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CLASSIFICATION

PD-AAI-317

PROJECT EVALUATION SUMMARY (PES) - PART I

Report Symbol U-447

1. PROJECT TITLE <b>Hanang District Health Project</b>			2. PROJECT NUMBER <b>621-0138</b>	3. MISSION/AID/W OFFICE <b>Tanzania</b>
5. KEY PROJECT IMPLEMENTATION DATES			4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY)	
A. First PRO-AG or Equivalent FY <u>77</u>	B. Final Obligation Expected FY <u>81</u>	C. Final Input Delivery FY <u>82</u>	Final Joint <input type="checkbox"/> REGULAR EVALUATION <input checked="" type="checkbox"/> SPECIAL EVALUATION	
6. ESTIMATED PROJECT FUNDING			7. PERIOD COVERED BY EVALUATION	
A. Total EST. \$ <u>600,000.</u>			From (month/yr.) <u>1977</u>	
B. U.S. \$ <u>524,000</u>			To (month/yr.) <u>Sept. 1981</u>	
			Date of Evaluation Review <u>OCT. 2, 1981</u>	

8. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
1. USAID plans an orderly termination of its involvement in the initial phase of the project o/a November 30, 1981.	Paul Ehmer	Sept. 30, 198
2. CODEL plans to attempt to raise interim funding to cover the period from December 1, 1980 to June 30, 1981, and possibly a lesser amount to match expected GOT funding for the subsequent year.	Sr. Margaret Rogers	Oct. 31, 1981 June 30, 1982
3. Project staff will support CODEL and Hanang District Government funding efforts by providing plans and budget estimates.	Sr. Jeane Lynch	ASAP
4. Hanang District government will budget funds for Village Health activities for the year beginning July 1, 1982, and subsequent years. the members	William Mgalula	Oct. 31, 1981
5. USAID will distribute final evaluation report to team in Tanzania and Kenya and to project staff to facilitate the obtaining of interim funding.	John Burdick	ASAP
6. The team leader will deliver a copy of the report to CODEL. <u>PES Narrative</u>	Frank Dimond	Oct. 15, 1981
13. Summary (See Executive Summary in the Report.)		
14. Methodology (See Methodology section in the Report)		
15. External Factors (Covered in prior evaluation)		
16.-19. Inputs - Goal (See V, Measurement of Technological Change )		
20. Beneficiaries (See Background Section)		
21. Unplanned effects (Discussed throughout Report)		
22. Lessons Learned (See conclusions)		

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS			10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT	
<input type="checkbox"/> Project Paper	<input type="checkbox"/> Implementation Plan e.g., CPI Network	<input type="checkbox"/> Other (Specify)	A. <input type="checkbox"/> Continue Project Without Change	
<input type="checkbox"/> Financial Plan	<input type="checkbox"/> PIO/T		B. <input type="checkbox"/> Change Project Design and/or	
<input type="checkbox"/> Logical Framework	<input type="checkbox"/> PIO/C	<input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Change Implementation Plan	
<input type="checkbox"/> Project Agreement	<input type="checkbox"/> PIO/P		C. <input checked="" type="checkbox"/> Discontinue Project from point of view of AID involvement	

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)		12. Mission/AID/W Office Director Approval	
Paul Ehmer, Public Health Advisor, USAID/Tanzania		Signature <i>Barry M. Riley</i>	
Frank Dimond, Team Leader, AFR/DP/Evaluation		Typed Name Barry M. Riley, Ag. Director	
		Date <u>Oct 3, 1981</u>	

HANANG DISTRICT HEALTH PROJECT, 621-0138

FINAL EVALUATION, SEPTEMBER 23-28, 1981

"EACH ENDING, A NEW BEGINNING"

OCTOBER 1, 1981

	NAME	DESIGNATION
1.	Mr. Frank Dimond	Team Leader, AFR/DP/Evaluation
2.	Dr. Edward Moshi	Co. Team Leader, Regional Medical Officer, Arusha Region
	<u>TEAM MEMBERS</u>	
3.	Dr. Mohammed Amri	Ministry of Health, Senior Medical Officer, Training.
4.	Mr. Paul Ehmer	USAID Project Manager, Public Health Advisor
5.	William Mgalula	District Planning Officer, Hanang District
6.	Sister Margaret Rogers	CODEL Africa Coordinator
7.	J&P Rutabanzibwa	Ministry of Health, Medical Demographer, Planning Unit
8.	Dr. Roy Shaffer	Community Health, African Medical and Research Foundation, Nairobi, Kenya.
9.	Dr. Chris Wood	Director of Training, African Medical and Research Foundation
	<u>PROJECT STAFF PARTICIPATING IN REPORT PREPARATION</u>	
10.	Sister Jeane Lynch	Medical Missionaries of Mary, Project Director.
11.	Sister Marian Teresa Dury	M.C.H. Supervisor, Mary Knoll
12.	Brother Joseph Rose	Business Manager, Holy Ghost Fathers
13.	Nd. V.M. Tairo	DHL, Barbaig
14.	Nd. C. Makaben	DHL, Gorowa
15.	Nd. W.P. Masunga	Liaison Officer/ DHL Bashnet
16.	Mwl. Y.J. Masasi	Training Supervisor

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### Annexes:

- A1. Questions Raised in AID/W Interviews with Team Leader
- A2. Selected Areas of Interest by Evaluation Team Members
- B. List of Handouts given the Evaluation Team
- C. Village Data

NOTE: Annex B Compilation, Hanang Village Health Project

Compilation of copies of all handouts listed in Annex B are available upon request from USAID/Tanzania or AFR/DP/PPE in AID/W.

## CONCLUSIONS

The concluding section should be brief. It needs to be based on the Team product, and is fully based upon it. Two types of conclusions are called for from this program evaluation:

### Policy Conclusions (Findings)

It will be noted that the evaluation of this program generates findings that are potentially relevant to development policy in general. They are not limited in their application to the health sphere. This result is not intentional; it comes out that way.

### Program Conclusions (Recommendations)

Generically speaking this is a program, not a project. Once basic health services are started, everyone concerned, not least the target population, expects them to continue. A project can be terminated upon completion, while a program if serving a basic need must continue as long as the need exists. In this case the project level is in the village.

### Project Conclusions (Revised Logical Framework)

The project design as presented in the original logical framework for the project is not evaluable. A new logframe is presented, and then tested on the basis of data generated in part by the program's data system and in part by the Team's interviews.

Findings and Recommendations are paired, so that each policy conclusion can be implemented as far as the program is concerned. Each is identified by an Arabic numeral for sequence, under a Roman numeral heading indicating from which working group report the conclusion stems. Discussion underlying all conclusions is found in Sections I through V.

## I. Program Development

F 1. Had the Government of Tanzania been more involved in program development, the relevance of the program to emerging GOT policy would have been greater. The program design did not sufficiently recognize the need for a gradual and orderly transition to GOT management.

R 1.a That outside funding be sought for support of project activities necessary to strengthen and maintain in the villages the services of the Village Health workers trained by the project. This funding will be necessary to sustain project activities from Dec. 1, 1981 - June 30, 1982, when the Government of Tanzania will be able to include funding in its own budget for support of project activities for its fiscal year 1982/1983.

R 1.b That financing for the period July 1, 1982 - June 30, 1983 be jointly shared by the Government of Tanzania and the identified outside donor. The Government of Tanzania, through the District Medical Officer, should pick up total funding for the established Village Health Worker Program beginning July 1, 1983.

F 2. The program results in terms of costs and benefits are within a range of cost effectiveness. It is expected that the host government can manage to pick up the program and integrate it within its own health plan for Hanang District.

R 2. That a detailed plan be produced by the project staff in collaboration with appropriate Government of Tanzania officials at the District level, which describes how the project will be sustained during its maintenance phase. This plan should include a detailed budget that indicates necessary outside funding for the period of Dec. 1, 1981 - June 30, 1982 and shared funding for the period of July 1, 1982 - June 30, 1983. The plan for GOT funding must be completed and in the hands of the District Government by October 31, 1981.

F 3. A small pilot undertaking by a PVO has provided valuable lessons for the implementation of the GOT's primary health care plan. This experience is likely to be used in proportion to the degree the host government feels it is being consulted.

R 3.a That project staff in collaboration with Government of Tanzania officials continue to explore appropriate options for the supervision of the Village Health Workers trained under the project, beginning with the options described elsewhere in this report and consistent with newly written Government policy in this area soon to be issued officially

R 3.b That the option of pursuing the idea of the selection, training and utilization of Village Health Leaders as described in the project be further explored as a way of bringing services to the household level.

R 3.c That those MCH clinics at the village level that have been established by the project be continued, where possible with Government support, to be coordinated through the nearest health center or Dareda Hospital and that the option of providing refresher training to all VHWS in this area be pursued as a way of introducing these clinics into the villages.

## II. Program Results: Improving Village Health

- F 4. The information system designed for this program failed basically at the grass-roots level, because project reporting from village health leaders (VHLs) did not come in by and large. Where it did come in, the data was fed in to a central point. Feedback was limited.
- R 4.a A thorough review of the "primary" health information instruments. This review should include input from V.H.L.s.
- R 4.b There should be a thorough review of the overall information system. Checks should be made on design and duplicate reporting. Effort should be made to reduce the total number of pieces of paper being handled. Each instrument should have simple identification which fits an overall information flow system.
- R 4.c We suggest relatively less concentration on reporting attendances at meetings. Instead try to get more information on the attitudes and practices of the people.
- F 5. Success or failure of village health leaders (VHLs) to perform in program outreach is a vital indicator of overall program impact. The record in this case is, at best, mixed.
- R 5. This project's operation must be said to be focussed "beyond the dispensary." In a similar vein, project leaders should study the VHL's influence "beyond the lecture." What happens there should be the most important factor in decisions regarding selection, training and ongoing moral support of VHLs.

### III. The Information System

- F 6. The System has been able to meet some of its stated objectives. It has been difficult, however, to measure the impact of the Project on health status (Objective 3). Although it is well understood that not to have information does not necessarily mean there has been no impact, it is nevertheless a failure of the system if it cannot meet its objective.
- F 7. The system is too sophisticated to be replicated by the districts especially within the context of the Primary Health Care Program. However, the system has provided Tanzania with experience which is invaluable for designing a national PHC data system.
- R 6.a. Presentation of data or its analysis needs to be improved. As it is, one needs to have Project staff members nearby to explain the "tables" and other handouts about the project.
- R 6.b. A better balance needs to be struck between information collection and use. Too much is collected, little is used, and less feedback.
- R 7. In designing a national PHC data system, the following should be considered:
- a. Stating very clearly what the objectives of the data collection and analysis system are.
  - b. Identifying what data is needed, by whom and for what purpose.
  - c. There should be a minimum amount of forms.
  - d. Feedback (to the villages especially) mechanisms should be carefully planned so as not to have merely a one-way flow of information.

#### IV. Training and Supervision

- F 8. The training of VHWs has extended health services in Hanang District from 25% of villages 4 years ago to 95% over the period with about a 10% drop-out.
- F 9. Agreement between program and village regarding the selection criteria and role of VHWs has not been reached. While villages would prefer the more mature VHW because of greater stability and less likelihood of loss on the training investment, younger candidates are better qualified and are thought by program staff to perform better. As more is learned about the factors that make VHWs excel it may be possible to resolve differences in this area.
- F10. Training has been competent on the whole with conclusive evidence that later groups have been better selected and trained than earlier ones. Its most controversial aspect has been a high failure rate. The measurement of training effectiveness in terms of supervisory rating of the trainee on the job has not been performed effectively. Not enough is known about the factors in good VHW performance. Many details of training invited suggestions for improvement.
- R 8. A program be maintained to select and train further VHWs, to fill the existing gaps in the villages and the future gaps caused by resignations.
- R 9a That more time be spent introducing, explaining and planning the program with the village leaders, Education, Social Welfare and Culture Committee and villagers before the candidates are selected for training. Training should only begin when a sense of need has been established. Training should not be undertaken until the village is committed to support the program.
- R 9b Greater emphasis should be put on selecting candidates who are established in the village.
- R10a The program must be adapted to lower the drop out and failure rate (56%).
- R10b The size of classes should be reduced to ideally 20 or maximum 30.
- R10c A system of continuous assessment should be established (probably towards the end of each classroom and field session) so that poor performance can be identified while there is time to remedy it.
- R10d Assessments should include a checklist of activities undertaken by trainees.

- R10e A system to allow those who fail assessments to be re-assessed within a reasonable time should be established.
- R10f More relevant teaching aid should be developed and/or collected.
- R10g Attempts to teach VHWs how to learn by themselves should be increased. For example they might be made to study handouts before a discussion, rather than reading them after a lecture.
- R10h Supervision by training staff should be improved for field sessions. With increasing numbers of villages to be supervised the attention to trainees has decreased.
- R10i Practical training in environmental sanitation should be increased so that VHWs can build better latrines (including making concrete slabs - the cost of which is approx. the same as a bottle of beer) and which protect water sources.
- R10j Health education in schools should concentrate more on demonstration of good latrines and water protection.
- R10k Information system: This should produce continuous records on the progress of students. Records of performance in villages should be used for monitoring training.

- F 11. VHWs are found to receive two types of supervision, administratively from village authorities, and both professionally and administratively from program staff. Competition in the area of administrative supervision may increase as the GOT implements its program and as villages increase payments to VHWs giving them more legitimate right to supervise.
- R11a It is hereby recommended that there should be constant supervision from the dispensary staff as an ultimate policy. \*But since the dispensaries are overcrowded at the moment it is recommended that there should be a health assistant who will be specifically assigned supervision, either at divisional level or for a Health Center catchment area.
- R11b The administrative supervision should continue to be by the village government.
- R11c The District Medical Officer should be in charge of Village Health Program. He should budget and supervise.
- R11d Supervisory visits should be on monthly rather than the present bi-monthly cycle if resources permit.
- F 12. Supervision and performance rating of VHWs after completion of training has not been implemented fully.
- R12a Training evaluation of VHWs performing their tasks should be continued for at least one year after their certification.
- R12b The supervisor or village chairman or headteacher, according to topic or task should rate the VHW on a rating scale for performance which should be prepared to suit the local situation.

V. Measurement of Technological Change

F 13. The program appears to work in that inputs feed through to purpose level using a revised logframe. It appears to be manageable in that village performance can be compared, and analyzed, and the factors in good performance identified. The program is capable of generating the data which program management would need to control, expand, and justify the program.

R 13. Program management should use a revised logical framework as a management tool, checking continually on how the action moves from outside (program) input, to target population input, through a sequence of impacts. Better indicators should continually be sought out. Just as data generation should be kept simple, data handling should be based on a manual system, which could be computerized eventually on a national level.

## Methodology of the Evaluation

The methodology used for the Hanang District Rural Health Project Evaluation was unusual; one hesitates to say unique. For such a small project, an OPG of \$524,000 elaborate evaluation effort hardly seemed in order, but a large team of nine not counting project personnel had assembled under Paul Ehmer's initiative, and this fact alone required an attempt to make the best use of the available talent. The field work period, when the team would be together was only six days. There had been no scope of work prepared. Except for the Team Leader who knew none of the team before-hand, the other team members had had a degree of prior association with the project or each other. Project staff was welcomed to participate in team deliberations, on working groups, etc., and provided indispensable support to the overall effort.

The Team Leader proposed that the large team be divided into working groups under chairpersons who would be responsible for analyzing each aspect of the project. The breakdown into topics was the following:

### Project Inputs:

- Strategy
- Organization
- Methodology

### Project Outcomes:

- Direct Impacts
- Indirect Impacts
- Ultimate Impact (Replication)

The team accepted this arrangement at the first meeting. However, on the third day they decided to modify the working group structure as follows:

- Background
- Program Development
- Program Results
- The Information System
- Training
- Conclusions

Another fortuitous decision at the outset was the designation of Dr. Edward Moshi, Regional Medical Officer as co-Team Leader. Dr. Moshi later chaired the final debriefing session with District and Divisional leaders. His position in the GOT health structure is key to utilization of the experience this project is generating.

The Team Leader had conducted interviews with decision makers in AID/W prior to departure in order to find out what they hope to learn from such an evaluation. He had arranged the issues disclosed by the interviews in the six categories he had originally proposed for the working group organization. At the first meeting, team members were asked to write down

the issues they were most concerned with in the evaluation. The AID/W issues and the team issues are presented as Annex A, -

A response to the AID/W issues appears as an Executive Summary. The report deals with issues as seen by the Team.

The Project Director presented a proposal for visits to 9 villages. (See Annex B, List of Handouts for the Evaluation Team, Item 2.) Of the nine, seven were among the top group of nine villages among the approximately 80 covered by the Project, as we later learned through our own data collection efforts. Other formal interviews with District and Divisional authorities were arranged, as were visits to Dareda Hospital, an MCH clinic, etc. A party was offered the Team by the District Party Secretary, and in turn District and Divisional party leaderships were provided with a debriefing on the final day.

The challenge of such a large team, covering a heavy schedule of site visits, in a very brief period was dealt with through rigorous scheduling, strong decentralization of effort, and full reliance on sector working groups. To the above difficulties must be added the problem of the handouts, which came a few at a time on successive days, with no master list available, the fact that there was no electricity curtailing the possibilities of evening work, and sudden afternoon gusts of wind which picked up papers and spread them around the floor. The widespread need to speak and understand Swahili was no major problem, with almost all team members fully fluent, although the need to translate slowed things down a lot. However, the team was more than a match for the obstacles, members were invariably on time, and working groups seized responsibility with alacrity. The staff support was excellent, logistics well-managed, and most of the team managed a grueling half day of mountain climbing and a visit to Tarangire Game Park.

The working groups handled their assignments competently, overlap was minimized through effective informal coordination, a chairman of each group handled the writing and oral reporting on progress at meetings. Meetings were well-attended, held to time limits, discussions were cut off repeatedly with the suggestion that individuals get together outside, decisions were taken by majority and one might say unanimity with the Team Leader imposing a leader's prerogative on the group only in the interests of keeping on schedule. In fact, the Evaluation Team's operations were more that of a seminar than an audit.

Having worked his way out of reporting responsibilities, and unable to marshal the conclusions until the field work phase had terminated, the Team Leader focussed on the original project design. It was found to be adequate to support implementation but not to measure results.

The project logic was analyzed from the outside interventions (project inputs), to changed health practices (target group inputs), to improved health status (outputs), to improved quality of life (purpose) to project replicability (goal). Indicators were sought for each of these elements from the Project Information System. Moreover, supervising personnel at the divisional levels on both the professional and administrative sides

were asked to rate village projects in terms of accomplishment.

Using a 3x5 card system, one per village, the Team Leader entered data, and developed a simple manual computer for testing the revised project logic. The results produced high correlations indicative of a program that works is easily managed, and can achieve considerable impact. The results of this effort are presented in the section on Measurement of Technological Change.

The result of the evaluation is diverse, at once critical and sympathetic, using data where available, and improvising where not. The central issue of the viability of this pilot project has not been resolved, and cannot be without decisions by the Government of Tanzania. The Government's participation on the team was strong in numbers, active, and zealous in defending legitimate GOT viewpoints. Those sponsoring the project, especially CODEL, were on the side of the project looking for ways for it to survive. The AMREF contingent were the professional rural health specialists analyzing the details of the delivery system dispassionately. The team was balanced, making the job of leadership unexpectedly easy because the reporting was balanced. The degree of harmony was surprising, even when people held quite divergent views on thorny issues, and if a couple of people seemed at odds there was a big neutral majority to coerce the contenders toward moderation.

The cost of the evaluation was not large in either person-months or dollars despite the team size. The working group reports were largely completed prior to departure from Babati. A core of four team members travelled to Dar es Salaam on Sept. 29, where they had three working days to agree on the final version, brief the Mission, with final typed copies of the report in Mission hands, and on the way to AID/W and CODEL.

## Background

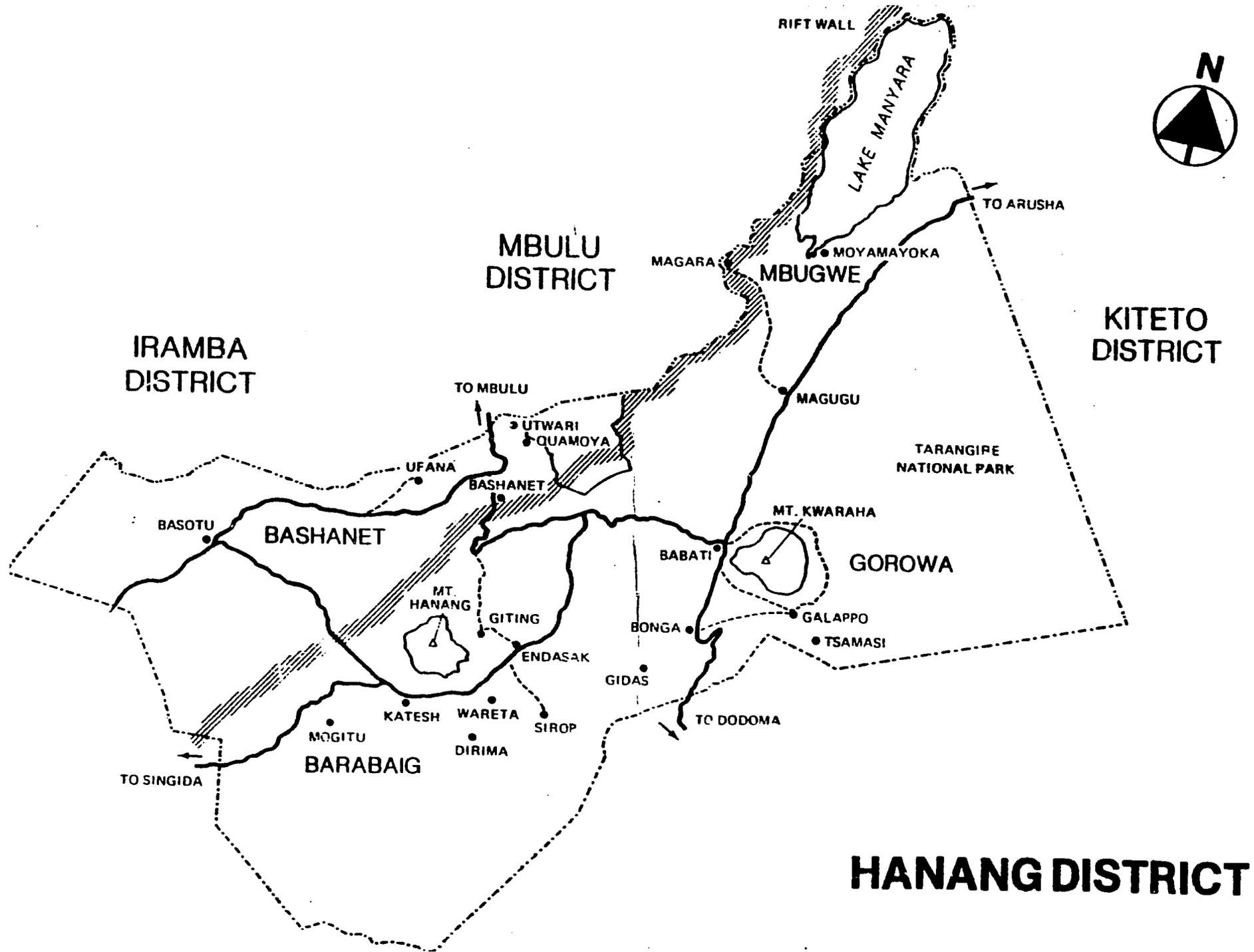
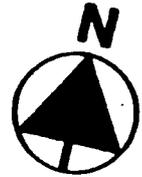
### I. Introduction

The Hanang Village Health Project was undertaken to provide a viable model for Tanzania to extend its existing health care delivery system to the village level. Its purpose is to improve the health status of rural villagers in Hanang District by utilizing the present social and political structure, encouraging self reliance and village cooperation to accomplish development objectives. Project activities include: recruitment and selection of villages to participate in the project; selection and training of 2 villagers from each village to serve as village health workers; collection and utilization of health, nutrition and general information concerning participating villages; initiation of health activities by the Village Health Worker in the villages; selection and training of Village Health Leaders to serve under the Village Health Worker at the health unit level; the training of Village Health Workers to teach health, treat minor illnesses, give first aid, participate in Maternal and Child Health activities in the village; supervise environmental hygiene in the village and participate in the discussions and decisions of the Health Committee in the village.

Hanang District lies within the Rift Valley. It was formerly a sub-division of Mbulu District in Arusha Region. It is approximately 3,298.5 square miles in size with a population of 240,000 people. It has four divisions - namely, Barbaig, Bashnet, Gorowa and Mbugwe. These four divisions are in turn subdivided into 28 wards which have a total of 113 villages. Altitudes range from 3,500 to 5,000 feet although Mt. Hanang rises to over 11,000 feet. Major crops are maize, beans and with extensive livestock holdings.

The Project is funded by CODEL (Coordination for Development - a Consortium of Ecumenical Organizations) - through an Operational Program Grant from USAID (United States Agency for International Development). The Project holders are the Medical Missionaries of Mary, whose headquarters are in Drogheda, Ireland. Other members of CODEL participating in the Project are a Maryknoll Sister and a Holy Ghost Brother. Cooperation with the Tanzania Government has been operative throughout the life of the Project. The implementation of the Project has been through the combined efforts of Tanzania (Gov. and non-Government staff) and expatriate staff, working together to achieve the aims of the Project.

The initial time frame for the Project was 2-1/2 years. An extension of 2 years was granted after the completion of that time span, bringing the total time span to 4-1/2 years, termination November, 1981. The total funding for the Project is \$499,000 (Tanzania Shillings 3,992,000/=).



# HANANG DISTRICT

## II. History of the Hanang Village Health Project

The Project came into being through the initiative of the Medical Missionaries of Mary who were involved in providing curative medical services in Dareda Hospital in Hanang District. Although their work had been developed by missionaries, it had been incorporated into the formal government health system. The Sisters were concerned that the simple delivery of curative services would fail to produce long-term benefits to the community and they collaborated with the Government to develop the Hanang Village Health Project, designed to deliver essentially preventive services in the rural villages.

Much of the foundation work and research for the Project in 1975 - 1977 was done by the representative of the Medical Missionaries of Mary, Sister Jeane Lynch with Dr. M.A. Malugu, District Medical Officer, Mr. Masaoe, District Health Officer with assistance of Sister Martha Collins, who, at the time was the Doctor i/c, Dareda Hospital. At the same time, in the U.S.A. Sister Joseph Anthony, M.M.M. was searching for funding for the proposed project. CODEL was approached and after becoming interested in the proposal agreed to fund a pilot phase on condition that the Project was approved by the Tanzania Government. This approval was given by the Tanzania Government through the Regional Development Director, Arusha, after it had been approved by the District. It was understood at that time that the Government would continue to run the services started by the Project, once the funding was over. The original funding obtained from CODEL was Tanzania Shillings 2,630,376/= (\$340,000). In order to meet this amount, CODEL obtained a grant from USAID with the condition that an information gathering and monitoring system be incorporated into the project.

Under this grant, the purpose of the Project was to extend the existing health care delivery system to the village level and to test the feasibility of the information collecting system.

## III. Implementation of Project

### A. Training

Preparations, making contacts with the villages, etc., were begun on 1st January 1977. The Pilot Project phase was begun on 1st May, 1977 in four villages, one in each division of the District - Bonga, Matufa, Endagaw and Luxmanda. The first activity was a survey done in each of the pilot villages before the first training session began. The first formal training session began June 1, 1977 at the center in Babati, for eight trainees - 2 from each village selected from among other candidates nominated by the village. These trainees continued for two four-week sessions followed by field work in their villages. Nutrition Surveys were done in their villages by Project and Government Medical Staff and Village Health Leaders were selected by the villagers. The work of the Trainees was supervised in the villages by Division Health Leaders appointed

by the Project. A seminar was given at the Center to orient these DHLs to their responsibilities in the field.

Following the decision by MMM/CODEL on 24 August 1977 to go into the operational phase, plans were made for choosing these villages and planning the program. Fourteen villages were chosen from Mbugwe and Gorowa Divisions. It was decided to include the Pilot Group in these new groups (Called OPG I and OPG II) because it was felt that their training had been inadequate. OPG I began their two year period of training on 2 January 1978. OPG II began on 31 January 1978. These training periods consisted of four one-month classroom sessions each followed by 5 - 10 weeks of field experience in their villages.

In October 1978, as plans were being made for the coming evaluation of the Project by CODEL/USAID in February 1979, it was decided to delay the intake of OPG III villages until after the evaluation in order to incorporate recommendations from the evaluation into their training program. This evaluation took place on February 22, 1979 the team consisting of Rev. Patrick Cullen and Rev. Boyd Lowry both CODEL, Mr. Gilson and Dr. Henn (USAID). At this time, a draft proposal was put forth by the Project for an extension of 2 years ending November 30, 1981. This proposal was later formally approved and application was made for the extension following communications between USAID, Dar es Salaam and Hanang Village Health Project through CODEL, New York. This grant was approved in 1979.

OPG III Trainees from 15 villages started their training course on 7 May 1979. Many of the recommendations from the evaluation were implemented with this group - especially new educational approaches including the use of the Bar Graph, teaching in primary schools and increased use of the demonstration method. The period of training was also increased to 10 months. Another change was the Placement of the Nutrition Survey during the first field experience session in order to give the trainees a picture, earlier in the training, of the health of the children in their villages.

OPG I and II returned in November and December 1979 for their Refresher Course after their year of field experience. Final examinations were held at this time, on completion of which they received their certificates, signed by the D.M.O. and Project Director and issues by the Area Commissioner.

Successful candidates received full certificates qualifying them to:

1. Teach health to the villagers
2. Treat minor illnesses
3. Give first aid
4. Assist in MCH activities in the village - MCH Clinics, etc.
5. Supervise environmental hygiene in the village
6. Be a member of the Health Committee in the village

OPG IV villages, 19 in number, were accepted into the Project on 27 April 1980 and are expected to complete their training in November 1981. Twenty-two OPG V villages were accepted into the Project on 2 November 1980. This group finished their first year of training in September 1981. In the original plan of the Project, it was expected that this group would complete their training period (Refresher Course) under the supervision of the D.M.O. in November 1982.

In 1980, an arrangement was made with Dareda Hospital Nursing School whereby fourteen of their student nurses went to OPG I and II Project villages to obtain Community Nursing Experience. They stayed for one month in the village, all arrangements for accommodations, etc. having been made by Project staff with the Trainees in the villages. This experience was of mutual benefit to trainees and student nurses as they worked together to teach and help the villagers.

Summary. From the beginning of the Project until Sept. 1981, 95 villages were accepted into the Project from a total of 114 villages in Hanang District. A total of 192 Trainees (considering Ayasanda as two villages - thus 4 Trainees were trained.) So far, 43 Trainees (OPG I, II, III) have completed their training and have received full certificates. Those still required to repeat examinations and thus considered still in training number 60. OPG IV trainees, 38 in number, are expected to complete their training in November 1981 and 44 OPG V trainees will finish under the D.M.O. in November 1982.

During the time of the training of the VHWs, Village Health Leaders were selected and have received some elementary knowledge of health matters from the trainees. Some of these in turn have begun to teach the people in their health units.

#### B. Extension of MCH Services

During the span of the Project, MCH mobile clinics were initiated in twelve Project villages. (See MCH Evaluation Paper.) In addition, contact was made with Haydom Hospital and an MCH Clinic was started in Basodesh and is still continuing. These mobile clinic services account for 36% of the total MCH services in Hanang District and approximately 25% of all the immunizations given in the District (based on 1980 figures). The Project has conducted these clinics with the assistance of the Staff of Dareda Hospital, Babati Health Center, Katesh Health Center and Magugu Health Center and the staff of Endasak Dispensary. Transport was provided by Project vehicles.

#### C. Curative Services

Originally, it was hoped that MCH Clinics would be started in 32 Project villages but constraints of staff and petrol shortages dictated otherwise. However, it was felt, in the course of the Project, that curative services should go along simultaneously with prevention. Therefore, stress was placed on the extension of curative services in the village rather than on

the initiation of an MCH Clinic. At present there are 18 villages which have medicine boxes with curative services being given by the VHW on certain days of the week. (See Evaluation Paper).

#### D. Information Gathering and Monitoring System

From the beginning, an information gathering and monitoring system has been operative in the Project, yielding general information about the villages, health status in the villages and data regarding project activities in the villages. Through the village committee structure, the information is passed on to the village leaders themselves and to District Health Personnel. Monthly reports were also sent regularly for most of the span of the Project to Ministry of Health officials, CODEL, USAID and other interested individuals (see attached list).

#### E. Nutrition Surveys

A Nutrition Survey of Children 0 - 10 years was done in all Project villages at least once: Pilot Villages - Sept/Oct. 1977; OPG I and II Villages in July/August/September 1978; OPG III Villages in June/July 1979 and OPG IV villages in June 1980 and OPG V villages in December 1980/January 1981. For the last three groups, the N.S. was used earlier in the training period in order to give a picture of the nutrition status of the children and the common illness and diseases found in the village. The information by way of village profile was then used early in both the teaching programme and the practical work. For each village a list of borderline malnutrition children was made and follow-up was done by the VHW through the health units. The VHW measured the arm circumference of the children once per month. Through special funding, eighteen scales were bought and distributed to selected villages to facilitate this follow-up of the borderlines. In villages with no scales, the weights were done at the nearest MCH Clinic. Following the nutrition survey teaching demonstrations of nutritious food and its preparation was done in 47 villages to Village Health Leaders and mothers of borderline children and malnourished children (Kwashiorkor and Marasmus). A grand total of 49,487 children were examined in the first nutrition surveys and 947 in the repeat N.S. of sample villages in August, 1981.

#### F. Seminars

In order to promote greater participation of local leaders, health personnel, teachers, etc., in achieving the goals of the Project, Seminars were given to:

1. Head Teachers, Education Coordinators, Ward Secretaries, and Village Secretaries
2. Staff of Government Health Centers/Dispensaries and Voluntary Agencies
3. Divisional Secretaries
4. Village Leaders in Bashnet Division

### G. Staff

Throughout the 5 years, there were several changes of staff, both key staff and other categories. This because of problems towards the end of the period, when the future of the Project was uncertain.

At the end of 1980, the Director, who had been with the project since the beginning, left, and was not replaced for 6 months. The Steering Committee consisting of heads of Departments, directed the Project for 2 months, after which, the Business Manager was appointed Acting Director by CODEL.

The Project Data consultant, a qualified statistician left in late 1980, and was not replaced. He was also holding a Government position of Field Officer and was not replaced in this government job for 9 months. A Health Officer was then seconded by the Government to be Field Officer.

During 1981, the office supervisor and office and data staff left. This made it necessary to bring in three Divisional Health Leaders to be center staff. The fourth is a Health Officer seconded by Government, and another Health Officer is at present being trained as a D.H.L.

The nurse midwife working with the MCH coordinator left the Project during 1981 and the Government seconded a nurse midwife in her place.

Finally, three out of four drivers had left the Project before September 1981.

### WORKING GROUP REPORTS I TO V

The Background section as well as Working Group Reports are presented as drafted by group Chairmen. Many team members participated on or contributed to more than one group. The conclusions include all of the recommendations identified by the working groups, and in fact are taken verbatim from their respective reports. The findings have been developed by the Team Leader, and are presented one on one to the recommendations.

- I. Program Development
- II. Program Results: Improving Village Health
- III. The Information System
- IV. Training and Supervision
- V. Measurement of Technological Change

• Program Development

Project Objective: to provide a viable model for Tanzania to extend its existing health care delivery system to the village level.

The Project has tried to extend the existing Government preventive health services to the rural areas through the training of Village Health Workers, chosen according to established criteria from among candidates presented to the Project by the villages. Because villages in this area of Tanzania are often spread over a wide area, it was felt that a further extension to the household level would require the inclusion of an additional cadre, called Village Health Leaders, who would be responsible for following up on certain health activities for 10-15 households in their area.

The Village Health Worker (VHW) is a villager with no previous health background and a primary education, who is trained by the Project in an alternating series of classroom and field work sessions that extend over a period of nearly one year. These trained VHWs then return to their villages to undertake a number of simple health activities, including the provision of health education, gathering basic demographic and disease incidence data, investigations and advice to villagers regarding basic environmental conditions in the village, investigations and follow-up of malnourished children, and attendance and assistance at nearby dispensaries, rural health centers or MCH clinics, including treatment of simple health problems and referral of more complex ones to the established treatment facilities in the area. The Village Health Leaders (VHLs) are given health education by the VHWs and are expected to pass this information along to the families in their units, as well as collecting the basic disease and demographic data at this level.

Once the Village Health Workers are trained and return to their villages, they are supervised by Divisional Health Leaders, who periodically travel to all villages in their Division to provide support and continued education to the VHWs in the area. Presently the Divisional Health Leaders reach every village on the average of at least once every 2-3 months. In addition, Divisional meetings are held once every 1-2 months, led by the Divisional Health Leader and attended by the VHWs of the area. During these meetings information collected by the VHW, is recorded by the DHL and stored for future use by the Project and the Government.

There are presently 113 villages in Hanang District of which 87 were brought into the Project at some time during its four year life through the selection and initiation of training of VHW candidates from these villages. Some VHW candidates did not finish their training and some have not been active upon returning to their villages. At the present time there are 73 villages that are still considered to be active in the Project. A total of 180 VHWs have been selected, of which 166 are still active in the Project. Of the 26 villages in the district not initiated into the Project, only 6 do not have an established rural health center or dispensary. 12 villages which were initiated into the Project, but dropped out also do not have these facilities which means that Hanang District now has only 16% of its villages without some form of health services. Without the VHWs this figure would be 75%.

Following completion of formal training in Babati, the VHWs return to their villages for one year, at the completion of which they return to Babati for a three week refresher course followed by a final exam. If they pass their exam, they receive a certificate from the Project. To date 43 VHWs have passed their exam out of a total of 99 in three training groups. One other group of 37 trainees will be returning for their refresher course in October 1981, and the last group of 44 trainees finished their basic training in September 1981 and would not be due back for their refresher and final exam until November, 1982. Since funding from AID/CODEL under this Project ends in November 1981, it was expected that these trainees would receive their final refresher under the supervision of the District Medical Officer.

It was anticipated during Project design that the Government of Tanzania, through the District Medical Officer, would assume responsibility for supporting those activities necessary to maintain the services of the VHWs who had been trained by the Project. Since present Project funding will terminate at the end of November, 1981, it is appropriate to examine this issue of future Government support.

During the Project, funding was made available to support the selection, training and supervision of the VHWs who were designed to be the basic link to extend the health system to the village level. The Government's long term goal in the provision of health services to the rural areas is to have an actual dispensary in each village. This goal is presently far from being reached with over 8,000 villages in Tanzania, having approximately 2,300 dispensaries to date. The concept of using a cadre of local paramedical personnel to bridge this gap led to this Project and others like it throughout the country during the past few years.

Even in a limited area such as Hanang District, the four years of the Project have been insufficient to firmly establish a long term program. The last group of trained VHWs just reached their villages in September 1981. The concept and groundwork of a VHW program have only just been introduced. Consolidation of the program will require many more years. Since the original design did not anticipate what would happen following the end of present funding, the evaluation team feels that a smoother transition to Government of Tanzania responsibility must be effected. Although it is already very late for new plans to be made and discussions held in this area, it is felt that quick action on the part of Project personnel and Government officials can bring about this smooth transition.

Due to changes in key Project personnel during the last year, it was not possible to prepare a plan and budget for maintenance activities in time for submission and inclusion during GOT fiscal year 81/82, which began July 1, 1981. Therefore, the earliest that funding could be made available by the GOT would be July 1, 1982, which begins FY 82/83. This leaves a gap between December 1, 1981 and June 30, 1982, during which it will be necessary to seek further outside funding. Following discussions with Project personnel and GOT officials, it was further felt that the period July 1, 1982- June 30, 1983

should be a time of shared support between GOT and outside donors to allow for the gradual transition period as discussed above. This would avoid the abrupt transition that would otherwise be inevitable with its attendant high risk of losing the Project altogether.

It is essential that the Project personnel understand the GOT planning and budget cycle, which requires that the District plan and budget for FY 82/83 be completed by December 31, 1981. This means that project proposals must be in the hands of the District Planning Officer by October 31, 1981. The months of November-December 1981 are used to consolidate the plans from all sectors to produce the overall district budget. This only leaves the month of October for preparation of the plan.

It is suggested that this plan include provisions for the maintenance and support of VHWs already trained by the Project. This will mean that no further basic training be given to new VHWs from other villages not now included, or to new trainees in villages where the Project trained VHW is no longer functioning. The expansion of the Project through training of more VHWs must be based on solid commitment by GOT.

It is expected that curriculum and training materials developed by the Project will be useful to the GOT in implementing its own VHW training programs. The Ministry of Health has just spent the last year developing its own plan for the implementation of a primary health care system. An important part of this system is a proposal to train VHWs for all villages of Tanzania. Implementation of this plan is expected to begin July 1, 1983. Therefore, in Arusha Region, and in Hanang District particularly, the VHWs already trained will become part of the national program, while replacements and VHWs for new villages will be trained under the new Government program. This means that further Project activities will be integrated into the new program and will consist of mainly supporting the VHWs already trained. The support machinery for VHWs, developed under this project may provide a basis for the future Government of Tanzania program to train VHWs to meet national needs.

One key area of support that the follow on activities must address is that of continuing education. Regular refresher courses must be provided to update knowledge and skills of VHWs, as well as other rural health workers. It is expected that at least one week per year of continuing education will be provided for all VHWs trained under the Project through the Government's new Continuing Education for Health Worker Program, presently being implemented in Arusha Region. This course would be given in Babati. In addition some further days might be provided for in the Project extension, but these courses of only a few days at a time might more cheaply and appropriately be held in each Division during periodic divisional health meetings for the VHWs.

The other key area of consideration for follow-on activities is that of administration and supervision. One important factor in this area is transportation. Presently, transportation capabilities within the district are very low and the high cost and short supply of petrol is a critical consideration. The Project has implemented a system of supervision at the

divisional level for the VHWs. Under the Project these supervisors are known as Divisional Health Leaders (DHLs). This was a new cadre of personnel created by the Project and paid out of Project funds. Since it is not a Government cadre, these people cannot be picked up by the GOT and could not continue functioning after the Project funding ceases.

For this reason the Project has proposed that Health Assistants (HA), who are GOT employees assigned at the divisional level, become "DHLs". The Project has been able to bring two such HAs into the Project as well as one HA, assigned at the district level, to act as Project "field officer". This only leaves two divisions presently being covered by Project "DHLs". It is anticipated that these DHLs would continue to function during the period of December 1, 1981-June 30, 1982, and would work with and train HAs in their areas to take over their functions following this period. This would mean that by July 1, 1982, only GOT personnel would be operating at all field supervisory levels of the Project.

One other option for supervision which should be explored is that of supervising the VHWs from the nearest dispensary. Each dispensary now serves 7-10 villages in its area. It is government policy that eventually support for VHWs will come from the nearest dispensary. Presently, staffing shortages in the dispensary and jurisdictional administrative conflicts between villages make this option difficult to implement. Under present staffing patterns, the rescheduling of clinical duties for dispensary staff to enable them to effectively supervise the VHWs in their area would be difficult. This option does ease the transportation problem posed by using people at the divisional level as discussed above. These options should be carefully considered and a decision made as to which to include in any longer term extension.

During the interim periods described above a further important area of consideration should be the close collaboration between the Project Director and the District Medical Officer, who is in charge of all health activities in the District. This will insure that when the Project is ready for GOT takeover, this essential function will be undertaken by the appropriate Tanzanian official with a capability to keep the activities going.

An analysis of budget figures at Regional and District levels was undertaken during the evaluation to determine levels of GOT support that would be feasible and appropriate to sustain Project activities. The following table shows the results of this investigation

(1 US \$= TSh.8.)  
Arusha Regional Health Budget (80/81)

(TSh)		
Development	Recurrent	Total
2,404,000	27,945,000	30,349,000

Hanang District Health Budget (81/82)

(TSh)		
Development	Recurrent	Total
184,000	2,967,258	3,151,258

## Hanang District Recurrent Health Budget (81/82)

(TSh)

Curative	Preventive	Rural Health Centers	Dispensaries	Total
177,291	646,685	1,344,142	799,140	2,967,258

Assuming a 15% rise in the budget for 82/83, there would be approximately TSh.3,625,000 available for health in Hanang District. Discussions with health officials in the district indicate that they place a high priority on this Project and would put it above the construction of a new rural health center. If it is reasonable to assume that 10% of the total District health budget might be made available to support this Project in its next phase, this would amount to approximately \$45,000. While that figure would rise over time it is only about one-half the present annual rate of Project expenses excluding capital investment. Project expenditures must be reduced to expect the GOT to be able to provide future support.

### MCH Mobile Clinic Service of the Hanang Village Health Project

In Hanang District there are 13 Government clinics, 7 voluntary agency clinics and 18 mobile clinics. Of the 18 mobile clinics, 12 of them are the responsibility of the Hanang Village Health Project. As a result of these the Project is responsible for 36% of the clinic services; 12% of total attendance of pregnant mothers; 24% of total attendance of children under five. Of the total immunizations given in the District, the project's MCH clinics account for 20% of BCG; 25% of DPT; 25% of Polio; 25% of measles and 25% of tetanus toxoid.

The Project made the necessary arrangements with the villages to make it possible for a mobile clinic to function. Staff from Dareda Hospital, Endasak Dispensary, Magugu, Babati and Katesh Health Centers were used. The Project staff coordinated schedule and transportation.

In the original project design, it was intended that 32 villages would be serviced with MCH mobile clinics. This has not proved feasible due to the following factors:

1. shortage of staff
2. increased cost and shortage of petrol
3. poor participation on the part of the Village Health Leaders in the in the work of the clinic
4. Government policy which favors static rather than mobile clinics

To establish static clinics that would be within reach of all the villagers will take several years. If MCH services are to be available to all, mobile clinics seem to be inevitable. The cost, however, is prohibitive. One possible solution might be to upgrade the training of the VHW's to enable them to assume some of the duties of the MCH clinic. They would need a bicycle and thermos for the collection of vaccines from the local dispensaries or health centers.

At present there is a MCH component integrated throughout all four classroom sessions in the VHW training program (see Annex B, Item 39 for

the syllabus followed). It aims at helping the Trainee to have a greater awareness of the health status of the mothers and children; to recognize health problems of children and help solve them or refer the child to the nearest health facility when necessary; to recognize and help prevent health problems in pregnancy; to recognize those children and pregnant mothers who are "at risk" and refer them to the nearest health facility; to help, in an emergency, a pregnant mother to give birth safely or get her to the nearest facility. This training could be expanded through additional classes and practical work thus equipping the VHW to fulfill most of the duties of the MCH clinic.

The GOT wants to maintain the services that have been provided by the Project mobile clinics, but now discourages mobile clinics because of high transport costs. With increased training through refresher courses and a bicycle the VHW could be trained to continue with the clinics already established. This would lead to mobile supervision of these services, with the goal of providing both supervision and services in every village.

#### GOT Planning Process

The following section provides an overview of the GOT planning process at the district level which must be taken into consideration in preparing future proposals.

The GOT planning process starts at the village level. The village assembly prepares and approves a list of projects for which it wishes to obtain government support in the following financial year between the months of September and November. The list is presented to the district office through the respective ward and division.

At the same period the sector heads\* at the district level (district functional managers) prepare their proposals which are intended to be implemented in the following financial year. Village proposals and sector proposals are compiled at the district level by the District Planning Officer to form a district plan.

The projects are consolidated by relating them with national guidelines. The national guidelines include all sector policies focussing priority areas to be emphasized in the next financial year and the probable amount of money a region may get in that year.

A detailed district plan is prepared including the total cost. The sectors are integrated together. The district plan is coordinated with the manpower available in the district and other personnel anticipated to be employed from various national institutions. Other costs termed as "other charges" are worked out. These include the cost of running vehicles, equipment and machinery, allowances, various supplies etc.

\*Sectors included are Health, Education, Culture, Ujamaa & Cooperative, Works, Lands, Water, Natural Reserves, Agriculture, Livestock and Trade.

The district plan is then presented to the various district government and party meetings for approval. The necessary amendments are made by the meeting members. The district plan is then forwarded to the Region for further processing. These activities have to be completed by the first week of January.

At the Regional level, district plans are compiled by sector with the added proposals of the regional sector heads (regional function managers). The proposals are consolidated to form a regional plan. The regional plan is presented to government and party meetings for approval. The final document is prepared and forwarded to the Prime Minister's Office by March.

The Commissioner for Planning and Control in the Prime Minister's Office convenes meetings between regions, line ministries, finance and planning ministries. The meetings consolidate the regional plans with the line ministry proposals. The ministries of finance and planning incorporate the parastatals proposals with those from ministries and regions to form a national plan.

These tasks have to be completed by the end of May. Normally in the second week of June the national plan is presented before the national assembly where the members of parliament discuss and approve the plan. The Ministry of Finance then allocates the funds to regions and Ministries starting from 1st July, the time when the new financial year starts.

See Findings F1-3, Recommendations R1-3, pp 2,3

## II PROGRAM RESULTS:

### IMPROVING VILLAGE HEALTH

#### 1. PLAN

There are two main ways in which the project is intended to improve health:

- (1.1) Preserve existing health
- (1.2) Restore health

1.1 Preservation of existing health is accomplished in the following ways mainly:

- 1.1.1 Health Education, mainly on hygiene, nutrition, water and waste
- 1.1.2 M.C.H. services, particularly immunizations, growth monitoring, pregnancy monitoring and chemo-prophylaxis.

1.2 Restoration of health is accomplished in the following ways:

- 1.2.1 Monthly home visits to children found malnourished
- 1.2.2 Promotion (especially through schools) of home treatment of diarrhoea (ORS)
- 1.2.3 Curative treatment from the "First Aid Box" in some villages.
- 1.2.4 Moral support and some drug supply to TB patients.

#### 2. INFORMATION FLOW

Information regarding fulfillment of the plan is intended to flow "upward" through the system in a variety of forms initiated at different levels as follows:

FLOW OF HEALTH INFORMATION

IS  
(Project  
Mradi)

Summary Sheet  
for each village  
HU-1 Data  
Demography  
Problem priority  
Nutrition

Jedwali 79-1  
Demography  
Cows  
Latrines

DHL  
(Division  
Tarafa)

TMAVP-1  
(Collation of Villages)  
Same as HU-1

Another un-designated set  
of collations 1. HU-1  
information  
2. Teaching sessions  
3. School talks  
4. M.C.H. clinic  
participation  
5. Curative Service ("Box")  
6. Meeting attendances  
7. Nutrition Rehab  
8. Immunizations  
9. Environmental Hygiene  
10. T.B. Program  
11. Assistance and Problems

V.H.W.  
(Village)  
Kijiji

TMA VP1  
(Collation of Units)  
Same format as HU-1  
5 Diseases  
Births and Deaths

Record  
and Verbal  
reports at  
monthly  
meetings

V.H.L.  
(10 cell unit)  
Kundi

HU-1  
5 Diseases  
Births and Deaths

Verbal

The People



by  
record  
or  
verbal

### 3. GENERATION OF DATA

The projected system has not produced all the information it was intended to. So the discussion will be in two parts: data we have obtained and data we failed to get.

#### 3.1 Data Obtained

3.1.1 The M.C.H. clinic program has its own attendance and morbidity data system. Each clinic can be taken to be fairly representative of that village, even though the data did not come through the main informational pipeline i.e. it was not "community based".

This clinic-derived data is presented in tabular form below. The only clearcut evidence of improvement concerns measles incidence.

#### M.C.H. DATA

	Attendance		INCIDENCE				
	TOTAL CHILDREN	TOTAL PREGNANTS	UNDER WEIGHT	KWASH,	MARASMUS	DIARRAEA	MEASLES
June 79	353	279	90	2	3	50	8
" 80	1363	465	160	11	13	75	0
" 81	2202	419	102	12	4	87	0

3.1.2 The nutritional rehabilitation program data comes in two forms: (1) monthly VHL home visits to cases and (2) the follow-up detailed clinical assessment by specialists. The former information was incomplete. The later seemed to indicate that there was only a 36% improvement in "borderline" cases despite intensive contact by VHLs.

3.1.3 The environmental sanitation emphasis is epitomized by the latrine. Now a properly built and used latrine itself is not "improved health". But there is an indisputable cause-effect relationship. Hence the mention herein of prevalence figures for latrines. The project's promotional activities should be causing a rise in the prevalence of latrines. The data adduced from field surveys however indicates only an average 4% overall rise in prevalence of latrines associated with project input.

#### Percent of Homes with Latrines

##### Before project input

74%  
(Range 9-97)

##### After project input

77%  
(Range 46-100)

Presumably improvement in utilization of latrines has been significant - though un-measurable.

Moreover, a gross under statement of accomplishment in the statistics is

suspected. There is something inconsistent about a meagre 4% increase in latrine prevalence, when many villages show large increases of up to 50%. Also it should be noted that the lower end of the range has risen from 9% to 46%, impressive if accurate. What brings down the average increase is a considerable number of villages reporting large drops in the number of latrines. At a time when preventive health is being stressed any drops at all are suspicious. Either over-enumeration on the baseline or under-enumeration on the subsequent survey is suspected.

### 3.2 Data expected but not obtained.

3.2.1 The main "pipeline" of information starting within the HU-1 form (see chart) has not flowed. Reasons for this failure include the following:

3.2.1.1 People. In initiations of HU-1 the VHLs may be incompetent in their reading or writing or in their diligence in observing and reporting. A few VHLs do regularly produce good reports, but one cannot build on such sketchy material (roughly 10%). Likewise, but not as critical may be failure of accuracy or diligence on the part of VHWs and DHLs.

3.2.1.2. The documents themselves may be problematic. The HU-1, as simple as it seems to outsiders, has been too complex for barely literate VHLs. Furthermore the plethora of forms predisposes to confusion at all levels. There is no systematic identity system for the 30 or more data forms which make up the "pipeline."

3.2.1.3. The "system" includes many potential hinderances to the flow of information. Landrovers break down, petrol is unavailable, supplies of paper fail to come from outside, etc.

3.3. Impressions. Despite the paucity of "hard" health data arriving at project headquarters the evaluation team heard much anecdotal evidence to the effect that the project is indeed contributing to improvement of the health of the people of Hanang District.

3.3.1 The people in all areas spoke of decreases in measles and diarrhea and improved health practices. They all knew the litany of health which is being taught. If they are practising half of what they are reciting their health must be improving. The project villagers showed a great appreciation and interest in the project. The village government and political leaders are aware of the project. This is supported by the fact that the village governments pay some of their VHWs.

The project staff has been diligent and resourceful to the extent that, they are very much accepted by the villagers.

The villagers seem to understand what the project is all about and support its objectives.

3.3.2. Civil and political authorities at all levels were familiar with and enthusiastic for the project. This is very indirect, yet significant evidence of influence for improved health.

3.3.3. Wherever we visited, the project staff provided numerous anecdotal accounts of improved health on the part of individuals there. This information is not "hard" data, but it is first-hand and therefore significant.

3.3.4. Inferences can be made from the following indirect data presented in Section V, Measurement of Technological Change.

In summary, though we lack the expected statistical picture on improved health, the impressionistic picture is consistently positive.

#### 4. Attitudes of Traditional Health Workers

Traditional health workers or birth attendants exist in Hanang District as throughout Africa. However, project staff scarcely mentions them. Obviously they could be prime candidates for VHLs even if lack of education would disqualify them for the more rigorous VHW training program.

It is surely well-known that people with experience if not utilized can easily fall into negative attitudes. Possibly, the spotty performance of VHLs has been influenced by such countervailing forces. On many African health projects, training attempts to focus on traditional health workers rather than new personnel. An investigation of the attitudes and reactions of traditional health workers towards the project might provide considerable insight into the problems of outreach.

#### 5. Discussion

Improvement in health and the documentation of that improvement are primarily functions of the work of the VHL. This review has brought out the weakness of the current VHLs as documentors of improved health. We must face the possibility that good documentation of health changes might reveal these VHLs to be weak as agents of actual change. Either of these possibilities (workers as documentors or weakness as agents of change) have import for the selection-training-moral support process.

See Findings F4-5, Recommendations R 4-5, p. 4.

### III. THE INFORMATION SYSTEM

#### A. THE OBJECTIVES OF THE SYSTEM

The information system for the Hanang Village Health project was set up with 3 objectives in mind and these were:-

1) "To gain an overview of village health conditions and problems. The information collected through this system should assist in planning health activities at the village level."

2) "To monitor project implementation in terms of the financial, commodity and extension inputs into the project, the direct project results or outputs. The initial effects of project activities on and the behavioral patterns of villages". (or treatments) The information collected would be used for project management i.e. to help in making decisions concerning project implementation where need be.

3) The third objective of the system was to provide information which would be used "To evaluate the impact of the project on the health of the villagers". There was a fourth objective which was implicit in the project plans and that was to have an information system which could be replicated in other districts.

#### B. HOW SYSTEM WAS TO ACHIEVE OBJECTIVES - INSTRUMENTS

##### 1) Planning Stage

The initial stages of the project involved identifying which types of data would be collected at village level and this was done by the trainees and the project staff. It had to also be decided how this data was going to be stored and tabulated. A decision was made that all data should be put on magnetic tape and later transferred to a computer. A consultant was hired to design a system which would serve the needs of the project and also have the possibility of being adopted elsewhere.

Before the project got through its pilot stage, it was realized that a computerized information system was totally unrealistic in the Tanzanian situation, therefore all tabulations etc. were to be done manually.

##### 2) DESIGN OF FORMS - DATA COLLECTED

Having reviewed over 30 forms most of which are in Kiswahili for collecting data, only 9 were found to be of relevance in discussing the objectives of the information system. For the first objective "to gain an overview of village health conditions and problems" there are the following forms:

(a) Disease Attitude Form - this form is filled out by a villager selected to come for training as a village health worker (VHW).

It contains a question on the most common diseases in the candidate's village and asks the candidate to give reasons for the diseases and what the villagers see as the cause of these diseases.

(b) The Census Book - This book details the number of people in each household in the village, number of acres of farmland, education level of people in the house. There is also information on animals kept, whether there is a latrine, etc.

(c) Health Problems in the Village Farm - This form is filled out by the Trainees and members of the Education, Culture and Social Welfare Committee. It contains information (for each village) about diseases, personal hygiene, water, food and environmental sanitation.

(d) Form TMA - N-S (VHW fills it in) Questionnaire form which is completed by households with children under five years of age sampled by Trainees. It gives information on breastfeeding, child feeding, hygiene, nutrition, environmental sanitation, use of products grown on the shamba (farm) and children's vaccination history.

(e) Form TMA-HU-1 filled in by village health leaders for every 10 houses. It provides information on five common childhood diseases in the area, whooping cough, vomiting and diarrhoea, coorons, measles eye diseases and births and deaths. This is the most important form as far as monitoring health is concerned.

The above forms have helped both the village health workers and the trainees to gain an insight into village health problems. The data collected is being used in training sessions and provides trainees with data to make comparisons of village health situations. However, the form which goes into details of village household - TMA-N-S has so far only been administered once. The Disease Attitude Form has also been filled out once by the trainees. This means that there is no comparable (recent) data which could be used to measure impact (The third objective of the monitoring and evaluation system).

The second objective was "To monitor project implementation". The information system provides information which monitors project activities from selection of village health worker trainees to final examinations. Each group of trainees has been classified according to period when their work on training began. The village is classified in the same manner e.g. OPG group V (See appendix on trainee profile or characteristics.) This makes it easier for the project staff to measure the amount of work done by each group and thus enable them to change

training approaches. The groups also provide comparable data on the number of village health leaders recruited and how many are "active" i.e. collect data at the 10-house-cell level. Project staff in the data collection section compile the information collected from the field and feed back to project staff concerned with management.

The third objective was "To evaluate the impact of the project on the health of the villages. It has been said that "a viable health unit at the ten-house level will be the measure of success of the whole project (from project paper July 1977) and it is at this level that impact was going to be measured. As far as data collection is concerned, the village health leaders (someone selected from among a group of 10-15 houses) is responsible for collecting information on births, deaths and diseases on the TMA-HU-1 form. The VHL is trained by the village health worker in data collection and the above forms are collected during monthly meetings with the village health workers and divisional health leaders. At this VHL level, the information system has been riddled with problems, mainly of non-reporting by the VHLs. From examination of HU-1 returns, it appears that only 10% of the VHLs are able to collect the data and report to the VHW. As a result, the most important instrument in the information system has been unable, in this evaluation, to provide us with enough data to measure impact of the program on health of the villagers. Another problem with using this impact data has been the lack of adequate compilation of this data in a form which would be easily understood and used by the Evaluation Team. By this is meant that analysis and presentation of data by the staff/the information system has been quite unsatisfactory. Consequently, in order to measure impact the Team has had to choose indicators such as the availability of latrines since project began (See section II ). This will presumably give us a crude indication of the project activities on the behavioral patterns of villagers. Another source of data on impact<sup>are</sup> the Nutrition forms. The first one is an examination form for all children 0-10 years of age and the second is a form for borderline cases who are followed-up by the VHW. Here again, it has been difficult to assess the extent to which project activities have led to improved nutritional status of the children in Hanang District.

Apart from these data forms there are also various reports from divisional health leaders and project staff when they visit the project area. These reports give accounts of project progress and problems and provide the project staff and DHLs with information to base their decisions on.

### C. HAVE THE OBJECTIVES BEEN MET?

Comments from the previous evaluation on the Hanang monitoring and evaluation system provide us with an insight into how the system has developed and what have been its main problems.

In the February 1979 Evaluation, it was found that the system continues to meet the needs of the project ...and (the) extent to which

all implementation approaches a health impact are being monitored and assessed makes this effect somewhat unique, and potentially of greater replication value" However, the evaluation concluded that although the system (appeared) to be well thought out and was working reasonably well, it was too sophisticated for those whom it was primarily intended to serve - the villagers. This criticism touches on the question of presentation and feedback of the data or information. The presentation of information leaves a lot to be desired. The tables are not easily understood (although the intention of having them is clear), to the extent that one needs a member of the project staff to explain what they mean. On the question of feedback, the project depends on the village health worker to inform the villagers of the outcome of analysis of data collected from the village. This aspect of the information system has not been successful in-so-far as letting villagers know of their problems is concerned: The 1979 evaluation recommended the simplification of the system in order to meet the needs of the villagers for whom it was intended.

The second evaluation report (March 1980) made the following observation: "The project information gathering system has also been refined and although it seems a bit complex to an outsider, is reported to be operating effectively..."

From this evaluation the system is still complex. It can be said that the people who have benefited the most from the system have been the project staff. From their point of view, the information system provides them with enough data to "monitor project implementation".

There are over 30 different data forms within the system. There is lack of adequate staff at Project Headquarters assigned to work with the data especially the analysis and presentation of information. There have been problems with staff turnover not only within the data section at Project Headquarters but within the whole project. At times there have been only two staff compiling data collected from the field.

To a certain extent, the information system has been able to reach its objectives, especially objectives one and two. The third objective was perhaps too ambitious in terms of time available (limit) to meet the objectives. Improving health is a long-term process which is influenced by many factors, e.g. economic, social, cultural etc. It is difficult to measure levels of health in a place like Tanzania where health measurement indicators are still being explored let alone expecting an information system of a project like this one to field sufficient and reliable data to measure impact on health.

### Replicability

Tanzania is presently preparing for the implementation of the Primary Health Care (PHC) program the backbone of which is the training of village health workers. Once the program is in full swing, different information will have to be collected e.g. village baseline, health problems affecting villages etc. similar information as is now being collected by the Hanang Village Health Project. However, it will not be

possible to install, at district level, information systems as "sophisticated" as this one. Firstly there will not be as many funds available and also staff with enough knowledge in data processing and analysis. Secondly, there are also too many data forms involved at this level, which, will not be possible to maintain in a national program. Lastly, the information system at the central level i.e. Ministry of Health is less than adequate and needs to be organized in order that the district <sup>data</sup> be more meaningful. (The assumption here is that the central level ought to provide guidelines/guidance on how to establish an information system.)

See Findings F6-7, Recommendation R6-7, p. 5.

### Additional Perspective on the Information System

After the conclusion of field work, the Team Leader met by chance Mr. Damian Do Amsi who had designed and managed the project data system until one year ago. An attempt to arrange a meeting of Mr. Do Amsi with other team members also in Dar failed. Therefore, the Team Leader interviewed Mr. Do Amsi, and obtained the following impressions.

Two opposing principles exist - centralization and decentralization - for design of an information system.

Centralization: All information is fed up to a central point, analyzed and fed back to the periphery.

Decentralization: All information is intercepted at decentralized points, in this case the villages, compiled, analyzed in village meetings, and transmitted to the central point for info and further analysis. Village authorities feed back directly through VHLs to people.

At the early stages of this project, beginning with DAI and including the intervention of Mr. Do Amsi, the principle of decentralization was observed. On the other hand, what Roy Shaffer describes as the present working of the system with a diagram in Section II is very much a centralized system. The recommendations of Jean Rutabanzibwa in Section III to simplify the system's operation might be accomplished in part by returning to the principle of decentralization.

Mr. Do Amsi believes that the decentralized village operation of the data system can work, and will work with adequate support. However, this requires that supervisory personnel be provided adequate incentives and skills so that their work will center on village support rather than bureaucratic chores. A good village - level data system, that village people can understand and operate, will help to provide supervisory people with the information they need to do their job well. The flow of info on field results will keep their interest where it should be, on how villages are doing. Top project staff will have comparative data by division to facilitate its overall supervision.

#### IV TRAINING AND SUPERVISION

In order to improve the health of the rural population of Hanang District, the project decided to explore a way of extending health care beyond the health centers and dispensaries into the villages. This was to be done by selecting and training a special cadre of Village Health Workers who would themselves train another group of Village Health Leaders. At the time the project started there were no accepted national criteria for selection, training, assessing performance, or methods of supervising the newly trained staff, and the project has had to develop its own methods for each of their tasks.

#### SELECTION

Before selection of trainees could take place the village government and villages had to be informed of the project aims. This was done after discussion with district authorities by a letter to the Divisional Secretaries who arranged meetings in the villages. These were attended by the project staff. At these meetings the roles of the future VHW's were discussed and criteria for selecting them were formulated. These generally included:

1. One male and one female
2. That be resident of the village
3. Good general conduct and willingness to serve
4. At least standard 5 or preferably 7 (primary education)

Each village was requested to nominate 5 of each sex. These were then given (1) An intelligence test (Mill Hill) (2.) A composition to write and (3) An interview by the village authorities and project staff. For details on candidates nominated giving number, education, age, sex, marital status and number with children for OPG 3, 4 and 5 and for similar details on candidates selected Annex B, Items 8 through 15.

#### Comment

In view of the difficulty of older people accepting advice from younger, and married women being willing to learn from unmarried it is surprising that so many under 25 years of age and unmarried were selected. There are difficulties in finding older people with sufficient education, especially women. Only time will tell whether using "having land, a house, a spouse and children" would be more valuable criteria than an educational standard.

The village leaders, ward secretaries and divisional secretaries appeared on interview to have a good grasp of the selection process now. Perhaps more time discussing the project and starting to formulate a village programme before the selection is undertaken would pay off in the long run even though donor agency deadlines were violated in so doing.

## TRAINING:

The aims of the training programme were to produce a village health worker who could:-

1. Teach health
2. Treat minor illnesses
3. Give first aid
4. Participate in MCH
5. Supervise environmental hygiene in the village
6. Participate in the discussions and decisions of the Health Committee in the village

A goal - oriented course comprised initially of three, then four, and more recently five alternating sessions of classroom and field training was established. Each session lasted approximately one month and this part of the training took from 8 to 10 months. (17 months for the pilot group). This was followed by one year in the field before the trainee returned for the final examination.

During the classroom session the students lived in self-help hostels in Babati and attended classes at the project training centre.

During the field sessions they returned to their own villages and carried out what they had learnt in class.

### Student intake and output

The dates of the pilot and 5 subsequent intakes (labelled OPG (1-5)) of students is shown in Table 1. The number of students starting the course, finishing the class sessions, returning (year later) for the final certificate examination and then passing or failing is also shown. The names of 43 VHWs receiving the final certificate, by village, ward and division is given in Annex B, Item 40.

### Content of Course

The course is designed to meet the training aims. The topics covered by broad groups include:-

1. Communication
2. Project write ups
3. Survey
4. Census
- 5.a Environmental sanitation and hygiene
- 5.b Nutrition
6. Census data
7. Generative themes
8. How to teach adults
9. Diseases
10. First Aid

11. M.C.H.

12. Questionnaire testing

- See Annex B Item 41

Table I

Training of VHWs, dates, and numbers of students starting and completing the courses.

VHW Student Group	Dates			Numbers				
	starting classes	Finishing classes	Compl. course	Start. classes	Fini. classes	Taking Exam.	Fail Exam.	Obtai Cert.
Pilot	July.77	Nov. 78	Nov. 79	8				3
1st intake OPG 1	Jan. 78	Nov. 78	Nov. 79	28	56	44	12	14
2nd intake OPG 2	Jan. 78	Nov. 78	Nov. 79	28				15*
3rd intake OPG 3	May.79	Jan. 80	May.81	35	29	27	16	11
4th intake OPG 4	Apr. 80	Mar. 80	(Oct.81)	37	(35)	?		
5th intake OPG 5	Nov. 80	(Sep. 81)	(Oct.82)	44	(39)	?		
TOTAL	X	X	X	180	166	71	28	43

( ) Dates and of figures in brackets are expected

\* Including 1 who re-took environmental sanitation after return to village.

NB Among the 99 in the pilot and first three intakes 28% dropped out before the final certificate examination. Of 71 who took the exam 28 (40%) failed. Therefore the successful completion rate was 43%. (43 certificates for 99 starters through OPG 3)

The way in which these topics are broken down into the four main classroom sessions, and the hours devoted to each is given in Annex B, Item 42.

Teaching methods:

The main method used during the classroom sessions is lecturing. This is augmented by a number of practical exercises. During the field sessions students are set a number of tasks such as doing a census or a survey. They discuss this with the village secretary a/o chairman and then proceed.

They may (or may not) be visited by the Divisional Health Leader or project staff during their field work.

Recent groups have had a two week seminar on the psycho-social method of teaching during their 5th and last classroom session. This method does not appear to be used in the VHWS own teaching.

### TEACHING MATERIALS

There is a general shortage of relevant teaching material.

All students are issued with cyclostyled Kiswahili lecture notes. Recently these have been issued in indexed folders at the beginning of each class session. All students are now given a copy of Huduma za Afya Vijijini and more recently Mahali Pasipo na Daktari.

A small library of books that may be borrowed is available. (for list see Annex B, Item 43). Very detailed wall charts are sometimes used. Little use is made of flannel graphs except in M.C.H.

### STUDENT EVALUATION

At the end of the last classroom session a written examination is held in 6 subjects and practical tests given in 3.

1. 1st Aid and practical
2. M.C.H. " "
3. Medicine " "
4. Environmental sanitation
5. Diseases
6. Teaching methods.

If any student fails any subject a letter is written to the staff of the nearest dispensary where he is meant to go once a week, informing them that this student needs extra attention in this subject.

The final certificate examination - in the same subject - is given at the end of the review week after one year (See Annex B Item 44). A copy of the certificate given is shown as Annex B, Item 45. It should be noted that (1) few, if any, tests (except in M.C.H.) are conducted during or at the end of each classroom review.

(2) No checklist of practical work undertaken, or performance rating is included in the examination marks.

(3) Out of 99 students commencing the first four courses only 43 passed the final examination i.e. a failure rate of 56% for the course.

(4) The 12 who failed in November 79 and the 16 who failed in May, 1981 have not yet had an opportunity to re-take the exam. (They are going to have an opportunity shortly)

COSTS

Training costs are inevitably difficult to isolate from other project and government costs which average 7,303/= (nearly \$1,000.) per student.

At first no daily allowance was paid, then a 10/= allowance was started and now it is increased to 12.50. Some trainees also receive assistance in money or food from their villages.

Table 2 Costs of VHW training

Daily allowance @ 12.50 per day for approximately 135 days	1,703/=
Hostel rent - proportion per student	250/=
Purchase of equipment (desks, beds, etc)	150/=
Books, school materials	200/=
Staff salaries (3 more or less fulltime 190,000/= divided among 40 student per year)	5,000/=
Cost per student	<u>7,303/=</u>

N.B. This does not include.

Rent as maintenance or overhead for teaching facilities, cost of travel or time of part-time lecturers from government, Dared Hospital or other project staff.

COMMENTS

A new training programme for a relatively new cadre of health workers has been established and developed over 4 years.

This is a major achievement and due credit should be given to all concerned. With the advantages of hindsight a number of criticisms can be made.

Analysis of the student records (for the first 99) shows that there has been a 56% drop-out and failure rate from intake to certification. This indicates that there is a lack of adjustment/coordination between objectives, teaching, student support and assessment.

The structure of the course - alternating classroom and field sessions appears appropriate, though the supervision of field work has decreased in the latest groups. This can to some extent be compensated for by detailed instructions before field work and discussion of reports afterwards - but this does not provide protection for the student for whom things go wrong, which may lead to wasted time. The content of the course is generally appropriate. In the time available only a superficial judgment is possible. It would appear that

1. The expectation that VHWs, can learn to teach VHLs how to teach may be unrealistic.
2. It is very difficult, within the local culture, to interest male students in M.C.H. This leads to a high failure rate in examination.
3. There appears to be insufficient practical training in environmental sanitation. The quality of latrines constructed and the failure to protect water supplies indicate insufficient development of the appropriate skills.
4. There appears to be a major over - emphasis on record-keeping, the uses of which are not easily apparent.

The teaching methods used require careful consideration to see if greater participation could be achieved and more self-learning developed.

If the psycho-social method is to be expected of students it should be used with them.

Attempts should be made to develop more local teaching aids particularly picture and flannel graphs that could be used by VHWs in the villages.

The evaluation of students seems to have been based on the traditional academic pattern and to be ill-suited to the objectives of the training programme. A system of continued assessment incorporating checklists of activities undertaken and performance ratings should be developed. Methods for continuing education should be developed. These will depend on inculcating a pattern of self-learning during basic training and on providing the means - through "promotive" supervision, reading and refresher courses.

### PERFORMANCE

This section deals with the evaluation of field performance of qualified VHWs (Village Health Worker) as was conducted in the project.

The most useful records available for VHW field performance, is the Trainee and Village rating by village work activities (see Annex B Item 23-25). The evaluation was based on 5 observations (indicies).

1. Whether attended a clinic at Zahanati (dispensary) weekly.
2. Sent in at least one monthly report for 1981.
3. Attended at least one implementation meeting.
4. Teaches Village Health Leader once a week.
5. Teaches once a week in primary school.

Every Village Health Worker could score a maximum of 5 points on that rating scale. The results are given by groups and also villages and wards.

The results.

GROUPS I AND II

WARD	VHW	AVERAGE SCORE OUT OF 5 MAX.
BASHNET	12	2.0
BARBAIG	27	2.25
MBUGWE	11	1.2
GOROWA		1.1

GROUP III

WARD	VHW	AVERAGE RATING OUT OF 5 MAX.
BASNET	12	2.6
BARBAIG	4	3.2
MBUGWE	5	2.3
GOROWA	8	2.6

GROUP IV

WARD	VHW	RATING
BASHNET	8	3.5
BARBAIG	6	3.9
MBUGWE	10	2.9
GOROWA	12	3.5

The second source of information (qualitative) was obtained through an interview of (a group of 4-7) leaders of each of the Divisions. The question was; by observing performance of the VHW, are they adequately trained? All four groups answered YES but three went on to recommend periodic continuing education through refresher courses, seminars, workshops in order to keep up their performance or upgrade their proficiency.

No recorded information for evaluation of group V was available (Evaluation by DHL is done based on their own observation and is reported to the project team but no records are available)

Based on data available from table I, II and III for groups I - IV, group IV scored 2.9 to 3.9 points on a possible maximum score of 5 points, making it the best group. Group III comes next with a score ranging from 2.3 to 3.2. The remaining two groups scored 1.1 to 2.25 out of 5. This is a poor performance, particularly when criteria for scoring are considered.

#### PERFORMANCE SUMMARY/DISCUSSION/CONCLUSIONS

Evaluation of field performance of the Village Health Workers was not conducted on a systematic basis or in an ideal manner, such as field observation of workers actually doing the tasks or systematic interviews or questionnaires, but rather it is implied from analysis of work diaries and records. Apart from being an indirect way of evaluating performance the method cannot test the whole range of knowledge skills, attitudes acquired through training as well as organizational integration and overall effectiveness as a VHW. The result so obtained may be criticized as having low validity and reliability.

However the fact that performance assessment was not carried out systematically does not necessarily mean the field performance of qualified VHWs is less than ideal. They seem to be doing a lot of good work in the areas of M.C.H. attendance, increase in the number of latrines dug, disease statistics, etc (See Annex B). This is further confirmed by the interview results as mentioned earlier. It is a fact routine performance assessment of qualified health workers, whether Doctors, Nurses, Health Officers etc. is not generally carried out in most parts of the World, Tanzania included. It is only implied from the results of their service or subjective evaluation (opinion) of their immediate supervisors.

#### SUPERVISION

Supervision is focused on the Village Health Workers. Other cadres will receive less emphasis as has been the case with the VHLs. The Village Health Workers are supervised mainly by the Divisional Health Leaders. Hanang District is divided in four divisions namely, Bashnet, Barbaig,

Mbugwe and Gorowa. There are four Divisional Health Leaders, one for each division. There is a vehicle available for each division health leader (DHL) so that he makes a schedule consisting of times, days and specific activities where necessary, of visiting each Village Health Worker (VHW). All the villages are visited at least once every 2 months. Initially it was at least once every 4 to 6 weeks for all the Divisions. The supervisor spends one to three days in each village with the VHW, and during this time he observes, criticizes teaches or suggests various activities. Areas for supervision in collaboration with local authorities include these activities.

- coordination with Village government
- Training of Village Health Leader (VHL)
- Monthly return forms/report including other statistics e.g. attendance register.
- Performance of VHW in any tasks
- (Safe) water supply
- Lesson plan for Health Education
- Nutrition programme supervision
- Environmental sanitation, in particular refuse disposal, cleanliness of surroundings, houses and latrines.
- Data collection

Information so obtained is reported back to the Village Health project team in the District, and where necessary the project staff may choose to visit any village for further supervision, directly. Apart from the Divisional Health Leader others who supervise the VHW includes:

- The Headteacher of a Village Primary School on areas concerning teaching methodology, in so far as Health Education is concerned.
- The Village government, through its Committee on Education, Culture and Social Welfare (In all the Village governments, there are 5 village government committees. Others are Finance and Planning, Production and Marketing, Defence, Transport and Works. The village government is more concerned with making a schedule or timetable for health-related activities to fit in with all other activities, as well as seeing that everyone including the VHW performs his part. In addition to the Committee, the village government as a whole is the overall Supervisor for all activities in the village.

An interview was conducted with leaders on September 26, 1981 from all the 4 divisions, one division at a time. Among the numerous questions asked was one on supervision, "Are the VHWs adequately supervised?" The answer in all four divisions was "Yes" they felt the supervision is adequate, if not excellent, and that the DHL may come late, but generally he never skips a date.

There is no doubt the structure of supervision in the project is excellent. However one needs to observe or read reports on supervision before one can have a full understanding on the proceedings of supervision, methodology, the discussion and suggestions given to the VHW by the DHL, etc. In the absence of that, it is difficult to analyse critically the effectiveness of supervision. However, with available information it seems to be excellent and working. In considering the general structure of health services in Tanzania, the supervision of health activities follow this order, The Regional Hospital staff supervises the Health Centres which supervise the Dispensaries which in turn supervise the health posts, to First Aid boxes for villages. This structure is shown below:

#### Supervision

Level	Type of Institution
National	Ministry of Health
REGION	The Regional Hospital
DISTRICT	The District Hospital
DIVISION	Health Centre
Ward	Dispensary
Village	Aid Post

With the present government structure the VHW will logically have to be supervised by the Dispensary Staff (RMA etc). But if the project was going to be started elsewhere it might be more feasible to have supervision of the Village Health Worker conducted at divisional level by the Health Centre Health Assistant or Health Officer making it one of his assigned tasks. The dispensaries are generally poorly staffed and are severely overworked/crowded. It will be difficult for the staff to absorb additional responsibilities at least for the time being.

See Findings F8-12, Recommendations R8-12, pp 6-8.

## V. Measurement of Technological Change

Development involves technological change. This project as designed certainly was intended to modify a broad range of health practices ( a technical package). The target population was to be exposed to the new technology through formal channels by trained VHWs, who would in turn train VHLs, who would finally reach the entire population.

In order to measure change, the baseline situation would have to be known, and data collected periodically to document the degree of change in each practice. The quite ambitious measurement undertaking has not gone far enough to draw very reliable conclusions about change of practices, much less to document impacts on health status.

The original logframe indicates a measurement of number of VHWs, but not of VHLs. It also indicates a measurement of people reached, and of village participation. None of these measures would be indicative of impact on health status.

This logic was adequate to support the project implementation, but has serious weakness for evaluation purposes. The following logic was therefore developed, which emphasizes the target group role, particularly at the input level. (see p 50)

The reason for emphasizing target group inputs arose through a rational process that recognized the Hanang District "Project" as a health program, with projects occurring at Village level. In fact the Village was expected to provide all of the human resources, VHLs and VHWs for example, as well as whatever payment was required, supervision of these people in terms of village health objectives, and the decision-making process for undertaking activities in the village. The Hanang District "Program" recognized that its function was to support village activities through training, technical supervision, and limited logistic support.

Project Logic

The original logical framework included in the OPG proposal presented by CODEL in early 1977 was the following:

<u>Narrative</u>	<u>Measures of Achievement</u>	<u>Assumptions</u>
Goal To strengthen the capacity of the Ujamaa structures to improve living standards.	Growth of village participation in work on priority needs.	Continuity in collaboration and coordination by all interested parties.
Purpose a) To improve the health of a significant number of rural people in Hanang District and b) to test the feasibility of the proposed health delivery system.	200,000 people in 7500 ten - house units in 40-90 villages being reached through the program.	a) TanGov continues support for the project. b) Village support adequate and consistent
<b>Outputs:</b>		
a) Health delivery	a) System in use	a) Adequate number of trainees available.
b) Baseline data collection	b) System in effective use.	b) Data processed on timely basis.
c) Instruction methodology	c) Methodology tested and in use.	c) Village cooperative in both health delivery work and data collection.
d) Health workers with improved training	d) 41-67 health workers trained and working.	
<b>Inputs:</b>		
a) CODEL	Project budget	Funds available on timely basis and TanGov inputs adequate
1. Personnel		
2. Equipment		
3. Miscellaneous		
b) GOT		
1. Personnel		
2. Facilities		
3. Equipment		

NOTE: The above targets are both imprecise and inconsistent. As indicated on pp 13 and 16 they have certainly been met:

1. 95 villages of 114 total in Hanang District were accepted into the project.
2. They would certain about 200,000 people out of total district population of 240,000.
3. At an average of 20 ten-house visits per village, this works out to 1900 units, which usually contain more than 10 houses each.
4. A total of 192 VHWS have received training.

Revised Logical Framework

<u>Objective</u>	<u>Indicator</u>	<u>Availability of Data</u>
Goal: GOT support for on-going implementation	Willingness of GOT to pick up Hanang, integrate it into National Health System, and utilize project experience.	Will depend on reaction of GOT to joint evaluation process
Purpose: Improved quality of life	Village financial support of VHWs (proxy indicator)	Special project reports for 1980 and 1981 (6 months)
Outputs: Improved health status	Assessment of project quality in each village (proxy indicator)	Supervisory ratings
Target Group Inputs: Changed health practices	Types and magnitudes of changes in health practices	HU-1 form filled in by VHLs
Outside Inputs: Incentives to change practices	Program inputs	Administrative records

### Program Inputs

As indicated in the Revised Logical Framework, data on program inputs can be provided by administrative records. Such inputs include training of VHWs, provision of First Aid Boxes, provision of MCH mobile clinical services, provision of reporting forms, etc. The length of time that such inputs had been available in each village was attainable from program training records. Also the program has an indicator of VHW performance by village on a scale of 0 to 10.

### Target Group Inputs

Target group inputs represented change of practices. We were able to document four such changes by using data from project records, and most important we could get them as village indicators. These were the following:

#### Change in latrine prevalence:

Increase of more than 5%	2 points
From + 5% to - 5%	1 point
Drop of more than 5%	0 points

#### Use of First Aid Boxes:

First Aid Box in use	2 points
First Aid Box ready but not in use	1 point
No First Aid Box	0 point

#### Oral Rehydration Classes given:

All 8 planned	2 points
Some of the 8	1 point
0	0 point

#### VHW Participation in MCH Clinics (indicator of turnout):

Excellent to Very Good	2 points
Fair to Good	1 point
No MCH Service	0 point

The total points could be added, to indicate on a scale of 0 to 8 points where each village stood on changing health practices.

Outputs: The Team Leader asked each Divisional Health Leader to rate villages under his supervision according to the degree of accomplishment as good, fair or poor. In interviews held with delegations of political leaders headed by Divisional Party Secretaries the same question was asked. These surveys provided two sets of data that were fairly close but not identical.

Little data other than anecdotal was available on change of health status. Accordingly the supervisory level ratings were used as a general indicator of health status improvement, first of all because supervisors should know what is going on in each village and secondly because there was undoubtedly an improvement going on somewhere. This source of data is believed to be a reliable indicator not of the magnitude of change but of the location of change.

Purpose: Neither is there any data on improvement of quality of life, not even anecdotal evidence. However, there has been a dramatic increase in Village Government payments to VHWs over just one year from close to zero in the first half of 1980 to an average of over Shs. 2,300 total per month during the first half of 1981. The practice of villages paying VHWs has been given firm support by the political leadership in one division. This change has all the earmarkings of impact.

We may suppose that Village leadership, responsive to the target population, are either perceiving a program that works or responding to a public perception that it works (that it improves their lives). In any case the payment figures per month for VHW salaries as distinct from training support are available in handouts.

Goal: The goal is the willingness of the GOT to pick up the program and continue it. During the evaluation, the Team received strong and consistent indications at all levels from the target population to the District leadership that the program should be continued. CODEL appears willing to go to bat for interim funding to allow time for GOT budgeting to take effect July 1, 1982.

All of the information is positive, but we will not be sure until the transition is accomplished. However, if the GOT does pick up the tab as is hoped this will be because the program has been successful in changing practices, in improving health, in raising living standards, all at costs within a GOT ball-park. The verdict on goal accomplishment must wait a little. Meanwhile, in an orderly transition there is an opportunity for further impact to the extent that this program serves as a guide for future GOT health policy in the Region.

Measurement of Impact: The results indicated from the data are shown in Annex C. To assemble this data the Team Leader used a 3 x 5 card for each village and then entered scores for each indicator. This method of data processing is like an old fashioned computer but manual in nature. It is easy, quick and provides accurate results. As each item of data is added, the number of possible permutations and combinations rises geometrically.

Team members were invited to use the "computer" to test data. One test was done on village project rating vs training group (OPG). Not surprisingly to the Training Staff, the prize went to OPG III. This little exercise done in a few minutes, surely much quicker than a modern computer could have done it including time for programming, entering data, etc., confirmed to some extent the accuracy of the data used.

Several other tables are presented for illustrative purposes, simply to indicate some of many uses of the data generated.

Measurement of Impact

53

<u>Time</u>	<u>VHW Quality</u>	<u>Health Practices</u>	<u>Village Rating</u>	<u>Av. payment per mo. per VHW</u>
MAX 3.5 Yrs.	MAX 10 points	MAX 8 points	MAX 4 points	NO MAX
2.5	6.4	5.7	4 (10)	SH. 50
2.4	6.2	3.2	3 (9)	SH. 35
1.8	4.1	2.9	2 (21)	SH. 8
1.3	2.2	1.4	1 (19)	SH. 0
2.2	2.8	1.9	0 (17)	-

From the above figures it is apparent that the following indicators at the village level correlated quite well, especially if villages rated 0 are left out. (Some of the latter were in fact not rated, and got a 0 by default)

Duration of the project  
 Quality of trainee performance  
 Changes of health practices  
 Rating of village as seen from supervisory level  
 Average payments per VHW

Village Rating vs OPG (Training Group)

<u>Project Duration</u>	<u>OPG</u>	<u>VILLAGE RATING</u>		
		<u>Total Score</u>	<u>No. of Villages</u>	<u>Average Score</u>
3.5 yrs	(II)	58	32	1.8
2.5 yrs	(III)	33	16	2.1
0.9 yrs	(IV)	26	19	1.4
0.7 yrs	(V)	11	9	1.2

The highest level of accomplishment has been made by OPG III. The Project Staff considers that this is the best selected and trained group.

There is a tendency for a higher rating if the project has been operating longer.

Data on Trainees From OPG III, IV and V

<u>Age of Trainees</u>	<u>Candidates</u>	<u>Selected</u>
15-19	69	22
20-24	55	16
25-29	24	6
30+	7	1
 <u>Marital Status</u>		
Single	95	25
Married	61	20
 <u>Education</u>		
None	0	0
0-4 yrs	21	2
5-7 yrs	130	44
7+ yrs	4	2

According to the above, in selection, youth was an advantage, married st an advantage, and education an advantage.

Total Payments to VHW  
by 6 mos Period

Jan - June 80	Shs. 630
July - Dec. 80	8,440
Jan - June 81	14,210

See Finding 13, Recommendation 13, p. 9.

An Effort to Answer Questions Raised in Interviews Conducted by the Team Leader Prior to the Evaluation with AID/W and CODEL Decision-Makers (See Annex A for List of Questions)

The evaluation report deals with the majority of the questions raised, but not consciously so. This summary is prepared by the Team Leader to supplement the information contained in the report and attempt to deal with all of the questions raised in some fashion. The answers follow the groupings of questions but not necessarily the order within groupings. Project and program are used somewhat interchangeably reflecting the fact that this is a program, but called a project.

### I. Strategy

The project strategy was ambitious, to train a VHW cadre to in turn train a much larger VHL cadre to provide grass roots leadership in changing health practices across a rural district of a quarter million inhabitants. The strategy relied heavily on village leadership to select participants, train VHWs and VHLs, pay training costs, supervise them, and pay any VHW salaries. The approach is both appropriate and within the realm of the economically sustainable.

The PVO did not bring the MOH fully into its strategy in the beginning even though it would have to at phase-out. CODEL was inexperienced in handling its first OPG, but has supported MMM, and indicates a willingness to see the effort through. If CODEL's role could be better played, it would be in assuring that the PVO coordinates properly with the host government from the beginning to achieve an orderly transition at termination. In other words CODEL need not know about health, but should be on top of typical procedural problems, helping the action agency to plan effectively.

The key to avoiding similar problems is a good logical framework (strategy) but addressed to program and policy. AID ought to have a standard sectoral logframe for rural health projects that reflects AID needs for accomplishment and data to back it up. CODEL, on the other hand ought to have a policy logframe to cover programs in the basic human needs areas. A logframe for a project such as this ought to derive both from CODEL and AID experience with their respective designs. Such standard designs for policy and program if steadily improved as lessons are learned will help avoid typical implementation problems, provide better cost control, and reduce the monitoring burden as predictability improves.

The evaluation asserts that something is working and attempts to show how the program can be managed. This is addressed through an analysis of the technical change process, an attempt at revised program logic, and some compelling data correlations.

### II. Local Organization

The strong point of the project is the training aspect which is rigorous to a fault. Trainees appeared highly competent, and the more competent VHWs were obtaining salaries negotiated with village governments. The

supervision was complex, possible conflicts needing to be studied and ironed out. The decision to train both men and women VHWs worked out satisfactorily, and there was even some evidence of role reversal - men getting into traditional women's areas such as MCH, and women interested in environmental sanitation.

The indigenous staff has grown in competence, but their continuing in present roles is threatened by poor transition planning. The village is collaborating in supervision and financial support especially where quality of service is good. While unpaid VHWs are not feasible in the long run, especially after their thorough training and certification, voluntary VHLs are certainly feasible.

Men are very active on village committees, and show particular interest in water supply, latrines, better stoves, etc.

### III. Methodology

The technical package is both preventive and curative, and is within a replicable cost range. The project has found that needs for curative services must be met along with health education aimed at prevention. The data system has been impractical; its imposition by AID at the start of the project unwise. The project is awash in forms and at sea as far as effective data utilization. The data system cannot be institutionalized without simplification.

Village Health activities were organized through training of trainers (VHWs) who would achieve outreach by in turn training VHLs. It appears to have worked in enough instances to sustain belief in its effectiveness among the district people. Assistance is geared to self-help efforts, and works because standards must be met. VHWs have failed, VHLs have failed, and villages have failed. But as many more have succeeded.

Men are reported to receive more treatment than women at all health facilities up to Dareda Hospital, except for MCH clinics. We observed massive treatment in hospital of cataracts, TB and hernia. The men's ward at Dareda Hospital is seriously overcrowded, with men literally lying on the floor. A new men's ward is next in priority, according to Sister Margareth Garnett, Director.

The project has helped in defining priorities, and villages differ on emphasis. But nothing has been done about a totally inadequate kitchen with dirt floor, flies, and no counters, shelves, hooks or cupboards. To ask people to boil water and wash dishes with three stones for a stove and no running water, while operating in a hovel may be a bit impractical. Attacking the kitchen problem is admittedly difficult. The kitchen is a woman's place, but building and equipping it can best be handled by men. A brick floor, a fuel efficient stove with a grate, vertical walls, windows, screens, counters, shelves, hooks and cupboards, are all technically feasible for local masons and carpenters, but there are no prototypes for any of these things.

The management burden for AID of a small project is relatively large, but one has to look at results in relation to the burden. Many large projects do not begin to penetrate into villages the way this one has nor to thoroughly train people who will stay and work in villages. There is no alternative health service available. Unless public health can be made cost effective, much of the Tanzanian public will continue to do without.

#### IV. Direct Impacts

The project data system intended to measure morbidity and mortality, but has not done so. It has proposed a massive census enumerator - type system with VHLs filling out endless forms. One alternative approach to measuring morbidity would be periodic district-wide sample surveys, which would be simpler, cheaper and more accurate. Another would be using hospital records, particularly for longer term impact on specific disease incidences.

Progress toward objectives is good. The target population is sold on the services, some more than others. Villages appear to understand the proposed practices and can discuss them. Medicine boxes are popular, but are only established where there is a qualified VHW. About 12 villages have the box, but are waiting for the VHW to qualify, so that the boxes are not yet in use. 18 are in use.

Project benefits appear to be at least commensurate with costs; otherwise villages would not be coming up with financial support. Transport costs are a problem for the GOT to deal with, and could impede transfer of responsibility.

Some of the data generated in the evaluation is based on assumed supervisory knowledge of health improvements. Health problems are apparently widely understood, but in many instances advice cannot be followed for want of resources.

This project may have accomplished more than other projects because it did not attempt to pay village level personnel. This turned out to be a vacuum into which village government could step. The GOT would probably not have attempted unpaid VHWs.

Preventive medicine is viewed as counterpart to curative services. At the village level curative services are extremely limited. Therefore, in a male-dominated village project atmosphere, preventive medicine looms large. Males are more involved in building latrines and protecting water sources.

Almost every village in Hanang had the chance to participate and about 10% dropped out. A larger number displayed mediocre performance. The project set high standards, and some villages could not or would not meet them. For those that did the advantages were great. The impacts although poorly documented, are along lines of GOT interest. Curative services involving facilities have been intensively used. The PVO brings to the project a dedication, a discipline, a rapport with the target population, and a practical eye on costs that are valuable attributes.

## V. Indirect Impacts

Indirect impacts are difficult to measure without some hard data on direct impacts. One clear indirect impact has been the sudden move of villages into paying VHW salaries. This has been associated with the best village projects, and would appear to indicate the existence of related impacts. However, or yet ties to other sectors are not available.

The program is sustainable because its cost can probably be adjusted to GOT feasibility. Certain cost aspects are not permanent. Expatriate salaries, costs of buildings, and the very heavy training costs might be reduced in a later service maintenance phase. These costs have amounted to 50% of project cost for the current build-up phase. If the GOT will continue to rely on the village financial contribution it will maintain a valuable incentive for good VHW performance while helping control its own costs.

Phase-out over a two year period is hoped for.

## VI. Spread Effect

CODEL hopes to help ease the transition to GOT pickup. Outside medical TA will continue to be available even if the project terminates, and the need for it will recede. The Arusha Health component project proposal was not based on the Hanang experience, apparently because neither Mission nor GOT were that enthusiastic. But GOT health officials and political leaders appear supportive now. It is expected that the Hanang activity will be picked up, although not replicated. Nevertheless, influence may be felt on GOT policy. The inclusion of a strong GOT contingent on this evaluation will encourage GOT utilization of project experience. Had the PVO insisted on more GOT involvement in project policy from the beginning the potential impact would have been much greater. Going it alone has evidently little pay off.

The amount spent was possibly a bit high. The project stuck to its objectives. Not all were met, but a convincing try was made. The economic environment of Tanzania is a factor affecting implementation of this type of project, but is not decisive. The transportation cost is a major concern of the GOT affecting its attitude toward such things as remote supervision and mobile service since these tend to be more transport-dependent.

QUESTIONS RAISED IN AID/W INTERVIEWS WITH TEAM LEADERStrategy (Roles and Functions)

Role of PVO: is it designed to do things for people or  
involve them?

How much should CODEL be involved?

How does CODEL relate to member organizations regarding  
project development and support?

Should CODEL function as technical resource organization?

Is the approach appropriate? Is it economically sustainable?

How can costs be minimized in the design phase?

How is the coordination between CODEL and MOH?

Is MMM working itself out of a job?

Is AID's policy consistent with respect to PVOs?

How can monitoring burden be reduced?

Is the functional separation of preventive and curative  
programs as in Hanang efficient?

What will work?

What can be managed?

How can problems on earlier projects be avoided in  
future projects?

Is the contractor moving to turn responsibility over?

## Local Organization

Capacity of indigenous staff to manage independently?

Were counterparts trained to be self-sufficient?

Are illiterate VHWs as effective as literate workers?

How effective is system of supervision?

Was man-woman role effective in obtaining involvement  
of both?

Can women be brought into men's role areas?

Is there anything organizational that men do?

What is role of VHW's?

Was voluntary effort feasible (UJAMAA)?

Can community collaborate to finance/support?

## Methodology

How to deliver low cost preventive health care package to rural people.

Can data system be used or replicated?

Is DAI system feasible?

What was method used to organize health activities in villages?

What support by project? Why has it worked?

Is assistance targeted to realistic priorities?

How are men affected? Hypertension, kidney disease, venereal disease? Does project treat men equitably or are men systematically excluded? What do men die of, and does anyone care?

Are men involved in water and sanitation projects?

Has the project helped in defining needs and priorities?

What is the management burden of such a project?

Can efforts to collect baseline data be documented? Methods used; how institutionalized?

What is role of people themselves in defining needs and priorities?

Was DAI methodology appropriate?

Was technology appropriate? Why or Why not used?

What relation to commercial system?

## Direct Impacts

Do we measure morbidity? Is data base reliable?

Progress toward meeting objectives?

Is there evidence the target group is availing itself of the services?

Is advice understood and is it feasible?

How is medicine box maintained?

Can VHW provide relevant information and medicines?

How do benefits relate to costs?

Are personnel and transport costs under control?

Has health improved? Beneficiaries should know?

Can better understanding of health problems be documented?

Are death rates cut?

Why has the project accomplished things as compared to other projects?

Has preventive medicine been successful? How has usual emphasis on curative medicine been avoided?

Why did some villages not participate ?

What impact can a PVO have?

How do impacts fit into total health picture?

What use made of facilities?

## Indirect Impacts

Can increased productivity be linked to health improvement,  
at least conceptually?

Any difference in water usage in comparison to non-participating villages?

Does the health activity contribute to efficiency in other sectors?

Are future health burdens reduced?

Is program sustainable and how?

What are real costs vs permanent results?

When should phase-out occur?

What have we learned about costs, community participation, self-finance?

Does good health lead to some productive result?

## Spread Effect (Replication)

Will the activity be picked up by MOH when CODEL leaves?

Has the dependence on outside TA been reduced?

Is Arusha Health component based on Hanang experience?

If not, why not?

Have health officials been convinced?

Have films been taken and shown? Has a brochure been prepared?

Can it be replicated? or institutionalized via MOH?

Is this a replicable model?

Will a successful PVO model influence TANGOV?

What is govt planning to do at phase out?

Are isolated projects worth effort?

What happens when they terminate?

What was required to make project sustainable?

Should we have spent less; placed more reliance on  
local capacity?

Is a growth environment in the country essential?

Did the project do what it said it was going to do?

HAMING VILLAGE HEALTH PROJECTSELECTED AREAS OF INTEREST BY EVALUATION TEAM  
MEMBERS DURING EVALUATIONT.A.R. MSAJULAEVALUATION: HELSI KALEVA - HAMING

This Project is fully externally funded. Sooner or later the project will be handed over to the Government of Tanzania. The District is the primary beneficiary; and it is the one which will be responsible to run some of the activities of the project. Resources in terms of manpower and funds are required to run these activities. The question is how do we intergrate the activities of the project with other current activities in the district.

PAUL EHLER

1. Question of what level of resources - financial, manpower and commodity - will be needed to maintain the VHVs that have already been trained. A comparison should be made between these levels that were necessary for the "project" and what levels will be necessary for maintenance. Following this comparison some attempt needs to be made to assess whether the level identified for maintenance is feasible to be provided by the Government.

- How much field work is necessary to maintain supervision and support?
- What level of transport is now necessary to support?
- What will the DHAs do following the termination of project, then who will supervise the VHVs.
- Will the Government either pick these people up or supply others to fulfill their functions.

JEAN RUTABANZLEWA - MINISTRY OF HEALTH HQ. PLANNING UNIT

1. Information System: (1) What objectives were - What information was going to be collected - how. this was collected stored - ? System of retrieval
- (2) How is the information used (and to whom is this sent - who uses it) - This would of course include how it is analysed.

2. LCH - to what extent are these VHW involved in LCH i.e.
  - (a) giving services (what kinds of LCH service)
  - (b) capable of dealing satisfactorily with problems that present themselves - what is their relationship with LCH clinic(s) staff?
  
3. The VHW's - How do they perceive their role as health workers.
  - What problems are they facing now and what problems do they think could be solved in the near future (and how i.e. suggest solutions) This would entail talking to the VHW's - and listening to what they have to say (Preferably at the 26th September Meeting in Endasak)
  
4. Village Leaders - Their role in the implementation of this programme - their views on health, their views on the VHW.
  - Where the programme has failed - what are the possible reasons.

ROY

1. Observe teaching sessions
  - (a) VHW of VHL and
  - (b) VHL of villagers
  
2. Practical, measured changes which can be attributed to influence of programme. ( I have a list of 10 possible items to select from)
  
3. Observe a few home visits (if such is part of a VHL's work)
  
4. Informal conversations with villagers eliciting their concepts of and opinions of VHLs.
  
5. Informal conversations eliciting knowledge and attitudes to the life changes (behaviour) the programme is trying to bring about.

DR. H. MARI (SMOT) - MINISTRY OF HEALTH

To what extent has/have the objectives for the project been realized.

The main objective; "To raise the Health status of the people in Hanang District"

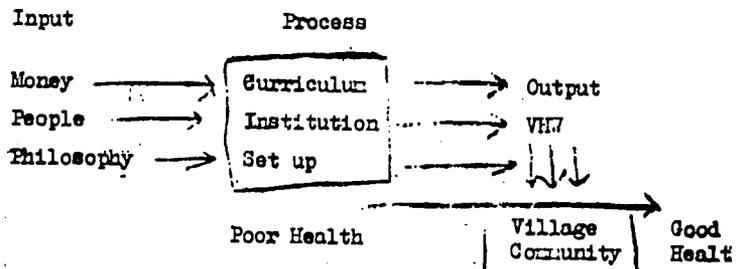
a. Was there any baseline survey for diagnosis of health status of Hanang, before implementation

b. What were the indices for judgement/measurement (incidence, prevalence, vital statistics, morbidity, mortality)

Syllabus/curriculum for the training of VHW

Strategies for mobilizing and motivating the community towards achieving the goals.

Financial implications



EDWARD

1. Has the Government and Party fully participated from the beginning of the project?
2. Did the project Designers see the need to incorporate the Government and the Party in designing and implementing this project? How.....
3. What were the objectives of the project
4. Was the curriculum based on the District Health priorities and Health problems.
5. Was there any base line survey which was carried out at least to know the health problems of the district.
6. How many villages in the district have health facilities and which do not have?

7. Did you only teach VHW for those villages without health facilities? And if Yes why?
8. What was the achievement (How many VHW trained)
9. Could have this project . . . been achieved by using the existing Health System?
10. How is the continuing Education for the VHW going to be met?

SR. MARGARET ROGERS

AREA OF INTEREST/CONCERNS

1. What shape does the project take as of November, 30th and the financial implication of the new shape?
2. What is the capability/willingness of the Government to assume responsibility for continuation of service?
3. What are the do's and don't's learned from the experience of this project that can be shared with others?
4. Will this project be fully and truly integrated into the Government forthcoming primary health scheme or will thus run parallel with a certain amount of rivalry with the project eventually withering to be replaced by the Government's service?

Possible Activities

Chris Wood

- |           |  |
|-----------|--|
| Wed. 8.00 | Meeting with Area Commissioner                                     |
|           | " " Project Staff  |
|           | " " Evaluation Team  |
| Thurs.    | Go on one of the village visits                                    |
| Fri       | Visit Babati Health Centre, District Health Hqrs - interview staff |
| Sat       | Visit one Division with Divisional Health Leader                   |
| Sun       | a.m. free - 3.00 Evaluation team meeting                           |
| Mon       | 8.00 - 12.00 Meeting with District Staff                           |

I would be particularly interested in looking in more detail at any of the following aspects of the project

1. Selection and Training of staff
  2. Integration of 'project' with 'district service'
  3. Environmental Health project output in the villages
- Any other activities you suggest

HANANG VILLAGE HEALTH PROJECT

LIST OF HANDOUTS FOR THE EVALUATION TEAM

- 1) List of Project Staff
- 2) Some few Villages likely to be of interest
- 3) List of people who have associated with project
- 4) Hanang District Villages & Status in project
- 5) Draft write up - intergration of project on Govern. activities
- 6) Basic instrumets - roject information system
- 7) Envermental sanitation survey
- 8) Candidates provided ORG III, IV & V
- 9) Trainees selected ORG III, IV & V
- 10) Candidates presented - ORG III
- 11) Selected Trainees ORG III
- 12) Candidates Presented ORG IV
- 13) Selected Trainees ORG IV
- 14) Candidates Presented ORG V
- 15) Selected Trainees ORG V
- 16) Draft Write Up - between VHWs & Village Government
- 17) Payment Services - VHW
- 18) Approaches To Teaching - Health Education Methodology
- 19) Education Programme
- 20) Evaluation Review - Education Programme
- 21) V.H.W. Involved in Teaching - Oral Rehydration & P. Schools
- 22) Communications Workshop Evaluation ORG III
- 23) Groups I & II Trainees List By V. work activities
- 24) Group III Trainees List By V. work activities
- 25) Group IV Trainees List by V. work activities
- 26) Health Education in 35 Project Villages
- 27) Frequency of Village Health activities - Village Interviews Aug. 1981
- 28) First aid Boxes
- 29) M.C.H. Clinics
- 30) V.H.L. Participations M.C.H. Activities
- 31) V.H.L. - Her Involvement as V.H. Worker
- 32) Former Borderlines Repeat Exams. August, 1981
- 33) Borderline Followup August, 1981
- 34) Frequency of Arm Circumference - Borderline Aug./Sept. 81
- 35) Borderline Follow-up Results
- 36) Financial Contribution to Villages Community Health Workers During 1981 (January - June)
- 37) Financial Contribution by Villages to C.H.W. during 1980
- 38) Codel: Hanang Village Health Project Financial Status Report - By year Dec. 1977 through Aug. 1981 (2)
- 39) MCH Training Program

HANANG VILLAGE HEALTH PROJECT

- 40) ORODHA YA WAHUDUMU WA AFYA WALIOPATA VYETI KAMILI
- 41) Provisional Training Syllabus
- 42) MASOMO YANAYOFUNDISHWA MUHULA WA KWANZA MAJUMA SITA
- 43) Library Books
- 44a) HUDUMA YA KWANZA KWA OPG I & II (FIRST AID)
- 44b) MTHANI - M.C.H. - OPG I & II (MCH)
- 44c) MTHANI WA MADAWA OPG V (MEDECINES)
- 44d) Usafi wa Mazingira (Muda saa 1½) (ENVIRONMENTAL SANITATION)
- 44e) MAGONJWA - JARIBIO (DISEASES)
- 44f) MTHANI WA MWISHO WA MUHULA WA IV OPG IV (TEACHING METHODS)
- 45) HATI YA UTHIBITISHO

## ANNEX C

VILLAGE DATA

(Taken from Project Handouts and Supervisory Ratings)

Division/Village	OPG	VHW SCORE	HEALTH PRACTICES					TOTAL	SUPERVISORY RATINGS		
			B	C	L	O	P		T	TOTAL	
<u>Barbaig Division</u>											
BARJAMOD	II	2	2	1	1	0	4	2	1	3	
BASSODESH	IV	1	0	0	1	0	1	0	1	1	
BASSOTU	II	0	0	0	1	0	1	0	0	0	
ENDAGAW	II	6	2	2	2	0	6	2	2	4	
ENDASWOLD	III	10	2	0	2	2	6	2	2	4	
GEHANDU	IV	0	0	0	1	0	1	0	0	0	
GETAGHUL	II	6	2	0	0	2	4	2	1	3	
GIDAHABABEIG	IV	8	1	0	0	2	3	1	0	1	
HIDET	II	5	0	0	1	0	1	1	0	1	
HIRBADAW	II	1	0	0	0	0	0	1	1	2	
ISHPUNGA	V	0	0	0	1	0	1	0	1	1	
MARA	IV	7	0	0	0	2	2	0	2	2	
MASAKTA	II	7	2	2	1	2	7	2	2	4	
MASQARADA	V	0	0	0	1	0	1	0	2	2	
MATANGARIMO	V	0	0	0	1	0	1	0	1	1	
MEASKRAN	IV	8	1	0	1	2	4	0	2	2	
MOGITU	II	1	0	0	1	0	1	1	0	1	
WARETA	III	6	1	0	2	2	5	1	1	2	
<u>Bashnet Division</u>											
ARRI	II	4	2	1	0	2	5	1	1	2	
BERMI	V	0	0	0	1	0	1	1	0	1	
DAREDA	II	5	2	1	2	0	5	1	2	3	
DOHOMU	III	10	2	2	2	2	8	2	2	4	
GUSE	II	8	2	0	2	2	6	2	2	4	
ENDAMANAGH	IV	10	1	0	1	1	3	1	1	2	
GAJAL	V	0	0	0	1	0	1	1	0	1	
LUXMANDA	II	0	1	1	1	0	3	1	0	1	
MADUNGA	II	2	0	0	1	2	3	0	0	0	
MANAGHA	IV	6	1	0	2	2	5	1	1	2	
MANDI	III	2	0	0	2	0	2	1	0	1	
MANGANJWA	V	0	0	0	1	0	1	2	0	2	
NAR	III	7	2	0	1	2	5	1	1	2	
QAMEYU	IV	7	0	0	1	1	2	1	1	2	
SABILO	II	5	1	1	1	0	3	2	1	3	
SECHEDA	III	6	0	0	0	2	2	1	0	1	
SHARMO	III	4	2	0	2	2	6	2	2	4	
UTWARI	III	8	0	0	1	2	3	2	1	3	

Division/Village	OPG	VHW SCORE	HEALTH PRACTICES					TOTAL	SUPERVISORY RATING		
			B	C	L	O	P		T	TOTAL	
<u>Gorowa Division</u>											
AYASANDA A.	III	6	0	0	2	2	4	1	1	2	
AYASANDA H.	III	4	0	0	2	2	4	1	2	3	
BOAY	II	0	1	1	1	0	3	2	0	2	
BONGA	II	4	1	0	1	0	2	0	1	1	
CHEMCHAM	IV	6	0	0	1	1	2	0	1	1	
DAGHAILOI	IV	4	0	0	1	0	1	0	1	1	
DURU	IV	10	0	0	0	1	1	1	2	3	
ENDABEG	II	2	2	2	1	1	6	2	2	4	
ENDAGWE	V	0	0	0	1	0	1	1	0	1	
ENDANACHAN	IV	9	0	0	1	2	3	0	2	2	
ERRI	IV	4	0	0	0	0	0	0	0	0	
GEDEMAR	II	1	0	0	1	1	2	1	1	2	
GIDAS	II	7	0	0	1	0	1	1	1	2	
GWEDABOSHA	III	9	1	0	1	2	4	1	2	3	
HALLA	IV	2	0	0	1	0	1	0	1	1	
HOSHAN	IV	10	0	0	1	2	3	2	2	4	
IMBILILI	II	4	2	0	1	2	5	2	2	4	
KIRUNDOGO	IV	5	0	0	1	0	1	0	0	0	
MAISAKA	II	0	0	0	1	0	1	0	0	0	
MAJENGO	II	2	0	0	1	0	1	1	0	1	
MANAGHA	II	1	0	0	1	0	1	0	0	0	
MWIKANTSI	II	2	1	1	1	1	4	1	1	2	
NAKWA	V	0	0	0	1	0	1	1	0	1	
NANGARA	II	0	0	0	1	0	1	0	0	0	
SIGINO	V	0	0	0	1	0	1	1	0	1	
TSAMASI	III	3	0	0	1	1	2	1	1	2	
<u>Mbugwe Division</u>											
GICHAMED	II	3	2	0	1	2	5	0	0	0	
KISANGAJI	IV	6	0	0	1	0	1	1X	-	2	
MAGARA	II	0	0	0	1	1	2	1X	-	2	
MAPEA	III	10	0	0	2	0	2	0	-	0	
MASWARE	III	5	2	0	1	2	5	0	-	0	
MATUFA	II	3	2	1	0	1	4	0	-	0	
MAWEMAIRO	II	0	1	0	1	0	2	0	-	0	
MINJINGU	II	0	0	0	1	0	1	0	-	0	
MOYA MAYOKA	III	2	2	0	1	2	5	1X	-	2	
MWADA	II	3	2	0	1	1	4	2X	-	4	
SANGAIWE	II	2	0	0	1	2	3	1X	-	2	
SARAME	IV	6	0	0	2	0	2	0	-	0	
VILIMA VITATU	IV	8	0	0	1	1	2	0	-	0	

X - As no technical supervisory measurements were received, the political supervisory measurement was doubled.

PD-AAI-317

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ANNEX B COMPILATION

Hanang Village Health Project

September, 81 Evaluation

621-0138 Tanzania

HANANG VILLAGE HEALTH PROJECT

LIST OF PROJECT STAFF

	NAME	DESIGNATION
1.	Dr. S. E. Mushi	District Medical Officer ++
2.	Dr. Jeane Lynch	Director
3.	Brother Joe Rose	Business Manager
4.	Nd. W. P. Masunga	Liaison Officer/DHL Bashmet
5.	Mwl. Y. J. Masasi	Training Supervisor +
6.	Nd. A.A.H. Killinga	District Health Officer ++
7.	Sister Marian Teresa	M C H Supervisor
8.	* Nd. Marcel Akonaay	Health Officer/Field Officer +
9.	* Nd. Stephen Hyera	District TB and Leprosy Co ordinator /R.M.A. +
10.	Nd. V. M. Tairo	Divisional Health Leader/Barbaig
11.	Nd. C. Makaben	DHL/Gorowa.
12.	* Nd. L. Ako	Health Officer/DHL Mbugwe +
13.	Nd. Agnes Mshana	Nurse/Midwife +
14.	*Nd. D. Matle	Driver/Mechanic
15.	*Nd. Juliana Umbe	Data Clerk
16.	* Nd. F.P. Mponzi	Typist

Swahili preferred for interview

++ Govt. Officials associated with the Project

+ Seconded from the Government.

17/9/1981.

HANANG VILLAGE HEALTH PROJECT  
SOME FEW VILLAGES LIKELY TO BE OF INTEREST TO VISIT DURING EVALUATION:

	VILLAGE	REASON
1.	Masakta	<p>(a) <u>Health Education:-</u></p> <ul style="list-style-type: none"> <li>- VHW teach VHLs every Saturday - 3 pm</li> <li>- VHLs some of whom are Adult Education Teachers teach adult education classes every Wednesday - 2 pm.</li> <li>- Success of rehydration lesson to school children.</li> </ul> <p>(b) <u>Village Participation:</u></p> <ul style="list-style-type: none"> <li>- Village gives a stipend of Shs. 200/= to VHW, (the female VHW has moved out of the village after marriage) Village chose another candidate +is supporting her</li> <li>- Village has bought uniform for VHW.</li> <li>- VHW is always present during Clinic.</li> <li>- The Secretary to Education Cultural and Social Services Committee is always present at the Clinic.</li> <li>- VHLs make advance preparation and are always present in turn at the Clinic to assist.</li> </ul> <p>(c) <u>Medicine Box</u></p>
2.	Endaswold	<p><u>Medicine Box and Success of Rehydration Lesson to school children</u></p>
3.	Endagaw	<p><u>Village Participation in Clinic</u></p> <ul style="list-style-type: none"> <li>- Both VHWs attend clinic</li> <li>- VHLs make advance preparation and assist during clinic.</li> <li>- Secretary to Education, Cultural and Social Services Committee always attends and assists in registering mothers and children</li> </ul>
4.	Guse	<p>(i) <u>Village Participation:</u></p> <ul style="list-style-type: none"> <li>- Village Chairman is always aware of most health activities conducted by VHWs</li> <li>- Village give a monthly stipend of Shs. 90/= to each VHW.</li> </ul> <p>(ii) <u>Health Education:</u></p> <ul style="list-style-type: none"> <li>- VHWs give health education to school children and adult education classes weekly</li> </ul> <p>(iii) <u>Medicine Box</u></p>
5.	Dohoma	<p>(i) <u>Medicine Box</u></p> <p>(ii) <u>Village Participation</u></p> <ul style="list-style-type: none"> <li>- VHWs attend at every clinic.</li> <li>- VHWs make advance preparation for the clinic and attend on clinic day to assist.</li> <li>- Village give a periodical stipend to every VHW.</li> </ul>

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	VILLAGE	MEMBER
6.	Utwari	<u>Health Education:</u> <ul style="list-style-type: none"> <li>- VWVs give health education to mothers from time to time on clinic days at the local dispensary.</li> <li>- Female VHW with local LCH Aids follow up borderline children from time to time.</li> </ul>
7.	Sarano	VHWs follow children once a month to see to <u>up</u> their health
8.	Imbilili	(1) <u>Medicine Box</u> (ii) <u>Health education</u> <ul style="list-style-type: none"> <li>- VHWs teach VHWs</li> <li>- VHLs teach Adult Education Classes once a week</li> </ul>
9.	Hoshan	<u>Health Education</u> VHWs teach VHLs every Saturday starting at 2 pm.

17/9/1981.

LIST A PEOPLE WHO HAVE ASSOCIATED THEMSELVES WITH THE PROJECT

LIST A PEOPLE WHO HAVE ASSOCIATED THEMSELVES WITH THE PROJECT

NAME	PLACE OF WORK	DESIGNATION	ASSOCIATED WITH THE PROJECT IN
1. Sr. Connie Krautkremer	Nangwa Girls Secondary School	Headmistress	Conducted Communications Workshop ORG I & II
2. Sr. Peg Donovan	Community Education for Development Success of Shinyanga	Co-Director	Conducted Communications workshop ORG III
3. Sr. Anita Magovern	"	"	"
4. Dareda Hospital	Dareda Hospital	MM Doctor and Sisters Clinic staff e.g. RNAs, Nurse/Midwives Tutors of Nursing School	Teaching VHVs, consultations and mobile clinics.
5. Dr. Margaret Garnett	Dareda Hospital	Medical Officer i/c.	Medical consultations.
6. Mrs. Gudamu	Dareda Hospital	Matron	Providing staff to Project activities when need arises -e.g. in teaching, Nutrition survey and Nutrition Demonstration. Providing MCH Clinical Experience for female trainees.
7. Babati Health Centre Staff	Babati	Medical staff and Nurse/Midwives	Teaching VHVs, consultations and mobile clinics etc.
8. Mrs. Josephine Manga	Babati Health Centre	District of Hanang's MCH co-ordinator	Teaching VHVs, consultations re mobile clinics etc Chairman MCH Coordinat. Committee.
9. Nd. Mgodo	Babati Health Centre	Medical Assistant	Teaching VHVs
10. Mrs. Mary Mayo	Katesh	Ujamaa and Co-operative Development Worker	Teaching VHVs nutritious and its preparation
11. Nd. Athanas Malley	Endasak	Rural Medical Aid	Nutrition Survey
12. Nd. Moses	Katesh	g. Divisional Party Secretary	General direction and supervision of Project activities in his division.

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NAME	PLACE OF WORK	DESIGNATION	ASSOCIATED WITH THE PROJECT IN
13. Nd. G.L. Ellward	Bashnet	Divisional Party Secretary	Running seminars to get village leaders involved in running the Project. General direction and supervision of Project activities.
Dr Insa Rikien Katesh Health Centre Staff	K.C.M.C. Katesh	Formally. Dr 1/0 Dareda Medical staff/ Nurses-midwives.	Medical Consultations Mobile Clinic. Barjamed Teaching VHW - Consultation
Nd. Kileo 14. Nd. H.S. Quorro	Dept. of Animal Husbandry Bashnet	Babati Education co-ordinator.	Teaching VHW - Constultations Conducting seminars to involved village leaders in Project activities, - Teaching health subject to VHWs.
15. Pastor Joseph Seni	Babati	Pastor - SDA Church	General direction and supervision of Project activities in his division
16 Nd. G. Songay	Babati	Divisional Party Secretary	General supervision of teaching health education to Adult Education Classes and Primary Schools.
17 Nd Kimangano	Babati	Divisional Education Co-ordinator	Nutrition Surveys.
18 Nd. John Nyoni	Bonga	Rural Medical Aid	Nutrition food Demonstration Teacher MCH, Nutrition Teacher: Nutrition Survey
19 Nd. C. Jororo	Magugu	Senior Staff Nurse	General direction and supervision of Project activities in his division
Nd. Salewa Nd. Mpangaji	" "	M. A. " "	Involved in initial stages of project and on-going development
20 Nd. Michael Tlagwe	Magugu	Divisional Party secretary	Running Nutrition Surveys whenever required
21 Nd. L. Tluway	Babati	CCM Driver former Project driver	Teaching VHWs how to teach School children
22 Nd. Lucas Paul	Bonga	Former B.M. Dareda	
23 Nd. P. Sisti	Daghaloi	Village Manager	

- GENERAL:** A good number of Party and Government officials at all levels have associated themselves with the Project in some way or other - e.g.
- (i) Divisional and Ward Party Secretaries have assisted in some way to get project activities running in their places of work
  - (ii) Divisional and Ward Co ordinators have helped a lot in providing teaching in Primary Schools.
  - (iii) Headteachers and their assistants have supervised and assisted VHWs while they were giving health education to their school children.
  - (iv) Dispensary staff have helped VHWs while they are doing practical work in their dispensaries; some of them have participated in Nutrition Surveys.
  - (v) See also paper on "What has been done to intergrate the Project in Government Activities"

HANAN'G VILLAGE HEALTH PROJECT  
HANAN'G DISTRICT VILLAGES AND THEIR STATUS IN THE PROJECT

DIVISION	PILOT & OPG I & II	OPG III	OPG IV	OPG V	NOT INCLUDED YET IN H.V.H. PROGRAMME
BARBAIG	<u>Endagaw</u> Bassotu* a + Hirtadaw Mogitu * b Barjamod Hidet * c Masakta Gotaghul	Wareta Endaswold	Bassodesh Mara Measkru Gidahababeig Gehandul* d	Garawaj Gawidu* e Mulbadaw Ishponga Masqaroda Matangarimo Simbay * f	Getanawasi Dang'aida Jordonu Nangwa + Dirna + Nyasenet Gitting + Gendabi +
					Dawari + Murumba + Balangidalalu + Endasak + Sirop + Katesh + Hwanga
BASHNET	<u>Luxaranda</u> Hudunga Sabilo Dareda Arri Guse	Sacheda+ Nar Utware + Mandi Dohomu Sharuo	Endamanagh Qameyu Managha	Maganjwa Bemai Gajal	Ufana + Bashnet + Seloto <del>/</del>

+ = These Villages have Government or Mission Dispensaries

~~/~~ = Designated District Hospital (Dareda) is in Seloto Village.

\* = These Villages have not been followed for various reasons:-

- (a) Bassotu Male Trainee did not attend all class sessions. Village participation was very poor from the beginning.
- (b) Mogitu Female VWV has moved out of the village and the male VWV occasionally leaves the village.
- (c) Hidet The VWV are not participating in health work and village has not given them any help.
- (d) Gehandul Trainees were unable to complete class sessions. No support from village
- (e) Gawidu Female trainee died and the male trainee did not return for the class sessions
- (f) Simbay Trainees were unable to complete classes; village participation poor.

DIVISION	PILOT & ORG I & II	ORG III	ORG IV	ORG V	NOT INCLUDED YET IN H.V.H. PROGRAMME
MBUGWE	<u>MATUPA</u> Magara * g Mawemairo Gichamed Hwada + Sangaiwe + Minjingu + h	Moyamayoka Mapea Masware	Sarame Kisangaji Villina Vitatu		Magugu +
GOROWA	<u>Bonga</u> * i + Endabeg Gedemar * j Majengo * k Inbilili Nangara * l Managhat * m Maisaka * n Gidas + Boay Hwikantoi	Ayasanda * Esansasi Gijedaboshka	Duru Hoshan Endamochan Dagailoi Kiru Ndogo Erri Chenchen Halla	Ayamango Orng'adida Qash Eubu Gidabaghar Kiru Dick Malangi Sigino Endagile Endagwe Nakwa Himiti	Riroda + Gallapo + Kiongozi + Singe Mamire + Endakiso + Babati Njini + Kiru Six +

= These villages have Government or Mission Dispensaries

= These villages have not been followed for various reasons

\* = Ayasanda is counted as two villages in the Project - Ayasanda/Ayasanda and Ayasanda Haran.

- (g) Magara Female VHW has been married outside the village - Male VHW is not doing any health work
- (h) Minjingu One VHW is now Party Secretary of the village - The second VHW got no financial support from the village and has left to be employed outside the village.
- (i) Bonga Village does not give any financial support to the VHWs - hence (?) the male VHW applied for RMA course and has been selected, the female is not doing any health work.
- (j) Gedemar Male VHW has left the village and the female VHW has been ill.
- (k) Majengo Both VHWs show no interest in health work
- (l) Nangara No village back up for the trainees hence VHWs have lost interest in their work; the male VHW is employed in Babati
- (m) Managhat No village back up for the trainees hence VHWs have lost interest in their work
- (n) Maisaka Neither VHWs came for Refresher course;  
- The male VHW was assigned a new job with village. The female VHW has been married and the husband refuses to allow her to do Project activities.

12/9/1981

5-1

HANANG VILLAGE HEALTH PROJECT

DRAFT WRITE UP ON: WHAT HAS BEEN DONE TO INTEGRATE THIS  
PROJECT IN GOVERNMENT ACTIVITIES:

When Hanang Health Project was started in 1977 the general understanding between CODEL and Tanzania Government was that all activities which would be started and run by the Project would be integrated into the Medical Services and run by the District Medical Officer as he does for other medical activities. For this reason, since the inception of the Project various steps were being taken to involve the Government, starting at village level to District level, in running various Project activities.

Village Level:

- (i) Village Council (being the village Government) had given approval for the Project to be started in the village.
- (ii) Only villagers who were accepted by the village Government could be taken for posts of village Health Worker and village Health Leader
- (iii) Village Health Workers (VHWs) are members of the Educational, Cultural and Social Services Committees in their villages hence they are members of the village Council. In one village (Jiri) the VHW is Chairman of the Educational, Cultural and Social Services Committee
- (iv) VHWs inform village leaders of all activities which they have been assigned by the Project to do while they are in the villages.
- (v) Village Educational, Cultural and Social Services Committees have been asked to decide which lessons on health should be given to Primary School children and to adult Education Classes.
- (vi) Some Villages give monthly stipends to VHWs; other give stipends periodically
- (vii) Some villages have bought or built medicine boxes and provided a room for VHWs to attend their patients.
- (viii) Some villages have shown interest by requesting MCH Clinics - where their requests have been accepted, they have provided a building where the MCH Clinics could be run; in most villages which receive the services of a mobile Clinic, VHWs make advance preparations for the day of the clinic and participate fully.

Ward/Division Level:

attend

- (1) Division Health Officers/VHVs Divisional Implementation meetings; in two Divisions they are: Secretaries to this meeting. They also supervise VHVs in their various assignments e.g. environmental sanitation.
- (ii) Divisional Party secretaries have instructed government officers in their divisions to be involved in Project activities by making sure that VHVs are carrying out their duties. On some occasions they have opened and attended VHVs divisional implementation meetings
- (iii) Divisional Education Co-ordinators have involved themselves by instructing their ward counterparts and Primary School teachers to help VHVs to conduct health education in adult Education classes and Primary Schools
- (iv) Government, Party and other leaders, mainly of the education department, have involved themselves in running seminars about Project activities e.g. in Bushnet Division, the Divisional/Ward Education Co-ordinators, Rural Medical Aids, Ward Secretaries, Headteachers of Primary School and Divisional Health Officer participated fully in running seminars on village responsibilities in the Project.

District Level:

- (1) The Area Commissioner has shown special attention to this Project e.g. in his letter Ref. No. CCM/BBT/A.1/2/96 dated 7/12/79 he directed that VHW should participate in implementation meetings at village, ward and divisional level. On some occasions he listened to the VHVs problems and offered useful suggestions - e.g. at one time he encouraged VHVs to be patient in their work and show that their work is useful to the people; then he would see to it that villages do something for their service.
- (ii) Area Commissioner, District Party Chairman, District Party Executive Secretary and District Development Director have individually on different occasions opened or closed VHVs class sessions.
- (iii) District Medical Officer and District Health Officer attend and participate in Project meetings - mainly Steering committee and Implementation Committee meetings, sometimes acting as chairman of these committees.

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- (iv) District Medical Officer provides medicines to villages which have medicine boxes
- (v) District Development Director has approved secondment of three government staff (one teacher, a nurse midwife and a health Officer in charge of a division) to work full time with the Project.
- (vi) DMO provides staff to assist in Nutrition surveys, teaching classes and running mobile clinics initiated by the Project.
- (vii) District Health Officer is chairman of Project monthly Planning committee meetings.
- (viii) District Education Officer allowed the Project to conduct seminars for Divisional and Ward Education Co-ordinators and head teachers of Primary Schools so that they could involve themselves in directing and supervising VH/s teaching of health in Primary School and Adult Education classes. He has also issued a supply of books for the use of VH/s in the villages.
- (ix) Different District Functional Managers and Officers of other categories (e.g. District Agricultural officer, District Ujamaa and Co operative Development Officer etc) have given lectures on various subjects to VH/s. On some occasions the DDD has provided the services of typists and drivers to the Project.

25/8/81.

HANANG VILLAGE HEALTH PROJECT

BASIC INSTRUMENTS OF THE PROJECT INFORMATION SYSTEM.

1 OBJECTIVE ONE: To gain an overview of village health conditions and problems. The principal need for this information is to assist in planning activities on the village level, e.g. to help Village Trainees in their efforts to define and carry out health activities appropriate to a given village.

A. INSTRUMENT USED FOR DATA COLLECTION.

1. Form TMA - 1 which gives a composition picture of the information of the projection in the village together with trainee Selection, etc.
2. Disease Attitude Form: which was filled in by the trainees at the beginning of the trainees program. It is especially for the use of the medical teaching staff.
3. The Census Book: This was completed by the trainees during their first classroom session. This included demographic and environmental sanitation data.
4. The Health Attitudes Survey: Which was completed by the trainees in conjunction with the members of a village representing Education Culture and Social welfare. This committee was formed during the first field work period for this specific purpose.
5. Form HU - 1 Incidence of Diseases, Birth and Deaths: This is filled in by the village health leaders monthly and is collected by the trainees.
6. Form TMA - N - 5 Questionnaire: This was completed by the trainees from the sample households.
7. TMA - 5 - 1 Nutrition Surveys: From this survey was organized conducted by a team of staff members from the project assisted at different time by Dareda Hospital, Babati Health Centre, the local health facility and the village. This survey provides information on nutrition level, JCG coverage, enlarged
8. The Trainee Course form Assessment: This is filled in by the trainees after every classroom session and is used to assess the impact of the course of the trainees.

II. OBJECTIVE TWO: To monitor project implementation in terms of the financial, commodity and extension inputs into health Education and clinic activities, the direct projected result, or outputs, and the initial effects of project activities on the behavioral patterns of villagers. The information is used largely for project management purposes, i.e. to track activities in order to determine whether what was scheduled has in fact been accomplished, and to identify problems, assess their causes and prescribe solutions. Monitoring information is used to signal needed actions on the part of the project staff with regard both to implementation and to possible modifications in project design.

B. INSTRUMENTS FOR MONITORING PROJECT IMPLEMENTATION.

1. An Attendance Register Form of the VHL training session. Which is filled in by the trainees.
2. The Trainees Monthly Report: Is filled in by trainees. This is used by the Teachers, the DHAs and the project Staff generally for information trainee participation in meetings, the current code in use in the village and the progress of health related activities.

3. Forms for the receipt of field Activities Records:

- a) Census Implementation Record: This lists the number of households visited in one working day by the trainees.
- b) Receipt form for HU-1 the (Record of the incidence, Diseases, Births & Deaths):
  - ( HU - 1 ): There are 3 copies of this form:
    - i ) One is kept by the trainees and gives them information on the number of VHLs who are Reporting
    - ii ) One is kept by the DHL as another check on VHLs
    - iii ) The third copy is kept by the Information staff as a cross check on field work and as a safeguard against losses etc.

4. A combined record of VHL attendance (at the VHLs training sessions) and the HU - 1 (incidence of Diseases, Births). This record shows progress made over a period time. It also shows the relationship between VHL attendances and the number of forms completed by them.

5. Monthly Reports: Division Health Leaders (DHL).

- a) TMA - D2 which gives information on project activities taking place in the DHL's Division and also gives an index of available village reports (13). It gives information on MCH clinics, meetings attended by the DHL at Division and village level reasons for the DHL visits to the villages. This information generates the field administrators chart (see below).
- b) Form TMA D 12 is the DHL's village report which cross checks information received on the trainees monthly report form. It also gives the DHL an opportunity to evaluate or correct the monthly collection forms of the trainees and VHLs.

B. METHODS USED AT THE CENTRE FOR MONITORING PROJECT ACTIVITIES:

- 1. A Register of codes being used in the village health education classes.
- 2. A Register of the resolutions passed by VHLs in the units.
- 3. A Register of health related activities in progress.

These register are kept by a central staff member to enable him to follow the progress of the trainees in the villages. It is also used as a basis for his reports to the monthly implementation meeting.

- 4. A wall chart kept in field administrator. Office which confirm about visits and meeting in the village. And is used as a basis for his report to the monthly implementation meeting.
- 5. MCH activities are summarised; record is kept which gives information; on the date of any given clinic, health facility which staff the clinic; and the attendances of mother and children. This is used primarily by the MCH Supervisor.
- 6. Data Processing Activities; Job sheets are kept for each staff member in the information office showing which job is being done and how much time has been expended the job.

7. Special activities. The Nutrition Survey (refer to writeup).
- b) Other monitoring instruments: A weekly field plan was made out by the staff and the trainees together in the last week of each classroom session. This plan was followed by the trainees on their return to the villages. They made adjustments to the schedule as required in their villages. On their return to classroom they discussed this schedule and the problems which arose during the field work.
8. Monthly implementation report meeting: At this meeting, presentations of the past month's happenings are given and plans for the following month are made. Problems of implementation are discussed and solutions offered. This is an opportunity for DHAs and the Central Project Staff to meet and exchange ideas.

III OBJECTIVE THREE: To evaluate the impact of the project on the health of villagers. This component of the information system looks at behavioral changes related to nutrition and hygiene practices, and changes in the incidence of selected diseases. The primary use of this data is determining the appropriateness of project approaches, possible needed changes in project design, and the potential for replicating the approach elsewhere.

A. DATA SOURCES FOR MEASURING THE IMPACT OF THE PROJECT.

There are two categories of data which measure project impact. One category is concerned with improving the health of the villagers and the other category with the independence of the villagers in the implementing the project and the replicability of the project in other districts in Tanzania.

1. CATEGORY - I Improving the health of the villages;
  - a) The HU - 1 form will generate time series data on selected childhood diseases in the village. On analysis this data will show changes which have taken place.
  - b) Time series data on attendances at MCH clinics.
  - c) Progress reports on health related activities being generated from the health education session, village meetings and other health inputs, MCH clinics Presentation of village health profiles etc.
  - d) Data collected annually will give an indicator of behavioral change and health-disease patterns. Sources are. The: Questionnaire, The Nutrition survey etc.
2. CATEGORY II: Ability of individual villages to be independent in carrying on the work of the project and replicability of the project in other districts.

Indicators of this are:

- a) Attendance at classes
- b) Numbers of VHAs returning HU - 1 forms.
- c) Various approaches used in individual villages which have contributed to the success of their program.
- d) Decreasing involvement of the DHA in the village problem solving sessions.
- e) Ability of the villagers to conduct their own clinic in conjunction with their nearest health facility.

MRADI VA ... / IJAJINI MILYANI HANANIG  
(ENVIRONMENTAL SANITATION SURVEY)

NUMBER, CONDITION AND PERCENTAGES OF HOUSES AND LATRINES, BY VILLAGE, DIVISION AND INSPECTION DATE DURING 1979,80 AND 81

DIVISION	VILLAGE	DATE INSPECTED	NO OF HOUSES INSPECTED	WALL		WINDOW		ROOF					LATRINES										
	VILLAGE			'EMBA'		'DUNI'		PRESENT		MISERABLE		THATCHED	CORRUGATED ALUMINIUM	'UDONGO'	PRESENT		USED		STURDY				
				NO	%	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%		
E A R E B A I C	Getoghal	8/79	293	198	.68	95	.32	42	.14	251	.86	278	.95	13	.04	2	.01	234	.80	175	.75	94	.40
	"	5/80	204	123	.60	81	.40	31	.15	173	.85	183	.90	17	.08	4	.02	192	.94	181	.94	110	.57
	"	3/81	307	274	.89	27	.09	28	.09	272	.89	283	.92	13	.04	-	0	190	.62	142	.75	88	.46
	Mucoban	2/81	308	278	.90	22	.07	65	.21	246	.80	252	.82	9	.03	1	.003	203	.66	162	.79	28	.14
	"	4/81	329	313	.95	12	.04	136	.41	190	.58	312	.95	13	.04	4	.001	290	.88	269	.93	138	.48
B A S H N E E	Guse	5/80	145	109	.75	35	.24	34	.23	108	.74	135	.93	10	.07	-	0	129	.89	112	.87	82	.64
	"	1/81	231	226	.98	5	.02	48	.21	177	.77	172	.74	13	.06	3	.15	220	.95	215	.98	169	.77
	"	6/81	207	195	.94	12	.06	31	.15	172	.83	156	.75	11	.05	31	.16	204	.99	203	.99	171	.84
	Secheda	2/80	279	220	.79	57	.20	30	.11	241	.86	26	.09	12	.04	239	.86	233	.84	220	.94	182	.78
	"	1/81	261	143	.55	20	.08	57	.22	110	.42	49	.19	9	.03	190	.73	190	.73	174	.92	96	.51

BEST AVAILABLE DOCUMENT

DIVISION	VILLAGE	DATE INSPECTED	NO OF HOUSES INSPECTED	W A L L				W I N D O W				R O O F						L A T R I N E					
				'IMARA'		'DUNI'		PRESENT		ABSENT		THATCHED		CORRUGATED ALUMINUM		'UDONGO'		PRESENT		USED		STURDY	
				NO	%	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%	NO	%
G O R D W A	Bijedibeshka																						
	"	1/80	289	138	.48	151	.52	125	.43	164	.57	252	.87	27	.09	10	.03	244	.84	233	.95	195	.83
	"	3/81	261	209	.80	52	.20	149	.57	112	.43	216	.83	35	.13	10	.04	228	.87	221	.97	203	.89
	Lyneanda H	2/80	170	52	.31	18	.11	110	.65	56	.33	97	.57	69	.41	3	.02	141	.83	135	.96	110	.78
	"	5/80	330	315	.95	15	.05	190	.58	139	.42	182	.55	111	.33	7	.02	310	.94	308	.99	306	.99
	"	9/80	164	156	.95	8	.05	100	.61	64	.39	93	.58	70	.43	3	.02	149	.91	148	.99	139	.93
M B D G W E	Matufa	8/89	314	295	.57	214	.42	501	.97	10	.02	431	.84	42	.08	29	.06	299	.58	244	.83	29	.10
	"	8/81	511	368	.72	137	.27	249	.49	245	.48	386	.76	34	.06	86	.17	366	.72	323	.88	212	.58
	Vilina-Vitatu	2/81	351	303	.86	48	.14	26	.07	325	.93	306	.87	13	.04	29	.08	218	.62	1212	.97	31	.14
	Vilina-Vitatu	6/81	261	207	.79	54	.21	64	.25	197	.75	172	.75	172	.66	74	.28	126	.48	111	.88	101	.80

September, 1981.

HANANIG VILLAGE HEALTH PROJECT VILLAGE AND TRAINEES SELECTED

CANDIDATES PROVIDED OPG III, IV & V

	OPG III					OPG IV					OPG V				
	BARB.	BASH.	GOR.	MB.	TOTAL	BARB.	BASH.	GOR.	MB.	TOTAL	BARB.	BASH.	GOR.	MB.	TOTAL
<b>1. SELECTED OF VILLAGE</b>															
Number of Villages approached	8	9	10	6	33	8	6	14	3	31	11	3	12	0	26
Number of Villages dropping out (Refusals)	5	3	6	2	16	3	3	6	0	12	5	0	0	0	5
Village wanting the project but failing to get candidates	0	0	0	0	0	1	0	0	0	1	0	0	0	0	1
Village failing to get trainees of both sexes	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>2. TRAINEES SELECTED</b>															
Number of male trainees provided	14	22	18	17	71	23	19	27	18	87	25	16	64	0	105
Number of female trainees provided	9	25	10	9	53	18	18	11	11	58	11	9	30	0	50
Education of Trainees:															
None	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
0 - 4	2	6	5	5	18	6	11	3	5	25	5	3	13	0	21
5 - 7	21	41	22	19	103	34	26	35	24	119	30	21	79	0	130
7+	0	0	1	2	3	1	0	0	0	1	1	1	2	0	4
Adult Educ.	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
<b>3. Age of Trainees:-</b>															
15 - 20	7	28	12	13	60	12	27	20	10	69	13	8	48	0	69
20 - 25	6	13	6	5	30	17	8	10	9	44	16	10	29	0	55
25 - 30	7	4	7	3	21	12	2	7	4	25	5	5	14	0	24
30+	2	2	3	5	12	0	0	1	6	7	2	2	3	0	7
<b>4. Marital Status of Trainees:-</b>															
Single	13	35	16	17	81	25	32	23	17	97	23	17	55	0	95
Married	10	12	12	9	43	16	5	15	11	49	16	8	37	0	61
<b>5. Trainees with Children:</b>															
Female	3	2	4	1	10	9	2	5	5	21	3	7	11	0	21
Male	6	18	10	6	30	5	4	7	6	22	10	4	16	0	30

HANANIG VILLAGE HEALTH PROJECT VILLAGE AND TRAINNEES SELECTED  
ORG III IV & V:

	ORG III					ORG IV					ORG V				
	BAJ.J	BASH.	GOR.	MB.	TOTAL	BAR.	BASH.	GOR.	MB.	TOTAL	BAR.	BASH.	GOR.	MBU.	TOTAL
1. SELECTED VILLAGES	3	6	4	4	17	4	4	6	5	19	7	3	12	-	22
2. TRAINEES SELECTED															
Number of male trainees provided	3	6	4	4	17	4	4	6	5	19	7	3	12	-	22
Number of female trainees provided	3	7	4	4	18	4	4	6	5	19	8	3	12	-	23
Education of Trainees:															
None	0	0	0	0	0	0	0	0	0	0	0	0	0	-	0
0 - 4	0	1	1	3	5	0	0	0	2	2	1	0	1	-	2
5 - 7	6	12	7	5	24	7	8	12	8	35	13	5	23	-	44
7+	0	0	0	0	0	1	0	0	0	1	1	1	0	-	2
Adult Education	0	0	0	0	0	0	0	0	0	0	0	0	0	-	0
3. Age of Trainees:-															
15 - 20	3	5	5	3	16	5	4	7	2	18	8	1	13	-	22
20 - 25	2	7	2	3	14	1	3	3	3	10	6	2	8	-	16
25 - 30	1	0	0	1	2	2	1	2	2	7	1	2	3	-	6
30+	0	1	1	1	3	0	0	0	3	3	0	1	0	-	1
4. Marital Status of Trainees:-															
Single	4	9	5	6	24	6	6	7	2	21	9	2	14	-	25
Married	2	4	3	2	11	2	2	5	7	16	6	4	10	-	20
5. Trainees with Child.															
Female	2	1	2	2	7	2	2	3	4	11	2	3	4	-	9
Male	0	3	3	1	7	1	1	0	4	6	4	2	3	-	9

SEPTEMBER 1981

~~Trainees who have~~  
~~been completing classes~~ **BARBAIG VILLAGE HEALTH PROJECT**

+ One Trainee has no information about age

CANDIDATES PRESENTED NO. CPG III

	TRAINEEES PROVIDED			EDUCATION OF PROVIDED			AGE OF TRAINEES PROVIDED				MATITAL STATUS		TRAINEEES WITH CHILDREN	
	M	F	NONE	0-4	5-7	7+	15-20	20-25	25-30	30+	SINGLE	MARRIED	M	F
<b>BARBAIG (Tarafa)</b>														
1. Warota	5	1	-	1	5	-	3	-	2	1	3	3	3	1
2. Endaswola	5	4	-	-	9	-	2	3	4	-	5	4	2	2
3. Maskiroda *	4	4	-	1	7	-	2	3	1	1	5	3	1	-
4. TOTAL	14	9	0	2	21	0	7	6	7	2+	13	10	6	3
<b>BASHIET (Tarafa)</b>														
1. Nar	5	5	-	-	10	-	8	1	1	-	7	3	2	-
2. Utwardi	3	2	-	-	5	-	2	3	-	-	3	2	-	-
3. Secheda	2	2	-	1	-	-	2	2	-	-	2	2	2	-
4. Mandi	6	5	-	-	11	-	9	2	-	-	11	-	-	-
5. Dohama	2	5	-	-	7	-	4	3	-	-	7	-	-	1
6. Sharno	4	3	-	5	2	-	-	2	3	2	2	5	4	1
7. Guse	0	3	-	-	3	-	3	-	-	-	3	-	-	-
TOTAL	22	25	0	6	41	0	28	13	4	2	35	12	8	2
<b>GOROWA (Tarafa)</b>														
1. Aysenda	10	5	-	2	12	1	8	3	3	1	9	6	5	1
2. (Haraa)														
3. Tsanasi	3	4	-	3	4	-	2	1	2	2	3	4	3	2
4. Gijedrboshka	5	1	-	-	6	-	2	2	2	-	4	2	2	1
TOTAL	18	10	0	5	22	1	12	6	7	3	16	12	10	4
<b>MBUGHIE (TARAF)</b>														
1. Kisangaji	6	3	-	1	8	1	8	2	3	3	7	2	1	-
2. Mapea	5	3	-	4	3	1	2	-	3	3	4	4	4	
3. Moya nyoka	3	2	-	-	4	1	2	2	-	1	3	2	1	1
4. Maswara	3				4		2	1	1	1	3	1	-	1
TOTAL	17	8	0	5	19	2	14	5	7	5	17	9	6	2

SELECTED TRAINERS OFC III

DIVISION	TRAINEE'S SELECTED	AGE		EDUCATION							AGE OF TRAINEES				MARRIAGE STATUS		TOTAL
		Y	M	0-4	5-7	7+	15-20	20-25	25-30	30+	SINGLE	MARRIED	MALE	FEMALE			
<b>BARBAIG DIVISION</b>																	
1	Wareta	Rehema G. Solla	43	30													
		Sebastiano K.J. Baynitt	39	45													
2	Endaswold	Cecilia K. David	29	55													
		Benedict B. Panza	18	50													
3	Measkron (Q)	Sarah Yohana	35	45													
		Hussein Njoka	24	50													
		TOTAL			0	0	6	0	3	2	1	0	4	2	0	2	
<b>BASHNET DIVISION</b>																	
1	Nar	Esabela N. Naked	38	55													
		Eu. Damian B. Maales	43	30													
2	Utwari	Nathalia N. T. Rastimu	17	60													
		Safari Mchuno	47	60													
3	Secheda	Justina L.M. Samaytu	31	70													
		Joseph A.M. Samaytu	26	40													
4	Mandi	Josephine Haya	38	60													
		Dionice Slaa	36	60													
5	Dohomu	Adelhaida A. Lyimo	26	45													
6	Sharmo	Justin Stephen	39	45													
		Leocadia Tsazara	35	40													
7	Guse	Nicolaus H. Bukhav	21	45													
		Mariam H. Hendriko +	34	55													
		TOTAL			0	1	12	0	5	7	0	1	9	4	3	1	
<b>GORONA DIVISION:</b>																	
1	Ayasanda (Haraa)	Teklamary Malaki	22	55													
		Uo. J. Mangay	41	55													
2	Ayasanda	Mariam Swalehe	54	50													
		Tembea D. Goti	34	60													
3	Tsamaci	Teresa Stephen	12	30													
		Gabrieli M. Gudalin	24	50													
4	Gijedaboshka	Adamu S. Sanko	31	50													
		Teresia S. Lodu	14	80													
		TOTAL			0	1	7	2	5	2	0	1	5	3	3	2	
<b>MBUGWE DIVISION</b>																	
1	Kisangaaji	Raphael M. Harman	29	55													
		Clemencia K. Makizi	39	40													
2	Mapea	Hawa K. Juma	16	30													
		Julius T. Nduta	32	75													
3	Moya Mayoka	Titus Philipo	30	50													
		Albina B.A. Ami	40	50													
4	Masware	Tausi L.A. Ngolira	35	65													
		Martin M. Lobuva	39	90													
		TOTAL			0	3	5	0	3	3	1	1	6	2	1	2	
		GRAND TOTAL			0	5	30	0	16	14	2	3	24	11	7	7	

AUGUST, 1981

NOTE

\* Rating Less than 2+

+ One Trainee

(C) Trainees withdrew before completing course;

HANAMIG VILLAGE HEALTH PROJECT  
CANDIDATE PROVIDED OPG IV

	TRAINED PROVIDED		EDUCATION OF TRAINEES				AGE OF TRAINEES				MARTIAL STATUS		TRAINEES WITH CHILDREN	
	M	F	NONE	0-4	5-7	7+	15-20	20-25	25-30	30+	SINGLE	MARRIED	MALE	FEMALE
1. Vilina Vitatu	2	4	-	-	6	-	4	1	-	1	4	1	1	1
2. Sarane	6	3	-	1	3	+	1	+	1	3	5	4	2	2
3. Erri	4	1	-	3	2	-	-	3	1	1	3	2	2	1
4. Kiru Ndogo	3	2	-	-	5	-	2	1	2	-	2	3	1	1
5. Kisanga	3	1	-	1	3	-	3	-	-	1	3	1	-	-
<b>TOTAL</b>	<b>18</b>	<b>11</b>	<b>0</b>	<b>5</b>	<b>24</b>	<b>0</b>	<b>10</b>	<b>9</b>	<b>4</b>	<b>6</b>	<b>17</b>	<b>11</b>	<b>6</b>	<b>5</b>
<b>GOROMA</b>														
1. Chenchen	4	1	-	-	5	-	2	3	-	-	4	1	1	-
2. Daghailoi	5	3	-	2	6	-	2	-	5	1	2	6	4	2
3. Halla	2	3	-	-	5	-	2	2	1	-	3	2	-	2
4. Endanachen	6	2	-	-	8	-	5	3	-	-	4	4	1	1
5. Hoshan	6	1	-	-	7	-	7	-	-	-	7	-	-	-
6. Duru	4	1	-	1	4	-	2	2	1	-	3	2	1	-
<b>TOTAL</b>	<b>27</b>	<b>11</b>	<b>0</b>	<b>3</b>	<b>35</b>	<b>0</b>	<b>20</b>	<b>10</b>	<b>7</b>	<b>1</b>	<b>23</b>	<b>15</b>	<b>7</b>	<b>5</b>
<b>BASHNET</b>														
1. Manogha	3	6	-	9	-	-	7	2	-	-	7	2	-	-
2. Qameyu	5	5	-	1	9	-	5	3	2	-	8	2	3	-
3. Endarannagh	5	5	-	1	9	-	9	1	-	-	10	-	-	-
4. Basodesh	6	2	-	-	8	-	6	2	-	-	7	1	1	-
<b>TOTAL</b>	<b>19</b>	<b>18</b>	<b>0</b>	<b>11</b>	<b>26</b>	<b>0</b>	<b>27</b>	<b>8</b>	<b>2</b>	<b>0</b>	<b>32</b>	<b>5</b>	<b>4</b>	<b>2</b>
<b>BARBAG</b>														
1. Gidaha-babieg	6	5	-	-	11	-	2	7	2	-	8	3	-	2
2. Measkron	5	6	-	-	10	1	6	2	3	-	7	4	2	2
3. Marra	7	5	-	3	9	-	1	5	6	-	6	6	1	5
4. Gebandu	5	2	-	3	4	-	3	3	1	-	4	3	2	-
<b>TOTAL</b>	<b>23</b>	<b>18</b>	<b>0</b>	<b>6</b>	<b>34</b>	<b>1</b>	<b>12</b>	<b>17</b>	<b>12</b>	<b>0</b>	<b>25</b>	<b>16</b>	<b>5</b>	<b>9</b>
5* Masq.	5	4	0	2	7	0	5	2	1	1	4	5	2	1

+ There is no information of one Trainee about Age

\* The Village was disqualified and none of the Trainees were selected again thereafter. Totals not included above.

MRADI WA AFYA VIJLJINI WILAYATI HANAN'G

SELECTED TRAINEES ORG IV

MBUGWE:	TRAINEES PROVIDED	TRAINEES PERFORMANCE			EDUCATION OF TRAINEES PROVIDED				AGE OF TRAINEES PROVIDED				Marital Status		Trainees with Children	
		ILL ILL	COMP - OSITION	RATING	NONE	0-4	5-7	7+	15-20	20-25	25-30	30+	S	M	M	F
1. Vilima Vitatu	1. Agness Alfonso	27	41	28	-	-	V	-	-	V	-	-	-	-	-	V
	2. Wilbroad Njaiko	19	41	32	-	-	V	-	-	-	V	-	-	V	V	-
2. Sarauo	1. Amina Salcha	19	34	29	-	-	V	-	-	V	-	-	-	V	-	V
	2. Adriani J. Kebola	32	22	24	-	V	-	-	-	-	V	-	-	V	V	-
3. Eeri	1. Acripina Mayo	37	29	26	-	-	V	-	-	V	-	-	V	-	-	V
	2. John Lohey	38	27	26	-	-	V	-	-	-	V	-	-	V	V	-
4. Kiru Ndogo	1. Ashura Iddi	29	33	19	-	-	V	-	V	-	-	-	-	V	-	-
	2. Ramadhani salim	24	29	33	-	-	V	-	-	V	-	-	-	V	V	-
5. Kisangaji	1. Clemensia Makina	38	38	28	-	V	-	-	-	-	V	-	-	V	-	-
	2. Gloya Bura	26	37	33	-	-	V	-	V	-	-	-	-	V	-	-
						2	8	0	2	3	2	3	2	7	4	4
<b>GOROWA ;</b>																
1. Ohomohen	1. Martha Alawa	29	33	30	-	-	V	-	V	-	-	-	V	-	-	-
	2. Joseph Bura	30	35	30	-	-	V	-	-	-	-	-	V	-	-	-
2. Dughailoi	1. Mary Martin	25	20	29	-	-	V	-	V	-	-	-	V	-	-	-
	2. Athmani O. Wawa	16	27	25	-	-	V	-	-	V	-	-	-	V	-	-
3. Halla	1. Selina Tumaini	17	24	31	-	-	V	-	-	V	-	-	V	-	-	-
	2. Tandei Simon	32	27	23	-	-	V	-	V	-	-	-	V	-	-	-
4. Endanachan	1. Teresa Mulile	30	29	30	-	-	V	-	V	-	-	-	V	-	-	-
	2. Maa. Gadiye	33	36	31	-	-	V	-	V	-	-	-	V	-	-	-

	TRAINEES SELECTED	TRAINEES PERFORMANCE			EDUCATION OF TRAINEES PROVIDED				AGE OF TRAINEES PROVIDED				Marital Status		Trainees with Children		
		MILI HILE	COMPOS- ITION	RATING	NONE	0-4	5-7	7+	15-	20-	25-	30+	S	M	M	F	
									20	25	30	0					
<b>GORONA: con't.</b>																	
5.	Moohan	1. Evalina Ana	40	34	31	-	-	Y	-	Y	-	-	-	Y	-	-	
		2. Khalili Iddi	48	43	29	-	-	Y	-	Y	-	-	-	Y	-	-	
6.	Duru	1. Lucy Sula	15	32	31	-	-	Y	-	Y	-	-	-	Y	-	-	
		2. John Daffi	35	33	30	-	-	Y	-	Y	-	-	-	Y	-	-	
						0	0	12	0	7	3	2	0	7	5	0	3
<b>BASIMBYT:</b>																	
1.	Ilanagan	1. Veneranda Dominio	24	40	25	-	-	Y	-	-	-	-	-	Y	-	Y	
		2. Patriok T. Ilhano	38	36	25	-	-	Y	-	Y	-	-	-	Y	-	-	
2.	Qincy	1. Tasiana L. Batloite	19	44	32	-	-	Y	-	Y	-	-	-	Y	-	-	
		2. Pascali N. Yaato	49	33	29	-	-	Y	-	Y	-	-	-	Y	-	-	
3.	Endananang	1. Elizabeth Saktay	27	34	27	-	-	Y	-	Y	-	-	-	Y	-	Y	
		2. Karoli B. Misco	47	19	25	-	-	Y	-	Y	-	-	-	Y	-	-	
4.	Basodesh	1. Marselina Sayelina	34	31	24	-	-	Y	-	Y	-	-	-	Y	-	-	
		2. Liberati H. Bayo	42	37	28	-	-	Y	-	Y	-	-	-	Y	-	-	
						0	0	8	0	4	3	1	0	6	2	1	1
<b>BARBAIG:</b>																	
1.	Gidahababieg	1. Rahabu Anlo	45	29	27	-	-	Y	-	Y	-	-	-	Y	-	Y	
		2. Onari Iddi	39	31	25	-	-	Y	-	Y	-	-	-	Y	-	-	
2.	Maasikron	1. Clementina E. Kiraang	27	22	23	-	-	Y	-	Y	-	-	-	Y	-	-	
		2. Benedict Gadiya	22	32	27	-	-	Y	-	Y	-	-	-	Y	-	-	
3.	Mara	1. Yudita William	15	27	25	-	-	Y	-	Y	-	-	-	Y	-	Y	
		2. Adreas Dachano	40	34	28	-	-	Y	-	Y	-	-	-	Y	-	-	
4.	Gahandu	1. Rosemary Ally	34	21	24	-	-	Y	-	Y	-	-	-	Y	-	-	
		2. Elikarimu H. Sirgaw	39	47	26	-	-	Y	-	Y	-	-	-	Y	-	-	
						0	0	7	1	5	1	2	0	6	2	1	2

OPG 7 CANDIDATES PRESENTED

TARIFA	KATA	KISIJI	TRAINERS		EDUCATION		OF		TRAINERS		OF		TRAINERS		MARRIED	STATES		CHILDREN
			M	F	NONE	0-4	5-7	7+	15-20	20+	25-30	30+	SINGLE	MARRIED				
														M		F		
BARBAIG	Basodeah	Gawidju	3	1	4	-	-	4	-	-	0	-	-	4	-	-	-	-
	Basotu	Gawidu	5	2	-	-	6	1	-	4	-	1	2	5	1	3	-	-
	Basotu	Mulbadaw	1	1	-	-	2	-	-	-	2	-	-	2	1	1	-	-
	Gehandu	Ishponga	6	2	-	-	8	-	-	5	-	-	7	1	-	1	-	-
	Masakta	Masqaroda	5	2	-	-	3	4	-	3	2	1	1	3	4	-	3	-
	Sirop	Matangama	2	1	-	-	3	-	-	3	-	-	1	2	-	2	-	-
	Sirop	Simbay	3	2	-	-	2	3	-	1	2	2	-	3	2	1	-	-
	<b>TOTAL</b>			25	11	0	5	30	1	13	16	5	2	23	16	3	10	-
BASHNET	Dabil	Maganjwa	5	5	-	2	8	-	5	3	2	-	8	2	3	1	-	
	Zareda	Barmi	3	1	-	-	3	1	-	1	1	2	1	3	1	2	-	
	Dareda	Gajal	8	3	-	1	10	-	3	6	2	-	8	3	3	1	-	
	<b>TOTAL</b>			16	9	0	3	21	1	8	10	5	2	17	8	7	4	-
GOROWA	Gallapo	Ayamango	4	3	-	3	4	-	1	3	2	1	1	6	2	2	-	
	Gallapo	Orng'adida	6	1	-	-	6	1	2	3	2	-	6	1	-	1	-	
	"	Qash	6	3	-	1	8	-	4	4	1	-	5	4	-	2	-	
	Gidas	Bubu	8	1	-	2	7	-	6	1	1	1	3	6	2	2	-	
	"	Gidabaghar	3	2	-	-	5	-	2	3	-	-	1	4	2	1	-	
	Kiru	Kiru Diok	5	4	-	2	7	-	6	1	2	6	6	3	1	1	-	
	"	Malangi	3	1	-	-	4	-	2	2	4	-	4	-	-	-	-	
	"	Sigino	10	1	-	4	6	1	3	4	4	-	4	6	1	4	-	
	Mamire	Endagile	5	1	-	1	5	-	4	2	-	-	6	-	-	-	-	
	Riroda	Endagwe	6	4	-	-	10	4	5	5	-	-	7	3	2	1	-	
	"	Nakwa	3	2	-	-	5	-	3	1	1	-	4	1	-	-	-	
	Singe	Himiti	5	7	-	-	12	-	10	-	1	1	8	4	3	2	-	
	<b>Total</b>			64	30	0	13	79	2	48	29	14	3	51	37	11	16	-

HANAI'G VILLAGE HEALTH PROJECT

ORG-V SELECTED TRAINEES

		TRAINEES PERFORMANCE			EDUCATION OF TRAINEES			AGE OF TRAINEES				MARRIAGE STATUS			CHILDREN	
		MILL. HILL	COMPO-SITION	RATING	NOTE	0-4	5-7	7+	15-20	20-25	25-30	30+	SINGLE	MARRIED		MALE
<b>BARBAIG</b>																
1. Garawaj	Albina Yame	13	32	25	-	-	✓	-	✓	-	-	-	✓	-	-	-
	Ibrahim Isaay	20	34	28	-	-	✓	-	✓	-	-	-	✓	-	-	-
2. Gawidu	Martha Alute	32	39	30	-	-	✓	-	✓	-	-	-	✓	-	-	-
	Peter Gendwa	14	20	25	-	-	✓	-	-	✓	-	-	-	✓	✓	-
3. Mulbadaw	Ester Gidasayda (Mrs Sefania)	15	33	27	-	-	✓	-	-	✓	-	-	-	✓	✓	-
	Yuda Bura	20	37	26	-	-	✓	-	-	✓	-	-	-	✓	✓	✓
4. Ishponga	Eliwaja E. Mambi	31	32	25	-	-	✓	-	✓	-	-	-	✓	-	-	-
	Clement Kijanga	36	32	25	-	-	✓	-	-	✓	-	-	-	✓	-	-
5. Masqaroda	Grace S. Paul	14	34	25	-	-	✓	-	-	✓	-	-	-	✓	-	-
	Stephen Juna	32	39	26	-	✓	-	-	-	✓	-	-	-	✓	-	-
6. Matangarimo	Paulina Gidoghamu	17	30	24	-	-	✓	-	✓	-	-	-	-	✓	✓	-
	Labay Rosa	21	25	24	-	-	✓	-	-	✓	-	-	-	✓	-	-
7. Simbay	Mwajuma Swalehe	15	32	29	-	-	✓	-	-	✓	-	-	-	✓	✓	✓
	Petro B. Qwaray	35	29	27	-	-	✓	-	✓	-	-	-	-	✓	-	✓
8. Barjanod	Martina Hando*	-	-	-	-	-	-	-	✓	✓	-	-	-	✓	-	-
TOTAL		-	-	-	0	1	3	1	8	6	2	0	9	6	4	2
<b>BASHNET</b>																
1. Maganjwa	Julia T. Bayo	17	31	23	-	-	✓	-	-	✓	-	-	-	✓	✓	✓
	Pius Dabi	30	31	27	-	-	✓	-	✓	-	-	-	-	✓	-	-
2. Birmi	Veronica Charles (Mrs Shauri)	28	23	27	-	-	✓	-	-	✓	-	-	-	✓	✓	✓
	Charles Dantel	15	38	29	-	-	✓	-	-	✓	-	-	-	✓	✓	✓
3. Gajal	Margareth Peter	16	31	24	-	-	✓	-	✓	-	-	-	✓	✓	✓	✓
	Gervas Geay	29	36	28	-	-	✓	-	✓	✓	-	-	-	✓	✓	✓
TOTAL					0	0	5	1	1	2	3	1	2	4	2	3

**NOTE:**

\* The Trainees was selected without being interviewed

		TRAINEES PERFORMANCE				EDUCATION OF TRAINEES				AGE OF TRAINEES				MARRIED		SINGLE		SEX	
		HILL	HILL	COMPO-	RATING	NONE	0-4	5-7	7+	15-20	20-25	25-30	30+	SINGLE	MARRIED	MALE	FEMALE		
GOROWA 1. Ayamango	Mwanhawa Ally	37	26	25	-	-	v	-	v	-	-	-	-	v	-	-	-		
	Abdi Rajabu	21	27	27	-	-	v	-	-	v	-	-	-	-	-	-	-		
2. Orang'ndida	Futari O. Mjenja	41	29	30	-	-	v	-	-	v	-	-	-	-	-	-	v		
	Lucas P. Dareda	20	34	27	-	-	v	-	-	v	-	-	-	-	-	-	-		
3. Qash	Victoria P. Mjenja	19	26	27	-	-	v	-	v	-	-	-	-	-	-	-	-		
	Kheri H. Mjeja	30	35	32	-	-	v	-	-	-	-	-	-	-	v	v	-		
4. Bubu	Nada B. Sumaye	34	32	27	-	-	v	-	v	-	-	-	-	-	-	-	-		
	Flavian Ensohal	31	22	21	-	-	v	-	-	-	-	-	-	-	-	-	-		
5. Gidabaghar	Sofia Hassani	25	20	24	-	-	v	-	v	-	-	-	-	-	-	-	v		
	Mohamed Mpangalla	25	39	31	-	-	v	-	-	v	-	-	-	-	-	-	v		
6. Kuru Dick	Tanbu A. Saidi	37	34	30	-	-	v	-	v	-	-	-	-	-	-	-	-		
	Marko Panga	35	26	24	-	-	v	-	v	-	-	-	-	-	-	-	-		
7. Malangi	Mwanidi Abdi	27	30	26	-	-	v	-	v	-	-	-	-	-	-	-	-		
	Martin Sulle	32	37	25	-	-	v	-	-	v	-	-	-	-	-	-	-		
8. Sigino	Mwanjan Husseni	19	41	28	-	v	-	-	-	v	-	-	-	-	-	-	v		
	Yusuf O. Muhomi	19	36	30	-	-	v	-	-	v	-	-	-	-	-	-	-		
9. Endagile	Hadija Husseni	20	26	28	-	-	v	-	v	-	-	-	-	-	-	-	-		
	Allu O. Hathu	30	24	24	-	-	v	-	v	-	-	-	-	-	-	-	-		
10. Endagwe	Dinnh Sunny	24	38	32	-	-	v	-	-	v	-	-	-	-	-	-	-		
	Mabiwa Thama-handi	27	24	25	-	-	v	-	v	-	-	-	-	-	-	-	-		
11. Nakwa	Nada Khwantlay	16	30	23	-	-	v	-	v	-	-	-	-	-	-	-	-		
	James G. Bani	12	90	30	-	-	v	-	-	-	v	-	-	-	-	-	-		
12. Himiti	Josephine Josia	37	43	25	-	-	v	-	v	-	-	-	-	-	-	-	v		
	Mohamed Nondi	25	19	29	-	-	v	-	-	-	v	-	-	-	-	-	v		
TOTAL					0	1	23	-	13	8	3	0	14	10	3	4			

16-1

HANAN'S VILLAGE HEALTH PROJECT

DRAFT WRITE - UP ON: THAT CONTRACTOR WILL INCLUDE  
AGREEMENTS BETWEEN VHWS AND VILLAGE GOVERNMENT  
OUTLINING MUTUAL RESPONSIBILITIES

In 1977 when the Hanan's Village Health Project started to recruit trainees (Village Health Workers) most Villages agreed to assist the trainees financially when they were in Babati studying. This financial support varied from Village to Village according to the Village's financial ability, their understanding and interest in the importance of the Project. However as this undertaking by the Village was almost a prerequisite for the Village to be selected, those Villages which were selected for training were required to enter into an agreement. In the course of time during and after training some trainees just dropped out, left the Village or just decided not to work at all in their Village; e.g. in Kinjingu both trainees just stopped doing any health work; in Kisangaji one male trainee dropped out during training; in Mogitu, one female VHW left the Village; in Managha the male VHW joined other paid employment and in Madunga neither VHW did any health work.

This question of commitment on both the part of the Villages and the VHWS arose during the 1979 evaluation, and the Area Commissioner commented on it in one of his addresses to the VHWS sometime in late 1979. Some Villages, although they had not entered into a signed agreement with their VHWS, resorted to "common law". For example, in Sabilo, when the female VHW was engaged to a man from a neighbouring Village, the Village Leaders intervened and decreed that he either pay the costs of the training of his fiancée which the Village had incurred or move to his fiancée's Village (Sabilo). The man chose the latter and has since been living in his wife's Village. In Mawemairo, a similar situation occurred. In Sharmo the male trainee decided not to play his part as VHW and the Village Government has resolved that he pay the training costs the Village incurred.

In early 1980, the Project took steps to draft a simple agreement and advised Villages starting with OPG IV to enter into a written agreement (sample attached). Almost all Villages in OPG IV and V have made these agreements. However the enforcement and effectiveness of these agreements have not yet been assessed; but it is very likely that their enforcement will be done under customary law under the umbrella of the Party - Chama cha Mapinduzi or the Village Government i.e. the VHW might be called to a party committee or Village Council and be asked to refund all the training expenses the Village Government had incurred. This is very likely to happen where VHWS have started to do some visible health activities which have observed results - e.g. dispensing medicine from a medicine box in the Village.

21/9/1981

HANAN'G VILLAGE HEALTH PROJECT

AGREEMENT BETWEEN A VILLAGER WHO IS TO BE TRAINED TO BE  
VILLAGE HEALTH WORKER AND THE VILLAGE GOVERNMENT

I.....(Full Name)

Do hereby solemnly promise that during my training to be given by the Hanan'g Village Health Project, I will stay and live in my Village ..... until the end of my training; also I do promise that after training I will serve my Village as a Village Health Worker for three years.

The Village, on the other part, undertakes to help Ndugu ..... in every possible way depending on the ability of the Village in order to enable him/her to serve the Village until his/her services are no longer required by the Village.

This Agreement has been signed this ..... day of ..... 198....

Between

Name ..... (Village H.W.)  
Signature .....  
Date .....

And

Name .....  
Designation .....  
Signature ..... On behalf of the Village.  
Date .....

In the Presence of

Name .....  
Post .....  
Date .....

HANANIG VILLAGE HEALTH PROJECT  
PAYMENT SERVICES - VILLAGE HEALTH WORKERS

When the Project started in 1977 the original stand was to stress to the village, ward, division and district leaders and VHWS themselves that VHWS were volunteers and that financial assistance to them while they were in the villages performing their duties was not necessary however, villages were encouraged to give financial support to VHWS while they were in Babati pursuing their course. In fact, financial support for VHWS when they were in their respective villages was discouraged and one divisional party leader flatly rejected the idea during early 1979. Figures on financial support used were obtained from the VHWS when they came to Babati for training. Early contributions for Pilot, ORG I and II villages were shown in the Project first evaluation 1979, Chart 3.

In the course of time however, it was evident many VHWS after training were disillusioned as money started to be the moving power in villages. Exemption of VHWS from participation in village communal work as compensation for their work in villages was no longer an incentive to VHWS. Health education, which is the main thrust of the Project was almost non-existent in many villages. Many reasons were raised for this failure - e.g. non existence of adult health education classes etc, - which was true in some cases, but the main general outcry from many VHWS was lack of financial support from their villages. A tug of war developed between VHWS and their village leaders - VHWS complained that they did not do their work in the villages as required of them because they had no support (they meant mainly financial support) from the villages, on the other hand the village leaders complained that the VHWS were not performing their duties so they should not be paid for doing nothing.

As this argument became evident to the Project sometime in late 1979 / early 1980 the Project decided that it was important to review the original stand with regard to financial support for VHWS while they were in villages. Seminars/dialogue with village leaders, ward and divisional secretaries were undertaken and it was generally accepted by these leaders that financial support was to be encouraged and VHWS on their part had to have a programme of work which was to be approved by village authorities. This programme of work had of course, to be followed.

Ironically, the divisional party leader who had discouraged financial support in 1979 was the first to encourage it this time. It was in his Divisional Implementation Meeting that a recommendation made by the ward secretaries was passed unanimously requiring a minimum stipend of shs. 100/= to be given to VHWS who have a programme of work and adhere to it.

The present general thinking at national level as regards financial assistance is that the village supports their VHWS, and in future the Government in turn could assist the villages to meet such expenses.  
1/8/1981.

HANANG VILLAGE HEALTH PROJECT  
APPROACHES TO TEACHING HEALTH EDUCATION METHODOLOGY

The Health Education methods employed were adapted from the work of Paulo Freire. We chose this method because we wanted Trainers Village Health Workers and Villagers to come to a knowledge of their own health problems, and to try to solve them themselves.

We have ways of finding out what the health problems in a Village are ie.

- Census
- Village Health problems survey (to survey common and pressing health problem as identified by villagers)
- Nutrition survey,
- Questionnaire
- Diseases attitude Forms etc.

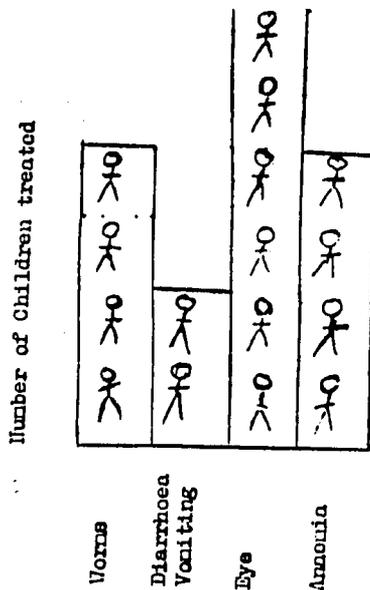
The results are presented to the trainers: And then it is up to them, the village Health Leaders and the Villagers to begin to find answers to the problems.

These problems are subsequently translated into 'codes' which are used in discussion with the Villagers to determine whether in fact the problems are prevalent in the Village and what solutions can be found for them.

It has appeared that this approach to health education is too long and arduous. Alternative approaches have been tested.

- A. The use of graphs ie.
    - Pictographs
    - Bargraphs
    - Pie charts: in stead of making 'codes'
  - B. Teaching Health education to Primary School Children (The Oral - Rehydration)
  - C. Demcnstration eg. Cooking demonstrations etc.
- A. (i) Using Nutrition Survey results

A pictograph for each village is prepared: Taking as a base the number of children treated for various illnesses and giving the number of children with those illnesses.



- (ii) This feedback is presented to the VHL and discussed.
  - (iii) A lesson is given on one of the major diseases found usually beginning with the most prevalent disease.
  - (iv) They discuss possible solutions to that problem. A plan is made for implementation.
  - (v) Each VHL then follows this Pattern (i-iv) when teaching in their health units.
1. (i) After some time the VHW meet with the VHL for the classes again
- (ii) Reports be given from the health units as to what has been done since the last class re health lesson. If nothing has been done, why not?
  - (iii) Discussion of special health problems in the health units
  - (iv) Discussion to whether a new health topic should be introduced or whether they should continue with the topic from the previous class.
  - (v) If agreeable; introduction of the new health lesson; following the same pattern as above. A: (i - iv) and v

To make sure that the Trainers are able to use this method we went through the following stages:

- (1) Stage I: Demonstration lessons were given to them in the Classroom. They pretended to be a group of village Health Leader they could be teaching.
- (2) Stage II: A return demonstration class was done by elected trainers.
- (3) Stage III: The trainers then went to their Villages; together with the VHL they followed the same pattern steps I-II: as above.
- (4) Stage IV: Those Village health leader who showed that they could use this method were allowed to introduce it in their health units.

We first approached this method with OPG IV during their 2nd class session from 20th July - 23rd August, 1980 and during their 3rd class session starting 21st September - 25th October, 1980. We expected this group to begin this new type of teaching in Villages 15th March, 1981.

OPG V were taught this method during their 2nd class session starting 25th January, - 28 February, 1981 and during the 2nd class session from 29th March - 2nd May, 1981. We expect them to begin this type of teaching in Village From 20th September, 1981 after Completing their 4th class session.

#### D. Problems

- (a) We have not yet proved the effectiveness of this method because we have not had any follow-up in Villages. In general poor attendance of VHLs classed has been a problems.

#### Future Plans

We intend to encourage the trainers to use these graphs when teaching in Schools and to the adult education sessions.

HUMANIG VITAMIN B12 PROJECT

19-1

EDUCATION PROGRAMME

A second approach arising from the recommendations of the 1979 evaluation was that Practical Experience in Teaching Health to Primary School Children be included in the Project syllabus. Since the main emphasis previously had been on educating adults, this new approach required the incorporation in the Project syllabus of theory on Teaching Methods for Primary School Children. The District Education Officer was approached re this idea and he agreed to allow this to be tried out in Hannan'g District.

"Teaching Methods for Primary School Children" was then introduced into the Project Syllabus and theory was given by a Central Staff teacher formerly a Primary School teacher. The Head Teachers and Staffs of the Primary Schools in Babati were approached and oriented to the plan and arrangements were made for the Trainees of OPGIII to practice teach in the Babati Primary Schools.

The ~~choice~~ of lessons was discussed by the Education Programme Committee and the Primary School Health Syllabus was reviewed for possibilities. At about this time, an article in SALUBRITAS (published by the American Public Health Association) re a Suggested Curriculum Guide for Oral Rehydration (Dr. Jon Rohde, Rockefeller Foundation) was read by a Staff Member. The article was sent for, was discussed by the Ed. Programme Comm. and seen to be a most appropriate vehicle for health teaching in the Primary Schools. The guide consisted of a story and seven lessons on Diarrhea, its dangerous results in the body and the preparation of the oral rehydration solution at home. These lessons and the story were translated into Swahili. This appeared to be an ideal plan for teaching the children in the schools and also for giving a large number of trainees an opportunity to practice teach in a limited period of time.

The plan was implemented and proved to be quite successful. First, demonstration lessons were given to the Trainees, who pretended to be the children they would be teaching. This was followed by a return demonstration class by elected trainees, taking one lesson each until the unit was completed. The Trainees then went to the Primary Schools for their practice teaching. Standards IV through VI were included in the plan, and the teachers of these classes sat in on the classes and constructively criticized the trainees teaching after the class. Three Central Staff teachers also supervised the teaching and evaluated the performance of the Trainees.

As part of the teaching plan for these classes on Oral Rehydration, each child was given an information sheet, explaining very simply what diarrhoea does to the body and how to prevent this by making up the oral rehydration solution at home, i.e. a pinch of salt, a teaspoon of sugar in a half - litre (beer bottle) of water. Each child was to take <sup>this information sheet</sup> home and put it in an easily accessible place (on the floor or wall) to stimulate conversation, questions, etc. and to follow through with the teaching parents and neighbours what they (the children) had learned. (As an aside, it might be mentioned here that even members of the hospital staff and others mentioned having been taught by their children how to prepare the oral rehydration solution.) A simple test on the unit was given to the children and corrected together with them.

When the trainees returned to their villages, part of their field experience was to teach Oral Rehydration in the Primary Schools in their villages. The described plan was also taught to the Trainees of OPG I and II, who were brought back to the centre specifically for that purpose, and to OPG IV and V. The latter have not yet had the opportunity to teach the unit in their village primary schools as the children were on holiday at the time of the trainees field experience.

Attached is a summary of the number of lessons taught in sixty-two villages. In 26 Primary Schools, all the lessons of the unit were taught while in 8 schools at least the first four lessons were taught. Hopefully we can say that a good number of parents and neighbours have been reached by this method of teaching health. To take it a step further, one might even hope that the decrease noted in the admissions to Dareda Hospital for Gastro-enteritis (1979 - 152; 1980 - 124) might in part be due to this teaching.

Other lessons included in this plan for teaching practice in the Babati Primary Schools were Malaria, Care of Eyes, Scabies and Good Nutrition. (OPG IV and V only).

It would seem that his approach, teaching health in the primary schools, is a good one for Village Health Workers and is a way of reaching the future generation of mothers and fathers in the villages. However, while the unit on Oral Rehydration was stressed and carried out on a fairly large scale, it is not certain whether the other lessons that were taught were introduced into the village primary schools. Neither is it known how many village Health Workers have, on their own, made up lesson plans for other health topics. Transfer of knowledge in this way seems to be difficult for them, despite the fact that they were taught and had practice in making up lesson plans.

HUMANIG VILLAGE HEALTH PROJECTEVALUATION REVIEWEDUCATION PROGRAMME

III. A third approach <sup>arising</sup> from the recommendation of the 1979 evaluation was the Cooking Demonstration method to teach both the need for nutritious food and the simple preparation of nutritious meals. This method is considered an important tool in helping the mothers of borderline malnutrition children to improve the nutritional status of those children.

The cooking demonstration involved:

1. Advance planning and notification of the village
2. Discussion re the central meeting place and time.  
Preparation of this place before the class.
3. Provision by the VHLs of utensils and food needed for the demonstration:
  - a. Maize flour, cassava flour, millet flour as samples of carbohydrate foods.
  - b. Beans (ground), peanuts, cowpeas, milk, eggs, as samples of body-building foods (or other protein equivalent available in the village e.g. fish)
  - c. Spinach, tomatoes, onions, fruit as sample of protective foods.
4. Cooking the various foods, making combinations for a balanced diet - e.g. porridge of maize flour with egg (or beans or milk, etc.), ugali with spinach, tomatoes and onions, addition of fruit to the meal etc.
5. After the demonstration, the cooked food was distributed to the mother and children to taste
6. Questions are invited and problems re availability, cooking, etc. are discussed.
7. Where necessary, translation is done in the local language.

This method of teaching was carried out in three stages:

1. Classroom - lessons on good nutrition are followed by the demonstration of the preparation of these foods by a Nutrition Teacher as it would be done in the village. Return demonstrations are then done by the Trainees as they would be doing in the village.
2. Village -
  - a. Demonstration by the Nutrition Teacher, assisted by the Trainees, to the Village Health Leaders and Mabalozzi. The Trainees and Viongozi make all the preliminary preparations.

b. After a few days, the demonstration by the Trainees to the Villages Health Leaders of a Kitongoji and the mothers of the borderline children (and any others who come) in that Kitongoji.

c. The demonstration by the Village Health Leaders to the mothers of the borderline children in their health units.

Plans were made in the monthly meeting of the Planning Committee to conduct these demonstrations in the villages, as well as do the preliminary notification. The demonstrations <sup>were</sup> done in ...~~1~~... villages in 1979, ...~~2~~... villages in 1980 and ...~~3~~... villages in 1981. Follow-up demonstrations by the Trainees were carried out in most of these villages; follow-up demonstrations have been given by the Village Health Leaders but data is not available at this time.

Initial reaction on the part of the VHLs and the mothers was very favourable and they seemed to be impressed with the need to give their children nutritious food. In Eartaig Division, there was some resistance, especially to using eggs and/or beans with porridge, as this is not a custom. Stress then had to be placed on the use of meat and increasing the amount of milk already given to the children but who nonetheless were underweight. An attempt was made in all the demonstrations to encourage the combination of abaazi (cow-pea) flour and maize flour, which combination provide a protein meal.

In order to cover the above number of villages, the cooperation of the MCH Coordinator was sought, who in turn requested the EDH Aides and MCH Nurses in the District to plan and carry out these demonstrations using transport provided by the Project. Also, Dareda Hospital Students Nurses, whose community health experience was obtained in JRG III villages worked closely with the Trainees and conducted the Nutrition Demonstration in those villages.

Informal feedback eg. comments from the Trainees, Viongozi, etc. the reduced availability of eggs for selling in the village, the reduction in the number of Borderlines needing to be followed in the villages etc. would encourage one to surmise that this approach has been successful in improving the nutritional status of many children  
Data incomplete.

in Hanang District. In a recent Nutrition Survey on Malnourished Children and Borderlines done in August/September 1981, it was shown that there was 36% improvement in the nutritional status of those children who were shown to be malnourished in the first Nutrition Survey done in their villages. While it is not the purpose of this review to prove that the cooking demonstration was an causative factor in bringing about this improvement, it is hoped that it had some influence.

The demonstration method has also been used in teaching care of the eyes, building of pit latrines, boiling water, etc.

September 1981

VILLAGE HEALTH WORKERS INVOLVED IN TEACHING ORAL  
REHYDRATION IN VILLAGE PRIMARY SCHOOLS

TARIFA	OPG	KILJI	TRAINERS INVOLVED IN TEACHING		COMPLETED SESSIONS OUT OF 8 PLANNED
			FEMALE	MALE	
Barbaig	Pilot	Endagaw	-	-	0
	II	Barjamod	-	-	0
	II	Getagmul	+	+	8
	II	Hidet	-	-	0
	II	Hirbadaw	-	-	0
	II	Masakta	-	-	0
	II	Mogita	-	-	0
	III	Endasiwold	+	+	8
	III	Wareta	+	+	8
	III	Basrodesh	-	-	0
	IV	Meashron	+	+	8
	IV	Mara	-	+	8
	IV	Gidahabieg	+	+	8
Bashnet	Pilot	Luxmunda	-	-	0
	II	Ari	-	+	8
	II	Dareda Kati	-	-	0
	II	Guse	+	+	8
	II	Madunga	+	+	8
	II	Sabillo	-	-	0
	III	Nar	-	+	8
	III	Utwari	+	+	8
	III	Seoheda	-	+	8
	III	Mandi	-	-	0
	III	Dohomu	+	+	8
	III	Sharmo	-	+	8
	IV	Managha	+	+	8
IV	Qameyu	-	+	6	
IV	Endamanang	+	+	4	
Gorowa	Pilot	Bonga	-	-	0
	I	Boay	-	-	0
	I	Endabeg	-	-	6
	I	Gedmar	+	-	4
	I	Gidas	-	-	0
	I	<del>Tobillili</del>	-	+	8
	II	Majengo	-	-	0
	I	Managhat	-	-	0
	I	Mwikantsi	-	+	3
	I	Nangara	-	-	0
	III	Ayasanda (Paraa)	+	+	8
	III	Ayasanda Ayasanda	+	+	8
	III	Tsamasi	+	+	4
	III	Gijedaboshka	+	-	8
	IV	Chemchem	-	+	5
	IV	Daghailoi	-	-	0
	IV	Halla	-	-	0
IV	Endanachen	-	+	8	
IV	Hoshan	+	+	8	
IV	Duru	+	+	5	

: 2 :

TARAFU	OPG	KIJUJI	TRAINEES INVOLVED IN TEACHING		SESSIONS COM- PLETED OUT OF 8 PLANNED
			Female	Male	
Mbugwe	Pilot	Matufa	+	+	5
	I	Magara	+	+	1
	I	Mawemairo	-	-	0
	I	Mwada	+	+	2
	I	Sangaive	+	+	8
	II	Qiohweza	+	+	8
	III	Mapea	-	-	0
	III	Moya Mayoka	+	+	8
	III	Masware	+	+	8
	IV	Vilina Vitatu	+	+	3
	IV	Sarame	-	-	0
	IV	Err	-	-	0
	IV	Kiru Ndogo	-	-	0
	IV	Kisangaaji	-	-	0

\* = Both Trainees are Male

Sessions completed not  
specified for the number of  
classes taught.

10 September, 1981

Description of Community Education for Development, Shinyanga:

In January of 1976, a program of education entitled Community Education for Development was begun in Shinyanga Diocese. This is basically a leadership training program. Its purpose is to offer educational programs and communication skills to community leaders of every kind (catechists, adult educators, village leaders), so that they may be able to participate more fully in the building and development of their own respective communities. The program is carried out by the team meeting with adult leaders for three-four days seminars in the villages or at any appropriate center. The end result of such a seminar might be to strengthen a system of on-going education in nutrition or health or to set up a small village industry... this depends on the local situation and the consciousness of the group. The primary aim of the adult educators is to start the community to action; the follow up work done is to support them in this action. Never is there either aim or effort to do the action for the community. Such a conscientization approach has been found to be very encouraging and effective as well as utterly consistent with the situation and ideals of Tanzanian self-reliance.

A particular emphasis of the program in 1979-80 has been the development of teams of Tanzanians equipped to use these adult education methods in their own communities and neighboring villages. Training programs in dialogue education have been offered at Mipa Leadership School in Shinyanga Diocese, stressing particularly the use of the psycho-social method, group leadership skills with adults, and action in awareness raising. In 1981 the CED team together with these Tanzanian teams have designed and given seminars to parish councils and small Christian communities throughout the diocese.

Evaluation of Communications Workshop to Village Health Workers:

From May 26 - 29, 1981, we on the Community Education for Development team at the request of the staff of the Mwadi wa Afya Vijiini, gave a communications workshop to the OPG III group of village health workers. Based on a questionnaire given to the participants before the seminar in which they identified their most important communication difficulties, we designed a program which addressed three overall areas which seemed to need reflection, discussion, and input: communication within self, communication with one's teammate, communication with the villagers and village leaders.

Through various exercises, role plays, and input on specific communication skills, the students were helped to look at the mis-communication that takes place in their own concrete situations, they searched together for possible underlying causes, and they grappled with ways to improve their own relationships with one another and with those in the villages with whom they live and work.

In retrospect several aspects of our time together with these young people come immediately to mind. First, it seemed extremely helpful that the group already knew each other well. They were able to diagnose their difficulties with one another and with the villagers with ease and were able to provide numerous examples on which to base observations. This familiarity with one another and with their work situations provided a concreteness which was especially beneficial in relating input being given by us to their own specific situations. In other words what could have remained fairly theoretical input became alive and real to them because it was linked to their own accumulated experience.

The fact that the participants knew and felt a certain amount of comfortableness with one another, obviously contributed too to the overall responsiveness of the group even when looking at situations of conflict. We were struck by their openness, by their willingness to look within themselves and acknowledge possible areas of trouble, by their honesty in sharing with one another and with us, and by their tremendous involvement in all aspects of the work. Partly this could be due to the educational approach itself which begins with experience and moves to new learnings. We felt it also meant that these people were really hungry and ready for input on self awareness and awareness of others, and that once aware, they were truly anxious and prepared to do something positive about improving their own situations.

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One of the biggest areas of difficulty that surfaced often during the week was the problem these village health workers have in being given recognition by village leaders, especially in having their goals and work incorporated into village plans. We feel this kind of situation is particularly hard for young fairly inexperienced people and eventually tends to erode self-confidence and contribute to a certain element of discouragement. In order to cope with this and other problems ~~in this way~~ we think it important ~~that in whatever way the~~ Madira Afya project continues, it also continue to incorporate time for the village health workers to step back from their village experiences from time to time by means of a workshop and find solidarity and support (mutual) in reflecting on and finding solutions to their common issues.

We felt enriched by our opportunity for exchange with them, and in turn we feel they gained new courage and insights to implement some of what they learned.

Sisters Peg Donovan and Anita  
Magovern, CED Shinyanga.

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GROUPS I & II TRAINEES LIST BY VILLAGE WORK ACTIVITIES

TARAFU	KIJIJI	WASHAURI	ELIMI					1980 & 1981	2-1981	Village
			ZAHAMAT 1981	ELIMU-1981	Uchekiwa 1981	mashting 1981	VHS 1981			
B A S H N E T	(Luxmanda) (Plot Village)	Petro Guro	-	-	-	-	-	0	0	
	Guse	Juliana Shauri Modestus Mafine	+	+	+	+	+	4	3	
	Madunga	Kapigoro Zakaria Bali Samit	-	-	+	-	+	2	2	
	Sabilo	Selma Uchay Petro Dragur	-	+	+	-	-	2	5	
	Akri	Balbira P. Joseph Petro Masangu	-	+	-	-	-	1	4	
	Dareda Kati	Klotida Kessy Modestus Lagzen	-	+	+	-	+	3	3	
	B A R B A I G	Endagaw (Pilot Village)	Petter Dabu Maxrek Mearuru	-	+	+	-	-	2	4
		Hidet	Fausta Mwarali Martini Dura	+	+	+	-	-	2	5
		Barjamod	Dora Doro	-	+	+	-	-	2	2
		Masakta	Theresia Yziray Zebedayo Owaang	-	+	+	-	+	3	7
Magitu		Daniel Manga	-	-	-	-	-	2	6	
Getaghuli		Rodina Gidegaida Simon Eseno	+	+	+	-	-	2	3	
Hirbadaw		Elizabeth Kalle Nico G. Ganga	-	+	-	-	+	3	1	
M B U G W E		Matufa (Pilot Village)	Idi Shaba Bernadeta Bacili	+	-	+	-	+	3	3
		Mawemairo	Manori Atterani Suzanne Mwangi	-	-	-	-	-	0	0
		Gichameda	Margari Owari Stephano Bengi	-	-	-	-	-	0	0
	Sangaiwe	Anastazia Sabri	+	-	+	-	+	3	2	
	Mwada	Leonard Felipe	+	+	+	-	+	3	3	
	Magara	Sergio Kadolo	-	-	-	-	-	0	0	
	Bonga (Pilot Village)	Elizabeth John Mohamed Bakari	-	-	+	-	-	11	4	
	Majengo	Himisi Mchiru Musca Kirinza	-	-	+	-	-	1	2	
	Nangaru	Remadhani Heilema Habaiba Sefu	-	-	-	-	-	0	0	
	G O R O W A	Mwikantsi	Fuatael Tlowari Sista Burna	-	-	+	+	-	2	2
Gedamar		Anastazia Pahn Dodo Baghatu	+	-	-	-	-	1	1	
Boay		Sulemani Atterani Magdalena Mwangi	-	-	-	-	-	0	0	
Gidas		Filimon Mjunga Sabina Fredrick	-	-	+	+	+	3	7	
Habitog		Monica Sindi Theresa Mwangi	-	-	-	-	+	1	2	
Imbilili		Juriana Bakari Eliaka Somya	-	+	+	-	+	4	4	
Managha		Jura Rungu Est. Mwa	-	-	-	-	-	0	1	

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TRAINING GROUP

III: TRAINEE AND VILLAGE RATING BY VILLAGE WORK ASSIGNMENTS

		ZIMANATI 81	Signature 1981	U. K. K. School	1980 & 1981	Trainee Score	1980
<b>BARBAIG: (TARAF)</b>							
1. Wareta	1. Ichema G. Solla	-	-	-	+	1	
	2. Sebastiano K. J. Bynitt	+	+	+	+	5	5
2. Endaswold	1. Cecilia K. David	+	+	+	+	5	
	2. Benedict B. Panga	+	+	+	+	5	10
<b>BASHNET (TARAF)</b>							
1. Har	1. Et. Dandira B. Inolen	+	-	-	-		
	2. Tsabela N. Nakoi	+	+	+	-	2	
2. Utwari	1. Safari Mhomo	+	+	+	+		
	2. Nathalia N. T. Rastira	+	-	-	-		
3. Secheda	1. Justine L. M.	+	+	-	-	2	
	2. Josephine M.	+	+	-	-	1	3
4. Mendi	1. Josephine Fava	-	-	-	-		
	2. Dionice Elsa	-	-	+	-	1	3
5. Dohoma	1. Josephine M.	+	+	+	+	5	
	2. Aboligama A. Ewiro	+	+	+	+	5	10
6. Shemo	1. Leopoldia Mwarara	-	+	+	+	4	
	2. Nicolaus E. Fuhay	-	-	-	-	0	4
<b>GOROWA: (TARAF)</b>							
1. Ayasanda (Harca)	1. Uo J. Nangay	+	-	+	-	3	
	2. Teklamary Malaki	-	-	-	+	1	4
2. Ayasanda	1. Tembea E. Goti	+	-	+	-	3	
	2. Mariamu Swalche	+	-	+	+	3	5
3. Tsamasi	1. Gabriel M. Gidalin	-	-	+	+	2	
	2. Teresa Stephen	-	-	+	-	1	3
4. Gijedaboshka	1. Adamu S. Sanko	+	+	+	+	5	
	2. Teresi S. Modu	+	-	+	+	4	9
<b>MBUCWE: (TARAF)</b>							
1. Mapea	1. Hawa K. Juma	+	+	+	+	5	
	2. Julius T. Nduta	+	+	+	+	5	10
2. Moya Mayoka	1. Albina B. A. Ani	-	-	-	+	2	2
3. Masware	1. Tausi L. A. Ngellina	-	-	-	-	0	
	2. Martini M. Lobivu	+	+	+	+	5	5

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**TRAINEE AND VILLAGE RATING BY VILLAGE WORK ACTIVITIES**

**TRAINING GROUP IV:**

		24th Nov 81	30th Nov 81	7th Dec 81	14th Dec 81	21st Dec 81	Pr. School 1980 & 1981	Trainee Score	Village Score
<b>MHIGWE:</b>									
1. Vilima Vitatu	1. Agnes Alfonso	+	-	+	-	+	+	4	
	2. Willroad Njalko	+	-	+	-	+	+	4	6
2. Sarame	1. Anina Salehe	-	-	-	-	-	-	1	
	2. Adriani J. Kabola	+	-	+	-	+	+	5	6
3. Erri	1. Agripina Mayo	-	-	-	+	-	-	1	
	2. John Lohay	+	-	+	+	-	-	3	4
4. Kiru Ndogo	1. Ashura Iddi	-	-	-	+	-	-	2	
	2. Ramadhan Salimu	+	-	-	+	-	-	3	5
5. Kisanga-ji	1. Clemensia Makina	+	-	+	-	-	-	3	
	2. Giloya Bura	-	-	+	-	-	-	2	3
<b>GOROWA</b>									
1. Chemchem	1. Martha Alawa	-	-	-	-	-	-	2	
	2. Joseph Bura	+	-	+	-	+	+	4	6
2. Daghaloi	1. Mary Martin	-	-	-	-	+	+	2	
	2. Athmani J. Wawa	-	-	-	-	+	+	2	4
3. Halla	1. Serina Tumaini	-	-	+	-	-	-	1	
	2. Tadei Simon	-	-	+	-	-	-	1	2
4. Ehdanachan	1. Teresia Mihalé	+	+	-	+	-	-	4	
	2. Musa Gadiye	+	+	+	+	+	+	5	9
5. Hoshan	1. Svalina Ama	+	+	+	+	+	+	5	
	2. Khalili Iddi	+	+	+	+	+	+	5	10
6. Dum	1. Lucy Sule	+	+	+	+	+	+	5	
	2. John Daffi	+	+	+	+	+	+	5	10
<b>BASHNET</b>									
1. Managha	1. Veneranda Dominik	-	+	-	-	-	-	2	
	2. Patrick TL Hhando	-	+	+	+	-	-	4	6
2. Gameyu	1. Tasiana L. Batlaite	+	-	+	-	+	+	4	
	2. Paskali M. Yaato	+	-	+	+	-	-	3	7
3. Ehdamanang	1. Elizabeth Sektay	+	-	+	+	+	+	5	
	2. Marseli B. Fiso	+	+	+	+	+	+	5	10
4. Basodesh	1. Mawelina Savarina	+	-	-	-	-	-	1	
	2. Liberati N. Bayo	-	-	-	-	-	-	0	1
<b>MARRAIG</b>									
1. Gidahababieg	1. Prisca Paul	-	-	+	+	+	+	4	
	2. Omasi Iddi	-	-	+	+	+	+	4	8
2. Measkron	1. Clementina E. Mwaso	-	-	+	-	+	+	3	
	2. Benedicte Gadiye	-	-	+	-	+	+	3	6
3. Mara	1. Valita Mwalimu	-	-	+	-	+	+	5	
	2. Andreas Agnaro	-	-	+	-	+	+	2	7

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**NUMBER AND PERCENTAGE OF LITERATES AND PERCENTAGE DIFFERENCES BEFORE  
HIGH-SCHOOL EDUCATION IN 35 PROJECT VILLAGES BY DIVISION AND TRAINING ROUTE**

TARIFA	TRAINING		BEFORE		AFTER		PERCENTAGE DIFFERENCE	
			NO OF LITERATES	%	LITERATES	%	INCREASE	DECREASE
BARRI	Pilot	Endagaw	478/547	.87	440/440	1.00	.12	
	II	Getaghul	226/241	.66	190/438	.48		.18
	II	Hirbadaw	225/265	.85	164/140	.74		.11
	III	Masakta	386/432	.89	363/398	.91	.02	
	III	Wareta	139/398	.32	345/454	.76	.44	
	IV	Endaswold	194/411	.47	385/414	.93	.46	
	IV	Gidabababiez	457/462	.99	203/240	.85		.14
	IV	Measakron	315/340	.93	290/327	.88	.05	
	IV	Mara	557/569	.98	416/556	.75		.23
DAHEHE	II	Arri	168/196	.86	87/135	.64		.25
	II	Guse	194/216	.90	204/207	.99	.09	
	III	Dareda Kati	98/656	.87	335/353	.95	.09	
	III	Nar	250/276	.90	248/269	.92	.02	
	III	Utware	226/259	.87	223/261	.85		.02
	III	Secheda	207/259	.80	190/252	.73		.07
	III	Mandi	38/397	.09	187/408	.46	.36	
	III	Dohomu	177/370	.48	286/345	.83	.35	
	III	Sharmo	26/165	.16	105/167	.63	.47	
	IV	Guse	194/216	.90	204/211	.97	.07	
	IV	Managha	516/632	.82	280/317	.88	.06	
	IV	Qameyu	415/464	.89	89/103	.86		.03
	IV	Endamonang	163/189	.86	163/187	.87	.01	
GORWA	III	A/Haran	121/172	.70	149/188	.91	.21	
	III	A/Ayasanda	227/326	.70	438/409	.90	.20	
	IV	Gijedaboshken	279/372	.32	228/271	.87		.05
	IV	Daghailoi	495/511	.97	461/489	.94		.03
	IV	Endannahan	312/412	.76	261/327	.80	.04	
	IV	Erri	226/259	.87	40/70	.69		.18
	IV	Hoshan	249/357	.70	230/346	.66		.04
	IV	Kiru Ndogo	228/265	.85	209/252	.83		.02
MUGV	Pilot	Matufa	500/501	.97	366/511	.72		.15
	III	Mopea	105/229	.36	111/135	.82	.49	
	III	Mosware	111/210	.53	100/182	.55	.02	
	IV	Wiliwa Vitatu	172/351	.49	126/261	.48		.01
	IV	Sarame	136/246	.55	105/123	.85	.30	

FREQUENCY OF VARIOUS VILLAGE HEALTH ACTIVITIES BY  
TARIFA REPORTED DURING VILLAGE INTERVIEWS AUG. 1981.

BARBAIG : 2 VILLAGES	VILLAGE HEALTH LEADERS	OTHERS		SCHOOL CHILDREN	TOTAL
		WOMEN	MEN		
NUMBER OF PEOPLE INTERVIEWED	5	8	7	16	36
<b>I. HEALTH EDUCATION</b>					
Village Health Leader	0	8	4	0	12
Primary School	0	2	2	0	4
Adult Education	0	8	6	0	14
Village Section	0	2	2	0	4
<b>II. NUTRITION:</b>					
Demonstration	0	5	2	0	7
Feeding	0	7	5	2	14
Planting	0	4	4	0	8
Borderlines	0	3	2	0	5
(PATA) Buying	0	6	6	0	12
<b>III. M.C.H.</b>					
Clinic	0	5	5	3	13
Attending	0	3	5	3	11
Helped	0	3	0	0	3
Others	0	1	0	0	1
<b>IV. REHYDRATION:</b>					
Knows something	5	0	0	14	19
Showed mother	0	0	0	0	0
Helped child	1	0	0	9	10
<b>V. ENVIRONMENTAL SANITATION</b>					
House to house visits	0	8	7	16	31
Window	0	1	0	1	2
Latrines	0	0	0	0	0
Good condition	0	8	7	11	26
Being Dug	0	5	7	13	25
Pits	0	3	3	2	8
<b>VI. PERSONAL HYGIENE:</b>					
Water Boiled	0	8	7	15	30
Wells cleaned up	0	0	0	0	0
Bathing	0	8	6	9	23
Washing	0	5	6	8	19
Eyes	0	3	0	1	4
Swept	0	8	7	14	29
Household utensils	0	8	7	14	29
<b>VII. MEDICINE BOX:</b>					
	0	0	0	0	0
PARTICIPATION RATING*		19%			

**Note\*** Each person interviewed was asked whether he/she personally participated in each activity reported. This rating is based on individual participation for the Division.

\* After interviews were conducted in Barbaig and Gorowa Divisions, the interview technique was changed to verifying each reported activity by asking the name of the person who was doing the activity. Hence the lower number of verified activities and participation for Bashnet and Nbugwe Divisions.

**FREQUENCY OF VARIOUS VILLAGE HEALTH ACTIVITIES BY TARAFU  
REPORTED DURING VILLAGE INTERVIEW AUGUST, 1981:**

BASHNET 2 VILLAGES	VILLAGE HEALTH LEADERS	OTHERS		SCHOOLS CHILDREN	TOTAL
		WOMEN	MEN		
NUMBER OF PEOPLE INTERVIEWED	1	7	9	20	37
<b>I. HEALTH EDUCATION:</b>					
Village health leader	0	7	9	11	27
Primary School	0	1	0	3	99
Adult Education	0	0	2	4	6
Village Section	0	1	0	0	11
<b>II. NUTRITION:</b>					
Demonstration	0	2	1	0	3
Feeding	0	6	1	1	8
Planting	-	-	-	-	-
Borderlines	0	6	4	6	10
Buying	0	1	0	0	1
<b>III. M.C.H.s:</b>					
Clinic	0	0	1	0	1
Attending	0	1	0	2	3
Helped	0	0	0	0	0
Others	0	3	5	7	15
<b>IV. REHYDRATION:</b>					
Knows something	1	-	-	20	21
Showed mother	1	-	-	18	19
Helped child	1	-	-	7	8
<b>V. ENVIRONMENTAL: SANITATION:</b>					
House to house visits	0	5	9	7	21
Window	0	0	0	0	0
Latrines	0	0	0	0	0
Good condition	0	1	1	0	2
Being dug	0	1	1	6	8
<b>VI. PERSONAL HYGIENE:</b>					
Water boiled	0	5	3	1	9
Walls cleaned up	0	1	0	0	2
Bathing	0	0	0	0	0
Washing	0	1	0	0	1
Eyes	0	0	0	0	0
Swept	0	1	1	4	6
House held utensils	0	4	4	5	13
<b>VII. MEDICINE BOX:</b>					
	0	1	2	0	3
PARTICIPATION RATING*					5%

\* (Refer footnote on BARB sheet).

3

FREQUENCY OF VARIOUS VILLAGE HEALTH ACTIVITIES BY TARARA REPORTED DURING VILLAGE INTERVIEWS AUGUST, 1981:

GOROWA 2 VILLAGES	VILLAGE HEALTH LEADERS	OTHERS		SCHOOL CHILDREN	TOTAL
		WOMEN	MEN		
<u>NUMBER OF PEOPLE INTERVIEWED</u>	6	8	6	18	33
<u>I. HEALTH EDUCATION:</u>					
Village Health Leaders	0	8	6	0	14
Primary School	0	4	1	0	5
Adult Education	0	1	5	0	6
Village section	0	0	0	0	0
<u>II. NUTRITION:</u>					
Demonstration	0	8	6	4	18
Feeding	0	1	2	0	3
Planting	0	0	0	0	0
Borderlines	0	4	0	0	4
Buying	0	0	0	0	0
<u>III. M.C.H.:</u>					
Clinic	0	1	1	0	2
Attending	0	0	0	0	0
Helped	0	0	0	0	0
Others	0	0	0	0	0
<u>IV. REHYDRATION:</u>					
Knows something	6	-	-	18	24
Showed mother	1	-	-	11	12
Helped Child	2	-	-	6	8
<u>V. ENVIRONMENTAL SANITATION:</u>					
House to house visits	0	8	5	0	13
Window	-	-	-	0	0
Latrines	-	-	-	0	0
Good condition	0	0	1	0	1
Being dug	0	0	1	0	1
Pits	0	1	0	0	1
<u>VI. PERSONAL HYGIENE:</u>					
Water boiled	0	2	0	0	2
Wells	0	1	0	0	1
Bathing	0	2	1	0	3
Washing	0	2	0	0	2
Eyes	0	1	0	0	1
Swept	0	3	1	0	4
House holds Utensils	0	2	0	0	2
<u>VII. MEDICINE BOX:</u>					
	-	-	-	-	0
<u>PARTICIPATION RATING*</u>					14%

Note: \* (Refer footnote on BARHAIC sheet.)

FREQUENCY OF VARIOUS VILLAGE HEALTH ACTIVITIES BY TARAFI  
REPORTED DURING VILLAGE INTERVIEWS AUGUST, 1981:

MEUGWE 2 VILLAGES	VILLAGE HEALTH LEADERS	OTHERS		SCHOOLS CHILDREN	TOTAL
		WOMEN	MEN		
NUMBER OF PEOPLE INTERVIEWED	2	8	6	17	33
<b>I. HEALTH EDUCATION:</b>					
Village Health Leaders	0	8	6	0	14
Primary School	0	2	3	0	5
Adult Education	0	3	2	0	6
Village section	0	5	4	0	9
<b>II. NUTRITION:</b>					
Demonstration	0	8	6	12	26
Feeding	0	6	1	3	10
Planting	0	4	0	1	5
Borderlines	0	6	3	2	11
Buying	0	5	0	1	6
<b>III. M. C. H:</b>					
Clinic	0	5	0	0	5
Attending	0	5	0	0	5
Helped	0	2	0	0	2
Others	0	0	0	0	0
<b>IV. REHYDRATION:</b>					
Knows something	2	1	1	17	19
Showed mother	0	1	1	4	4
Helped child	1	1	1	8	9
<b>V. ENVIRONMENT SANITATION:</b>					
house to house visits	0	5	6	0	11
windows	0	5	4	0	9
Latrines	0	5	3	0	8
Good condition	0	4	2	0	6
Being dug	0	6	4	0	10
Pits	0	7	4	0	11
<b>VI. PERSONAL HYGIENE:</b>					
Water boiled	0	7	6	5	18
Wells cleaned up	0	3	3	0	6
Bathing	0	1	0	0	1
Washing	0	1	0	1	2
Eyes	0	1	1	0	2
Swept	0	6	6	0	12
House hold Utensils	0	7	4	0	11
<b>VII. MEDICINE BOX:</b>					
	-	-	-	-	0
PARTICIPATION RATING*					6%

Note \* ( Refer foot note on Ba rbaig shaol )

HANAN'G VILLAGE HEALTH PROJECT

FIRST AID BOXES PROGRAMME IN HANAN'G DISTRICT

Sometime in 1974/75 before the introduction of the Hanan'g Village Health Project in this district, the Government had introduced First Aid Boxes in the villages. It was the responsibility of the Government (Ministry of Health) in the District to build first aid boxes for some few selected villages. The village then selected a young person (male/female) from the village who was to be trained at the nearby dispensary or health centre for about three months. He/she was to be a volunteer. After this training he/she was to go back to the village to give first aid treatment. Medicines were to be collected from Babati Health Centre.

Six boxes were made and distributed to Matufa, Boay, Kiru, Gichamedu, Gidahababieg and Gehandu. However only Matufa and Boay offered treatment (Boay only for a short time). Matufa continued with services even after the introduction of the Village Health Project. Initially, the emphasis in the Hanan'g Village Health Project was on preventive services rather than curative services. Later, it appeared that villagers were not very enthusiastic about receiving health education only. It was then decided that treatment for minor illnesses should be offered in the villages.

One of the MDH recommendations coming from the 1979 evaluation was that when the Project is introduced into new villages, stress will be placed on the provision of an extension curative service (medicine box) rather than on opening an MDH Clinic in the village.

Therefore, in late 1979, after the first evaluation it was stressed that curative services would be offered in villages which had a village Health Worker who had passed his/her examination in dispensing medicine. The village was required to build a medicine box and provide a room where the medicine box could be safely kept and in which the VHW could work. At present there are 18 villages which have medicine boxes.

- |           |               |                 |
|-----------|---------------|-----------------|
| 1. Nar    | 7. Masakta    | 13. Endabeg     |
| 2. Guse   | 8. Endogaw    | 14. Mivnda      |
| 3. Dareda | 9. Endasiwold | 15. Masware     |
| 4. Dohomu | 10. Getaghul  | 16. Moya Mayokn |
| 5. Arri   | 11. Barjanot  | 17. Matufa      |
| 6. Sharmo | 12. Imbilili  | 18. Gichamedu   |

The following villages have medicine boxes but for various reasons do not have curative services e.g. no room to put the box, no qualified VHW who could give treatment etc. These Villages are:

- |                    |                |
|--------------------|----------------|
| 1. Sabilo          | 8. Measiron    |
| 2. Warata          | 9. Hidet       |
| 3. Bonga - Kandakn | 10. Easkaroda  |
| 4. Gijedaboshkn    | 11. Gidababieg |
| 5. Managha         | 12. Lwizantsi  |
| 6. Luxmanda        | 13. Bory       |
| 7. Endamangh       | 14. Lawenciro  |

20/9/1981

50

HANANG VILLAGE HEALTH PROJECT  
MCH EVALUATION REPORT

29-1

MCH CLINIC

MCH Mobile clinics have continued on a monthly basis in twelve villages. These are:

VILLAGE	PARTICIPATING STAFF	CHILDREN AVERAGE ATTENDANCE (1980)	TRAINER PARTICIPATION
Luxmanda	Dareda Hospital	137	Fair (1)
Endagaw	Endasak Dispensary	203	Very good (2)
Matufa	Magugu Health Centre	61	Fair (2)
Sabilo	Dareda Hospital	221	Good (1)
Arri	Dareda Hosnital	219	Good (1)
Masakta	Dareda Hospital	305	Excellent (1)
Mwikantsi	Babati Health Centre	158	Good (1)
Endabeg	Babati Health Centre	170	Excellent (1)
Boay	Babati Health Centre	162	Good (2)
Barjamod	Katesh Health Centre	105	Fair/Good (1)
Dohomu	Babati Health Centre	201	Very Good (2)
Dareda Kati	Dareda Hospital	303*	Good (2)

Four of the above clinics have been started since the 1979 evaluation: Boay (1979), Barjamod (1979), Dohomu (1980), Dareda Kati (1980). In order to begin the clinic at Dareda Kati, an arrangement was made with Dareda Hospital whereby the Staff of Katesh Health Centre would service the Nangwa Mobile Clinic with the petrol provided by the Project and the Dareda Staff would then service the Dareda Kati Clinic. This has proved a workable arrangement.

In Hanang District there are 13 Govt. Clinics, 7 Vol. Agency Clinics and 18 Mobile Clinics; of these 18 mobile clinics, twelve are conducted in Project Villages.

The table above shows the average attendance of children at these clinics during 1980. In regard to the contribution of these clinics to the total MCH Clinic work in Hanang District, the following pertains:

- a. Service: Hanang Village Health Project provides
  - 36 % of Clinic Services in Hanang District; 12 % of total attendance of pregnant mothers; 24 % of total attendance of children under five years.
- b. Immunization. Of the total number of immunizations given in Hanang District, MCH clinics, those given in the Mradi MCH mobile clinics accounted for the following percentages: BCG - 20%; DPT 25%; Polio 25%; Measles 25%. Tetanus Toxoid 22%.
- c. Health Education: In each clinic each month, a health talk is given to the mothers on various health problems (with special reference to current health problems in the village).

\* Clinic opened in October 1980. Average based on 3 months attendance. .../2...

- d. Medicine to prevent malaria and to improve the health of the pregnant mothers in distributed during each clinic; medicine is also provided for the treatment of minor illnesses.
- e. When milk is available from the Babati Health Centre /Dareda it is distributed to underweight children in the clinics.

MCH CLINIC REQUEST OUTSTANDING:

- 1. Mawemairo - The difficulty continues regarding the place of the clinic i.e. at the border of Matufa and Mawemairo thus servicing mothers from both villages. At present, the attendance at Matufa Clinic is poor and the mothers from Mawemairo are not attending the Matufa clinic in any appreciable number. Also, neither Village Health Worker in Mawemairo is active.
- 2. Hidet - Neither VH7 is active. No further interest shown on the part of the village.
- 3. Hilbadaw - No word has been received from Iambi Hospital re their starting a mobile clinic in Hilbadaw. Whether this is due to lack of interest on the part of the village is not known. Neither VH7 is active.
- 4. Mandi - This village is not far from Sabilo, which has a mobile clinic.
- 5. Dareda Managha - This village is not far from Arri and Dareda Kati which both have clinics.

CONSTRAINTS RE OPENING NEW MCH MOBILE CLINICS

Since the 1979 evaluation, in which the constraints re opening of new MCH Mobile Clinic were considered, it was recommended that when the Project is introduced in new villages, stress will be placed on the provision of and extension curative service (medicine box) rather than on an MCH Clinic in the village. Therefore, no further requests have been received. Neither have they been encouraged because of the following continuing constraints:

1. Inadequate staff to service the clinics. Originally, it was hoped that the Staffs from the nearest dispensary/MCH Aide Station would service the clinics. However, when this arrangement was made, shortage of staff at these stations (due to illness, maternity leave, transfers, attendance at courses, etc.) proved to be a problem. One clinic had been designated the responsibility of a health centre, - two others had been designated the responsibility of dispensaries/MCH Aide Stations but because of shortage of staff and constant difficulties servicing these clinics, the responsibility had to be assumed by the Staff of the Babati Health Centre.
2. Confirmation that the Government policy would not allow for the continuation of mobile clinics, once the Project funding was over. This fact had a great influence on the decision not to start new clinics in Project villages. It was felt by the former Director and the staff that it was not right to raise the expectations of the people in the village re having a mobile clinic and then have the clinic dropped after a short time when the funding was over. Even in the 1979 evaluation, it was evident that the original goal of opening MCH Clinics in 32 villages was unrealistic. However, it was hoped that at least 20 clinics would be started. In light of the above, this too has been unrealistic.
3. Increasing cost and shortage of Petrol. This has curtailed many Project activities, and has had an influence on considering the opening of any new MCH clinics.
4. Poor participation on the part of Village Health Leaders in the work of the MCH clinic. Verbal agreements were made with the village before clinic was started that the VHLs would take some responsibility but this has not proven to be the case. (This situation is described in more detail in the report on Village Health Leader participation in Project activities.)

11. MCH TRAINING PROGRAMME:

The MCH component of the Training Program is integrated throughout all four classroom sessions. It aims at helping the Trainee to have a greater awareness of the health status of the mothers and children in their villages; to recognize health problems of children and help solve them or refer the child to the nearest health facility when necessary;

..... /.....

to recognize and help prevent health problems in pregnancy; to recognize those children and pregnant mothers who are "at risk" and to refer them to the nearest health facility; (in the case of the female trainee) to help a pregnant mother, in an emergency, to give birth safely or, if necessary, take them to the nearest health facility immediately.

Attachment 1 gives a detailed description of the MCH Training Programme.

As per the recommendation of the 1979 evaluation, the MCH Theory and Clinical Experience were increased in order to prepare the trainee to take a greater leadership role in MCH activities in the village.

Clinical experience, including MCH, was begun earlier in the training programme in order to help the trainee to become more self-confident in practical work - e.g. participating in the MCH Clinics - weighing children, filling out Child Health cards, giving immunisations giving health education, examining ante-natal patients dressing wounds, giving out medicine, etc. The MCH Clinical Experience for female trainees was increased from three to six weeks - three weeks in a Health Centre and three weeks at Dareda Hospital. We are grateful to the Staffs of these facilities for helping to train these Village Health Workers.

However, even with the increased time, it has not been possible for all female trainees to directly assist a mother giving birth, although all had many opportunities to observe complications of labour.

As regards follow up in the villages, no attempt is made to set up these trainees as village midwives following only six weeks experience. However it is hoped that the VHW will be called upon if there is a problem or an emergency - in fact, this has happened in a few villages. Also, it is hoped that the Village Health Worker will be able to work with the Traditional Birth Attendant and to help her become more aware of the need for cleanliness, the dangers of some birth practices, the need to send mothers with complications to the hospital for delivery, etc. An inherent difficulty here is that the VHW is much younger than the TBA and has less experience so her assistance might not be welcome. This collaboration with the TBA is an area which needs much more research and in the event of continued funding, should be explored.

ATTACHMENT 1.

MCH TRAINING PROGRAMME

The MCH component of the Training Programme consists of the following:

A. 1st Session:

- a. Introduction to Maternal and Child Health; responsibilities of the trainees in regard to maternal and child health in the village; importance of proper nutrition.
- b. Introduction to MCH Clinics - importance, purpose services provided, Road to Health card; responsibilities of the trainees and VHLs in the work of the clinic; setting up a mobile clinic in the village.

B. 2nd Session:

- a. Principles and Practice of Health Teaching in MCH Clinis
  - (i) Methods of Health Teaching
  - (ii) Individual preparation and practice in class giving a health talk - self - evaluation, evaluation, by teacher and classmates.
  - (iii) Clinical Experience in MCH Clinic at Babati Health Centre - observation and practice giving health talk.
- b. Nutrition - importance of proper diet; signs and symptoms of malnutrition, Kwashiorkor, Marasmus.
  - (i) Demonstration of preparation of nutritious food.

C. 3rd Session:

- a. Immunizations - Principles and Practice.
  - (i) Meaning of vaccines; preparation needed; types of vaccines; preparation needed; cold chain.
  - (ii) Types of syringes used; measuring amounts.
  - (iii) Principles of Sterility; Sterile Technique Practice.
  - (v) Practice in giving injections using a sponge; practical examination
  - (vi) Clinical Experience at Babati Health Centre

## D. 4th Session

- a. Pregnancy, Childbirth, Mother and Child Care (Midwifery)
  - (i) Anatomy & Physiology of Reproductive Systems (Male -Female)
  - (ii) Signs & Symptoms of Pregnancy
  - (iii) ANTENATAL Records; Antenatal Care; Diet During Pregnancy
  - (iv) Palpating the Fundus; Foetal Heart; Normal/Abnormal Pres.
  - (v) Complications of Pregnancy; need for referral.
  - (vi) Signs and Symptoms of Abortion Treatment; First Aid.
  - (vii) Childbirth; Normal Delivery; Assisting in an emergency
  - (viii) Care of newborn child; care of mother after childbirth
  - (ix) Complications in Childbirth; Postpartum Hemorrhage - signs, symptoms, emergency care, need for referral
  - (x) Tribal customs, good and bad, surrounding childbirth
  - (xi) Child Care (xii) Family Planning
  - (xiii) Diseases of the Female Reproductive System.

b. Clinical Experience at Babati Health Centre

c. Final MCH Examination

## E. CLINICAL EXPERIENCE IN MIDWIFERY (FEMALE TRAINEES ONLY) - 6 weeks

a. Experience in MCH Clinic, Labour Ward, Delivery Room, Maternity Ward, Nursery at a Health Centre (3 weeks) and Dareda Hospital (3 weeks).

b. Review session following Clinical Experience.

September, 1981

HANANIG VILLAGE HEALTH PROJECT

VHL PARTICIPATION IN MCH ACTIVITIES

An important assumption and expectation of the Project from the beginning was that the VHLs would play an important role in recognizing health problems in the Village, reporting them, helping the mothers in their health units to prevent and solve these problems. This, of course included their being aware of the need to bring their children to MCH Clinic. In those villages where MCH Clinics were started, the village was responsible for providing a place to conduct the clinic and the required equipment. In addition to this, it was understood that the VHLs would participate in the work of the clinic, along with the Trainees - prepare the place, bring the tables, chairs, water, etc.) as well as help to weigh the mothers and children, keeping order in the lines, etc.

While this cooperation and participation was excellent during the preliminary meetings and during the first few clinics, it declined as the clinics continued in many places. The attached table shows the participation of the VHLs in MCH Clinics held since June, 1979. Unfortunately, some of the clinic reports do not have any record of VHL participation so this is marked N/R on the Chart, in contrast to '0' where it was definitely known that the VHLs were not present. In some clinics where the VHLs themselves may not have attended but members of the Health Community or other responsible villagers did participate, their number is noted.

In one clinic (Luzmanda), no VHLs from that village participate in the work of the clinic. However, an interested VHL from a nearby village (Secheda) attends and works in the clinic every month. In other villages, the VHLs may not attend the clinic but they do help to clean the clinic building beforehand. In these cases, it is necessary to request the help of other interested persons to bring the equipment needed. In two villages, gracious African hospitality is seen as important participation and VHLs are involved in preparing a meal for the staff following the work of the clinic.

A verbal agreement was made before the opening of the clinic that the VHLs would take their turns, Kitongoji by Kitongoji, preparing the clinic site and helping in the work of the clinic. However, this arrangement fell by the wayside in most villages and in those villages where there is VHL participation, the same VHLs show up for every clinic.

While it would be difficult to draw any valid conclusion from the data available, it would appear that the participation of VHLs in MCH Clinics is not as great as had been expected.

21/9/1981

VHL PARTICIPATION IN KCH CLINICS

	NO. VHL	1979						1980												1981								
		JUN.	JUL.	AUG.	SEP.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY.	JUN.	JULY.	AUG.	SEPT.	OCT.	NOV.	DEC.	JAN.	FEB.	MAR.	APR.	MAY.	JUN.	JUL.	AUG.
DOHOMU	30									9	2	2	3	0	5	2	1	3	6	1	2	2	1	ab 2	ab 3	ab 3	ab 3	
ENDAGAN	20	3	6	3	1	4	3	5	2	4	2	2	3	2	N/R	0	2	4	4	2	4	4	2	N/R	5	2	2	1
MATUFA	22	0	2	N/R	N/R	N/R	3	N/R	N/R	3	NO CLN	NO CLN	3	NO CLN	5	4	0	4	NO CLN	NO CLN	N/R	1	N/R	2	6	8	4	2
LUXHANDA	9	N/R	0	0	N/R	N/R	N/R	0	N/R	N/R	2*	1*	1*	1*	2*	1*	2*	1*	0*	1*	N/R	0	1*	N/R	1*	0	1*	N/R
SABILO	15	0	0	1	1	1	1	8	1	1	1	1 <sup>a</sup>	1	1	1	1	1	N/R	1	2	1	1	N/R	1	1	1	1	N/R
ARE I	9	0	N/R	N/R	N/R	N/R	N/R	1	0	1	3	0	0	0	N/R	N/R	1 <sup>a</sup>	0	0	NO CLN	N/R	1	0	NO CLN	N/R	0	N/R	N/R
KASAKTA	18	0	0	0	3	N/R	N/R	2	0	2 <sup>a</sup>	3 <sup>a</sup>	2	4	3	1 <sup>a</sup>	1	1	0	2	N/R	1	1	4	2	2	2	2	4
MJKANTSI	10	6 <sup>a</sup>	4	2 <sup>a</sup>	2	4	1	3	3 <sup>b</sup>	1	3 <sup>a</sup>	N/R	N/R	1	3 <sup>b</sup>	2	3 <sup>b</sup>	2	3	1	0	0	0	3 <sup>b</sup>	N/R	1	2	3
ENIABE	19	3 <sup>b</sup>	2 <sup>b</sup>	4 <sup>b</sup>	4 <sup>b</sup>	4 <sup>b</sup>	6 <sup>b</sup>	6 <sup>b</sup>	2 <sup>b</sup>	6 <sup>b</sup>	4 <sup>b</sup>	4 <sup>b</sup>	4 <sup>b</sup>	11 <sup>b</sup>	8 <sup>b</sup>	8 <sup>b</sup>	11 <sup>b</sup>	8	6	1	N/R	0	NO CLN	N/R	N/R	0	5 <sup>b</sup>	3 <sup>b</sup>
POAY	11	3	1	1	3 <sup>b</sup>	2	0	2	4	3	2	4	2	1	3	2	N/R	3	N/R	3	1	2	2	3	2	1	2	2
BARJAHOD	9							6	3	4	3	3	N/R	3	3	2	3	N/R	0	N/R	N/R	2	0	2	1	0	3	N/R
MAREDA KATI	34																	7	N/R	N/R	N/R	N/R	N/R	N/R	N/R	N/R	4	N/R

\* From Sacheda Village

a. Including member of Health Committee

b. Includes those who cooked the meal

N/R = Not Reported

21/9/1981

31-7

HANANG VILLAGE HEALTH PROJECT

RE: ND. CHRISTINA GARA - VHL: HER INVOLVEMENT  
AS VILLAGE HEALTH WORKER - SAHEDA

When Saohoda Village was accepted in the Project early in 1979, Christina Gara was one of six (two female & four male) aspirants for Village Health Work. Christina Gara got 45 marks in her Composition and 29 in Mill Hill, Yustina Lohay got 70 and 31 marks respectively; consequently Yustina was selected as a Trainee for OPG III.

On completion of her fourth assessment, as usual Yustina went back to her Village to work there as a Village Health Worker. During her work (e.g. practicals at the nearby dispensary - Satchet) she had no support or encouragement from the Village leaders or her parents at home.

In fact she alleged that her parents said there was no need of even buying her clothes because she did not help in family work; instead she spent more time in Village work. On the other hand the Village (said the Chairman) could not pay her anything before it was able to assess her work. Yustina therefore was disillusioned and decided to look for opportunity somewhere else; so she went to Basodah where her brother works as a teacher and she was enrolled as a school girl.

In the meantime, Christina had been an active Village health leader and it seems that since she had lost her first chance to become a VHW she felt now the time was ripe for her to show her interest and ability. So she started (presumably after encouragement from Joseph the male VHW, to go for practical work at Saohoda Dispensary and went to assist at Luxmanda MCH Clinic the nearby Village. The Village gives her travel and food money for VHWs monthly meetings at Basmet but no other support - her counterpart gets no other help either.

Christina Gara was to be accepted for the OPG V last classroom session (for future MCH practicals) provided the village would pay for her food while she was here. However the Village was not enthusiastic and did nothing about this although DHL Basmet had discussed the matter with both the Chairman and Secretary - and, they had agreed to pay for her when she was in Babati for training.

There was time, sometime in May, 1981 when Christina said that her father was then complaining of her involvement in Village voluntary work without any hope for further training or employment. He threatened to stop her from doing any additional work. In fact he wrote a letter, dated 15/6/1981 to DHL Basmet seeking clarification about the future of his daughter. The DHL in course of his duty met Mzee Gara and explained to him that the Project could not at this time do anything for Christina as far as training is concerned. However Mzee Gara was congratulated for being lucky enough to have such a daughter who is ready to help others voluntarily and was encouraged to let Christina continue with any voluntary work she is doing at present.

...../2.....

Lastly it was pointed out clearly her training was the responsibility of Sacheda Village with whom Mzee Gara was advised to co-operate. This verbal explanation was followed by a letter Ref. No. MAVH/KAT/BASHNET/53 dated 30/7/1981, copied to the Project Director, Divisional Party Secretary - Bashnet. Ward Secretary, Ufana and Village Secretary, Sacheda. Christina is still attending practicals at Sacheda Dispensary, helping at Luxmanda Clinic and attending VEW Monthly Meetings at Bashnet.

As pointed out above the Project at the present time could not do anything for Christina except keep her in mind for future training under whatever new arrangement will be effective after 30/11/81. At the same time, however, the Village can encourage her to do practical work at Sacheda Dispensary or Nafco or Dareda Hospital if possible.

13/8/1981.

HAMANIG VILLAGE HEALTH PROJECT

FORMER BORDERLINES REPEAT EXAMINATION AUG. 1981

	NORMAL		BORDERLINES		TOTAL	THE INTER- VAL IN MONTHS SINCE LAST EXAMINATION
	NO	%	NO	%	NO	
VILIMA VITATU	4	(36)	7	(64)	11	13
MAPEA	47	(7)	19	(29)	66	25
S.ERAME	14	(78)	4	(22)	18	13
ENDANACHAN	16	(64)	9	(36)	25	15
A/HARRA	38	(64)	21	(36)	59	25
MANDI	41	(37)	71	(63)	112	25
SILRHO	55	(58)	40	(42)	95	25
MANAGHA	75	(30)	171	(70)	246	13
ENDAS	23	(14)	139	(86)	162	25
MEASKRON	25	(17)	123	(83)	148	13
TOTAL	338	(36)	604	(64)	942	

22.9.81

BORDERLINE FOLLOW-UP AUGUST, 1981

TARAPA	KIJIJI	BORDERLINE DIAGNOSE 1979-1980	BORDERLINE ATTENDED AUGUST, 1981		DID NOT ATTEND						TOTAL NON-ATTENDERS	
					REASON UNKNOWN		MOVED AWAY		DIED			
					NUMBER	%	NUMBER	%	NUMBER	%		
BARBAIG	ENDASIWOLD	204	162	(79)	26	(13)	16	(8)	1	(.05)	43	(21)
	HEASKRON	174	148	(86)	25	(14)	-	-	1	(.05)	26	(15)
BASHNET	MUNAGHA	337	246	(73)	89	(26)	1	(.02)	1	(.02)	92	(27)
	MUNDI	168	112	(67)	56	(33)	-	-	-	-	56	(33)
	SILRMO	106	95	(90)	6	(6)	5	(5)	-	-	11	(10)
GOROLA	A/HARLA	102	59	(58)	43	(42)	-	-	-	-	43	(42)
	ENDAMACHAN	36	25	(69)	4	(11)	7	(19)	-	-	11	(31)
MBUGGE	ILPEA	106	66	(62)	17	(16)	21	(20)	-	-	40	(38)
	SARAME	30	18	(60)	6	(20)	6	(20)	-	-	12	(40)
	VILLEN MITATU	16	11	(69)	4	(25)	1	(6)	-	-	5	(31)
TOTAL		1,279	942	(74)	276	(22)	57	(4)	5	(4)	339	(26)

FREQUENCY OF ANEMIC BORDERLINE CLASSES; FOR REPEAT BORDERLINES EXAMINED AUGUST/SEPTEMBER, 1981\*

TARAFU	KIJIJI	DATE OF FIRST NUTRITION SURVEY	AUG. 1981										
			B B	B Y	B R	Y B	Y Y	Y R	R B	R Y	R R	Q	TOTAL
BARBAIG	ENDASIWOLD	JULY, 1979	14	3	0	3	0	0	2	1	0	0	23
	MBASKROH	JULY, 1979	17	0	0	3	2	0	1	0	0	0	25
TOTAL			31	3	0	6	2	0	3	1	0	2	48
BASHNET	MANDI	JULY, 1979	33	2	0	2	0	0	0	0	0	4	41
	SHARMO	JULY, 1979	53	0	0	0	1	0	1	0	0	0	55
	MBAGHA	JULY, 1979	55	0	0	7	5	0	3	0	0	5	75
TOTAL			141	2	0	9	6	0	4	0	0	9	171
GOROMA	MBDAMACHEN	JULY, 1980	12	0	0	3	1	0	0	0	0	0	16
	MBARUA	JULY, 1979	30	0	0	5	0	0	0	1	0	2	38
TOTAL			42	0	0	8	1	0	0	1	0	2	54
MBUGWE	VILINA VITATO	JUNE, 1980	2	0	0	0	1	0	0	0	0	1	4
	SARILE	JUNE, 1980	10	1	0	1	0	0	1	0	0	1	14
	MARWA	JULY, 1979	34	1	6	0	1	1	2	0	0	2	47
TOTAL			46	2	6	1	2	1	3	0	0	4	65
GRAND TOTAL			260	7	6	24	11	1	10	2	0	17	338

NOTE \*= Borderline 1979/80 matched with Normals August/September, 1981

BB= Blue remaining Blue  
 BY= Blue Changing to Yellow  
 BR= Blue Changing to Red  
 YB= Yellow Changing to Blue

YY= Yellow remaining Yellow  
 YR= Yellow changing to Red  
 RB= Red changing to Blue  
 RY= Red changing to Yellow  
 RR= Red remaining Red

FREQUENCY OF ARM CIRCUMFERENCE CHANGES FOR REPEAT BORDERLINES EXAMINED AUGUST/SEPTEMBER, 1981\*

TARAPA	KIJIJI	DATE OF FIRST NUTRITION SURVEY	AUG. 1981		AUG. 1981		AUG. 1981		AUG. 1981		AUG. 1981		AUG. 1981	
			B B	B Y	B R	Y B	Y Y	Y R	R B	R Y	R R	Q	TOTAL	
BARBAIG	END/SIWOLO	JULY, 1979	90	14	4	10	11	0	3	1	3	1		
	NEASKRON	JULY, 1980	54	3	0	31	16	1	5	6	1	0		137
TOTAL			114	17	4	41	27	1	8	7	4	1		117
BASHNET	HANDI	JULY, 1979	52	5	2	4	5	0	0	0	0	3		71
	SHARNO	JULY, 1979	19	3	1	2	3	1	2	0	2	7		40
	MENAGHA	JULY, 1980	91	18	0	5	34	6	1	6	5	5		175
TOTAL			162	26	3	11	42	7	3	6	7	15		282
GOROMI	END/MOCHI	JULY, 1980	1	2	3	1	1	1	0	0	0	0		9
	A/IL R...	JULY, 1979	17	0	0	1	0	0	1	2	0	0		21
TOTAL			18	2	3	2	1	1	1	2	0	0		30
MBUGWE	VILINA VIEMBU	JUNE, 1980	2	1	0	1	2	0	1	0	0	0		7
	S/R...	JUNE, 1980	2	0	1	0	0	0	0	0	0	1		4
	MAREA	JULY, 1979	7	3	1	3	2	2	0	1	0	0		19
TOTAL			11	4	2	4	4	2	1	1	0	1		30
GRAND TOTAL			335	49	12	58	74	11	13	16	11	17		596

NOTE \* Borderline Diagnosed 1980 matched with repeat Borderlines Examined Aug /Sept., 1981  
 EB= Blue remaining Blue  
 BY= Blue changing to Yellow  
 BR= Blue changing to Red  
 YB= Yellow changing Blue

YY= Yellow remaining Yellow  
 YR= Yellow changing to Red  
 RB= Red changing to Blue  
 RY= Red changing to Yellow  
 RR= Red remaining Red

## HANANIG VILLAGE HEALTH PROJECT

## BORDERLINE FOLLOW-UP RESULTS

## DARDIG

AGE	ENDASTWOLD						MEASKRON						
	BORDERLINES DIAGNOSED JULY, 1980		JULY, 1980 BORDERLINES EXAMINED AUGUST, 1981		BORDERLINES DIAGNOSE AUGUST, 1981		AGE	BORDERLINES DIAGNOSED JULY, 1980		JULY, 1980 BORDERLINES EXAMINED AUGUST, 1981		BORDERLINES DIAGNOSED AUGUST, 1981	
	NO.	%	NO.	%	NO.	%		NO.	%	NO.	%	NO.	%
0	18	.09	-	-			0	5	.03	-	-	-	
1	27	.13	-	-			1	19	.11	1	.01	-	
2	15	.07	12	.08	8	.06	2	16	.09	11	.08	8	.07
3	15	.07	15	.09	12	.09	3	14	.08	16	.11	14	.11
4	16	.08	14	.09	9	.07	4	15	.09	17	.12	11	.09
5	24	.12	21	.13	18	.13	5	25	.14	14	.10	10	.08
6	24	.12	18	.11	17	.12	6	28	.16	24	.17	23	.19
7	22	.11	15	.09	10	.07	7	15	.09	19	.13	17	.14
8	16	.08	13	.08	13	.09	8	17	.10	20	.14	15	.12
9	13	.06	18	.11	18	.13	9	10	.06	5	.03	4	.03
10	10	.05	8	.05	8	.06	10	8	.05	8	.05	8	.07
11			8	.05	6	.04	11			8	.05	8	.07
12			15	.09	15	.11	12			1	.01	1	.01
13			3	.02	3	.02	13			-		-	
Q	5	.02	-	-	-		Q	3	.02	-		4	.03
TOTAL	205	1.00	160	.99	137	.99	TOTAL	175	1.02	144	1.00	123	1.01

September, 1981.

HAWAII VILLAGE HEALTH PROJECT

BORDERLINE FOLLOW-UP RESULTS

BASHNET

MANAGHA						MANDI							
AGE	BORDERLINES DIAGNOSED JULY, 1980		JULY, 1980 BORDERLINES EXAMINED AUGUST, 1981		BORDERLINES DIAGNOSED AUGUST, 1981		AGE	BORDERLINES DIAGNOSED JULY, 1980		JULY, 1980 BORDERLINES EXAMINED AUGUST, 1981		BORDERLINES DIAGNOSED AUGUST, 1981	
	NO.	%	NO.	%	NO.	%		NO.	%	NO.	%	NO.	%
0	26	.08	-				0	8	.05	-			
1	42	.12	18	.07	10	.06	1	11	.07	-			
2	25	.07	33	.13	25	.15	2	14	.08	3	.03	2	.03
3	37	.11	26	.11	17	.10	3	18	.11	9	.08	5	.07
4	40	.12	25	.10	19	.11	4	15	.09	5	.04	2	.03
5	26	.08	24	.10	19	.11	5	12	.07	19	.17	11	.15
6	42	.12	30	.12	21	.12	6	17	.10	13	.12	8	.11
7	29	.09	30	.12	22	.13	7	17	.10	8	.07	6	.08
8	36	.11	27	.11	18	.11	8	25	.15	14	.12	9	.13
9	14	.04	12	.05	6	.04	9	18	.11	12	.11	6	.08
10	15	.04	9	.04	5	.03	10	10	.06	13	.12	6	.08
11			4	.02	2	.01	11			7	.06	7	.10
12			7	.03	7	.04	12			5	.04	5	.07
13			-		-		13			2	.02	2	.03
Q	5	.01	1	.004	-		Q	3	.02	2	.02	2	.03
TOTAL	337	.99	246	1.00	171	1.01	TOTAL	168	1.01	112	1.00	71	.99

SHARLO						
AGE	NO.	%	NO.	%	NO.	%
0	6	.05	-			
1	4	.04	-			
2	5	.04	7	.07	3	.08
3	16	.14	6	.06	5	.15
4	5	.04	8	.08	1	.03
5	9	.08	8	.08	1	.03
6	12	.11	6	.06	1	.03
7	19	.17	14	.15	10	.25
8	20	.18	7	.07	2	.05
9	2	.02	10	.11	4	.10
10	12	.11	9	.09	6	.15
11			9	.09	5	.13
12			3	.03	1	.03
13			5	.05	1	.03
14			-			
15			1	.01		
Q	2	.02	2	.02		
TOTAL	112	1.00	95	.97	40	1.04

BARAT'S VILLAGE HEALTH PROJECT

BORDERLINE FOLLOW-UP RESULTS

GOROWA

ENDANGERED							A/HANA						
AGE	BORDERLINES DLAGNOSED JULY, 1980		JULY, 1980 BORDERLINES EXAMINED AUGUST, 1981		BORDERLINES DLAGNOSED AUGUST, 1981		AGE	BORDERLINES DLAGNOSED JULY, 1979		JULY, 1979 BORD. EXAMINED AUG., 1981		BORD. DLAGNO- SED AUG. '81	
	NO.	%	NO.	%	NO.	%		NO.	%	NO.	%	NO.	%
-	-		-				0	6	.06	-			
1	4	.11	1	.04	1	.11	1	14	.15	-		-	.
2	3	.08	1	.04			2	10	.11	1	.02	1	.06
3	4	.11	1	.04	1	.11	3	10	.11	9	.15	3	.14
4	4	.11	3	.12	1	.11	4	7	.07	9	.15	4	.19
5	5	.14	3	.12	1	.11	5	7	.07	7	.12		
6	3	.08	5	.20	3	.33	6	11	.12	7	.12	1	.05
7	2	.06	4	.16			7	10	.11	2	.03	2	.10
8	6	.17	3	.12	2	.22	8	9	.09	6	.10	1	.05
9	2	.06	2	.08			9	8	.08	5	.08	2	.10
10	3	.08	-				10	2	.02	4	.07	3	.14
11			2	.08			11			6	.10	1	.05
12			-				12			2	.03	2	.10
13			-				13			1	.02	1	.05
Q			-				Q	1	.01	-		-	-
TOTAL	36	1.00	25	1.00	9	.99	TOTAL	93	1.30	59	.99	21	1.02

September, 1981

BORDERLINE FOLLOW-UP RESULTS

MAPEA							LIDUGYE							SARILE						
AGE	BORDERLINES DIAGNOSED JULY, 1979		1979 BORDER- LINES EXAMINED AUGUST, 1981		BORDERLINES DIAGNOSED AUGUST, 1981		AGE	BORD. DIAGNOSED JUNE '80		1980 BORD. EXAMINED AUGUST, '81		BORD DIAGNOSED AUGUST, '81								
	NO.	%	NO.	%	NO.	%		NO.	%	NO.	%	NO.	%							
0	5	.05	0		0		0	5	.17											
1	14	.13	1	.02	0		1	2	.07	2	.11									
2	11	.10	9	.14	1	.05	2	2	.07	2	.11									
3	16	.15	7	.11	3	.16	3	4	.13	1	.05									
4	9	.08	8	.12	2	.11	4	4	.13	1	.05									
5	6	.06	8	.12	3	.16	5	1	.03	2	.11	1	.25							
6	13	.12	7	.11	1	.05	6	1	.03											
7	17	.16	13	.20	4	.21	7	3	.10	2	.11									
8	9	.08	4	.06	3	.16	8	3	.10	2	.11									
9	4	.04	5	.08	1	.05	9	2	.07	2	.11	2	.50							
10	0	0	2	.03	1	.05	10	1	.03	1	.05									
11			1	.02			11			2	.11									
12							12			1	.05	1	.25							
13							13	2	.07											
Q	2	.02					Q													
TOTAL	106	.99	66	1.01	19	1.00	TOTAL	30	1.00	18	1.01	4	1.00							

VILIMA VITATU

AGE	BORDERLINES DIAGNOSED JUNE, 1980		1980 BORDER- LINES EXAMINED SEPT. 1981		BORDERLINES DIAGNOSED SEPT. 1981	
	No.	%	No.	%	NO.	%
0	3	.19			0	
1	3	.19			0	
2	1	.06	3	.27	3	.43
3	2	.13	1	.09	1	.14
4	1	.06	3	.27	1	.14
5	2	.13	0	0	0	
6	1	.06	0	0	0	
7	-		2	.18	1	.14
8	-		0	0	0	
9	1	.06	1	.09	0	
10	2	.13	1	.09	1	.14
11			0	0	0	
12						
13						
Q						
TOTAL	16	1.01	11	.99	7	.99

September, 1981.

MRADI WA ATYA VIJIZINI WILAYANI HANANG:

FINANCIAL CONTRIBUTIONS <sup>72</sup> VILLAGES COMMUNITY HEALTH WORKERS DURING 1981. ( JANUARY - JUNE):

✓ Sent

DIVISION	WARD	VILLAGE	Jan.		Feb.		March		April		May		June		Jumlah	
			*	+	*	+	*	+	*	+	*	+	*	+	*	+
	Gitting	Barjamod	*	+	*	+	*	+	*	+	*	+	*	+	*	+
	Bassotu	Bassotu														
		Hirbadaw														
	Endassak	Endaraw														
		Getarhul														
	Gidahababieg	Hidet			300/=											300/=
	Masakta	Masakta	200/=		200/=		200/=		200/=			200/=		200/=		1200/=
	Katesh	Mogitu														
	Katesh	Wareta														
	Endassak	Endaswold	196/=		196/=		196/=		196/=	1250/=		196/=				1800/3250/=
	Masakta	Masharoda														
	Gidahababieg	Gidahababieg														
	Endassak	Menakron														
		Gehandu														
	Gehandu	Mard														
	Bassodesh	Basodesh														
		Garawja														
	Bassotu	Gawidu														
		Hulbadaw														
	Gehandu	Ichipong'a														
	Masakta	Masharoda														
	Sirop	Mintangarimo														
		Simbay														

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BEST AVAILABLE DOCUMENT

Division	Ward	Village	Jan		Feb.		March		April		May		June		Jumln	
			*	+	*	+	*	++	*	+	*	+	*	+	*	+
B E N E F I C I A R Y	Dareda	Arri	30/=	+	20/=	+	20/=	++	*	+	*	+	150/=	+	220/=	
		Dareda	80/=		120/=		80/=		400/=		400/=		130/=		1,210/=	
	Bashnet	Guse	180/=		100/=		100/=		280/=		150/=		133/=		280/=	1,290/=
	Ufana	Luzmanda														300/=
	Madunga	Madunga														
	Dabil	Sabilo	440/=		120/=		100/=		100/=		100/=		100/=		400/=	
	Bashnet	Har	100/=		100/=		100/=				300/=		100/=		300/=	
	Madunga	Utware									400/=		400/=		800/=	
	Ufana	Scheda									300/=		400/=		400/=	200/=
	Dabil	Mandi									1000/=		600/=		640/=	600/=
	Dareda	Dohomu	60/=		80/=				40/=						800/=	600/=
		Sharmo													200/=	
	Dareda	Manazha		580/=							200/=				150/=	580/=
	Madunga	Qameyu		400/=					100/=						150/=	580/=
	Bashnet	Endamanagh		800/=				500/=	80/=		70/=				600/=	800/=
	Dareda	Barmi		500/=											800/=	500/=
	Dabil	Gajal														500/=
		Maganjwa		170/=				150/=							150/=	170/=
NB (2) Only financial assistance to male VHW was recorded Source: DHE. monthly Report																
G O V E R N M E N T	Gidas	Boay														
		Bonga														
		Gidas	120/=		120/=		120/=		120/=		120/=		120/=		720/=	
	Riroda	Endabeg	200/=		200/=		200/=		200/=		200/=		200/=		1,200/=	
	Gallapo	Gedemar														
		Hajenro														
	Kiru	Imbilibi														
Singe	Ikisala															
	Manazha															
	Manzara															
Manire	Milcants															

BEST AVAILABLE DOCUMENT

Division	Village	March		April		May		June		July	
		*	+	*	+	*	+	*	+	*	+
Bonga	Ayazura (Hawra)										
Gallapo	Tripura										
Gidas	Gijed	120/=	120/=	120/=	120/=	120/=					
Lamire	Cherchen										
Kiru	Dugheloi										
	Erri										
	Kiru Hlogo										
Gallapo	Halla										
Bonga	Enduchan										
Riroda	Hoshan										
	Duru										
Gallapo	Ayamango										
	Orng'adida										
	Qash										
Gidas	Bubu										
	Gidabchar										
Kiru	Kiru Dick										
	Malamai										
Riroda	Sigino										
	Endagile										
Endagwe	Hakra										
Singe	Himiti										
Hagugu	Gichameda										
	Matufa	100/=	100/=								
	Mawomiro			150/=		150/=					
	Sangaiwe										
Hagara	Hagara										
Himiti	Hajingu										
Hwada	Hwada										
Hagugu	Hapea	100/=	100/=	150/=	150/=	150/=					
	Masward	60/=	60/=	100/=	100/=	100/=					
				100/=	100/=	100/=					
				60/=	60/=	60/=					

M B U G V E G O R O W

They get 120 periodically

They do get when they are in BBT for training

Each get 50  
 \* Only one village gets.  
 500  
 300

BEST AVAILABLE DOCUMENT

.....A/

Division	Ward	Village	Jan.		Feb.		March		April		May		June		Jumlah	
			*	+	*	+	*	+	*	+	*	+	*	+	*	+
LEBUKTA	Magara	Mozevoko	*	+	*	+	*	+	*	+	*	+	*	+	*	+
	Mogugu	Sa...														
		Kisagali					450/2									
		Vilira Vitatu													450/2 @ 90¢ = 225¢	

**Note:**

- \* Financial assistance given while trainees (VHWs) are working in the villages
- + Financial assistance given while trainees are studying in Babati.

**Sources**

- (i) Village Profile and
- (ii) Divisional Health leaders Reports

**BEST AVAILABLE DOCUMENT**

IRIADI WA AFYA VIJIJINI WILAYATI - IANANG

FINANCIAL CONTRIBUTION BY VILLAGES TO COMMUNITY HEALTH WORKERS DURING 1980

Division	Ward	Village	Jan.	Feb.	March.	April	May	Juni	July	Aug.	Sep.	Oct	Nov.	Dec	TOTAL
B A R A I G	Gitting	Berjunod	* +	* +	* +	* +	* +	* +	* +	* +	* +	* +	* +	* +	+
	Bassotu	Bassotu													2,200
		Hilbadaw													
	Endasak	Endasak													
		Getachul													
	Gidahababi	Hidet													
	Masakta	Masakta													
	Katesh	Hoyitu									400/=	400/=	400/=	400/=	1,600
	Katesh	Wareta													
	Endasak	Endasak-old													
	Masakta	Masakroda										750/=		800/=	1,550
	Gidahababi	Gidahababi													
	Endasak	Endasakron								2,200/=					2,200
	Gehandu	Gehandu								1,660/=					1,660
		Gehandu								3,175/=					3,175
Bassodesh	Bassodesh														
	Garawja								2,165/=					2,165	
Bassotu	Gavidu														
	Hilbadaw														
Gehandu	Ishipongana														
Masakta	Masakroda														

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Division	Ward	Village	Jan.		Feb.		Marsih		April		May		Juni		Julai		Ago.		Sep.		Okt.		Dec.		+	*			
BARRAG	Saro.	Matangarino	*	+	+	*	+	+	*	+	*	+	*	+	*	+	*	+	*	+	*	+	*	+	*	+			
		Sinbay																											
	Darede	Arri																											
		Darede Kati															100/=		320/=										
	Bashnet	Guse																											
	Ufana	Iuganda															180/=		180/=		10/=								
	Madunga	Madunga																											
	Dabil	Sabilo																											
	Bashnet	Nar																											
	Madunga	Utvari																											
	Ufana	Sacheda																											
	Dabil	Hendi																											
	Darede	Dohomi																											
		Sharmo															100/=												
	Dare la	Hanarion																											
	Madunga	Qaneyu															600/=												
	Bashnet	Enlamang																											
	Darede	Bermi																											
		Gajal																											
	Dabil	Hargunwa																											

B A S H N E T

BEST AVAILABLE DOCUMENT

Ward	Village	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Yr. Total
Gidas	Doy	*												
Bonga	Bonga													
Gidas	Gidas													Occ.
Riroda	Endaber													Occ.
Gallapo	Gedemar													Occ.
	Majengo													Occ.
Kiru	Imbilili													
Singe	Maisaka													Occ.
	Hanazha													
	Hangara													
Mamire	Mwilkantoi													
Bonga	Ayasanda (Haraa)													
	Ayasanda													
Gallapo	Tsamasi													
Gidasi	Gijedaboshka													
Mamire	Chemchem			120/=	120/=	120/=	120/=	120/=	120/=	120/=	120/=	120/=	120/=	1,300/=
Kiru	Daghailoi													
	Erri													
	Kiru Mdogo													
Gallapo	Halla													+ 740/=
Bonga	Endanachan													+ 544/=
Riroda	Hoshan													
	Duru													
Gallapo	Ayamango													
	Orag'adida													
	Qash													
Gidas	Bubu													
	Gidaberber													
Kiru	Kiru Diek													
	Mlangi													

BEST AVAILABLE DOCUMENT

Division	Ward	Village	Jan.	Feb.	March	Apr.	May	June	July	Aug.	Sep.	Oct.	Nov.	Dec	JUL.
GONDVA	Riroda	Sigino	* +	* +	* +	* +	* +	* +							
	Endagwe	Endagile													
		Nakwa													
	Singe	Himiti													
M E R U G W E	Magugu	Gichamedu													
		Matufa	50/=												
		Mawemiro													
	Mangara	Sangaiwe							100 50/=		75/=				
		Magara													
	Mkiti	Mijingu							200/=						
	Mwada	Mwada													
	Magugu	Kapea													
		Masware													
	Magara	Moyanyoka								150/=					
Magugu	Sarame														
	Kisangaaji								1310/=						
Mkiti	Vilima Vitatu							698/=							

Note :

- \* Financial assistance given while trainees (VHWs) are working in the Villages
- + Financial assistance given while trainees are studying in Babati

Sources (1) Village Profile and  
 (2) Divisional Health Leaders Reports

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1980 - 2 K 2 VILLAGE REARER PROJECT  
 FINANCIAL STATUS REPORT - BY YEAR  
 09. 77 - March - AUG. 81

CATEGORIES	DEC. 77 NOV. 78	DEC. 78 OCT. 79	DEC. 79 NOV. 80	DEC. 80 AUG. 81	TOTALS 01.81	TOTALS 1.81
SALARIES & GRATUITIES ---	157,727.40	213,622.15	284,771.10	126,260.40	106,613.54	685,140.55
COMMODITIES ---	1,597.00	28,115.50	2,355.00	6,070.00	1,764.13	38,415.50
BUILDING ---	19,076.45	100,254.05	59,680.10	-	29,695.56	199,000.00
MAINTENANCE ---	31,781.95	-	-	-	3,772.71	31,781.25
FOOD - SALARIES ---	93,033.40	100,033.10	100,033.10	70,033.55	46,316.62	377,135.55
FOOD - GENERAL ---	40,000.00	40,000.00	40,000.00	30,000.00	10,710.00	150,000.00
ENTRIES - LABOR & MGR ---	130,695.70	251,117.10	329,759.75	221,250.00	120,401.71	1,042,015.75
ENTRIES - OTHER ---	26,519.00	55,771.10	61,311.75	71,075.00	20,816.17	272,177.75
ENTRIES ---	60,016.20	67,117.20	137,200.15	119,290.00	40,332.12	342,015.25
DEPRECIATION ---	36,613.75	60,522.00	85,492.25	30,126.90	27,653.14	241,004.00
DETA ---	105,942.30	73,870.50	126,502.85	35,221.05	41,192.16	329,556.80
TOTALS ---	772,693.95	1,012,206.50	1,237,574.15	612,347.50	481,190.00	3,842,541.70

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ATTACHMENT 1.

MCH TRAINING PROGRAMME

The MCH component of the Training Programme consists of the following:

A. 1st Session:

- a. Introduction to Maternal and Child Health; responsibilities of the trainees in regard to maternal and child health in the village; importance of proper nutrition.
- b. Introduction to MCH Clinics - importance, purpose services provided, Road to Health card; responsibilities of the trainees and VHLS in the work of the clinic; setting up a mobile clinic in the village.

B. 2nd Session:

- a. Principles and Practice of Health Teaching in MCH Clinis
  - (i) Methods of Health Teaching
  - (ii) Individual preparation and practice in class giving a health talk - self - evaluation, evaluation, by teacher and classmates.
  - (iii) Clinical Experience in MCH Clinic at Babati Health Centre - observation and practice giving health talk.
- b. Nutrition - importance of proper diet; signs and symptoms of malnutrition, Kwashiorkor, Marasmus.
  - (i) Demonstration of preparation of nutritious food.

C. 3rd Session:

- a. Immunizations - Principles and Practice.
  - (i) Meaning of vaccines; preparation needed; types of vaccines; preparation needed; cold chain.
  - (ii) Types of syringes used; measuring amounts.
  - (iii) Principles of Sterility; Sterile Technique Practice.
  - (v) Practice in giving injections using a sponge; practical examination
  - (vi) Clinical Experience at Babati Health Centre

D. 4th Session

- a. Pregnancy, Childbirth, Mother and Child Care (Midwifery)
  - (i) Anatomy & Physiology of Reproductive Systems (Male -Female)
  - (ii) Signs & Symptoms of Pregnancy
  - (iii) ANTENATAL Records; Antenatal Care; Diet During Pregnancy
  - (iv) Palpating the Fundus; Foetal Heart; Normal/Abnormal Pres.
  - (v) Complications of Pregnancy; need for referral.
  - (vi) Signs and Symptoms of Abortion Treatment; First Aid.
  - (vii) Childbirth; Normal Delivery; Assisting in an emergency
  - (viii) Care of newborn child; care of mother ~~after~~ childbirth
  - (ix) Complications in Childbirth; Postpartum Hemorrhage - signs, symptoms, emergency care, need for referral
  - (x) Tribal customs, good and bad, surrounding childbirth
  - (xi) Child Care (xii) Family Planning
  - (xiii) Diseases of the Female Reproductive System.

b. Clinical Experience at Babati Health Centre

c. Final MOH Examination

E. CLINICAL EXPERIENCE IN MIDWIFERY (FEMALE TRAINEES ONLY) - 6 weeks

a. Experience in MOH Clinic, Labour Ward, Delivery Room, Maternity Ward, Nursery at a Health Centre (3 weeks) and Dareda Hospital (3 weeks).

b. Review session following Clinical Experience.

September, 1981

ORODHA YA WAHODUMU WA AFYA WALIOFATA VYETI KAMILI:

JINA	JINA	KIJIJI	KATA	TARIFA	KIKUNDI
Nicodemus Madme Petro Bhoko Klotida Kessy Nicodemus Lagwen		Guse Sabilo Dareda Kiti "	Bashmet. Dabil Dareda "	Bashmet. " " "	II II II II
Peter Dutu Margareth Magumu Fausta Hangali Martini Duma Cecilia Kinyay Zebedayo Qwang Rosina Gedasayda Simoni Mayda Elisabeth Matle Nicolaus Samba Lea Girgis "		Endagaw " Hidet " Masakta " Getaginul " Hirbadaw " Bassota "	Endasak " " " Masakta " Endasak " Bassota " " "	Barbaig " " " " " " " " " " "	Pilot II II II II II II II II II II
Iddi Shija Stephen Senge Anastazia Sabri Leonard Philip Akwelina Stephen		Matufa Gichameda Sangaiwe Mwada "	Magugu " Mwada " "	Mbugwe " " " "	Pilot II I I I
Mohamed Bakari Remadhani Phylema Fuataeli Thway Selemari Athumani Magdalena Mada Philemon Mjungu Monica Saidi Thomas Margwe Jumane Bakari Elialca Ngonya Juma Rajabu "		Bonga Nangara Mwikani: 1 Boay Boay Gidas Endabeg " Imbilili " Managha	Bonga Singe Mamire Gidas " " Riroda " Kiru " Singe	Gorowa " " " " " " " " " " "	Pilot I I I I I I I I I I
Leocade Qaw Rehama G. Solla Cecilia K. David Sebastian K. Baynit		Barjamod. Wareta Endaswold Wareta	Gitting Katesh Endasak Katesh	Barbaig " " "	I III III III
Dionisio Thao Adellaida Lyimo Leoadia Thaxras Marja N. Hendriko "		Mendi Dnhomu Sharmo Guse "	Dabil Dered. " Bashmet	Bashmet. " " "	III III III III
Uc. J. Nangay Mariamu Swalehe Teresia S. Modu		A/Hazaa Ayasanda Gijedaboshka	Bonga " Gidns	Gorowa " "	III III III
Albina B. A. Ami		M/Mayoka	Magara	Mbugwe	III

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MANANG VILLAGE HEALTH PROJECT  
PROVISIONAL TRAINING SYLLABUS

BEST AVAILABLE DOCUMENT

No.	TOPIC	CONTENTS
1.	<u>COMMUNICATIONS</u>	<ol style="list-style-type: none"> <li>1. The opening of the course - 1/2</li> <li>2. Our expectations</li> <li>3. The aims of studying leadership</li> <li>4. Human relations - E: A</li> <li>5. Principles and process of communications.</li> <li>6. Group dynamics -</li> <li>7. Recognising and involving formal and informal leadership -</li> <li>8. Motivation and mobilization -</li> <li>9. Political Education -</li> <li>10. Co-operation - E</li> <li>11. Principles of economics as applied to health</li> </ol>
2.	<u>PROJECT (MINE) OPS.</u>	<ol style="list-style-type: none"> <li>1. Name of the project</li> <li>2. General Description</li> <li>3. Locations and pilot initiation</li> <li>4. Planned activities</li> <li>5. Trainees</li> <li>6. Project evaluation</li> <li>7. Benefits</li> </ol>
3.	<u>SURVEY</u>	<ol style="list-style-type: none"> <li>1. Recognising and drawing out village generative themes</li> <li>2. Teaching survey procedure</li> <li>3. Developing and using codes</li> <li>4. Force field analysis</li> <li>5. Decision making</li> <li>6. Seven steps on planning</li> </ol>
4.	<u>CENSUS</u>	<ol style="list-style-type: none"> <li>1. What is the project information system</li> <li>2. Trainees role and work in the information system</li> <li>3. Census activities</li> </ol>
5. A	<u>ENVIRONMENTAL SANITATION &amp; HYGIENE</u>	<ol style="list-style-type: none"> <li>1. Health - Introduction to what it is -</li> <li>2. Personal hygiene</li> <li>3. Environmental and sanitation hygiene - N: A</li> <li>4. Interrelationship between social, physical, environmental, psychological and economic factors in health</li> <li>5. Cultural practices affecting health -</li> <li>6. Government medical policy - health care delivery system</li> <li>7. History of development of Tang dia. Government</li> </ol>
5. B	<u>NUTRITION</u>	<ol style="list-style-type: none"> <li>1. Ulishaji wa kifaya</li> <li>2. Nutrition - related to health</li> <li>3. Nutrition - related to health</li> <li>4. Nutrition - related to health</li> </ol>

~~Co-incident and infection medical services~~

~~8. Close link between economic development and improved health.~~

- 6. Census Data
  - 1. Summarised data and sample
  - 2. Preparation of a list of dwellings

- 7. **GENERATIVE THEMES**
  - 1. Preparation of codes on
    - Nutrition
    - Environmental, sanitation and personal hygiene
    - Water
    - Practice ~~of teaching health education~~ on *Teaching generative health themes*
  - ✓ - preparation of a calendar

- 8. **HOW TO TEACH ADULTS**
  - ✓ → How adults learn
    - Practice in conducting group discussion
    - Skill in imparting knowledge to adults
    - Scheduling of group activities
  - ✓ - How to build self confidence of village health leaders.
    - Teaching *1000 ya 113000 7 m 4 - 14 - 1*

- 9. **DISEASES**
  - Summary of diseases transmissions pattern - preventive measures.
  - ✓ - Communicable diseases introduction
  - Vaccinations - techniques, storage, problems
  - Hygiene
  - Milk-borne diseases
  - 1st ✓ - Whooping cough
  - Anatomy and physiology
  - 1st ✓ - Eye care, diseases - prevention
  - 1st ✓ - Malaria: cause, treatment, prevention
  - ✓ - TB
  - Leprosy
  - Upper respiratory diseases - colds, pneumonia, rheumatic fever and tonsillitis
  - 1st ✓ - Gastroenteritis - diarrhoeal diseases (typhoid - worms)
  - Polio
  - ✓ - Sleeping sickness
  - Antibiotics
  - ✓ - Anthrax
  - ✓ - Bilharzia
  - ✓ - Mental illness
  - Venereal diseases
  - Liver diseases - *infectious hepatitis* ...../3-  
- *alcoholic*
  - Alcoholism
  - Home remedies for simple common illnesses

30

10. FIRST AID <sup>1st</sup> <sub>2nd</sub>
- ✓ - Dressing <sup>1st</sup>
  - First Aid <sup>2nd</sup>
  - ✓ - Poisoning <sup>3rd</sup>
  - Dispensing medicines <sup>4th</sup>

11. M.C.I. <sub>1</sub> <sup>2nd</sup>
- ✓ - M.C.I. Clinics organization
  - M.C.I. approach to women; trainees role
  - Child welfare clinic recording activities

12. QUESTIONNAIRE TESTING <sub>3rd</sub>
- Village health questionnaire
  - Village health leaders on going
  - Monitoring
  - Recording of trainees
  - Impressions of project information system

VILLAGE ACTIVITIES

- Surveys
- ① - Collection of Village Health Leaders
- Census
- ② - Teaching <sup>Teaching how to put down in layers</sup>
- Health Education to village health leaders <sup>Simple, relevant, practical</sup>
- ③ - Questionnaire (pogaji) <sup>Nutrition survey</sup>
- <sup>working with</sup>

PROJECTS

1. Poultry Rearing
2. Gardening ✓
3. Animal Husbandry

- ① Project management
- Survey
  - Census
  - M.C.I.

- ③ Census
- Census data
  - <sup>...</sup>
  - <sup>...</sup>
  - <sup>...</sup>
  - <sup>...</sup>

# BEST AVAILABLE DOCUMENT

42-1

MAKHO YA MAFUNDO YA KIMATAIFA

MAKHO YA MAFUNDO YA KIMATAIFA

MAJUMA SIFA

MASOMO	WAKATI SIFA	MABEBO
- Ufunguzi wa kozi .....	2	
-Overall-view of the course .....	2	
-Fomu ya maradhi vijijini .....	4	
-Matagemeo yetu (our expectations).....	4	
<del>Project write ups</del> .....	0	
-Organization and roles .....	6	
-Madhumuni ya kujifanua Uongozi .....	2	The aims of survey
-Kutambua Uongozi rasmi na usio rasmi .....	3	Recognizing and drawing out village health generative themes
-Recognizing and drawing out village health generative themes .....	4	
-Teaching How to do survey on village health problems .....	6	
-Madaraka vijijini .....	10	
-Wajibu wa kamati ya Elimu Utamaduni na Ustawi wa jamii .....	3	Roll of Education, Social Welfare & Culture Committee
-Introduction to information gathering .....	4	
-Census activities .....	30	
-Communications .....	6	
-Nutritional Diseases .....	2	
-Nutrition survey practical .....	6	
-Nutrition survey theory .....	4	
-Office procedures .....	4	
-Nutrition related to health .....	15	
-Cultural practices affecting health .....	3	
-Human relations .....	4	
-Mobilization and motivation .....	4	
-History of medical services Government and Mission Medical policy .....	2	
-Introduction to M.C.H. .....	6	
Health introduction .....	1	
-Personal hygiene .....	2	
-Environmental and sanitation hygiene .....	4	
-Close link between economic development and improved health .....	4	
-Selection of village Health leader .....	4	
-Planning for field activities .....	18	
-Study .....	16	

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# BEST AVAILABLE DOCUMENT

42-2

MAJUMA WA KAZI WA VIKIUNZI WA HAMA B.

MAJUMA WA KAZI WA VIKIUNZI WA HAMA B.

MAJUMA WA KAZI.

MAJUMA	MAJUMA	MAJUMA
-Introduction to session II.....	2	
-Majadiliano kutoka kila kijiji.....	4	
-Kupokea taarifa ya utafiti.....	4	
-M.S.H.....	6	
-Information system.....	35	
-Diseases (Magonjwa).....		
-Kifaduru, Mnyoo ya tumboni.....	8	
-Saruru, Magonjwa ya sono, Kutarisha na kutapika, Magonjwa ya ngozi		
-Roma ya mbu (Malaria)		
-Jinsi watu wasima wanavyojifunza	24	
-Ufundishaji, Muhtasari wa sono		
-Azimio la kazi		
-Andalio la sono		
-Utaratibu wa shughuli za vikundi.....	2	
-Kujifunza kwa njia ya vikundi.....	2	
-Jinsi ya kujenga kujiamini		
kwa viongozi wa afya vijijini.....	4	
-Wajibu wa Kamati ya E/U.....	2	
-Kupanga ratiba ya shughuli vijijini..	10	
-Huduma ya kwanza.....	16	
-Machubuko.....		
-Kuteguka, kuvunjika		
-Kikazo (Kisigo) cha kwanza damu		
-Kusurusha		
-Kupurusha kwa maarifa		
-Mishuko		
-Kutumia bandaaji na magongo		
-Kusafirisha mgonjwa		
-Kuumwa na nyoka, kuumwa na mbwa		
-Majeraha, Vidonda na kutokwa na damu		
-Kuunyua na moto		
-Mato eo ya mifupa wa hali ya lishe		
-Mwili wa Binadamu (Mifupa)		
-Mifupa wa Endocrine		
-Micho, siliko, matesi mwilini		

# BEST AVAILABLE DOCUMENT

42-3

HIRADI WA AFYA VIJIJINI WILAYA MAMBAJI  
MASOMO YANAYOFUNDISHWA MSHULA WA TATU  
MASOMA MAMANO

MASOMO	KUDA KWA MASAA	MABLAGO
Maelezo juu ya mambo yatakayofu- shwa mshula wa tatu .....	2	
Majadiliano juu ya msingi uli silizofenyika vijijini ....	4	
Kufundisha somo la kuhara .....	14	
Mazoezi ya kufundisha shule ya msingi .....	16	
Majadiliano kuhusu ufundishaji .	2	Preparation of <del>the</del> Teachers Methods
Review of Gastro - enteritis ....	2	
Matumizi ya maji .....	2	
I/S .....	46	
First aid .....	8	
Kilimo .....	4	Preparation
Antibodies (Askari wa mwili) .	2	
Medicines .....	12	
Immunization .....	18	
M.C.H .....	2	
Jinsi watu wazima wanavyojifunza TB	4 4	Preparation of <del>the</del> <del>the</del>
Cough, colds pneumonia .....	2	
Folio .....	2	
Ukoma .....	2	Preparation
Abdominal diseases .....	2	
Kupanga ratiba .....	6	Preparation of <del>the</del> <del>the</del>
Kukabidhi vifaa .....	2	Preparation of <del>the</del> <del>the</del>

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SYLLABUS FOR VILLAGE HEALTH WORKERS - SECTION ON MCH (LET FOR AND FIELD HEALTH)

THEORY SECTION

- I. Pregnancy, Maternity Child birth, Mother and Child Care (Midwifery)
  - A. Anatomy and Physiology of the Male and Female Reproductive Systems; Menstruation; Conception. (Lecture classes - on all women)
  - B. Signs and symptoms of Pregnancy.
  - C. Underwriting ante-natal records with a view to a visit to pregnant mothers in the villages.
  - D. Antenatal Care.
  - E. Diet during Pregnancy; Anemia.
  - F. Palpating the Fundus; Listening to the foetal heart.
  - G. Normal and Abnormal Presentation.
  - H. Understanding the need for referral of pregnant mothers with problems or complications of pregnancy.
  - I. Signs and symptoms of Abortion; Treatment; Signs of .
  - J. Childbirth: normal delivery; assisting at a delivery in an emergency.
  - K. Care of new-born child.
  - L. Care of mother following delivery and during post-natal period.
  - M. Complications in Childbirth; post-natal haemorrhage - signs, symptoms, emergency care, treatment, need for referral /
  - N. Critical customs (good and bad) surrounding childbirth.
  - O. Child care.
  - P. Family Planning
  - Q. Diseases of Female Reproductive system.
- II. Clinical Experience in Sub-st Health Centre. (2 weeks)
- III. Final MCH Examination
- IV. Clinical Experience in Midwifery (Female Trainees) - 6 Weeks
  - A. Experience in MCH Clinic, Labour Ward, Delivery Room, Maternity Ward, Nursery at a Health Centre (Babati, Magu - 3 weeks) and at Dareda Hospital (3 weeks)
- V. Evaluation of MCH Clinical Experience in Health Center/Hospital
- VI. Planning for Field Experience in the villages.
- VII. HANDOUTS
  - A. anatomy and Physiology of the Reproductive System.
  - B. Health of Mothers During Pregnancy, Delivery and After Child birth.
  - C. Clinical Experience Records
    - 1. Short medical History of two selected patients
    - 2. Record of Dressing done, medicines given and infections
    - 3. Record of Midwifery Experience.

BEST AVAILABLE DOCUMENT

Ukulima Kwa Waalimu wa Vijijini - Rodger & Lacey (2 copies)  
 Maendeleo Na Kushinda - Rivers-Smith & Spencer  
 Mazungumzo Ya Mone Fe  
 Hadithi Ya Bakuria wa Tanganyika - Kingdon  
 Sheria Na Haki za Wanawake - E.N. Munuo  
 Kufuma Kumefanywa Rahisi - Norah Lyth  
 Maji Na Ardhi - Clements & Topham  
 Mapishi ya Kwetu na Mengineyo - Matemba  
 Malezi Bora Ya Watoto Kitaifa  
 Are You Too Fat? Je, Una Kiriba-tumbo - Maletnlema  
 Maendeleo N Jasho #3  
 Maji Ni Mali (PB)  
 Asili Ya Chumvi Ya Bahari (PB)  
 Uzungumzi Katika Ukulima - Staple  
 Usafi Huleta Uzima (PB)  
 Instrukta Ni Mwalimu - Paper Back - 3 copies)  
 Mtoto Wako Anavyozaliwa  
 Nyongeza Za Ukunga (Paper Back - 3 copies)  
 Afya Ya Familia - Mpango wa Uzazi  
 Uzazi Wa Majira

\*\*\*\*\*  
 BOOKS PURCHASED LAST YEAR

Tropical Hygiene For Schools - 3 copies  
 Nuru ya Nyumbani - 4 copies  
 Enlightening the Family - 1 copy  
 Health Education - Scotney  
 Ukunga na Utunzaji - 3 copies  
 Watoto Wetu  
 Kanuni za Kufunga  
 Maarifa Mapya  
 - Mdoe Na Mama Yake  
 - Imani Na Matendo  
 - Mafundisha ya Afya  
 Mwili wa Binadamu  
 Helping the Rural African Mother  
 Nutrition for Developing Countries  
 Child Health  
 Utunzaji wa Watoto - Maletnlema  
 Usiku wa Mashaka - 3 copies  
 Tupiganu na Sufura - 3 copies  
 Linda Afya Yako - 2 copies  
 Obstetric Emergencies  
 - Malezi ya Nyumbani  
 Mtu ni Afya - Green copies - 5 ; Blue copies -5

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BOOKS BORROWED BY MW. MASASI FROM GCM - 29th May 1979

TULE CHAKULA BORA - 2 copies  
MAARIYA YA NYUMBANI (2) - 2 copies  
KUFOMA KUMEFANYWA RAHISI - 2 copies  
KUISHI NI KUJIFUNZI - 3 copies  
BUSTANI YA MBOGA - 1 copy  
MSIMULIZI YA KAZI KATIKA KIJIKI CHETU - 2 copies  
LINDA AFYA YAKO - 2 copies  
MTOTO NA MALEZI - 4 copies  
BUSTANI YA NYUMBANI - 1 copy

DATE DUE ----- 17th June 1979

*Ret 2 by Masasi*

LIST OF HEALTH EDUCATION BOOKS

BOOK (KITABU)	PRICE (BEI)
<u>TROPICAL HYGIENE FOR SCHOOLS</u> * E.J. EVANS.....	
<u>UTUNZAJI WA MAMA NA WATOTO VIJIJINI</u> - T.MALETNLEMA .....	
<u>CHILD HEALTH</u> - BALDIN, HART, HEENGES & VERSLUYS.....	
<u>KANUNI ZA KUPUNZA NA KULEA WATOTO</u> - A.K. KYEJO.....	
<u>UKUNGA NA UTUNZAJI WATOTO VIJIJINI</u> - M. KAISI.....	
<u>MWILI WA BINADAMU</u> - DR. H.R. FOLMER.....	
<u>MAFUNDISHO YA AFYA</u> - ESTHER KOBUNE.....KILA KITABU =	
<u>HEALTH EDUCATION</u> * NORMAN SCOTNEY.....	
<u>HELPING THE RURAL AFRICAN MOTHER TO CARE FOR HER CHILD</u> - DESJARDINS...	
<u>LINDA AFYA YAKO</u> - J.C. MPOMBO .....	
<u>WATOTO WETU</u> * - V. RUTH HUME .....	
<u>MAARIPA MAPYA YA KUELIMISHA AFYA</u> - S.J. MAMUYA .....	
<u>ENLIGHTENING THE FAMILY</u> - DISCUSSIONS AND DEMONSTRATIONS FOR LEADERS F.A.O. PROGRAMMES FOR BETTER FAMILY LIVING .....	
Published in Nairobi, Kenya, Box 30470	
<u>NURU YA NYUMBANI</u> (Swahili version of the above book).....	
<u>NUTRITION FOR DEVELOPING COUNTRIES</u> - MAURICE KING et al .....	

ANY OTHER TEXTS AVAILABLE FOR HEALTH EDUCATION:

	PRICE
HUMAN ANATOMY IN PICTURE 8/=	5 copies
Kitabu cha Afya kwa wafu wazima na wataumwa	7/50 1 copy
Color Guide to Human Physiology	5/= 2 copies.
Elimu za wafu wazima	

44a-1 i = bid  
First Aid

MRADI WA AFYA VIJIJINI. J. HANANG

JINA. ....

KLJJI .....  
.....

MITHANI WA MARUDIO: HUDUMA YA KWANZA KWA OPG-I & II

Kima maswali 5, unapaswa kufanya maswali mame tu.

1. Mtoto Hamisi amekunywa sumu kali sana mdomo ulimi wake una madonda. Je utamsaidiaje?

.....  
.....  
.....  
.....

2. Nico amepata ~~ajali~~ <sup>ajali</sup> amesanguka na picipiki, amepata mvunjiko wa ~~khasida~~ wa mguu. Je utamsaidiaje?

.....  
.....  
.....  
.....

3. Mtoto wa Mama Asha alikuwa anacheza karibu na moto na chungu kilikuwa jikoni akanwagikiwa na maji yaliyochanika akaungua vibaya sana mkono wote. Je utamsaidiaje?

.....  
.....  
.....  
.....

4. Mke wa Akomasay: aliyekuwa anakata kumi kwa bahati mbaya alijikata mguu na panga damu ikatoka kwa nguvu sana kama bomba na damu ina ule uwakundu mweusi. Je utamsaidiaje?

.....  
.....  
.....  
.....

(b) Je unafikiri huyu mama amejeruhi mahipa wa aina gani?

.....

(c) Nini kazi ya mahipa ya aina hii ndani ya mwili?

.....  
.....  
.....

Chagua jibu moja tu uweke alama azunguko kwenye herufi lenye jibu Sahihi.

5. Dalili za mshtuko ni:

- A. Kipuzua upesi upesi na kwa kidhaifu
- B. Kuhadaka kutoelewa vizuri na kuzirai nusu
- C. Mapigo ya moyo wa haraka haraka na mlegevu
- D. Ngozi baridi na yenye unyevunyevu
- E. Hakuna hapo juu

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2.

(F. Zote hapa juu

G. A, B, C, D.

(b) Ni lazima kikazo kilegezwe kila baada ya Dk. 10 - 15

A. Kwani sehemu chini ya kikazo itakosa hewa

B. Kwani sehemu chini ya kikazo itakosa damu

C. Kwani sehemu chini ya kikazo itakufa ganzi na kufa

D. Zote hapa juu.

Babati,

21/3/80.

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MRADI WA AFYA VIJIJINI - HANAING

MTIHANI - M.C.H. - OFG I & II

Jina.....

Tarehe.....

1. Maria Neema, ana mimba ya miezi mitatu, anaomba msaada wako. Anasema kwamba alikuwa anatapika kila asubuhi wiki hii. Je, utamshauri hini? Utampa dawa gani?

2. Rahma Bakari, ambaye ana mtoto wa miezi mitano, anakuambia ana shida ya ukosefu wa maziwa ya mama. Anataka kujua mahali pa kununua maziwa ya kopo na chupa ya kumlishia mtoto. Je, utamshauri nama gani?

3. Maria Bura ana mimba ya miezi mitano, anakuambia kwamba anachoka upesi baada ya kazi kidogo, na anaona kizungusungu. Anaomba vidonge vya nguvu. Je Utamwuliza maswali gani? Utamshauri/utamtibu kwa nama gani?

4. Umsulizwa kutoa somo la "ANEMIA" katika MCH Kliniki ili kuwafundisha wajawazito. Orodhesha mambo matano juu ya "ANEMIA" ambaye utaweka katika mpango wa somo lako.

5. Salome Juma, ambaye amezaa mwezi uliopita, anakuja katika kituo chako kwa dawa. Alisema anaumwa sana ziwa lake, na ziwa huvimba. Je, utamshauri/ utamtibu namna gani?

6. Unatembelaa nyumba katika kijiji chako na kukuta Mama Mjamsito mmoja, na kumsuliza kama anahudhuria MCH Kliniki (kwa wajawazito). Anakujibu bahudhuri na pia bahitaji kufanya hivi kwa sababu amezaa mara tano kijijini bila shida. Je, utafundisha faida gani ya Kliniki ya wajawazito?

## 7. (Ni lazima washauri wa wanaume wajibu swali hili)

Mke wa Tluwaj anamleta mtoto wake kituo chako. Anasema mtoto ametoa migoo kwenye choo. Amewahi kutibiwa mara tatu hospitali lakini hakupata rafuu. Utamshauri mama nini.

## 8. Mke wa Akonaay alijifungua jana usiku alitokwa na damu nyingi sana sana nao wamakuja kwako kutoka ushauri.

- (a) Je, unafikiri mke wa Akonaay atakuwa na dalili zipi?
- (b) Utatoa ushauri na matibabu gani?

9. Chagua jibu moja au zaidi kutoka namba za kushoto inayostahili na kuleta maana kamili ukilinganisha na namba za kulia. Jaza namba hiyo (au hizo) mstari uliowazi mkono wa kulia.

1. Smallpox Vaccine a. \_\_\_\_\_ Ikiwa vaccine hii haikusababish-  
kovu, ni lazima kumpa mtoto va-  
ccine tena.

2. Tetanus Toxoid vaccine b. \_\_\_\_\_ Dunga sindano hii kwenye paja.

3. BCG. Vaccine c. \_\_\_\_\_ Usimpe mtoto asiye chini ya  
mieri sita.

4. DPT Vaccine d. \_\_\_\_\_ Vaccine hii, inapopewa na  
wajawazito, itawalinda yeye i-  
minba yake kutoambukizwa na  
njwa ule.

5. Polio Vaccine e. \_\_\_\_\_ Baada ya kutoa vaccine  
barafu, ni lazima itumiwe k-  
wakati wa masaa 2 - 3.

f. \_\_\_\_\_ Vaccine hii inatolewa  
katika sehemu ya pega la kulia.

g. \_\_\_\_\_ Vaccine hii inatolewa kwa mdomo  
kila mwezi kwa miezi mitatu.

h. \_\_\_\_\_ Vaccine hii inatolewa mdomo  
ya 28, 32, na 36 wakati wa ujuzi.

i. \_\_\_\_\_ Baada ya kumpa mtoto vaccine  
mwanbie mwanbie asiguse sehemu  
vaccine inatolewa.

j. \_\_\_\_\_ Vaccine hii inatolewa Intrad-  
mally.

k. \_\_\_\_\_ Ni lazima iwe baridi kila mara.

l. \_\_\_\_\_ Vaccine hii inatolewa mdomo  
baada ya mtoto kuzaliwa.

m. \_\_\_\_\_ Ikiwa mtoto ameugua ugonjwa huu  
ana ualama kwa hiyo, hakitaji  
vaccine hii.

n. \_\_\_\_\_ Vaccine hii inalinda mtoto kup-  
mbana na ugonjwa tatu.

MRADI WA AFYA VIJIJINI WILAYANI - EANANG.

AFYA YA MAMA MJAMZITO:

- 1. Madhumuni ya kutoa huduma kwa hawa kina mama vijijini ni:-
  - (a) .....
  - (b) .....

- 2. Dalili za mimba ni:-
  - (a) .....
  - (b) .....
  - (c) .....
  - (d) .....
  - (e) .....

- 3. Dalili za kuharibika kwa mimba ni:-
  - (a) .....
  - (b) .....
  - (c) .....

Matibabu ya kuharibika kwa mimba, kana mimba haijatoka:-  
 .....

4. Je? Unaweza kujua kana mama mjanzi to na ni chini ya miezi mitano bila kumpina?

- 5. Utamshauri mama mjanzi to nini juu ya chakula bora wakati wa ujauzito?
  - 1. ....
  - 2. ....
  - 3. ....
  - 4. ....
  - 5. ....

- 6. (a) Mimba ya kawaida huohukua miezi tisa au hiki .....
- (b) Kana mimba ikikua mpaka katikati ya kitovu na mfupa wa kinona, tunasoma mimba ina wiki ..... itaandikwa katika cheti .....

7. Kitangulizi cha kawaida ni ..... kitangulizi kisicho cha kawaida ni ..... au .....

.....  
Dalili za hatari au matatizo <sup>kabla</sup> ya kujifungua ni:

- (a).....
- (b) .....
- (c) .....
- (d) .....
- (e) .....
- (f).....
- (g).....
- (h).....
- (i).....

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9. Matatizo ya Mama baada ya kujifungua ni:

- (a).....
- (b).....
- (c).....

10. Utanfanyiaje Huduma ya Kwanza :

- (a) Mama ambaye anatoka damu nyingi sana baada ya kucaa (PPH):  
.....  
.....  
.....  
.....
- b) Mtoto ambaye anezaliwa na hapurui au halii baada ya kurtoa uchafu kinywani na puani:  
.....  
.....  
.....  
.....

MRADI WA AFYA VIJIJINI - HANANG.

REFRESHER COURSE (OPG. I & II:) MCH TEST

Jina la Mtahiniwa; .....  
Tarehe.....

1. Mkuu wa MCH Kliniki amomba uwafundishe Wakina Mama sono la "Mlo Kihanganyiko" Orodhesha mambo yaliyo kuhusu sasa katika mpango wa sono lako.
  - 1.
  - 2.
  - 3.
  - 4.
  - 5.
2. Hadija Abdallah, ana ninba ya miezi saba anikuambia kwamba kila siku amehoka sana ni mdhaifu. Miguu yake imevinba na unapobonyeza, ibabaki kwa muda. Je, unachana ana shida gani? Je, utamshauri/Utantibu namna gani?
3. Mambo yaliyo: Unaitwa kwenda nyumba moja katika kijiji chako kwa sababu mama mmoja amejifungua sasa hivi na hata ndugu mmoja hakuwepo kumsaidia. Unapofika nyumbeni, unona mtoto ambaye amezaliwa analia na amelala chini pamoja na placent ya kitovu kilikuwa hakijakatwa. Je, elezea utafanya nini?
4. Theresia Charles, ambaye alikuwa amejifungua wiki iliyopita, anakuambia unamwa tumbo kwa siku tatu, na demu na ute wa uzazi hutoa harufu mbaya na uhasa hutoka ukani. Je, utamshauri/utantibu kwa namna gani?
5. Mama Paulo anakuja katika kituo chako na mtoto wake, mwenye umri wa mwaka moja. Mtoto huyu alikuwa akiharisha sana kwa siku moja na inaonekana kama maji yanaye matope. Ana hana kidogo. Utamshauri/Utantibu namna gani?
6. Mara kwa mara, anawashauri wakina mama wapeleke watoto wao kwa MCH Klinik. Faida ya kliniki ni nini?
  - 1.
  - 2.
  - 3.
  - 4.
  - 5.

MAJALIMU YA KIMATAIFA

MAJALIMU YA KIMATAIFA

1. Juma amejiua kwako na malalamiko haya yafuatayo - amaseme amekohoa sifa watu na kifua kiramama pamoja na homa. Udingusa umuona ana homa ili?
  - a) Je utambuje katika sanduku la huduma?
    - 1.
    - 2.
    - 3.
  - b) Utamshauri nini
2. Mekuja kwako mtoto wa miaka mitatu alifutana na mama mtoto huyo ana chida ya upele mwiili mzima
  - a) Utantitu na dawa gani?
  - b) Toa maelezo namna atakavyopakana.

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3. Mzee Kare amekupa kichochi wizi ya kutu na kichwa kichakana na mnygo homa. Eleza kutua utakazochukua na utatibu utakavyompa.
 

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4. Mtoto wa miaka miwili amelewa kwako akiwa<sup>a</sup> naharicha.
  - a) Utampa dawa gani insaidie?
  - b) Utamshauri nini mama yake?

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5. Dawa ya chloroquine inatumika kwa njunja wa malaria (mtu mzima)
 

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6. Mtu mwenye ukosefu au upungufu wa damu nitampa \_\_\_\_\_ ili karidisha damu kwa muda wa \_\_\_\_\_
7. Eleza utafanyaje akiya mama nja msito na matatizo ya kuuzwa tunbo sako.
 

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8. Majogore kutibiwa na
 

(1)	_____
(2)	_____
(3)	_____
9. Mtoto wa miaka 6 akiwa na mnyoo nitampa \_\_\_\_\_ (taja na kiasi)
10. Utamsaidiaje mtoto mwenye surua na lamshauri nini mama yake
 

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28/9/1981.

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HANANG VILLAGE HEALTH PROJECT.

Jina .....

Tarehe .....

OPG I & II REFRESHER COURSE

MTIHANI - MADAWA.

1. Andika maana ya ufupi:

	<u>Maene yake</u>	<u>Lini</u>
T.D.S:	_____	_____
B.D.	_____	_____
O.D.	_____	_____
Q.I.D	_____	_____
P.R.N.	_____	_____
Stat	_____	_____

UTOAJI WA VIDONGE:

Dawa	HUTIBU UGONJWA GANI?	KIPIMO KWA UMRI				MUDA
		Chini ya miaka 4	Miaka 1 - 4	Miaka 5 - 12	Walubwa zaidi ya 12	
ASPIRIN						
CHLOROQUIN						
SULFADIMIDINE						
FEROUS SULFATE						
ARMY COUGH TAB.						
KEFRAX (levamisole)						
MULTIVITAMIN TABLETS						

Dawa za KUPAKKA NA KUFUNGA VIDODDA:

D/WA	MATUMIZI YAKE	NAMA YA KUTUMIA
GENTIAN VIOLET		
BENZYL BENZOATE		
EYE OINTMENT		

~~MBINDI WA AFYA VIJIJINI - HUKUMU~~  
M T I H A N I - Usafi wa Mazingira (Muda saa 1)

1. Mafunzo ya afya katika Clinic za Akina mama na watoto yanapangwa kama; Eleza:
  - (a) .....
  - (b) .....
  - (c) .....
  
2. Eleza maana ya afya
  - (1) .....
  - (2) .....
  - (3) .....
  
3. Nyumba ya kuishi binadamu inatakiwa iwe na sifa gani? Eleza:
  - (1) .....
  - (2) .....
  - (3) .....
  - (4) .....
  - (5) .....
  
4. Mwili kuhitaji vyakula gani?
  - (1) .....
  - (2) .....
  - (3) .....
  
5. Maji hueneza mgonjwa kama:
  - (1) .....
  - (2) .....
  - (3) .....
  - (4) .....
  - (5) .....
  
6. Chakula kisipotayarishwa kuhifadhiwa na kulwa katika hali ya usafi, chaweza kusababisha mgonjwa ya hatari na ya kama kwa muda mfupi, Eleza ni mgonjwa gani hayo:
  - (1) .....
  - (2) .....
  - (3) .....
  - (4) .....
  - (5) .....
  - (6) .....
  
7. Chagua tibu sahihi, moja tu lizungushie alama ya mviringo:
  - (a) Maji wa chakula kisichotashaleza kuhitaji ya mwili unaweza kusababisha
    - (a) Kwashiorkor (Unyafusi)
    - (b) Upojazo (Marasmus)
    - (c) MPU
  
8. Vipimo vya shimo la choo:
  - (a) Kina cha kwenda chini ni futi 6 na upana usizidi futi 1
  - (b) Kina cha kwenda chini ni futi 5 na upana usizidi futi 6
  - (c) Kina cha kwenda chini ni futi 15 na kuendelea na upana usizidi futi 3

9. Nyumba chafu inasababisha ugonjwa gani? Yataje:
- (a) .....
  - (b) .....
  - (c) .....
  - (d) .....
10. Taja njia inayoweza kueneza ugonjwa wa safura kwa binadamu
- (1) .....
  - (2) .....
11. Eleza njia ya kuzuia ugonjwa wa safura
- (1) .....
  - (2) .....
  - (3) .....
12. Nitajie dalili unazoweza kutambua kuwa mtoto ana unyafuzi:-
- (1) .....
  - (2) .....
  - (3) .....
13. Nitajie nambo muhimu kila fya yanayahitajika:
- (1) .....
  - (2) .....
  - (3) .....
  - (4) .....
  - (5) .....
14. Mdhurumi ya kuanzisha vijiji ni kuwezesha wanavijiji kuishi katika utaratibu ambao unaweza kupata huduma za lazima kwa urahisi ili wawese kupambana na madui watatu ambao ni:-
- (1) .....
  - (2) .....
  - (3) .....
15. Nitajie dawa zinazotumika kwa kuzuia maradhi ya kuambukizwa:
- (1) .....
  - (2) .....
  - (3) .....
  - (4) .....
  - (5) .....
  - (6) .....

MRADI WA AFYA VIJIJINI OFG - V

100/0

MTIHANI - USAFI WA MAZINGARA ( MUDA MASAA 2

JINA LA MWAHINIWA \_\_\_\_\_  
TAREHE \_\_\_\_\_

MASWALI:

1. Katika kijiji chako unakoishi, Ally Moka aneukwa na Mbwa mwenye kichaa, ni hatua gani utachukua ya kumsaidia mgonjwa huyo.
 

(3) (1) Ushauri  
(2) mpitolele mtu mwenye msaizi auji  
(3) ni ganyu au kichaa
2. Hitajie dalili sita za kichaa cha Mbwa kwa Binadamu akiunna.
 

(6) (1) Sehemu  
(2) ...  
(3) ...  
(4) ...  
(5) ...  
(6) ...
3. Wanaohitaji kula chakula kingi zaidi katika milii yao ni watu wa namna gani?
 

(4) (1) ...  
(2) ...  
(3) ...  
(4) ...
4. Takataka zinawazo kuleta hasara gani kwa Binadamu zitaje hasara au madhara.
 

(5) (1) ...  
(2) ...  
(3) ...  
(4) ...  
(5) ...
5. Mtu apooa mara kwa mara katika mwili wake anaweza kupata na mgonjwa gani? Hitajie mgonjwa mtano.
 

(5) (1) ... (2) ...  
(3) ... (4) ...  
(5) ...
6. MICHANGO YA VIJIDUDU, duniani kote vinatuenea kutoka kwa mgonjwa hadi kwa mtu mzima kwa njia kuu nne (4) Zitaje njia hizo 4.
 

(6) (1) ...  
(2) ...  
(3) ...  
(4) ...
7. Taja sehemu sita ambazo maji huweza kupatikana:-
 

(6) (1) ... (2) ...  
(3) ... (4) ...  
(5) ... (6) ...
8. Mafunzo ya Afya katika Clinics za akina mama na watoto yangepangwa kama...
 

(5) (1) ... (2) ...  
(3) ...
9. Eleza maana ya Afya kwa kifupi.
 

(5) (1) ...  
(2) ...  
(3) ...

Siti

10. Nyumba ya kishi Binadamu inatakiwa iwe na sifa gani? Eleza site ujuzo

12

- (1) Maadani ya Kibinadamu
- (2) Ujuzi wa kutafuta maji
- (3) Ujuzi wa kutafuta maji
- (4) Ujuzi wa kutafuta maji
- (5) Ujuzi wa kutafuta maji
- (6) Ujuzi wa kutafuta maji

11. Mwili upahitaji vyakula gani? Zitaje aina tatu (3)

3

- (1) Choko
- (2) Kutepa
- (3) Kulitaka

12. Maji hueneza magonjwa yapi, yataje magonjwa saba (7)

8

- (1) Kipindiro
- (2) Malaria
- (3) Homa
- (4) Ujuzi wa kutafuta maji
- (5) Kulitaka
- (6) Kulitaka
- (7) Kulitaka

13. Chakala kisipotayarishwa, kuhifadhiwa, na kulikwa katika hali ya usafi, chawesa kusababisha magonjwa ya hatari na ya kuu kwa mda mfupi. Taja magonjwa sita.

6

- (1) Kipindiro
- (2) Kulitaka
- (3) Kulitaka
- (4) Homa
- (5) Kulitaka
- (6) Kulitaka

14. Chagua jibu lililosahihi moja tu, lizungushie alama ya mwingo katika jibu sahihi.

1

- (a) Ulagi wa chakula kisichotosheleza mahitaji ya mwili kumaweza kusababisha
  - (a) Kwashakor (Unyafuzi)
  - (b) Marasmus (Upojazo)
  - (c) MPC

1

(b) Vipimo vya Shimo la choo ni:-

- (a) Kina cha kwenda chini ni futi 6 na upana usizidi futi 1
- (b) Kina cha kwenda chini iwe futi 15 na kwendelea na upana uwe futi 2½ hadi 3, na urefu wa pembeni uwe futi 4 hadi 6
- (c) Kina cha kwenda chini iwe futi 2 na upana futi 4 na urefu uwe futi 11 kwa pembeni.

15. Nyumba chafu yaweza kueneza magonjwa gani? Yataje magonjwa matano.

5

- (1) Ujuzi wa kutafuta maji
- (2) Fura
- (3) Homa
- (4) Ujuzi wa kutafuta maji
- (5) Malaria

16. Taja njia mbili zinazoweza kueneza ugonjwa wa safura kwa Binadamu.

2

- (1) Kutokana na choko
- (2) Kutokana na choko

B. Eleza njia ya kuzidua ugonjwa wa safura

4

- (1) Choko
- (ii) Choko
- (iii) Choko
- (iv) Choko

17. Nitaje dalili ambazo zinazolawezesha kutambua kama mtoto ana Unyafuzi (Kwashakor).

4

- (i) Tumbo kubwa
- (ii) Tumbo kubwa
- (iii) Tumbo kubwa
- (iv) Tumbo kubwa

18. Madhumuni ya kuanzisha Vijiji ni kuwawezesha Wanakijiji kuishi katika Utaratibu ambao unawawezesha kupata huduma na lazima kwa urahisi, ili waweze kupambana na madui watatu ambao ni:-

3

- (i) Ujuzi
- (ii) maradhi
- (iii) madui

19. Nitajie mambo au vitu muhimu Kiafya inayohitajika katika maisha ya Binaadamu

6

- (1) Maji
- (2) Hali ya
- (3) Changamoto
- (4) Ujuzi
- (5) Malazi wa Magonjwa
- (6) Utupaji wa Talo wa Mifupa

20. Nitajie dawa zitumikazo kwa kuzuia maradhi ya kuambukiza - Vaccines) Taja dawa hizo kufuatana na magonjwa yaliyoorodheshwa hapo mbele.

6

- (1) B.C.S Vaccine huzuia ugonjwa wa Kifua kikuu
- (2) S/P Vaccine huzuia ugonjwa wa Ndui
- (3) T.T Vaccine huzuia ugonjwa wa Pepopunda
- (4) Mexone Vaccine huzuia ugonjwa wa Surua
- (5) D.P.T Vaccine huzuia ugonjwa wa Kifaduro
- (6) P.O.H Vaccine huzuia ugonjwa wa Kupooza

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MRADI YA AFYA V IJIJINI - HAWANGOPG. I & II - REFRESHER COURSE

Jina la Mtahiniwa.....

Tarehe.....

ENVIRONMENTAL HYGIENE TEST:

1. (a) Taja mambo matano kuhusu usafi wa mazingira
- (b) Mwanamataji anapaswa kuishi katika nyumba ya namna gani ?
2. (a) Taja mgonjwa mame yaletwayo na maji machafu.
- (b) Inatuhidi kufanya nini ili tuelewea na haya maradhi ?
3. Mzee Hanisi ametunwa kwako kupa ta ushauri wa kujenga choo
  - (a) Eleza jinsi gani mzee Hanisi achinbe choo, na choo hiyo iwe wapi na ya namna gani
  - (b) Eleza hatari za kwenda kinyesi ovyo wyo nje ya choo, na mgonjwa yanayosababishwa na kwenda kinyesi ovyo.
4. (a) Eleza mambo muhimu kwa wanavijiji kuhusu usafi wa mwili.
- (b) Eleza kwa kifupi njinsi utakavyotoa elimu ya afya kuhusu usafi wa mwili katika shule ya msingi

MRADI WA AFYA VIJIJINI WILAYA YA HANANG

Hina la Mthaniwa \_\_\_\_\_ MAGONJWA - JARIBIO

1) Andika orodha ya dalili za maumivu makali na za hatari za tumbo:

- i) \_\_\_\_\_
- ii) \_\_\_\_\_
- iii) \_\_\_\_\_
- iv) \_\_\_\_\_
- v) \_\_\_\_\_
- vi) \_\_\_\_\_
- vii) \_\_\_\_\_

2) Mtoto mdogo mwenye umri wa maka moja na nusu anaharisha. Bada ya kumwona na kumpa dawa zake, utamshauri mama yake vipi jinsi ya kufanya nyumbani kurudishia maji ya mwili kwa mtoto wake. (Uzito wa mtoto huyo wastani ni kilo 10)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3) Orodhesha dalili za hatari ambazo zinafuatana na kuharisha sana kwa watoto wachanga na wadogo.

- i) \_\_\_\_\_
- ii) \_\_\_\_\_
- iii) \_\_\_\_\_
- iv) \_\_\_\_\_
- v) \_\_\_\_\_
- vi) \_\_\_\_\_

4) Mtoto mdogo ni ugonjwa wa macho. Jicho moja liliko jekundu na linatoa usaha. Utatumia dawa gani? \_\_\_\_\_  
Utamshauri mama yake kufanya nini nyumbani?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5) Malalo ni ugonjwa wa \_\_\_\_\_, Uhasababishwa na \_\_\_\_\_  
Utamshauri wanavijiji kufanya: \_\_\_\_\_  
na kukinga maradhi haya.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Jina la Mtihaniwa: \_\_\_\_\_

6) Polio ni ugonjwa wa \_\_\_\_\_  
Unasababishwa na \_\_\_\_\_  
Unazuiwa na \_\_\_\_\_  
Utanshauri mama wa mtoto wa mtoto mdogo mwenye nguu ambao umepotea kufanya nini? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7) Kifua Kikuu ni ugonjwa unaoletwa na vijidudu vinavyoitwa \_\_\_\_\_  
\_\_\_\_\_  
Hushambulia sehemu za mwili kana vile \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mgonjwa anaendelea kutumia dawa hizo kwa muda wa \_\_\_\_\_

Dalili za kifua kikuu (hasa cha mapafu):

- i) \_\_\_\_\_
- ii) \_\_\_\_\_
- iii) \_\_\_\_\_
- iv) \_\_\_\_\_
- v) \_\_\_\_\_

Hawa ni:

Nawafahamu watu \_\_\_\_\_ (wangu pi) wanaoleta dawa ya T.B. kijijini mwangu.

8) Ukoma ni ugonjwa wa \_\_\_\_\_ ina \_\_\_\_\_  
Unasababishwa na \_\_\_\_\_

9) Kuna aina tatu za ukoma  
i) \_\_\_\_\_  
ii) \_\_\_\_\_  
iii) \_\_\_\_\_

10) a) Watoto wanaweza kuzaliwa na ukoma	<u>Kweli</u>	<u>Si kweli</u>
b) Ukoma ni ugonjwa wa kulogwa na mshawi	<u>K</u>	<u>SK</u>
c) Kuka mahali panaoja watu wengi husaidia uambukisaji ukoma:	<u>K</u>	<u>SK</u>
d) Ukoma ni ugonjwa wa ubongo hasa.	<u>K</u>	<u>SK</u>
e) Watu wazima wanaambukizana ugonjwa wa ukoma. Watoto wa shule hawawezi kuambukizwa na ukoma.	<u>K</u>	<u>SK</u>

Tarehe \_\_\_\_\_

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MRADI WA AFYA VILIJINI - HANANG

MSIMBAZI WA UGONJWA

1. Taja sababu zinazoweza kuleta Ugonjwa wa Kubarisha.

- A. 1. ....
- 2. ....
- 3. ....
- 4. ....
- 5. ....

B. Dalili za hatari za kubarisha ambapo mtu lazima aende Hospital kupewa Dawa kwa njia ya Mshipa ili kurudisha maji mwilini ni:-

- 1. ....
- 2. ....
- 3. ....
- 4. ....
- 5. ....

2. A. Kifua Kikuu ni Ugonjwa unapitwa na .....  
na kuhambulia sehemu kama:-

- 1. .... 2. ....
- 3. .... 4. ....
- 5. ....

B. Dalili za Kifua Kikuu cha Mafafu ni:-

- 1. ....
- 2. ....
- 3. ....
- 4. ....

3. A. Ukoma ni Ugonjwa wa ..... na .....

B. Dalili zake kuu ni:-

- 1. ....
- 2. ....
- 3. ....

4. Eleza unayojua juu ya Ugonjwa wa Malaria.

5. Kichomi ni Ugonjwa wa .....

Dalili zake ni:-

- 1. ....
- 2. .... 3. ....
- 4. .... 5. ....

.....2/

6. Utamtambua je mtu mwenye Ugonjwa wa Tezi za Kocni?

7. A. Popopunda huIstwa na ....., na Ugonjwa huingia kwa njia ya .....

B. Dalili za Alama ni kama ifuatavyo:-

- 1.
- 2.
- 3.

8. Taja matatizo yanayoweza kutokea kwa mtoto aliyegua Surua.

- 1.
- 2.
- 3.
- 4.

9. Ni zipi dalili za hatari za K\_kohoa ambapo Mgonjwa lakima amede hospital?

- 1.
- 2.
- 3.
- 4.

10. A. Eleza maana ya Askari wa mwili

.....

.....

.....

.....

B. Askari wa mwili hutengeneza mwilini katika sehemu zifuatazo:-

- 1.
- 2.
- 3.

44 f. / Taahiri Dallah

MURIDI WA AFYA VIJIJINI HANANG.

KETIHANI WA MWISHO WA MUHULA WA IV OPS. IV

KUFUNDISHA:

Zifuatazo ni sifa za mwalimu mtawala na mwalimu wa kundi. Hebu zipange sifa za kila mwalimu upande wake:

- anawatisha watu, anawakomea na kuwakaripia watu, anafundisha mambo sio watu, anawaona watu kazi. watoto wadogo anakusidika warafunzi, anajiona mkubwa wa watu, anajiona mojawapo wa watu, mwenye kushirikiana nawazir, anaheshimu watu, anawasikiliza r. kutia moyo watu, anafundisha watu sio mambo tu anajitahidi kujifunza njia za kuongoza majadiliano.

Mwalimu Mtawala	Mwalimu wa kundi
-----------------	------------------

Zifuatazo ni sifa za watu wazima waka alama (✓) pale unapoona ni kweli.

- (i) Wanjiona watu wa na an, wenyekudai heshima ( )
- (ii) Wanakumbuka;
  - 40% wanayosikia tu
  - 30% wanayosikia na kuona
  - 20% wanayogundua wenyewe ( )
- (iii) Wanakumbuka:
  - 20 % wanayosikia tu
  - 40% wanayosikia na kuona
  - 30 % wanayogundua wenyewe ( )
- (iv) Wanakumbuka:
  - 30% wanayosikia tu
  - 40% wanayosikia na kuona
  - 20% wanayogundua wenyewe ( )

- (v) Wana ujuzi mwingi; wanakwisha na kuolewa, kuzaa, kulea watoto n.k. ( )
- (vi) Wanajifunza na kusubiri matokeo mwa bandaye.
- (vii) Wanajifunza kwa faida ya mara: Matokeo ya leo.

Kwa kutumia kijiitabu cha 'USIKUBALI KULI ELVI':

Fanya yafuatayo:

1. Soma Kijiitabu chote.

2. Gawa katika masomo mawili

(i) Andika kichwa cha sono la I

(ii) Andika Kichwa cha sono la II

3. Andaa namna utakavyofundisha sono la I

4. Andaa namna utakavyofundisha sono la II

MRADI WA AFYA VIJIJINI WILAYANI - HANANG.

Jina la Mtahiniwa ..... Kijiji cha .....

ELIMU YA WATU WAZIMA:

1. Zifuatazo ni sifa za watu wazima:

i) Wanajiona watu wa maza, wenye .....

ii) Wana ....., wamekwisha oa na kuolewa,  
kuzaa, kulea watoto nak.

(iii) Wanajifunza kwa ..... Matokeo ya leo.

iv) Wanakumbuka:

(a) 20% Wanayo .....

(b) 40% Wanayo .....

(c) 80% Wanayo .....

2. Tunapofundisha kwa kutumia ishara huwa tunafuata hatua n: ne katika  
somo moja.

- Hatua ya kwanza ni kuhusu .....

- Hatua ya pili ni kuhusu .....

- Hatua ya tatu ni kuhusu .....

- Hatua ya nne ni kuhusu .....

3. Tunapowafundisha viongozi wa Afya, kuwaandaa mpaka wawe tayari kufundisha  
katika vikundi vyao vya majadiliano:-

Tunafuata hatua zifuatazo:-

Hatua ya kwanza .....

Hatua ya pili .....

Hatua ya tatu .....  
.....

Hatua ya nne .....  
.....

4. Katika kupanga mpango Inara kuma hatua 7 za kufuata hebu zitaje:

- 1. ....
- 2. ....
- 3. ....
- 4. ....
- 5. ....
- 6. ....
- 7. ....

5. Maimamizi mkuu anayetazamiwa kuleta mafanikio katika mpango mzima wa Mradi wa Afya ni KIONGOZI WA AFYA KIJIJINI. Taja mambo ambayo unapaswa kufanya juu ya kiongozi wa afya ili kumjenga kujiamini.

- 1. ....
- 2. ....
- 3. ....
- 4. ....
- 5. ....
- 6. ....
- 7. ....

1 - - - - - 24  
 2 - 4        6

**MRADI WA AFYA VIJIJINI**  
**IDARA YA AFYA**  
**WILAYA YA HANANG'**  
**HATI YA UTHIBITISHO**

*Hii ni kuthibitisha kwamba*

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*amefuzu mafunzo ya Wahudumiaji wa Afya Vijijini yaliyoendeshwa na Mradi wa Afya Vijijini Hanang' kwa kushirikiana na Mganga Mkuu wa Wilaya kuanzia \_\_\_\_\_ mpaka \_\_\_\_\_*

*Ameruhusiwa kufanya shughuli zifuatazo :*

- Kutoa elimu ya afya*
- Kutibu shida ndogo ndogo na kutoa dawa zilizoruhusiwa kijijini*
- Kutoa huduma ya kwanza*
- Kusaidia katika shughuli za M. C. H.*
- Kuangalia usafi wa mazingira kijijini*
- Kuwa Mjumbe wa Afya katika Halmashauri ya kijiji*

*Cheti hiki kinatambulikana katika kijiji cha \_\_\_\_\_*

*Wilaya ya Hanang' tu na kimetolewa tarehe \_\_\_\_\_*

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**Mganga Mkuu**  
**Wilaya ya Hanang'**

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**Mkurugenzi**  
**Mradi wa Afya Vijijini**

**Cheti hiki kimetolewa bila ya masahihisho yoyote.**