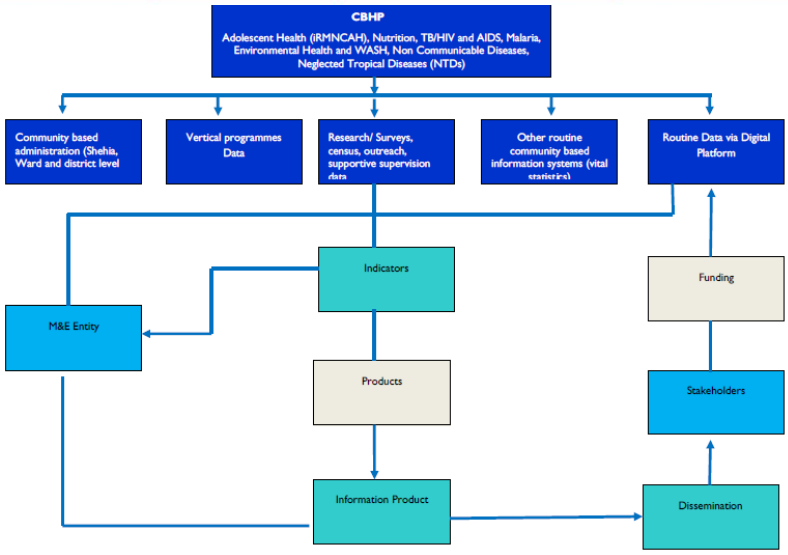
THE REVOLUTIONARY GOVERNMENT OF ZANZIBAR

Monitoring Toolkit for Community Based Health Program in Zanzibar

The Health Promotion Unit
in collaboration with
The Training Unit

CVH & SHCC 2021



MINISTRY OF HEALTH - ZANZIBAR

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Care
AYFSRH	Adolescent and Youth Friendly Sexual and Reproductive Health
CBHP	Community Based Health Program
CHIS	Community Health Information System
CHMT	Council Health Management Teams
CHVs	Community Health Volunteers
CHW	Community Health Worker
CSO	Civil Society Organizations
DOT	Direct Observation Treatment
DPs	Development Partners
ECD	Early Childhood Development
ETE	End Term Evaluation
FBO	Faith Based Organizations
FP	Family Planning
GBV	Gender Based Violence
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
INGOs	International Non-government Organizations
IPC	Infection Prevention and Control
IPs	Implementing Partners
IYCF	Infant and Young Child Feeding
LLITN	Long lasting Insecticide Treated Net
LMIC	Low and Middle Income Counties
M&E	Monitoring and Evaluation
MIP	Minimum Intervention Package
MNCH	Maternal, Newborn and Child Health
MOHSWEGC	Ministry of Health, Social Welfare, Elderly, Gender and Children
MPDSR	Maternal and prenatal death Surveillance and Response
MTE	Mid Term Evaluation
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
PORALGSD	President's Office, Regional Administration, Local Government and Special Department
PPFP	Post Partum Family Planning
RCH	Reproductive and Child Health
RGoZ	Revolutionary Government of Zanzibar
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
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
WHO	World Health Organization
WIT	Willows International Tanzania
WRA	Women of Reproductive Age
ZCHS	Zanzibar Community Health Strategy

Contents

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 participationin management and running of the health system, particularly the primary health care through establishment and supportingfunctions 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 wasa need to restructure the health system by strengthening the implementation of Primary Health Care (PHC). This was doneso as to shift from an individualized, passive, curative, vertical system to a population - based, integrated, proactive model fordelivery 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 ofPHC.

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 **minimum intervention and service package (MIP)** for CHV is a practical example of how the Government, in collaboration with its development and implementing partners work together to interpret the ZCHS intoaction 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 anoverview of community based interventions and services that are within the scope of work and mandate of the CHV. Itintends 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 thecountry.

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 theinvolvement of communities in the governance of the health systems is inevitable and beneficial, and that implementation ofthe 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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Dr. Fatma H. Mrisho Principal Secretary

MOH-Zanzibar

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 workingtools for the Zanzibar Community Based Health Program of which one of them is this Minimum Intervention Package (MIP) forSHCCs. 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, theprocess 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 thelast stage of reviewing the and endorsing the drafts of the various tools.

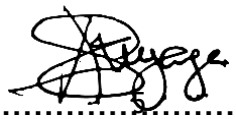
The Government would like to recognize and mention a few individuals and organizations that made specific contributions to the process. Among them is Mr. Abdurahman Kwaza, from the Health Promotion Unit (HPU) of the MOHSWEGC. Mr Kwaza provided strong leadership and guidance to the process; he coordinated 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 andactive 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 ofHealth Promotion Unit, of the MOHSWEGC who was always at hand to support and lead the HPU team and the team ofconsultants 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 thesetools for Community Health Services of Zanzibar. The group draws its members from a holistic spectrum of health programs inZanzibar 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 ExecutiveOfficer 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 forthe 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 forSHCC. In particular, the Government would like to thank Mr. Selemani Mbuyita who was the Lead Consultant together with hiscolleagues 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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Dr. Ali S. Nyanga
Director of Preventive Services and Health Education

1 Introduction

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. This includes strengthening of thePrimary 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 components. The Ministry of Health, Social Welfare, Elderly, Gender and Children (MOHSWEGC) through its Zanzibar Community Health Strategy (ZCHS) has embarked atrevitalising provision of the community health services at community. The intention is to improve access to services by patients or clients within the community where they live but also promoting preventive health services and reduce the cost of running the curative care system.

The ZCHS directs that delivery of the community based health services at the community level will primarily be conducted by Community Health Volunteers (CHVs) and overseen by Shehia Health Custodian Committees (SHCCs).The World Health Organization (WHO) has recognized these two entities as the most powerful resource in empowering communities to take charge of health matters in their localities. CHVs, as a synonymous name for Community Health Workers (CHW), are entrusted with the responsibility of ensuring that, the strategic objective inthe 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.

The scope of work of the CHVs under the support and supervision of SHCCs cuts across several programmatic healthareas. Their roles and functions cut across all health programs that have part of their services being delivered atcommunity level. These include the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH), Early Childhood Development (ECD), nutrition, TB and HIV/AIDS, malaria, disease outbreaks, neglected tropical diseases, non-communicable diseases, environmental health and WASH.

To empower and support the functioning of CHVs and SHCCs, a number of working tools have been developed. These include training manuals for the two entities and defining minimum intervention and service packages that are tobe delivered at community level.

Although the CBHP of Zanzibar has a long history, the integrated CBHP approach is juvenile and requires a close supervision, monitoring and evaluation linked to effective learning.

This booklet is prepared to guide the key implementers of the Zanzibar CBHP, through CHVs and SHCCs to monitor,learn and evaluate the functions and activities of CHVs and SHCCs together with their expected outcomes. It proposes the main learning agenda as suggested by the ZCHS and enlists potential monitoring indicators as were proposed by key stakeholders in the course of designing and developing the program.

2 The Learning Agenda

2.1 M&E for Learning

For a program to be useful, it should be able to inform the beneficiaries if progress is positively or negatively made. It should also be able to bring the useful information, on a timely manner, for decision making and planning. Thesefeatures can only be effective if the program integrates a strong M&E component in its design. An effective M&E plan should constitutes essential components as illustrated in Table 1 below:

Table 1: Essential components of an effective M&E

S#	Component	Description
1	Organizational structures with M&E functions	Establish and maintain a network of organizations responsible for M&E at the national, sub-national and service delivery levels
2	Human capacity and skills for M&E	Ensure adequate skilled human resources at all levels of the M&E system to ensure completion of all tasks defined in the annual costed M&E work plan. This requiressufficient analytical capacity to use the data and produce relevant reports
3	Partnership to plan, coordinate and manage M&E system	Establish and maintain partnerships among in-country and international stakeholders involved in planning and managing the national M&E system
4	National multi-sectorial M&Eplan	Develop and regularly update the national M&E plan, including identified data needs, national standardized indicators, data collection procedures and tools aswell as roles and responsibilities for implementation
5	Annual costed M&E work plan	Develop an annual costed M&E work plan including specified and costed M&E activities of all relevant stakeholders and identified sources of funding; use this planfor coordination and for assessing the progress of M&E implementation throughout the year
6	Advocacy, communication and culture for M&E	Ensure knowledge of and commitment to M&E and the M&E system among Policy makers, program managers, program staff and other stakeholders
7	Routine program monitoring	Produce timely and high-quality (valid, reliable, comprehensive and timely) routine program monitoring data
8	Surveys and surveillance	Produce timely, valid and reliable data from surveys and surveillance systems
9	National and sub-nationaldatabases	Develop and maintain national and sub-national databases that enable stakeholders to access relevant data for formulating policy and for managing andimproving programs
10	Supportive supervision and data auditing	Monitor data quality periodically and address obstacles to producing high quality (valid, reliable, comprehensive and timely) data
11	Evaluation and research	Identify evaluation and research questions, coordinate studies to meet identified needs and enhance the use of evaluation and research findings
12	Data dissemination and use	Disseminate and use data from the M&E system to guide the formulation of policy and the planning and improvement of programs.

2.2 Learning Questions

This M&E toolkit will seek to answer the following questions. All data to be collected should be targeted to answerthese questions:

Q1: Community Health Service Delivery: To what extent has the CBHP in Zanzibar has been able to deliver Essential Community Health Intervention Package at Shehia level through comprehensive and integrated services bythe National CHVs?

Q2: Community Health Volunteers (Human Resources): To what extent has the CBHP in Zanzibar hassufficiently and equitably distributed the well-trained or empowered Community Health Volunteers in all Shehias?

Q3: Community systems and structures for ownership and accountability: To what extent has the CBHP inZanzibar has been able to effectively establish and revitalize the formation and functioning of Shehia Health CustodianCommittees?

Q4: Information, communication and Technology: To what extent has a strong, functional and harmonizedCommunity Health Information System (integrated in the DHIS2) that provides data for decision making by CHV supervisors, CHMT and MOH level been developed and put in place?

Q5: Leadership, accountability and coordination at all levels: To what extent has the CBHP in Zanzibar been able to establish sufficient policy support and funding for the implementation and coordination of community health activities at all levels?

2.3 Engaging Stakeholders

In order for the M&E to be successful, engagement of all key stakeholders of CBHP in Zanzibar is a requisite. Theseinclude 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), Private sector, Civil Society Organizations (CSOs), Community Based Organizations (CBOs), Council Directors, Council Health Management Teams (CHMT), health facility managers, service providers, Shehia Consultative Committees (SCCs), Councillors, Shehas, Shehia Health Custodian Committees, Community Health Volunteers (CHV) and the general population.

These stakeholders demonstrate different levels of strength in the way they participate contribute and influence the CBHP as a whole and the M&E plan in particular as shown in the Stakeholder Influence Matrix shown below (Figure 1).

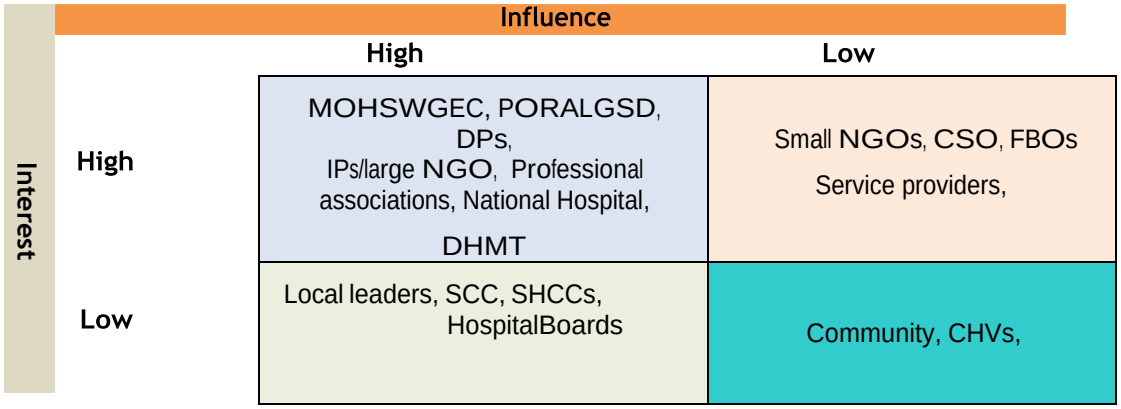


Figure 1: Stakeholder engagement plan

2.3.1 The Home of M&E for CBHP in Zanzibar

The M&E division together with the Strategic Coordination Forum is responsible for facilitating the monitoring andevaluation process for the ZCHS II and hence for monitoring and evaluation of the CHVs and SHCCs functions and performance. This includes selection of appropriate performance indicators for community based health services for inclusion into the prioritized health sector milestones and M&E framework as defined in the Zanzibar Health SectorStrategic Plan (ZHSSP IV).

At the national level, the HMIS unit maintains the CHIS in the DHIS2 database that contains aggregated data from all Shehias, PHCUs and Districts. The HMIS is able to create dashboards from the CHIS to highlight progress around keyindicators. The HPU, ICT, and HMIS are responsible to prepare customized dashboards for visualization of community based information to different categories of users of the information including Health Managers and Directors within the MOHSWGEC and in the PORALGSD, including the HPU, Directorates, Programme Managers, Principal Secretaries, Ministers, hospital managements, service providers, community leaders and citizens.

The Head of the HPU at the MOHSWGEC and their counterpart in the LGA at the PORALGSD will equally use the information to prepare quarterly reports to be presented at the Community TWG meeting. These reports, the reviews and guidance of the Community Health Technical Working Group

(TWG) will form the basis for supportive supervision, mentoring and coaching for district and community levels.

2.3.2 Advancing the M&E agenda

The mission of the ZCHS sets the main agenda for the M&E. It is the intention of the RGoZ through the integratedCBHP to ensure that "all Zanzibar is secure their right to quality and equitable health services provided through Primary Health Care facilities in a cost effective and affordable manner". In order to watchdog this, an effective M&E plan that also offers an opportunity for learning is required.

In addition, the M&E framework for Zanzibar CBHP should serve and contribute to the overall monitoring of the ZHSSP IV. Similarly, the indicators for monitoring the functioning of CHVs and SHCCs should also provide platformfor monitoring of the Zanzibar Community Health Strategy (ZCHS – 2019-2025). The M&E framework proposed in this Monitoring toolkit therefore should inform the ZHSSP IV and the ZCHS.

Five leaning agenda are thus defined namely:

1) Improving the provision of sustainable, equitable, effective and efficient community-based primary health services in all parts of Zanzibar
2) Deploying national Community Health Volunteers in an integrated and coordinated manner
3) Revitalizing the performance of Shehia Health Custodian Committees and other community support systemsto effectively coordinate community health interventions implemented at Shehia level
4) Institutionalizing the Community Health Information System (CHIS) to provide real time community data fordecision making at community (Shehia and Ward), district and national level.
5) Strengthening systems and structures for management, leadership, accountability and coordination ofcommunity health services at all levels.

Each of these five agenda is unpacked further to detail specific items for effective follow up using sets of indicators thatare included in appropriate sections of this toolkit. The M&E framework for community based health services specifies the processes to capture, analyse and disseminate community health information that will provide progress and overallperformance on these five agenda.

2.3.3 The M&E plan and process

2.3.3.1 Overall plan

The Community Based Health Program through the functions of CHVs and SHCCs will be monitored through continuous collection and analysis of data and information at all levels to determine how well the CBHP is being implemented as compared to anticipated results. This entails the measurement of annual outputs and analysing them toassess progress towards the agreed outcomes as per the Monitoring and Evaluation framework elaborated in the next section of this toolkit.

Community Health Volunteers are responsible for carrying out community health services at community (Shehia) level. Their functions include routine data collection. Data will be collected using digital tools (mobile applications) and CHVswill capture data on an on-going basis as they interact with the community and perform their regular duties. As arequisite, the resulting data should be reviewed by CHV supervisors on a monthly basis and should include CHV performance and quality assurance checks. Relevant data will be automatically aggregated at the Shehia level, and everyquarter a representative from the SHCC will visit the CHV supervisor or CHMT to collect the information and sharequarterly aggregate data with the SHCC. The data will also be shared with the facility-in charge and others as needed. The CHV supervisor at each PHCU will review the data entered by CHVs for each Shehia and give immediate feedback to CHVs if obvious errors, discrepancies or deviation from the norm is noted. Relevant feedback on performance of the individual CHV will likewise be provided accordingly.

Since the data will be collected through a digital system and imported into the DHIS2, it will be immediately accessibleby the DHMT (at district level), and the MOHSWGEC/PORALGSD (at national level). The HMIS of the MOH should ensure access to DHIS-2 by the HPU at the MOHSWGEC and LGA at the PORALGSD.

At district Level, the Health Promotion Officer (HPO) at the CHMT will review data from all Shehias entered in thedigital platform through DHIS-2's CHIS or through automated analytical dashboards at Shehia, PHCU, or district level. The HPO will share dashboard data and findings with the Assistant Director and the CHMT on a quarterly basis in order to plan and take action. The Assistant Director should ensure that automated reports sent to the regional level include basic information from the district regarding community health. A robust community health information systemis critical to avail data to inform policy, planning and decision making while at the same time

evaluating quality of service, access, availability and utilization.

The MOHSWGEC, the PORALGSD and Implementing Partners (IPs) have developed quite an advanced Community Health Information System (CHIS). The CHIS has a strong component for capturing feedback to decentralized levelswhere the data originated. At the same time, the CHIS is designed in such a way that it is easy for local generators of data to own and use the data for improving local services provision. The MOHSWGEC and PORALGSD have ensuredan integrated data flow system that allows information from various sources to be available for stakeholders to analyzeand review as needed for monitoring and evaluation of community based interventions.

2.3.3.2 Monitoring performance of individual CHV

In one way or another, the data system followed up by the supervisor should be able to capture the information onCHV proactive and customized household visits using a dashboard system for easy follow up and performance evaluation. During their training, CHVs will have received an emphasis of developing their routine work plan whichinclude routine household visits. During these routine household visits, CHVs will be trained to identify clients withspecial needs that cannot wait until a next round of regular household visits. Such clients will have special needs that would require customized visits" as extra visits beyond the planned routine visits. Customized visits constitutes an important approach to support and proactively serve the CHV's clients (especially women of reproductive age andchildren) based on their reproductive and health needs such as fertility intentions and others. These visits are essentially and proactively initiated by the CHV and they should form part of their individual performance evaluation. This can be linked to individual CHV performance tracking and evaluation indicators such as:

- Monthly number of customized visits,
- Number of women identified by the CHV for early antenatal care
- Number of women sensitized by the CHV who completed ANC routine visits in line with the WHO recommended schedule
- Proportion of contacted WRA with need tailored to specific RMNCAH messages
- Timeliness of work of individual CHV (measured as percentage of children under five treated within 24 hours of symptom onset), and
- Quality of work of individual CHV (percentage of children under five treated without protocol error) etc. This analysis can be performed after every six-month post-intervention period.

2.3.4 The M&E systems cycle

The M&E system will be implemented through the following sub-systems:

1) Routine community based health information system through the digital platform
2) Other routine community based information systems such as vital statistics
3) Vertical programmes with a community based component implemented by the Government agencies (TB/HIV
&AIDS, Malaria, WASH, RMNCAH and others) and Implementing Partners.
4) Local Government community based administration (Shehia, Ward and district level)
5) Community based research information (census, health related surveys, outreach, supportive supervision data etc.)

While the monitoring will be routine and continuous, there shall be two phases of the evaluation of the CBHP in Zanzibar. These will be Mid-Term Evaluation (MTE) and End-Term Evaluation (ETE). The MTE will potentially be conducted at end of year 2022 and ETE in 2025.

2.4 The Monitoring Framework

2.4.1 The monitoring plan and framework

Figure 2 below describes how the M&E cycle will work for the Zanzibar Community Health information System (CHIS). It summarizes sources of community data and how its accountability, data processing and dissemination will beconducted. The following components form part of the M&E framework:

2.4.1.1 Collaborating programs

The Zanzibar Health Information Strategy identifies Community Health Information System (CHIS) as one of its essential components, both in data generation as well as a focus in its M&E Plan. Unlike other arms of the

ZanzibarHealth Information System (HIS), the CHIs is the newest and young. Several developments are under way includingdefining sets of indicators to be used under the auspices of integrated minimum intervention and service package (MIP) for implementing community based health services. The health programs that will require and use this CHIS form partof this M&E plan.

2.4.1.2 Sources of data

As described under section 2.3.4, the CHIS will draw data from five main sources namely

1) Routine community based health information system through the digital platform
2) Other routine community based information systems such as vital statistics
3) Vertical programmes with a community based component implemented by the Government agencies (TB/HIV&AIDS,
Malaria, WASH, RMNCAH and others) and Implementing Partners.
4) Local Government community based administration (Shehia, Ward and district level)
5) Community based research information (health related surveys, outreach, supportive supervision data etc.)

2.4.1.3 Strategic position of M&E Unit

Under the CHIS, routine data generated on a daily basis by CHVs through the digital platform will constitute the main source of community data. Complemented by the vertical program data and routine vital statistics data, the three sources will constitute data set that will be managed by the M&E unit within the MOHSWGEC.

From time to time, the M&E unit will work with other IPs through surveys and other types of research to generateeven more complimentary data to inform progress and performance of the Zanzibar CBHP.

2.4.1.4 Defined indicators

This toolkit has included in the next sections, sets of indicators from various strategic health programs under theMOHSWGEC. It will be a responsibility of the M&E unit to make sure that, the indicators are well defined and updated from time to time to match the Government and IPs' needs and requirements. With the completion of the MIP forSHCC and CHVs, the list of indicators will be exhaustive.

2.4.1.5 Customized types of routine reports

CHVs, members of SHCC together with CHV's supervisors will be responsible to produce various reports from timeto time. The will be provided with generic reporting templates under the support of their supervisors. Similarly, the M&E unit will be responsible for producing routine reports as will be required by the MOHSWGEC.

2.4.1.6 Other information products

The M&E unit together with other vertical programs and IPs are expected to utilize their strategic programs support wider use of the generated data including publications.

2.4.1.7 Dissemination strategy of information products

All CBHIS stakeholders are expected to support wider distribution and dissemination of the various products produced.

2.4.1.8 Stakeholder engagement

IPs and other stakeholders are expected to support the M&E plan through

- Technical support in strengthening the CHIS and its corresponding digital platform
- Funding of M&E Plan
- Conducting customized surveys and research on CBHP and services

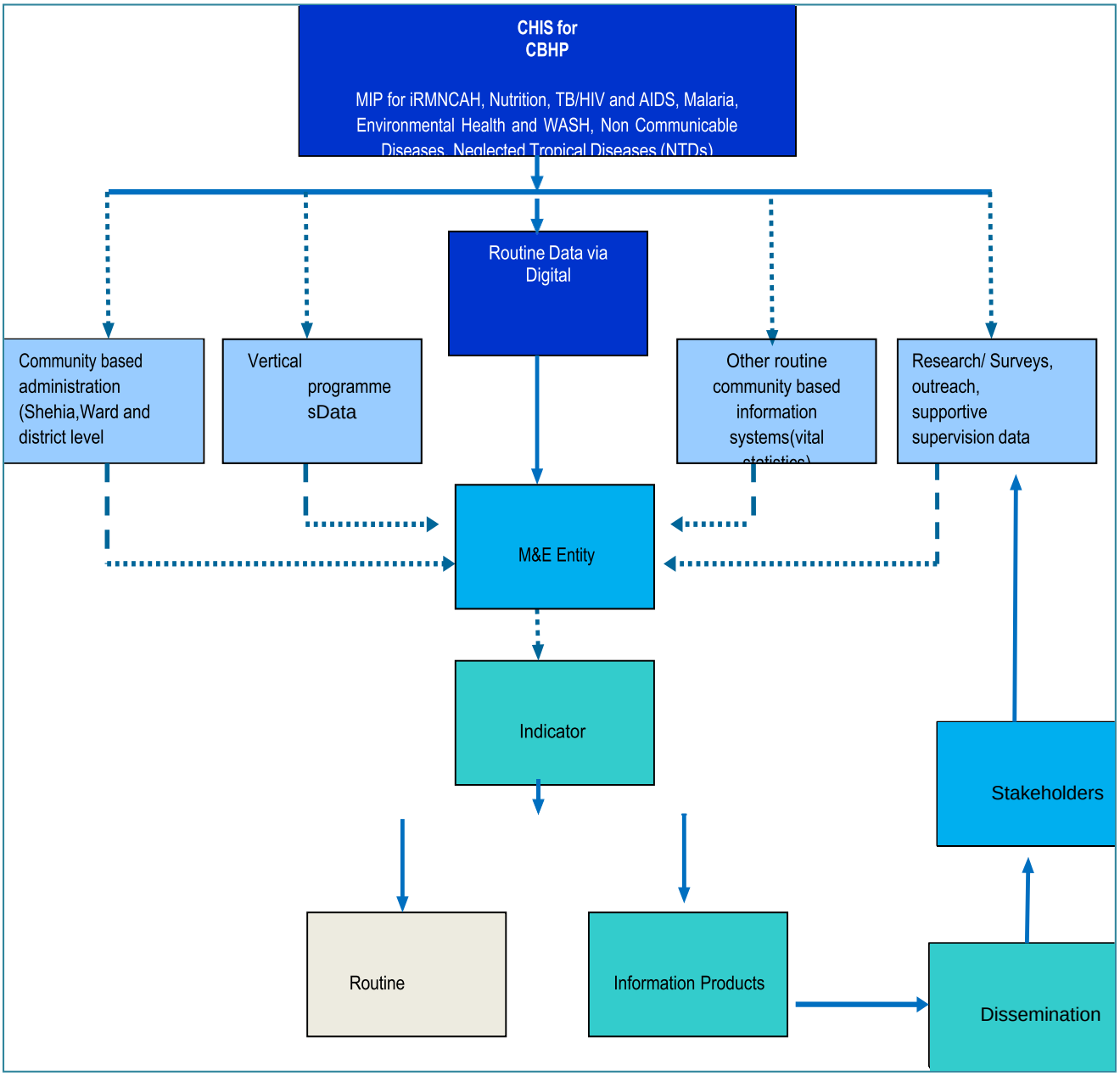


Figure 2: Monitoring plan for CBHP in Zanzibar

2.4.2 Data Flow

Figure 3 provides an overview of data flow for the CHIS of the Zanzibar CBHP

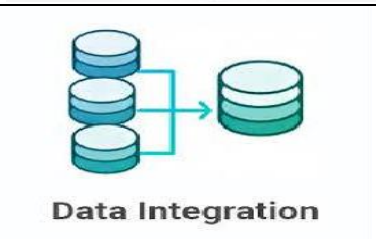
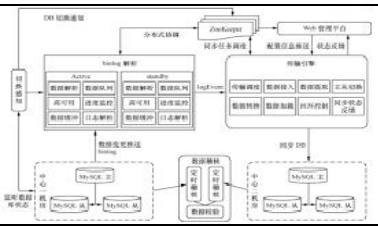
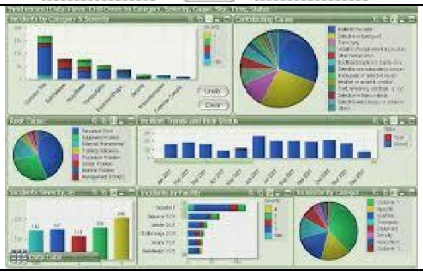
Level	Data Activity and Flow	
Household level (in Shehias)		CHV makes a regular and customized household visits
		Information entered intomobile phone based application
Supervisors & HMIS		• Data received onto Digital Platform fromvarious CHVs acrossZanzibar • Quality checksconducted
HMIS and M&E		Community data from all sources (including verticalprograms) integrated into CHIS
		CHIS integrated into DHIS-2
HMIS/M&E, Programs, IPs and Supervisors		Data processed and displayed on Dashboards
M&E and IPs		

Figure 3: Data follow for the Community Health Information System (CHIS) in Zanzibar

2.4.3 Setting targets

The ZCHS has set targets to be achieved collectively through the implementation of the CBHP. Table 2 provides a listof the defined targets and available baseline status.

Table 2: Broad Targets of the Zanzibar CBHP initiatives

Component of CBHP	Target	Baseline
Community Health ServiceDelivery	By 2025, all Shehias receive over 90% of the integrated community health intervention packages delivered by CHVs	0%
Community based Human Resources/CHV	By 2025, over 90% of all Shehias are served by national program CHVs at a ratio determined appropriate for workload and in line with global recommendations	0%
Community systems and structures for ownership and accountability	By 2025, over 95% of all Shehias have functional Shehia Health Custodian Committees	0%
	By 2025, 90% of PHCUs have functional, restructured PHCU Boards (i.e., meeting regularly on a monthly or quarterly basis support community health activities	17%
Information, communicationand Technology	By 2025, community health data are available in DHIS-2 through the Community Health Information system.	National CHIS under development; Data not available in DHIS-2
	By 2025, all CHVs, their supervisors and health managers at all levels are using a digital platform for integrated service delivery, data collection and supervision	400 CHVs and 67 supervisors are using adigital platform
Leadership, accountability and coordination at all levels	By 2025, community-based health services implemented by actors are monitored and evaluated as per agreed schedule and 80% of all actors achieve over 80% performance of set targets and milestones,	Only one program (RMNCAH) is monitored MTE &ETE Reports tobe used as measures

2.4.4 Monitoring Indicators

While the digital platform is well underway in its development, the integrated indicators to capture the integrated scope of community based health programs are still growing. The list of indicators provided below (Table 3) is provisional based on the situation analysis conducted during the course of development of various tools for integrated minimum intervention/service package. The list is also complemented by the guidance and recommendations of the ZCHS (II). Over a period of time additional indicators might be deemed necessary to be added and ultimately theirintegration in the ZCHIS as defined in the digital platform.

Table 3: list of indicators for Monitoring the implementation of the Zanzibar CBHP

	Indicators	Level (Output vs Outcome)	Means of Verification	Frequencyof report Generation
	RCH/MNCAH Indicators			
1.	Proportion of women delivering at home	Outcome	Routine Data on Digital Platform	Quarterly
2.	Number of live births from home deliveries	Outcome	Routine Data on Digital Platform	Quarterly
3.	Number of still births from home deliveries	Outcome	Routine Data on Digital Platform	Quarterly
4.	Number of children identified at household level with fever within 24 hours of occurrence	Outcome	Routine Data on Digital Platform	Quarterly
5.	Number of children identified with cough at household level	Outcome	Routine Data on Digital Platform	Quarterly
6.	Number of children identified at with diarrhea at household level	Outcome	Routine Data on Digital Platform	Quarterly
7.	Number of women sensitized by CHV for early booking of ANC within the first trimester	Output	Routine Data on Digital Platform	Quarterly
8.	% age of males accompanying their partners to ANC clinics (for male involvement)	Outcome	Routine Data on Digital Platform	Quarterly
9.	Number of households visited by CHV for integrated reproductive health education sessions includingdanger signs during pregnancy	Output	Routine Data on Digital Platform	Quarterly
10.	Number of women initiated (adopted)use of family planning methods with support of a CHV	Output	Routine Data on Digital Platform	Quarterly
11.	Number of women counseled on family planning commodities	Output	Routine Data on Digital Platform	Quarterly
12.	Number of women initiated by CHV to receive vaccination	Outcome	Routine Data on Digital Platform	Quarterly
13.	%age of defaulters for vaccination identified and followed by CHV	Outcome	Routine Data on Digital Platform	Quarterly
14.	%age of defaulters for vaccination contacted and recovered by CHV	Output	Routine Data on Digital Platform	Quarterly
15.	Number of referrals made by CHV to health facilities from the community (various reasons)	Output	Routine Data on Digital Platform	Quarterly
16.	Number of effective referrals made by CHV to health facilities from the community (various reasons)	Output	Routine Data on Digital Platform	Quarterly
17.	Number of fulfilled referrals made by CHV to health facilities from the community (various reasons)	Output	Routine Data on Digital Platform	Quarterly
18.	Number of contacted WRA with need tailored RMNCAH messages within Shehia by CHVs	Outcome	Routine Data on Digital Platform	Quarterly
19.	Number of pregnant women whose pregnancies were detected as early as 84 days of gestation	Outcome	Routine Data on Digital Platform	Quarterly
20.	Number of women who received comprehensive post-abortion care (PAC)	Outcome	Routine Data on Digital Platform	Quarterly
21.	Number of women who were counseled by CHV to attend Postnatal Care PNC within 7 days after delivery	Output	Routine Data on Digital Platform	Quarterly
22.	Number of women initiated (adopted)use of family planning methods with support of a CHV post-delivery (PPFP)	Output	Routine Data on Digital Platform	Quarterly

	Indicators	Level (Output vs Outcome)	Means of Verification	Frequ encyof report Gener ation
23.	Number of women who were counseled by CHV to have their new born attend PNC according to thenational guidelines (e.g. within 48 hours,7 days after delivery)	Output	Routine Data on Digital Platform	Quarterly
24.	Number of married couple counseled on Family planning	Output	Routine Data on Digital Platform	Quarterly
25.	Number of women who are exclusively breast feeding within 6 months post-delivery	Outcome	Routine Data on Digital Platform	Quarterly
26.	Number of prenatal death happening at home and recorded by CHV	Outcome	Routine Data on Digital Platform	
	Early childhood development related indicators			
1.	Number of households identified and practicing early childhood development services	Outcome	Routine Data on Digital Platform	Quarterly
2.	Number of pregnant women who received early childhood development counseling at household levelby CHV	Output	Routine Data on Digital Platform	Quarterly
	WASH related indicators			
1.	Number of households with safe and clean water	Outcome	Routine Data on Digital Platform	Quarterly
2.	Sources of water used by households in the community	Outcome	Routine Data on Digital Platform	Quarterly
3.	Number of households with latrines	Outcome	Routine Data on Digital Platform	Quarterly
4.	Number of households that use latrines			
	Nutrition related indicators			
1.	Number of households received education session about nutrition for under five children	Output	Routine Data on Digital Platform	Quarterly
2.	Number of children with malnutrition identified by CHV referred for further management	Output	Routine Data on Digital Platform	Quarterly
3.	Number of children with malnutrition referred for further management			
	Malaria related indicators			Quarterly
1.	Proportion of households with impregnated long lasting nets (ILLN)	Outcome	Routine Data on Digital Platform	Quarterly
2.	Proportion of households utilizing ILLN	Outcome	Routine Data on Digital Platform	Quarterly
3.	Number of households received education session for SBCC	Output	Routine Data on Digital Platform	Quarterly
4.	**Non Communicable Diseases related Indicators**			

	Indicators	Level (Output vs Outcome)	Means of Verification	Frequ encyof report Gener ation
5.	Proportion of people in the community who received counseling on NCD	Output	Routine Data on Digital Platform	Quarterly
6.	Number of people identified having signs and symptoms of Non communicable diseases	Output	Routine Data on Digital Platform	Quarterly
7.	Number of people in the community who received health education on common NCDs			
8.	Number of people in the community identified having Modifiable NCDs risk factors			
9.	Number of the people in the community sustained Road tragic accident			
	TB and HIV/AIDS related indicators			
1.	Proportion of family caregivers trained on quality home based care for patients with chronic illnessesincluding PLHIV	Output	Routine Data on Digital Platform	Quarterly
2.	Proportion of PLHIV and persons suffering from other chronic illnesses utilizing comprehensive IHBCservices	Outcome	Routine Data on Digital Platform	Quarterly
3.	Proportion of patients who adhere and retain to the treatment by reporting period.	Outcome	Routine Data on Digital Platform	Quarterly
4.	Number of clients provided with spiritual, psychological and emotional support by reporting period.	Output	Routine Data on Digital Platform	Quarterly
5.	Number of clients referred for appropriate care by reporting period	Output	Routine Data on Digital Platform	Quarterly
6.	Proportion of patients, families and OVC provided with social, legal and livelihood support, by reportingperiod.	Output	Routine Data on Digital Platform	Quarterly
7.	Number of clients referred for appropriate care, by reporting period	Output	Routine Data on Digital Platform	Quarterly
	Neglected Tropical Diseases (NTD) related indicators			
1.	Number of people in the community who have received ay message about NTDs	Output	Routine Data on Digital Platform	Quarterly
2.	Number of cases notified			
	Others			
1.	Number of newborn delivered at home and linked to the facility	Outcome	Routine Data on Digital Platform	Quarterly
2.	Number of newborn deaths	Outcome	Routine Data on Digital Platform	Quarterly
3.	Number of infant deaths			
4.	Number of death of under five children	Outcome 17	Routine Data on Digital Platform	Quarterly
5.	Number of maternal death	Outcome	Surveillance Reports	Quarterly
6.	Number of adult deaths due to any cause happening at home	Outcome	Surveillance Reports	Quarterly

	Indicators	Level (Output vs Outcome)	Means of Verification	Frequ encyof report Gener ation
7.	Number of GBV cases			
8.	HPU related indicators (number of CHV trained etc)			
9.	Number of VAC cases			
10.	Proportion of CHVs who have completed visits/contacts as per work plan in a given time period (quarterly).	Outcome	Supervisors report	Quarterly

	Accountability related indicators			
1.	Number of Shehias that have been able to formulate SHCCs	Output	Activity report	Annually
2.	Number of functional SHCCs	Outcome	Assessment/Survey report	Annually
3.	Number of SHCCs that have received training to carry out their roles and functions	Output	Activity report	Quarterly
4.	Availability of working tools for SHCCs	Output	Activity report	Annually
5.	Number of SHCC that have received supportive supervision by the Government and or IPs	Output	Activity report	Quarterly
6.	Proportion of community members in Shehias who know the existence of the SHCC	Outcome	MTE & ETE	Mid Term
7.	Proportion of community members who have ever interacted with SHCCs	Outcome	MTE & ETE	Mid Term
8.	Proportion of SHCCs that have conducted all four quarterly meetings per year	Outcome	Assessment/Survey report	Quarterly

3 Cross-Cutting Areas

3.1 Data Quality Assurance (DQA)

The main output of any monitoring activity is generation of data. Crucial to the successful performance of the M&E system is the quality of the data it generates. In line with this requisite, data quality assurancewill be performed periodically to verify reported data, identify strengths or gaps in the systems supporting data collection, build M&E capacity, and address challenges found at each level for overall improvement of data quality. The CBHP through the M&E team in the MOHSWGEC will ensure at leastone annual data quality assessment, covering national level by looking at the CHIS as linked to the DHIS- 2, at district level to assess how the supervisors are supporting the lower levels in ensuring quality ofdata generated and at the community levels to determine how CHV comply to principles of data quality.

At the district level, DQAs will be integrated into quarterly supervision visits. It is recommended that a DQA be performed at least twice per year for every Shehia and include at least one indicator per intervention delivered at the community level by the national CHV.

3.2 Assessing Quality of Services

Under the leadership of the M&E unit, regulated and planned assessments of quality of services renderedby the National CHVs to the community should be implemented. The following methods of assessments shall be used:

1) Household visits embedded in supportive supervision visits: where a convenient sample of households randomly selected will be visited by the team of supervisors when supervising CHVs and SHCCs. The following sample of questions will be used to assess community perceptions on the quality of services

a. Have you ever been visited by the CHV? How many times in the last three/six months?
b. What services did you receive from the CHV?
c. How has your interaction helped you to improve your health/the health of your household members?
d. What other services would you need to receive?
e. How do you find your CHV? If there is anything he/she has to improve when serving you, what could that be?
f. To what extent are you satisfied with the services you receive?

2) Surveys: where the M&E unit together with the vertical programs and IPs will plan and conduct surveys from time to time that will include among other things assessing satisfaction of the community based health services as rendered by the National CHVs.

3.3 Equity

As a component of M&E, equity will be ensured during data collection, analysis and reporting. Duringdata collection, data collection tools must have considered capturing population diversities such as age, sex, social economic status (importantly collected during Shehia Profile development), marital status, geographical distances from health facilities, presence or absence of chronic illness in the household andothers. These parameters are important to guide the analysis of data at an aggregate level and hence determine equity dimensions. The interpretation following the data analysis should be equity sensitive and responsive in order to determine if there are any inequities in the process and design of the CBHP.

3.4 Resourcing the M&E for CBHP

The M&E plans will not yield to the expected outputs and contribute to the outcomes of the CBHP if itis not resourced. Both human and financial resources are required to support its implementation.

There are only two main ways that the Community Based M&E plan can be resourced: through the Government commitment and through support from IPs.

3.4.1 Central Government

A successful M&E will only happen if the Government is fully committed to fulfilling the following:

- Facilitates effective development, recruitment, and deployment of CHVs in every Shehia asplanned and instructed by the ZCHS (II);
- Ensures availability of a harmonized and integrated CHIS that accommodate all health programs;
- Ensures adherence to guidelines, standards, and regulations;

- Promotes and oversees coordinated implementation research at community level that integrateaspects of client satisfaction and other indicators as illustrated in the list of indicators above;
- Ensures timely submission of reports, as well as proper storage and documentation of records;
- Provides relevant feedback and dissemination of data and strategic information to all stakeholders involved in CBHP interventions;
- Ensures integration of data quality activities into routine supervision at all levels
- Conducts a data quality assessment at least once a year to assess the status of the data collectedand reported by National CHVs;
- Ensures that districts conduct DQAs at least twice per year.

3.4.2 Partner Support

While the Government will assume the overall responsibility of ensuring that the M&E is running, IPsshould also come forward to support the Government efforts. The involvement of key stakeholders from both the public and private sectors is critical to a successful implementation of the M&E plan. Non-Governmental stakeholders may support the M&E through:

- Mobilize resources to finance the M&E plan;
- Provide technical support, especially on managing and running the digital platform;
- Provide technical support in conducting data quality assessment, data analysis and reporting;
- Participate in supportive supervision to integrate M&E aspects;
- Conduct implementation research whenever possible to augment data generation in some dimensions that are not integrated in the CHIS.

3.5 Managing Knowledge

The generated data will not be helpful if they are not interpreted and inform the stakeholders of what really happens in the community. It is expected that, the generated data will be processed and used forlearning. The following methods will be used to bring out learning through the M&E plan:

3.5.1 Publications

The M&E unit in partnership with IPs should ensure that, the data generated from the community and ascaptured through the digital platform and integrated in the CHIS are published in peer review journals. Itis recommended that, a minimum of at least one publication per year should be aimed.

3.5.2 Editorials

It is recommended that, the TWG for CBHP in Zanzibar should aim to develop a newsletter or prepare editorials in existing journals or newsletters.

3.5.3 Reports

Quarterly, semi-annual and annual reports will be developed and disseminated by the M&E unit and other stakeholders.

3.5.4 Presentations

The M&E unit in collaboration with the TWG and IPs should aim to take part in scientific conferences and conduct presentations to share learning from the implementation of the Zanzibar CBHP. Forums can include Annual Joint of Health Sector Review and others.

3.5.5 Webinars

All stakeholders should aim to use different Webinar platforms within and beyond Zanzibar todisseminate the learning from the Zanzibar CBHP.

3.5.6 Dashboards

The digital platform under the Zanzibar CHIS has included in its design ability to automated generationof simple

analyses displayed in Dashboards. Both generic and customized (based on stakeholders' needs and requirement) Dashboards.

3.6 Portfolio Review

The M&E plan is key to a successful implementation not only of the CBHP in particular, but also of the ZCHS (II) as a whole. There is a room for making reviews of the two community based plans if the M&Ewill effectively inform its progress over time. There shall be two reviews of the CBHP, namely the Mid Term Review/Evaluation (MTR/MTE) or End Term Evaluation (MTE).

3.6.1 Implementation Research

The IPs are recommended and encouraged to use the National CHV presence in the community as an opportunity to integrate implementation research so as to augment the M&E diversity.

4 References

1. ICRW. 2010. Monitoring Toolkit: How to Develop a Monitoring System for a Community Rights Workers Program. International Centre for Research on Women.
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4. MOHSW. 2012. Health Information System Strategic Plan (2012-2020). The Revolutionary Government of Zanzibar
5. MOHSW. 2013. Zanzibar Health Sector Strategic Plan III (2013/14-2018/19). The Revolutionary Government of Zanzibar
6. MOHSWEGC. 2019. Zanzibar Community Health Strategy (2019–2025). The Revolutionary Government of Zanzibar
7. MOHSWEGC. 2020. Zanzibar Digital Health Strategy 2020/2-2024/25. The Revolutionary Government of Zanzibar
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5 Annexes

5.1 Data collection tools

The digital electronic form integrated on mobile phones as an application

5.2 Supervision checklist

Included in integrated Supervision Manual for CBHP supervisors