDs)

3.7.6.1 Introduction

Non communicable diseases (NCDs), also known as chronic diseases are types of diseases that tend to be of long duration and are the result of a combination of genetic, physiological, environmental and

behavioural factors. The main types of NCD are cardiovascular diseases (such as heart attacks and stroke), cancers, chronic respiratory diseases (such as asthma) and diabetes.
NCDs disproportionately affect people across the whole world but more often in low- and middle-income countries where more than three quarters of global NCD deaths occur. In Zanzibar, NCD constitutes one of the major public health problems. Traditionally, treatment of NCDs is more expensive than their preventive interventions. Health promotion over NCD is thus one of the most important interventions. Health promotion for prevention and living with NCDs at community level is required and the role of CHVs on this cannot be overemphasized.

3.7.6.2 Interventions for NCDs included for health promotion at community level

The following presentation provides a service package for Non Communicable Diseases that will require health promotion aspect (Table 14).

Table 14: Community based service package for NCDs

Stage	Interventions	Services to be provided by CHV
Infancy	Exclusive breastfeeding for 6 months	Linked to RMNCAH and Nutrition programmatic areas
	Nutritionally adequate and safe complementary feeding	
	Breastfeeding up to 2 years of age or beyond	
Childhood and adolescence	Social and Behavioural Change Communication	Provide life skills education
		In collaboration with SHCCs, educate importance of and sensitize and promote physical activity in school and society
		In collaboration with SHCCs and the responsible officers from the education sector, educate and promote safe and healthy foods in schools
		In collaboration with SHCC, educate the community on risks and dangers of using food products high in salt/sugar/unhealthy fats
Adulthood	Maternal nutrition	Linked to RMNCAH programmatic areas
	Tobacco prevention and cessation programs	Educate community on dangers and risks associated with use of tobacco (smoking, chewing etc.)
	Availability and affordability of food	Educate and promote storage and food reserves to ensure availability for the family/household across the whole year
	Physical activity	Educate, sensitize and promote adaptation of exercising behaviour to improve physical activity (home, workplaces etc.)
	Effective prevention and care of risks and diseases	▪ Educate on early signs and symptoms of NCDs ▪ Recommend and facilitate referral to closest facility for persons presenting clear risks, signs and symptoms of NCD

3.7.6.3 Implementation of NCD interventions including health promotion

Note to Facilitators!
This module is complemented by handout #8 that provides knowledge and service delivery orientation to CHVs. Use the handout to orient the trainees on how to conduct health promotion for nutrition health services described above. Use role plays, illustrations and other interactive training methods as much as possible and as guided in the handouts. Ask the trainees to also read the handout at their own time.

3.7.7 Unit 7: Neglected Tropical Diseases (NTDs)

3.7.7.1 Introduction

Neglected tropical diseases (NTDs), are a group of diseases that occur under tropical and sub-tropical climate conditions and are intimately linked to poverty. Examples include Buruli Ulcer, Chagas Disease, Cysticercosis, Dengue Fever, Guinea Worm Disease and Human African Trypanosomiasis. These diseases thrive in areas where access to adequate sanitation, clean water and healthcare is limited, and where people live in proximity with animals and infective disease vectors, such as in remote and rural areas, informal settlements or conflict zones.

Although not all forms of the NTDs are found in Zanzibar, it is however not safe from these diseases and hence their prevention is very important. Since most of these diseases are associated with poverty, living conditions and behaviours, health education though health promotion at community level is hence very important.

3.7.7.2 Interventions for NTD included for health promotion at community level

Table 15 below summarizes recommended community based service package that will require health promotion by CHVs.

Table 15: Community based service package for NTDs

Interventions	Services to be provided by CHV
Innovative and intensified disease management	▪ Provide education on NTDs and their importance ▪ Provide notification of notable increased incidence of NTDs in the catchment area to the closest facility
Vector control and pesticide management	Linked to malaria and environmental health programs
Safe drinking-water, basic sanitation and hygiene services, and education	Linked to environmental health and WASH program

3.7.7.3 Implementation of NTDs interventions including health promotion

Note to Facilitators!
This module is complemented by handout #9 that provides knowledge and service delivery orientation to CHVs. Use the handout to orient the trainees on how to conduct health promotion for nutrition health services described above. Use role plays, illustrations and other interactive training methods as much as possible and as guided in the handouts. Ask the trainees to also read the handout at their own private time.

Module 2: Screening and Recognition of Danger Signs and Risks

3.8 Learning Outcomes

At the end of this module, trainees are expected to be able to understand, explain and demonstrate;

- *The concept of screening and early identification of pregnancy,*
- *Danger signs related to RMNCAH, Nutrition conditions, TB/HIV and AIDS, Malaria, and NCD,*
- *Risks of unhealthy conditions associated with community based health services,*
- *How to conduct screening.*
- *Linking the outcomes of screening with referrals*

Total time for this module is 2hours and 30 minutes.

Note: This module is complemented by handout 10.

3.9 What is screening?

Note to Facilitators!
Introduce the concept of screening by engaging and involving the trainees in the following activity:

- Write the following words in a power point slide using different font sizes (Large, medium, very small)

- ACTING
- Attaining
- Action

- Ask the trainees, to stand at the far back of the class and one by one read the words from the slide. Those using glasses should take off their glasses when reading.
- Sort out those who are able to read all the three words without any problem and those who are not able to.
- Explain to the trainees that what you did is an example of screening for eye sight. It means sorting out a certain abnormal condition from several others that are normal.
- Ask the trainees to sit back to their places and use your lecture slides to orient the trainees on the rest of the section content

Apart from conducting health promotion activity, CHV's second biggest role will be conducting screening of community members who potentially present symptoms of illness/diseases. Literally screening refers to as the systematic application of a test or inquiry to identify individuals at sufficient risk of a specific disorder to benefit from further investigation or direct preventive action.
Most often these individuals may have not sought medical attention on account of symptoms of that disorder or may be under treatment or care and yet develop risky symptoms that require immediate medical attention and management.

Examples of screening

1) In observing a pregnant woman, you find that she has her legs swollen. This is not a good sign as swollen legs indicates excessive proteins in the body which may cause high blood pressure and which in turn could probably lead to pre-eclampsia.
2) In a group of young men, you notice that one of them keeps dozing off all the time despite your effort to wake him/her up. This can be a suspect case of a drug user and addict. You can call him/her aside and ask several questions that will confirm your suspicion that he/she is drug abused.
3) You may conduct a home visit and find that a two year old baby girl has oedema of both feet and severe wasting. This might be a case of severe malnutrition.

3.10 What are danger signs and risks?

In the above example of the pregnant woman, swollen legs are an example of a danger sign. Similarly, if a pregnant woman experiences excessive bleeding before labour, during labour and or after delivery, the excessive bleeding is another example of danger sign.
Danger signs are safety signs for warning when a hazard or a hazardous condition is likely to be life-threatening. They may manifest in adults and children, men and women, sick and well people and may be abrupt or slowly manifesting. Among the services that CHVs are expected to deliver is screening of danger signs. These are most common in services related to reproductive, maternal, newborn and child health. They are also important in malaria related services, TB/HIV and AIDs, in early childhood development services and in nutrition.
On the other hand, a health risk is the chance or likelihood that something will harm or otherwise affect your health. Unlike danger sign, risk does not necessarily mean that something bad will definitely happen. It's just a possibility. Some conditions put us in more risks of being affected than others. Some people are more exposed to risk conditions than others. Several characteristics, called risk factors, can be used to assess whether one is at high or low health risks.

Examples of health risks

- A pregnant woman who takes alcohol is at risk of having a premature birth, delivering a baby with brain damage and problems with growth and development or a baby with low birth weight.
- Someone who smokes cigarette is at high risk of contracting lung cancer than someone who does not smoke
- People working in charcoal business are at higher risk of suffering from TB than those who are working in offices
- People with multiple sex partners are at more risk of contracting HIV than those who are abstaining or limited to one partner.

- Teen girls who are exposed to early sexual activity may face a risk of conception of unwanted pregnancies

3.11 How to conduct screening?

Screening for danger signs and health risks can be conducted using different methods and approaches. These can include:

- Observation of the condition of a potential suspect of a given ill health condition.
- Asking a person a series of questions that will lead to unveiling potential exposure to health risks. This may also include a popular method called "taking history". This generates signs and symptoms from the individual client.
- Assessment and evaluation by using several measurements such as taking measurement of arm circumference of an under five child to determine his/her nutritional status.
- Diagnostic testing such as rapid test for malaria or taking samples/specimens for laboratory testing.

You facilitator will take you through specific screening methods for danger signs and health risks for RMNCAH, early childhood development, nutrition, TB/HIV and AIDS, malaria, NCD and NTDs.

Note to facilitators!

Engage the trainees in screening for potential obesity among themselves using Body Mass index Calculation.

- Draw a height scale on the one wall of the class using chalk or any other temporary writing material. Ask each trainee/CHV to take their height measurements and record
- If you can improvise a weigh scale, ask each trainee to take his or her weight. Otherwise, ask each of them if they know their weight. Record that as well
- Ask each trainee to calculate their BMI using the standard formula and their resultant interpretations as shown below.
- Trainees should be able to demonstrate and interpret their results

$$BMI = \frac{\text{weight (kg)}}{\text{height (m)}^2}$$

Body Mass Index Interpretation

BMI < 18.5:	Below normal weight
BMI >= 18.5 and < 25:	Normal weight
BMI >= 25 and < 30:	Overweight
BMI >= 30 and < 35:	Class I Obesity
BMI >= 35 and < 40:	Class II Obesity
BMI >= 40:	Class III Obesity

- Let the trainees appreciate this as one method of conducting screening for NCDs. Lead them to read the various handouts that provide orientation for other programmatic areas.

3.12 Which service packages will include screening?

CHVs will be expected to conduct screening for some ailments and health conditions at the community level. These will include:

3.12.1 Unit 1: Screening for RMNCAH related services

The following services (Table 16) will include a screening role by the CHV.

Table 16: RMNCAH interventions involving screening services

Component of RMNCAH	Interventions	Services to be provided by CHV
Reproductive health	Reproductive Cancers	▪ Screening of patients displaying indication of potential reproductive cancers
	Elderly	▪ Screening for indications for non-communicable diseases

	servicers into RMNCAH program	related to sexuality such as signs and symptoms of prostate cancers
Maternal Health	ANC services	▪ Early detection/identification of pregnancies at the community level. ▪ Screening and identifying pregnant women with danger signs and risks of developing complications e.g. anaemia, pre-eclampsia, poor nutrition, vaginal bleeding etc.
	Referral	▪ Early detection and referral for pregnancy complications
	Postnatal care	▪ Early recognition and referral of Postpartum/post-delivery danger signs
Newborn Health	Essential newborn care package	▪ Screening and Identifying newborns with danger signs which may lead to complications
Child Health	Early Childhood Development (ECD)	▪ Identify and support maternal stress and threats to child development during pregnancy ▪ Identify threats to child development (e.g. milestone check, depression, child protection, positive discipline, neglect, and violence)
	Management of common childhood illnesses	▪ Identifying children with diarrheal diseases, pneumonia and fevers for prompt care seeking and management.
Adolescent Health	Adolescent and Youth Friendly Sexual and Reproductive Health (AYFSRH) including HIV services	▪ Educate youths on reproductive health and sexuality (both individually and in groups) ▪ Link and promote access to youth friendly sexual and reproductive health services in a close/nearby facility ▪ Distribute commodities such as condoms and FP commodities to needy youths ▪ Identifying youth with high risks of HIV and drug abuse followed by counselling and referral for HIV testing services and care

3.12.1.1 Screening/Early Detection of Pregnancies

Early identification of pregnancy is an important entry point for most of the high impact iRMNCAH interventions such as effective ANC, FP counseling and provision, health facility delivery, immunization, pregnancy nutrition, PPFP, postnatal care, post abortion care (cPAC etc. All the aforesaid interventions lose their meaning and essense if they are not delivered timely along the pregnancy milestone of a woman.
CHVs should prioritize this intervention as the most important of all other RMNCAH interventions.

3.12.1.1.1 How to conduct early detection of pregnancy

There is a famous medical saying which says *"every woman of reproductive age is pregnant unless proven otherwise"*. This means that, CHVs should always be alert with women of reproductive age (WRA) that they are always potential candidates for pregnancy. When conducting household visits, engage all women of reproductive age in a conversation to assess a possibility if they might be in their early stages of pregnancy even if the visit was for something else. The following sets of questions may be used to engage a woman towards early detection of pregnancy:

Ask

- If she feels nausea and vomiting
- If she has accumulation of saliva most of the time in her mouth
- If she experiences stomach pains
- If she experiences loss of appetite
- If she has or has not experienced her regular menstrual period

If the woman experiences one or several of the above signs/symptoms, advise and encourage her to visit the closest health facility immediately for a confirmatory pregnancy test.

In addition, observe also

- If she has presented danger signs that require immediate attention and hence provide her with a refrral
- Observe the general apperance of the woman the first time you meet: her facial expression, if she looks pale, if she sweats, if she has tremors or trembling, difficulty in breathing etc.
- Ask general questions such as:
    - Do you have any problem?
    - Are you worried of anything?
    - How old is your pregnancy?

Keep record of all the information you ar provided with.

3.12.1.1.2 Referral for a pregnant woman

As a CHV, you consider referring the woman to the closest health facility always when you detect any signs or symptoms that require immediate attention of a health provider. Ask the following qiestions to guide you arrive into a conclusion if the woman need a referral:

- Vaginal bleeding
- Severe headache
- Excessive vomiting
- Convulsion
- Severe abdominal pains
- General body malaise and the feeling of being sick most of the time
- High fever
- Shock and or fainting.

Note to Facilitators!
This section is complemented by handout #10 that provides knowledge and skill orientation to CHVs. Use the handout to orient the trainees on how to conduct screening for various RMNCAH services described above. Use role plays, illustrations and other interactive training methods as much as possible and as guided in the handouts. Ask the trainees to also read the handout at their own private time.

3.12.2 Unit 2: Screening for danger signs and risks for nutrition intervention

CHVs will also be expected to conduct screening activity for some services related with nutrition as shown in Table 17 below.

Table 17: Screening services related to nutrition interventions

Stage	Interventions	Services to be provided by CHV
During pregnancy	Healthy nutrition during pregnancy and lactation	Detect and identify pregnant women who are likely to be anaemic and refer for testing
Post delivery		Identify feeding problems and growth failure and advice accordingly
Infancy and childhood	Infant and Young Child Feeding (IYCF) practices and nutrition	Conduct screening for early recognition and referral for malnutrition (including MUAC and Conduct home growth monitoring and records Follow up of missed appointments and missed opportunities for immunization
General population	Balanced diet and eating behaviours	▪ Assess and identify people with potential risks of falling victim of NCD

Note to Facilitators!
This section is complemented by handout 4 and guidelines embedded in the digital platform in

the mobile phone that provide guidance to CHVs. Use the guidelines to orient the trainees on how to conduct screening for various nutrition health services described above. Use role plays, illustrations and other interactive training methods as much as possible and as guided in the handouts. Ask the trainees to also read the handout at their own private time.

3.12.3 Unit 3: Screening of danger signs and risks for TB/HIV and AIDS

Table 18 provides a list of screening services related to TB/HIV and AIDS

Table 18: Screening services related to TB and HIV and AIDS

Category	Interventions	Services to be provided by CHV
Community based TB interventions	Community active TB case-finding and referral	Conduct active TB case-finding and referral in the community
	Tracing of patients lost to follow-up	Conduct household level patient tracing to identify lost to follow up patients linked to the closest facility records
Community based HIV and AIDS interventions	Home based care for critically ill patients	Conduct regular visits to critically ill patients and identify conditions that may need immediate management: Recommend for referral or offer recommended care as per national guidelines Follow up of missed appointments and lost to follow clients

Note to Facilitators!
This section is complemented by handout #5A, 5B and the embedded digital platform in the mobile phone that provide guidance to CHVs. Use the handouts and the mobile platform to orient the trainees on how to conduct screening for various TB/HIV and AIDS services described above. Use role plays, illustrations and other interactive training methods as much as possible and as guided in the handouts. Ask the trainees to also read the handout at their own private time.

3.12.4 Unit 4: Screening danger signs and risks for malaria

Malaria during pregnancy is one of the conditions that can put the woman into risks of pregnancy complications. Similarly severe malaria is fatal among under-five children and can lead to convulsions. Table 19 provides guidance on when to screen women and children for malaria so that a prompt action can be taken.

Table 19: Screening services related to Malaria interventions

Interventions	Services to be provided by CHV
Malaria in pregnancy	Conduct household visits to identify women with potential possibility of having malaria in pregnancy and its associated dangers and risks
Malaria among under five children	Conduct household visits to identify under five children with potential possibility of having malaria in pregnancy and its associated dangers and risks

Screening of pregnant women for malaria can be conducted through

- Asking the woman:
  - if she always sleeps under a treated mosquito net,
  - if she has ever experienced any malaria symptoms such as fever, headache and general body malaise.
- Observing the woman if she presents any symptoms of malaria (fever, headache and diarrhoea) and advise her to go for testing

Screening of the under five children can be conducted by:

- Observing the condition of the child if she/he presents any sign or symptom of malaria (feverish, diarrhoea, vomiting, refuse to breast feed).
- Taking history including asking if the child sleeps under a mosquito net.

During training, your facilitator will orient you and demonstrate practically how to perform screening for malaria.

Note to Facilitators!
This section is complemented by handout #6and the embedded digital platform in the mobile phone to CHVs. Use the handout and the mobile platform to orient the trainees on how to conduct screening for various malaria services described above. Use role plays, illustrations and other interactive training methods as much as possible and as guided in the handouts. Ask the trainees to also read the handout at their own private time.

Module 3: Conducting Follow up of Missed Routine Visits/Services,

3.13 Learning Outcomes

At the end of this module, trainees are expected to have learnt and be able to explain and demonstrate the following:

- *The concept of follow up in health service delivery;*
- *The concept of routine services in health service delivery;*
- *The importance of conducting follow up at community level and*
- *How to conduct follow up and for which services.*

Total time for this module is 1 hour

3.14 Introduction

One of your functions and responsibilities as CHV, is to conduct visits to the households or families within your communities. These visits may have several purposes such as conducting education as part of health promotion, conducting counselling and in some cases making follow up of patients whose treatment or care require several visitations to the facility. It is therefore important to understand the concept of follow up, its reasons and how to conduct follow up visits.

3.15 What is follow up?

Note to Facilitators!
Start this session by asking one of the CHVs who has been practicing to explain what she/he used to do when following up of clients who required routine services such as pregnant women. Ask him/he to explain:

- Which services he/she conducted that required follow up
- How frequent did he/she conduct follow up to the same person
- What information did he/she provide to the client or recoded from the client
- What other services he/she offered to the client? Was there any time a referral was required?

After the trainee has explained this to the rest of the class, use your lecture slides to orient the trainees on the rest of the content under this section.

In health service provision, "follow up" refers to care given to a patient over time after finishing or during consecutive treatment phases for a disease or a health condition. It can be conducted in health facilities where the patient is required to go back on scheduled periods or at home by service providers during outreach or by CHV during home visits. If conducted in health facilities, follow-up care involves regular medical check-ups, which may include a physical exam, blood tests, and imaging tests. If it is conducted at home, follow up may include assessment and screening of the condition of the patient, reminding the patient on the date to return to the treatment and care centre. In some cases, follow up may result to referrals. Follow up may help to identify and remind patients on their missed visits to health facility.

3.16 What is a missed routine visit or service?

Let' use an example of a pregnant woman. Once a woman suspects that she is pregnant, she will be expected to visit the closest health facility which provides Antenatal Care (ANC) services. The current guidelines require the woman to attend to the ANC clinic every month after the first visit, preferably as soon as after two months of pregnancy. Due to a number of reasons, such as forgetting the date, not seeing the importance of going back and others, a woman may miss one or several schedule visits of her ANC clinics. These are what we call missed routine visits. A missed visit is when a patient fails to attend his/her scheduled clinical visit to a facility for any reason.

3.17 What is the importance of follow up?

Missed visits may be very damaging to the course of treatment or care provided to the patient and ultimately to his/her health. For pregnant women, missed visits may mean and lead to exposure to complications that may lead to undesirable outcomes of the pregnancy. CHVs are expected to play a vital role, through planned **follow up** visits at household level to help women, children, the sick and community at large to adhere to the course of treatment and care.

3.18 Services that require follow up

Follow up visits need to be conducted particularly for people with health conditions that take a long period of treatment or care and have scheduled return to facility visits. They may include:

- Pregnant women for Antenatal Care (ANC visits), health facility delivery and PPFP preparedness.
- Breastfeeding mothers.
- Family planning adopters/users of short and long acting reversible contraceptives (LARC).
- Newborn and infants for early childhood development milestones.
- Under-five children with various forms of malnutrition.
- Postnatal Care clients
- Immunization clients or schedules
- Diabetic patients.
- People with hypertension,
- Patients with cardiovascular accidents (e.g. stroke).
- People with generalized heart disease,
- People living with HIV/AIDS.
- Tuberculosis patients.
- People with mental health problems.
- People with impairment and disability.

Follow up visits are also very important for early childhood development program where despite of not being sick, new-borns and infants are highly recommended to be followed up on their growth milestones. Additionally, follow up is essential to be conducted to all clients who were referred to the health facility for the purpose of documenting respective referral outcomes and provision of individualized need tailored education.

3.19 How to conduct an effective follow up?

In order to conduct an effective, follow up visit, CHVs will need to have all the skills required for health promotion activity. In addition, they need to have;

- Home visit skills;
- Screening skills;
- Rehabilitative care for clients with some health conditions such as PLWHA;
- Interpersonal skills;
- Counselling skills;
- Training skills for caregivers within the family;
- Skills in mobilizing community resources.

In the course of your training, you will be equipped with these skills from different sections, modules and units of this training manual. Similarly, your Facilitator will orient you on some of these skills as well. Read also **handout number 11** for further learning.

Note to Facilitators!
This section is complemented by handout #11 that provides knowledge and skill orientation to CHVs. Use the handout to orient the trainees on how to conduct follow up for various services described above. Use role plays, illustrations and other interactive training methods as much as possible and as guided in the handouts. Ask the trainees to also read the handout at their own private time.

Module 4: Individual and Group Coaching

3.20 Learning outcomes

At the end of this module, trainees are expected to have learnt and be able to explain and demonstrate the following:

- *The meaning of the concept of couching and methods of conducting coaching activity;*
- *The importance of coaching among roles and functions of CHVs;*
- *How to conduct effective couching activity;*
- *Range of services that will require couching by CHVs.*

Total time for this module is 1hour and 30 minutes

Note: This module is complemented by handout 12

3.21 Introduction

Coaching is another competence that all CHVs are expected to possess. CHVs should acquire enough skills in conducting couching in the same way they do when conducting other education sessions. This activity is also expected to be conducted during household/home visits (individual couching or empowerment) or in group of people within the community (group couching or empowerment). Coaching is slightly different from training.

3.22 What is coaching?

Note to Facilitators!
Use your lecture slides to conduct training of the content under this module. Use practical examples, drawing experience from experienced CHV as much as possible. Use handout #12 as a supplementary resource. Ask trainees to read handout #12 on their own whenever possible.

Coaching is the process of equipping people with the tools, knowledge, and opportunities they need to fully develop themselves to be effective in their commitment to themselves. It entails explaining, orienting, and demonstrating to someone or group of people on how something get to be done but with an emphasis on influencing behaviours and attitudes towards improving outcomes. While coaching is usually commonly used at work places, it can also be used at family and household levels to influence change and behaviour.

Examples of coaching activities

1) Green vegetables are usually beneficial if they are not too much cooked. However, many people would feel like they are eating "leaves" if the vegetables are not well cooked. A CHV can explain, show how to prepare beneficial vegetables and serve vegetables to one or a group of women at home or in the community.
2) A CHV can explain and demonstrate to a mother with a diarrheal child how to prepare oral solution for the child by mixing clean and safe water with proportionate salt and sugar.

3.23 Why coaching?

It is important for CHVs to have coaching competence and skills because some of the health promotion activities will require more than just sessions of health education. CHVs need to have the knowledge, tools, resources, skills and ability to demonstrate some of the health related practices that promote health. For example, while women would be emphasized and encouraged to attend regular ANC clinic every months, lack of finances for transport to and from the facility might be the reason for non-compliance of regular visit. Coaching women with entrepreneurship skills that will enable them earn their own income, small as it can be, could be useful to promote good health seeking behaviour during pregnancy.

3.24 Which services will require group and or individual coaching?

Some of the services that may require coaching include:

- Recognition and referral of postpartum danger signs;
- Early detection of pregnancy;
- Initiation of ANC during first trimester and completion of recommended 8 ANC contacts;
- Special care for small babies (low birth weight and premature babies);
- Delivery preparedness and referral for Health Facility delivery;
- Early recognition of neonatal danger signs and referral;
- Recognition of danger signs and referral for PAC;

- Healthy behaviours including exercises and hygiene;
- Creating demand and referral for modern family planning;
- Baby WASH practices;
- Early childhood development including:
    - Early stimulation during pregnancy;
    - Newborn stimulation;
    - Bonding;
    - Safety and empowerment;
    - Attachment;
    - Responsive and interactive parenting.

3.25 How to conduct an effective coaching?

A good football coach is the one who knows football as a game: Not necessarily the best player but has classroom knowledge, has experience, knows tactics and tricks, has the capacity to instigate and influence psychological push in his/her players and can demonstrate how and when to do what! CHVs are also expected to possess similar abilities and capacities: offer knowledge, explain, show and demonstrate, orient, advise, counsel and the like. All the competences imparted to you in the course of this training intend to prepare you to be a person with these abilities. From different chapters, modules and units you will acquire all the necessary knowledge and skills required. However, the following features are important to make you a good coach when fulfilling your roles and functions:

- Coaching might not be a onetime activity. Frequent visitation or group meetings may be necessary. Each time ensure to give feedback to the observed change or progress among your clients. .
- In a group coaching, create a culture of team feedback and learning the best practices from each other.
- Sometimes, your clients may lose hope and my want to end midway. Encourage your clients to their attainable limits.
- Coaching is learning and any learning is two ways. Be open to your clients' ideas. Always ask employees for opinions.
- Build confidence of your clients. For example, if some of them are capable to become peer educators but seem to be shy, encourage them that they can do and giving them positive feedback when they try.
- Don't do what they have to do for them. Allow them to practice.
- Tolerate and support failure. Do not discourage your clients/group members.
- Recognize them as often as possible. Recognition is usually a better reward than money. As an output of coaching, recognize their performance when they improve on what you have oriented them.
- You may need to make a roadmap and concrete plan of the subject you want them to improve. For example, if you want them to improve in preparation of complementary feeding for infants, do the different tricks and types at different times.
- Be ready to help whenever you help is sought.

Module 5: Conducting Effective and Fulfilled Referrals

3.26 Learning outcomes

At the end of this module, trainees are expected to have learnt and be able to explain and demonstrate the following:

- *The meaning of referrals and reasons for referrals;*
- *Important considerations for providing referrals;*
- *How to provide effective referral service;*
- *Services and conditions that CHVs may need to consider providing referrals.*

Total time for this module is 1 hour

3.27 Introduction

Across different levels of health system, there are two broad types of health services, namely preventive and curative services. Preventive services are those services that do not include an element of treatment or cure. Curative services are services that include provision of treatment or cure. Most of the health services to be provided by CHVs at community level are preventive (with its largest part being health promotion activity) health services.

In doing their work, CHVs may come across community members whose health conditions require advanced preventive health services or curative services. In such circumstances, CHVs should provide and encourage referral to the closest health facility for appropriate management or education on the subject matter of which is beyond the scope of work of the CHV.

3.28 What is referral?

Note to Facilitators!

- Refer back to the organization and arrangement of the hierarchal health system for Zanzibar starting from the community/household as the lowest level of a health system.
- Use a flip chart to sketch the health system indicating the various levels of care.
- Explain which services are available in which level among the described health system levels. Explain also why such arrangement/why some services are not available in some parts.
- Show them which level are they expected to refer their clients for appropriate management of their health conditions as a result of screening.
- Ask one of the experienced CHV to narrate their personal experience of providing referral from the community/household to a particular facility level
- Use your lecture slides to conduct training on the rest of the content under this module.

When a person or patient is moved from a lower level service providing facility to a higher level, we call that a referral. In the context of working environment of CHVs, referral will entail advising and or encouraging patients whose health conditions require management by skilled personnel, to seek health care or services in the immediate level of health facilities.

There are two types of referrals; from home to facility and from one lower facility to a higher level facility. The former is the sole responsibility of CHVs. With the knowledge of screening, CHVs will be expected to advise and encourage community members if health conditions indicate risks or danger signs or need specific services that CHVs cannot provide (e.g. Long acting reversible or permanent FP methods - LARPM)to seek health care from the closest health facility.

3.29 Why referrals happen?

In the context of working environment and conditions of CHV, referrals can be provided due to one or several of the following reasons:

- The health condition require curative services of which is not available at community level/outside health facility,
- The health condition is an emergency and requires immediate attention of a health professional,
- The type of service is not available in the community,
- The CHV does not have the knowledge, skills and competences required to serve the client,
- It is among the services that are only allowed to be provided in health facilities such as ANC, delivery and PNC services.

3.30 Which Services require referral services?

Referrals will be required for:

- All pregnancy related complications.
- Long acting reversible and permanent FP methods (LARPM)
- All identified pregnant women for ANC
- Health facility delivery
- All newborn related complications as manifested by the symptoms and danger signs.
- All severe forms of malaria among under five children
- All severe diarrheal diseases among under five children
- Cases of NCD that have shown indication of danger signs and risks

- Youths and adolescents who have received health education and are ready to receive youth friendly services or adolescent sexual and reproductive health services.

Note to Facilitator!
Orient the trainees on how to provide referral including filling in a **referral form** (Job aid # 1)

Module 6: Research, Monitoring and Evaluation (M&E)

3.31 Learning Objectives

At the end of this module, trainees are expected to have learnt and be able to explain and demonstrate the following:

- *The meanings of research, monitoring and evaluation;*
- *Functions and responsibilities of CHV which encompass monitoring and evaluation;*
- *How and when CHVs will participate or conduct research;*
- *The meaning of supervision and how CHVs will be supervised;*
- *The concept of data and the process of collecting data for research and for monitoring and evaluation;*
- *Writing reports of various types and purposes.*

Total time for this module is 2 hours

3.32 Introduction

Note to Facilitators!
To a large extent this module should be trained using lecture slides. However, practical sessions should be integrated to provide trainees with knowledge and skills of

- Supervision checklist to know and learn issues that are included when receiving supportive supervision by their various supervisors
- Examples of digital forms that CHV would use to collect data. This will be explained further in the next module.
- Exercises on report writing and orientation to reporting templates.

3.32.1 Defining Research

It is perhaps useful to reflect on the use of research and means by which it is conducted in order to comprehend its definition. We conduct research on a particular subject because we are facing a gap of knowledge in solving a particular problem which then call for scientific evidence to propose a solution.
Research is therefore a process of systematic inquiry that entails collection of data using suitable methodologies, documentation of information, analysis and interpretation of that data/information which will lead to drawing a scientific solutions and conclusion to the studied thematic problem and recommend for potential action.
CHVs will be expected to take part in research in two ways: as participants supporting the Government and the implementing partners who will be conducting research in your catchment areas and as primary researchers when conducting your own situation analysis to develop profile of your Shehias. Similarly, your other role is to conduct monitoring and evaluation (defined below) which has a component of research in it.

3.32.2 Defining Monitoring and Evaluation (M&E)

Monitoring and evaluation as used in the context of roles and functions of CHVs entails the systematic process of collecting, analysing and using information to track progress of a program, project or an activity when trying to reach set objectives. The information collected helps to guide management decisions and planning. Monitoring usually focuses on processes, such as when and where activities occur, who delivers them and how many people or entities they reach.

3.32.3 Functions and responsibilities related to research, monitoring and evaluation role

The overall objective of implementing a monitoring and evaluation component of the Community Based Health Program (CBHP) is to optimize opportunities for evaluation of community based

interventions and deciding if the program is making any difference based on local evidence. Generally, CHVs will be expected to participate in reporting routinely on various agreed indicators (such as births and deaths, pregnancies, ANC contacts, monthly disease surveillance reports and CBHP activity and progress reports etc.). They will also participate in client assessments to identify social needs and problems as well as records of care, support and protection provided to households as a whole but to vulnerable groups in particular (e.g. most vulnerable children (MVCs), people with disabilities, people living with chronic illnesses and elderly).
To facilitate monitoring of all these activities as well as tracking records of all services provided through the above discussed programmatic interventions, the following key services related to M&E will be performed by CHVs (Table 20):

Table 20: Community based service package for M&E

Interventions	Services to be provided by CHV
Data and statistics	▪ Keeping record of all services provided based on the agreed and developed set of indicators for each program area ▪ Tracking community deaths (including maternal and neonatal) within catchment area ▪ Participate in research activities taking part in catchment areas
Community Health Information System	▪ Filling forms, (most e-forms) with information on services delivered as defined by the set of agreed indicators ▪ Uploading and synchronizing of e-filled forms to the CHIS ▪ Prioritize household visits among clients especially WRA with need tailored RMNCAH messages ▪ Providing customized clients follow up ▪ Enabling referral effectiveness and referral fulfilment among clients
Report writing, reporting and dissemination	▪ Prepare both activity and progress reports on a monthly and quarterly basis as directed by supervisors ▪ Prepare summaries and provide feedback to supervisors, SHCCs, SCC and community at large

3.32.4 Supervision

In the context of your work, one important element of M&E is supervision. Supervision refers to as a process that involves a manager or leader meeting regularly and interacting with worker(s) to review their work. Supervision aims to provide accountability for both the supervisor and supervisee exploring practice and performance. In the context of roles and functions of SHCCs and CHVs, the later will receive supervision from the former and will happen when members of the SHCCs visit and review the work of CHVs. When supervision includes supporting the supervisee technically and demonstrating how to perform a task in a better manner it is called supportive supervision.
In order to be consistent when supervising various CHVs or the same CHV at different periods of time, a checklist is usually required. The checklist is used during monitoring to verify if an activity has been implemented correctly. This is where supervision is linked to M&E. It can also be used to give feedback to the persons implementing the activity to help them improve. Your facilitator will orient you with an agreed supervision checklist that should be used during your supervision activity.

3.32.5 Unit 2: Record keeping

Beyond the monitoring and evaluation role and in the context of regular CHVs' activities, record keeping shall refer to as the art and act of keeping track of the history of CHVs' activities, by creating and storing all formal records or information. Recordkeeping for CHV is specifically linked to the use of digital platform which shall be described in later sections of this manual.

3.32.6 Unit 3: Data collection and analysis

Collection of data, storing, organizing, analysing and reporting are key elements of research and M&E. In a very simple explanation, data are units of information, presented numerically (quantitative)

or in narrative form (qualitative) that are collected through observation, review of documents and inquiry to people called study participants/subjects or objects. They are values of qualitative or quantitative variables about one or more persons or objects. When expressed in a singular state are called datum.

3.32.6.1 Data collection

All the activities that will be conducted by CHVs will generate data. When conducting health education sessions or conducting home visits data will be generated, Records such as how many people attended the education sessions, how many were males and how many were females, how many topics were discussed etc. constitute records to be kept and are the data. CHVs will have an obligation of collecting these data, from their own activities or through short surveys that may deem necessary to be conducted to inform their routine work. At any time, when CHVs will be in need of collecting data from surveys (for example, during development of Shehia profiles), the following should be considered:

- Tools should be prepared for data collection. Tools may be digitalized to collect data electronically (using tablets or smart phones) or can be paper based.
- Data collection should be conducted in a comfortable, safe and private environment to ensure full confidentiality of the respondent (the person interviewed to give information).
- Prior to administering a questionnaire, the participant needs to be fully informed of the risks and benefits of being involved in the study, the right to withdraw from the study at any time and how the anonymity and confidentiality of their data will be handled. This should be done in a simple language which the respondent can easily understand, preferably using their local language. Only through this process can a respondent provide an informed consent to participate in the study and administration of the questionnaire can be done.
- During data collection, it is important to conduct regular/close supervision of the data collectors to avoid cheating if the person collecting the data is a hire.
- Conduct regular data checks including spot checks, data verifications, re-interviews of selected participants etc.
- Ensure proper storage and handling of all data collection tools and equipment e.g. electronic tablets, anthropometric equipment etc.

3.32.6.2 Data Analysis

Like data collection, data analysis is also an element of both research and M&E. Data analysis means applying means of making the data meaningful. It involves modelling the data in order to bring out meaningful information. It is usually guided by study objectives and hypotheses. A detailed data analysis plan needs to be formulated in advance during proposal development stages of the study. It is vital to ensure that the analysis plan will be able to answer the study questions. The process of data analysis starts from simple statistics such as descriptive analysis, cross tabulations to advanced statistical analysis using regression methods.

Once the data is collected and cleaned, it is ready for analysis. During this phase, one can use computer based data analysis tools and software to conduct the analysis. There are different applications/software for both quantitative and qualitative data analysis. One can also conduct simple analyses manually using simple software such as excel, access and others. Data analysis will help to understand, interpret, and derive conclusions based on the requirements.

CHV will not be obliged to conduct data analysis. They will benefit from the use of the digital platform which is automated to produce some simple analyses and reports from the integrated data within the platform.

Notes to Facilitators!

Group the trainees in groups of 4 to 6 people. using the below data set, ask them to conduct the following computations

Number of households which are female headed.

Number of households which have elders.

Numbers of households do not have any child off 1 to 5 years old.

Total number of under five children in this population.

Total number of adult males in this population
Help them to find the way to make these calculations if they get stuck.
After the exercise, use your lecture slides to train the rest of the content under this section

Head of Household	Sex of Head of HH	# of HH members	Male members	female members	children below 1 year	Under-five children	Adolescents	Adults	Elders
Hemed	M	8	4	4	1	1	0	2	0
Mahmoud	M	4	3	1	0	1	1	2	0
Juma	M	5	3	2	1	1	1	2	0
Shakila	F	4	1	3	0	0	1	2	1
Khadija	F	6	3	3	1	2	1	2	0
Kombo	M	5	2	3	1	0	1	2	1
Suad	F	6	2	4	0	1	1	2	0
Makame	M	4	1	3	0	0	2	2	0
Mohammed	M	5	1	4	1	1	1	2	0
Rashid	M	4	1	3	0	0	2	2	0
Mwinyihajj	M	3	1	2	1	0	0	2	0
Issa	M	5	3	2	0	1	1	2	1
Hanzuruni	M	4	1	3	1	0	1	1	1
Kwerekwe	M	7	2	5	2	1	2	2	0
Masama	F	6	2	4	1	1	1	2	1
Rubby	F	5	1	4	1	1	0	2	1
Khamis	M	6	1	5	0	1	2	2	1
Zainab	F	7	2	5	0	0	4	1	2
Mwanawewe	F	11	4	7	1	2	4	2	2

3.32.7 Unit 4: Report writing

As part of record keeping, CHVs will be expected to be writing reports. In a simple definition, a report is a type of documentation by writing that is organized concisely while identifying and examining issues, events, or findings that have happened in a physical sense. It can be a report on events or findings from a supervision activity or even research investigation.
Your supervisors will inform you during your work what kind of reports you need to prepare. These may include activity ports, research/survey reports, meeting reports etc. In so doing, CHVs will need to have some basic knowledge and competences of preparing a good report.

3.32.7.1 Features of a good report

The following are features of a good report:

- Simplicity - simply structure and organized;
- Clarity - easy to understand;
- Brevity - uses concise and short sentences that improves comprehension;
- Positivity - present issues as they were found or report but without blaming or pointing fingers;
- Punctuation - follows standard writing principles;
- Approach - chronologically organized with subtitles whenever possible;
- Readability - content easy to read from good handwriting or appropriate font type and size;
- Accuracy - presents issues correctly with minimal errors.

3.32.7.2 Sections of a standard meeting report

A meeting minutes draft should include:

- The name of your organization,
- Type of meeting that took place,
- The date of the meeting,
- The place of the meeting and the time it began,
- Names of members/participants to the meeting,
- Titles of meeting participants and their different roles in the meeting,

- The agenda,
- Summary of minutes from the previous meeting that were ratified by the board or other people with authority,
- Meetings proceedings,
- Description of its resolution, if there is one,
- Signature space.

3.32.7.3 Sections of a standard activity report

As a matter of accountability, every activity should be accompanied by an activity report. An activity report is the one that reports what happened following an execution of a particular activity. The purpose of the activity report is to communicate your results and conclusions from the activity. The activity report should be organized as follows:

- Cover page
- Organization name/author of the report
- Date and location
- Introduction
- Description of the activity include type, place of execution, people involve and their roles etc.
- Results and Discussion
- Conclusion and recommendations (if applicable).

Note for Facilitators!
Provide the trainees with exercises of writing reports and using templates for preparing your various reports (Job Aid number 2A and 2B)

Module 7: Digital Platform for CBHP in Zanzibar

3.33 Learning Outcomes

At the end of this module, trainees are expected to have learnt and be able to explain and demonstrate the following:

- *The concept of digital platform including the available digital platform;*
- *How to use the digital platform;*
- *Type of information or data included in the digital platform;*
- *Users of the digital platform and the various uses.*

Total time for this module is 4 hours

3.34 What is a digital platform?

For many years, record keeping and processing of information used to be conducted on paper. We call this process paper based. Collection of data, storing, analysis and reporting were all paper based. In the modern world, paper based practices become more and less used. Instead, electronic means of collecting, storing and processing information becomes increasingly common and used.
Historically, CHVs in Zanzibar had also been collecting information and reporting on paper. Of recently, progress has been made whereby most of the information that CHVs will collect at the community level as a result of fulfilling their roles and functions have been made electronic and data can electronically be collected, stored, aggregated, analysed and reported. This is happening using a **digital platform** that has been developed which serves all key stakeholders who collect, analyse, report and use the reports from CHV work.
A digital platform is therefore a digital (electronic) environment which consists of the Web Application and devices such as Mobile Applications (on phones or tablets), that facilitate communication between these and other external services in an integration manner.

3.35 How does it work?

Notes to Facilitators!

- Use handout 13 and 14 to orient CHV with an overview of digital platform
- You will need mobile phones or tablets with uploaded application for digital platform. This platform is in place (at least for some services) and can be used during training. Ensure that each CHV has one mobile phone with an embedded application that supports the digital platform. After orienting the trainees with the theory part of the digital platform using your

lecture slides, introduce the trainees on the mobile phone and exercise features, functions and how to use the platform.
- Organize the class in pairs whereas one person becomes the CHV and the other the family member when exercising filling in household information during an imaginary household visit.

A digital platform is not a product by itself but rather an imaginary (intangible) ground where "different entities come to play and contribute to a desirable output". It is composed of people, processes, and tools, that enables individuals and teams to rapidly develop, iterate, and operate digital services. In the context of the CBHP, a designated digital platform is available which is used by CHV at their end to collect data and upload into the system and the centrally positioned technicians who oversee the server to see the data coming and can analyse and produce results on a timely manner. CHVs will use mobile phones or tablets to collect and store all information related to their work and will upload this information on the digital platform. On real time basis, the technicians at central level can tell who sent the data/information, what is it about and can validate its correctness right away.

3.36 Who uses the digital platform?

The digital platform is used by many stakeholders of CBHP. CHVs can upload and review data when they can and need. The Government through MOHSWGEC and PORALG-SD can also access the database in the digital platform and run automated analysis to produce statistics for decision making. The same can be done by the various implementing partners supporting CBHP in Zanzibar. Researchers, trainers, service providers, health managers and community leaders can all make use of the digital platform and its features and services. However, in order to be able to use the platform, access should be provided by using credentials (passwords and codes).

3.37 What kind of information is included?

All the services that have been described in chapter 2 of this manual as well as specific indicators described under M&E can be found in the digital platform. Your facilitator will orient you practically on the digital platform using mobile phone.

3.38 How is the digital platform used for reporting?

The digital platform comprises of information from all CHVs in Zanzibar, all stored at one place. Those managing the central servers or IPs with access to the data base can either use the automated features to develop types of analysis they want or can use the raw data to run their own statistical analysis and produce results. Using these analytical results, interpretation can be made and report on them.

Those with limited knowledge of conducting statistical analysis can benefit from the automated functions that are included in the digital platform system by reviewing the generated reports (Dashboards). Reports such as percentage of pregnant women who delivered at home or in health facilities, percentage of under-five children who presented conditions of severe malnutrition and others can be generated and viewed.

Module 8: Cross-cutting Programs

3.39 Learning Outcomes

At the end of this module, trainees are expected to have learnt and be able to explain and demonstrate the following:

- *The concept and meaning of leadership and its associated features including how CHVs can exercise leadership and or interact with leaders.*
- *The concept and meaning of participatory planning in health including how CHVs can participate in planning.*
- *The concept and meaning of resource mobilization for health and how CHVs can participate in mobilizing resources for community based health services.*
- *The concept and meaning of emergency preparedness and response (EPR) and how CHVs should take part in responding to emergencies.*
- *The concept and meaning of emerging diseases and how CHVs should take part in responding to Emerging Diseases.*
- *The concept and meaning of gender and gender integration and how CHVs can be*

gender responsive in their daily routine wok.

- *The concept and meaning of GBV and VAC and how CHV can take part in addressing GBV and VAC.*

Total time for this module is 4 hours

3.40 Introduction

Note to Facilitators!
This section should be trained using a lecture approach. However, questions and answers should be employed whenever appropriate to reduce monotonous of long time theoretical training and to cultivate two way communications while harnessing learning from the trainees.

CHVs will be expected to participate in a number of cross cutting activities which might not necessarily look like direct services to community but they are determined to be important to facilitate service provision (Table 21).

Table 21: Community based service package for cross-cutting activities

Interventions	Services to be provided by CHV
Leadership	▪ Attend community meetings and use as platform to provide health education on various topics for different programs ▪ Participate in SHCC's meetings and provide feedback of activities and service delivery ▪ Link Sheha, SHCCs, SCC and health facility in matters related to service delivery in the community
Participatory health planning	▪ Participate in development of health plans in the Shehia under the leadership of SHCCs
Resource mobilization	▪ Work in collaboration with SHCCs in resource mobilization activities to support implementation of CBHP in the respective Shehia
Emergency preparedness and response (EPR)	▪ Participate in emergency preparedness and response activities in collaboration with other entities such as task force teams, office of Sheha, SHCCs, SCC and health facilities
Emerging Diseases	▪ Provide household level health education on emerging diseases including Covid -19
GBV and VAC	▪ Identify and report
Gender relations	▪ Integrate gender across all lines of work

3.41 Unit 1: Leadership

3.41.1 Introduction

Experience has shown that, after successfully working with the community, community members tend to build trust to CHVs. The trust will include the community positive perception on CHVs as knowledgeable, problem solver and resource persons. These are attributes of leaders. It means, over time CHVs will constitute part of the Shehia (community) leadership. It is important therefore to learn basics of leadership.

3.41.2 Defining Leadership

Literally, leadership is the art, capacity and ability of an individual or a small group of individuals to influence and guide others in a larger group (followers or other members of the group). This is a crucial role that CHVs are expected to also play. Implementing the **leadership** intervention shall mean having CHVs contributing to making sound and in some instances difficult decisions, creating and articulating a clear vision, establishing achievable goals and providing the community members and other stakeholders in the Shehia with the knowledge and tools necessary to achieve those goals.

CHVs should be enabled to exercise self-confidence, acquire strong communication and management skills, to be creative and innovative, demonstrate perseverance in the face of failure, readiness and willingness to take risks, openness and acceptance to change, and responsiveness in times of crises.

Leadership Roles and Functions which CHVs will participate

CHVs are expected to work in close collaboration with the SHCC and the Sheha in ensuring that community health and agreed community health interventions are improved and become successful respectively. Some of the roles and the functions that CHV may participate include those shown in Table 22 below.

Table 22: Functions and responsibilities related to Leadership

1. Sensitizing the community to take part in community health activities and facilitate identification of health priorities and problems;
2. take part in leading development of participatory community health plans in the Shehia;
3. take part in leading implementation of all community based services delivered in the Shehia;
4. Provide leadership of overall community based health services in the Shehia and all managerial roles;
5. Support, motivate and encourage community to carry out their functions and help resolving challenges facing the community on a timely manner;
6. Take part in leading efforts to ensure full involvement and participation of the community in all relevant health related affairs in the community is prioritized;
7. Initiating, mobilizing and actively participating in health-related activities and health interventions such as village health days, mass campaigns, national and international commemorations days (e.g. World Health day, TB, HIV/AIDS, malaria, etc) in the respective Shehia;
8. Participate in surveillance and overseeing of risk communication and community engagement in the respective Shehia during disease outbreaks and disasters;
9. Attend and facilitate conflict resolution processes and play an advisory role in all activities related to community based health services.
10. Maintain communication with the community, SHCCs, service providers, and Council health managers and administrators.

3.42 Participatory health planning

Planning is one of the functions and or responsibility that the CHVs will be participating. Literally planning is the art and process of organizing ideas about the activities required to achieve a desired goal. It is usually preceded by identifying a vision, mission and goal. In any sectorial development, planning is the first and foremost activity to achieve desired results. It also involves the creation, maintenance and evaluation of the plan over time.

3.42.1 Planning needs to deliver

While it is important to be personally organized and motivated as a leader, it is perhaps even more important to be able to plan and deliver for the Shehia.

- These areas are key management skills, but the best leaders will also be able to turn their hand to these. The best vision in the world is no good without the plan to turn it into reality.
- Alongside strategic thinking, therefore, go organizing and action planning, both essential for delivery of your vision and strategy.
- Project management and project planning are also helpful skills for both managers and leaders.
- Good risk management is also important to help you avoid things going wrong, and manage when they do.
- Leaders also need to be able to make good decisions in support of their strategy delivery, and solve problems.
- With a positive attitude, problems can become opportunities and learning experiences and a leader can gain much information from a problem addressed.

3.42.2 Planning require strategic thinking skills.

Perhaps the most important skill a leader needs and what really distinguishes leaders from managers is to be able to think strategically. This means, in simple terms, having an idea or vision of where you

want to be and working to achieve that. The best strategic thinkers see the big picture, and are not distracted by side issues or minor details. All their decisions are likely to be broadly based on their answer to the question '*does this take me closer to where I want to be?*'
A strategic thinker should be able to create a compelling vision; they must also be able to communicate it effectively to their followers, which is partly why communication skills are also vital to leaders. Creating a vision is not simply a matter of having an idea. Good strategic thinking must be based on evidence, and that means being able to gather and analyse information from a wide range of sources. This is not purely about numbers, but also about knowing and understanding your market and your customers, and then and this is crucial using that information to support your strategic decisions.

3.42.3 The concept of participatory community health plans

A participatory planning process is one in which all the stakeholders are involved. It's often the most effective and inclusive way to plan a community intervention. A participatory process provides community ownership and support of the intervention; information about community history, politics, and past mistakes; and respect and a voice for everyone. It also takes time, care, mutual respect, and commitment. In order to conduct such a process well, you have to carefully consider what level of participation is most appropriate under the circumstances. You also must identify the stakeholders, and make sure they all get to the table, using communication techniques designed to reach them.

Care must be taken in getting the process under way. The person and methods chosen to convene it can both send messages about your intentions, and have a great effect on which and how many participants you attract. The process must be maintained over time, so that momentum will not be lost. If you can manage a planning process that meets all these requirements, the chances are that you will come up with a successful community intervention, one that truly works and meets the community's needs.

In order to understand the planning mechanism in health care settings, Managers/ health planners including CHVs, need to understand the basic concepts involved in the planning process. This unit explains these concepts and describes the aims and process of preparing the Comprehensive Health Plan.

3.42.4 Planning Components

Any systematic planning process will involve identification and description of the following five components.

a) Input

These are resources that contribute to conducting and delivering the output. They are what we use to do the work. These include: finances, personnel, equipment and buildings.

b) Output

The final product (goods or services) produced for delivery. It may be defined as 'what we produce or deliver'.

c) Activity

It is the process that is used to produce the desired output and ultimately outcomes. In this sense, an activity describes what we do (e.g. conduct 5 days training on Management of Cholera to 20 Environment Health officers from Central District).

d) Outcome

These are immediate results (for specific beneficiaries) which are the consequences of achieving a specific output. Outcomes should relate clearly to institutional goals and objectives set out in its plans. Outcomes are what we wish to achieve (e.g. better health for all citizens of the district).

e) Impact:

This refers to the results of achieving specific outcomes, such as reducing morbidity and mortality.

3.42.5 Health Care Planning

It is an orderly process that results to health plans (short term, medium or long term) that include

- Defining community health problems,
- Identifying unmet needs and
- Surveying resources to meet them,
- Establishing priority goals, that are realistic and feasible and
- Projecting administrative action to accomplish the purpose of proposed programs

3.42.6 Why Health Planning?

There are a number of reasons for health planning. The common ones are:

- To meet necessary standards or achieve the set objectives to improve the health status of the specified population
- Translation of a national health plan, strategies and the Plan of Work into regional or district plans
- To use the available resources in a cost effective and cost efficient way
- Re-planning on the basis of an already existing plan, for the purpose of reviewing existing health problems and needs and rendering services which are more effective and efficient
- Emergence of a new health problem (e.g. AIDS, Ebola or re- emergence/resurgence of a known health problem e.g. TB, Malaria) which may require a special strategy or programme
- To ensure co-ordinated efforts and actions by all stakeholders
- To ensure needs for special groups of population are taken into consideration
- To support and inform health monitoring and evaluation.

Health Planning is dictated by central policies, National policies, Local health need (Health Needs Assessment), Man power, Pressure (Local, National, Political).

3.42.7 Aims and Objectives of Health Planning

- The aim of health planning is to improve the quality of services given to ensure that health status can be maintained.
- It also aims to provide health care for a given community according to the community objectives and health needs.
- Health Plans should be implementable and have goals that can be achieved. They should also be responsive to the health needs of the people the plans are for.

3.42.8 Types of health needs

There may be different perceptions of health needs. The perceptions may be from the point of view of health professionals and/or the community. Health needs could be either objective or subjective.

3.42.8.1 Objective health needs

These are health needs that are determined by epidemiological means (i.e. incidence, distribution and control of diseases).

3.42.8.2 Subjective health needs

Subjective health needs, are usually seen by the community as important problems. Their importance may or may not be verifiable (be proven) epidemiologically. Any non-disease health need falls under this category.

3.42.9 Considerations for effective health planning

To achieve the aim of health planning, a number of objectives have to be achieved, these are:

- To ensure equity of health services to all members of the community
- To ensure continuous health services to the community
- To identify appropriate interventions to meet community needs of high priority.

3.42.10 Types of Plans

There are three common types of plans: annual, medium and long term:

1. Annual Plan

This is a one-year action plan. It is usually part of a long-term plan of which the activities are specifically stated to be covered in one fiscal year. The plan comprises of 12 calendar months regardless of which month it begins e.g. January to December or July to June. An example of an annual plan is the Comprehensive District Health Plan.

2. Medium term

This is a two to three-year plan, which may be an extension of the annual plan. Examples include the rolling plan and forward budget (Mid-Term Expenditure Framework).

3. Long term

This is a five years, or longer, plan which relates to longer projections and whose activities are stated in broader terms.

3.42.11 Facility and District (Council) Comprehensive Health Plans

3.42.11.1 Meaning of Health Facility Plan

These are plans that each health facility develops annually. The facility in-charge leads the process of developing these plans. In their development, they follow a long process which includes conducting a situational analysis in the communities within the catchment area of the facility followed by prioritization of the long lists of health needs communities might have identified.

3.42.11.2 Components of facility health plan

The health facility plans are developed using specified and pre-determined planning structure usually provided by the Ministry of health as planning guidelines. They comprise the standard components of a plan including social economic profile of the population, health problems and needs, burden of disease, priority areas, resource analysis and resource mobilization plans, essential interventions, targets and timelines. Other components include descriptions of what would be the inputs and outputs, which activities will be implemented, what would be the expected outcomes and in a long run what would be the impact.

3.42.11.3 The planning Cycle of facility health plan

The development of health plans follows the Government's fiscal (financial) year which usually starts on July each year. This means, plans should be ready for approval before the ministry of Health presents its budget during the Budgetary Parliamentary session (April through June). It also means that, before completion of a previous year's plan, process to develop a new plan should start.

3.42.11.4 Meaning of Council Comprehensive Health Plan (CCHP)

This is an annual work plan for the particular district council which describes all available inputs in terms of human resources, materials and financial inputs from various partners and government and how they are planned to produce outputs (i.e. health services to all population segments in the respective district). It also considers the needs and demands of the community as well as health information for the catchment area.

A district health plan is a summation of all health facility plans. As thus, it cannot be developed until after all health facilities have developed their plans and submitted to the district Council. This is the reason it is called a comprehensive health plan.

3.42.11.5 Components of the CCHP

Components of a district or council comprehensive health plan are similar to that of health facility plan. However, a district level situational analysis which leads to development of the district health and socio-economic profile replace that of community profile included in the facility plans.

3.42.11.6 The planning Cycle of CCHP

The planning cycle of CCHP is similar to that of health facility plan.

3.42.11.7 Role of CHVs in development and implementation of health facility plans and CCHP

CHVs are better positioned to develop a better situational analysis than service providers from the health facilities. As thus, CHVs, through the routine data they collect and through quick and short survey can strengthen the planning process by supporting health facilities to have access to more and timely data for planning. CHVs can contribute to:

- Defining community health problems,
- Identifying unmet needs,
- Surveying resources to meet them,
- Establishing priority goals, that are realistic and feasible and
- Supporting health facilities project administrative action and activities for a successful implementation of the health plans.

3.43 Resource mobilization

Most of the community based health activities are financed and furnished with non-financial resources by the Government or by implementing partners. Occasionally, some additional activities emerge within the community and community find itself obliged to organize itself and mobilize required resources to meet the emergent needs. Resource mobilization described here fits with such context.

Resource mobilization in the context of scope of work of CHV shall mean all activities involved in securing new and additional resources to enable the community meet any emergent needs arising from planned or ad hoc implementation of community based health plans. The concept of resource mobilization goes hand in hand with making better use of, and maximizing, existing resources (i.e. resource management).

The following are the key elements and considerations of resource mobilization:

- Resource mobilization is not a ad hoc activity. It should be a well-planned activity with a defined plan for its execution.
- Study and explore all possible sources of resources. These could be Government, NGOs, IPs, CSOs, FBOs, community members or individual with strong financial base.
- Observe legal framework and follow the prevailing laws and regulations for resource mobilization.
- When approaching potential contributors/donors, do not directly talk about money but talk about your mission, vision, plans, expected outcomes and extended benefits. Include in the description the possible benefits to the expected donor/funder.
- Resource mobilization should go hand in hand with education on health priorities and needs, gaps and challenges and plans to overcome the challenge
- Talk about people's health benefits as the main reasons for resource mobilization and not about things (cars, buildings etc.). Things should be secondary by showing how they will impact people's health.
- Be specific and precise on what you are asking for. Be clear on the type and quantity/amount of resources you are trying to mobilize with a good analysis of how you arrived to that.
- Involve in the team conducting resource mobilization people who have a good name in the community: trustful, honest and respected by the community.
- Start with networking leading to partnership prior to resource mobilization. Make the contributor a partner and a friend.

3.44 Emergency preparedness and response (EPR)

Note to facilitators!
It is highly recommended that an expert is invited to conduct training for this specific section. The session should be supported by practical examples that have happened before and how they were handles while linking with the new role the National CHV can provide to support the efforts.

The world comprises of predicable and non-predictable events. There are times, unknown to any of us natural or manmade hazards may occur. At such time, fear, frustration, panic, pain and loss of life and resources may happen all at the same time. In such circumstances, people usually look for help from anyone with knowledge on how to overcome the hazardous event/the emergency or with resources to help.

Every country has its Emergency Preparedness Response plans and protocols. It is important for CHVs to be part of these plans and protocol. As thus, basic knowledge one EPR is required.
EPR is the process of turning awareness of the natural hazards and risks faced by a community into actions that improve its capability to respond to and recover from disasters. Emergency response is rapidly evolving and requires readiness in terms of knowing what to do, how to handle such natural hazard and which procedures or protocols to follow. If possible, a technical person from the EPR national team can be invited to talk to you of EPR plans in Zanzibar.

3.45 Emerging Diseases

From time to time, some diseases which take some forms which are new and not well understood by our health professionals tend to occur. These are diseases whose incidence in humans has increased in the past two decades or threaten to increase in the near future. These diseases respect no national boundaries, and can challenge efforts to protect societies an communities when trying to prevent and control their spreading. Covid-19 pandemic is a good example of an emerging disease.
During periods of emerging diseases, CHVs are expected to play the following roles

- In collaboration with health professionals (e.g. health facility staff in catchment area) conduct surveillance and notification of suspected and traceable people believed to have contracted the disease
- Work with health professional to create awareness and build correct knowledge and understanding of the disease including means advocated for its prevention and control.

3.46 Gender Integration

The word "gender" refers to the relationships that exist between men and women when they live, work and thrive together in a given context or environment. Gender is not equal to sex. Sex describes if one is a man or a woman (male or female). Gender describes how the man and woman interact including power dynamics between them. In broader terms, other groups such as people with disabilities, vulnerable children and others are also considered in this definition of gender. As a result of these interactions and power dynamics in them, an imbalance is always a possibility. These imbalances lead to gender inequality and inequities.
If not well factored in our programs, these imbalances can be perpetuated and become harmful to some population segments in our community. As a result, we need to either mainstream or integrate gender in all of our activities. Figure provides a difference between gender mainstreaming and gender integration and suggest what need to be done to ensure that our programs or activities are gender responsive.

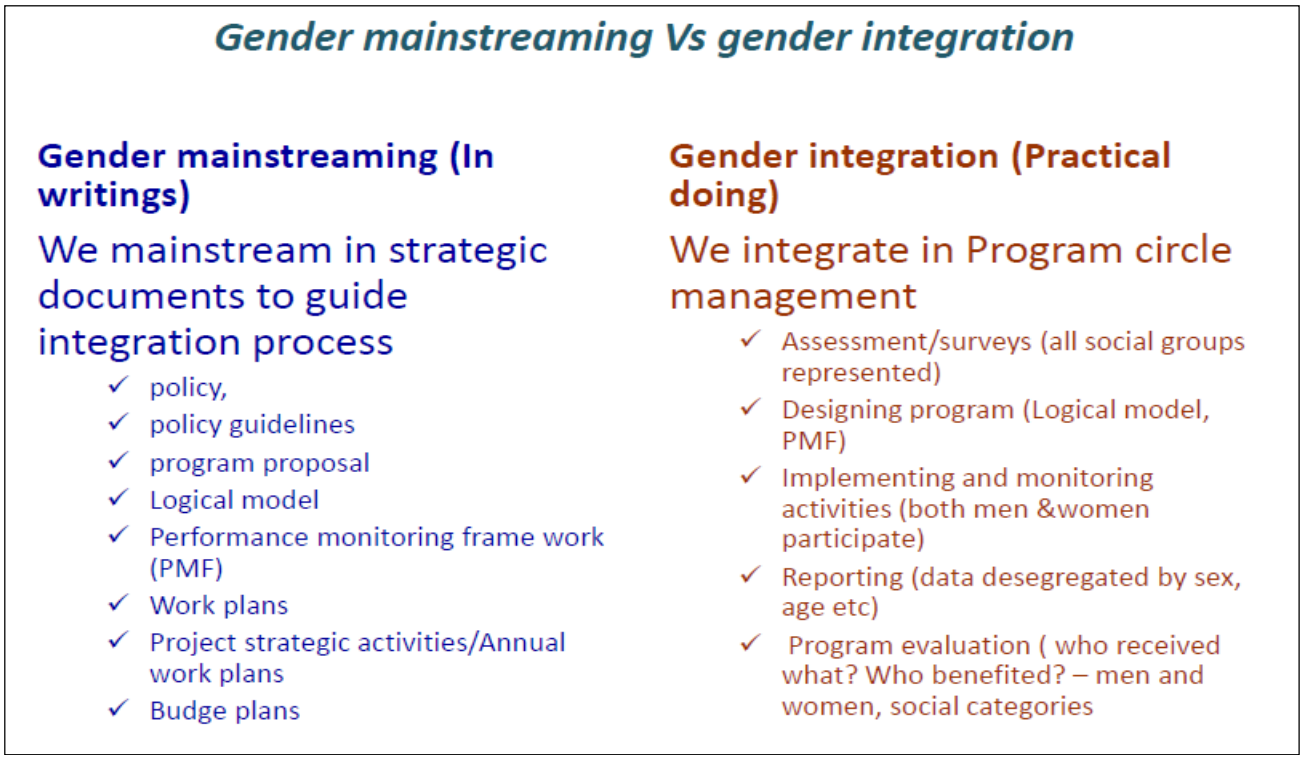


Figure 6: Simple definition of gender mainstreaming and integration.
Source: Mbuyita and Rwegasira, 2019.

CHVs are expected more to contribute to gender integration in their routine functions. These include tasks such as promoting and ensuring male involvement in reproductive health - which unfortunately is commonly seen as a female responsibility. CHVs can also be gender sensitive by always collecting data that is sex segregated to allow comparative analysis between women and men.

3.47 Gender Based Violence (GBV) and Violence Against Children (VAC)

In the previous section gender was defined as the relationship between men and women when they interact in their daily lives. In some occasions these relationships tend to be unfair and which deprives rights of another person. For example, the relationship between a wife and husband is a gender relation; it is expected that a fair and equal considerations on what they do together as they live would be possible. However, when the husband develops a habit of beating or physically harming the wife, that becomes a gender based violence (GBV). Other examples of gender based violence include child marriage, female genital mutilation, trafficking for sex or slavery, intimate partner violence and sexual (rape), emotional or psychological violence.

GBV is therefore a collective term for any act, omission or conduct that is perpetuated against a person's will and that is based on socially ascribed differences (gender) between males and females. The term refers to violence that targets individuals or groups on the basis of their being female or male.

On the other hand, Violence Against Children (VAC) is when the mistreatment or deprivation of one's rights is done on children. VAC includes all forms of violence against people under 18 years old, whether perpetrated by parents or other caregivers, peers, romantic partners, or strangers. Table 23 below summarizes actions or practices that are globally described as VAC.

Table 23: Description of actions and practices defined as VAC

SN	Practice or Action considered as VAC
1.	Maltreatment (including violent punishment) involves physical, sexual and psychological/emotional violence; and neglect of infants, children and adolescents by parents, caregivers and other authority figures, most often in the home but also in settings

	such as schools and orphanages.
2.	Bullying (including cyber-bullying) is unwanted aggressive behaviour by another child or group of children who are neither siblings nor in a romantic relationship with the victim. It involves repeated physical, psychological or social harm, and often takes place in schools and other settings where children gather, and online.
3.	Youth violence is concentrated among children and young adults aged 10–29 years, occurs most often in community settings between acquaintances and strangers, includes bullying and physical assault with or without weapons (such as guns and knives), and may involve gang violence.
4.	Intimate partner violence (or domestic violence) involves physical, sexual and emotional violence by an intimate partner or ex-partner. Although males can also be victims, intimate partner violence disproportionately affects females. It commonly occurs against girls within child marriages and early/forced marriages. Among romantically involved but unmarried adolescents it is sometimes called “dating violence”.
5.	Sexual violence includes non-consensual completed or attempted sexual contact and acts of a sexual nature not involving contact (such as voyeurism or sexual harassment); acts of sexual trafficking committed against someone who is unable to consent or refuse; and online exploitation.
6.	Emotional or psychological violence includes restricting a child’s movements, denigration, ridicule, threats and intimidation, discrimination, rejection and other non-physical forms of hostile treatment.
	Source: WHO, 2021

In our daily lives, some of us engage in some of the actions that are considered to be GBV or VAC unknowingly. We were born seeing our parents and grandparents doing so and hence normalize some of these actions. With this training, CHVs are expected to be aware of these various forms of GBV and VAC and become advocates for change. Using the principles of health promotion, sensitization and counselling, CHVs are expected to:

- Build knowledge of GBV and VAC among the community members in the communities they work.
- Work with community leaders to identify, develop and implement interventions that promote gender equality and hence discouraging GBV and VAC
- Include in their surveillance GBV and VAC practices and events and intervene through counselling, referral to treatment and rehabilitation centres or to legal and judiciary systems.

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Annexes

4.1 Handouts

4.1.1 Handout 1A: Community entry

4.1.2 Handout 1B: Overview of IPC and Counselling

4.1.3 Handout 2: Implementing a Social Behavioural Change Communication (SBCC)

4.1.4 Handout 3A: Delivering RMNCAH services to the community

4.1.5 Handout 3B: Complementary RMNCAH

4.1.6 Handout 4: Delivering nutrition health services to the community

4.1.7 Handout 5A: Delivering TB services at the community level

4.1.8 Handout 5B: Delivering HIV and AIDS services at the community level

4.1.9 Handout 6: Delivering malaria related services at the community level

4.1.10 Handout 7: Delivering environmental health and WASH services

4.1.11 Handout 8: Delivering NCD related services in the community

4.1.12 Handout 9: Delivering NTD related services in the community

4.1.13 Handout 10: Screening services for RMNCAH interventions

4.1.14 Handout 11: Services included for follow up

4.1.15 Handout 12: Conducting couching at community level

4.1.16 Handout 13: The Zanzibar Digital Platform

4.1.17 Handout 14: Mobile Phone for Digital Platform

4.1.18 Handout 15: Surveillance

4.2 Job Aids

4.2.1 Job Aid 1: Referral form

4.2.2 Job Aid 2A: Templates for meeting report

4.2.3 Job Aid 2B: Templates for activity report