Mid-Term Review (MTR) of the Health Sector Strategic Plan V (HSSP V)

Community Engagement Report

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2. Acknowledgements

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3. List of Tables

Acronyms

CBHP	Community-Based Health Program
CHWs	Community Health Workers
CPP	Community Pharmaceutical Premises
DHIS 2	District Health Information Software 2
DHFF	Direct Health Facility Financing
HFGCs	Health Facility Governing Committees
HMIS	Health Management Information System
HPS	Health Promotion Section
HSSPV	Health Sector Strategic Plan V
LGAs	Local Government Authorities
MERLA	Monitoring, Evaluation, Research, Learning and Adaptation
NCDs	Non-Communicable Diseases
CHFT	National Community Health Task Force
UCS	Unified Community System
PHCs	Primary Health Care Committees
PO-RALG	President's Office-Regional Administration and Local Government.
RCCE	Risk Communication and Community Engagement
TDHS	Tanzania Demographic and Health Survey
ToTs	Training of Trainers
VHCs	Village Health Committees
WAJA	Wahudumu wa Afya Ngazi ya Jamii
WDCs	Ward Development Committees
WASH	Water, Sanitation and Hygiene

4. Executive Summary

Background: HSSP V emphasizes the critical role of communities in improving health outcomes by prioritizing community engagement in health promotion, disease prevention, and service delivery through Community Health Workers and local health committees. This summary outlines key evaluation questions that assess the progress of community engagement and participation in alignment with the targets of HSSP V.

Methods: This was a qualitative assessment utilizing a variety of data collection techniques, including a desk review of relevant policies, guidelines, and research documents, key in-depth interviews, focus group discussions, and direct observations. The qualitative assessment involved 37 Focus Group Discussions (FGDs) and 6 In-Depth Interviews (IDIs) with a variety of stakeholders, including members from Village Health Committees, Village Social Service Committees, Ward and Council Public Health Committees, and Health Facility Governing Committees (HFGCs). It also engaged community groups such as mothers of children under five, adult men, the elderly, adolescents, and people with disabilities. This diverse participation allowed for a comprehensive understanding of community health issues and governance.

The Integrated Community Health Worker Program, with its emphasis on local community involvement, inclusive governance, evidence-based approaches, and the use of digital platforms like UCS, plays a vital role in enhancing the responsiveness of Tanzania's local health systems. However, while progress has been made, there are significant challenges in achieving the set referral targets. Accelerated efforts, particularly in improving referral systems and expanding the use of the UCS, will be necessary to ensure that the health system becomes more responsive and accessible to all.

In conclusion, health literacy and awareness efforts have led to improvements in sanitation and hygiene practices, and various initiatives are contributing to behavior change at the community level. However, greater collaboration between the health and education sectors, as well as further integration of health topics into educational curricula, is necessary to build on these successes and ensure long-term improvements in community health outcomes. The roll out of Community health program amid Universal Health Insurance implementation is a great opportunity for promoting self-employment, for newly trained health professionals such as midwives, clinical officers, and doctors who have recently join the health labor market

Key Findings

Clarity on community engagement strategies defined in the HSSP V theory of change

The HSSP V emphasizes community empowerment as a critical component of improving health outcomes. The plan promotes "community-based health services" and prioritizes the engagement of volunteer Community Health Workers (CHWs) at Mtaa/village and hamlet levels to strengthen the link between health services and the community.

Progress on community engagement

Several strategies to enhance community engagement and empowerment have been developed and are being implemented to strengthen health systems at the grassroots level. Key initiatives include the active involvement of Community Health Workers (CHWs), the enhancement of local government committee roles, and the promotion of multi-sectorial collaboration to address social determinants of health. The implementation of the **2021 National Operational Guideline for Community-Based Health Services** has begun,

providing a framework for community-focused interventions. The introduction of the **Revised Primary Health Care Committee Guideline** in 2022 further supports these efforts by strengthening local governance structures to enhance community participation. In January 2024, Tanzania launched the **Implementation Guideline for the Integrated and Coordinated Community Health Workers Program**, marking a significant milestone in formalizing and integrating CHW roles. To support CHW implementation, MoH developed a revised **National Operational Guideline for Community Based Health Program in 2024**. In addition, the**National Community Engagement Guideline for Primary Health**, initiated in 2024 and nearing completion, aims to standardize community engagement in Tanzania by establishing context-specific methods, utilizing government structures, improving coordination among stakeholders, and enhancing capacity for effective health intervention.

In line with HSSP V's focus on enhancing community awareness and health literacy, Tanzania launched two **"Mtu ni Afya" awareness campaigns** in 2023 and 2024, emphasizing prevention, community engagement, and environmental hygiene with the theme "My Health, My Responsibility." In response to the Marburg outbreak and Mpox threat, Tanzania developed and implemented a Contingency Plan for Monkeypox Disease in 2024. This plan prioritized Risk Communication and Community Engagement (RCCE), involving Community Health Workers (CHWs) and local leaders to raise awareness, educate the public, and strengthen community preparedness against the disease. These RCCE efforts while improving public understanding of the virus and ensuring a coordinated response at the community level, also contributed to the improving water, sanitation and hygiene indicators.

While progress has been made in community engagement strategies, resource constraints and community misconceptions continue to limit the effectiveness of these efforts. Additionally, HSSP V lacks specific indicators to monitor community engagement's impact on health outcomes. This may be partially attributed to the limited involvement of local government representatives in the strategic decision-making process during HSSP V development.

Community health workers integration into the health and wellbeing system, and impact on theirinvolvement on the overall effectiveness of health services

The Implementation Guideline for the Integrated Community Health Workers Program, introduced in January 2024, initially set a target to train 28,000 CHWs across 10 priority regions during the 2023/2024 period. In September 2024, the training began with the inclusion of an additional region, but only **11,515** CHWs were enrolled, resulting in a shortfall of **16,485** trainees. In each of the 11 regions, two districts have been selected to train two CHWs (one male and one female) from each hamlet/Mtaa. In addition, at the village/Mtaa level, there is CHW Peer Leader who is the welfare focal person for the fellow CHWs. Aligned with HSSP V

priorities, the training program emphasizes a comprehensive package of community-based health care, social welfare, and nutrition services delivered through ten structured modules.

To strengthen community monitoring systems and enhance continuity of care as outlined in **HSSP V**, Tanzania introduced the **Unified Community System (UCS)** in 2023. The Unified Community System (UCS) is a digital platform designed to integrate community-based health services, supporting health promotion, early screening, and efficient referral processes to health facilities. It facilitates real-time monitoring of health interventions and indicators, enhancing efficiency, accountability, and the overall effectiveness of community health systems. UCS is currently utilized in all 26 regions in Tanzania and provides a platform of various community level indicator visibility. To date, the Unified Community System (UCS) has facilitated over 10,000 referrals from community health actors including Community Pharmaceutical Premises (CPP) to health facilities. As envisioned in HSSP V, the Unified Community System (UCS) exemplifies a successful public-private partnership (PPP) at the primary health care level, by integrating private sector support to enhance service provision.

Strengthening Local Government Structures to Ensure Community Accountability in Health Programs

HSSP V commits to strengthening community governance and enhancing the capacity of committees to promote community participation in health decision-making. Building on the 2022 Revised Primary Health Care Committee Guideline, which highlights the roles of Ward and Village PHC Committees in inclusive health governance, development of materials for training of trainers is underway necessary to capacitate PHC on their roles. Furthermore, the 2023 AHSP report and HSSP V data collection findings underscores that decentralizing management responsibilities to health facilities and communities has significantly improved community engagement in health sector planning, budgeting, and service delivery. Key challenges include the limited recognition of CHWs within local government committees, which restricts their involvement in critical decision-making processes. Furthermore, the capacity of local government structures, such as Health Facility Governing Committees (HFGCs), remains insufficient for effectively executing their mandated responsibilities, undermining the overall governance and accountability in health service delivery.

The new integrated and coordinated CHW and PHC Committee guidelines, currently being implemented, have elevated the role of Community Health Workers (CHWs) by formally recognizing them as key members of PHC committees, reporting to village Government and working closely with social welfare office

Implementation Gaps and Recommendations

A significant gap in the implementation of community engagement strategies is the shortfall in Community Health Worker (CHW) training, with first-year enrollments falling to less than half of the projected target. This raises

concerns about meeting the long-term goal of training 109,971 CHWs by 2026/2027, which may affect the program's scalability and overall effectiveness. To address this, through the formulated National Community Health Task Force, it is crucial to prioritize resources mobilization and support for CHW training plans, ensuring comprehensive coverage and alignment with the objectives set forth in HSSP V. While community engagement has shown progress, it is important to ensure adequate capacity building for Health Facility Governing Committees (HFGCs) regarding their roles and responsibilities. Additionally, the inclusion of process indicators in HSSP V, such as monitoring the functionality of HFGCs, service provided by CHWs, gender inclusion, and the use of community scorecards, is necessary to effectively track and evaluate community engagement efforts. Increasing funding for health promotion and addressing social determinants of health is crucial to combating community misconceptions and fostering improved health outcomes. While implementation of the Integrated and coordinated CHW program is on-going, aligning with Unified Community System (UCS) is crucial to ensure enhancing the efficiency and effectiveness of community health services.

5. Introduction/Context

The **Health Sector Strategic Plan V (HSSP V)** underscores the vital role of community engagement in improving health outcomes by integrating **Community Health Workers (CHWs)** and strengthening local health governance through **Health Facility Governing Committees (HFGCs)**. This approach is rooted in the **theory of change**, which posits that empowering communities to participate in health promotion, disease prevention, and service delivery is essential to achieving sustainable health improvements. By formalizing community health structures, providing comprehensive CHW training, and fostering multi-sectorial collaboration, HSSP V aims to create resilient grassroots health systems capable of addressing both routine and emergent health needs.

Though strategies were embedded in the definition of the strategic outcomes on community health systems and health education, outcomes and outputs were not defined. The HSSP V did not include **specific indicators** to measure the impact of community engagement on health outcomes. All the same, there is no indication on regional focus for the defined interventions, and the strategies to target the most vulnerable group by community interventions are not specified. This gap is partly attributed to the **limited involvement of local government representatives** in the plan's development and the **under-resourced capacity** of HFGCs, which impairs effective decision-making and governance. Evaluation findings highlight that local representatives participated only during data collection, rather than as active contributors in strategy development, undermining comprehensive community engagement tracking.

While community engagement is recognized as a cornerstone of sustainable health outcomes, the absence of clear, measurable indicators makes it difficult to assess the extent to which communities are involved in decision- making, planning, and implementation of health programs. This gap not only limits the evaluation of progress but also reduces accountability and the ability to identify areas that require improvement. Without robust indicators, it becomes challenging to monitor the impact of community-based initiatives, such as the role of Health Facility Governing Committees (HFGCs) or the integration of Community Health Workers (CHWs) into local health systems.

Therefore, this evaluation will align the monitoring of progress with the planned objectives of the main policy documents and operational frameworks referred to in the HSSP V.

6. Methodology

This assessment employed qualitative methods, including desk reviews of policies and guidelines, in-depth interviews, focus group discussions (FGDs), and direct observations, to evaluate community engagement within the HSSP-V framework. Conducted across eight regions—Kigoma, Arusha, Rukwa, Dar es Salaam, Geita, Mtwara, Dodoma, and Njombe—selection of the study regions targeted RMNCAH indicators, particularly maternal and neonatal mortality rates. Regions were selected based on performance metrics, with a mix of rural and urban districts categorized as high or low performers.

A total of 37 FGDs and 6 in-depth interviews involved stakeholders such as HSSP V developers, MoH and PO-RALG respective officers, Local Government Authorities, Community Health Workers (CHWs), and community groups, including mothers of children under five, adolescents, the elderly, and people with disabilities. Committees such as Village Health and Ward PHC Committees were also engaged. This comprehensive approach provided insights into community health systems' governance and service delivery effectiveness.

7. 3. Results

3.1 Community Health Workers (CHWs) empowered to deliver high-impact, integrated, and people-centered health and social welfare services at the Mtaa and hamlet levels

1.1.1. Progress towards the targets

Table 1: Progress towards CHW training and activities

Targets 2026/ Commitment	Baseline	Current achievement (2024)	Progress status
Formalize CHW roles and integrate into the health system	No formalized system	CHW program launched; partial integration achieved	Ongoing
82,648 CHWs trained by 2026	28,000	11,515/28,000	Intervention is at risk (41% of the milestone 2024 achieved).
10 Priority regions covered under CHW program by 2023/2014	10	11 regions	Exceeded target
79 districts conducting training of CHWs	79	22/79	Intervention is at risk (28% of the milestone 2024 achieved)
CHWs engaged in community health activities	Undefined	20,487	On track

1.1.2. Interventions implemented:

Key interventions to strengthen the community health program included the rollout of the **2021 National Operational Guideline for Community-Based Health Services**. The guidelines define procedures for CHWs nomination, training modality, incentive packages and services that CHWs will provide based on national health priorities. The guidelines were updated in 2024 to align with the G**uidelines for Integrated and coordinated Community Health workers Program** officially launched on 31st January 2024 to enhance CHW roles in delivering integrated health and social welfare services. These efforts aim to streamline processes, improve coordination, and ensure effective delivery of health and social welfare services at the community level.

Standardized tools have been developed to guide communities **in identifying, nominating, selecting, and utilizing Community Health Workers (CHWs)** at the hamlet and Mtaa levels, ensuring effective integration into the health system. **Working tools for CHWs have** also been developed to enhance their skills and ensure uniformity in service provision. Clear roles and responsibilities, along with technical and administrative reporting lines for CHWs. These tools are facilitating establishment of an **integrated**

platforms to disseminate accurate information and address diverse needs of community members, including adolescent boys or girls, people living with HIV and other communicable diseases, people living with disabilities of chronic diseases, and the elderly.

In line with HSSP V vision of having trained CHWs operate at Mtaa and hamlet levels, a standardized **curriculum for Integrated CHW training was developed in 2023,** encompassing 10 modules aligned with the National Essential Health Intervention Package. Training modules are covering health promotion; reproductive, maternal, child and adolescent health; communicable and non-communicable disease; malnutrition; social welfare practice; emerging and re-emerging diseases and conditions of public health concerns; and environmental health and sanitation. The CHW training package favors CHW working with peer groups toaddress specific needs for adolescents, people living with HIV, disabilities and chronic diseases.

In September 2024, training of CHWs commenced. 10 priority regions for the first phase of CHW training are Kagera, Geita, Mbeya, Njombe, Kigoma, Tabora, Tanga, Lindi, Songwe, and Pwani. One additional region (Ruvuma) was added in September 2024 making a total of 11 regions covered.

MoH had developed resource **mobilization and sustainability plans for CHWs**. As per the 2024 National Operational Guideline for Community Based Health Program**,** Community-Based Health Program (CBHP) in Tanzania will be funded by the Central Government, Local Government Authorities (LGAs), development partners, and villages.

The **National Community Health Task force (CHFT)** was initiated in 2024. To provide strategic oversight, coordination, and resource mobilization.

To ensure CHWs are motivated and retained, the Ministry of Health (MoH) established **performance-based incentive**s. CHWs now receive a standardized stipend of 100,000 TZS monthly. These payments are facilitated through the Direct Health Facility Financing (DHFF) approach, ensuring transparency and efficiency.

Unplanned Interventions Contributing to Progress

The **Risk Communication and Community Engagement (RCCE)** initiatives, originally unplanned in the HSSP V, have significantly contributed to community health improvements. These efforts were implemented during the 2023 Marburg Virus Disease outbreak and the 2024 Mpox threat, focusing on hygiene promotion, disease surveillance, and public awareness campaigns addressing misconceptions. Key highlights include:

- **Strengthening disease surveillance**, WASH practices and raise public awareness to curb the outbreak's spread.
- **Utilizing MoH's toll-free call center** service to assist with health-related inquiries and emergencies.

- **Conducting training Initiatives**.
- **Distributing educational Materials**.
- **Organizing media Campaigns**.

Table 2: Summary of Community Engagement Efforts

Outbreak Response	Activity	Details	Region
Marburg 2023	Training of CHWs	734 CHWs trained	Kagera
	Training of Local Leaders	61 leaders trained	Kagera
	Disease Surveillance	CHWs and leaders supported surveillance	Kagera
	CHW and Coordinator Orientation	146 coordinators and CHWs trained across 13 regions	13 regions
Mpox 2024	Educational Material Distribution	150,900 brochures distributed in public places 2,400 distributed in religious institutions	13 regions
	Media Campaigns	75 sessions, social media, and newspapers utilized	N/A

1.1.3. Challenges and unfinished agenda

Resource and logistical barriers to train the remaining 71,133 CHWs by 2026 and increase geographic distribution: Only 22 over 79 districts are covered, far below expectations. The funding of Community Health Worker (CHW) program, is the **not sustainable**. While initial investments may cover program startup costs, including training, tools, and infrastructure, consistent financial resources are required to maintain operations, support CHW remuneration, and provide continuous professional development. While a total of $ **359,789,316.78** is required to fund implementation of CHW program over five years (2023-2028), only **$ 12,864,992 and Euro 500,000** is available from Global Fund ($ 5,480,377), Susan Thompson Buffet Foundation –Phase I ($ 7,000,000), Irish Aid (Euro 500,000) and Health Basked Fund ($ 384,615,385).The reliance on fragmented or short-term donor funding often creates uncertainties, making it difficult to ensure long-term program sustainability. Additionally, competing priorities within government budgets and local authorities may limit the allocation of adequate resources to the program.

Action Plan

- Through CHFT, accelerate CHW recruitment, address funding gaps through government and partner resources, and strengthen partnerships to meet training goals and improve community health systems.
- Streamline alignment between Implementing Partners (IPs) and district health teams for CHW payments through Direct Health Facility Financing (DHFF) to ensure timely, transparent, and efficient fund disbursement, enhancing coordination, communication, and trust among stakeholders.

Level of Priority

- Within six months.

3.2: An integrated community health program enhancing the responsiveness of local health systems

1.1.4. Progress

Table 3: Responsive Local Health System through Community Referrals

Targets 2025/2026-Commitment	Baseline 2020	Current achievement	Progress status
80% ofclients with successful referral from CPP to health facility[1]	4200/6447	63.6%	In danger
60% ofclients benefiting successful referral from community to health facility[2]	27.8% (6447/ 23166)	25.5% (17281 / 67631)	In danger. The progress is too slow.

The Integrated and Coordinated Community Health Worker (CHW) Program is central to improving health services at the community level in Tanzania. The program ensures that CHWs are well-integrated into local contexts and gain the trust of the people they serve. This approach fosters both ownership and accountability, making healthcare more accessible, responsive, and tailored to local needs.

The **inclusion of local governance structures** has been pivotal to ensuring that the CHW program remains inclusive and responsive to all community members, regardless of their socioeconomic status. This ensures that every individual has a voice in health service planning and delivery. To reinforce this, the **Revised Primary Health Care Committee Guideline**, introduced in 2022, advocates for a multi-sectoral approach to strengthening local governance mechanisms. This inclusive governance structure not only makes

[1] Afya- Tek dashboard in transition into UCS

[2] Routine MoH Data/UCS 2023

healthcare more accessible but ensures that the services provided are equitable and tailored to meet the diverse needs of the population.

Progress has been made towards **improving monitoring systems** and the **use of data for effective priority settings at the community level**. The MoH has also developed the **Monitoring, Evaluation, Research, Learning, and Adaptation (MERLA)** system, which utilizes a participatory research approach. This system ensures bottom-up reporting with top-down feedback to support community health planning and decision-making. As outlined in the 2024 National Operational Guideline for Community-Based Health Services, the MERLA framework integrates community-level data into systems like the Health Management Information System (HMIS), Unified Reporting System, and DHIS-2. Both paper-based and digital tools are used to ensure effective data collection, analysis, and adaptation at all levels. Through the MERLA framework, the services provided by CHWs—including preventive, promotional, curative, rehabilitative, and palliative care—are tracked to ensure continuous performance improvement.

In 2023, the Ministry of Health (MoH), PORALG, and implementing partners initiated the development of the **Unified Community System (UCS)**, a robust digital platform designed to enhance healthcare delivery. UCS integrates three mobile applications—WAJA, Community Pharmaceutical Premises (CPP), and KITUONI App—each focusing on different aspects of health services. WAJA and CPP support community-based interventions, while KITUONI focuses on facility-level interventions. The system also features a dashboard that visualizes data collected through these applications and allows for real-time monitoring.

UCS aligns with the MoH's vision of creating a unified digital health platform at the community level, as laid out in the National Digital Health Strategy (2019-2024) and the National Primary Health Care Rolling Digital Transformation Roadmap (2023-2027). This integration ensures that local health systems are not only responsive but also technologically equipped to meet evolving health needs. Implemented in 182 district councils across Tanzania, **UCS draws from successful community health programs** addressing key areas such as HIV, maternal, child, and adolescent health, as well as support for vulnerable populations. It serves as a model of public-private collaboration, improving service delivery by ensuring continuity of care and real-time data usage.

Through UCS, digital referrals have been initiated from the community level to health facilities, improving timely access to care (mailto:https://digitalsquare.org/blog/2023/12/18/ik44z5fs1tlmqmdgqyzm2f4at4r73k?subject=https://digitalsquare.org/blog/2023/12/18/ik44z5fs1tlmqmdgqyzm2f4at4r73k)

1.1.5. Challenges and unfinished agenda

Despite notable progress under the Health Sector Strategic Plan V (HSSP V), several key areas remain unfinished in the implementation of the Community Health Workers (CHW) program in Tanzania. A significant gap persists in the **recruitment and training of the targeted number of CHWs**. While interventions have equipped some CHWs with skills in preventive, promotion, and curative care, the shortfall in meeting planned recruitment targets hampers the program's reach and effectiveness.

Moreover, while progress has been made in integrating digital platforms like the Unified Community System (UCS), further alignment with broader health information systems and expanded incorporation of additional disease conditions, such as non-communicable diseases (NCDs) and tuberculosis (TB), is required. **Governance structures** for CHW reporting and oversight including **PHC committees** also need strengthening to ensure accountability and effective service delivery.

A significant challenge is the misalignment between the **Integrated and Coordinated CHW Program** and the **Unified Community System (UCS)**. While the UCS leverages existing Community Health Workers (CHWs) for service delivery, it predominantly engages CHWs who were trained before the launch of the comprehensive training curriculum under the Integrated CHW Program. This disconnect creates inconsistencies in service quality and delivery, as the newer training emphasizes a holistic approach, equipping CHWs with skills in preventive and curative care that are absent in the older cohort of CHWs. The lack of a unified approach undermines the efficiency and effectiveness of the UCS, limiting its ability to integrate fully with the broader goals of the Health Sector Strategic Plan V (HSSP V). Bridging this gap requires harmonizing training and operational standards, ensuring that all CHWs, are equipped to deliver consistent and integrated health services.

Action Plan

1. Integrate the Unified Community System (UCS) platform with the Community Health Worker (CHW) program to streamline data management, improve coordination, and ensure timely support, training, and resources for CHWs, enhancing efficiency and tracking health indicators.

3.3: Communities are improving their health behavior

1.1.6. Progress

Table 4: Community Behavioral Indicators

Targets 2025/2026- Commitment	Baseline 2020	Current achievement	Progress status
Households with improved toilets	72.9% (2022)	77.5% (2023)	In progress
Households with any form of toilets	98.5% (2022)	98.6% (2023).	On track
Households with hand washing points	48.1% in 2022	54.5% in 2023	In progress

Access to safely managed sanitation[3]	31.8% in 2022	34.8%	In progress

Health education efforts have contributed to significant improvements in water, sanitation, and hygiene practices among households, as reflected in the 2023 Annual Health Sector Performance (AHSP) report.

1.1.7. Interventions

The Ministry of Health, through its **Health Promotion Section**, continues to leverage various communication channels to educate the public on critical issues, including social determinants of health, environmental hazards, and preventative measures. Specifically, a **health Promotion and Prevention at Workplace Unit** was established in 2023, aiming to improve employee well-being and foster healthier work environments. Guidelines for this initiative are in progress, with plans to expand its reach to various sectors in the coming years.

To increase community awareness, the Ministry of Health has **developed and distributed educational materials**, reaching large audiences via multiple platforms. In 2023, a total of 12,964 educational sessions were broadcasted on television and radio. Additionally, the MoH used social media platforms such as Instagram, Facebook, X (formerly Twitter), TikTok, and WhatsApp to share educational posts. One notable initiative is the "*Kinga magazine*", launched in 2023, which is published quarterly. This magazine aims to educate, promote, and engage the community in preventive health initiatives, documenting key interventions and activities within the health promotion sector.

Efforts to implement **health promotion campaigns** have been crucial in encouraging healthier behaviors and practices. A major initiative in 2023 and 2024 was the launch of the "*Mtuni Afya*" campaign (https://mtuniafya.co.tz/). The first phase, initiated by President Samia Suluhu Hassan, focused on **raising awareness about health and hygiene,** particularly around sanitation and environmental health. The second phase, launched by Vice President Philip Isdor Mpango in May 2024, emphasized **personal health responsibility** with the theme "*My Health, My Responsibility*." This phase focused on key issues such as proper sanitation, hand washing with soap, safe waste disposal, and disease prevention. These campaigns aim to empower individuals and communities to take greater responsibility for their health and environment.

1.1.8. Challenges and unfinished agenda

Few initiatives to strengthen the partnership between the health and education sector were reported. Visits of health workers from nearby health facilities or health programs in schools and colleges to conduct screening

[3] 2023 AHSP Profile

of various diseases among school children are limited. Screening for vision and hearing particularly are not conducted as expected.

Additionally, school health guidelines, which were anticipated to be developed, are still pending. Topics related to sanitation, nutrition, child safety, health screening, and vaccinations have yet been fully integrated into school curricula as planned. Moreover, the education sector wasn't involved in defining the profile and designing the curriculum for community health workers training. This weak partnership between the health and education sectors has led to the underutilization of opportunities for self-employment, particularly for newly trained health professionals such as midwives, clinical officers, and doctors who have recently joined the health labor market.

In the context of universal health coverage and huge human resource for health gap in the public sector, unemployed qualified health workers could play a critical role in expanding primary healthcare services in villages without dispensaries, and providing supervision for village health volunteers.

While community education and promotion efforts have led to some improvements in environmental health outcomes, the HSSP V assessment highlights a significant **gap in behavioral risk factors knowledge**. This gap is further exacerbated by low awareness of critical health issues, which hampers community engagement in behavior change initiatives and efforts to strengthen the health system. Many communities lack a comprehensive understanding of the connection between behavior and health outcomes, resulting in persistent misconceptions as narrated below

> *"Some seasons are not good and not necessarily that people are not practicing healthy behaviors, it is just a passing wind "upepo umepita" coming with diseases like cholera and diarrhea"* (FGD Women, Mtwara)

This disconnect underscores the urgent need for targeted health promotion efforts that address social determinants of health, such as education, living conditions, and access to clean water and sanitation.

Qualitative assessment identified several factors limiting community engagement in behavior change and health system strengthening initiatives. Key among these are the lack of community ownership of health responsibilities and insufficient representation of community perspectives in health decision-making committees, which undermine trust and active participation. Despite their close relationship with the community, CHWs reported to often excluded from key committees, such as the Ward Development Committee and Health Facility Governance Committees. This exclusion not only limits the influence of community-oriented insights in decision-making but also highlights a lack of recognition of CHWs' roles by some committee members.

In addition, community members perceive health as primarily the government's responsibility, which diminishes their active participation in behavior change initiatives as narrated here by the CHW

""*Limited interaction between community leaders and the people makes things worse. Health issues are often just touched on briefly during street or village meetings or in the occasional outreach programs while on the other hand people believed that the Government should do everything for them, hindering their active participation in health related initiatives.*" (Community Health Worker, Njombe)

Limited interaction between leaders and community members, coupled with the prevailing perception that health responsibilities lie solely with the government, hinders meaningful participation in health-related efforts. Addressing these challenges requires fostering community ownership of health issues, improving communication between leaders and the community, and integrating health discussions more deeply into local forums. Strengthening these aspects can drive more inclusive and effective health interventions, ultimately improving health outcomes at the grassroots level.

Action Plan

- Increase funding for community health promotion, focusing on social determinants of health like education, nutrition, clean water, sanitation, and housing, to address the root causes of poor health and promote long-term well-being

  Level of Priority

- Within one year

3.4 Community representatives are fully involved in selecting priority intervention and strengthening accountability at all levels of the health system

1.1.9. Progress

Table 5: Community Accountability Indicators

Targets 2026/ Commitment	Baseline	Current achievement	Progress status
% of Administrative and technical support of CHWs by Local Government	0	0	Unknown
83% of the HFGCs to be fully functional by 2024 as per 2023 AHSP	0	Unknown	Unknown
X LGAs and community health governance structures are capacitated in resource tracking, planning and monitoring	0	0	Unknown
At least 3 quarterly meetings involving SWAP members are organized in 80% of Districts	0	Unknown	Unknown

The governance and operational structures for Community Health Workers (CHWs) have been streamlined under the **2024 Implementation Guideline for Integrated and Coordinated CHW Program**. CHWs now report through a structured hierarchy from the village level to the national level. This ensures better coordination, accountability, and integration of community health services, aligning with the Health Sector Strategic Plan V (HSSP V).

Training and **capacity-building initiatives** have been implemented **to strengthen Local Government Authorities (LGAs)' ability** to provide administrative and technical support to CHWs. The **Primary Healthcare Committee Guideline**, revised in December 2022, reinforces the role of Village Health Committees (VHCs), Ward Development Committees (WDCs), and Health Facility Governing Committees (HFGCs) as key structures for managing and delivering primary healthcare. The government has prioritized **participatory needs assessments** to align health programs with community priorities. These assessments enable communities to actively contribute to the design of services that address their specific health needs.

To enhance grassroots participation, the **2021 and 2024 Community-Based Health Services Guidelines** have included CHW Peer Leaders as formal members of HFGCs, with CHWs serving as co-opted members. This participatory approach ensures that community members have a voice in planning, budgeting, and decision-making for health services. In consequence, decentralizing management

responsibilities to health facilities and communities has significantly improved engagement in health planning and budgeting as reported in the 2023 Annual Health Sector Performance (AHSP) report. This collaborative approach has empowered health facilities to set priorities and manage resources effectively, strengthening local governance and accountability.

Below are some highlights of reported contribution of communities in improving the availability, utilization and access to health services

- In the Arusha region, community members actively contributed to improving health service availability by dedicating time, labor, and resources to construction projects. They engaged in activities like clearing sites, transporting materials, and preparing environments for building health centers. This collective effort showcased their commitment to enhancing healthcare infrastructure and fostered a sense of ownership and responsibility for local health services
- In the Mtwara region, community health workers (CHWs) were reported to play a vital role in improving healthcare access and outcomes. They support key activities such as nutrition, environmental sanitation, and disease identification, bridging the gap between formal healthcare facilities and the local population. CHWs were said to deliver essential services, including maternal and child health care, basic disease prevention, and health education, particularly in underserved areas. Through outreach efforts, they enhance accessibility to healthcare for communities located far from health facilities, ensuring that basic services reach even the most remote populations.
- In Kurasini (Dar es Salaam region) the community demonstrated its role in improving the availability, utilization, and access to health services by actively advocating for the construction of a dispensary. Responding to their request, the government established the facility, addressing a critical local need. Similarly, in Yombo (also in Dar es Salaam region), the community's persistent demand and recognition of the growing requirements led to the upgrade of a dispensary to a full health facility, further enhancing healthcare access. However, there are instances where community requests exceed available resources, limiting the government's ability to meet certain demands. This highlights the dynamic interaction between communities and authorities in striving for improved healthcare services.

1.1.10. Challenges and unfinished Agenda

Qualitative assessment identified several community-related factors hindering the achievement of outcome and impact indicators related to community engagement and accountability, these include;

1. **Poor Coordination and Information Sharing**: Weak links between health system levels, local government authorities, and communities impede information flow. Majority of councilors, ward leaders, and CHWs were unaware of the Health Sector Strategic Plan, limiting its dissemination.

> "*That's exactly the situation I find myself in; how can I prioritize issues when I am unaware of the government's strategies for this year or even for the next five years? If I, as a local government authority, am not informed about HSSP V, how can I effectively communicate this to my community? As someone responsible for implementation, I should be fully informed, even about whether the chairperson has received a letter and shared it with the public*" (FGD Village Council)

2. **Low Community Awareness**: Limited understanding of health issues and unclear pathways for raising concerns hinder effective health interventions at the village and street levels, this is well narrated here

> "*Sometimes, we need a platform to raise our concerns about health services, but there is no clear guidance on where to direct them. While we may discuss issues with village officers, little action is taken. Village meetings are rare, and when they do occur, health matters are often discussed only briefly and with minimal focus"* (FGD, Adult men, Dodoma)

3. **Limited community representation in decision making**: Insufficient community involvement in health decision-making creates a disconnect between policies and local priorities, reducing the effectiveness of interventions. The qualitative assessment revealed that Community Health Workers (CHWs) are often inactive members and not engaged in Ward Development Committee (WDC) meetings. For instance, in Mtwara region, some councilors reported being unaware of CHWs, while in Dar es Salaam region, despite councilors working closely with CHWs on community services, they still do not participate in WDC meetings.
4. **Challenges Faced by CHWs**: Community health workers, essential for bridging health systems and communities, struggle with low recognition, inadequate collaboration with local leaders, and insufficient resources to support their work.

Integrating participatory approaches in health service planning is crucial for ensuring inclusive and equitable healthcare. Involving communities, local leaders, and stakeholders in decision-making empowers individuals, fosters ownership, and helps tailor services to local needs. This approach improves accessibility, relevance, and cultural appropriateness of health interventions, especially for marginalized groups.

A key unfinished agenda is the capacity building of Health Facility Governing Committees (HFGCs). The training provided to HFGC members has been inadequate, limiting their ability to effectively support and drive community engagement in health services. The HSSP V assessment highlights a critical gap in capacity building for these committees, which are key structures for fostering community participation in health service planning and delivery. Many HFGC members lack the necessary skills and knowledge to fulfill their roles, such as understanding their governance responsibilities, effectively mobilizing community resources, and facilitating constructive dialogue between health facilities and the communities they serve. This gap undermines the committee's ability to advocate for community needs, monitor health facility performance, and ensure accountability.

While efforts to strengthen accountability through Health Facility Governing Committees (HFGCs) are progressing, monitoring key indicators remains a challenge under the Health Sector Strategic Plan V (HSSP V). This indicates that while implementation is underway, there is limited tracking of achievements to measure progress effectively.

Action Point

- Strengthen community engagement by providing structured training for Health Facility Governing Committees (HFGCs) in health governance, leadership, financial management, and community mobilization to empower communities and enhance their involvement in health decision-making and advocacy.

- Enhance Monitoring, Evaluation, and Learning (MERLA) by integrating community engagement indicators, including CHW performance and HFGC functionality into the HSSP V monitoring frameworks to track progress, assess service effectiveness, and measure the impact on health outcome

Level of priority

- Within six months

8. 4. Major Changes in Planned Interventions

Unanticipated health crises, including the **COVID-19 pandemic**, the **Marburg outbreak**, and the emerging **Mpox threat**, required swift adjustments and the development of contingency plans focusing on **Risk Communication and Community Engagement (RCCE)**

Another critical intervention, the **Unified Community System (UCS)** launched in 2023, leverages digital technology to monitor health services, enabling real-time data collection and facilitating over **10,000 community referrals**, enhancing the efficiency and effectiveness of community health programs

These unplanned interventions underscored the pivotal role of CHWs and community leaders in public health emergency responses, prompting HSSP V to reprioritize resources and strategies to enhance public health preparedness. In addition, the crises contributed to improving **Water, Sanitation, and Hygiene (WASH)** indicators by accelerating investments in hygiene infrastructure, promoting widespread hand washing campaigns, and strengthening community awareness of infection prevention practices, thereby enhancing the resilience of communities to future health emergencies.

9. Interventions carried forward

- **Training of Community Health Workers (CHWs):**

  Continued efforts to train CHWs across 22 districts in 11 regions, focusing on building capacity for delivering preventive, promotion, and curative health services at the community level.

- **Mobilizing Resources for the Community Health Worker Program:**

  Efforts to solicit funding to support CHW program through the established National Community Health Task Force

- **Development of Training Materials for Trainers of Trainers (ToTs):**

  Ongoing creation and dissemination of training materials to capacitate PHC committees, ensuring enhanced governance, community engagement, and service delivery.

- **Strengthening CHW Payment Mechanisms:**

  Aligning implementing partners and district health teams to streamline CHW payment through Direct Health Facility Financing (DHFF)

10. 6. Discussion

Quality of interventions

Effectiveness and efficiency

The new Integrated and Coordinated Community Health Worker (CHW) Program in Tanzania enhances efficiency by streamlining healthcare delivery at the community level through clear structures and roles. By leveraging the existing local governance systems, such as village and Mtaa governments, the program ensures that CHWs are well-integrated into the community and that their activities are coordinated with district health teams and other local health service providers. This reduces duplication of efforts, optimizes resource allocation, and ensures that health services are provided where they are most needed. The use of tools for data collection and reporting, integrated with existing health management systems, further enhances efficiency by allowing monitoring, feedback, and evidence-based decision-making. The program's comprehensive approach also reduces the burden on health facilities by addressing preventive and basic curative needs at the grassroots level, allowing healthcare resources to be utilized more effectively across the system.

The National Task Force has been established to provide strategic oversight, coordination, and to develop a resource mobilization and sustainability plan for the CHW program, ensuring pooled funding from various sources, integration into local health plans, and long-term community ownership of health initiatives.

On the other hand, financial sustainability remains critical, with an estimated cost of 2,359,940 TZS per CHW for training and an estimated annual budget of 99.7 billion TZS required for implementation. To ensure long-term success, the program through the National Community Health Task force prioritizes resource allocation at both the central and local government levels and underscores the importance of mobilizing additional domestic and external funding to sustain the Community-Based Health Program.

This shortfall highlights the need for increased resource mobilization and strategic planning to meet future targets, particularly as the combined deficit over two years (2023/204 and 2024/2025) stands at 43,809 CHWs. The program's structured training, aligned with Health Sector Strategic Plan V (HSSP V), equips CHWs with skills in health care, social welfare, and nutrition through ten comprehensive modules.

The Ministry of Health in Tanzania has made significant progress in mobilizing resources to implement the planned interventions for HSSP V, particularly those focusing on community-based health programs and Community Health Workers (CHWs). However, resource availability remains a challenge. The five-year budget for Tanzania's Community Health Worker (CHW) program is set at 899.5 billion TZS, with 11% (approximately 99.7 billion TZS) allocated for Phase 1 implementation in the 2023/2024 fiscal year. During this phase, the program focused on training CHWs, with an actual expenditure of 27.2 billion TZS, successfully covering the training of 11,515 CHWs. This investment reflects a significant commitment to strengthening community health services but also highlights the need for efficient resource utilization. The current funding of $12,864,992 and €500,000 from development partners and the Health Basket Fund falls significantly short of the $359,789,316.78 required for the five-year implementation (2023-2028) of the CHW program. This substantial gap underscores the urgent need for enhanced resource mobilization to ensure the program's sustainability and effectiveness.

The weak collaboration between the health and education sectors is a limited factors for effectiveness and efficiency of health promotion activities. This limited collaboration has hindered the effective utilization of self-

employment opportunities, particularly for newly qualified health professionals such as midwives, clinical officers, and doctors entering the workforce.

By fostering collaboration across health sectors, UCS ensures that resources are used efficiently to deliver high-quality, cost-effective services. In addition, the unified community system supports HSSP V targets by ensuring equitable access for underserved populations, culturally relevant interventions, and strengthened governance, driving progress toward universal health coverage and improved health outcomes.

The combination of planned and unplanned interventions has enhanced community health awareness and disease prevention measures. CHW activities, such as Village Health and Nutrition Days, demonstrated significant community-level impact, improving health behaviors and promoting access to essential services.

Relevance

Community interventions align with the Health Sector Strategic Plan V (HSSP V) vision and national health priorities, ensuring CHWs address critical health and social challenges in their communities. CHW Training and RCCE activities align closely with national priorities outlined in the HSSP V, the 2021 National Operational Guideline for Community-Based Health and 2024 Implementation Guideline for Integrated and Coordinated CHW program. Similarly, the community health program aligns closely with the Human Resource for Health (HRH) Strategic Plan by addressing workforce gaps, emphasizing task-shifting, supporting CHW training, ensuring equitable distribution, integrating CHWs into the health system, and mobilizing resources for CHW sustainability.

Equity

The Integrated and Coordinated Community Health Worker (CHW) Program promotes equity by ensuring that health services are accessible to all, particularly marginalized and underserved communities. CHWs are operating in remote and rural areas, reducing barriers such as distance, transportation, and financial constraints that often prevent individuals from accessing healthcare. With the training package for Integrated and Coordinated CHW program in which CHWs are currently trained on, CHWs will focus on providing health education to enable communities includingthe poor to access nutrition, sanitation and health services. CHW roles will ensure that vulnerable populations, including women, children, and those in hard-to-reach areas, receive equal attention.

People centeredness

The CHW program offers a comprehensive health and social welfare package, including preventive and basic curative care, delivered close to home, even in remote areas. By aligning CHWs with local governance structures, the program creates a responsive and coordinated system, improving access to essential health services and ensuring a more accountable and sustainable healthcare system. Efforts to involve communities in identifying CHWs and engaging local leaders emphasize a participatory approach to health improvement.

Gender

The new Integrated and Coordinated Community Health Worker (CHW) Program promotes gender sensitivity by ensuring equal opportunities for both men and women to participate as CHWs. Each hamlet or Mtaa is mandated to have two CHWs—one male and one female—to promote balanced representation and address the diverse health needs of the community effectively. This approach recognizes the unique roles and contributions of both genders in health service delivery, such as addressing gender-specific health issues like maternal health, family planning, and gender-based violence. Additionally, the inclusion of gender considerations in the training curriculum and operational guidelines further supports equitable service delivery and enhances the program's capacity to respond to the needs of all community members. The lack of clearly defined metrics for community engagement hinders the ability to assess the effectiveness of strategies and initiatives, making it difficult to ensure that local needs are adequately addressed and that progress towards key goals, such as Universal Health Coverage (UHC), is being achieved.

Ethics

Ethics is the cornerstone for community based health programs. The Integrated and Coordinated Community Health Worker (CHW) Program upholds ethical principles in service provision by emphasizing respect for human dignity, equity, and confidentiality. As per the CHW curriculum, CHWs are trained to deliver services without discrimination, ensuring that every individual, regardless of gender, age, socioeconomic status, or cultural background, has access to quality healthcare. The program reinforces the importance of informed consent, empowering individuals and communities to actively participate in decisions about their health. Additionally, CHWs are guided by a code of conduct that prioritizes professionalism, transparency, and accountability, fostering trust between CHWs and the communities they serve. These ethical considerations enhance the integrity and sustainability of community-based health services.

11. Anticipated or emerging threat

Community-based health programs in Tanzania, while crucial for advancing universal health coverage (UHC), face several anticipated and emerging threats that could compromise their effectiveness and sustainability:

- **Financial Instability:** Dependence on donor funding and inconsistent government allocations pose risks to long-term sustainability, especially for programs requiring continuous investments in personnel, infrastructure, and digital systems like CHW program.
- **Limited Community Ownership:** Inadequate community involvement and ownership in program design and implementation can lead to poor adoption of health interventions and reduced effectiveness.
- **Workforce Challenges:** Attrition rates among Community Health Workers (CHWs), inadequate incentives, and limited opportunities for professional development threaten the retention and motivation of the workforce.
- **Misalignment between National Programs**: A key threat to the CHW program is the misalignment between the Integrated and Coordinated CHW Program and the Unified Community System (UCS), resulting in inconsistent service quality and undermining the program's efficiency and integration with broader health sector goals.
- **Policy and Governance Gaps:** Inadequate enforcement of operational guidelines, coupled with fragmented coordination among stakeholders, could hinder program implementation and accountability.

- **Rising Disease Burdens:** Increasing prevalence of non-communicable diseases (NCDs), mental health issues, and emerging infectious diseases may overwhelm existing community-based health structures.
- **Socio-Cultural Barriers:** Persistent health-related misconceptions, stigma, and resistance to behavior change can undermine health promotion efforts and uptake of services.
- **Climate Change and Environmental Health Risks:** Changing climatic conditions may exacerbate health challenges like malnutrition, waterborne diseases, and vector-borneillnesses, increasing the burden on community health systems.

12. Recommendations

1. **National Community Health Task Force** to jointly develop and implement a **National CHW Recruitment and Training Acceleration Plan** with involvement of the Ministry of Education, to meet training and deployment targets by June 2025.
2. Directorate of Policy and Planning and PO-RALG to update the **Direct Health Facility Financing (DHFF) Implementation Framework** to ensure alignment with CHW payment processes by June 2025. Additionally **orientation** of HFGCs on their roles in finance, leadership and overall governance is recommended.
3. **Directorate of policy and planning to r**evise the **HSSP V Monitoring Framework** to include community engagement indicators and CHW performance metrics before September 2025.
4. **Directorate of Preventive services** to develop in collaboration with the PO-RALG, the Ministry of Education and the Ministry of Community Development, a **School Health Collaboration Plan** to integrate health education topics into school curricula. Include topics on sanitation, nutrition, child safety, health screening, and vaccinations in school curricula, and organize visits to conduct health screenings and awareness sessions in schools.
5. **Directorate of Preventive Services** should prioritize increasing funding for health promotion initiatives and addressing social determinants of health. These measures are essential to combating misconceptions within communities and fostering improved health outcomes.
6. The implementation of the Integrated and Coordinated CHW Program should prioritize alignment with the Unified Community System (UCS). The **Directorate of Preventive Services** and the **Directorate of ICT** must collaborate to enhance the efficiency and effectiveness of community health services. This alignment will optimize resource utilization, improve coordination, and strengthen the delivery of health interventions at the community level.

13. Updated Results Framework

Results	Baseline 2023	Target 2026	Milestone 2023/2024	Source of data	Preconditions	Responsible of the implementation
Updated Strategic Objective 1: Community Health System						
Updated Output: Number of CHW trained	28,000	82,648	11,515	https://www.instagram.com/wizara_afyatz/reel/DAGKwTlKq0i/?hl=en Implementation Guideline for Integrated and Coordinated CHW program 2024	Sustainable funding	MoH, Po-RALG and CHFT
Updated Outcome 1.1: Household with adequate Sanitation facilities (%)	75%	>50%	72.3%	HSSP V, 2023 AHSP profile	Sustainable funding for health promotion campaigns	MoH and Po-RALG
Updated Outcome 1.2: Household with safe drinking waters sources (%)	92.5%	>80%	79.15%	HSSP V, 2023 AHSP profile	Sustainable funding for health promotion campaigns	MoH and Po-RALG
Updated Strategic Objective: Governance at community level						
Updated Outcome N.1: Full functional of HFGCs	83%	Not available in HSSPV	<83%	2023 AHSP profile, HSSP IV	Inclusion of HFGC indicators into the HSSP V	MoH and Po-RALG

Results	Baseline 2023	Target 2026	Milestone 2023/2024	Source of data	Preconditions	Responsible of the implementation
					framework, measuring i.e. membershipand training, meeting frequency	

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14. Annex 1: Methodology and Methods

1.1 Objectives of the thematic area

Community engagement, one of the key thematic areas of HSSP V, focuses on evaluating the role ofcommunity participation in health governance and the contributions of Community Health Workers(CHWs) in delivering essential services. This includes assessing the effectiveness of Health Facility Governing Committees (HFGCs) and the impact of CHW program as envisioned in various National policy and guidelines on primary health care. The Mid-Term Review identifies progress, challenges, and gaps in areas such as funding, recruitment, and coordination between national and local stakeholders. The primary aim is to contribute towards refining the strategy and ensure that the goals of HSSP V, especially achieving Universal Health Coverage (UHC), are successfully met by 2025/2026.

1.2 Evaluation questions for the thematic area

1. The extent and ways in which the local communities have been engaged in setting priorityfor health sector
2. Clarity on the expected impact of community engagement in the HSSP V theory of Change
3. Involvement of community representatives in the problem analysis and strategic choicesduring the development of the health sector strategic plan
4. Involvement of the community in the health services governance
5. Root causes of limited engagement of communities in behavior change and health systemstrengthening initiatives
6. Contribution of the communities in improving the availability, utilization and access tohealth services
7. Community related factors facilitating or limiting the achievement of outcomes and impactindicators
8. Alignment of the Community health program with HSSP V strategies, HRH strategic plan,HRH production plan and other strategic plans
9. Recommendation for improved engagement of communities in the governance structureand partnership for a for improved monitoring of the HSSP Vethod

1.3 Study sites and Sampling

The HSSP-V Mid-Term Review (MTR) was carried out across eight regions, each representing one of Tanzania's eight zones. These regions—Kigoma, Arusha, Rukwa, Dar es Salaam, Geita, Mtwara,Dodoma, and Njombe—were selected based on key RMNCAH performance indicators, particularly neonatal and maternal mortality rates. RMNCAH is one of the four result-based monitoring and evaluation areas of the HSSP-V. Within each region, two districts were chosen for the assessment, based on a mix of rural and urban settings, and categorized as best or poor performers based on theirneonatal death rates. Data collection primarily relied on qualitative interviews, with participants including members from the Local Government Authority, Community Health Workers (CHWs), and beneficiaries. The details of the study participants by region and district are presented in Table 1.

Table 1: Study Districts and Sample Size

REGION	DISTRICT	LGAs*	CHWs	BENEFICIARIES **	TOTAL
Kigoma	Kigoma MC	2	1		**5**
	Kibondo MC	1		1	
Arusha	Arusha DC	1		1	**4**
	Longido DC	1	1		
Rukwa	Sumbawanga MC	2	1	1	**6**
	Kalambo DC	2			
Dar es salaam	Temeke MC	2	1	4	**9**
	Ubungo MC	1		1	
Geita	Bukombe MC	2	1		**5**
	Geita DC	1		1	
Mtwara	Mtwara MC	1	1	1	**4**
	Masasi MC	1			
Dodoma	Dodoma MC			1	**4**

	Kondoa DC	2	1		
Njombe	Njombe TC	2	1	1	**6**
	Makete	1		1	
Total		**22**	**8**	**13**	**43**

Note: Total Number of FGDs conducted- **37;** Total Number of IDIs conducted - **6**

*Village Health Committees, Village Social Service Committees, WDC, HFGCs, Village PHC committees, Ward PHC Committees, Council PHC Committees, Full Council, District Health Secretary

**Mothers of children under five, adult men, elderly, adolescents and disabled groups

1.4 Study design

This was a qualitative study employing multiple data collection methods, including a desk review ofrelevant policies, guidelines, and research papers; key in-depth interviews; focus group discussions;and direct observations. A comprehensive overview of the study design and data collection methodologies is provided in the main report

1.5 Data collection and Data analysis

Qualitative data management and analysis was done using Framework Analysis. The first step towards data management and analysis involved four study team members to familiarize themselveswith the transcribed data. Transcripts were coded independently by four study team members taking into account newly emerging topics. The codes were developed using NVivo (Version 12+) computer assisted, qualitative data analysis software. The lists of codes were then reviewed by all team members before agreeing on the final codes. The four research assistants and the study PI coded the remaining transcripts. The final codebook was then grouped into themes and approved byrespective team members. The data analysis was done by triangulating between different data collection methods, while the interpretation was made in joint discussions among study teams involved in the assessment.

1.6 Limitations

A notable limitation of the assessment was the challenge in securing participation from key stakeholders, particularly councilors. Many potential participants required financial compensation before agreeing to participate in the study, which constrained the ability to conduct interviews witha sufficient number of councilors. Consequently, the sample size for this important group was smaller than anticipated, potentially limiting the diversity of perspectives and insights into local governance dynamics.

1.7 Ethical consideration

Oral consent was sought from study participants. Prior to that, participants were provided with an information sheet to read and understand their roles and rights as study participants. Participants were told that participation in the study is voluntary and that they are free to withdraw from the study anytime they wish. To minimize coercion, participants were not paid for their participation butcompensated with transport costs where relevant. The information sheet was written in Kiswahili language and participants were allowed to ask any questions they had regarding the assessment.

Research clearance was sought from Ifakara Health Institute IRB.

1.8 **Evaluation Design Metrics**

Table 2. Draft Evaluation Design Matrix Tanzania HSSP V Mid-Term Evaluation

1. Evaluation Question	2. Sub-question	3. Type of sub-question/ Descriptive/ normative/c ausal	4. Measure or Indicator	5. Target or Standard (for normative questions only)	6. Baseline data?	7. Data Source	8. Design Strategy for Question	9. Sample or Census	10. Data Analysis

1. Are community engagemen tstrategies clearly defined in the HSSP V theory of change?	1. How explicitly does the HSSP V theory of change articulate the role and impact of community engagement in achieving health outcomes? 2. What are the specific pathways outlined in the theory of change through which community engagement is expected to contribute to the strategic goals? 3. Are the assumptions about the impact of community engagement in the theory of change clearly stated and supported by evidence? 4. What indicators are established to measure the impact of community engagement, and how well do they align with the expected outcomes in the theory of change? 5. What processes were used to involve community representatives in the problem analysis and decision-making	Descriptive	1. Degree of specificity in the pathways outlined for community engagement. 2. Number of clearly defined intermediate outcomes associated with community engagement 3. Stakeholder understanding of the community engagement pathways. 4. Proportion of strategic choices that can be directly linked to community representatives' input. 5.Level of satisfaction among community representatives regarding their influence on the strategic plan 6. Documentation andincorporation of community feedback.	Having well-defined, clearly articulated, and actionable plan for community engagement thatis seamlessly integrated into the overall strategic framework of HSSP V.	1. Review HSSP V to identify pathways in the theory of change that link community engagement activities directly to strategic health outcomes 2. Interview with high-level officials to gauge their understandi ng of how community engagement is expected to lead to health outcomes. 3. Review HSSP V meeting minutes, reports, and the final	1. Review of HSSPV 1. Minutes from meetings and workshops held during the development of the HSSP V 2. Interviews and surveys conducted with key stakeholders, including community representatives, policymakers, health sector officials, and CHWs 3. Reports from community consultations, public forums, and stakeholder engagement sessions conductedas part of the HSSP V development process. 4. M&E reports that track the implementation of the HSSP V, particularly focusing	1. Documen t review (Govt documents, publication, reports ect) 2. Qualitati ve interviews	1. Purposive sample of study participants engaged in the development of HSSP V	1. Analyze data on health outcomes that are linked to community engagement initiatives. Look for correlations between the intensity of community engagement activities and improvements in key health indicators (e.g., immunization rates, maternal health). 2. Themati canalysis

	phases of the HSSP V								

	development? 6. To what extent did community representatives influence the identification of key health priorities and strategic choices? 7. How was feedback from community representatives incorporated into the final health sector strategic plan?				strategic plan to identify strategic decisions that were influenced by community representative's feedback. 4. surveys or interviews to assess how satisfied community representatives are with the extent to which their insights were considered and integrated into the final strategic plan	on community engagement activities. 2. Reports from			

2. To what extent has the reinforcement of Local Government structures strengthened to ensure community accountability in community health programs?	1. What specific measures that have been implemented to strengthen the capacity of Local Government structures in managing and supporting community health programs? 2. How are Local Government structures well integrated with other local services (education, agriculture, social services, etc) 3. How have Local Government structures improved their coordination and communication with Community Health Workers (CHW) and other related community structures? 4. What challenges are Local Government structures facing in the reinforcement process, and what strategies are being employed to address these challenges? 5. How well do the PHC committees functioning and better linked to HFGCs,	Normative	1. Number of capacity- building training sessions conducted for Local Government officials and community leaders 2. Percentage of Local Government staff trained in community health management. 3. Availability of resources and tools provided to Local Government structures (e.g., guidelines, management software, mobile technology for monitoring) 4. Implementation rate of new policies or protocols designed to enhance the management of community health programs (i.e.HSSP V through guidelines CHSB), 5. Frequency of coordination meetings between Local Government	Local government structures significantly reinforced to effectively support and enhance community accountability in health programs, resulting in improved program outcomes, increased community engagement, and established mechanisms for ongoing evaluation and transparency.	1. HSSP IV End line report 2. HSSP V baseline data for LGAs community accountability	1. The community based health service strategy/policy guideline 2. PHC committee guideline 3. Mixed method interviews or surveys with LGAs, CHWs and community members, Govt officials, (MoH and PORALG) 4. Publications 5. Meeting minutes of LGA	1. Document review (Govt documents, publication, reports etc.) 2. Mixed method questionnaires 3. Qualitative Interviews 4.Observation checklists	1. Purposive sample of study participants across all selected districts	1. Analytical Thematic analysis

	CHSBs, and Hospital Management Boards. 6. What is the level of influence that community members have in		structures and community health workers including key learnings						

	decision-making processes within health governance structures i.e social welfare? 7. What are the outcomes of community involvement in health governance in terms of improved accountability, transparency, and responsiveness of health services? 8. How are HFGCs continue to be capacitated to monitor the quality of services 9. What evidence exists to show that community contributions have led to measurable improvements in health outcomes or health service performance? (availability, utilization and access to health services?)								

3. How effectively are community health workers being integrated into the health and wellbeing system, and what impact does their involvement have on the overall effectiveness of health services?"	1. How clearly defined are the roles and responsibilities of community health workers within the current health and wellbeing system, and how well are these roles communicated to both CHWs and other healthcare providers? 2. How well are CHWs integrated into existing community development and social welfare services at the village and hamlet levels? 3. Coverage of Community health workers (CHW) at village and hamlet levels, 4. Covarage of CHWs incentives through performance-based payment modalities 5. To what extent are CHWs empowered with working tools to effectively perform their duties 6. What specific roles and responsibilities,	Analytical	1. Number and frequency of coordination meetings between CHWs and community development/social welfare services at the village and hamlet levels. 2.Percentage of CHWs trained as part of integration into health system (including health promotion training areas/topics i.e. nutrition, sanitation) 3.Existence/coverage of formal referral pathways between CHWs and social welfare services and health facilities. 4. Coverage rate of vulnerable groups by CHW services through i. e. peer groups (including adolescent females who remain vulnerable to HIV, people living with HIV and other communicable	CHWs are effectively integrated into the health and wellbeing system, with clearly defined roles, adequate training and support, measurable improvements in health outcomes and service delivery, and effective collaboration and communication with other healthcare providers	1. HSSP IV End line report 2. HSSP V baseline data	1. The community based health service strategy/policy guideline 2. Operational Guideline for CHW training 3. Curricullum for intergrated CHW training 4. MoH Unified Community System Digital M&E platform 5.LGA reports/minutes 6.TDHS 2022 7. Interviews/survey/ qualitative with CHWs, MoH/PORALG relevant personnel, LGAs, social welfare units, vulnerable groups 8. Publications/report	1. Document review 2. semi structured interviews	1. Purposeive sample of study participants accorss all selected ditricts	Analytical Thematic analysis

	outcomes and challenges do CHWs have in supporting vulnerable groups, and how effectively are these roles being fulfilled? 7. How successful are CHWs in meeting the specific needs of vulnerable groups, such as		diseases, chronic diseases and the elderly) 5. Client satisfaction rate among vulnerable groups 6. Percentage of			s 9. HSSP V 10. HRH Strategic Plan 10. HRH production plan 11. Annual health sector performance report 13.Community			

	adolescents, people living with HIV, those with disabilities, and the elderly 8. What measurable improvements in health service delivery and patient outcomes can be attributed to the involvement of community health workers? (i.e. improvement in ANC attendance and delivery at health facilities) 9. What are the outcomes of community involvement in health governance in terms of improved accountability, transparency, and responsiveness of health services? 10. How are HFGCs continue to be capacitate to monitor the quality of services 9. What evidence exists to show that community contributions have led to measurable improvements in health outcomes or health service performance? (availability, utilization and access to health services?)		individuals/vulnerable groups who adhere to follow-up appointments or recommended interventions provided by CHWs. 7. Feedback from social welfare service providers on the effectiveness of CHWs. 8. Percentage of program activities, initiatives, or interventions that directly support the key priorities outlined in the HSSP V 9. Number and relevance of HSSP V performance indicators integrated into the Community Health Program's monitoring and evaluation (M&E) framework 10. Percentage of HRH strategic plan priorities (e.g., workforce			health program report 14. KII with community representatives 15.2021 TDHS			

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Resolutions