ZIMBABWE

NATIONAL COMMUNITY HEALTH STRATEGY 2020 - 2025

Revitalising and moderinizing the community based primary healthcare approach for UHC

Foreword

The Government of Zimbabwe's mandate is to "Take all practical measures to ensure the provision of basic, accessible and adequate health services throughout Zimbabwe". In order to fulfil this mandate, Zimbabwe is working towards the achievement of Universal Health Coverage and Sustainable Development Goals. Community health is expected to play a catalytic role and accelerate progress. With respect to the Sustainable Development Goals, our focus is on the third goal which addresses all major health priorities and calls for ending preventable maternal and neonatal deaths; ending communicable diseases; reducing non-communicable diseases and other health hazards; and ensuring universal access to safe, effective, quality and affordable medicines and vaccines. Furthermore, increased participation of communities in health will contribute to positive outcomes for the general population leaving no one behind.

Community-based primary health care is the vehicle through which these goals will be achieved. Over the years, community-based primary health care service delivery has contributed significantly to improvements in health outcomes, including an increase in national life expectancy from 59.6 years to 63.1 years (WHO Data, 2018). These gains have been realised through increased participation and contribution of communities towards health. Despite this, the community health system still faces several challenges that negatively impact health outcomes.

Recognizing the current gaps and challenges in health delivery system, the Ministry of Health and Child Care, in collaboration with other ministries, civil society organizations, private sector and development partners, developed a National Community Health Strategy (NCHS) for 2020 to 2025. This strategy is guided by the National Health Strategy for Zimbabwe, which highlights community health coordination as central to the recommended reforms for a functional and sustainable community health system. The NCHS will support the national health strategy in achieving its desired health outcomes including: reduction in the maternal mortality ratio, neonatal mortality rate and under-5 mortality rate; reduction in the number of new HIV infections; and reduction in malaria incidence.

The NCHS will achieve this by extending quality health services beyond health facilities to the community, ensuring patient-centred services are equitably distributed and accessible to every Zimbabwean, particularly vulnerable and marginalized populations, ensuring no one is left behind. The NCHS also serves as a blueprint for national level community health planning and governance and will therefore play a pivotal role in the coordination of stakeholders. It is time to take stock of our experiences to see what has worked well and what needs to be improved to engage and empower communities in health service delivery. I therefore appeal to all actors in community health; programme managers, civil society organizations, development partners and all implementing partners to make use of this strategy as a key guiding document and to actively contribute to the successful implementation of the strategy in collaboration with the leadership and coordination of the MOHCC. Working together with a unified vision, we can ensure the provision of basic, accessible and adequate health services nationwide.

Honourable Dr. Obadiah Moyo, (MP)
Minister of Health and Child Care

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Developing a National Community Health Strategy is a complex endeavour that requires the input, collaboration, and support from an array of stakeholders from the community to national level.

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Dr Gibson Mhlanga
Acting Secretary for Health

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List of Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
BCC	Behaviour Change Communication
BCF	Behaviour Change Facilitator
CBD	Community Based Distributor
CBOs	Community Based Organizations
CCHP	Community Comprehensive Health Package
CHAI	Clinton Health Access Initiative
CHS	Community Health Services
CHW	Community Health Worker
DHE	District Health Executive
DHIS2	District Health Information System 2
DHT	District Health Team
GOZ	Government of Zimbabwe
HCC	Health Centre Committee
HDF	Health Development Fund
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
MDGs	Millennium Development Goals
MOHCC	Ministry of Health and Child Care
MOFED	Ministry of Finance and Economic Development
MOLG	Ministry of Local Government Public Works and Urban Development
MOPSLSW	Ministry of Public Service, Labour and Social Welfare
NCDs	Non-Communicable Disease
NCHS	National Community Health Strategy
NGO	Non-Governmental Organization
NHS	National Health Strategy
NHIS	National Health Information System
PHE	Provincial Health Executive
PHC	Primary Health Care
PMD	Provincial Medical Director
PHT	Provincial Health Team
RDC	Rural Development Council
SDG	Sustainable Development Goal
TWG	Technical Working Group
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VHC	Village Health Committee
VHW	Village Health Worker
VIDCO	Village Development Committee
WADCO	Ward Development Committee
WHO	World Health Organization
ZSARA	Zimbabwe Service Availability and Readiness Assessment

Executive Summary

Community health provides basic health services to rural and urban communities by preventing and treating disease, creating awareness, and transferring knowledge to the people. This empowers communities to take an active role in health and health-related issues and to contribute effectively to the country's development agenda.

Zimbabwe has a long history of involving communities in addressing social, cultural, political and economic determinants that underpin their health. Community health promotes active participation in the planning, delivery, utilisation, and ownership of health services.

Community health services are predominately delivered through village health workers (VHWs) who are women and men that deliver a wide range of services at household level and act as the bridge between the formal health system and communities. Community based initiatives have contributed to positive health outcomes in Zimbabwe including: a reduction in maternal and under-five mortality. This has been realized through promotion of early antenatal care (ANC) bookings and institutional deliveries, and conducting postnatal care visits at the community level. Conducting social mobilization and defaulter tracking has led to improved immunization rates and increased uptake of other MNCH services. Other achievements include:[1]

- Increasing awareness of and the prevention of communicable and non-communicable diseases
- Promoting treatment adherence to antiretroviral therapy (ART), directly observed treatment strategy (DOTS), and malaria treatment resulting in the reduction of deaths and disabilities due to these and other communicable diseases
- Promoting construction of protected wells and Blair Ventilated Improved Pit Latrines (BVIPL) for improved water and sanitation
- Providing valuable community-level information to the National Health Information Systems (NHIS) for disease surveillance, early warning, and national planning

Despite these achievements, Zimbabwe's community health system continues to face several challenges, which undermine progress made towards the country's commitment to achieve the Sustainable Development Goals (SDGs), especially SDG 3. Following a community health ecosystem assessment that involved an analysis of findings from the National Health Strategy (NHS) mid-term review, the 2019 HIV programme review, and a community health situational analysis, the following challenges were identified:

- The multiplicity of community health worker cadres with varying backgrounds, training, and remuneration
- Lack of a standardized, integrated package of services delivered at the community level that holistically addresses the health needs of the Zimbabwean population
- Inadequate training, supportive supervision, coaching, and mentorship of VHWs

[1] Ministry of Health and Child Care. (2016). The Village Health Worker Strategic Document

- Frequent stock-outs of basic commodities and malfunctional equipment required for community health service delivery
- Poor institutional coordination in programme planning and implementation across various actors including government and implementing partners

It is against this backdrop that the Government of Zimbabwe developed the National Community Health Strategy which guides the establishment of an integrated community health programme that addresses the identified weaknesses. This strategy was developed through a robust consultative exercise that included more than 400 stakeholders engaged through technical working group meetings, three National Stakeholder Workshops, one MOHCC top management review meeting, one technical writing retreat, and one-on-one interviews and consultations at national, provincial, district, and community in four provinces (Mashonaland Central, Manicaland, Midlands and Matabeleland South). As part of this process, extensive desk reviews were also conducted.

The vision of the National Community Health Strategy is aligned to the Ministry's vision of attaining the highest possible level of health and quality of life for all Zimbabweans. It is also aligned to MOHCC's mission of ensuring equitable access to quality, integrated community-based health services that respond to local health needs across the life course through meaningful community participation.

The following guiding principles underpin the approach to achieving the vision and mission outlined in the NCHS; equity, high quality care; integration; transparency, accountability; ownership and participation, and continuous monitoring, evaluation and learning. The principles of equity demand that all Zimbabweans have access to high-quality care. Integration promotes patient-centred care while reducing inefficiencies and duplication of efforts. Community ownership and participation is the cornerstone of successful implementation of community based primary health care where all citizens are empowered to improve their own health and to hold formal health systems accountable.

The National Community Health Strategy was developed to accelerate the achievement of the National Health Strategy (NHS) goal of UHC. It addresses the emerging health challenges and prevailing weaknesses in the current community health system and provides a strategic framework across the following areas:

1. Community Engagement

The aim of community health is to increase ownership, participation, and engagement of communities in the planning, implementation, monitoring, and evaluation of their health. This can only be achieved if there are strong structures that support community health and promote social accountability mechanisms. To this end, key interventions will:

- Capacitate and collaborate with prioritized community structures particularly, community health management structures, to enhance community participation in priority-setting, planning, and decision-making
- Refine the roles and responsibilities of local community structures and households in supporting integrated community health service delivery
- Promote health awareness and the adoption of healthier lifestyles
- Empower communities and ensure their involvement in the governance of health services through appropriate capacity building

- Develop and provide guidelines to strengthen community participation, including among youth and adolescents, people living with disabilities, and other vulnerable or marginalized populations, in the implementation of the national community health programme
- Organize households into networks that are empowered to effectively and efficiently implement the community health intervention packages
- Invest in community-led approaches that empower vulnerable groups (women, adolescents, etc.) to overcome barriers in accessing care

2. Community Health Service Delivery

The community health system plays an integral role in delivering promotive, preventive, basic curative, and rehabilitative services. A defined community health service package has been developed using the life-cycle approach, to deliver patient-centered interventions at specific stages of life and at the appropriate level of care. The community health service package comprises effective interventions from pregnancy, birth, infancy, childhood, and adolescence, to adult and geriatric care. Delivery of services outlined in the community health service package will be integrated at the community level to improve the economic efficiency and equity of health service delivery.

3. Human Resources for Community Health

The government of Zimbabwe will adopt one coordination mechanism, and implementation and reporting framework. This will ensure that the required community health workforce is available, functional and equitably distributed. The capacity of training institutions and other community health support structures will be strengthened. VHWs will also be incentivized to improve motivation, coverage, and ultimately retention.

Recruitment and roles

– Going forward, VHWs will be recruited based on set selection criteria and with active involvement of the community. There will be:

- A core cadre of VHWs who are trained on and responsible for the integrated delivery of the entire community health package. They will receive continuous in-service training to enhance their capacity to address new and emerging health issues

- Peer groups/networks, that serve as action and learning oriented groups. These peer groups/networks will provide support to defined networks of households or population groups within their neighborhood

The operations of these groups will be defined in the community health implementation plan. MOHCC will develop a framework to identify and approve the continued operation or development of the peer groups/networks. MOHCC will also determine how these groups shall be linked to the formal health system.

Supervision, mentorship and coaching mentorship

– VHWs will be supervised by supervisory teams. The teams include:

- Dedicated peer supervisors (promoted VHWs) who will provide monthly supportive supervision to their assigned teams of VHWs

- Supervision by health facility teams who in addition to conducting monthly data compilation and data audits, will spend a portion of their time supervising peer supervisors to ensure they are performing well in their roles. The portion of time to be spent conducting supervision will be determined during the implementation planning process, when the VHW:Supervisor ratio is determined, and supervisor workload analysis performed.
- Upon establishment of health posts, clinic-level supervision responsibilities will be decentralized to the health post level.
- The core cadre of VHWs will supervise the peer groups/networks
- Other decentralized administrative structures such as the Village Health Committee, Health Center Committees and the District Health Executive, will continue to play an oversight and implementation role as stipulated in their terms of reference

VHWs will receive accreditation upon successful completion of pre-service training

VHWs will be incentivised through financial and non-financial means, commensurate with their work. While VHWs will receive performance-based incentives, they shall not be remunerated exclusively or predominantly through this mechanism

Career progression guidelines outlining transition from VHW to peer supervisor, will be developed by the MOHCC in collaboration with other relevant government agencies and partners in community health. As the community health system evolves, the feasibility of creating linkages between VHWs and other professions will be assessed

A framework for implementation of human resource components of the community health strategy will be developed. These will include:

> Refining the selection criteria for VHWs and peer groups/networks
> Review of suitable remuneration and incentives for VHWs in collaboration with other relevant sectors

4. Community Health Supply Chain Management

In order to provide sufficient selected commodities and equipment for community health service delivery, the following interventions will be undertaken:

> Administer stock management refresher training to VHWs, peer supervisors, and health facility teams to help them to better identify their stock needs and forecast for accurate orders
> Allocate adequate selected commodities and equipment for VHWs
> Distribute tools for safe storage of supplies by VHWs
> Leverage the use of technology for improved stock management at the clinic level

5. Community Health Management Information Systems

For a robust community health management information system, the following interventions will be undertaken:

- Leverage the growing use of modern technology to improve the quality of care, supervision, reporting and stock management – this is in line with the MOHCC's e-Health strategic plans
- Harmonize data collection into unified reporting formats, including a standardized VHW register and standardized supervision reporting forms
- Integrate reporting by peer groups/networks trained to cascade specific interventions to the community health information system
- Disaggregate community level data from district level data for increased visibility into community-specific health outcomes
- Increase regularity of data quality audits by supervisors and develop feedback mechanisms for VHWs
- Explore linkages with other community-based information systems such as Rural WASH Information Management System (RWIMS) among others for a robust community led data for local level use and decision making

6. Governance, Leadership and Coordination:

There will be one governance, leadership and coordination framework for community based primary health care. The governance structure will include:

- A national coordinator, who is responsible for overseeing policy, strategy and implementation of the National Community Health Strategy.
- At sub-national levels the Provincial Health Executive, District Health Executive, Health Center Committees and Village Health Committees will be strengthened in order to better play their functional oversight and implementation roles
- The programme will be integrated into the existing subnational governance structures. Community health technical working groups will be formulated at all levels of government in order to promote good governance at all levels
- Inter/ multi-sectoral coordination mechanisms will be established at all levels of government

7. Financing for Community Health:

Community health is a priority for the Government of Zimbabwe. As a result, the government will continue to allocate finances towards the programme. This NCHS will also be used as an advocacy tool and serve as an essential resource for Zimbabwe's fundraising efforts[2]. MOHCC will collaborate with MOFED in identifying the most suitable interventions for sustainable community health financing.

Community health financing will be aligned to the broader national health financing strategic initiatives. Some of the interventions to be explored include:

[2]The NCHS will be used as a resource for resource mobilization with donors such as the Global Financing Facility, Global Fund (for the 2021 investment case) and the Health Development Fund

Efficiency gains and waste reduction:

- Increase efficiency gains from existing national and external assistance resources
- Strengthen planning and governance around procurement

Increased investment in community health:

- Increase reliance on public resources for the health sector through the national budget process
- Improve predictability and level of external resources

Innovative health financing mechanisms:

- Introduce innovative revenue-raising schemes such as excise taxes whose revenue will be ring-fenced for the health sector

Capacity building:

- Strengthen capacity to monitor financial performance through Public Financial Management and enforce lines of accountability

The National Community Health Strategy prescribes equity and universal access to health in the spirit of self-reliance, self-determination and taking responsibility for communities' own health as stipulated in the PHC Approach, Zimbabwe Transitional Stabilization Programme and Constitution of Zimbabwe. This strategy is also aligned to the strategic objectives of the National Health Strategy. The community health strategy will be implemented over a period of six years and implementation will take place across two phases.

Phase 1 sets the foundation of the community health system before launching and scaling activities. It will focus on setting the community health system up for success through activities such as (but not limited to) establishing governance and coordination mechanisms at all levels of the health system; developing HRH guidelines; developing the VHW training curriculum and aides; recruiting additional VHWs where needed; strengthening community level supply chains and advocacy towards increased community health funding by government and funders. Phase 2 will focus on implementing additional activities such as (but not limited to) training VHWs on the integrated package of services, scaling up community health service delivery, and digitalization of community health service delivery and reporting. Monitoring, evaluation and learning activities will be conducted across the entire implementation period. The timelines for Phase 1 and 2 will be developed during the implementation planning phase.

Ongoing monitoring of programme implementation will be conducted. A mid-term evaluation will be performed and lessons will be used to inform the second part of strategy implementation.
It is expected that the implementation of all community-based primary health care activities will align with the strategic framework presented in this document.

NATIONAL COMMUNITY HEALTH STRATEGY
INTRODUCTION

Introduction

Background

Community health is regaining prominence in Zimbabwe and many other countries globally as a means to achieve Universal Health Coverage (UHC) and the Sustainable Development Goals (SDG). Zimbabwe has prioritized community health as a stepping stone to achieving SDG3;

> "
> Ensure healthy lives and promote well-being for all at all ages
> "

At the core of SDG3 is the provision of basic health services to all rural, urban and peri-urban communities. The ultimate goal of community health is to achieve improved health outcomes by simultaneously building the capacity of community actors and strengthening service provision at the household level.

In the African region, the African Union (AU) has called upon member states to create an enabling environment for community health development, establish unified national health systems, and improve financing for community health programs. In 2017, under the auspices of the AU Commission, African countries mapped the implementation of a CHW initiative that aims to recruit, train and deploy two million CHWs across Africa by 2020. Zimbabwe is a signatory to the above global and regional declarations and commitments. The development of this National Community Health Strategy is a manifestation of the Government of Zimbabwe's commitment to achieving not only these global and regional declarations, but also improved health, social, and economic wellbeing for all Zimbabweans.

Evidence for Primary Health Care and Community Health Services

There is substantial evidence to show the positive role of community health in addressing challenges and disparities in health systems. This evidence calls for a primary health care system that is proactively orientated to communities, families and individuals. The health system as a whole must also be comprehensive, participatory and linked with other services and activities that improve population health (WHO, 2008; Gilson et al., 2008).

In the joint statement on Integrated Community Case Management (ICCM), the World Health Organisation (WHO) and United Nations Children's Fund (UNICEF) highlight the findings of the Child Health Epidemiology Reference Group (CHERG). These findings estimate that community management of all cases of childhood pneumonia could result in a 70% reduction in mortality from pneumonia in children less than 5 years old. In addition, community case management (CCM) of malaria can reduce overall and malaria-specific under-five mortality by 40% and 60% respectively, with severe malaria morbidity falling by 53%. Oral rehydration salts (ORS) and zinc are effective against diarrhoea mortality in home and community settings, with ORS estimated to prevent 70% to 90% of deaths due to acute watery diarrhoea, and zinc estimated to decrease diarrhoea mortality by 11.5%.

In addition to the health gains highlighted above, investment in community health has shown a return on investment of 10:1, meaning, for every dollar invested, a return of $10 is gained owing to increased productivity, insurance against costly epidemics like Ebola as this approach focuses on prevention, and disease surveillance and benefits from employment of VHWs[3].

[3] Dahn, B., Woldermariam, A., Perry, H., Maeda, A., Glahn, D., Panjabi, R., Merchant, N., Vosburg, K., Palazuelos, D., Lu, C., Simon, J., Pfaffmann, J., Brown, D., Hearst, A., Heydt, P., Qureshi, C. (2015) Strengthening Primary Health Care: The Investment Case for Community Health Workers, Financing Alliance for Health

In recognition of this, heads of state and government representatives, met in Astana on 25 and 26 October 2018. At this meeting, they reaffirmed their support for investing community health systems as a building block towards strong primary health care systems.

Zimbabwe Context

History of Community Based Health Services in Zimbabwe

Zimbabwe has a long history of community-based primary health care planning and delivery dating back to 1980, when the then new government adopted Primary Health Care (PHC) as its chosen approach to health services delivery. In 1981, the government initiated the training of and support of VHWs. Indeed, some of the notable achievements in health outcomes and impact can be attributable to the use of VHWs to deliver services at community and household level. Examples of these achievements include increased access to family planning, decreasing rates of new HIV infection, and decreasing HIV/AIDS-related mortality. Since 1980, all national health strategies have incorporated a community health pillar.

The community health programme has had a positive impact on health in Zimbabwe. VHWs have been crucial to the expansion of frontline health services to marginalized and hard-to-reach populations. However, a mapping exercise conducted by the MOHCC and UNFPA in 2016 revealed that, within Zimbabwe, there are 77 community-based cadres delivering differentiated services at the community level. This fragmentation has resulted in inefficient utilization of human resources and finances, due to duplication of services and poor coordination. In response to these findings, a community system strengthening framework was developed in 2017. A year later, in line with rebirth of PHC, the National Community Health Strategy for Zimbabwe, which will guide and oversee all community health activities in the country was developed.

Going forward, the MOHCC will harmonize the various community health cadres and strengthen the role of its community health workforce to provide a comprehensive and integrated package of services. This will reduce fragmentation and improve the quality of services provided by frontline cadres.

Demographic Context

According to the 2012 census, Zimbabwe had a total population of 13,061,239 which comprised 6,280,539 (48%) males and 6,780,700 (52%) females. The population is estimated to have risen to 16.9 million as of 2018 and the population is expected to continue growing. The population is distributed across 10 provinces (8 rural and 2 metropolitan) and 63 districts. There are approximately 3,076,222 households, with an average household size of 4.2 persons (ZimStat National Report – Zimbabwe Population Census 2015). The total fertility rate is estimated at 4.3 children per woman, and the age-specific fertility rate for women aged 15-19 years is 120 births per 1,000 women (MICS 2014). The population growth rate is estimated at 2.7% per year.

67% of Zimbabweans live in rural areas. These rural areas comprise a variety of community settings including communal areas, large commercial farming areas, plantation communities, and mining communities, all with varying settlements.

Epidemiologic Context

Communicable diseases are the major causes of morbidity and mortality. Despite decreases in both incidence and prevalence, HIV/AIDS, TB and malaria remain significant public health problems. Diarrhoeal diseases including typhoid and cholera have been on the increase due to deteriorating water and sanitary conditions. While there has been a decrease from 651 deaths per 100,000 live births (2015 ZDHS), maternal mortality is still high at 462 deaths per 100,000 live births (MICS 2019). Neonatal, infant and under-five mortality rates are still unacceptably high at 32, 47 and 65 deaths out

of 1,000 livebirths respectively (MICS 2019). Malnutrition is one of the leading underlying causes of under-five deaths. The 2019 MICS data shows that 24% of children are stunted, 3% are wasted, 10% are underweight, and 3% are overweight. Water and sanitation coverage stand at 64% and 37% respectively, while the children under-five sleeping under an insecticide treated net is 15%. Implementing high impact community interventions would see the poorly performing indicators improving. For example, the promotion of exclusive breastfeeding by VHWs through community-based interventions has proven to be highly effective. Currently in Zimbabwe, 42% of children within the 0 – 5 months age group are exclusively breast-fed. According to one estimate, 13% of under-five deaths could be prevented by the universal practice of exclusive breast-feeding (MICS 2019).

Non-communicable diseases (NCDs), which include cardiovascular diseases, cancer, chronic respiratory diseases and diabetes mellitus, are on the rise. It is estimated that 33% of deaths in Zimbabwe (World Health Organization – Non-communicable Diseases (NCD) Country Profiles, 2018) are due to NCDs. Community based health promotion and treatment support activities can be instrumental in promoting healthy lifestyles, early diagnosis and successful treatment of chronic diseases.

Health Delivery System

The health system operates at four levels of care, namely primary, secondary, tertiary, and quaternary. The primary level is comprised of VHWs rural health centers or clinics that offer basic maternity, preventive, and curative services. This level of care extends to VHWs who provide promotive, preventive, minor curative and rehabilitative services at household level. For communities, VHWs are the first point of contact with the formal health system. The country has a total of 1,912 health facilities composed of central, provincial, district, mission (Faith Based Organisation - FBO), and private hospitals, as well as urban and rural primary care facilities. Of the 1,912 health facilities, 1,695 are primary care facilities, most of which are located in rural areas.

Table 1 Levels of Health Care in Zimbabwe[4]

Facility Type	Staff	Population Served	Types of Service Provided
Primary Level			
Community level	VHWs	100 households	Mainly preventive and promotive health services with minor curative (iCCM) and referral as appropriate
Rural health centres and clinics	2 to 4 technical staff (2 to 3 Nurses, Environmental Health Teams), Nurse Aide and General Hand	5,000 to 10,000 people in rural areas Up to 40,000 people in urban areas	Both curative and preventive services including in-patient services (5 beds)

[4]Minister of Health and Child Care. (2015), Zimbabwe National Health Strategy 2016-2020

Secondary Level			
District Hospitals	30 to 53 technical staff and auxiliary staff	100,000 to 150,000 people	Both curative and preventive services including in-patient services with 25 to 50 beds, emergency surgical service and blood transfusion
Tertiary Level			
Provincial Hospitals	Over 100 technical staff	Over 500,000 people	Both curative and preventive services including in-patient services
Quaternary Level			
Central Hospitals	Over 300 technical staff	Over 1 million people	Specialized care

Zimbabwe currently faces a critical health worker shortage. The Zimbabwe Service Availability and Readiness Assessment 2015 report (ZSARA) reported an overall density of the core health workers of 8 core health workers per 10,000 population. This is only a third of the WHO-recommended target of 23 per 10,000 population. In addition to the deficiency in the number of professional health workers, ZSARA also noted that the national health facility density was 1.1 facilities per 10,000 population nationally against the WHO-recommendation of two health facilities per 10,000 population.

Legal and Institutional Context

Community health services in Zimbabwe are embedded in the constitution and guided by several laws that mandate and guide government ministries, departments, institutions and senior policy makers in the involvement of communities in health services. These laws include the Public Health Act, Health Services Act, Traditional Leaders Act, Rural District Councils Act and Councils (Urban) Act.

The MOHCC has taken several steps to institutionalize community health services through relevant policies. The current Ministry's Human Resources Policy states that:

> "The Health Service Board will "strengthen mechanisms for community involvement in prevention, care, treatment and good governance of health services, in line with the Health Sector reforms". The Human Resources for Health Strategic Plan for 2017 – 2020 states that, the ministry will seek to (a) provide a platform for the coordinated engagement of Community Health Workers; (b) create a separate establishment for Community Health Workers guided by National Health Strategy and the Strategy for Community Health Workers."

NATIONAL COMMUNITY HEALTH STRATEGY

SITUATION ANALYSIS FOR COMMUNITY HEALTH SERVICES IN ZIMBABWE

CHAPTER TWO

Situation Analysis for Community Health Services in Zimbabwe

The first step of the National Community Health Strategy development process was understanding the current state of community health services in the country. For this, a situational analysis was conducted, informed by: a desk review of relevant literature (global, regional and national); key informant interviews with multi-sectoral stakeholders; focus group discussions with key community level actors; and self-administered questionnaires with relevant stakeholders at the provincial and district levels.

Stakeholder consultations and validation workshops were convened to collate the findings with participants prioritizing key issues, and aligning on key recommendations. Key decisions on core components were refined during writing retreats.

Findings from the Situational Analysis

The situational analysis revealed that the community health system continues to play a key role on promotive, preventive, minor curative and basic rehabilitative services albeit with some gaps and challenges. The assessment recommended a re-design of the community health system to improve functionality, and sustainability.

The table below summarizes the key findings from the situational analysis of the community health system. It is presented along seven strategic areas which include:

1. Community engagement
2. Community health service delivery
3. Human resources for community health
4. Community health supply chain management
5. Community health management information systems
6. Financing for community health
7. Governance, leadership and coordination for Community Health Services

Key Findings:

STRENGTHS	WEAKNESSES	OPPORTUNITIES
Community engagement		
Zimbabwe has a history of working with community members to support community health services	Fragmentation of community interventions limits community awareness of what range of services they can access	Standardization and integration of health services at the community level Inform communities of the services available to them based on the community health service package
	Community health workers are often not directly accountable to their communities	Social accountability mechanisms for community health can be strengthened
Health Center Committee (HCCs) and Village Health Committee (VHCs) structures exist to ensure communities receive the services they are entitled to	Some HCC members are demotivated and do not perform their roles in community health due to lack of funding support e.g., for transport HCCs are health-facility-focused with limited community interaction	Capacity building and engagement for local level structures Orientation of HCCs and VHCs on their roles in community health
Community health service delivery		
A large community health workforce currently exists, providing a variety of service packages to address the health needs at the community level	Services are fragmented and provided by a plethora of community-based service providers which can be inefficient and confusing for the patient	Standardization and integration of health services for community level
Resources for community health worker pre-service and in-service training are available	Training for community health workers is predominantly partner-led and funded, resulting in rapid expansion of responsibilities and inconsistency in roles and poor quality of service delivery	A well-defined community health service package and standardized training curricula

STRENGTHS	WEAKNESSES	OPPORTUNITIES
Human resources for community health		
There is a pool of community health workers willing to volunteer their services	Multiplicity of community health workers with different backgrounds, training, remunerations	Cadre role harmonization
There is considerable coverage of VHWs (76%) against a target of 80% by 2020	Inequitable distribution of VHWs. Not all wards and villages have adequate coverage of VHWs and other cadres	Contextualization of VHW:Population ratios across geographies and recruitment of adequate VHWs
There is a VHW Strategic Direction Document that guides VHW engagement	Lack of defined legal or policy framework for engagement of community health workers involved in health service delivery	Development of legal or policy framework and accountability mechanism for community health workers
There is funding available for incentivisation of various community cadres	Remuneration of $14 is inadequate and not commensurate with the workload of VHWs	Government commitment to support the program through domestic resource allocation
Community health workers are receiving coaching and mentorship, albeit to varying degrees	Inadequate supervision of community health workers	Implement supervision guidelines and institute a hierarchy of supervision
	No integrated supportive supervision or mentorship checklists or tools exist	Develop integrated supervision checklists and dashboards
	No performance appraisal system for VHWs exists	A performance appraisal system should be instituted and integrated in regular supervision exercises
	No protocol for dealing with underperforming community health workers	Career progression pathway and other reward systems can be developed to incentivise VHWs Protocol for poor performance should be developed

STRENGTHS	WEAKNESSES	OPPORTUNITIES
Community health supply chain management		
The standard VHW kit is defined	VHWs do not have all the requisite tools, equipment and other supplies that they need to offer high quality services to communities	Training of VHWs on community supply chain management
	Frequent stock-outs of selected commodities at community level	A system to ring-fence VHW supplies at community levels can be developed
	Community level supplies and materials have historically not been incorporated into the MOHCC Physical Assets Management plans	Community level supplies and materials can be incorporated into the MOHCC Physical Assets Management plans
Community health management information systems		
Significant data collection through various methods and implementers of community health	Parallel reporting systems with some programs and partners maintaining vertical reporting not integrated into NHIS	Harmonized and standardized data collection and reporting forms for VHWs and improved coordination of partners
Data collection ongoing for community-based indicators	Limited data quality audits at community level[5]	Data entry clerks or health facility teams at facilities who can be utilized
The country piloted e-HR and is exploring use of mHealth	Paper based data collection used and is inefficient	Scaling up of digital technology use across the country
Many actors are involved in supporting the community health program	Database containing active programmes and partners in community health, and activities being conducted is not available	Mapping of community health actors and activities and data being collected

[5]As of July 2019, the completeness of VHW data was at 58.2% and timeliness was at 32.5%

STRENGTHS	WEAKNESSES	OPPORTUNITIES
Governance, leadership and coordination for community health		
There are governance structures from national (MOHCC) to ward level (HCCs) for community health stewardship	MOHCC structures face challenges of funding to perform their roles	Harmonized community health strategy and service package is currently being developed outlines governance, leadership, and coordination structures
	Poor coordination of community health activities within the MOHCC and across ministries	
Financing for community health		
Government has allocated funds for training and support of VHWs	Community health funding is not sustainable as it is dependent on partner funding	Government to explore funding mechanisms in the national health financing strategy The private sector through Community Trust Funds and Corporate Social Responsibility schemes has shown interest in funding community health services
Funding from partners available to support the programme	Funding for community health services is uncoordinated	A basket fund could be developed to pool and coordinate partner funding Donor Aid coordination presents an opportunity to understand who is doing what and where

With these findings in mind, various strategic recommendations were subsequently developed for the National Community Health Strategy. Improvements in key priority areas, especially service package delivery, supervision and mentorship, governance and coordination, and financial sustainability are pivot points to improve the quality of the programme.

This strategy uses a holistic systems approach to address the weaknesses in the current community-based primary health care system.

NATIONAL COMMUNITY HEALTH STRATEGY

STRATEGIC DIRECTION FOR COMMUNITY HEALTH 2020-2025

Strategic Direction for Community Health 2020-2025

CHAPTER THREE

The National Community Health Strategy (NHCHS) is complementary to the overall National Health Strategy for Zimbabwe 2016 – 2020, and the strategic plans of the departments within the MOHCC. This strategy builds on the experience and lessons learnt from the current community health programme in the country.

The strategy is organized around seven strategic areas based on the WHO Health Systems Framework:

1. Community Engagement
2. Community Health Service Delivery
3. Human Resources for Community Health
4. Community Health Supply Chain Management
5. Community Health Management Information Systems (cHMIS)
6. Governance, Leadership and Coordination
7. Financing

Under each strategic area, the strategy articulates relevant strategic recommendations and activities that will lead to increased access and utilization of community-based health services.

Vision and Mission

Vision:

The National Community Health Strategy is aligned to the Ministry's vision of attaining the highest possible level of health and quality of life for all Zimbabweans

Mission:

To ensure equitable access to quality integrated community health services that respond to local health needs across the life course through meaningful community involvement and participation

Goal:

To contribute to improving the health status of all the people, especially women and children, through scaling-up community-based interventions and other health promotion initiatives. The National Community Health Strategy will therefore contribute towards the reduction of morbidity and mortality – *specific goals will be based on the final NHS targets and will be articulated in the monitoring, evaluation framework.*

Guiding principles:

The principles underpinning the National Community Health Strategy are:

> Equity of Services – Providing access to a defined package of services across all socio-economic groups, vulnerabilities and geographical areas

> Pro Poor – Providing interventions for health conditions that disproportionately affect the poor

> Essential Quality Services – Offering a package of health services that all citizens should have access to, and ensuring that these services are provided to the highest standards

- Integration – Providing a seamless and responsive continuum of community health services that are integrated within the larger national health system and address the needs of recipients across their life course

- Transparency and Accountability – Ensuring that there is bi-directional transparency in data sharing and budget management between MOHCC and donor partners supporting Community Health activities, and that accountability for implementation and oversight is clearly defined and enforced

- Ownership and Participation – Promoting community engagement so that beneficiaries can identify and articulate their health issues and fostering collaboration with prioritized community structures

- Continuous Monitoring, Evaluation and Learning – Putting mechanisms and processes in place to check whether planned activities are being implemented as planned and whether expected results are being achieved and to apply corrective measures when results are below targets

- Collaboration with other Sectors – Recognizing that achieving complete physical and mental well-being requires actions and collaboration with different sectors

- Gender – Addressing gender issues that put women and girls at increased risk for ill-health and violence

Achieving the vision, mission, and goals advanced in this strategy will require a revised and strengthened community health system. This strategy institutionalizes community health within the larger national health system and marks a shift from verticalization to integration of health delivery – including preventive, promotive, and selected basic curative health services. The integrated health services will be provided by a community health cadre who will be trained on a regular basis, supportively supervised, adequately equipped and remunerated.

The development of this strategy was guided by the seven strategic objectives across the seven strategic areas. A detailed overview of each strategic objective and supporting activities are in the subsequent sections.

3.1 Strategic Area 1: Community Engagement

Strategic Objective:

- Strengthen community structures for meaningful community participation, ownership and involvement in community health service delivery

Strategic recommendations:

- Capacitate and collaborate with prioritized community structures
- Organize households into networks to facilitate increased community participation in community health service delivery
- Refine roles and responsibilities of local community management structures, in supporting integrated community health service delivery
- Promote health awareness and foster the adoption of healthier lifestyles
- Empower communities and ensure their involvement in the governance of health services through appropriate capacity building
- Invest in community-led approaches that empower vulnerable groups (women, adolescents, etc.) to overcome barriers to accessing care

The community unit structure is comprised of households, village governance structures (village heads, VIDCO, village health

committees, etc.) and affiliate health facilities. The new community health strategy will utilize existing community structures to avoid fragmentation and duplication of efforts.

The Health Center Committees, which are comprised of community members from the health center catchment area, are the focal point for community engagement with the formal health system. They are recognized by the Public Health Act as essential for coordinating health programmes in the area serviced by the health center and informing, educating, and empowering members of the community on health matters. As such, the capacities of HCCs will be strengthened in order to facilitate robust community participation in health matters.

Sensitization of community members on the new community health delivery system will also be conducted by the HCC with support from health facility staff to ensure community members are aware of what services are available, how then can be accessed, as well as their rights/entitlement to health.

The community structures

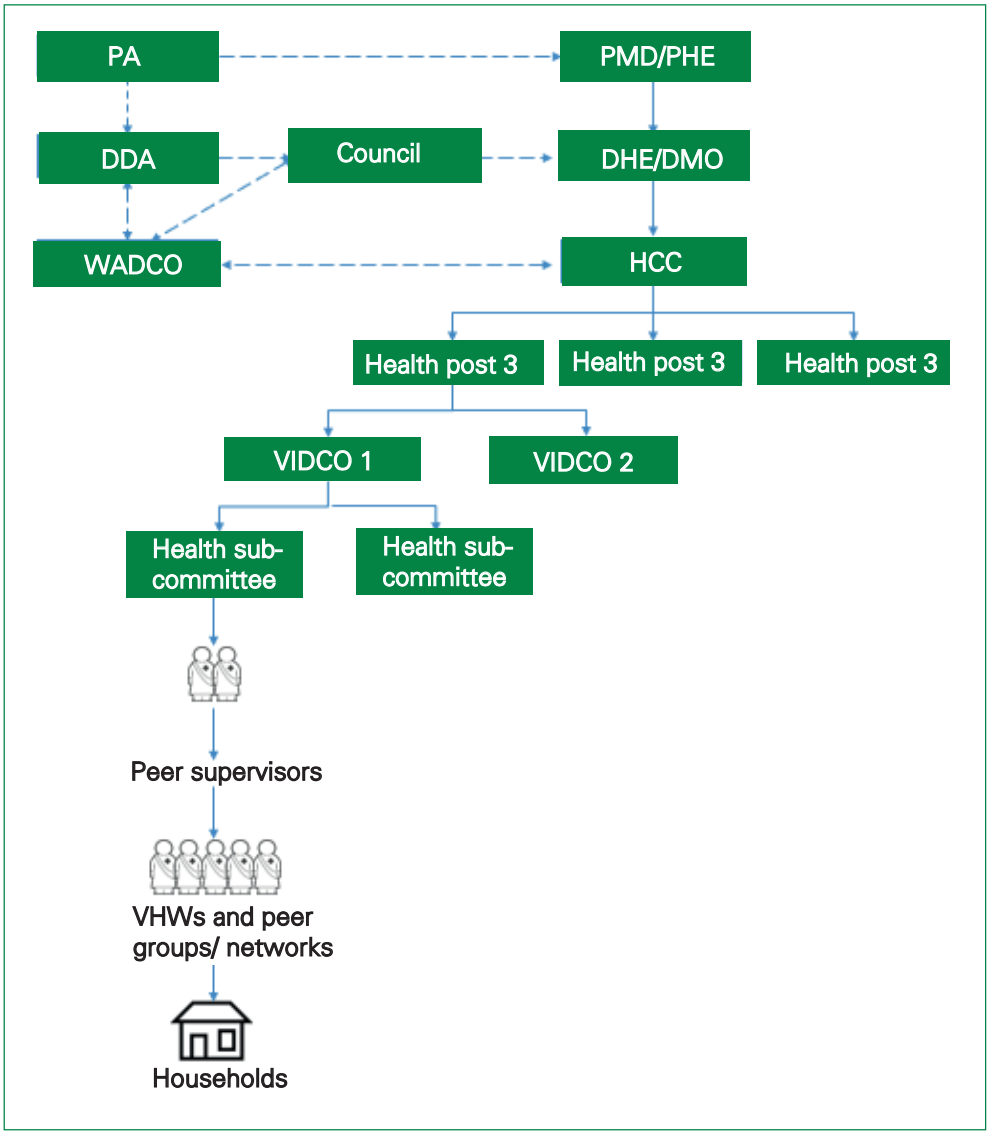


Figure 1 Illustrative Community Structure

Roles and responsibilities of community health structures

Households

> Households are both beneficiaries and participants in community health services delivery, and provide feedback to the health system. Households will receive health promotion and disease prevention messages from VHWs, as well as basic curative services outlined in the community health service package. Households will be organized into networks that are trained on the package and empowered with health promotion messages including for improved household hygiene and environmental sanitation.

Community Action Days

> Community Action Days will be convened to mobilise the communities and raise awareness of specific health-related topics and to share experiences and feedback on community health service delivery. During these, well-performing community health teams, households, and individuals will be recognized and rewarded by the HCC. The Community Action Days will occur on an annual basis and will be led by the community health team (clinic/health post team and VHWs), with support from the HCC. The action days will enhance community ownership and participation in community health leading to behaviour change. The community action days will be aligned to the recognition week for CHWs that will be launched and commemorated every year.

Village Assembly

> Village Assemblies are convened to discuss issues regarding the well-being and development of the village. With the guidance and oversight from HCCs and support from VIDCOs, these assemblies will be utilized as a platform for:
> VHW nomination by community members Discussion of key health indicators from the data collected by VHWs
> Implementation of community feedback mechanisms such as the community scorecard

Village Development Committee (VIDCO)

> The activities of the community-based players in a village are coordinated through the Village Development Committee which is selected by the Village Assembly and chaired by the Village Head. The VIDCO has various sub-committees including Health, Social Services, and Agriculture.

The Village Health Sub-Committee focuses on all health-related issues and provides feedback to the VIDCO through the Village Head. It is composed of the VHW, Village Head (Sabhuku), a church representative, youth representatives, women representatives, a traditional healer, a faith healer and a representative of the disabled.

The VIDCO health subcommittee will plan, implement and monitor health related activities. The functions will be co-defined with the district health team and other multi-sectoral structures at sub-national level.

The VIDCO health subcommittee will link with the local primary health facility and HCC through the local VHW and the health post. The responsibilities of the VIDCO will include amongst others:

> Identify and select eligible candidates to be trained as VHWs
> Facilitate uptake of services and behaviours promoted by the VHW
> Resolve disputes/challenges between VHWs and other community members and take corrective actions or escalate as necessary
> Ensure effective linkages and integration with other community workers from other line Ministries such as Agriculture, Social Services etc.
> Through the Headman, Chief and religious

leaders, coordinate and provide oversight in the provision of traditional and religious health services, and strengthen links to formal healthcare
- Promote adoption of healthy lifestyles, and disease prevention and control
- Effectively participate in disease control activities
- Champion messages shared by VHWs
- Take ownership of the programme and take full responsibility of the community dynamics that might hinder or facilitate progress
- Create an inclusive community environment that is child, youth and women-friendly

The Village Head in the subcommittee (who is mandated to keep up-to-date registers of names of villages and their inhabitants) together with the VHW (who keeps specific health related registers) should both be engaged as resources in the development of community health information systems.

Health Centre Committees (HCC)

- As established in the Public Health Act (Chapter 15:09 of 2018), HCCs are comprised of community members served by a Health Centre. HCCs serve as a bridge between communities and health facilities. As defined in the Act, the HCC will provide the following functions:
  - Inform, educate and empower members of the community on health matters
  - Use information gathered from the communities to plan, monitor and evaluate health programmes
  - Coordinate health programmes in the area serviced by the health center
  - Represent communities and their interests before relevant authorities
  - Support local health care planning activities, including resource mobilization
  - Support local community-based workers in health and advocate for a budget for community health service delivery
  - Perform other functions and duties as the Minister may assign

The HCC will ensure adequate linkages with other governance and community engagement structures including the WADCO, VIDCO and District Development Committees (DDCs). They will also supervise VHWs.

WARD Development Committee

- The WARD Development Committee is headed by the WARD Councillor who is an elected representative of the community. The Councillor also sits in the rural district/urban council which is the local government institution responsible for the socio-economic development as established by Section 59 of the Rural District Councils (RDC) Act and Section 20 of the Traditional Leaders Act. The WADCO:
  - Mobilises resources for community health service delivery at council level and from other community stakeholders such as Community Share Ownership Trusts, private companies etc
  - Provides oversight through the WARD Health Committee to VIDCOs and Village Health Sub-Committees
  - Coordinates and provides linkages with other structures including the HCC, RDC and other government structures

Non-profit organizations including Non-governmental Organizations (NGOs), Community Based Organisations (CBOs) and Civil Society Organisations (CSOs)

- These are organic voluntary and non-profit organisations that are based at

the community level to provide various community-based services including health, capacity building, advocacy and resource mobilisation. They shall work with VHWs and community leaders, under the coordination of the formal government health structures, to ensure preventive, promotional health services are integrated into community programming.

> These organizations will support the government structures to increase health rights awareness among populations, so as to encourage timely health seeking behaviour.

Interventions and activities

> Utilize existing community structures for the revised community health programme;
> Assess capacity gaps in the community leadership and structures, and build this capacity based on newly defined roles;
> Conduct community sensitization on the revised community health delivery structures before strategy implementation;
> Engage local leaders and community members in VHW recruitment, priority-setting and decision-making for VHW activities;
> Establish social accountability mechanisms within the community health system (e.g., scorecards, performance appraisals, and patient and community feedback on their community health experience);
> Provide an enabling environment for these community structures to perform their roles e.g., by providing logistical support to attend meetings
> Develop and provide guidelines to strengthen community participation, including youth and adolescents, in health development;
> Organize households into networks that are empowered to effectively and efficiently implement the community health promotion intervention packages.

3.2 Strategic Area 2: Community Health Service Delivery

Strategic Objective:

> Ensure provision of an integrated, comprehensive community health service package) of appropriate health services at the community and household levels

Strategic recommendations

> Deliver the community health service package in response to community health needs across the various life stages, taking into consideration local disease burden

> Integrate community health service delivery at the point of care

> Review the community health service package to ensure that it continues to address the dynamic needs of community

Community health service package delivery

- The community health service package is a package of preventive, promotive, curative and rehabilitative health services delivered to communities by frontline health workers, with the participation of community members. The services and interventions detailed in the community health service package address the health needs of communities taking into consideration equity, disease burden and health related priorities of the country. The continuum of care using the life course approach is illustrated below.

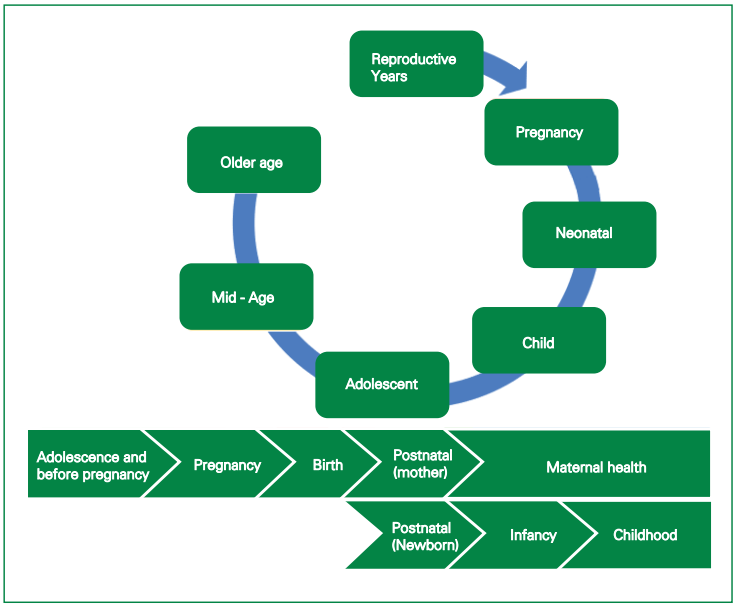


Figure 2 Continuum of care using the life course approach

The community health service package contains services that are critically needed to improve the health of Zimbabweans and its most vulnerable groups. It includes:

> Reproductive health
> Maternal and Newborn health
> Child health and nutrition
> Adolescent health
> Communicable disease
> Non communicable disease

Elderly care and mental health will be integrated across the various relevant intervention areas.

Integration of community health service delivery at the point of care -

Integration promotes the efficient use of time and resources by reducing duplication of efforts. Community health service delivery will be provided by a community health services team that includes:

> A core cadre of VHWs who are trained on and responsible for the integrated delivery of the entire community health package. They will receive regular in-service training to enhance their capacity to address new and emerging health issues
> Peer groups/networks, that serve as action and learning oriented groups. These peer groups/networks will provide support to defined networks of households or population groups within their neighborhood
> The VHWs and the peer groups/networks will conduct cross-referrals.
> Health facility teams who will be responsible for ensuring referrals are executed correctly.

Institutionalization of community-based care within the larger health system -

> VHWs do not replace the need for high quality facility-based care, but they are essential to achieving a fully integrated, high-functioning health system that reaches Zimbabweans in the communities where they live and work. The Ministry recognizes that VHWs are more successful and sustainable when they are formally integrated into the national health system, as illustrated below.

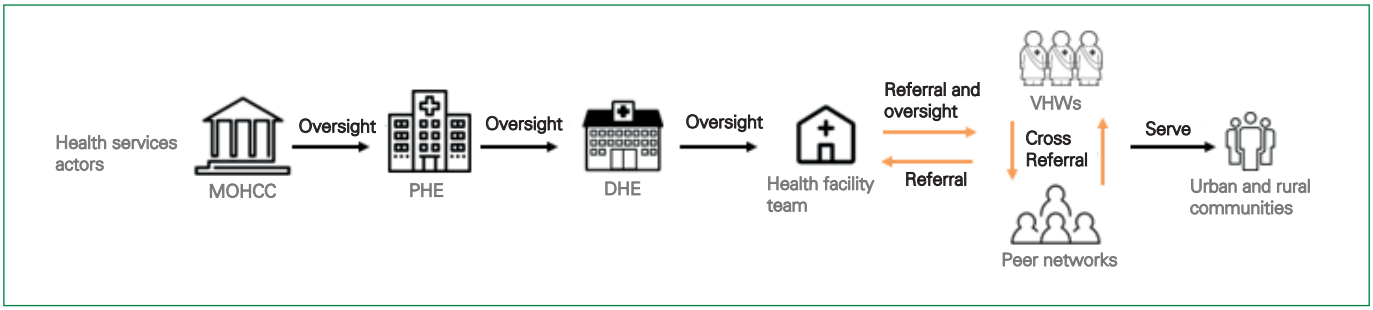


Figure 3 Community Health Integration into Broader Health System

Interventions and activities

- Establish well-defined and widely understood scopes of services that clearly delineate between community and facility-based services and interventions;
- Strengthen bi-directional referral systems between VHWs and health facilities and established health posts;
- Identify and select appropriate peer groups/networks to provide the additional differentiated services in support of the VHW;
- Integrate planning and programming (including financing, human resources and procurement) for community health services at district, provincial and national level;
- Regularly revise the community health service package services as needed;
- Make provisions for patient transportation especially in emergency cases such as labor and child complications;Revise CSO MOUs to align to the NCHS and devolution process, in consultation with the local community governance structures and CSOs. CSO activities will complement the operations of community health workers

3.3 Strategic Area 3: Human Resources for Community Health

Strategic Objective:

- Deploy a sufficient, equitably distributed, well-trained community health workforce that is supported and recognized within the national health system

Strategic recommendations:

Table 2: Summary of human resources for community health strategic recommendations

HR Component	Strategic Recommendation	High-level interventions and activities[6]
1. VHW selection and recruitment	> Define coverage ratios that reflect VHW role expectation, population density and geographic constraints and epidemiologic contexts > Define selection criteria aligned to the WHO recommendations[7] > Harmonise the existing cadres to: reduce their number, reduce duplication and for efficient use of resources	> Assess the feasibility of the current workforce coverage ratios (1:100 households) > Recommend a VHW:Population ratio taking into account the expanded package of services, and adapt for regional geographic and epidemiological variation > Conduct a district-level census of community health workers > Select VHWs with the aim of leveraging the resources and investments made on the current pool of cadres to date
2. Training and accreditation	> Provide pre-service and in-service training to recruited VHWs using a MOHCC-approved training curriculum > Provide accreditation to VHWs who pass the standardized written and practical tests	> Revise the VHW training curriculum and training programme > Evaluate the training curriculum using pre-post knowledge and skills assessments in pilot training groups before national rollout > Certify qualified VHWs > Review training curriculum and training package on an ongoing basis
3. Deployment	> Equip VHWs with the necessary resources to carry out their functions > Register all certified VHWs prior to deployment	> Procure and equip VHWs with necessary equipment, supplies and job aides > Update VHW database bi-annually
4. Supervision	> Strengthen the health facility supervision structure by utilizing supervision teams to provide supportive supervision > Pilot new supervision structure	> Introduce supervision by teams at the health facility level > Establish supervision guidelines > Train and equip supervisors > Develop standardized supervision tools, dashboards and reporting processes > Collate and analyse data, and utilize it for VHW performance appraisal
5. Incentivisation	> Develop the VHW incentive package, in collaboration with other relevant sectors	> Avail timely finances for VHW incentives > Periodically review VHW incentives in line with an agreed formula, funding and service delivery package > Develop and update investment cases for routine advocacy for domestic funding to remunerate VHWs
5. Opportunities for advancement	> Provide opportunities for career progression from VHW to peer supervisor	> Create guidelines for career progression from VHW to peer supervisor

[6]Detailed interventions are available in subsequent sections of the strategy
[7]World Health Organization. (2018) WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes (CC BY-NC-SA 3.0 IGO)

Human Resources for Community Health Overview:

1. VHW Coverage, Selection and Recruitment:

Coverage ratios

The government to Zimbabwe will work towards increasing the number of VHWs during the next five years of implementation, to meet the district-level needs. The Ministry will ensure the current coverage of 1:600 or 1:100 households is revised during implementation planning, to account for the expanded scope of services VHWs will provide. MOHCC will also ensure that the resulting recommended coverage ratio will be contextualized to community needs, geographical density and spread and other factors, and will be designed to promote equity in access to services. As such, the coverage and density of VHWs will vary by catchment area. Further, with the decentralization of health through the health posts, an additional review of the VHW: Population ratio will be conducted.

Selection and recruitment

It is critical that the right workers are selected, adequately trained, and deployed with the full support of the communities and health facility personnel they will work with. Selection and recruitment of VHWs will seek to leverage the resources and investments made on the current pool of cadres to date[8].

The following factors and attributes[9] should prevail in this process:

- Selection criteria and recruitment methods will continue to be designed to maximize women's participation in the workforce and overcome gender inequities
- VHWs will continue to be selected with community participation.
- Attitudes, expertise, and availability deemed essential for the job will be delineated prior to recruitment[10] and linked to specific interview questions/ competency demonstrations (e.g. literacy test)

The VHW selection process shall continue to be an inclusive process that includes the DHE, ward-level health facilities, multi-sectoral representation, community leadership, and the community.

The VHW selection process should ensure all members of the community have an equal opportunity to serve without bias based on gender, economic status, marital status etc. All VHWs should meet the following minimum criteria, which will be refined further:

- Minimum age of 18 years. The upper age limit and retirement age will be determined by MOHCC based on the specific roles of the VHWs
- Citizen of the Republic of Zimbabwe
- Resident of the catchment area and willing to spend significant time within the catchment area
- Competent in local language(s)
- Demonstrated ability to read and write through a competency-based approach rather than certification only based approach, to allow equal chances for women, people living with disability and other underserved groups[11]
- Good communication and interpersonal skills
- A person of integrity in good standing with the community who demonstrates commitment to community service and is capable of maintaining confidentiality

[8] To be defined based on the mapped community health workers
[9] Ballard, M., Bonds, M., Burey, J., Dini, H.S.F., Foth, J., Furth, R., Fiori, K., Holeman, I., Jacobs, T., Johnson, A., Kureshy, N., Lyons, J., Malaba, S., Palazuelos, P.,Raghavan, M., Rogers, A., Schwarz, R., Zambruni, J. (2018) CHW AIM: Updated Program Functionality Matrix for Optimizing Community Health Programs (DOI:10.13140/RG.2.2.27361.76644s)
[10] MOHCC will define the selection criteria for integrated and/or harmonized cadre
[11] World Health Organization. (2018) WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes (CC BY-NC-SA 3.0 IGO)

The illustration below provides an overview of the revised HR structured for community health.

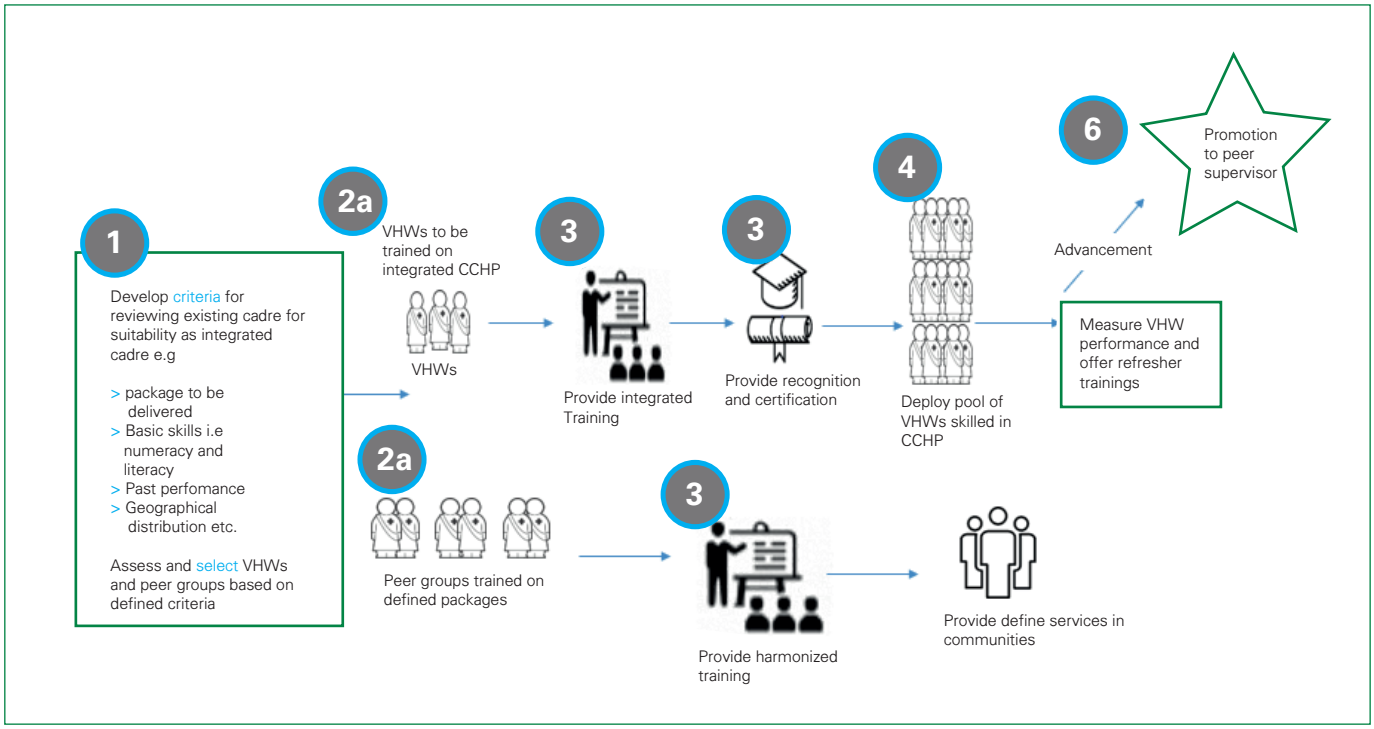


Figure 4 Illustrative HR structure for Community Health

Interventions and activities

> Redefine the desired selection criteria for recruitment of VHWs;
> To achieve efficient distribution of VHWs and peer groups/networks:

> Conduct a district-level census of all relevant cadres of the community health system to determine coverage gaps and deployment needs;
> Develop and institutionalize the use of district-level VHW registers to remove inactive VHWs, which will ensure resources are used effectively and that no communities go underserved.

2. VHW Training and Accreditation:

a. Pre-service training

VHW training design - Training will be guided by a revised curriculum. The training curriculum and material (manuals and guidelines) will be developed by MOHCC and the Ministry of Higher and Tertiary Education as appropriate. Wide stakeholder consultation and engagement will be critical to the development, evaluation and revision of the training curriculum and material in order to make the content responsive to changing health and programme needs. The training curriculum and material will be piloted among trainers and a sample of VHWs in order to identify areas for improvement.

Qualified trainers will be selected and trained by master trainers as per MOHCC guidelines and policies. The trainers will be trained at the district level and will be certified by the Secretary for Health and Child Care. VHW trainers will be distributed based on the needs of each district.

VHW training delivery - Trainings will capacitate VHWs with knowledge, skills and attitude required to deliver the community health service package. Pre-service training will be provided within one month of recruitment. The DHE will coordinate and oversee all VHW training with support from local government.

Key characteristics of the training will include:

- Balance of theory-focused knowledge and practice-focused skills, with priority emphasis on supervised practical experience;
- Balance of face-to-face and e-learning, with priority emphasis on face-to-face learning, supplemented by e-learning;
- Prioritization of training in or near the community: classroom-based training will be provided at the district-level, at low-cost venues (e.g., schools, clinics, or vocational training centers) while practicum training will be conducted in VHWs' communities;
- Delivery of training and provision of learning materials in a language that can be understood by the learner e.g. vernacular languages;
- The training curriculum will build both technical and soft skills (e.g. interpersonal communication skills);
- Training delivery should be innovative, creative, engaging and make use of visual aids and interactive methods that include role play, simulation, discussion, demonstration and visual and audio tools;
- A code of ethics should be developed and taught to VHWs to promote profe-ssionalism in service delivery, including the privacy of patient information, restrictions on the distribution of medications, and consequences for corrupt behaviour (such as withholding services for payments or gifts).

Training will be provided on a modular basis, allowing VHWs to return to their communities to provide services. VHWs will be deployed after completing the first module.

VHWs shall not bear any costs associated with training and deployment, such as the cost of transportation, meals, and lodging (where applicable). During the training period, the VHWs will receive a stipend, as they will be working full time.

Interventions and activities

- Develop a training curriculum in line with the integrated community health service package;
- Select and provide training of trainers;
- Provide pre-service and in-service training to VHWs using MOHCC- approved curriculum, based on the services packages the VHWs will be offering. Training will be both classroom and practicum-based and will take place in the same geographical areas in which staff will be deployed. This will be done in order to best incorporate contextual variation that may be relevant for them to succeed in their roles;
- Define and standardise training for peer groups/networks providing differentiated services at community level.

b. Refresher Training

VHWs will receive continuous capacity development through a series of refresher courses and mentorship, to reinforce initial training. Refresher trainings will be conducted every two years or as necessary, over a period deemed adequate to deliver these trainings. The District Health Executive will oversee the refresher trainings.

Interventions and activities

> Assess gaps in service delivery and identify VHWs requiring additional/ refresher training;
> Provide refresher trainings to VHWs every two years.

c. Accreditation

Accreditation - VHWs who complete the pre-service training and pass the standardized written and practical test (pass rate >50 -60%) will receive accreditation from the training institutions and any other body assigned by the government of Zimbabwe and MOHCC.

Certification - VHWs will be presented with official certificates by MOHCC, in line with the WHO Guideline, which suggests using competency-based formal certification for VHWs who have successfully completed all the pre-service training modules. Certificates will be signed by the Secretary of Health, allowing them to practice.

> Re-testing - Provisions for VHWs to re-test will be put in place in the case of failure to attain the minimum pass rate. Where the VHW has been inactive for a period exceeding 3 months, measures can be taken to replace them through a fresh recruitment exercise. Inactive VHWs hoping to re-join the program, can do so if:
> Gaps in service coverage exist in the community
> They are able to deliver the community health service package
> They still have the support and authorization from the communities

Interventions and activities

> Certify VHWs who pass the standardized written and practical tests;
> Allow VHWs who do not attain the minimum pass rate to retake the tests;
> Conduct fresh recruitment of VHWs in the event of attrition.

3. Deployment

Prior to deployment, VHWs will present their certificates to their direct supervisor at the health facility. The DHE will keep records of trained, deployed, active and inactive VHWs. This database will be reviewed and updated bi-annually.

Interventions and activities

Procure and equip VHWs with a standard uniform, identification badge and prerequisite equipment and supplies to VHWs;

> Update VHW database bi-annually. Districts and provinces shall be required to maintain all records of trained, deployed and active VHWs, as well as other VHWs. This will be used to inform periodic mapping of coverage and to identify areas of additional need. The database will contain the geographic location of VHWs as well as contact number so that it may be leveraged to support the roll out of a number of activities related to CHIS including reporting, supervision, referrals among others. The following guidelines shall be followed:
> Rosters of certified VHWs should be maintained by the DHE
> Facilities will contribute updates on newly active or inactive VHWs within their supervision to the DHE for incorporation into the roster
> All rosters should incorporate evidence of active deployment for all health workers

Rosters shall be revised and reassessed bi-annually to identify and remove VHWs who are inactive or whose certification has lapsed.

4. Supervision:

A multi-sectoral approach will be taken towards

oversight of the community health programme. MOHCC will collaborate with other ministries, such as the Ministry of Local Government, Public Works and National Housing in this effort. As the custodian of the programme, MOHCC will coordinate the development of supervision guidelines as well as allocate resources towards supervision such as training, relevant tools, and transportation.

An overview of the supervision structure at [illegible][12]

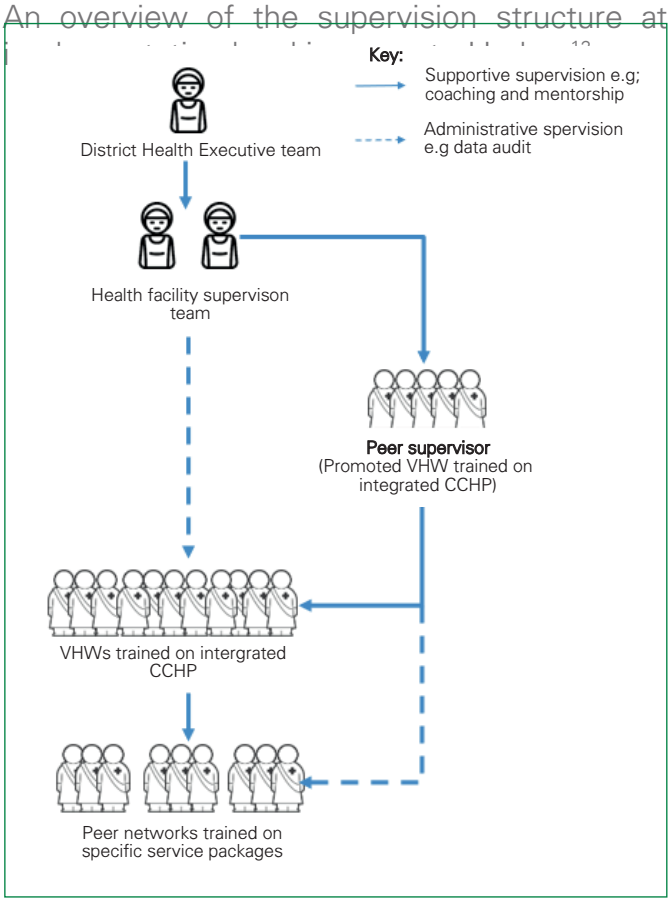


Figure 5 Illustrative Supervision Structure

Roles and responsibilities of the supervision team[13]

VHW supervision: VHWs will supervise the community health peer groups/networks in their communities. They will be equipped on specialized services being offered to special groups. Due to the special nature of services that will be provided by these peer groups/networks, it may not always be possible for VHWs to provide observational supervision (e.g., due to privacy concerns). In such cases, supervision will be limited to soliciting community feedback as well as ensure that cross referrals, data collection and reporting is conducted regularly and to a high degree of quality.

Peer supervision: Peer supervisors are VHWs who have been trained on the integrated community health service package and promoted into this role based on past performance and recommendation by the HCC. They will be dedicated supervisors who spend their time in the community, providing supportive supervision services to VHWs.

- The primary role of peer supervisors will be to ensure that VHWs effectively deliver the health services outlined in the community health service package at a high standard of care. They will also be responsible for ensuring referrals are executed correctly, and that data collection and reporting is conducted properly. Their responsibilities will include: mentoring, VHW performance appraisal, management, and supportive supervision.
- Peer supervisors will directly observe VHW job performance (including: service delivery, documentation, and completion of data collection and reporting forms) at a minimum frequency of once per month
- Peer supervisors will collate reporting and data collection forms from VHWs monthly, identify suspected data quality issues, and address them
- Peer supervisors will intermittently solicit community feedback on VHW performance in alignment with the community engagement strategy

They will make orders for replenishment of VHW supplies at the clinic on behalf of their

[12] Direct supervision is where there is a high level of interaction between the supervisor and the supervisee, and the supervisor provides supportive, clinical and administrative supervision. Indirect supervision has minimal interaction between the supervisor and supervisee, and the supervisor is accountable for the performance of indirect reports but do not manage them directly

[13] The proposed supervision model will be tested and refined during the implementation phase

supervisees, where necessary

In order to facilitate supervision, each supervisor will receive a standard set of supplies that includes:

i. A standard uniform
ii. An identification badge
iii. A mobile phone and/or mobile phone credit as determined to be necessary
iv. A durable mode of transport (such as a bicycle) or transportation reimbursement as determined to be necessary.
v. VHW supervisor manual and integrated supervision checklist
vi. Standard VHW equipment

Health facility team supervision - The team will convene monthly data reporting meetings with the peer supervisors and VHWs. At these meetings, they will conduct data quality audits to ensure the data submitted by VHWs is complete and of high quality, synthesize the data to identify emerging trends, and verify the supplies orders.

Health facility teams (HFTs) will provide supportive supervision to peer supervisors using a standardized integrated supportive supervision checklist. They will also obtain VHW feedback on the supervision support they have received from the peer supervisor.

The HFTs will conduct quarterly community based supportive supervision and annual performance appraisal for VHWs. The teams will recognize the best performing VHWs for example with certificates. Upon establishment of health posts, facility-level supervision responsibilities will be decentralized to the health post staff.

Joint supervision forum - Community level support and supervision will be integrated into on-going supervision visits by DHEs, local government, national level programmes and partners. Joint quality spot-checks will be conducted to assess the quality of services provided by VHWs and their supervisors. Support and supervision checklists will also be revised to include discussions and assessment of community health workforce.
Quality spot-checks will be conducted on a randomly selected set of VHWs and supervisors each quarter. During these spot checks, facility-based staff will:

> Solicit feedback on the VHW supervisor and the VHW
> Confirm VHWs and the VHW supervisor have the necessary tools and supplies to perform their duties

Supervisors will also ensure that facility-based supervisors and peer supervisors have adequate transportation support (and authorize procurement of approved transportation methods where there is none). In order to ensure sustainability, a maintenance plan will be followed to preserve the longevity of durable transport methods.

a. Specific roles include:

> District level supervision:
> DHE will collate data collection forms from health facility -based VHW supervisors monthly, identify suspected data quality issues, and ensure they are addressed
> DHEs serving as supervisors for facility-based VHW supervisors will intermittently solicit VHW feedback on facility-based VHW supervisors' performance

b. National level supervision:

> Supervisors will review quality of health services and interventions provided by VHWs; assess challenges in financing and management of community health activities; and review the implementation fidelity of the programme against national priority and guidelines

c. Local government supervision:

> Local governance structures such as the Health Centre Committee (HCC), Village Development Committee (VIDCO) and Ward Development Committee (WADCO),

will oversee community health service delivery within their areas of jurisdiction. Through Village Assembly convenings, the HCC will be able to collect patient feedback and cascade any emerging issues to the heath facility teams for action.

> The proposed supervision model will be tested and refined during the implementation phase.

Interventions and activities

> Introduce supervision by teams at the health facility level;
> Establish guidelines for minimum peer supervisor:VHW ratios, which should permit supervisors to directly observe VHW service delivery at least once per month, in line with WHO guidelines;
> Train and equip supervisors to provide meaningful, regular performance evaluation and feedback;
> Develop standardized supervision tools, performance dashboards and reporting processes;
> Collate and analyse data, and utilize it for VHW performance appraisal;
> Test new supervision model in selected districts. Ultimately scale the new supervision model

5. Incentivisation

VHWs, like any other cadre of health workers, should be remunerated. The WHO recommends the remuneration of practising VHWs with a financial package commensurate with the job demands, complexity, number of hours, training, and roles that they undertake. Remuneration not only compensates VHWs for their time and efforts in providing health services (which could have been otherwise spent pursuing other income generating activities), but also keeps them motivated and reduces attrition.

The government of Zimbabwe and MOHCC will formalize the incentivisation of VHWs. In accordance with WHO recommendation, VHWs shall not be incentivised exclusively through results-based incentives.
Equity and equality will be ensured in the distribution of in financial and non-financial incentives as well as rewards. These will be reviewed regularly. The government of Zimbabwe recognizes that:

1. VHWs will remain as volunteer cadres in the short to medium term, rewarded through financial and non-financial incentives. In the long run, with expansion of fiscal resources for health, the government aims to fully formalize VHWs into the civil services;
2. Variations exist in the types and levels of incentives provided to community health workers. The government will ensure that incentives and rewards for VHWs are standardized across districts, commensurate with levels of effort, training and services provided;
3. There is a need for efficient management of VHW incentives funding. Timely disbursement of incentives using payment methods that can be easily accessed at community level will increase motivation and satisfaction of VHWs.

The following non-financial incentives will be explored or continue to be provided:

1. Durable goods for personal use (such as food hampers and agricultural tools)
2. Benefits such as free treatment at government health centers
3. Recognition for outstanding performance through certificates, awards and public recognition through community structures

Other methods for communities to contribute towards incentives and remuneration for VHWs. The Government will ensure such contributions do not become informal user fees to access

services as this will create financial barriers to services.

Interventions and activities

- Develop the VHW incentive package during overall health system planning by conducting an initial assessment of VHW perspectives about the factors, financial or otherwise, that best motivate them as well as broader aspects, including duration and scope of VHW training, and level of effort in their role;
- Avail timely finances for VHW incentives;
- Regularly review and update the incentive package;
- Periodically review VHW remuneration in line with an agreed government guideline, funding and service delivery package;
- Develop and update investment cases for routine advocacy and lobbying of domestic funding to remunerate VHWs and ensure they are recognized as a formal health system;

6. Opportunities for advancement

Offering opportunities for career advancement for VHWs is beneficial because it leads to higher retention and job satisfaction. It also represents investment in and growth of human capital within the Zimbabwean health system. Well-performing VHWs will have the opportunity for career advancement to peer supervisor. Other recognition mechanisms can be explored at the health facility level.

As the community health system evolves, MOHCC will assess the feasibility of creating linkages between VHWs and other professions.

Interventions and activities

- Develop guidelines for career progression from VHW to peer supervisor.

3.4 Strategic Area 4: Community Health Supply Chain Management

Strategic Objective:

Provide sufficient commodities and equipment to enable the consistent provision of the comprehensive community health package.

Strategic recommendations:

- Integrate community health supply chain as part and parcel of the national supply chain distribution system
- Improve planning and coordination of the supply chain from the community to national level for timely delivery of sufficient volumes of commodities and equipment
- Adopt the use of technology for improved stock management at the health facility level

Increase allocation of funding towards community health supply chains including transport options

The recommendations above seek to address the two principal causes of stock-outs in community health supply chain due to financing challenges and human error in the requisition process.

Interventions and activities:

- Provide stock management training to VHWs and health facility staff;
- Quantify the level of selected commodities that are necessary for the provision of community health services;
- Strengthen supply monitoring and roll

out electronic stock/supply management technology;
> Provide the necessary equipment for community health service delivery (e.g., bicycles, weighing scales, thermometers, among others);
> Develop systems and provide resources for the maintenance of equipment;
> Provide storage boxes for the preservation of supplies;
> Distribute tools for safe storage of supplies by VHWs, with provisions for collection in villages facing security concerns;
> Provide training and infrastructure for disposal of health-care waste.

3.5 Strategic Area 5: Community Health Management Information Systems

Strategic Objective:

Develop an integrated community health information system that allows a multi-directional flow of data and knowledge

Strategic recommendations:

> Implement recommendations from the landscape assessment of existing community health data reporting channels across the country, and the indicators to be collected;
> Develop an integrated community health data system;
> Address parallel reporting through harmonization of data collection registers and tools, and integration of partner data into the national HMIS;
> In line with the MOHCC's e-Health strategic plans, leverage the growing use of modern technology to improve the quality of care, supervision, reporting and stock management;
> Integrate training on data management during the pre- and in-service trainings for VHWs, supervisors and HCCs;

Design data feedback mechanisms for VHWs, community structures and communities.

Interventions and activities

> Determine the routine data (and requisite indicators) that VHWs will track during the implementation planning phase;
> Harmonize all data collection tools for the national community health programme into a single folder that submits to one system linked to the HMIS. Peer groups/networks will also submit their data through VHWs into the HMIS, in order to provide holistic community health data;
> Review of data collected by VHWs at the monthly supervision meeting by VHW supervisors. Supervisors will also conduct data audits by reviewing the frequency and quality of data collected;
> Disaggregate village-level data from district-level data in order to allow communities access and use their data for disease surveillance and planning. To that end, HCCs can make requests for data from the health facility;
> Digitize community health service delivery from household visit scheduling, household data collection, referral coordination and stock management. This information will be centrally aggregated and made available to MOHCC and other levels of government for planning and decision-making;

3.6 Strategic Area 6: Governance, Leadership and Coordination

Strategic Objective:

Institutionalization of community health within the national health system and strengthening the implementation and coordination of community health services across all levels of government structures, from subnational to national.

Strategic recommendations:

- Institutionalize community health within the national health governance structure
- Improve coordination of community health between all levels of government and across partners

The national community health programme will be instituted within the national health governance framework and will be rolled out under the leadership of the MOHCC.

Governance, leadership and coordination structure:

There shall be a national coordinator or Director of Community Health Services to oversee the community health programme with support from a deputy director and two officers at national level. The Permanent Secretary will appoint or second an interim National Coordinator. The community health programme will be staffed by a team that has competences in key elements elements of primary health care. This team will be responsible for overseeing the day to day coordination of activities such as curriculum development, stakeholder coordination, resource mobilization and allocation, certification of VHWs, and provision of technical implementation guidance and support to decentralized implementation teams.

At sub-national levels, already existing structures will be utilized and roles reassigned at provincial and district levels. Where there is no capacity, an additional role will be created during implementation to inform future programming. The PHE, DHE, health facility teams, HCC and VHC will continue to play an oversight role. Multi-stakeholder community health technical working groups will be developed across the various administrative levels, from national to ward levels. These working groups will be responsible for providing technical planning and implementation support within their areas of jurisdiction.

Linkages with other ministries, programmes as well as local and traditional government structures will be strengthened. These stakeholders will be engaged in the implementation of the community health strategy through inter-sectoral collaboration forums.

The figure below illustrates the organizational structure for community health.

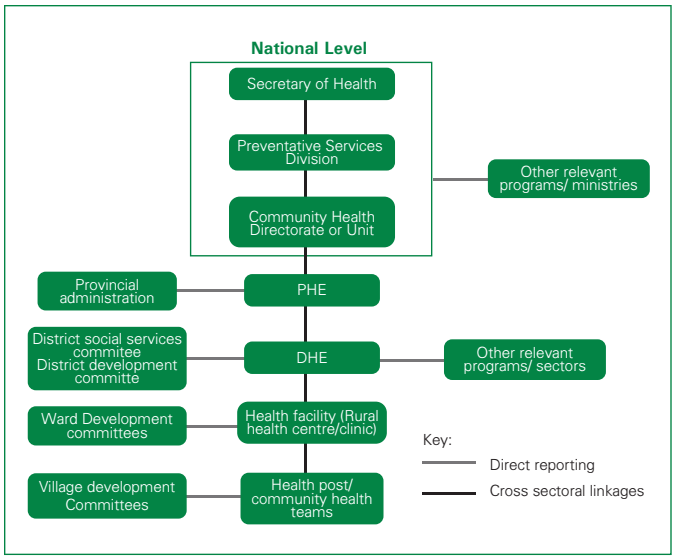
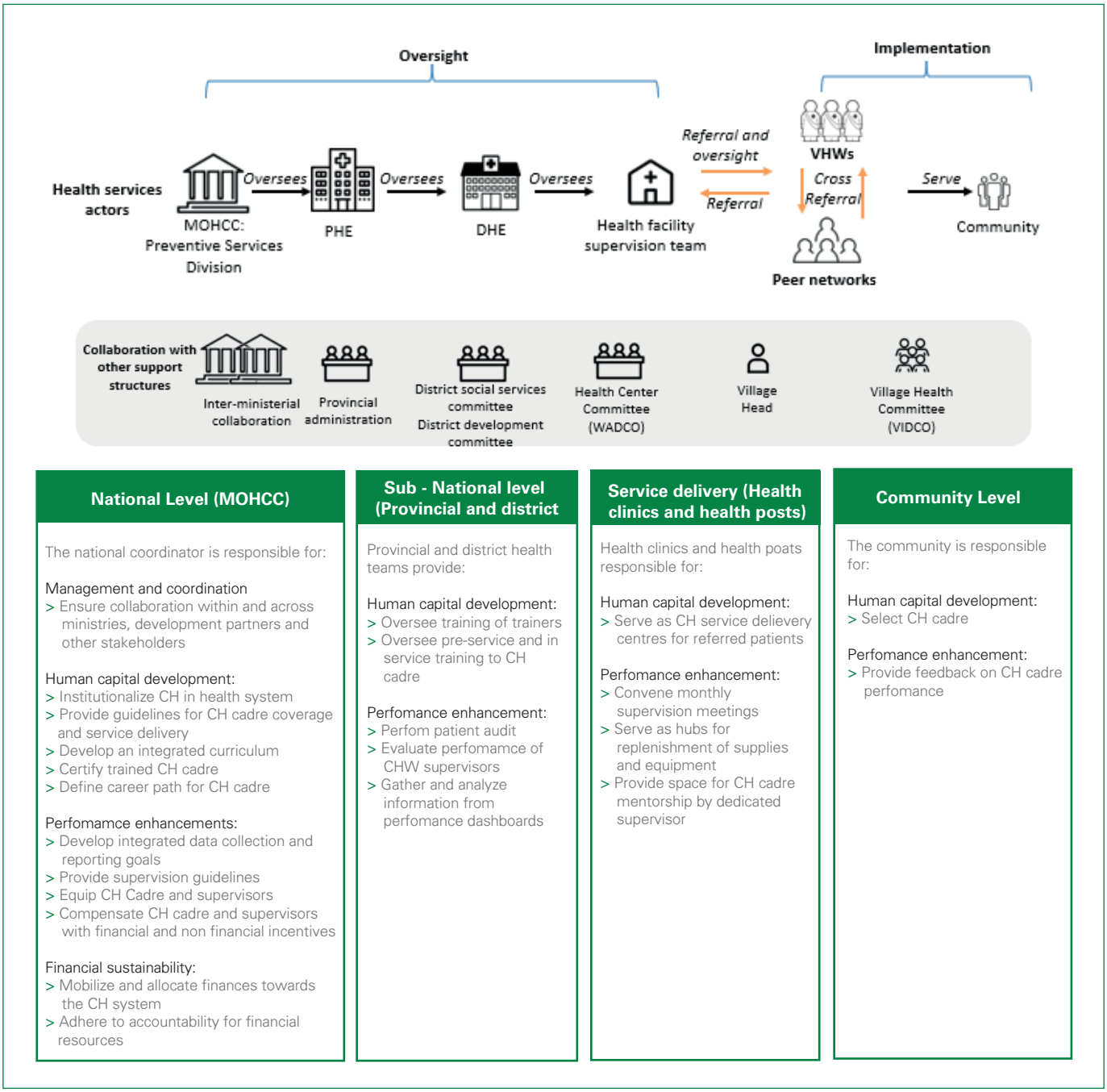


Figure 6 Community health reporting structure

Interventions and activities

> MOHCC will adopt the governance plan outlined below:



National Level (MOHCC)	Sub - National level (Provincial and district	Service delivery (Health clinics and health posts)	Community Level
The national coordinator is responsible for: Management and coordination > Ensure collaboration within and across ministries, development partners and other stakeholders Human capital development: > Institutionalize CH in health system > Provide guidelines for CH cadre coverage and service delivery > Develop an integrated curriculum > Certify trained CH cadre > Define career path for CH cadre Perfomamce enhancements: > Develop integrated data collection and reporting goals > Provide supervision guidelines > Equip CH Cadre and supervisors > Compensate CH cadre and supervisors with financial and non financial incentives Financial sustainability: > Mobilize and allocate finances towards the CH system > Adhere to accountability for financial resources	Provincial and district health teams provide: Human capital development: > Oversee training of trainers > Oversee pre-service and in service training to CH cadre Perfomance enhancement: > Perfom patient audit > Evaluate perfomamce of CHW supervisors > Gather and analyze information from perfomance dashboards	Health clinics and health poats responsible for: Human capital development: > Serve as CH service delievery centres for referred patients Perfomance enhancement: > Convene monthly supervision meetings > Serve as hubs for replenishment of supplies and equipment > Provide space for CH cadre mentorship by dedicated supervisor	The community is responsible for: Human capital development: > Select CH cadre Perfomance enhancement: > Provide feedback on CH cadre perfomance

Figure 7 Illustrative Governance Plan

a. National level:

A national coordinator for community health reporting to the Chief Director, Preventive Services will be responsible for national programme governance and coordination. The national coordinator will be responsible for planning, resourcing, and monitoring and evaluation of the community health program. The national coordinator will also coordinate various stakeholders across national, district, and community levels. By engaging with these structures, the national coordinator will ensure there is alignment in the strategic and operational priorities.

Key responsibilities of the national community health coordinator include:

- Develop guidelines and monitor adherence
- Provide technical implementation support to decentralized implementation teams
- Coordinate all levels of government by collecting and sharing information
- Track and coordinate partners and activities at the district, ward and village levels through stakeholder mapping and joint work planning
- Mobilize and allocate resources for the community health system
- Develop and oversee the implementation of a monitoring and evaluation scheme for the community health program
- Communicate matters related to community health both internally and externally

The national coordinator will promote collaboration with other line ministries on community health matters such as the Ministry of Local Government, Public Works and National Housing on governance issues; the Ministry of Lands, Agriculture and Rural Resettlement on nutrition issues; Ministry of Women Affairs, Gender and Community Development on gender and youth issues; and the WASH cluster on sanitation issues. This will be done through inter-ministerial committees at both national and district levels.

b. Sub-national level – Provinces and districts

Dedicated provincial and district level health teams will provide downstream programme implementation oversight.[14] Specifically, they will provide support in:

- Human capital development: Overseeing training of VHW trainers and training of VHWs
- Performance enhancement: Evaluation of VHW performance through patient audit and review of performance dashboards; evaluation of VHW supervisor performance; and assessment of community level data as part of disease surveillance

c. Service delivery facilities - Health facilities and health posts

Health facilities (in the short-term) and health posts[15] (in the medium to long term) will serve as community health hubs which provide the following services:

- Human capital development: Serve as service delivery centres for patients referred by VHWs. At these facilities, the nurses in charge will also conduct an assessment on whether the referrals by VHWs were executed correctly
- Performance enhancement: Convene monthly VHW supportive supervision meetings where community health data is audited and compiled and VHWs are mentored; and serve as replenishment hubs for VHWs supplies and equipment

d. Community level

At the community-level, communities who are the owners and drivers of community health, will be responsible for:

[14]Specific teams will be selected once the Directorate overseeing community health has been identified

[15]The Government of Zimbabwe has mandated the construction of 6,600 health posts across the country. Construction is currently underway

- Human capital development: Nominating VHWs based on the selection criteria; and accessing the community health services outlined in the community health service package
- Performance enhancement: Raising health concerns and providing feedback to VHWs and VHW supervisors

Community structures including VIDCOs and HCCs will play the oversight roles outlined in the community engagement section

Interventions and activities

- Improve coordination of community health between all levels of government through joint work planning and convening intra-sectoral forums;
- Improve coordination of partners and activities at the district level through stakeholder mapping and joint work planning;
- Orient stakeholders on the revised governance structure and implementation framework, and oversee adherence.

3.7 Strategic Area 7: Financing for Community Health

Strategic Objective:

Access sustainable community health financing to promote financial protection and equity, in line with the goals of the national health financing strategy

Strategic recommendations:

- Increased financing for community health as guided by the national health financing strategy

Funding and financing of the community health programme in Zimbabwe requires consideration of feasibility, exploration of innovative approaches and long-term sustainability. Given the pivotal role the community health programme has in the realization of better health, social and economic outcomes in Zimbabwe, identification of the right mix of funding sources, as well as efficient allocation of the different types of funds is key. The mix will involve increased domestic commitments, better utilization and allocation of donor funding and exploration of non-traditional sources.

Interventions and activities (aligned to the Zimbabwe Health Financing Strategy 2017)

- Increase efficiency gains from existing resources. This will involve better utilization and harmonization of funding allocation to reduce inefficiencies created by fragmentation;
- Gradually increase investment into the community health programme through public resources. Ongoing advocacy with the Ministry of Finance and Economic Development, and Parliamentarians will be conducted to emphasize the benefits of community health and the need for government budget allocation for sustainability and successful implementation of the program;
- Introduce results-based financing to incentivize workers offering community health services
- Strengthen existing partnerships and explore new partnerships with development partners for increased and efficient utilization of external funding
- Engage and promote the participation of the private sector through corporate social responsibility and public-private partnerships;

- Create a pool of health funds which will hold funds from government, development partners and private sector. The fund will avail resources for health overall, and will earmark funds for primary health care (as a component within PHC, the community health programme will be recognized by the fund). Spending from the funding pool will be coordinated by MOHCC;
- The national health financing strategy outlines that pooling of resources within health sub-sectors—that is, the government, private sector, and donor sectors in the short-medium term is a more administratively and functionally feasible reform. In the long term, a single pool for all government, donor, and non-governmental funds will be implemented;
- Build the capacity of community health teams at the national and district level in public financial management for efficient management and utilisation of community health resources in line with the existing government financial management system;
- In the longer term, Zimbabwe will explore innovative financing mechanisms such as Social Impact Bonds (SIBs) and/or Development Impact Bonds (DIBs). These mechanisms can be used to fund healthcare through contracts with private investors, who frontload the financing needed for community health interventions to health providers and outcome funders (to governments in the case of SIBs and to development finance institution, DFI, in case of a DIB). The financial return on these mechanisms is tied to the performance of the contract provider.

NATIONAL COMMUNITY HEALTH STRATEGY

MONITORING AND EVALUATION OF THE STRATEGY

Monitoring and Evaluation of the Strategy

The overall goal of the community health M&E plan is to provide a systematic approach to assessing the activities and outcomes of the community health programme. The plan spells out, by programme area, details of what information is needed including: indicators data sources, collection methods, flow, analysis, use and reporting, feedback, and the responsibilities of implementing partners and stakeholders.

The specific objectives of M&E include:

- Guiding planning of strategy implementation
- Strengthening coordination of all partners and stakeholders working in the area of community health
- Monitoring the relevance, effectiveness, efficiency, and impact of selected interventions
- Facilitating data collection and dissemination among implementing partners and stakeholders
- Supporting resource mobilization

The national coordinator at MOHCC will oversee monitoring of the implementation of the strategy. The coordinator will track the inputs and activities conducted in the community health programme in order to ultimately determine the outcomes and impact of the programme. Platforms for joint programme reviews, and monitoring, evaluation and learning will be developed, constituting various government agencies and partners.

A baseline study will be conducted at the beginning of strategy implementation. An annual M&E exercise and end of strategy evaluation will also be conducted tracking the following:

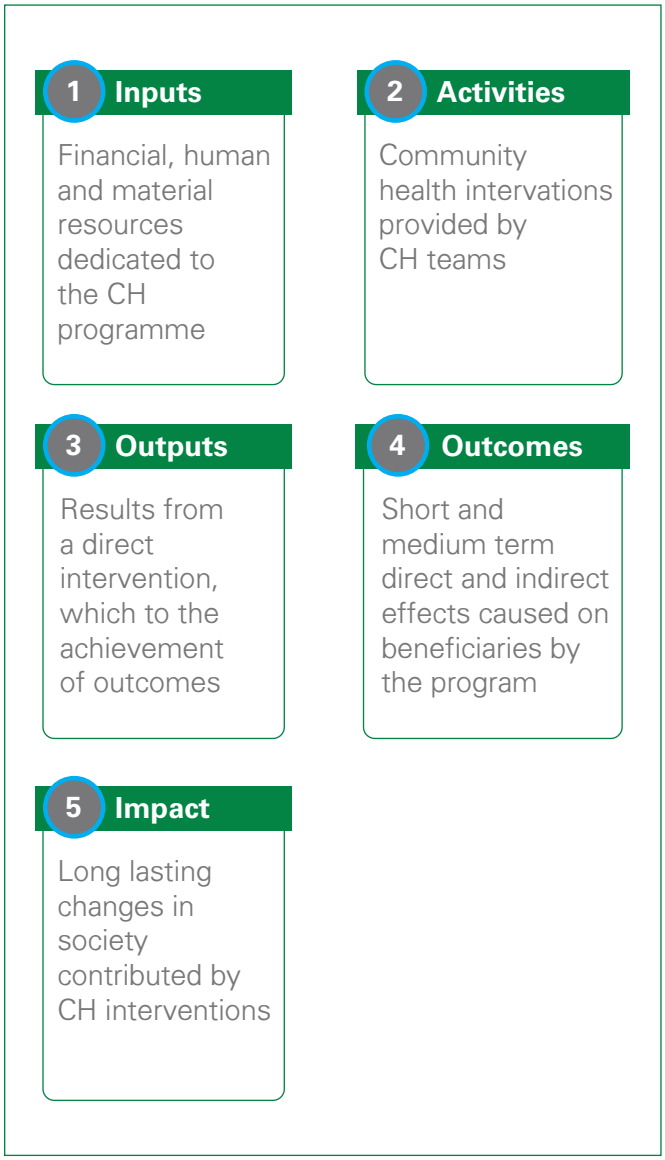


Figure 8 Illustrative M&E results framework

The monitoring, evaluation and earning framework will be developed during the implementation planning phase.

[1]As of July 2019, the completeness of VHW data was at 58.2% and timeliness was at 32.5%
[2] Detailed interventions are available in subsequent sections of the strategy
[3] World Health Organization. (2018) WHO Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes (CC BY-NC-SA 3.0 IGO)