**REVOLUTIONARY GOVERNMENT OF ZANZIBAR**

**MINISTRY OF HEALTH**

# STANDARDIZED AND INTEGRATED NATIONAL BASIC TRAINING MANUAL AND GUIDELINES FOR SUPERVISORS OF COMMUNITY HEALTH VOLUNTEERS AND SHEHIA HEALTH CUSTODIAN COMMITTEES

**Zanzibar Health Promotion Unit**

**In Collaboration with**

**Training Unit**

**June, 2021**

## Abbreviations

| | |
|---|---|
| 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 |
| PORALG | 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 |
| WIT | Willows International Tanzania |
| WHO | World Health Organization |
| WRA | Women of Reproductive Age |
| ZCHS | Zanzibar Community Health Strategy |

**Table of Contents**

Abbreviations ........ ii
Table of Contents ........ iii
Foreword ........ v
Acknowledgements ........ vi
Overview of Supervision Activity of Community Health ........ 1
Chapter 1 ........ 1
Volunteers in Zanzibar ........ 1
Time: 1Hour ........ 1
Learning Outcomes ........ 1
1.1 Background ........ 1
1.2 About this Manual ........ 2
1.3 Objectives of the Training of Supervisors of CHV and SHCCs ........ 2
1.4 Who Are the Supervisors for CHVs and SHCCs in Zanzibar? ........ 3
1.5 Training of CHV and SHCC Supervisors ........ 3
1.5.1 Approach ........ 3
1.5.2 Target Group ........ 3
1.5.3 Frequency of Supervision ........ 3
1.5.4 Evaluation methods: ........ 3
1.4.5 Certification ........ 3
Chapter 2 ........ 4
Training Content for Supervisors of CHVs and SHCCs ........ 4
Learning Outcomes ........ 4
Module 1: The Concept of Supervision ........ 4
1.6 Module Objectives ........ 4
1.7 Session 1: Definition of Traditional and Supportive Supervision ........ 5
1.7.1 Traditional supervision ........ 5
1.7.2 Supportive supervision ........ 5
1.8 Session 2: Qualities of a Good Supervisor ........ 5
1.8.1 Qualities of a good supervisor ........ 5
1.8.2 Barriers for being an effective supervisor ........ 6
Module 2: Functions and Tasks of Supervision ........ 6
1.9 Session 1: Functions ........ 6
1.9.1.1 Educative (formative) function ........ 6
1.9.1.2 Supportive (restorative) function ........ 7
1.9.1.3 Administrative (normative) function ........ 7
1.9.2 Tasks of a Supervisor ........ 7
1.10 Session 2: Supervision as the backbone of a functioning community health service provider system ........ 7
Module 3: Skills Required by a Supervisor ........ 8
1.11 Module Objectives ........ 8
1.12 Session 1: Effective Communication ........ 8
1.13 Session 2: Group Facilitation Skills ........ 9
1.14 Session 3: Problem Solving skills ........ 9
1.14.1 Problem Analysis ........ 9
Module 4: The Supervision Process ........ 11
1.15 Module Objectives ........ 11
1.16 Session 1 Introduction to the components of the supervision framework ........ 11
Session 2: Supervision functions/components ........ 12
Chapter 3 ........ 15
Content for Supervisors of CHVs and SHCCs ........ 15
Module 1: Content of Supervision for CHVs and for SHCCs ........ 16
1.18 Module Objectives ........ 16
1.19 Session 1: The Broader Dimensions for Supervising Community Based Health Services 16
1.20 Session 2: Content that need to be focused at when conducting supervision to CHVs ........ 17
1.21 Session 3: Content that need to be focused at when conducting supervision to SHCCs ... 17

1.22 Session 4: Resources, tools and job aids that will be needed when conducting the supervision activity ... 17
Module 2: Community Engagement ... 18
1.23 Module Objectives ... 18
1.24 Session 1: Importance of Community Engagement in Supervision of CHVs and SHCCs .. 18
1.25 Session 3: How to Engage Communities During Supervision ... 18
1.25.1 Key Points on Community Dialogue ... 18
Chapter 4 ... 20
Cross -Cutting Considerations ... 20
Module 1: Monitoring and Evaluation in Supervision ... 21
1.26 Module Objectives ... 21
1.27 Session 1: Data Management and Analysis ... 21
Module 2: Ethical considerations in supervision ... 22
1.28 Module Objectives ... 22
1.29 Session 1: Code of Ethics in Supervision ... 22
1.29.1 Code of ethics ... 22
1.29.2 Confidentiality ... 22
1.29.3 Safety ... 22
1.29.4 Effectiveness ... 22
1.29.5 Contracts ... 22
1.29.6 Competence ... 22
1.29.7 Code of practice ... 22
1.29.8 Issues of Responsibility ... 22
1.30 .Session 2: Sustained Competence of Supervisors ... 23
Bibliography ... 24
Appendices ... 26
Appendix 1: Minimum Intervention Package (MIP) for CHVs ... 26
Appendix 2: Minimum Intervention Package (MIP) for SHCC ... 32

## Foreword

In 2011, Zanzibar formulated its first Community Health Strategy (ZCHS) with the main aim of 'streamlining' existingstructures 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 deliveriesand 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 theZCHS 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 PrimaryHealth 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 supportingthe 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 **Integrated Training Manual for Supervisors** of CHV and SHCCs is a practical example ofhow 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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**Dr. Fatma H. Mrisho**

**Principal Secretary**
**MOH-Zanzibar**

## Acknowledgements

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 HalimaKhamis, Head of Health Promotion Unit, of the MOHSWEGC who was always at hand to support and lead the HPU team andthe 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 supportand encouragement at various stages was important for the timely completion of the assignment. In this category, the TechnicalWorking Group (TWG) provided the instrumental and overall technical leadership of the work that led to development ofthese 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 entireactivity 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 inZanzibar), Ms Neema Sirima (Program Coordinator), Mwanahamisi Kilongo (Administrative Officer) and the entire WIT stafffor 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 consultantswho guided all processes and activities that led to availability of the manuals, guidelines and tools including this service packagefor SHCC. In particular, the Government would like to thank Mr. Selemani Mbuyita who was the Lead Consultant togetherwith his colleagues Mr. Issa Mussa, Dr. Yahya Ipuge and Dr. Emmanuel Matechi. Their hard work and commitment will foreverbe 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 inpromoting 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**
**MOH-Zanzibar**

Chapter 1

# Overview of Supervision Activity of Community Health Volunteers in Zanzibar

**Time: 1Hour**

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## Learning Outcomes

At the end of this chapter, trainees will understand and be able to explain

1) Objectives of the training of supervisors of CHV and SHCCs
2) Who are the supervisors for CHVs and SHCCs in Zanzibar
3) Knowledge requirement for CHV and SHCC Supervisors.

**Facilitation plan**
In facilitating this chapter, facilitators will need to use adult learning methods as much as possible.
**Facilitation methods**
Combine independent reading, Q&A, presentation and activities (exercises)
**Facilitation materials**
Notebook, sticky notes, flip chart, flip chart stand, marker pens, ball point pens, power point projector.
**Resources**
Power point facilitation slides, Minimum Intervention and service Package (MIP) for SHCCs, Training Manual for SHCCs, Facilitator's Manual for training SHCC, Zanzibar Community Health Strategy.
**Hands on activities**
In training some of the contents (see instructions under respective sections) be innovative by applying methodssuch as;

- Allowing trainees to narrate their own personal experience of conducting supportive supervision or beingsupervised
    - What did they supervise/supervised on?
    - Who were involved?
    - How was the supervision conducted
    - What followed after supervision?
    - How better do they think the supervision could be conducted than how it happened?

**Session Duration**
This session should be covered in a time period of not more than 1 hour
**Facilitation site**
Classroom, preferably in a U or semi-circle sitting pattern.

### 1.1 Background

In Early 2019, the Ministry of Health through Health Promotion Unit has revised Zanzibar Community Health Strategy. The Strategy has focused on revitalization of SHCCs and also approved CHVs that will be utilized to assist the implementation of a number of community health interventions at the primary level. Both SHCCs and CHVs will be provided with specific training in line with MIHP as outlined in theirtraining manuals. The Government intends to implement the CHV program nationwide for the first time, and therefore ZCHS has put emphasis that high level leadership and coordination is required.

It is apparent that provision of supportive supervision, mentoring and coaching is well reflected in theplans of both MOHSWGC as well PORALGSD. However, both policy and regulatory support are required to make sure that the CHV program fits in the current policies. As such, when defining the supervision mechanism, the pathway should start from the national level and flow across all other levels ofthe health systems.

There are existing Government structures that are already providing good leadership for CHV related activities in the Isles including a well-defined coordination structure from national to district level where;

- The MOH provides policy and technical guidance across all health programs.
- The HPU provides guidance in implementing all community-based health activities;
- The PORALGSD oversees implementation of all health programs across all levels.
- The DHMTs/ Council level have clear lines of coordination, management and accountability.

Good collaboration of the health sector to local government provides an additional opportunity for better and more effective supervision, and support for CHVs at the local level. Taking advantage of these existing features, the following strategies will ensure that supervision, coaching and mentoring is implemented in an effective and well-coordinated manner.

Administratively, the CHVs will report and be supported by the Sheha represented by SHCCs. Technical supportive supervision, mentoring and coaching for CHVs will be provided by the health facility serving the Shehia. MOH will develop or include a checklist for CHV supervision in the current PHC supervision guidelines.
A dedicated staff member at the PHCU (such as a Public Health Nurse or Environmental HealthOfficer) will be identified and assigned the role of HPO at the health facility level. Under theguidance of the PHCU facility in-charge, the designated facility HPO will provide routine supervision of CHVs and ensure continuum of health services from the community to health facilities. The facility based CHV supervisor will in turn report to and be supervised by the HPO at the CHMT.
The Sheha through SHCC will meet with CHVs at least twice every month (every two weeks) to discuss work progress and address any challenges faced in the community. The Facility based CHV supervisors will conduct monthly supportive supervision to all Shehias in the catchment area. Based on the findings of the supervision visits, a specific individualmentoring and coaching plan will be developed based on the needs of each CHV.

Use of the mobile application by CHV supervisors at PHCU and CHMT level will beinstitutionalized to monitor CHV performance.

- The capacity of Shehas and the SHCC to provide administrative support and leadership to CHVs will be built. This will include provision of training to increase their competence in supervision that includes resolving of unpredictable social challenges related to the work of CHVs.
- The Ministry and developing partners will be sensitized to allocate adequate funds to CHMTs and PHCUs to ensure that effective supportive supervision, mentoring and coaching for CHVs and SHCCs are conducted regularly and as planned.
- PHCU will provide regular updates and feedback to the SHCC on the performance of CHVs in their Shehia.
- HPU will monitor and provide regular training to update knowledge and skills of CHV and SHCCs supervisors at PHCU and CHMT levels.

### 1.2 About this Manual

This curriculum is designed for training of supervisors of CHV and SHCC from PHCU and CHMT levels who are entrusted with the responsibility of carrying out supportive supervision of Community Health Volunteers (CHVs) and Shehia Health Custodian Committees. The training content is designed to equip participants with knowledge, skills and attitudes to effectively support CHVs and SHCCs with an aim of improving community participation and quality of community-based health service delivery at community and household level.

### 1.3 Objectives of the Training of Supervisors of CHV and SHCCs

At the completion of this course, the participants shall be able to;

1. Describe concepts of support supervision
2. Demonstrate the skills required by a supervisor
3. Understand the process of supervision
4. Understand Content of supervision for CHVs and for SHCCs
5. Explain networking, partnership & community engagement

6. Discuss ethical considerations in supervision
7. Discuss monitoring and evaluation in supervision.

### 1.4 Who Are the Supervisors for CHVs and SHCCs in Zanzibar?

The Community Health Technical Working Group (TWG) in Zanzibar has defined supervisors as the persons who have sufficient knowledge of the Community Based Health Program (CBHP) as described by the Community Health Strategy of Zanzibar. There shall be five types of Supervisors: 1) the overall supervisors who will oversee both CHVs and SHCCs in a given District Council. 2) Facility Health in- charges who will provide supervision to CHVs in their respective catchment areas. 3) Technical personsdesignated and assigned by various Implementing Partners (IPs) to join the Health Promotion Focal Person during supervision. 4) CHV Supervisors who will be selected among the CHVs to supervise their peers. 5) The SHCCs will have a supervisory role over CHVs. However, the supervision aspect of SHCCs overCHVs has been described in the SHCC Training Manual which is integrated as part of their roles and functions, hence SHCCs do not constitute part of trainees targeted by this manual.

The overall supervisors will be derived among the members of the Council Health Management Team.From CHMT the focal Persons for Health Promotion activities in the Council will preferably be the overall supervisor for CHVs and SHCCs. In each Council, the Health Promotion Focal Person (HPFP) will be theteam leader of the team of supervisors in a given District Council assisted by technical persons from various IPs and facility in-charges drawn from all health facilities in the respective District Council.

### 1.5 Training of CHV and SHCC Supervisors

#### 1.5.1 Approach

The training methodology employed in this training is experiential, participatory and didactic to include:

- Role plays
- Group work and discussions
- Brainstorming
- Case scenarios and
- Mini-lectures.

#### 1.5.2 Target Group

This manual primarily targets the Supervisors of the Community Health Volunteers (CHV) and of ShehiaHealth Custodian Committees (SHCCs) who will be working as supervisors of Community Based HealthProgram (CBHP) under the Community Health Strategy in Zanzibar. These include the District Health promotion Focal Person, technical persons from different IPs, Facility In-charges and CHV immediate supervisors drawn among CHVs.

#### 1.5.3 Frequency of Supervision

Except for the Immediate CHV Supervisors, whose work is routine and most often daily, the rest of the Supervision activity will be conducted on a quarterly basis. There shall be four supervision activities in a year, following the annual Comprehensive Council Health Plan (CCHP) cycle.

#### 1.5.4 Evaluation methods:

- Pre and post course assessment
- Training course evaluation
- Observed practice.

#### 1.4.5 Certification

This course is designed to develop competency for implementing support supervision. Competency is attained through successful completion of all course activities including;

- Attending at least 90% of the class sessions
- Implementation of the activities on the work plans that will be developed at the end of the course.

# Chapter 2

## Training Content for Supervisors of CHVs and SHCCs

### Learning Outcomes

At the end of this chapter, and through the different modules and sessions, the trainees should be able to understand and explain

- The concept of supervision as opposed with supportive supervision
- Qualities of a good Supervisor
- Functions and tasks of Supervision
- Skills required by a Supervisor
- The supervision process
- Supervision functions/components

**Facilitation plan**

In facilitating this chapter, facilitators will need to use adult learning methods as much as possible.

**Facilitation methods**

Combine independent reading, Q&A, presentation and activities (exercises)

**Facilitation materials**

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

**Resources**

Power point facilitation slides, Minimum Intervention Package (MIP) for SHCCs, Training Manual for SHCCs, Facilitator's Manual for training SHCC, and Zanzibar Community Health Strategy.

**Hands on activities**

In training some of the contents (see instructions under respective sections) be innovative by applying methods such as;

- Group work
- Introduce activities to be conducted in groups that will help to illustrate what trainees have understood from the lecture part
- Provide the exercises in such a way that they build on one another leading to development of action plan for supervision activity to be implemented soon after training.

**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: The Concept of Supervision

**Time: 2 Hours**

### 1.6 Module Objectives

By end of this module, the participants will be able to:

1) Differentiate traditional supervision and supportive supervision
2) Describe the qualities of a good supervisor
3) Discuss the functions of supervision-educative, supportive and administrative
4) Outline the roles/tasks of a supervisor

## 1.7 Session 1: Definition of Traditional and Supportive Supervision

### 1.7.1 Traditional supervision

Traditional supervision is superficial. It only looks at the face value of the problem and not the root cause. It is often punitive, fault-finding and critical and therefore does not offer solution. It focuses on individuals rather than processes therefore do not endeavor to strengthen systems and processes that may cause disconnect between current outputs of health care to the expected standards. Traditional supervision emphasizes the past rather than the future. Further it's not continuous but it's rather intermittent and usually it creates resentment, suspicion, disintegration between team members rather than focusing on strengthening team work for quality service delivery.

### 1.7.2 Supportive supervision

Supportive supervision can be defined as 'a process of guiding, monitoring and coaching workers to promote compliance with standards of practice and assure the delivery of quality care services.

- The supervisory process permits supervisors and supervisees the opportunity to work as a team to meet common goals and objectives.
- It is about 'empowerment and not control, emphasizing building confidence and self-esteem through supportive feedback'.
- It is facilitated through an encouraging and respectful relationship with community health service provider.
- It sets expectations, monitors and assesses performance, identifies problems and opportunities in which the supervisor remains an intermediary promoting collaboration in problem solving and linking to external resources.

The concept of supportive supervision is to place within the health system individuals whose purpose is to coordinate the aspects of the health system which support community health service providers in service delivery. A supportive supervisor's job is to identify everything that his/her community health service providers need to succeed – including continued training, supply of medicines, easy mobility, emotional support etc. and ensure that these supports are in place. Good quality supervision is crucial for community health service providers to remain motivated and active in their jobs and to feel valued in their work.

Community health volunteers always feel a 'value-add' for participating in a supervision exercise, and not come to fear or avoid it. It should an opportunity to share their concerns, help them to overcome the challenges they have experienced in their work, and to learn more about the work that they are carrying out through the knowledge sharing and coaching of the supervisor. For many, supervision also means 'line-management' and therefore CHVs may feel reluctant to report the difficulties they have. This attitude will limit the effectiveness of the supervision in improving work quality and eventually lead to supervisees becoming demoralized. Creating and open dialogue and a mentoring relationship will be most effective in helping them to report, identify and resolve the problems they have and will lead to genuine improvements competencies improvement over time.

## 1.8 Session 2: Qualities of a Good Supervisor

The attitudes and relationships that develop between the community volunteers and supervisor are just as important as the day-to-day duties a supervisor will have. Supervisors provide the example for teaching and learning that community health service providers follow when they are in their communities. If the supervisor bosses and "talks down" to community health service providers, the community health service providers are more likely to "talk down" to community members. However, if the supervisor treats them as equals, notices their strengths and builds on them, they will be more likely to work the same way with people in their communities.

### 1.8.1 Qualities of a good supervisor

Include:

- Good listener
- More knowledgeable in technical issues than the community health service providers
- Resourceful, the one who make things happen when confronted by obstacles. This may be referred as having problem solving skills but it's also about being innovative and thinking 'out of the box' and being creative
- Have good communication skills

- Be a role model, be respectful, able to give community health service providers space to airtheir issues, able to show interest by the way they listen, acknowledging the strength of others
- Be able to observe confidentiality
- Being respectful; it's more than being considerate and polite. Being able to treat people as individuals, acknowledging their individual needs and aspirations
- Be Supportive i.e. being attentive to the community health service providers personal and professional needs; absence of a superiority complex; assistance with challenging aspects of the community health service providers work, being flexible like having flexible working hours
- Be a mentor and coach the community health service providers for good performance
- Knowing and being able to use the community health service provider's strengths
- Allowing the community health service providers to manage their own time and workload
- Fostering a relationship between the community health service provider and the clinic and hospital, to help integrate them into the local health system
- Ability to motivate community health volunteers to continue improving their skills
- Taking time to give frequent, constructive feedback on the community health volunteers' performance.

It may require that you as the supervisor start to think differently about what it means to be 'in- charge'. Though supportive supervision will take some practice, in the end we believe it will produce better resultsand ultimately alleviate suffering and help to save lives.

### 1.8.2 Barriers for being an effective supervisor

The barriers just identified are real, not imagined. Don't feel bad that you can't be an ideal supervisor all the time - nobody can! An effective supervisor knows their own strengths and weaknesses and learns touse those strengths and weaknesses wisely in day-to-day interactions with CHVs.

The first step to becoming an effective supervisor is to know one's own strengths and weaknesses. Since you've identified what you think an ideal supervisor looks like, and those things that happen that get in theway of being an ideal supervisor, spend a few moments thinking about what you need to overcome yourbarriers and improve your skills.

Supervisors have a powerful impact on supervisees' lives. A supervisee's relationship with his or her supervisor is often the most influential factor in whether the supervisee feels valued and respected atwork. Not surprisingly, feeling valued and respected is one of the biggest factors affecting a supervisee's decision to stay on the job or quit.

# Module 2: Functions and Tasks of Supervision

Time: 2Hours

### 1.9 Session 1: Functions

Support supervision has three main functions;

- Educative (formative) - proficient development of the supervisee
- Supportive (restorative) - welfare of the supervisee
- Administrative (normative) - quality assurance,

#### 1.9.1.1 Educative (formative) function

In supervision, knowledge and information, personal development and skills training is carried out. Supervision is also of learning by doing, allowing supervisees to reflect on their work with in the presence of an experienced person who enables that reflection. Supervisors inevitably fill in gaps in knowledge, increase skills, make practical what was only abstract knowledge but what must now become workingknowledge. A link is established between theory and practice. This function has been called the 'formative'function of supervision.

Supervision is directive in the behavioral approaches; in the humanistic it is more informal. The facilitativerole of the supervisor enables learning in the interaction.

#### 1.9.1.2 Supportive (restorative) function

The supportive role of supervision is emphasized more in the person-centered approach. It involves offering supervisees a forum where they are encouraged to look at their own issues and ask for or be given the encouragement they need to explore their way of working with clients. It is this function thatprovides the 'containment' side of supervision. Supporting supervisees as they struggle to work, as they deal with other's or the community members difficulties, as they engage emotionally with community members, takes place throughout all aspects of supervision. This function of supervision has been called the 'restorative' function.

#### 1.9.1.3 Administrative (normative) function

The administrative function has an eye on all aspects of the work that contain accountability and responsibility of the supervisee and the welfare of the client. Called the 'normative' function of supervision, it pays attention to the ethical and professional aspects of client work. It enables supervisees to monitor their own work as professionals.

It is here that supervisors become advocates, making sure that quality service is rendered and that ethicaland professional dimensions are maintained at a high level.

### 1.9.2 Tasks of a Supervisor

Tasks during supervision include:

1) Creation of Relationship between the supervisor and the community health volunteers,
2) Monitoring the professional and ethical aspects of supervision,
3) The supportive task of supervision,
4) The teaching task of supervision,
5) The evaluation task of supervision,
6) Consultation task of supervision,
7) The administrative task of supervision.

In summary**, Educative** focus on Professional development through capacity building, provide information & updates, mentorship &coaching. **Supportive** work on Emotional, motivational, problem solving, one on one and group supervision and **Administrative** involve adherence to guidelines, problem solving, provision of drugs and commodities, data management and giving feedback, quality assurance, conflict resolution and site support supervision.

## 1.10 Session 2: Supervision as the backbone of a functioning community health service provider system

In a nutshell and in the context of supervision within the community health service provider program, supervision contributes to:

**1) Continuing training:**
The mentorship and capacity building aspect of supportive supervision contributes to the up- skilling of the community health service provider

**2) Equipment and supplies**
Typically assessed through supervision visits

**3) Individual performance evaluation**
The basis of which comes from the supervision reports and data submitted over the course of the year

**4) Opportunity for advancement**
Supervision identifies good performance amongst community health service providers and therefore those which merit access to additional opportunities and skills based training can be identified through supervision

**5) Documentation and information management**

Supervision is typically the point of entry of data into the system – collection, collation, analysis, reporting and dissemination.

**6) Linkages to the health systems**

Supervision is typically the key way in which community health service providers are linked to the health facility staff. Supervision means building a mentoring relationship between them and individual health providers in the facility, builds a sense of accountability by the facility for the community health service providers providing services in the community.

**7) Community involvement**

Successful engagement of the community in the recognition of the community health serviceproviders work may particularly involve being able to feed into the supervision processes.

# Module 3: Skills Required by a Supervisor

**Time: 2 Hours**

### 1.11 Module Objectives

By the end of this module, the participants will be able to:

1) Define effective communication skills including attending skills, active listening and questioning
2) Demonstrate problem solving skills
3) Demonstrate advocacy skills.

**Refer to:**

- Role play: Effective listening skills (25 minutes)
- Role play: Role play Effective questioning skill (25 minutes)

Usually, a supervisor is a well knowledgeable person who is able to lead, support and guide his/her subordinates. However, while the knowledge of the content to be supervised might be well possessed,skills to facilitate and conduct the supervision activity might not necessarily be available among all supervisors. Below are the generalized skills that are important for supervisors to have.

### 1.12 Session 1: Effective Communication

It is exchanging information but with a realization of the desired outcomes on the person intended toreceive the information. Communication is a two-way process. It is the act of transmitting information, thoughts, opinions and feelings through speech, signs and actions from a source to a receiver. For a supervisor there is need to communicate effectively with the community health service provider otherwise the message, no matter how good, will not be heard or heeded. The communication processconsists of a message, source, channel, receiver, effect and feedback. Communication begins with a message that is developed at the source. The source channels the message to the receiver. This message has an effect which produces feedback.

The flow of communication between a supervisor and a supervisee needs to be smooth and clear – notonly in regard to the content, but in the way the content is conveyed. When people communicate, theytake in a number of messages apart from the spoken words. A supervisor's communication role also includes passing information from top management to the community health service providers.

Listening is equally important, if not, more in communication as sending the message. Making sure that what we think we heard is indeed what the other person said is an essential part of effective communication. Also, it's important to talk how listening and communication applies to all types of relationships, between couples, co-workers, parent and child etc.

## 1.13 Session 2: Group Facilitation Skills

Group supervision involves a group of community health service providers coming together with a supervisor and conducting regular supervisory activities such as: data collection and interpretation, problem solving, and continuing education.

The advantages of this method is that it takes a team approach which has been shown to be more effectivefor many contexts, it relieves the 'solitude of working' and helps community health service providers to feel like part of a bigger process and working towards common goals. The notion of 'peer pressure' isrelevant too, as public presentation of data and progress amongst team members, can lead to public recognition of their efforts and is a disincentive for low performance. From the groups, typically morecompetent members will emerge, who can be strengthened to provide additional support to the community health service providers – become 'lead providers' over time, taking on roles such as data audit / support, trouble shooting, and conducting observational assessment or case evaluations in the community (after their skills are well developed).

The peer-to-peer learning process which inevitably emerges during group approaches also has a hugevalue add to the project. Over time, community health service providers will become true experts indelivering services and many will encounter and overcome problems for themselves using local knowledge.This peer support may be a better source of solutions for overcoming cultural and behavioral barriers to health than that of the supervisor themselves.

The group approach, however, comes with limitations, key among which is the inability to identify falsification of data and observation of a home visit.

| **Activity 1**: Group dynamics- *Characters in a group (60 minutes). Use animal poster or any other facilitation aid* |
|---|

## 1.14 Session 3: Problem Solving skills

Problem solving is one of the skills required of a supervisor. Unfortunately, most supervisors lack skills to effectively solve problems. Problem solving skills entails analysis and identification of problems for them tobe understood and solutions to be formulated and implemented.

**Activities:**
- Activity one: Problem identification and analysis (30 minutes)
- Activity two: Problem prioritization (25 minutes)

### 1.14.1 Problem Analysis

| **Activity** 3: Problem Analysis (25 minutes) |
|---|

Problem analysis assists in defining a problem and identifying target areas for intervening in order to resolvethe problem. Problem analysis is dissecting a problem in order to understand how it emerged. It helps in understanding the root cause of a problem. When analyzing problems, one should:

- Use a problem tree
- Begin by identifying the principal causes
- Be honest
- Brain storm on why the problem is happening
- Concentrate on the common causes
- Keep asking 'but why?' until you have identified the root cause.

1. **Note: The question but why should be asked for each of the causes until it can no longer be answered/ ask.**

   Each group is asked to conduct a problem analysis of their selected problems and present back to theplenary: Conclude this session with engaging the trainees on two more activities namely Problem description (generated as an outcome of problem analysis where the root cause is established) and proposition of feasible solutions for the problem (after establishing the root cause of the problem).

**Activities:**
Activity 4: Problem Definition (25 minutes)
Activity 5: Suggesting Solutions for Problems (25 minutes)

# Module 4: The Supervision Process

**Time: 2 Hours**

### 1.15 Module Objectives

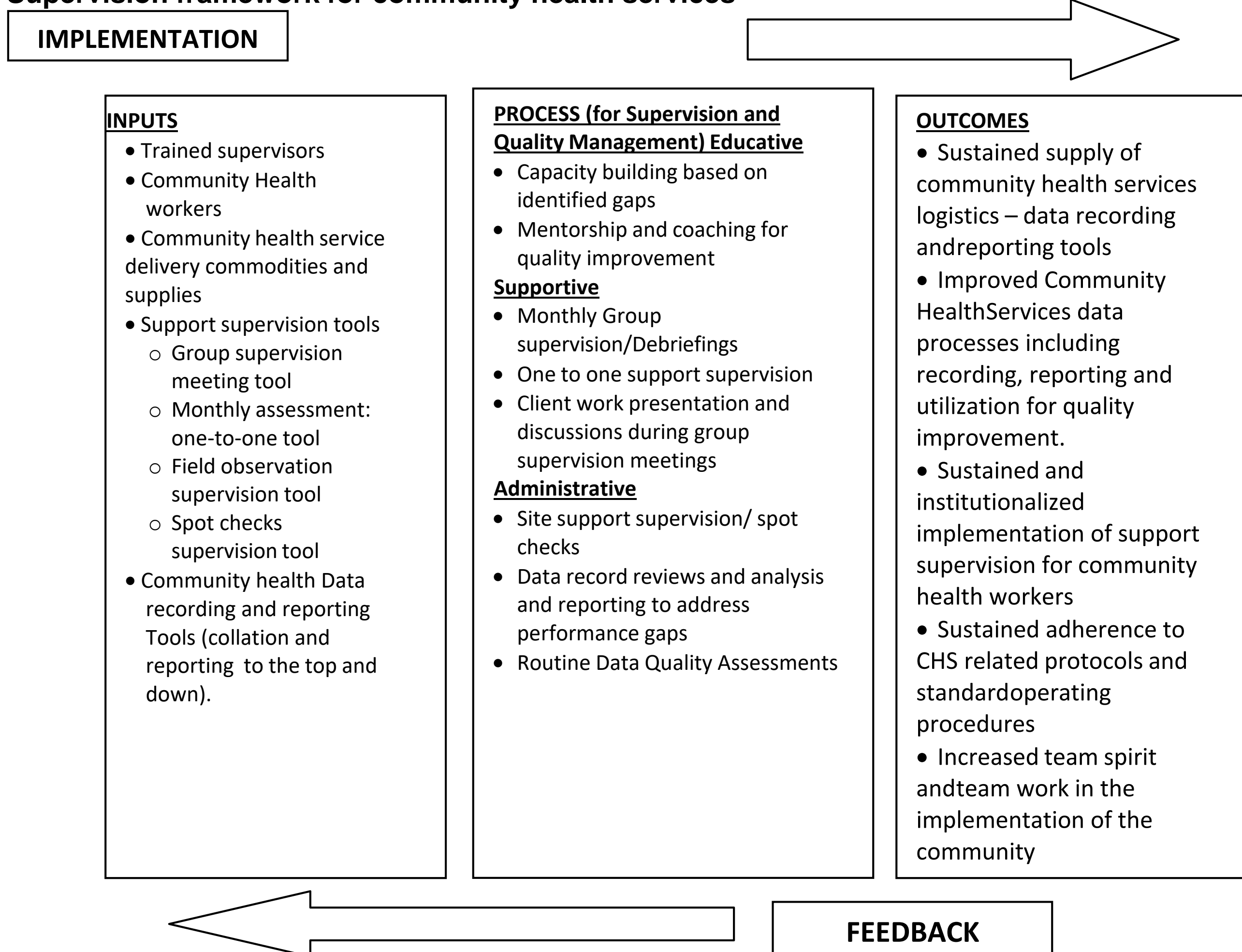
By end of this module, the participants will be able to:

1) Describe the components of the supervision framework for community healthextension workers
2) Demonstrate ability to implement activities in each of the supervision components
3) Demonstrate ability to effectively carry out group supervision.

### 1.16 Session 1 Introduction to the components of the supervision framework

**Activity 1:** Supervision functions (20 minutes)

**Supervision framework for community health services**



**Session 2: Supervision functions/components**

### 1.17.1 Educative function

Supervisors should be responsible for formal teaching, such as skills training, knowledge and information (theory base) and personal development of community health service providers by allowing them to reflect on their work with clients. The supervisors then fill in gaps in knowledge and skills and make practical what was only abstract knowledge but what must now become working knowledge. A link isestablished between theory and practice. This function has been called the 'formative' function of supervision.

It is done through:

**a. Capacity building within the groups**

Supervisors can use the group supervision meetings to increase the knowledge of community health service providers in a particular area of service where gaps have beenidentified or by facilitating topics that are related to their work in the community.

**b. Mentorship and coaching**

Mentorship is a system of practical training and consultation that fosters on-going professional development with an aim of yielding sustainable high quality community health services. Mentorship aims at promoting continuous professional growth and development amongst Community Health Volunteers consequently resulting in improved quality of community services. Mentorship will be undertaken by supervisors (mentors), with an objective of helping less experienced community health service providers (mentees) apply theoretical knowledge acquired from different learning forums to practice, build their capacity and motivate them to continuously provide quality services.

- Mentorship is not as easy as it sounds. It is not a one-off instructive activity, it takes time and patience
- Mentorship is a supportive relationship between a supervisor and supervisee
- Mentorship requires a willingness to share skills, knowledge, and expertise
- Mentorship is a professional alliance where a mentor who is more experienced
- Can provide a mentee guidance, advice, and assistance
- A good mentor takes a personal interest in the mentoring relationship and provides guidance and constructive feedback. S/he should get to know his/her mentee, what his/her mentee's goals are, and what his/her mentees strengths and weaknesses are;
- A good mentor values the opinions and initiatives of his/her mentees
- A good mentor motivates others by setting a good example
- A good mentor is authentic –"walk the walk" as they say – meaning the mentordoes what he/she teaches.
- A good mentor will genuinely listen to concern; know his/her mentee's projects byname and be able to ask him/her how things are going
- A good mentor can recognize his/her mentee's talent and potential, and work touplift that mentee.

**Importance of mentorship**

- Mentorship provides one-on-one coaching and support
- Mentorship provides coaching and counseling to a junior member of the team in handling frustration and disappointment, working through difficult situations, providing constructive criticism, and behaving with humility and compassion

- Mentorship offers employees professional and personal development, which in turn can leadto higher motivation and job satisfaction
- A mentor will hold a mentee accountable for his/her actions and can assist the mentee insetting realistic short-term and long term goals

A mentor is an advocate for a mentee in the broader system. A mentor is a trusted colleague to discuss problems and find solutions.

### c. Group supervision

This happens when multiple community health service providers gather to meet with the supervisor ineither the health facility or a village. Meetings usually include regular supervisory activities (collecting data, discussing problems, and continuing education) in a group rather than individually. Ideally groups should contain a maximum of 15 people and meet monthly.

It is often the time when providers realize how they can help and support each other. Group supervision provides a rich forum for providers to share their unique experiences and challenges. Group supervision is beneficial to supervisees in that it provides a greater range of feedback, support, challenges and viewpoints. Supervisors should make arrangements to provide at least one monthly group supervisorymeeting at the Health facility. Group supervision or debriefing is a mechanism for mitigating burnout among service providers in the helping and community work. Community health service providers faceburnout as a result of interacting with clients in the course of their work. Support supervision or debriefing is recognized as a key approach for strengthening the quality of all aspects of community healthservice delivery, through working with community health volunteers to identify areas of improvement and continuous proficiency development. Supportive supervision helps to maintain optimal providerperformance and hence facilitating the delivery of high quality services.

The advantages of this method is that it takes a team approach which has been shown to be more effectivefor many contexts, it relieves the 'solitude of working' and helps community health service providers to feel like part of a bigger process and working towards common goals. The notion of 'peer pressure' isrelevant too, as public presentation of data and progress amongst team members, can lead to public recognition of their efforts and is a disincentive for low performance. From the groups, typically morecompetent members will emerge, who can be strengthened to provide additional support to the community health service providers – become 'lead providers' over time, taking on roles such as dataaudit/support, trouble shooting, and conducting observational assessment or case evaluations in the community (after their skills are well developed).

#### i. Peer supervision

A group of providers who live close to each other and are at the same level (same job title) can meettogether to share experiences or do problem solving activities and discussion. This is particularly important if the CHV has more CHVs to supervise and is not able offer to offer group supervision to all of them at least once in a month.

#### ii. One-on-one supervision

It is usually considered as traditional supervision - is when the supervisor and the supervisee to meet todiscuss and provide support to make sure that the supervisee feels equipped and happy to fulfill their job effectively. The meeting needs to foster a culture of open discussion where supervisee has the time todiscuss any concerns, worries and constraints within their role and the setting as a whole. The key elements of one to one supervision are coaching, training, personal development and the focus on theirwell-being. It should also be a two way process that enables both parties involved to developing a positive and mutually supportive discussion and on-going development plan. This strategy, however, is ideal in contexts with sufficient numbers of qualified and available supervisors.

#### iii. Home visit support supervision

Home visit support supervision focuses on issues such as **capacity building, staffing, logistics and supplies, data management, linking community health service providers and health facilities**etc. CHVs should accompany or visit community health service providers in the field as they undertaketheir home visits to provide supervision on a monthly or quarterly basis. Supervision tools should be utilized to check and address all the service quality issues. Observed practice using a supervision checklist is a mechanism of providing

instant feedback to CHV on a community health service session they had just conducted in a home or in the community. Observed practice is conducted by the CHV (supervisor), with the consent of the client/beneficiary. The supervisor, using a structured tool, is present during the session and gives feedback at the end of the session, based on what they had observed. Where capacity gaps are identified a number of correctivemeasures including immediate feedback, refresher trainings during group supervision or other capacity building opportunities including mentorship can be employed. Supervisors should ensure linkages between the community health service providers and the health facilities through navigating and aligning both clinicand community based priorities through regular interaction with both clinic and community-based staff. Home visit supervision helps the supervisor to:

a. Build a relationship with community health service providers
b. Provide regular feedback and continuously help them improve their skills
c. Collect data on how the CHV program is going
d. Identify and troubleshoot logistical challenges
e. Give the community health service providers an opportunity to alert their supervisor to problems with the program
f. Motivate the community health service providers to do their job
g. Provide moral support for the inevitable challenges of rural health care
h. Reinforce the link between the clinic and the CHV and their community.

### iv. Spot checks

This is usually a type of direct observation: (Look, listen and learn-3L's). It means systematically observingobjects, events, relationships or people's behavior, listening to what people talk about in an emotional way (excitement, anger, fear and concern), and learning and recording these observations in an organized manner. One does this by conducting transect walks. A checklist is necessary to ensure completeness of observation, based on the indicators that can be assessed through this method. The quality of observation can be improved by participating with the community in their activities. The supervisor walks from point Ato B across the community often with the community health service provider. It is essential - in order to maintain trust - that community health service providers are informed that supervisors may occasionally perform spot checks.

# Chapter 3
# Content for Supervisors of CHVs and SHCCs

## Learning Outcomes

At the end of this chapter, trainees will understand and be able to explain:

1) The broader dimensions for supervising Community Based Health services
2) Content that need to be focused at when conducting supervision to CHVs
3) Content that need to be focused at when conducting supervision to SHCCs
4) Resources, tools and job aids that will be needed when conducting the supervision activity
5) Importance of Community Engagement in Supervision of CHVs and SHCCs

## Facilitation plan

In facilitating this chapter, facilitators will need to use adult learning methods as much as possible.

## Facilitation methods

Combine independent reading, Q&A, presentation and activities (exercises)

## Facilitation materials

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

## Resources

Power point facilitation slides, Minimum Intervention and service Package (MIP) for SHCCs, Training Manual for SHCCs, Facilitator's Manual for training SHCC, Zanzibar Community Health Strategy.

## Hands on activities

In training some of the contents (see instructions under respective sections) be innovative by applying methods such as;

- Group work
- Brainstorming and brain tapping
- Role plays
- Case studies
- Introduce activities to be conducted in groups that will help to illustrate what trainees have understood from the lecture part
- Provide the exercises in such a way that they build on one another leading to development ofaction plan for supervision activity to be implemented soon after training.
- Include a plenary session after group work to allow a comparative analysis of the group wok andhence learning from each other.

## 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: Content of Supervision for CHVs and for SHCCs

Time: 2 Hours

### 1.18 Module Objectives

This module aims to inform and enable supervisors to understand

- The broader dimensions of supervision of community based health services
- Content that need to be focused at when conducting supervision to CHVs
- Content that need to be focused at when conducting supervision to SHCCs
- Resources, tools and job aids that will be needed when conducting the supervision activity.

### 1.19 Session 1: The Broader Dimensions for Supervising Community Based Health Services

Supervisors for CHV and SHC are expected to be conversant of the Community Health Strategy (CHS) that governs and oversees all community-based health services in Zanzibar. Similarly, they are expected to be conversant with the defined minimum intervention and service packages that CHVs and SHCCs are expected to deliver. They should also understand the competences that CHVs and members of SHCCsare expected to possess based on their training content.

It should be noted that, while the minimum intervention packages and the training manuals provide detailed specific content for follow up during supportive supervision, the Zanzibar Community HealthStrategy is built in five pillars. These pillars constitute the broader dimensions that each supervisor need tobe conversant before going to the specific details of supervision. The pillars include:

- The policy framework within which the CBHP is derived from and built into what is contained inthe CHS.
- The service package that is approved for delivery at the community level by both, CHVs and SHCCs
- Management of the CBHP across different levels of the health system especially from the Councillevel downwards
- Quality assurance that is embedded in the framework of service delivery
- Community Involvement.

In order to conduct effective supervision, supervisors are advised to be guided by the following set of questions that will ensure that the supervision is comprehensive and nothing is left out (Table 1).

**Table 1: Guiding Questions During Supervision of CHVs and SHCCs**

| Pillars of CBHP | Guiding Questions |
|---|---|
| Policy | • What are the objectives of CHV/SHCCs supervision?<br>• Is there a functioning primary health care (PHC) supervision system and can itbe adapted/expanded to include CHVs/SHCCSs?<br>• Are there supervision standards and guidelines for CHV/SHCCs performance?<br>• Do the financial resources exist to sustain a CHV/SHCCs supervision system? |
| Service Package | • What services are CHVs/SHCCs asked to provide?<br>• What are the Dos and Don'ts for Service provisions? |
| Management | • Are management tasks and clinical tasks clear?<br>• What are the reporting lines during service provisions?<br>• Are supervisory roles clear and integrated into job descriptions?<br>• How is the team of supervisors composed?<br>• Have the supervisors been trained in supervision?<br>• Is there a supportive context for supervision (e.g., distances to travel for |

| | |
|---|---|
| | supervision hat are manageable, suitable transportation that is available)?<br>• Are there non-governmental organizations (NGOs) and civil societyorganizations that are currently conducting supervision?<br>• How are supervisors supervised?<br>• How are health facilities involved in the delivery of community health services? |
| Quality Assurance | • Is there a management information system?<br>• How do supervisors observe and monitor CHW performance?<br>• How do supervisors use data for decision-making and supportingCHVs/SHCCs?<br>• Has the quality of supervision provided been evaluated?<br>• What mechanisms exist for feedback from the community regarding theservices provided by CHVs/SHCCs or other health system issues? |
| Community Involvement | • Do supervisors make visits to communities?<br>• Do supervisors (or should they) make household visits with CHVs/SHCCs?<br>• Do community members provide feedback to the supervisor about theirCHV/SHCC?<br>• How involved are community groups and leaders in health and othercommunity issues? |

### 1.20 Session 2: Content that need to be focused at when conducting supervision to CHVs

Appendix 1 provides the content of the minimum intervention package for CHVs that defines services to be delivered by CHVs. During supervision, supervisors will be expected to make reference to this content. The complete description of how these services should be delivered and the required competences areincluded in the CHV Training Manual.

### 1.21 Session 3: Content that need to be focused at when conducting supervision to SHCCs

Appendix 2 provides the content of the minimum intervention package for SHCCs that defines services to be delivered by SHCCs. During supervision, supervisors will be expected to make reference to this content. The complete description of how these services should be delivered and the required competences are included in the SHCC Training Manual.

### 1.22 Session 4: Resources, tools and job aids that will be needed when conducting the supervision activity

In implementing the supervision activity, the supervisors may need to make reference to

1) Zanzibar Community Health Strategy (2019-2025)
2) Minimum Intervention Package for CHVs in Zanzibar (2021)
3) Minimum Intervention Package (MIP) for SHCCs in Zanzibar (2021)
4) Training Manual for CHVs in Zanzibar (2021)
5) Training Package for SHCCs in Zanzibar (2021)

Similarly, during the actual supervision activity, supervisors will need or have the following tools/job aids to assist them conduct the supervision effectively:

1) Supervision checklist
2) Monitoring and evaluation toolkit
3) Supervision reporting template
4) Dashboards.

# Module 2: Community Engagement

Time 1 Hour

## 1.23 Module Objectives

**Introduction:**

Community engagement' is a planned process with the specific purpose of working with identified groupsof people, whether they are connected by geographic location, special interest, or affiliation or identify toaddress issues affecting their well-being. The linking of the term 'community' to 'engagement' serves to broaden the scope, shifting the focus from the individual to the collective, with the associated implicationsfor inclusiveness to ensure consideration is made of the diversity that exists within any community. Community engagement can take many forms and covers a broad range of activities.

Community engagement works best where it is a process that enables relationships and trust to build and strengthen over time. Engagement events should be planned and designed with this in mind. Community groups may want to participate at a range of levels:

- Providing advice at the planning and designing level
- Undertaking some aspects of the engagement
- Delivering projects to meet some of the outcomes.

## 1.24 Session 1: Importance of Community Engagement in Supervision of CHVs and SHCCs

Supervisors have an important role of ensuring that CHVs deliver quality services to the community they serve. Health services assessed to be of high quality according to the provider-defined criteria is far from being ideal if the client is dissatisfied with it. There is evidence that involving the community in health solutions can help improve the quality of health care and even patient outcomes. The community members need to be involved in defining what quality service is and there is also need for feedback from the community about the kind of services they receive or would want to receive. This can help CHV inplanning and making decisions.

Community engagement is important for Community supervisors in the following ways:

- Community can be informed of policy directions of the government e.g. informing them of what Community Health Strategy entails.
- Community can be consulted as part of a process to develop government policy, or build community awareness and understanding towards the same e.g. making them understand and support the roles of both the CHEWs and CHVs.
- Community can be involved in a range of mechanisms to ensure that their issues and concerns are understood and addressed by Supervisors e.g. by getting feedback from them on work done by CHVs
- Through engagement the community will be considered in the decision-making process e.g. in dialogue days, and this will go a long way in encouraging their support towards initiatives such asaction days
- Collaborations can be developed with the community by developing partnerships to formulate options and provide recommendations to problems that affect them e.g. coming up with recommendations during dialogue days
- Community can be empowered to implement and manage change e.g. through involving them in action days and involving them in advocacy.

## 1.25 Session 3: How to Engage Communities During Supervision

### 1.25.1 Key Points on Community Dialogue

#### a) Community Dialogue

Is a mutual continuous exchange of views, ideas and opinions about an issue or a concern?

”Dialogue is one of the most important strategies in the Community Strategy to make people’s behaviour and community change. Organizing and facilitating Community Dialogue is done by the CHC, while the mobilization is done by the CHVs.

***Characteristics of Community Dialogue***

1. It involves interactive communication between two or more parties, aimed at reaching a common understanding on issues for the purpose of taking action
2. Dialogue meetings are held quarterly (4 times in a year) and members who participate includeCHVs,

CHEWs, CHCs, sub county Health Management teams, partners and members of the public.

**b) Key Points on How Community Dialogue can help**

- Seek to satisfy everyone's needs
- Win-win solutions
- Find other's strengths
- Look upon others as a friend
- Open up the communication
- Ask questions and show that you want to learn
- Create energy by listening actively, asking, inspiring in a positive way, and involving
- Seek more solutions.

## Chapter 4
## Cross -Cutting Considerations

At the end of this chapter, trainees should be able to understand and explain

1) What is means with Monitoring and Evaluation in Supervision
2) Data Management and Analysis
3) Ethical considerations in supervision
4) Sustained Competence of Supervisors

### Facilitation plan

In facilitating this chapter, facilitators will need to use adult learning methods as much as possible.

### Facilitation methods

Combine independent reading, Q&A, presentation and activities (exercises)

### Facilitation materials

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

### Resources

Power point facilitation slides, Minimum Intervention Package (MIP) for SHCCs, Training Manual for SHCCs, Facilitator's Manual for training SHCC, Zanzibar Community Health Strategy.

### Hands on activities

In training some of the contents (see instructions under respective sections) be innovative by applyingmethods such as;

- Group work
- Introduce activities to be conducted in groups that will help to illustrate what trainees have understood from the lecture part
- Provide the exercises in such a way that they build on one another leading to development of action plan for supervision activity to be implemented soon after training.
- Include a plenary session after group work to allow a comparative analysis of the group wok and hence learning from each other

### 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. Ask participants to be in groups of 3 to 4 people depending on the attendance
- Follow a series of activities that will lead to development of their action plan for supportive supervision activity.

### Session Duration

This chapter with its consecutive Modules and Sessions should be covered in a time period of not morethan 3 hours.

### Facilitation site

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

# Module 1: Monitoring and Evaluation in Supervision

**Time: 2 hours**

### 1.26 Module Objectives

By the end of this module, the participants will be able to:

- Describe the supervision data management process
- Demonstrate ability to effectively manage community health services data
- Demonstrate ability to implement activities in each of the supervision components
- Describe different methods of monitoring CHVs work
- Demonstrate ability to utilize supervision monitoring tools including the digital platform. This will also ensure that:

    i. The supervisor is able to develop a schedule to discuss priority topics such as emerging diseases, upcoming health events, and maintenance of continuum of care, and deliver refresher training on these according to local guidance, in group supervision sessions.
    ii. The supervisor is able to identify with health facility in-charges and community health service providers the best way of having community health service providers support the health facility and vice versa.
    iii. The supervisor is able to ensure that community health service providers are kept up-to-date on new health facility activities, promotion as well as scheduled health days and fairs that theyare required to assist in.
    iv. Supervisors is able to follow up on community health service provider data collection, ensuring regular, complete collection at each household visit to ensure data is being collected regularly and at each household visit.

If the community-based data system uses a paper-based platform, the supervisors should be able to regularly follow up on the compilation of reports by CHVs on a monthly basis for submission to the office for data entry.

### 1.27 Session 1: Data Management and Analysis

Data management is a process of gathering, modeling, and transforming data with the goal of identifying performance gaps, highlighting useful information, suggesting conclusions, and supporting decision making. Through data collection, variances can be detected thus a reliable way of monitoring quality. A plus for data analysis include the fact that it is accurate, data can be analyzed using different indicators like by age,sex, uptake, resources, type of illness etc. At the same time, identifying problems is easy. Setback for dataanalysis is that it is time consuming and requires a person with data analysis skills.

Supervisors need to be able to identify any gaps emerging from the data collected by the communityhealth service providers, address the gaps for example by working through the gaps with the community health service providers or giving feedback. The supervisors need to be know whom they report to andhow the information they get is used to address any emerging gaps within the community and ensure that results are observed.

In many systems, data collection sheets are the only form a supervisor is required to submit following supervision, i.e. there is a string emphasis on data collection, however, once it is collected it does not getused appropriately. Mostly, it is a one-way data flow and the community health service provider mayexperience little benefit from the data collected.

Supervisors should know what threshold levels for performance indicators are considered good, needing improvement, or poor and able to assess and share the feedback in order to identify the weaknesses and develop an action plan for the community health service provider to improve in that area.

Supervisors need to promote quality of the community health service provider’s work over the quantity e.g. looking at how many people in the houses took up the services, what were the outcomes of the treatment etc. rather than how many houses were covered or number of treatments given. Supervisorsneeded to support the community health service providers by looking at issues that make them work smarter and with greater effect than issues that make them work harder.

# Module 2: Ethical considerations in supervision

Time: 2 Hours

## 1.28 Module Objectives

By the end of this module, the participants will be able to:

1) Define the code of ethics in supervision
2) Demonstrate capacity to support supervisees in resolving ethical issues

## 1.29 Session 1: Code of Ethics in Supervision

- Participants to share ethical dilemmas and how they resolved them.
- Facilitator to engage the group in discussions and offering feedback.

### 1.29.1 Code of ethics

Is a set of statements about appropriate and expected behaviour of members of a professional group and, as such, reflects its values. The purpose of code of ethics is to establish and maintain standards for supervisors in their supervision work with the community health workers, hereinafter referred to as supervisees, and to inform and protect supervisees seeking supervision.

### 1.29.2 Confidentiality

The content of supervision is maybe highly confidential. Supervisors must clarify their limitsof confidentiality.

### 1.29.3 Safety

All reasonable steps must be taken to ensure the safety of supervisors and the communityhealth service providers during their work together.

### 1.29.4 Effectiveness

All reasonable steps must be taken by supervisors to encourage optimum levels of practiceby trainee supervisors.

### 1.29.5 Contracts

The terms and conditions on which supervision is offered must be made clear to work within the limits ofthat competence. This includes having their own supervision work supervised.

### 1.29.6 Competence

Supervisors must take all reasonable steps to monitor and develop their own competence and to workwithin the limits of that competence. This includes having their own supervision work supervised.

### 1.29.7 Code of practice

This code of practice is intended to give more specific information and guidance regarding the implementation of the principles embodied in the code of ethics.

### 1.29.8 Issues of Responsibility

The primary purpose of supervision is to ensure that the supervisor is addressing the needs of theCHV:

- Supervisors are responsible for helping Supervisees reflect critically upon that work.
- Supervisors and Supervisees are both responsible for setting and maintaining clear boundaries between working relationships and friendships or other relationships.
- Supervisors must recognize the value and dignity of Supervisees and Clients as people, irrespective of origin, status, sex, sexual orientation, age or belief.
- Supervisors should not exploit Supervisees financially, sexually, emotionally or in any other way. Supervisors are responsible for establishing clear working agreements, which indicate the responsibility of supervisees for their own continued learning and self-monitoring.

Both are responsible for regularly reviewing the effectiveness of the Supervision arrangement, and changing it when appropriate.

### 1.30 Session 2: Sustained Competence of Supervisors

Supervisors should continually seek ways of increasing their own professional development, including, wherever possible, specific training in the development of supervision skills.

Supervisors are expected to make arrangements for their own consultancy and support to help them monitor and evaluate their supervision. This includes having supervision of their supervision work. Supervisors have a responsibility to monitor and maintain their own effectiveness. There may be a need to seek help and/or withdraw from the practice of Supervision, whether temporary or permanently.

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## Appendices

### Appendix 1: Minimum Intervention Package (MIP) for CHVs

| Component | Interventions | Services to be provided by CHV |
|---|---|---|
| **Minimum Intervention Package for RMNCAH** | | |
| 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<br>▪ Provide need tailored comprehensive FP education and counselingat household level<br>▪ Conducting sensitization meetings with males, females, adolescent girls and boys and village leaders<br>▪ Conduct systematic follow ups to clients at the household level<br>▪ Sensitize community to attend and participate outreach services asplanned<br>▪ Provide and facilitate referrals of clients to closest health facilities and ensure referrals are both effective and fulfilled<br>▪ Keep records related to FP services in the working area |
| | Reproductive Cancers | ▪ Provide education and counseling at household level about reproductive cancers<br>▪ Provide and facilitate referral for patients relaying indication ofpotential reproductive cancers |
| | Gender and Male involvement | ▪ Sensitize the community at household level and in meetings on the importance of male involvement in reproductive health componentssuch as comprehensive FP, early initiation of antenatal care and health facility delivery etc |
| | Elderly servicers into RMNCAH program | ▪ Provide r accurate information, advice and link to reproductive health services for the elderly<br>▪ Screening for indications for non-communicable diseases related tosexuality such as signs and symptoms of prostate cancers |
| Maternal Health | ANC services | ▪ Early identification of pregnancies at the community level<br>▪ Sensitize early booking and completion of ANC visits<br>▪ Sensitize community and promote facility delivery (skilled delivery)<br>▪ Educate about birth preparedness and its importance<br>▪ Educate community members about danger signs during pregnancy,delivery and post delivery<br>▪ Promote healthy behaviors during pregnancy including recommended types of exercises, nutrition during pregnancy andothers.<br>▪ Educate community about risks and dangers of use of traditionalherbs/medicines<br>▪ Educate community on the availability of comprehensive post-abortion care (cPAC) |
| | Referral | ▪ Early detection and referral for pregnancy complications<br>▪ Facilitate referrals of already manifested complications duringpregnancy, during delivery (in case of home delivery) and postdelivery<br>▪ Proactively follow up to ensure referrals are effective (referral |

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| | | effectiveness) and fulfilled (referral fulfillment) |
| | MNCH supplies, commodities and medicines | ▪ Sensitize compliance to use of recommended pregnancy and post-delivery supplies, commodities and medicines at community level<br>▪ Distribute some of the selected supplies, commodities and medicines to needy clients (such as refill of ferrous, condoms andother FP supplies) at community level<br>▪ Act as a resource for stock out detection to inform appropriatesupply replenishment follow ups |
| | PMTCT | ▪ Linkage of couples living with HIV/AIDS with PMTCT services at closest health facility<br>▪ Tracking loss to follow up clients<br>▪ Provide education and counseling of PMTCT for exposed babies |
| | Postnatal care | Educate and sensitize clients and community at large on<br>▪ PNC- for mother (up to 42 days) and baby<br>▪ Educate early recognition and referral of PP danger signs<br>▪ Special care for small babies (low birth weight and prematurebabies)<br>▪ Healthy behaviors (including exercises and hygiene)<br>▪ Postpartum family planning (PPFP)<br>▪ Immunizations<br>▪ Use of LLITNs<br>▪ 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 abut 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<br>▪ Identify and support maternal stress and threats to child development during pregnancy<br>▪ Sensitize and providing couching to promote<br>o early stimulation during pregnancy<br>o newborn stimulation<br>o bonding<br>o safety and empowerment<br>o positive relationships; male engagement and family support<br>o attachment<br>o responsive and interactive parenting<br>▪ Identify threats to child development (e.g. milestone check, depression, child protection, positive discipline, neglect, andviolence) |
| | Management of common childhood illnesses | ▪ Educate community on use of ORS and zinc for home management of diarrheal diseases<br>▪ Educate community on detection and management of fevers andreferral of severe forms of fevers |
| | Routine U5 | ▪ Educated, sensitize and promote vaccination/immunization activities |

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| | vaccination and Vitamin A supplementation | and services<br>▪ Participate and support mass vaccination/immunization and VitaminA supplementation campaigns<br>▪ Track and identify defaulters of vaccination/immunization amongwomen and children and link back to closest health facility<br>▪ Keep record of defaulters and sensitized households and link tofacility records and ultimately to CHIS |
| AdolescentHealth | Adolescent and Youth Friendly Sexual and Reproductive Health (AYFSRH) including HIV services | ▪ Educate youths on reproductive health and sexuality (bothindividually and in groups)<br>▪ Link and promote access to youth friendly sexual and reproductivehealth services in a close/nearby facility<br>▪ Distribute commodities such as condoms and FP commodities toneedy youths<br>▪ Counsel and refer youth for HIV testing services and care |
| | Comprehensive knowledge, skills and positive behaviours on sexuality and reproductive health | ▪ Educate, sensitize, encourage and promote best practices and good behaviours on sexuality |
| **Minimum intervention Package for Nutrition Health** | | |
| During pregnancy | Healthy nutrition duringpregnancy and lactation | Educate, sensitize and promote healthy nutrition during pregnancy and lactation based on the locally availablefood/dietary options |
| | | Supply and refill micronutrient supplementation whenever is recommended |
| Post delivery | Breastfeeding practicesand 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 ChildFeeding (IYCF) practices and nutrition | Conduct screening for early recognition and referral for malnutrition (including MUAC and<br>Conduct home growth monitoring and records |
| | | Provide education on minimal acceptable diet and promote optimal nutrition (including complementary feeding, fooddiversity) |
| | | 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, the elderly and chronically ill persons<br>▪ Promote consumption of balance diet for optimal |
| For the elderly | Nutrition/Diet for the elderly | |

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| For chronically ill people | Nutrition/diet for chronically ill person | nutrition (including complementary feeding, food diversity) |
| **Minimum Intervention Package for TB/HIV and AIDS** | | |
| 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 educatio n and counseli ng. | Provide health education (including Infection prevention and control) and counseling on TB in general among thepopulation in the catchment area |
| Community based HIV andAIDS 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 educatio n and counseli ng. | Provide health education and counseling on HIV and AIDS in general among the population in the catchmentarea |
| | Treatment support | Conduct home visit and provide care as per national guidelines including refill of AVs for critically ill patients |
| **Minimum intervention Package for Malaria Services** | | |
| 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 preventionstrategies including use of LLITNs<br>▪ Participate in distribution of LLITNs<br>▪ Track use of LLITNs at household level and in the community at large |
| Environmental management and outdoorinsecticide spray (Lavicidying) | | ▪ Educate, sensitize and promote clean environment up-keeping as a strategy to prevent spread of malaria<br>▪ Collaborate with SHCCs to sensitize and mobilize special days for environment cleaning<br>▪ Participate in outdoor insecticide spray campaigns |
| Social and behavioral change communication (SBCC) | | Implement social and behavioral change communication as per national guidelines and available malaria SBCC package. |

**Minimum Intervention Package for Environmntal Healh and WASH**

| Prevention of water and air pollution to improve quality of water | | ▪ Educate, sensitize and promote good up keeping ofwater sources and the environment as a whole |
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| Protection and maintenance of water sources to maintain water quantity | | ▪ Provide education on WASH and its individual components |
| Food safety, hygiene and need for legal enforcement of Food safety regulations. | | ▪ Promote behavioral change in relation to WAH best practices on use of clean and safe water, constructionand use of toilets and hand washing with soap |
| Hygiene practices to promote hand | | |
| washing with soap or other agents (after defecation, after disposal of child faeces, and prior to preparing, eating and handlingfood) | | ▪ Keep records of household with sources of clean and safe water<br>▪ Keep record of households with and using toilets<br>▪ Educate communities on safety and quality of food andfood relate products<br>Notify government authorities in case of spread of foods and food related products with suspicion on theirquality and safety. |
| **Minimum Intervention Package for Non commuinicable Diseases (NCD)** | | |
| Infancy | Exclusive breastfeeding for 6 months | Linked to iRMNCAH 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 |
| | | I collaboration with SHCCs, educate importance of and sensitize and promote physical activity in school andsociety |
| | | In collaboration with SHCCs and the responsible officers from the education sector, educate and promote safe andhealthy foods in schools |
| | | In collaboration with SHCC, educate the community on risks and dangers of using food products high insalt/sugar/unhealthy fats |
| Adulthood | Maternal nutrition | Linked to iRMNCAH programmatic areas |
| | Tobacco prevention and cessation programmes | Educate community on dangers and risks associated with use of tobacco (smoking, chewing etc) |
| | Availability and affordability offood | Educate and promote storage and food reserves to ensure availability for the family/household across thewhole year |
| | Physical activity | Educate, sensitize and promote adaptation of exercising behaviour to improve physical activity (home, workplacesetc) |
| | Effective prevention and careof risks and diseases | ▪ Educate on early signs and symptoms of NCDs<br>▪ Recommend and facilitate referral to closest facilityfor persons presenting clear risks, signs and symptoms of NCD. |
| **Minimum Intervention Package for Neglected Diseases** | | |
| Innovative and intensified disease management | | ▪ Provide education on NTDs and their importance<br>▪ Provide notification of notable increased incidence ofNTDs in the catchment area to the closest facility |
| Vector control and pesticide | | Linked to malaria and environmental health programs |

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| management | |
| Safe drinking-water, basic sanitation and<br>hygiene services, and education | Linked to environmental health and WASH program |
| **Monitoring and Evaluation Activities** | |
| 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<br>▪ 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<br>▪ Uploading and synchronizing of e-filled forms to the CHIS<br>▪ Prioritization of household visits among clients especially WRA with need tailored iRMNCAH messages<br>▪ Providing customized clients follow up<br>▪ Enabling referral effectiveness and referral fulfillment among clients |
| Special events surveillance | ▪ From time to time emerging needs for surveillance |
| Report writing, reporting and dissemination | ▪ Prepare both activity and progress reports on a monthly and quarterly basis as directed by supervisors<br>▪ Prepare summaries and provide feedback to supervisors, SHCCs, SCC and community at large |

| **Cross-cutting issues** | |
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| Leadership and governance | ▪ Attend community meetings and use as platform to provide health education on various topics for different programs<br>▪ Participate in SHCC's meetings and provide feedback ofactivities and service delivery<br>▪ Link Sheha, SHCCs, SCC and health facility in matters relatedto 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<br>including Covid -19 |
| GBV and VAC | ▪ Identify and report |
| Gender relations | ▪ Integrate gender across all lines of work |
| Coaching and counseling | ▪ Provide life skills orientation to those with special needs individually and in groups<br>▪ Provide clients with advice service on rehabilitation on aspecific disability or disease<br>▪ Organize support for those with special needs<br>▪ Link those affected with services<br>▪ Support those who need services. |

### Appendix 2: Minimum Intervention Package (MIP) for SHCC

**Service Package by interventions to be implemented by SHCCs**
The following range of services will be provided by SHCCs:

#### 1.30.1 Intervention 1: Governance of the community based health services at the community (Shehia) level

- Overseeing that all processes and mechanisms for implementing CBHP at Shehia level are adhered to;
- Ensuring that all involved stakeholders at Shehia level are held to account for the collective goalof delivering services in the Shehia;
- Observing compliance to ethics by all stakeholders of community based health activities when implementing their different roles;
- Manage risks and ensure compliance to management and administrative protocols;
- Representing the community in all health-related activities initiated by higher levels of the health system hierarchy.

#### 1.30.2 Intervention 2: Providing leadership of the community based health program at the Shehia level

- Sensitizing the community to take part in community health activities and facilitate identificationof health priorities and problems;
- Leading development of participatory community health plans in the Shehia;
- Leading implementation of all community based services delivered in the Shehia;
- Provide leadership of overall community based health services in the Shehia and all managerial roles;
- Providing administrative support and participating in recruitment of CHVs at their respective Shehias;
- Support, motivate and encourage CHV to carry out their functions and help resolving challenges facing CHVs on a timely manner;
- Lead efforts to ensure full involvement and participation of the CHVs in all relevant health related affairs in the community is prioritized;
- 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;
- Supervise risk communication and community engagement in the respective Shehia during disease outbreaks and disasters;
- Attend and facilitate conflict resolution processes and play an advisory role in all activities related to community based health services;
- Maintain communication with the community, CHVs, service providers, and Council health managers and administrators.

#### 1.30.3 Intervention 3: Coordination of community based health activities and services atthe Shehia level

- Ensuring representation of the community an community priorities along the defined structural and reporting lines as described in the ZCHS 92019-2025) linking both local government andhealth sector ministerial authorities, DPs and IPs the Assistant Director (Health) and the officeof District Commissioner;
- Mobilizing and managing resources, both financial and material resources as a strategy for sustainability of SHCC's activities;
- Networking and sustaining partnership with various stakeholders and platforms at various levels of the government administration and health system in the context and purview of the Shehia
- Linking between the community and (a)health facility staff (b) PHCU boards through quarterly meetings and or ad hoc meetings as the need arises;
- Maintaining good working and reporting relationship with SCC through quarterly reports and
- representation in SCC meetings;
- Maintaining "book-keeping" for all financial resources.

### 1.30.4 Intervention 4: Monitoring (and evaluation) of community based health activitiesand services at the Shehia level

- Conducting performance appraisal related to community health activities in the Shehia;
- Keeping records related to SHCC activities including received reports from CHVs;
- Conducting data collection from various sources related to SHCC role of monitoring and evaluation;
- Conducting simple data analyses and interpretation to enhance utilization of data and get informed on own performance and that of the community at large;
- Writing reports to be shared in a quarterly basis to the community through different avenuesand for submission to supervisors and higher levels;
- Take part and or demand feedback from any research work conducted by any organization/institution conducted in their area of jurisdiction;
- Linking the information collected through various methods from various sources to the Community Health Information System (CHIS) and finally to the Health Management Information System (HMIS);
- Communicating information about community health program at large and for specific interventions in particular to various stakeholders at various levels.