

UNCLASSIFIED

PROJECT TITLE: HEALTH PROMOTION (PES) - PART I

PROJECT TITLE <b>HEALTH PROMOTION</b>	PROJECT NUMBER <b>62L-0133</b>	3. MISSION/AID/W OFFICE <b>TANZANIA</b>
--	-----------------------------------	--

4. PROJECT IMPLEMENTATION DATE	5. PLACE OF ENTRY EVALUATION
Start: 77 Plan: 81 Completion: 81	April 1979 Feb 1980

6. ACTION DESCRIPTION	7. RESOURCES FOR ACTION	8. DATE OF ACTION
1) That Contractor will prepare projections for expenditures for transportation from the present up to the end of project to determine whether more funds will be necessary and submit these projections to USAID/Tanzania.	Brother Joseph Rose	April 80
2) If necessary from 1 above USAID/T will assist CODEL in preparing project amendment to provide sufficient funds to maintain transport for the project.	Paul Zemor	April 80
3) That Contractor will revise health education methodologies used in teaching village health leaders to effect greater participation, confidence and success.	CODEL staff	April 80
4) That Contractor will initiate the signing of agreements between VWS and Village Development committees outlining mutual responsibilities.	" "	April 1980
5) That Contractor continue to monitor payment issues for VWS as regards achievement of Project objectives.	" "	April 1980
6) That Project collect data on village health activities initiated as a result of work in health units and that the data forms for all health information, when included in reports, be presented in a clear-cut, understandable manner with denominators for each category clearly identified.	" "	April 1980

9. CATEGORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS			10. ALTERNATIVE DECISION 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 checked="" type="checkbox"/> A- General Project Health Center	
<input checked="" type="checkbox"/> Financial Plan	<input type="checkbox"/> P10/T		B. <input type="checkbox"/> Capital Project Design and/or	
<input type="checkbox"/> Other (Specify)	<input type="checkbox"/> P10/C	<input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Staff Recruitment	
<input type="checkbox"/> Project Reports	<input type="checkbox"/> P10/P		C. <input type="checkbox"/> Miscellaneous Project	

11. PROJECT OFFICE AND HOST COUNTRY OFFICE	12. MISSION/AID/W OFFICE
Paul Zemor/Health, Nutrition, Population Office	Edward E. Stevens
Robert Gilman/Health Division Director	
Robert Gilman/Evaluation Officer	

April 1, 1980

13. Summary

The Hanang Village Health Project has been undertaken to provide a viable model for Tanzania to extend its existing health care delivery system to the village level. The Government of Tanzania is presently interested in this extension from the rural dispensary level (designed to serve a population of 6000-8000 people) to reach people in their villages. This project has developed a plan for the achievement of that goal. Its purpose is to help the health status of rural villagers in Hanang District by using the present political structure, encouraging self-help 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; creation and implementation of a health delivery system that consists of initiating health activities by the Village Health Workers in the villages; selection and training of Village Health Leaders to serve under the Village Health Workers at the health unit level (the size of these units may differ from village to village); the training of Village Health Workers to use first aid boxes to be stocked with basic medicines; and assistance for villages in establishing monthly mobile MCH clinics where necessary and possible, given limited personnel.

A two-year extension for the project was signed August 31, 1979, which brings total project funding to \$495,000 and extends the termination date to November 1981.

At the present time the first groups of 57 Village Health Worker trainees have been trained and have been working in the villages for over one year. A subsequent group of 30 trainees has just completed initial training in Babati and will shortly be returning to their villages to take up their work; and a new group of 40 trainees has been identified and will begin training in April of this year. As a result of experience gained with the first groups, the training schedule has been changed and some topics revised to make the training more effective and relevant to field problems encountered over the last year. Considerable progress has been made by the Project since the last evaluation in the areas of village identification and involvement of key village personnel in the present structure who are most crucial and appropriate for support at the earliest stages of project work to insure future commitment. It was noted that project personnel are much more confident at this time and have benefitted from the year of experience gained. 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, with data continuing to come in every month from the villages as planned.

Progress has been disappointing in other areas. The training in the villages of Village Health Leaders by the Village Health Workers has not been proceeding according to plan. Attendance of Village Health

Leaders at their training sessions has been very poor. Given this result, it has also followed that teaching by the Village Health Leaders themselves in the health units at the household level is progressing at a low level. For the first group of villages the creation of health units with continuing health educational programs has failed in most cases. The reasons for this are: inadequate leadership and commitment on the part of Village Health Workers, inadequate village leadership, involvement in other primary village activities and inappropriate teaching methodology at this level. The latter point is of particular importance for it was only recently realized that most Village Health Leaders weren't able to carry out health education activities simply because they could not read or write. Now, with an understanding of this problem new approaches will be tested. Some District and village officials have already suggested folding health education activities into village adult education activities. Also to be considered is the possibility of using primarily Village Health Workers at the village levels, thus eliminating the need for a lower echelon of workers cadre. The problem with this approach is that the Village Health Workers would then take a much longer time in reaching all the people in the village. It is expected that with the revision of the training program for the latest group, some of these problems will be solved, as the Project continues to monitor its own effectiveness.

The Project has been marginally successful in involving district level health personnel in some monitoring activities, leading to the likelihood that this function will be continued to some extent once project funds are expended. Specifically, the Bwana Afya at the district level and his divisional health inspectors are being brought into the Project in some villages, and it is expected that the number of villages being monitored in this way will slowly increase over the coming year. This is a key activity and must be given increased emphasis and priority to insure that personnel from the DMO's office are involved and can continue with project activities.

A more detailed review of activities to date in each project area will be presented to report on progress, problems and anticipated changes being considered.

### 1. Village Selection and Initiation

Each village being considered for inclusion in the Project is contacted three times, and is asked to select candidates for the VEW positions. During these initial contacts the Project staff assess the village according to a number of criteria developed by the Project, including effectiveness of village leadership, attendance at the meetings, enthusiasm and interest shown and methods of selection of candidates. On the basis of these criteria final decisions are made as to which villages will be brought into the Project.

At this time 48 villages have been initiated into the Project and 43 are still actively participating in Project activities. The importance of including all village leaders at the earliest stages of contact

has been re-emphasized by the project staff. In the beginning the Project was late in contacting the politically active people in each community and certain other leaders that didn't appear to be concerned specifically with health. These omissions created problems in mobilizing necessary support for the project and led to slow starts in some areas. Project leaders now better understand the social group with whom they must work and have made significant progress in choosing the right people to get participation of the majority. In one of the five villages where project activities have come to a standstill, it was reported that problems with village leadership, not specifically related to the project, caused the cessation of activities.

## 2. Selection and Training of Health Workers

Each contacted village nominates a number of candidates to be considered for the position of Village Health Worker. On the third visit by Project Staff to newly selected villages these candidates are tested and evaluated with a standardized set of criteria developed by the Project. These criteria include components from a non-verbal intelligence test, results of a written composition, personal characteristics noted during a planned activity, age, marital status, experience etc. Two candidates are chosen from each village -- one man and one woman. It was found through experience that this arrangement is most successful. In villages where two men had been selected, problems invariably arose when food preparation demonstrations were required. The Project will now reject a village if at least one qualified man and one qualified woman are not identified.

The candidates then go through approximately 10 months of training both in the classroom and in the field under the direction of project staff, after which they are sent back to their villages to carry out a particular series of health related assignments. During the training period a number of Village Health Leaders are also elected by the villagers. These people work under the direction of the Village Health Workers at the lowest political level in the villages -- the 10-cell unit. They are to establish health units at this level and actually gather monthly disease data and initiate health education classes in their health units.

The training of the Village Health Workers has been lengthened to 10 months, and considerably revised since the last evaluation to take into account implementation problems encountered. The first group to have received this revised training is due to leave for the field in March of this year and the coming year will reveal whether the changes have improved some of the weak points. The Staff feels quite confident now about this aspect of the Project and feels they have been able to develop and evolve over the first two years an effective training program that responds to the requirements which will be put on the Village Health Workers when they return to their villages.

The issue of payment for these workers was again discussed and has been carefully looked at during the past year. All villages without exception provide financial support for their trainees while they are undergoing training at the Project Headquarters in Babati. It is the period after this training when they return to work in their villages that is at issue. It is the Tanzanian government's official position that these Village Health Workers should not receive a pay -- they should be volunteers and should contribute in the spirit of Ujamaa with the knowledge that their work will assist their village's ability to achieve self reliance. There have been complaints from the Village Health Workers in the past concerning the lack of more substantial incentives for their work. This has led in some cases to villages deciding to pay these people, and in most cases to the workers being excused from the otherwise required communal work in the village. It is reported that less than half of the Village Health Workers are now being paid. Activity levels have been compared for villages where the workers are paid against those villages where the workers are volunteers, and it has been noted by Project staff that there are in fact no significant differences between them. There seems to be no correlation between level of activity and whether or not the workers are paid. There are villages in which paid workers are inactive and others where unpaid workers are active, leading overall to no discernable pattern.

The Area Commissioner in the district has stated that following a year of work in the villages, the villagers will see the value of the Village Health Worker if good work has been done, and at that time the village development committee could be approached for working out some means of reimbursement. If the health worker proves his/her usefulness to the people, the villages will respond. Some resources can be found even in the poorest villages to help pay back the VHWs for work they have done. This issue will continue to be monitored closely by the Project because of its implications for any similar type of program that may be initiated by the Government on a national basis. The Area Commissioner also stated that in the future villages are expected to raise revenue and that this may be a source of funding for individuals in the villages providing needed services, including health workers.

### 3. Village Health Activities

It is in this area that the Project is experiencing its most serious problems. Following their training, the Village Health Workers return to their villages and carry out a number of activities, many of which revolve around the continued training of the Village Health Leaders. An important project output is the creation of active health units by the villagers in each village, at which point the actual villager-initiated self-help activities might begin. Also there is to be a continuing program of health education carried out at this level by the Village Health Leaders. It has been noted that only 13% of the Village Health Leaders are regularly attending their own training classes conducted by the Village Health Workers and the health education program is continuing at the health unit level in only 14% of the health units established.

It has been found that the health education methods employed to date, which were adapted from the work of Paolo Freire have not been effective. The staff has determined that this method required more literate subjects and has been experimenting with other, less complicated and more interesting methods. There are a number of options being considered now and during the next year, these methods will be tested. It is expected that this will lead to greater village participation. Some of the health education classes are being held in conjunction with adult education classes, which has also proved to be more effective and is leading to greater involvement.

Another problem encountered has been the lack of job definition and mutual understanding of responsibilities between the Village Health Workers and each village. It is felt by Project staff that it's important for the VHW to be accountable in some defined way to the village. It has been suggested that the Village Health Worker sign an agreement with the Village Development Committee before beginning training which will spell out in more detail mutual responsibilities. It was agreed that the Village Secretary should be the one to monitor the VHW's progress and work in the village.

In addition, the staff has initiated a regular village visitation program in which Project staff travel to each village once during a 2-month period for a one-week stay to monitor project progress and check on village activity. It has been found that this program is essential to re-invigorate trainees and get village activities started again, if they have slacked off. This activity might be considered as the same thing as a periodic continuing education program for the VHWs and should be expected to accomplish some of the same goals as a continuing education program. District level health staff (as mentioned above) are involving themselves in these activities with an eye toward their future ability to continue once the formal project ends. A lack of personnel and funds for transport at this level will make it difficult for these people to maintain the same level of supervision after external funding ends, and this issue will have to be carefully considered in the coming years to insure that Project activities don't die.

Even presently this essential staff monitoring activity is being threatened by the continually increasing cost of petrol and related transportation costs. It appears at this time that the Project itself may have difficulty completing the activities projected with the transportation money allotted. Inflation and increasing costs are rapidly encroaching on the Project's ability to maintain its vehicles and keep them on the road enough to properly carry out project activities. This may necessitate a project amendment to obtain extra funds for this purpose.

#### 4. Monitoring and Evaluation System

The information gathering system has been elaborately designed and is yielding general information about the villages, health status in the villages, and data regarding project activities on a regular basis to the Project. Also, through the village committee structure, this information is passing to village leaders themselves and to district health personnel. In each village the VHL workers do work following training with a Village Profile that is compiled from various surveys taken in the village during the training period. These include: a census, a nutrition survey, a health survey, a health questionnaire and an environmental sanitation survey. Also monthly data from the VHL's comes to the Project concerning attendance at training sessions and problems in their areas with particular childhood diseases. An important group of Project activities center around the nutrition surveys done in each village on all children 10 years of age or under. Malnourished children are identified during these surveys and followed up later by VHL's. This activity was poorly coordinated in the first groups, but the timing has been changed in the later groups, resulting in earlier follow-up of these children. While presently providing invaluable health data which can be used at all levels, it is at this point somewhat doubtful that all present data collection will be carried on when the project terminates -- simply for lack of resources and transport.

#### 5. First Aid Boxes and MCH Clinics

First aid boxes are now available in 9 villages. It was hoped that each village would be able to establish such a box, which would be used and supervised by the Village Health Workers. There is a monetary constraint here, because each village must pay 400-500 TSh to establish the box, which sometimes is impossible. In addition there is not an adequate supply of drugs for the boxes so that none of them have a complete stock list. Some drugs are available from the District Medical Officer's store. There are 6 other villages that have obtained the materials for the box, but as yet have not been able to identify a place to put it. The Area Commissioner at the evaluation meeting took the names of these villages and intends to follow-up to make sure they get places for their boxes.

MCH clinics have been started in 11 villages up to this time. The Project only provides transportation for clinic personnel and logistical support (including some medicines for minor treatment) for these clinics, with the villages providing the site and other medicine provided from district health funds. The staff for these clinics come from already established health facilities in the area. The biggest constraint to the establishment of more clinics is the lack of enough technical personnel available to staff them. Also transport is a big problem, which without the Project would not be available. These clinics are very well attended and are in great demand by villagers in the area. The Village Health Workers help and participate in clinics in their areas.

#### 14. Evaluation Methodology

The purpose of the evaluation was to look at project progress after two years, to find out whether planned objectives were being met, and whether further adjustments will have to be made. Given the Government's present interest in extending a similar type of program to the national level during the next few years, it is important to monitor this project closely. The issues it raises will have to be carefully considered in any further project. USAID is presently planning to assist the Government of Tanzania in its efforts to implement a National Village Health Worker training program and lessons learned in the Mansang Project will have to be incorporated by USAID in its VHW program.

Information for this report was derived from periodic project reports, discussions with TanGov district and village officials and CODEL Project staff in Babati and elsewhere during a visit to the project site by USAID representatives.

#### 15. External Factors

There have been no major changes in the project setting which have had an impact on the project. The assumptions made remain valid.

#### 16. Inputs

It appears that insufficient funds have been provided in the project for the operation and maintenance of vehicles, which are a crucial part of the project as discussed above. In this case it appears that an amendment will have to be written for additional money for this purpose. The project financial manager is preparing a more detailed analysis to verify the extent of this problem. Following receipt of his recommendations, this office will take action to amend the project, if necessary or possible. With the two-year extension recently approved, the Project is funded at this time to the level of just under \$500,000. Any amendment would put life of project funding over this amount, which is theoretically the limit to which the Mission can act on its own without Washington approval. The Mission will investigate the possibility of approving this amendment here in Tanzania, without first having to go to Washington.

#### 17. Outputs

These areas have all been touched on above in more detail but will be summarized here as follows:

##### 1. Health Delivery System

- basic structure established with training and placement of 87 active Village Health Workers in 43 villages as of March 1980. (Five villages now inactive)

- Village Health Leaders in each village elected and being trained -- attend see page at this point.
- health education methodologies for village use have been found to be ineffective and are now being modified.
- VHL follow-up of borderline children identified in nutrition surveys -- assessing growth in first group has been revised for latest group of trainees
- health education demonstration techniques being used effectively with last trainee group in villages
- VHLs collecting monthly data on diseases and attendance at classes.
- use of the health unit for health education purposes has been disappointing to date
- some health activities have been undertaken in a few villages -- latrine, garbage pit construction, water protection.
- adult education classes being used in some villages in the place of VHL classes. In these cases the VHLs are not getting their planned instruction in teaching methods and therefore teaching at these health units has stopped.
- villager awareness of health issues reportedly increased
- first aid boxes set up in 15 villages.
- MCH ~~clinics~~ established in 11 villages.

## 2. Baseline Data Collection and Analysis System

- nutrition survey taken in all villages.
- VHLs collect monthly data on attendances at training classes and childhood diseases.
- census taken in all villages.
- health questionnaire completed all villages.
- environmental sanitation forms filled out for 11 villages as follow-up on census.
- health survey undertaken in all villages.

## 3. Instruction Methodology

- Babati training period for Village Health Workers has been substantially revised with time almost evenly divided between classroom and field work -- 10 month total.

4. Health Workers with Improved Training

- 99 Village Health Workers have received training, and 87 are now in their villages working (57 in the first groups and 30 in the latest group with the revised training schedule.)
- 20 more villages with 40 VHWs will come for training beginning in April 1980
- an as yet undetermined number (not to exceed 20) will come in the final phase in October 1980 to bring the project total villages to 20-80 by the completion of the project.

18. 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.

It has turned out to be very difficult to measure the health impact of the project, because it is nearly impossible to separate health effects brought by the project from health changes brought about by other factors external to the project. In the coming year it will be possible through the data collection system to note changes in some health indicators because baseline data has now been collected and comparison can be made, especially with regard to childhood diseases and children's nutrition status. It is anticipated that a second nutrition survey will be done in a number of villages for this purpose. Such a second survey has been done for 13 villages already. One problem has been that it is very difficult to identify the same children in the first and second survey, and therefore to compare their nutritional status each time. On the average only 30% of the children seen in the first survey could be positively identified as taking part in the second survey. This has occurred because of name changes and difficulties with positive identification because of lack of accurate birth records.

The health delivery system itself is proving to be feasible although it remains to be seen in the next year whether more health units will be functioning. The concept of the Village Health Leaders and their role will have to be carefully looked at following the introduction of new health teaching methods to assess whether they will begin to function more effectively, or whether it might have been too ambitious to try to train this cadre of workers. In this case, it will have to be determined whether the VHWs themselves can take on the extra burden of VHL duties effectively.

19. Goal

"To strengthen the capacity of the Ujamaa structures to improve living standards."

Since at this point only 20% of the Village Health Leaders are actively working in health work, and there have been no quantitative

reports regarding villager initiated health activities, it is difficult to report that much progress has been made toward this goal. An effort should be made by Project Staff to collect data on this aspect of village activities undertaken as a result of the project to assess progress toward the goal.

## 20. Beneficiaries

Initially, the objectives of the project included selecting and implementing the proposed health delivery system in all 110 villages of Hanang District. However, it was realized after 1 year that this goal was too ambitious, and consequently the project has been extended for two years and scaled down in regard to the number of villages to be covered. It is expected that 70-80 villages will be covered by the end of the project in 1981. At this point, assuming an effective delivery system is created, approximately 160,000 - 180,000 villagers will benefit directly and the entire population of 232,000 in Hanang district will have been provided greater access to health care services.

## 21. Unplanned effects

There have been no major unexpected results or effects of the project during implementation to date.

## 22. Lessons Learned

In view of the interest of the Tanzanian Government in implementing a Village Health Worker training program nationally in the near future, this project should be closely monitored to provide valuable field data on problems and approaches to setting up such a system. The following statements have been distilled from the more detailed findings of the evaluation as discussed above:

- It has been noted that village leadership is crucial to project success.
- Village political and non-health contacts need to be made early on and maintained to insure commitment.
- Some type of regular supervision and monitoring system is essential to maintaining Village Health Worker contact and keeping program activities going.
- Both men and women need to be involved in the system at the VHW level.
- Responsibilities and accountability need to be well defined and understood at the outset.
- The issue of payment still needs to be looked at, but at this point it appears that both volunteers and paid workers can be effective.

- It is unwise to try to proceed too rapidly in assuming that previously untrained people can respond quickly to be able to teach effectively and pass on accurate health information without ample time to build confidence and allow information to be assimilated.
- The availability of transportation is essential for maintaining communication and continued monitoring of project activities.

ARUSA 1

LIST OF PERSONS CONTACTED DURING EVALUATION

USAID

Mr. Thomas Luche - USAID/Arusha

GOVERNMENT OF TANZANIA

Mr. L.M. Mambo	Area Commissioner (CCM)
Dr. A. Mshanga	District Medical Officer
Mr. G. Songai	Divisional Secretary (CCM) - Gorowa
Mr. L.G. Bilauri	Divisional Secretary (CCM) - Bashalet
Mr. L.L. Biade	Divisional Secretary (CCM) - Barbaig
Mr. M.M. Tlughwe	Divisional Secretary (CCM) - Mbugwe
Mr. L. Ako	Divisional Health Inspector - Medical Department (Divisional Health Leader - Project)
Mr. A. Kilinga	District Health Inspector ("Bwana Afya")
Mr. S. H. Hermansin	District TB and Leprosy Coordinator (RMA) (also part time Project Worker)

CODEL PROJECT STAFF

Dr. Martha Collins	Project Director
Sr. Marian Teresa Dury	MCH Supervisor
Brother Joseph Rose	Business Manager
Mr. S. Msweti	Executive Secretary
Mr. W.P. Masunga	Personnel Officer
Mr. Y.J. Masasi	Training Supervisor
Mr. D. Sisti	Teacher
Mr. D. DoAmsi	Systems Analyst
Mr. H. Makando	Clerk, Information System
Mr. W. Tairo	Divisional Health Leader - Barbaig
Mr. H. Makaben	Divisional Health Leader - Gorowa

EVALUATION TEAM USAID/TANZANIA

Mr. Robert Gilson  
Mr. Paul Khuser