UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN

HEALTH QUALITY ASSURANCE DIVISION

BASIC STANDARDS FOR HEALTH FACILITIES

VOLUME 1

HOUSEHOLD AND COMMUNITY LEVEL

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ABBREVIATIONS

ADDO	Accredited Drug Dispensing Outlet
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-retroviral therapy
BCC	Behaviour Change Communication
BP	Blood Pressure
BSHFs	Basic Standards for Health Facilities
CHF/TIKA	Community Health Fund/Tiba Kwa Kadi
CHW	Community Health Workers
DOT	Direct Observed Treatment
FP	Family Planning
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
ICT	Information Communication Technology
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IPC	Infection Prevention and Control
MEO	Mtaa Executive Officer
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MVC	Most Vulnerable Children
NEHCIP– TZ	National Essential Health Care Interventions Package – Tanzania
NPEHI	National Package of Essential Health Intervention
NTDs	Neglected Tropical Diseases
OVC	Orphan and Vulnerable Children
PHC	Primary Health Care
PHAST	Participatory Hygiene and Sanitation Transformation
PHSDP	Primary Health Services Development Program
PLWHA	People Living with HIV/AIDS
STD	Sexual Transmitted Diseases
TB	Tuberculosis
TB-DOTS	Tuberculosis Direct Observed Therapy Short-Course
VEO	Village Executive Officer

FOREWORD

Development of Health Services in Tanzania Mainland has come a long way. The first efforts were by the German Colonial Government and later taken over by British Colonial Government. During that time, health services were mainly owned by the state with limited number of private for profit services provided in major towns while not-for-profit services were provided in rural areas by Voluntary Agencies including Religious Institutions.

After Independence (1961) and the Arusha Declaration (1967) health care facilities were re-directed towards rural areas and universal free medical services for all Tanzanians were declared. As a result of a policy of equitable distribution of health facilities, the number of health facilities increased significantly from 1961 to 1991. Hospitals increased from 98 to 175, Health Centres from 22 to 276, and Dispensaries from 875 to 3,014. On the other hand, the nationalization of some private health facilities in 1970 retarded the growth of the private sector. The government collaboration with Not-for-Profit Organizations was also limited. In 1977, private medical practice for-profit was banned through the establishment of the Private Hospitals Act Number 6 and its Regulations. Some of For-Profit Health Facilities were opened under the umbrella of “approved organizations”. Later, the importance of private health care delivery was recognized with enactment of the amendment of Private Hospitals Act Number 26 of 1991. This has resulted in increase in the number of health facilities in the country that was further enhanced with the start of Primary Health Services Development Programme (PHSDP) in 2007.

The PHSDP (2007-2017) aims at promoting access to basic health care for all as well as empowering and involving the community in the provision of health services. Specifically, the PHSDP aims at having a dispensary at each village, a health centre at each ward, a district hospital at each LGA level and upgrade regional hospitals to provide referral services while the specialized hospitals are to provide super specialized services. According to HMIS, up to 2014 there were 6,804 health facilities comprising of 256 hospitals (103 are owned by the Government, 103 are Faith Based Organizations, 38 Private and 12 are owned by the Parastatal Organizations); 709 health centres (458 belong to the Government, 154 Faith Based Organizations, 71 Private and 26 Parastatal); and 5,839 dispensaries (4251 are owned Government, 766 are Private, 613 Faith Based, and 209 Parastatal) in Tanzania Mainland.

The expansion of the health infrastructure necessitated the MoHCDGEC (by then Ministry of Health in 1996) to take initiative to establish guideline standards for health facilities. The BSHFs (2015) update the requirements contained in the guideline standards for health facilities (1996) based on developments in the health sector in terms of policy, guidelines, resource requirements and technology. The BSHFs are grouped into four volumes from community level to national level. The inputs covered in these volumes have financial implication to all stakeholders. Health facilities are required to use BSHFs as a reference tool for their strategic planning, yearly planning and operational budget.

These BSHFs Volume One (1) will be used by all stakeholders in Government, Private for Profit and Not for Profit Organizations to guide them in establishment and

running of health services at household and community level. Therefore, the MoHCDGEC urges all stakeholders to use these standards consistently when planning to establish or running health services at household and community level.

Ummy A. Mwalimu (MP)
MINISTER OF HEALTH, COMMUNITY DEVELOPMENT, GENDER ELDERY, AND CHILDREN

ACKNOWLEDGEMENT

The BSHFs reflect the Vision and Mission of the Ministry of Health, Community Development, Gender Elderly and Children (MoHCDGEC). They focus on what needs to be in place at all levels of care (from Community/Household level to hospital at level IV) to meet the vision.

Development of the standards is a product of an extensive consultation that started in 2011 with coordination of the Health Quality Assurance Division – through the Health Services Inspectorate and Quality Assurance Section, and the Curative Services Division – through the Hospital Reforms Unit. The tireless coordination efforts facilitated experts from various organizations and within the MoHCDGEC to provide inputs that have culminated in printing of the standards.

The MoHCDGEC would like to acknowledge the contributions of experts from the following organizations:

i. Association of Private Health facilities in Tanzania (APHFTA);
ii. Bagamoyo District Council;
iii. Baraza Kuu la Waislamu wa Tanzania (BAKWATA);
iv. Christian Social Services Commission (CSSC);
v. Eastern Zonal Health Resource Centre – Morogoro;
vi. Environment Health Practitioners Council;
vii. Hubert Kairuki Memorial University;
viii. Jhpiego;
ix. Mbeya Referral Hospital;
x. Medical Association of Tanzania (MAT);
xi. Medical Laboratory Scientists Association of Tanzania(MeLSAT);
xii. Medical Radiology and Imaging Professionals Council;
xiii. Medical Women Association of Tanzania (MEWATA);
xiv. Ministry of Health and Social Welfare–Departments, Sections, Units and Programmes;
xv. Muhimbili National Hospital;
xvi. National Health Insurance Fund;
xvii. National Health Laboratory Quality Assurance Training Centre;
xviii. Optometry Council;
xix. PharmAccess International;
xx. Pharmacy Council;
xxi. Prime Minister's Office Regional Administration and Local Government;
xxii. Private Health Laboratories Board;
xxiii. Private Hospital Advisory Board;
xxiv. Tanzania Association of Radiographers (TARA);
xxv. Tanzania National Nursing Association (TANNA);
xxvi. Tanzania Nursing and Midwifery Council (TNMC) and
xxvii. Tanzania Public Health Association (TPHA).
xviii. Tanzania-Netherlands project to Support AIDS control – Mwanza Region;
xxix. Tumbi Regional Referral Hospital;

Lastly but not least, the Ministry would like to thank all stakeholders (Public, Private-for-Profit, and Not-for-Profit) that will consistently use these BSHFs. I reiterate sincere appreciation from MoHCDGEC to everyone who in one-way or another contributed to drafting, finalization and printing of these standards.

Dr. Mpoki M. Ulisubisya
PERMANENT SECRETARY (HEALTH)

DEFINITION OF TERMS

Health is defined by WHO as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Household consists of one or more people who live in the same dwelling and also share at meals or living accommodation, and may consist of a single family or some other grouping of people

Community means a Group of households organised in a recognised government administrative structure.

Community Health Fund means a fund established by a local government authority in accordance with the provisions of the CHF act of 2001.

Council means (a) a District Council established under the Local Government (District Authorities) Act, 1982 or (b) an Urban Council established under the Local Government (Urban Authorities) Act, 1982.

Child means a person under the age of 18 years.

A young person in the Tanzanian context is a male or female aged between 15 and 35 years.

Adult means an individual aged between 35 and 60 years.

Old person means an individual who is 60 years and above.

Care giver means any parent, guardian, institution responsible for caring for children, village leader or a recognised village committee, teacher or any person responsible for caring for a child.

Care homes mean registered premises used for caring of patients, children or elderly.

Children's Home mean an institution other than an approved school and a retention home, where five or more most vulnerable children or children in need of care and protection are received, cared for and maintained, either gratuitously or for payment by a person who is not a relative or guardian of the child.

Disability means a person who has a physical or mental impairment which has a substantial and long-term adverse effect on his/her ability to carry out normal day to day activities.

Village means a village registered as such under the Local Government (District Authorities) Act No 25, 1982.

Village Council means a council of a village registered in accordance with the provisions of the Local Government (District Authorities).

Day Care centre means a nursery for the supervision of pre-school while parents work; also meant for provision of daytime training, supervision, recreation and often medical services for children of preschool age.

Premises means land, buildings, structures, basements and vessels and includes any cartilage, forecourt, yard or place of storage used in connection with building or part of that building; and in relation to vessels, includes aircrafts, a carriage or receptacle of any kind, whether open or closed.

Recreational ground means a piece of land set aside for public recreations.

Elderly care homes means home healthcare services provided by a certified agency.

Home-based infectious waste: These are infectious wastes generated at household level. They include sharps waste from self- injecting patients like diabetes, shaving and the like, non-sharps infectious waste like injuries and wound dressing and other infectious liquids.

Home based healthcare waste means clinical and related waste that is generated in a domestic setting by a visiting healthcare professional (e.g. doctor, nurse, and veterinarian) in the course of discharging their duties.

Animal waste means waste arising from the whole or any part of an animal or excreta.
Super structure means a structure that is built on top of the squatting slab of a pit latrine
Environmental friendly stove is a locally made stove that uses special type of charcoal, which is not from wood

CHAPTER 1.0: INTRODUCTION

The National Health Policy (2007) advocates for access to quality health and social welfare services for all at all service provision levels starting from house hold level to advanced levels. To facilitate the efforts of both public and private health sectors in delivering quality health services, the MoHCDGEC has compiled BSHFs at each level of Tanzanian health system.

The BSHFs were developed in order to:

1. To respond to the health and social welfare needs of the population in consistent with national health care delivery coverage plan (accessibility, equity, affordability and sustainability).
2. To adequately address the current and future public health challenges
3. To ensure that each level is prepared and equipped to implement the corresponding interventions with the required level of quality.
4. Facilitate appropriate health financing mechanism through proper categorisation of the health facilities.
5. Address challenges arising out of increasing number of the health facilities and the advancement of the science and technology of health care deliveries.
6. Respond appropriately to changing social, economic and political environment whereby the government has adopted the free economic system hence greater need of developing clear standards for guiding the delivery of quality health care services.

During the development process various guidelines were referred including the National Essential Health Care Interventions Package – Tanzania (NEHCIP–Tz). At each level, the list of interventions to be performed (services and management) is defined by the NEHCIP-Tz. (2013). A health intervention is a complex procedure that requires specific inputs to be performed satisfactorily in terms of quality and quantity of the following required resources:

- Premises
- Staffing
- Management
- Office & ICT equipment
- Vehicle
- General Medical Equipment
- Dental services
- Laboratory
- Radiology and Imaging
- Medical equipment

These standards have been presented into four (4) volumes namely:

Volume 1: Community/Household Level.

Volume 2: Dispensary; Health Centre; Stand alone Dental Clinic (run by Dental Therapist, ADO); and Stand alone Rehabilitation Medicine Facilities (Physiotherapy, Prothetics and Orthotics, Occupational Therapy, and Speech and Language Therapy) Level.

Volume 3: Level II Hospitals and I; Level 1 Clinics (Medical Clinic, GP-Clinic, Polyclinics, Comprehensive Dental Clinic run by MO, DO, etc.); and Level 2 Clinics (Specialised Clinics Run by Medical Specialists).

Volume 4: Level III and IV Hospitals; and Level 3 Clinics (run by Super Specialists).

This **Volume** is particularly targeted at household members, CHWs, community leaders, school heads, influential people, spiritual leaders and CHMT to assist in planning towards reaching these national standards at the earliest.

NEHCIP - TZ AT COMMUNITY/HOUSEHOLD LEVEL

The health interventions at this level encompass Health Promotion, Preventive, Curative, Palliative and Rehabilitative services, all adapted to the needs of the communities and based on public health concerns. With respect to health promotion, it is imperative to note that in order to address the community comprehensively there is a need to categorise them by age groups e.g. Children, Youth, Adults and the Elderly. In addition, because of the society's tendency to overlook the welfare of special groups, of late more attention has focused on social protection of marginalised groups e.g. persons with disability and vulnerable children.

The following are the main health and social welfare interventions at this level:

- Carry out campaigns on various health and social welfare issues guided by National or Global events. (See Annex E).
- Tailored individual follow up through Home-based care example chronic and long standing illnesses including PLWHA, Cancer patients and those under TB-DOTS.
- Specific services such as pregnancy and child growth monitoring or first aid
- Awareness creation through conducting education sessions for the whole community or for targeted groups such as the women and the school children.
- Conduct information, education and communication/behavioural and social mobilisation through community resource persons such as school teachers and other community health professionals
- Training of CHWs including community influential leaders such as religious, traditional and political leaders
- Provision of commodities used for health promotion, prevention, curative and rehabilitative.
- Addressing social determinants of health such as taking environmental actions related to water, latrines and wastes
- Rehabilitation services to people such as those with disability, mental health and those affected with drugs.
- Access to health, nutrition and social services to children, youth, elderly, OVC, MVC, PLHIV and Gender Based Violence (GBV).
- Psychosocial support such as to people with long standing illnesses including those living with HIV/AIDS, Cancer and after violence.

CHAPTER 2.0: MANAGEMENT AND LEADERSHIP OF HEALTH & SOCIAL WELFARE SERVICES

2.1 Governance and responsibilities

The Village or Mtaa Council has overall responsibility to oversee development and implementation of health interventions.

2.1.1 Household Level

2.1.1.1 At household level the main and most important health related management function is the implementation of all interventions required at household level including reporting to the local authorities of the epidemiological and demography events: including, births, deaths, nutritional status, food security and epidemics. The head of the household is responsible and accountable for reporting such events as early as possible. The household must provide feedback to the village/mtaa government about health services provision and its experiences with the health care providers (either private or public).

2.1.1.2 The household is expected to keep the best possible care of its "health books and health insurance (CHF) cards, growth monitoring cards, antenatal cards, appointment cards, and TB-DOTS treatment cards, HIV/AIDS (ARV) treatment cards as per guidelines in order to meet the respective schedules.

2.1.1.3 Both households and community leaders are accountable to the Village Health Committee which are responsible to oversee all health related activities in the village.

2.1.2 Community level

2.1.2.1 Community leaders i.e. the VEO/MEO guided by the Ward Executive Officer, have the responsibility of ensuring that all community members have access to the essential health and social welfare services.

2.1.2.2 Details on how the community leadership operates are shown in **Annex 2.**

2.1.3 Health financing and budgeting

2.1.3.1 Community leaders have responsibilities to mobilise, proper management as well as administration of funds and other resources for health interventions in the community. In order to ensure reliable health financing, community leaders are required to advocate for annual contribution to the community health fund.

2.1.4 Village Health Committee (VHC)

2.1.4.1 At the community level, Home Based Providers are answerable to the village Health Committee which is supposed to oversee all health services in the village.

2.2 Planning

2.2.1 Community health committee shall be involved and participate in all health-planning issues in the village using community approach method.

2.2.2 Plans shall be evidence-based, on data generated during service delivery and other relevant observations in the community.

2.3 Human Resource Management

2.3.1 The Village/Mtaa government authorities shall ensure that all Community Health Workers (CHWs) positions are filled and active. Also, they shall ensure availability of motivation and retention mechanisms of CHWs.

2.3.2 The dispensary/health facility in-charge or any designated staff from the health facility shall provide technical support to CHWs for clinical tasks.

2.3.3 Social welfare officers, health officers, community development officers, agricultural and other extension officers will provide non-clinical technical support.

2.4 Staffing levels and Management at community Level

2.4.1 Community Health Workers are the lowest category in the community health system who perform health related activities such as home visits, sanitation, nutrition, counselling, health education, first aid and treatments of simple and common health conditions based on established protocols. CHW are accountable to village government authority and in particular at the village health committee. However at a household level the main actors are Father, Mother, or Guardian. Children and other relatives are members of the family. **(See annex 1(b) and 3(b)** for staff offering services at the household and community levels)

2.5 Patient Access to Care

2.5.1 Patient access to health and social services

2.5.1.1 The provision of health and social welfare services at household and community level is the responsibility of the families and community members themselves and requires mobilisation of a range of resources including finances, knowledge and skills. The Village and Mtaa Government are mandated to oversee that health and social welfare services are delivered to the communities according to the national existing health policies, laws and regulations.

2.5.2 Client Service Charter

2.5.2.1 Services should be client oriented; the community health provision is expected to sustain high level of standards of conduct and ethics amongst the community health workers. The Client Service Charter, particularly patient rights to confidentiality, privacy and information should be adhered to and known to clients. The community should have the transparent functional mechanism to handle complaints.

2.5.3 Quality of Care

2.5.3.1 Continuous quality improvement mechanisms are expected to be institutionalized in the community level and coordinated with the supportive supervision from the higher level. A primary focus of health care should be on safety of clients as well as on effectiveness of care.

2.6 Management of Information and Communication

2.6.1 Data Management

2.6.1.1 Data on health and social welfare situation are collected at community level and reported to the nearby primary health care facilities including reproductive, maternal, new-born and child health, e.g., births as well as deaths particularly related to maternal, new-born and child health. Collection of data should also include GBV, disability, elderly, OVC/MVC, environmental hygiene and sanitation.

2.6.2 Communication

2.6.2.1 VEO or MEO should ensure mobilization and provision of health education to the community on various health issues. The community is expected to maintain transparent and efficient communication with the community health

workers, the users/clients and to organize ways for the users/clients to provide feedback on their experiences within the community.

2.7 Risk Management

2.7.1 Security of the community

2.7.1.1 Community leaders shall ensure safety and security of community members particularly elderly, children, and the physically challenged.

2.7.2 Infection Prevention and Control

2.7.2.1 Community health workers should guide the community members towards household environmental hygiene and sanitation, proper lighting and good ventilation. During community based care services the CHW should consider hand hygiene before and after contact with clients. Also, should ensure general cleanliness of the patient and wearing appropriate Personal Protective Equipment (PPE) when in direct contact with body fluids.

2.7.3 Occupational safety

2.7.3.1 The whole community shall be responsible to ensure that occupational risks that may arise from the working environment are minimized.

2.7.4 Waste Disposal

2.7.4.1 The community should ensure that waste disposal is done in compliance to council regulations. The principles of Infection Prevention and Control (IPC) should be applied during collection and disposal of domestic and health care waste. Solid waste generated by the household should be transferred to the communal collection facility or thrown in a waste pit for households in rural settings. Where wastes are transferred or collected by communal system, the household should store solid waste in a lined container with a lid. All liquid waste generated at the households should be handled and disposed of in a safe manner. The household are required to use improved sanitation systems. Health care waste generated from household should be transported safely to the nearby facility for the final disposal.

2.7.5 Fire

2.7.5.1 The community leaders shall make sure that the community structures has a system that adheres with fire safety and all members are trained on how to use the fire-fighting equipment and precautions in handling all inflammable materials.

2.7.6 Emergency/disaster preparedness and response

2.7.6.1 The community should have a plan to respond to the emergency/disaster. The emergence response initiatives should involve all community members.

CHAPTER 3.0: BUILDINGS, LOCATION, CONSTRUCTION PLAN

3.1 Premises

In relation to the various forms of interventions at this level the following premises are expected:

3.1.1 At household level

- Houses that can facilitate provision of home-based care to long standing illnesses such as diabetes, cardiovascular diseases, HIV/AIDS, cancer; physiological status such as pregnancy and social needs such as disability.
- Improved kitchen should be free from vermin and rats infestation, with storage facilities, food preparation areas which allow separation of raw food from cooked food on a clean surface and improved environmental friendly stove. There should be washing and drying facilities (racks) for kitchen utensils and adequate supply of clean water. In addition improved kitchen should have clean floor and walls and adequate lighting and ventilation,
- Improved toilets in urban settings should have flash cistern (European/Asian), water proof floor and walls with tiles or cement, hand washing facilities and soap, adequate clean water supply, ventilation and lighting. Improved pit latrines in semi- urban or rural settings should have superstructure roofed with iron sheets, pit hole must be covered with a lid and must have a vent pipe to remove odour, hand washing facilities and soap, adequate clean water supply, ventilation and lighting.
- Improved waste disposal: There should be proper refuse collection, storage and disposal appropriate for urban or rural setting e.g. dustbin, refuse pit or communal disposal sites. For disposal of liquid waste there should be appropriate established and maintained drainage system. To avoid stagnant water smooth draining of water due to rain or spillage should be ensured.
- Protected source of safe water in constructed wells individual should ensure the wells are deep and protected for safety. Households are encouraged to have storage tanks to ensure adequate supply of water. In urban settings where there is piped water, households should prevent leakage of water from taps to avoid contamination and wastage.
- Ensure food security and storage facilities; households should ensure adequate supply of food and storage facilities.
- Landscaping to ensure access and friendly environment should be promoted.

3.1.2 At Community level

The Village or Mtaa government shall ensure the housing and human settlements conform to the Public Health Act 2009 and the Urban Planning Act of 2007. Below are some of the key aspects that will promote a healthy environment:

- Shady locations and structures shelter for community activities: In both urban and rural settings communities should ensure user friendly space for recreational activities such as playground, parks, and/or construction of buildings such as community centres, day care centres or cinema halls for community events
- School standards which include open ground for physical activities, spaces for gardening, toilets and safe and clean water should be observed
- Protected source of safe water (collective source of safe water) - In communities with deep wells, there should be regular maintenance of the source. In case of communal tap or deep wells it should be fenced and well

protected. There should be proper draining of spilled water to prevent stagnation.

- Collective waste disposal facilities – The community shall select a site for waste disposal that is accessible and does not cause nuisance to the people. They should also ensure there are proper strategies for waste management, e.g., recycling, sanitary land filling.
- Communities should ensure enforcement of laws and by-laws that protect the health of the population such as designating smoke free areas, restricting littering of waste and alcohol intake during working hours and restriction of child employment. The community shall safeguard children from the worst forms of child labour and hazardous work stipulated in the Child Act.
- In communities residing in mines, industries, plantations there should be strategies to protect people and their families from occupational hazards, infectious diseases and child employment. The community leadership will ensure that no child under the age of 14 years is employed.
- Community should ensure all public premises; individual households and surroundings are healthy friendly, generally clean and well maintained including protection of water sources.
- Ensure availability of clean and well-maintained slaughterhouses.
- Monitor and prevent hazards from pollution due to air, water and environment

Premises at household and community level are as shown in annex 1(a)

3.2 Building/Infrastructure components should have the following characteristics

3.2.1 Household level

Generally a household consist of a main house and inhabitants. The household environment may include pets (cats and dogs) and other domestic animals like poultry, cow, donkey, goat and sheep. Important services that include water supply, waste management system, communication and electricity are a composition of a household.

3.2.1.1 Characteristics/ requirements of a household

A household (self-contained) should consist of bedrooms, living room, dining room, a kitchen, a toilet, store and a bathroom while for a non-self-contained house the toilets, bathroom, kitchen and store may be located outside the main house. The main house should have one bedroom for parents, separate bedrooms for the female and male children and the other for older girls/boys. Each room should have standard windows with 1/8 of the room size covered with mosquito screen. A room used for sleeping should have a minimum area of 3.0 square metres per person. A living room must be larger (minimum 4 square metres).

A household should be constructed with permanent material maintained in a good state of repair, hard, smooth and non-absorbent floor, walls plastered/painted, intact no leaking (roofing/ceiling) with adequate ventilation and adequate natural and artificial lighting. A household should also have a free emergency exit.

Where the kitchen, toilets and bathrooms are not within the main house, they should be conveniently located to minimize pollution that may arise due to the usage of these facilities. Where the poultry and domestic animals are kept they should be provided with separate shelter located at a distance that will avoid easy spread of **zoonotic** diseases and bad odour. Pets e.g., cats should be vaccinated against zoonotic diseases, dewormed, and dipped against fleas and other disease vectors.

3.2.1.2 Basic services

The house should have access to safe water supply for domestic use. Where piped water is not available or insufficiently supplied the house should install gutters for rainwater harvesting and storage water tank(s) that allow easy cleaning. Household with wells should certify their wells and keep them clean. A household should purchase water only from a certified vender. Irrespective of the source of water, water for drinking must be boiled. Basic lighting for the household may be provided by national power grid or solar, biogas or lanterns. The use of biogas kitchen stoves or improved charcoal or wooden stove is recommended.

3.2.1.3 Food Safety

As part of food safety interventions the household should use clean and dry utensil this can be achieved through drying utensils on a rack. The household should therefore ensure that it provides a utensil rack or special table for drying utensils. The house should also use separate storage and utensils for preparation of raw and cooked food. Cooked food should be covered and any leftover must be stored in desirable conditions.

3.2.1.4 Supplies

Supplies including mosquito net, first aid kit are basic health needs for a household. Each household should have and use treated mosquito nets and ensure that a first aid kit with all-important requirements is available. Other important supplies include soap for hand washing, bathing and other hygienic purposes.

3.2.2 Community Level

Apart from the village or mtaa government being well acquainted with the land plan of their catchment areas, further developments can be made to address the needs of the communities. The authorities need to ensure quality and availability of health promoting environment and services that include play grounds, open spaces for recreation, community centres, social halls, public institutions (community library, community administration, leadership offices, Schools, Social legal support, cultural activities, public toilets, market places, burial grounds, community pharmacy, Accredited Drug Dispensing Outlets (ADDO), special centres for orphans and the elderly, emotional, psychological and spiritual care centres, e.g., churches and mosques.

Children and physically challenged individuals need special provisions for washrooms. Social and economically disadvantaged persons, orphans and most vulnerable children and older people need to have specific provision for their care in the community. Community leaders will identify and list down social and economically disadvantaged people, most vulnerable children, youth and elderly persons for follow up and special care. All public places should ensure that they provide public toilets that are accessible for people with disability and the elderly.

3.2.2.1 Community Services and Amenities

Good landscape/garden with trees for shade and fruits should be available, installation of solar lights, rainwater harvesting and water storage facility are important facilities to be installed at all public places. Services like waste collection, transportation and disposal for both liquid and solid wastes should be provided by the community. In places where water is not supplied at household level, the

community should provide communal water collection point and protect it from pollution and vandalism.

3.2.2.2 ADDO Shops
There will be an ADDO shop in the community where essential medicines are purchased

3.2.2.3 Traditional and Alternative Services
Traditional health practitioners are alternative health care providers. Traditional medical practitioners are registered by the Ministry of Health and Social Welfare. The Community leaders will scrutinize, identify and list down traditional practitioners in the community. They must be registered at Traditional and Alternative Medicine Council in MOHCDGEC, use a standard consulting room with privacy, have a waiting area; pack and store medicines in a standard way as specified for ADDO shops. They will need to attend training now and then on contemporary issues e.g. IPC, HIV/AIDS, etc. The services be located separate from health facilities as per traditional and alternative medicine policy guidelines.

3.2.2.4 Slaughter House/ Abattoir:
Slaughter houses should be constructed in the outskirt of the community. It should have enough space, well maintained with permanent building, adequate ventilation and lighting. The drainage system should be maintained and well functioning with soak pit and adequate supply of clean and safe water, which should be intact and easy to wash floor and wall. In addition it should have stunning instruments, hanging rails, hand washing facilities, toilets bathrooms, changing rooms and soap. There should be waiting area for animals to rest.

3.2.2.5 Cemetery
There should be burial places in the community maintained and fenced, provided with toilets and well maintained drainage system, hand washing facilities and soap, adequate water supply and shelter within the cemetery compound.

3.2.2.6 Day Care Centres
The Village or Mtaa government shall ensure establishment of day care centres basing on the guidelines developed by the MoHCDGEC and Ministry of Education wherever there's an expressed need to do so.

3.2.2.7 Elderly Homes/Geriatric Centres
The Village or Mtaa government shall ensure the establishment of homes for the elderly whereby special care will be provided. The Village or Mtaa government shall ensure the homes are well maintained to cater for the needs of the elderly.

3.2.2.8 Rehabilitation Centres
The Village or Mtaa government shall ensure maintenance of existing rehabilitation centres that will facilitate integration of chronically ill patients into the society. New centres may be built whenever there's an expressed need. In addition these centres should provide physiotherapy and have rehabilitative equipment, e.g., walking crutches, walkers.

3.2.2.9 Youth Centres

The Village or Mtaa Government in collaboration with the Ward Development Committee (WDC) ensures the smooth running of youth centres within their localities. Whenever there's an expressed need the Village or Mtaa Government shall advocate to the community the establishment of such centres for the welfare of the youth.

3.2.2.10 Centre for Persons with Disability

The communities should be encouraged to advocate for persons with disabilities to be part of them. However, there are certain occasions whereby special centres need to be established in order to protect them or develop their intellect, e.g., schools for albino, the blind/ low vision, the deaf and dumb. The Village or Mtaa Government should ensure such centres are well maintained if they exist in their localities or sensitize communities to establish new ones when there's an expressed need. The Village or Mtaa Government should ensure they conform to the national laws and regulations. These facilities should be manned by professional in the respective disabled area.

3.2.2.11 Recreational Facilities

The Village or Mtaa Government shall ensure that there are spaces allocated for children playgrounds, outdoor sports for youths, adults and elderly, e.g., safe walking ground, football pitch, basketball and other games to encourage physical activity. Indoor facilities should be promoted for additional recreation.

3.2.2.12 Orphanage Centres

The Village or Mtaa Government shall maintain existing orphan centres within their localities basing on existing national laws and regulations on early childhood development and children welfare. Depending on the community expressed need a new centre may be established in collaboration with the WDC. The Village and Mtaa Government shall ensure the establishment of such premises conforms to national or international guidelines in order to safeguard the rights of the child.

3.2.2.13 Schools

Schools should be fenced with enough classrooms as per pupils, well ventilated and lighting, constructed with permanent materials with intact cement floor and plastered wall and iron sheets, adequate supply of safe water, adequate toilets for pupils and teachers separating both sex, hand washing facilities as per pupils, proper refuse collection and disposal system, first aid kit and safe play grounds or recreation room.
For boarding school-schools must have dormitories constructed with permanent materials separating males and females where applicable. Floor should be cemented, intact, and easy to wash and well clean painted walls. Dormitories should have enough windows, well ventilated and lighting, enough beds, well-maintained mattress with beddings free from bedbugs and lice infestation. In addition, the dormitories should have enough toilets and bathrooms as per number of pupils, flower gardens and shades for pupils to rest laundry and dining hall. There should be cupboards for keeping utensils and clothes. There should be washing facilities with soap. There should be dustbins per dormitory.

3.2.2.14 School Kitchen

Kitchen should be constructed with permanent materials with environmental friendly stoves, protected store to prevent vermin and rat infestation. It should be well maintained to prevent contamination, the floor should be cemented and intact, easy to wash and well clean painted walls, enough windows to allow free movement of air, enough lighting, adequate safe water supply and washing facilities and soap, changing rooms, well maintained drainage system, clean pots and utensil drying racks. There should be dustbins for keeping leftovers.

3.2.2.15 Police Post

The community should have a police post whereby criminal offences are addressed

CHAPTER 4.0: MEDICAL EQUIPMENT AND MATERIALS

4.1 Household level

4.1.1 The medical equipment that may be kept at household level include thermometers, Blood Pressure (BP) machines, Diabetes monitoring kits, weighing scales, etc. Information, Education and Communication (IEC) personalized materials for different health interventions are used to maintain health status.

4.1.2 The most important qualitative feature expected from such IEC materials is their adequacy to convey the health related messages to the targeted population. Therefore IEC materials, among others, should meet the following criteria:

- Answer the needs of the people
- Use wording and iconography acceptable and understandable by the targeted audience (common villagers, school pupils,)
- Have simple messages
- Be attractive and promote feasible measures or changes

4.1.3 Health professionals coming from dispensary/health centre or ward level to carry out specific activities must bring the required equipment with the same standards that apply at dispensary/health centre level, see annex 1(d) for the equipment and IEC materials.

4.1.4 Each household is recommended and expected to have a kit of basic first aid medicines, especially to handle young children conditions, e.g., oral rehydration salt, tabs/syrup paracetamol, skin disinfectant and band-aids, and medicines dispensed from facilities. First aid kit for injuries should have povidone iodine, arm sling bandages, vaseline, gauze, cotton wool, sanitary pads, scissors, safety pins to remove thorns and sterile surgical and clean gloves. The caregiver or custodian needs basic instructions for using the medicines, refer detailed list in Annex 1(e).

4.1.5 In the same first aid kit, there should be a CHF/TIKA card and some money for transport.

4.1.6 The First Aid box should be of wood or equivalent materials, measuring 30x20cm; with a door and a provision for a lock and key. It is kept in a secure, cool, dry place and not reachable by children.

4.2 Community Level

4.2.1 The Village/Mtaa Government will provide appropriate shelves or cabinets for keeping community medical equipment and materials that are yet to be distributed. The Village/Mtaa Government will also keep and maintain registers. Where there are social welfare facilities such as Day care centres, youth centres, elderly care homes then the relevant medical equipment and supplies shall be placed accordingly, see annex 1(d) for the medical equipment needed.

4.2.2 The community should identify means of transport in case of emergencies and a safe location for temporary storage of medicines as per their storage instructions. Where there are social welfare services such as day care centres, youth centres, and elderly care homes in a Village or Mtaa, then the relevant medicines based on national laws and regulations shall be stocked accordingly.

4.3 Outreach Services

4.3.1 Outreach services may include immunization and health education activities. On the occasion of outreach sessions at community level, the health facility staff is expected to carry the medicines and supplies required for the planned interventions. In case of epidemics, outreach services will be done in the community.

CHAPTER 5: HEALTH EDUCATION AND PROMOTION

5.1 Definitions

5.1.1 Health education is any combinations of learning experiences designed to facilitate voluntary adaptations of behaviour conducive to health. Most of health education promotions are not autonomous, or freestanding programs by themselves. They are embedded in other programs and many are identified.

5.1.2 Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well being an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well being. (WHO)

5.2 Priorities Areas

5.2.1 To achieve well-being of the community, health promotional activities are of paramount importance as they complement to other health interventions in the Health sector. These activities shall be conducted by the Community health workers based on priority areas as stipulated in the NEHCIP-TZ.

5.2.2 The priority areas include:

- Advocacy, health communication/education and social mobilization
- Community based health care/ initiatives
- School health
- Nutritional health
- Work place health/wellness initiatives
- Development of health communication materials (i.e., electronic and print-audio, visual or both, and for the physically challenged individuals).
- Documentation of evidence and lessons learnt in health promotion program

5.3 Implementation plan

The CHWs in collaboration with the village government with support from the supervising health facility shall prepare a plan for health education and promotion activities with a proper timetable/schedule(s). A clearly defined written communication between the CHWs, the Village Health Committee and VEO/MEO shall be established. In implementing the agreed plan, the CHWs shall work hand in hand with the staff of the supervising health facility and properly document every activity.

At the level of the community the supervising health facility can either be dispensary or health centre. Minimum number of visits are as shown in annex 1(c)

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ANNEXES

Annex 1(a) Premises at household and community level

Indicator
Household with access to improved water source
Household with improved toilets
Households with dish racks
Households with dustbins/ refuse pits
Households with toilets fitted with hand washing facility
Household with environmental friendly stove
School classrooms- Adequate ventilation, lighting, overcrowding, Boarding – beds, mattress, pillows free from vermin & bedbugs, lice infestation. • School toilets • School fence • School recreation • School water supply • School meals • School screening • School waste disposal • School laundry • School kitchen, utensils • School first aid kit
First aid kit
Community hall
Community library
Social welfare centre
Day care centre
ADDO shops
Communal tap
Market
Slaughter House
Cemetery
Communal waste storage facility

Annex 1(b) Service providers at Community/Household level

Designation	Expected number per 1,000 inhabitants.
Community Leaders	A minimum of 3
Community Health Workers (CHWs)	1 per 500 people
Community Legal advisor	2
Community Key Informants	2
Community Social Welfare Officer	1
Health Facility Staff	3
Health Assistant	1

Annex 1(c) Minimum number of visit for Public Health Professionals

Designation	Minimum frequency of visits
Medical Attendant	1 per 2 weeks
Nurse	1 per month
Health Assistant	1 per 3 months
Environmental Health Officer	2 per 6 months
Nutritional Officer	2 per 6 months
Clinical Officer/Assistant Clinical Officer	1 per 3months

Annex 1(d) Equipment and IEC Materials

IEC Materials for:	Households (HHs) / Village/Mtaa
Maternal, new-born, child and adolescent health	For all (HHs)
Malaria	For all HHs
TB & Leprosy	For all HHs
HIV/AIDS/STD	For all HHs
Outbreaks	For all HHs
Non-Communicable Diseases	For all HHs
Neglected Tropical Diseases	For all HHs
Nutrition	For all HHs
Improved Housing	For all HHs
Healthy Life Style	For all HHs
Hygiene and Safety at Work Place	For all HHs
Gender Based Violence	For all HHs
Orphan and Vulnerable Children	Where applicable
Most Vulnerable Children	Where applicable
Elderly	Where applicable
Disabled	Where applicable
Equipment and supplies	
Thermometers	Each HH
Blood Pressure (BP) Machines	Each HH
Diabetes Monitoring Kits	Each HH
Weighing Scales	Each HH
Shelves or Cabinet	Each Village/Mtaa Office
Register (s).	Depending on intervention
Condoms	Each HH
Insecticide Treated Nets (ITNs)	Each HH
First Aid Box	Each HH

Annex 1(e) Medicines and Supplies

Medicines & Supplies	Description	Unit	Quantity
Paracetamol	Tablets 500mg	Tabs	30
Paracetamol	Syrup 125mg/5ml	Bottle	1
Antihistamine	Cream	20g	1
Pain balm	Cream	20g	1
Benzoic acid Compound	Ointment (prepare from raw materials) (whitfield's)	30g	1
Calamine Lotion	Skin ointment/lotion, 100ml	Bottle	1
Povidone-Iodine	Solution 10% (100ml bottle)	Bottle	1
Chlorinated lime+Boric Acid	Solution (eusol), 500ml	Bottle	1
Gentian Violet	Solution 0.5% in water 50ml	Bottle	1
Benzoic acid Compound	Ointment (whitfield's)	40g	1
Oral Rehydration Salts (ORS) low osmolarity	Sachet to make 1 litre of solution containing Sodium chloride 2.6g, Sodium citrate 2.9g, Potassium chloride 1.5g and Glucose 20.5g) replacement solution	Sachet	3
Condoms Male	Latex	Unit	10
Condoms Female	Polyurathane sheet 15cm x 7cm	Unit	10
Mouth Wash	Solution	100ml	1
Charcoal, activated	Tablets	Tabs	30
Band Aid (for dressing)		Unit	20
Bandage, Cotton Wool	5cmx150cm	Unit	3
Methylated Spirit	1 Bottle 200ml		

Annex 1(f) Commodities and equipment stored in the toolbox used by CHW

Medicine	Supplies	Equipment
• Paracetamol • Oral contraceptives (refill) • Oral Rehydration Solution (ORS) • Amoxillin Disposable Tablets • Iron and Folic Acid Tablets • Artemether/Lumefatrine (ALU) Tablets • Deworming Tablets • Septrine/ Co-Trimoxazole • Disinfectant & Antiseptics	• Cotton Wool • Bottled Safe Drinking Water • Water Guard (chemical) • Gauze • Plaster • Bandages • Surgical/Razor Blade • Gloves • Soap • MUAC Tape Measure • Thermometer • Male & Female Condoms • Sputum Collection Containers • mRDT Test Kit for Malaria • Disposable Apron & Mask	• Scissors • Gallipot • Kidney Dish

Annex 2: Management at Community Level

Minimum Functions	Structure	Activity
Planning and Reporting		
The Village/Mtaa Government plan and report to Ward level then to Ward Council for consolidated health services data	Village/Mtaa Government, CHC	Prepare Annual Village/Mtaa Plan from the five years Village/Mtaa Strategic Plan and quarterly Report on CBMIS to the Ward Development Committee then to the Council Level
Governance		
The Village or Mtaa Council has overall responsibility to oversee development and implementation of health interventions.	Village/Mtaa Executive Officer Village/Mtaa Health Committee	Conduct committee meetings quarterly and Village or Mtaa Assembly twice a year
Health Financing		
▪ Mobilization of financial resources including collection of tax to be used for HFs and Community Health interventions ▪ Mobilization for annual contribution CHF/TIKA	Ward Development Committee Village/Mtaa Government/Village Social Services committee and CHF/TIKA Volunteer/Committee	▪ To organize meetings for Village/Mtaa to discuss on financing mechanism for health services ▪ Provide guidelines for management of CHF/TIKA
▪ Equitable access: The village authorities ensure that any community member access essential health and social welfare care ▪ Participate in making and enforcing by-laws in collaboration with the WEO	Village/Mtaa Government, Community Health Committee (CHC) and Health Facility Governing Committee (HFGC)	Village/Mtaa government include equitable access as an agenda during quarterly meetings
CBMIS/HMIS Data Management		
The Village/Mtaa Government ensure that all required health and social welfare data from HH level is captured, consolidated and submitted to HF management team	Village/Mtaa Government authorities or Committee CHWs	The CHWs report monthly to the Village/Mtaa Government and Health Facility Governing Committee focal person
Human Resources		
▪ The Village/Mtaa Government authorities ensure that all community health actor positions are filled and active	Village/Mtaa Government and Village Health Authorities or	• Quarterly review of Human Resource including community actors

Minimum Functions	Structure	Activity
▪ Ensure availability of motivational and retention mechanisms of CHWs at the Village/Mtaa	Committee	available in the village • Report quarterly human resource situation to the Ward level and then to the Council
Quality of care		
The Village Government Authorities ensure that referral of patients in need is organized and takes place accordingly,	Village/Mtaa Government & CHC CHW	Identify a transporter at community level and mobilise community fund for emergency transport
Emergency Preparedness and Response The Village/Mtaa Government anticipates local disaster/emergency and mitigate its impact by preparedness and urgent response	Village/Mtaa Government, CHC and Village/Mtaa Emergency Preparedness Committees (EPC)	• Conduct Quarterly EPC meetings • Ensure availability of required supplies and materials in place
Communication		
▪ Communication among committees as feedback on implementation of different health interventions in the community. ▪ Provide feedback to communities on their health status	Health Committees at Village and Ward level	Meet monthly or quarterly for feedback. Plan quarterly meetings with the community

Annex 3(a): Personnel at Household Level

SN	Member	Role	Activity
1.	Father/Mother/guardian	Head	Overall guidance, action, follow-up, to ensure provision of shelter, clothing and food including medical, social care and income generation.
2.	Children	Member	Help family activities and disseminate appropriate education and skills they receive from schools including technology
3.	Other extended members of family	Member	Help family activities and disseminate appropriate technologies including skills they receive from outside the family.

Annex 3(b): Personnel at Community level

Designation	Education level	Mode of Selection	Field of action
Community leaders and • VEO /MEO	Minimum ordinary level certificate with training	Government employee	Provide guidance and manage all activities in the village including health and social related activities
Village/Mtaa Health Committee	Minimum primary level	By community	Planning and follow up implementation, of health activities at the Village/Mtaa
Community Health Workers	Minimum level of education standard seven to form four (IV) with specific trainings	By community 1 CHW per 100HH depending on catchment area	Implement approved health and social welfare related activities at community level: • Reproductive, new born and child health services, • Control of communicable, non-communicable disease and other common diseases of local priorities • Community health promotion and disease prevention • Environmental hygiene and sanitation, OVC, MVC, GBV, nutrition
Health facility workers	Form IV with specific training	Selection by application	• Out reach • Supervision • Technical advise • Interpersonal communication and community awareness on various health issues.
Health Assistant	Form IV with specific training	Selection by application	• Technical advice and supervision on water safety, sanitation and hygiene promotion, diseases control strategies and environmental management pertaining to disease control, social mobilization on health issues.
Social Welfare Officer	Form IV with specific training	Selection by application	• Technical advice and counselling services in Day care centres, Children's Homes or orphanages, Youth centres, Elderly care homes.
CBO, NGOs, FBOs and other stakeholders	Minimum Diploma	By interest and acceptance by community	• Support health intervention in the community

Annex 3(c): Private Health Personnel

Designation	Diploma/Experience	Remark
Traditional practitioner	Literate or Standard 7 and above and special trainings	Must be registered by the Traditional and Alternative Health Practices Council
Accredited Drug Dispenser Community pharmacy	Form IV and special training	Must be licensed by the Pharmacy Council
Laboratory practitioners	Form IV with special training	Must be licensed by the Laboratory Council
Physiotherapist and Occupational Therapist	Form IV with special training	Must be registered by the Private Hospital Board. Currently they do not have one, hence, must be trained in the college accredited by MoHCDGEC
Private midwives	Form IV with special training	Must be licensed with Tanzania Nursing and Midwifery Council