

621-0138

HANANG District Village

Health Project

(CODEL)

Project Paper

FY 77

**CODEL**

**HANANG DISTRICT VILLAGE HEALTH**

**PROJECT PAPER**

**July, 1977**

## HANANG DISTRICT VILLAGE HEALTH PROJECT

### A. Introduction

#### 1. Rationale

Mwalimu Julius Nyerere, President of Tanzania, has often reiterated his belief that the wealth of a nation is in its people. This project ultimately aims to involve each villager in Hanang District in rural health activities. An improvement in health of adults and children alike will undoubtedly have a positive impact on the progress of development. Through this project it is intended to assist the Tanzanian Government to improve and expand its rural health delivery system by strengthening the weakest link in the chain of the delivery system itself. This major weakness is in the outreach to the family unit in the village from the rural health center and dispensaries. While this is certainly the weakest link in programs in many countries, Tanzania through its Ujamaa Village concept and organization provides an effective structure upon which to build.

The project as described in this paper effectively complements USAID/Tanzania Maternal/Child Health (MCH) Training Project. Under this program 18 centers are being constructed throughout Tanzania where approximately 2,000 MCH Aides will be trained for village level work. One of the training centers will be located in Mbulu District of Arusha Region.

#### 2. Tanzania's Rural Health Scheme

The Tanzanian commitment to rural development is reflected in the government's health efforts in rural areas where 90% of all Tanzanians live. A large proportion of the 1975/76 capital budget in health is devoted to rural development and Ministry of Health plans indicate that this emphasis will continue for at least the next few years. The primary goal of this rural health focus is to ensure by 1980 that 90% of Tanzania's population is within ten kilometers (walking distance) of a health facility. The movement of people into Ujamaa Villages should facilitate achievement of this goal.

It may be helpful to briefly present a profile of the health personnel found in rural Tanzania. The country is divided into 20 regions with a Regional Medical Officer in charge of all medical work in a region. Regions are divided into districts with District Medical Officers covering each district. Some of these officials may be doctors and some are up-graded Medical Assistants. There are various other medical staff in regional and district hospitals, health centers and dispensaries. These include Medical Assistants, Rural Medical Aides, Dispensary Aides, Midwives, Nurses and Health Auxiliaries. As suggested above, the health delivery link to the villages needs extensive strengthening and the Ministry of Health

is grappling with this problem. The implementation of the Village Dresser concept whereby a paid person with minimum training would be posted to a village with a meager supply of medical supplies has not been successful. Many of these people were not from the village where posted and in some instances have left their assigned area. This project has been designed as an alternative approach to a village health delivery system.

### 3. Brief Description of Hanang District

Hanang District was formerly a sub-division of Mbulu District (to the north) but in 1970 it was redesignated a separate district. This new administrative unit is approximately 3,300 sq. miles in size with a population of about 200,000 people. The district lies within the Rift Valley with altitudes in general ranging from 3,500 to 5,000 feet, although Mt. Hanang rises to over 11,000 feet. It is generally a good farming area with adequate soils and rainfall sufficient during most years. Major crops are maize, beans and wheat with extensive livestock holdings.

The district headquarters is located at Babati on the main Dodoma-Arusha road. A major road branches west from Babati to Singida, Tabora, and Mwanza. In general, roads are very poor and travel is slow and uncertain particularly in the rainy season. The district is divided into divisions, divisions into wards, with several villages in each ward. Villages are further divided in ten house groupings.

The largest medical facility in the district is the Dareda Mission Hospital which has recently become the Designated District Hospital. In addition to this major facility, there are three health centers and 22 dispensaries of which 15 are government, five are operated by voluntary agencies, and two are parastatal owned. Health in the district is no better or worse than in most areas of Tanzania. Even though in most years the food crops are adequate, malnutrition (kwashiorkor and marasmus) particularly among children is prevalent.

Tuberculosis is widespread and sleeping sickness (treated at the Magugu Health Center) is found in the district. Leprosy appears to be declining in number of cases but those persons inflicted with the disease are treated at the Mbugwe treatment clinic in the district. Other prevalent diseases include malaria, measles, schistosomiasis, gastroenteritis, infestations of hookworm and ascaris, pneumonia, and acute rheumatic fever with or without carditis in adolescents. At the present time there is little public health or preventive medicine work being done in the district although there is an Under Five Clinic held at Dareda Designated District Hospital. To remedy this situation, a key element of the project proposed in this paper will be the greater emphasis on 1) nutrition, 2) health education, 3) inoculations of children, and 4) family planning.

## B. Proposed Project

### 1. Introduction

This project has been designed in three phases - planning, pilot, and the long-term project. The entire project is about three years in length although delayed project approval has extended the planning phase by several months. However, for design purposes it can be considered that the planning phase is a six-month period beginning January 1, 1976 with the pilot phase commencing about July 1, 1976 and continuing through the end of the year. The two-year long-term project would begin in January, 1977 (although this could begin earlier or later depending on progress during the pilot phase).

### 2. Planning Phase

This period of time which has already started is being devoted to solidifying contacts in the district; obtaining national, regional and district clearances and approvals for the project; consulting with various village leaders; selection of the three or four villages to be covered in the pilot phase of the project; and making arrangements for the few expatriate personnel required for the project as well as lining up the several Tanzanian course instructors and trainees. Curriculum for teaching the project trainees is being developed along with the teaching methodology. Arrangements are being made for a teaching site, housing in Babati for the Project Administrator, and the purchase of various items of equipment. Refinements of the data collection system and baseline data gathering are in process or being accomplished. Much of this work is completed and all that is now required is final Arusha Region approval. It should be noted that Arusha Region has approved the project in principle but final approval will not be made until June 1976 after the region's planning committee meets (See Annex B). Dr. E. Tarimo, Director of the Preventive Services Division of the national Ministry of Health, has approved the project with only a few comments (see Annex C). The budget for this phase of the project is shown in Section D.

### 3. Pilot Phase

This phase of the project is designed to test the project's feasibility and work out the early implementation problems prior to commencing with the long-term project. The project team will work with only three or four villages, one in each division of the district, and will begin training eight health workers, several of whom will work in these villages.

An evaluation of the pilot phase conducted by project personnel will occur during the sixth (or so) month. This evaluation will not so much involve whether to continue the project or not (although that

will certainly be one of the questions to answer) but to determine what problems were encountered during the pilot phase and how they can be overcome. The evaluation will also look at the project design and determine whether it is still valid and whether any changes are required. A report of this evaluation will be circulated for review to CODEL and Tanzanian Officials directly concerned with the project.

#### 4. Long-term Project

##### a. Introduction

This project grows out of a two-year experience (May 1972 - April 1974) in the Mangida Ujamaa Village in Dingida Region which is directly southwest of Hanang District. This experience in one village had several health care aspects, both curative and preventive, with an intensive education program. The educational aspect was geared to reach all women with young children and focussed on hygiene and weaning food preparation. It was highly successful in terms of results, enthusiasm, participation and coverage. In the children, the anthropometric indices showed a decrease in third degree malnutrition. More convincing to the village women, because of full vaccination coverage, there were no deaths from measles in 1973-74, in contrast to areas immediately surrounding the village, where numerous deaths occurred from measles.

##### b. Project Purpose/Outputs

There are really two purposes of the project: (1) To improve the health of a significant number of rural people in Hanang District, and (2) To test the feasibility of the proposed health delivery system. While a 2-1/2 year period is a relatively short time, it should be sufficiently long to accomplish both purposes.

Project outputs will include a health delivery system; baseline data collection and an analysis system; health workers with improved training and instruction methodology.

##### c. Project Implementation

###### 1. Summary

Project headquarters will be in the district capital of Babati. The project trainees will be instructed by local health personnel, both expatriate and Tanzanian. They will then proceed to work in a selected village or villages with local people designated by the village and termed for project purposes, village health leaders. These leaders will work directly with other village leaders

down to the ten house chairman thus involving all the villagers. This health chain will not only be linked with Dareda Hospital but more directly with the nearest health center and/or dispensary and the resident medical and para-medical personnel. The project trainees will receive a small stipend but the village health leaders will be voluntary.

## 2. Personnel

Before explaining the project in more detail, a brief description of the project personnel will help to set the scene. The District Medical Officer will be ex-officio head of the project but the project will be directed on a day-to-day basis by a public health supervisor. Three assistants will work directly with the supervisor. Two Grade A Nurse-Midwives with both clinical and public health experience will act as division coordinators. Project assistance will be provided by other Tanzanian health staff including Medical Assistants, Rural Medical Aides, Midwives, Nurses, and consultants such as Mr. R. Tulahungwa, an expert on Public Health Education and a Tanzanian with unparalleled insight and skill in implementation of village programs. Exact personnel requirements will be worked out during the Pilot Phase of the project.

The District Development Director, the head of the Civil Service in the district and a key person in any development activity, will be invited to lecture to the VHLW groups and to second personnel (who will receive on-the-job training) for office, accounting, and data collection aspects of the project. Other district personnel, agriculture, crafts, community development, adult education, will take active parts in rounding out the picture for the VHLW Trainees.

And of course in each village the project will focus on the Village Chairman and Elders (Halmashauri) who are the influential leaders. The first village contacts will be made with these individuals, introducing them to the project and its purposes and gaining their approval and cooperation.

On the Codel side, personnel will be provided as follows:

a) a medical doctor

b) several missionary personnel will be working full time on the project, such as Sister Jeanne Lynch, a public health specialist.

c) Project administration will be covered by an expatriate, Sister Joseph Anthony who arrived in Tanzania in May, 1976.

It should be noted here that encouragement will be provided by regular visits by the supervisor, by medical mission personnel, and special visits by the local and district Government officials to mark various stages in the program. Supervision at all levels is of the utmost importance in a program such as this.

Incentives will be provided for trainees, health leaders and villagers who show interest and effort, through recognition, official visits and award days.

### 3. Selection and Training of Project Trainees

#### a. Overview of Proposed Training Program

The trainees will be local villagers who are already working in the health department or, when training is completed, will be taken into the Health Department as Health Auxiliaries. No more than one auxiliary per ward will be introduced into the existing health services. The trainees will receive an initial two months course and then special two week courses at intervals to help develop their ability to convey knowledge about health and disease to others. By building the program upon the local village health leaders, familiarity with already existing beliefs about health and disease will be assured.

#### b. Selection of Trainees

Candidates for this training will be selected from Standard 7 (7th grade in U.S.) leavers. Names will be put forward by the villagers; screening will be done by the public health supervisor; and final selection will be made by the District Medical Officer with approval of the District Development Director.

It is advisable to select trainees from this educational background because they relate better with the villagers than those who are already removed from village life style by salary, etc. The qualities which will be considered when candidates are chosen are:

- 1) Ability to relate well with people.

2. Initiative already demonstrated in their own work area.

3. Willingness to work irregular hours when needed.

c. Teachers

Those selected to give lectures and demonstrations (in Kiswahili) will be Rural Medical Aides, Medical Assistants, ~~missionaries~~ government doctors and nurse/midwives, veterinary and Agriculture Officers, community development workers as well as other government officials. Course matter for each two week course will be very simple, with special emphasis upon the manner of imparting this knowledge to the village health leaders.

d. Curriculum

Immunizations, record keeping, nutrition, infectious disease, tuberculosis, peri-natal care, family planning, hygiene, parasitic diseases, latrine construction, first aid and such non-health subjects as crop rotation, current events, crafts, will be in the curriculum. This wide range of subject matter will only be covered over a three-year time period in two-week sessions at regular intervals.

e. Methodology

Demonstrations will be the usual mode of teaching rather than didactic lectures only. Simulation exercises and role playing will form a part of the course. Carefully selected animated movies using a portable generator will be used. Special emphasis will be placed on the use of weight charts for monitoring child health because this has been demonstrated to be a very effective educational tool in village child health programs.

4. Introduction of the Village Health Trainees and the Village Health Program

a. Background: Ujamaa Structure and Organization  
Ujamaa is the Swahili word for 'family'. On the village level, there are certain characteristics which can greatly facilitate the implementation of a public health program, if these characteristics are recognized and built upon.

i) Political Unit - Usually several villages are within the jurisdiction of the local political unit, the Tanzanian African National Union Branch. Thus, village leaders are accountable to local TANU Branch officials for implementation of Government programs and policies in their respective villages. The villages are often visited by these officials.

ii) Village Elders - The village Chairman has a group of councilors called halmashauri. This group includes the secretary and treasurer. These elders are elected by the villagers and they are important facilitators in general village matters.

iii) Ten-House Divisions - A village is divided into groups of ten houses, each with a leader called a Miji Kumi. He is elected by the people and is the liaison between the village leaders and the people of his group. The Miji Kumi is respected and has an understanding of each home situation. Often he is a teacher in the adult education program conducted in a small shelter in his area. The Miji Kumi and/or his assistant preside at the settlement of family or neighborhood disputes within his area and usually his judgement and advice prevail. If this fails, the halmashauri hear the case and judgement is passed. In this manner intra-village problems, even serious ones, are negotiated and settled within the community.

iv) Village Schedule of Activity - All adults are expected to work on the cooperative farm at scheduled hours unless fulfilling some other official function within the community or impeded by blindness, old age, etc. The rhythm of life is that of an agricultural community. There are also hours set aside for activities such as adult education, civil defense exercises, meetings, etc. Labor is unsalaried. Cooperative profits are distributed to village members in proportion to their participation in village work.

#### Introductory Phase

This important stage will take place as follows:

**First:** The program supervisor and one assistant will meet with the leaders of Village I accompanied by the trainee health worker. The trainee will observe how contacts and arrangements are negotiated in initiating the program in the village.

Second: The trainee will visit Village II accompanied by another assistant supervisor and conduct the program initiation.

Third: The trainee will visit Village III accompanied by the supervisor and assistant, who will observe his methods and make suggestions. Failure to successfully get the program under way will not be subject for elimination of the trainee, rather a means of learning methods of approach.

c) Selection of Village Health Leaders

The approach to the villagers will first be made through concern for the health of their children, as future nation builders and leaders, then through family health. If the villagers decide to begin the program, they will be encouraged to choose a group of people who will be the teachers and catalysts of the village health program. It may be the ten house leaders (who have proved very effective in past experience) or their wives, or a group of women, young girls or young men. For each village the group would be of one type. If this procedure is followed through carefully it will insure early community involvement, a big step toward a successful program. The time period for this phase will vary from village to village.

d) Generating Community Involvement

A great deal of time will be budgeted for implementation through meetings and other methods of generating community interest. Whenever possible, meetings will be held in the evenings when villagers are more relaxed and will speak their mind more easily. There is no short cut to promoting active community involvement - it takes a great deal of time and patience and must be an outgrowth of decisions actually taken by the community in consultation with health leaders.

5. Initiation of Village Health Program and Training of Village Health Leaders

a. Village Health Care Program Guidelines;

At the village level there will be great latitude in the manner in which the village leaders see fit to organize the program under the following guidelines:

1. Weekly Education Sessions - Regularly weekly sessions will be held and the health liaison workers will instruct the selected village leaders. These sessions will be incorporated into village adult education programs.

ii) Health Related Activities - All health related activities will be coordinated by the Chairman, advisory board, dresser, health worker trainee and government officials in close cooperation with the ten-house leaders and the village health leaders. In many instances, these village roles will overlap in one person helping to reinforce the impetus given to implementation. Examples of these activities will be:

- (1) Immunization campaigns.
- (2) Monthly child welfare clinics with weighing and marking of weight charts. There will be no age limit for children, but an accurate estimate will be made of the child's age.
- (3) Tuberculosis case finding and follow-up.
- (4) Leprosy case finding and follow-up.
- (5) Latrine construction.
- (6) Model gardens.
- (7) Geriatric health care.
- (8) Formation of women's cooperatives and branches of the Umoja wa Wanawake (Women's National Organization for Developmental Progress).

b. Transfer of Responsibility

After the village health care program is adopted in a village and initial directions are taken, more and more responsibility for the running of the program will be taken by the trainee, while background supervision will be maintained by the public health supervisors. This is in keeping with the declared Tanzanian policy of self-reliance.

6. Involvement at the Ten-House Group Level

Following upon the attainment of rudimentary health knowledge by village health leaders (3 - 6 months) a ten-house program will be conducted by each leader.

a. Apex of Program

The ultimate aim of this whole project will be a closely coordinated ten-house health unit under the leadership of the miji kumi and health leader. A viable health unit at the ten-house level will be the measure of success of the whole project.

b. Program Components

Some aspects of this ten-house health unit will be:

- i. Education of adults by the health leader at weekly sessions in the local meeting place.
- ii. Coordination of all the village health activities by informing families of clinic times and actually being present at the clinic with them.
- iii. Birth and death registration.
- iv. Follow-up defaulters.
- v. Infectious disease surveillance.
- vi. Keeping records of such things as vaccinations, circumcisions, midwifery activity, tooth extraction, etc.
- vii. Interpretation for families of the weight charts, advising and, if necessary, coercing those with serious health problems.
- viii. Coordination of surveys of eye afflictions, dental surveys, etc.

7. Reporting and Evaluation

Monthly progress reports will be submitted by the liaison trainees to the program supervisor, who will in turn submit copies to the District Development Director and the District Medical Officer as well as to the sponsoring mission. These reports will be accompanied by comments as to the progress of each individual and of each village program. There will be a structured form for these reports.

It should be apparent to the reader that the project trainee health worker will be the key individual in this project and that this person must be willing to work under village conditions at irregular hours often meeting inconveniences and setbacks. Apparent also is the tremendous potential for improved health care and rural development with the successful training and utilization of the talents of these liaison workers. The monthly progress reporting system is designed to keep the project administration (supervisor, medical advisor, district officials, etc.) continually informed of project progress and problems. Trainees that do not measure up will be easily discovered and village programs that are faltering can be determined early and strengthened.

Near the end of the project, an evaluation will be held similar to the one to be conducted during the Pilot Phase. The major difference concerns the basic questions of project success and replicability in other districts of Tanzania. In addition, because of the latitude allowed in choosing types of persons for village health leaders and in implementing the program on a village and a ten-house level, there will be an opportunity to evaluate which type of leader and which manner of implementation is more successful. This will be measured in terms of community involvement, nutritional progress of infants, regularity of teaching sessions, attendance and comparative mortality studies.

### C. Project Data Collection

A vital element of this project involves the collection and analysis of data obtained throughout the district. In every development sector in Tanzania, including health, systematic data collection is non-existent even for small geographic areas. In many cases, local entities such as hospitals or health centers do have some statistics which are maintained but there is no organized, coordinated process for using this data beyond the entity itself or for expanding the collection area. It is the intention of this project to develop a simple data gathering system in Hanang District for the purpose of establishing a baseline of information and to determine the most cost effective method of continuing this data collection and analysis after the project is completed.

Collection of raw data will be commenced on a small scale with hospital and clinic records and information such as TB notifications from the District Medical Office files. As the project progresses, information gathering will include such fairly general items as village descriptive data, village location, presence of bore holes, etc. Data at the ten-house level will include birth and death registration, sputum surveys, menials, etc. (there are about 7,500 ten-house units in the entire program). As children will be a special project focus, health statistics on this group will be important.

The collected raw data will be transferred to magnetic tape and then put into the computer. This computerized data can then be used for further planning work in Tanzania.

Considerable planning has been done in the US by Codell in regard to the data processing and analysis work. Meetings were held in November 1975 with Mr. Joseph E. Butler of the Mirabella Associates of Chicago who will coordinate the entire data processing effort. These meetings covered such subjects as developing code structures, selecting data recording techniques, designing record formats, identification of values for use in the computer program, and developing both quantitative and qualitative criteria for measurement. The budget for this data collection and analysis work totals \$81,000 for the entire three-year project.

D. Project Budget

The project budget as presented below totals \$348,944 for the entire project and is divided into the planning phase, the pilot phase and the two-year project, with the data processing budget presented separately for convenience. As presented in this paper AID will provide \$297,450 of the required funds. With the delay in project approval, certain of the items listed in the planning phase have already been purchased.

1. PLANNING PHASE (January 1 through June 30, 1976)

\$ 4,000	Small car (VW or similar) for Project Coordinator
300	Microscope
200	Dictator Recorder - Cadmium Batteries
150	Cassettes
200	Charger & Transformer (alternator or small generator)
100	Calculator, rechargeable batteries
100	2 portable beds, sleeping bags
100	Typewriter
400	Office supplies, records, file cabinets, locks
1,000	Salaries and wages, trainee staff, 2 clerk assistants
1,000	Per diem travel, fuel & maintenance of car
3,500	Staff salaries, Coordinator, Business Manager
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\$11,050	Total (Fully funded by Codel)

2. PILOT PHASE (July 1 through December 31, 1976)

\$16,000	Two Land Rovers
2,400	Fuel & maintenance for Land Rovers
1,500	2 Tents for use in villages (for staff, men & women)
700	Movie Projector, 16 mm & accessories
200	2 Tape Players

PILOT PHASE (cont'd)

\$ 1,400	Salaries & allowances, 2 drivers
2,500	Per diem allowances, unforeseen supplies, etc
8,000	Staff salaries (2), plus clerks, trainees (at least 3)
4,000	Possible increased staff, consultants, other fees
3,744	Per diem for health trainees (\$3 x 8hr. x 6 days x 26 weeks) (maximum time computed - subject to DMO regulation)
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\$40,444	Total --(Fully funded by Codel or other organizations)

3. TWO-YEAR PROJECT (January 1, 1977 through December 31, 1978)

a. Personnel

US Medical Doctor in responsible charge	\$30,000	
Staff (some volunteer) - 6 qualified persons (Team leaders, Instructors, & Medical Teams ex clinics)	<u>34,000</u>	\$64,000

b. Allowances - Per diem for health trainees figured at \$3 per day, 6 days a week, for the initial 12 week period only. \$3 x 72 x 250 trainees

54,000

c. Transport - equipment, maintenance for 3 Land Rovers, with salaries and per diem for drivers, camping equipment, tents, sleeping bags, small generator (\$350) (includes 10% increase in price of equipment over 1974 figures)

69,600

d. Teaching Equipment - Additional tape players, cassettes, batteries

1,350

TWO-YEAR PROJECT (Cont'd) <sup>1/</sup>

e.	<u>Building Maintenance</u> , for headquarters, administrative and records offices, with equipment and supplies; office workers, trainees, data collection staff. General overhead charges	19,500
f.	<u>Consultants Fees</u> , per diem and travel where required	8,000
		Total \$216,450

4. DATA PROCESSING (Continuous)

a.	Conversion of raw data to an audible record in the field (Recorder, converter, batteries \$650; Cassettes, mailers \$350)	\$ 11,000
b.	Preparation of audible record for computer input (magnetic tape)	15,000
c.	Computer processing and analysis (administrative, programming, analyzing, travel, etc.)	30,000
d.	Projected on-going program commitment and data processing	15,000
e.	Computer time entire project	10,000
		Total \$81,000

The budget for the entire project are summarized as follows:

Planning Phase	\$ 11,050	<i>20,000</i>
Pilot Phase	40,441	<i>87,665</i>
Two-year Project	216,450	
Data Processing	81,000	<i>304,850</i>
<i>cont.</i>		<i>22,000</i>
Total	\$348,944	<i>453,515</i>

L/ Firm budget to be provided by Codel

In regard to this budget, a few explanatory notes may be helpful. No costs for housing, office or classroom space are included. It is planned that these will be made available from present mission facilities or assigned for use by district official. Two Land Rovers are needed during the Pilot Phase to cover the four-village area chosen for this first effort. As a total of five Land Rovers will be needed for the entire project, three additional ones will need to be purchased.

The project includes funds for operating and maintaining the Land Rovers as the Tanzanian Government does not have sufficient operating costs funds at this time (and probably won't have for the period of time of this project) to cover these costs. By covering these costs in the project, it will be assured that the project will not falter from lack of transportation.

Costs of certain items in the project are estimates as catalogs were unavailable for most equipment. The \$4,000 extra staff item depends on requirements as they develop in the Pilot Phase and the need for or the possibility of obtaining expatriate personnel, or for consultant fees.

Per diem allowances for the trainees is subject to revision by the FMO and the DDD.

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

Project Title & Number: HANANG DISTRICT VILLAGE HEALTH PROJECT

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	CRITICAL ASSUMPTIONS										
<p>Program or Sector Goal: The broader objective to which this project contributes:</p> <p>To strengthen the capacity of the ujamaa structure to improve living standards.</p> <p><u>Purpose:</u> 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.</p> <p><u>Outputs:</u> a) Health Delivery system; b) Baseline data collection and analysis system; c) Instruction methodology; d) Health workers with improved training.</p> <p><u>Inputs:</u> a) Codel  1. Personnel  2. Equipment  3. Miscellaneous diem, transportation  b) Tanzanian  1. Personnel  2. Facilities  3. Equipment</p>	<p>Measures of Goal Achievement: Growth of village participation in work on priority needs</p> <p>_____ people in <u>7500</u> ten house units in <u>40-50</u> villages being reached through this program.</p> <p><u>Outputs:</u> a) Health delivery system proven and in use; b) Data collection/analysis in effective use; c) Instruction methodology tested and in use; d) _____ health workers trained and working. ?</p> <p><u>Inputs: Codel Funding:</u></p> <table border="0"> <tr> <td>a) Planning Phase</td> <td>\$ 11,050</td> </tr> <tr> <td>b) Pilot Phase</td> <td>40,444</td> </tr> <tr> <td>c) Two-year Project</td> <td>216,450</td> </tr> <tr> <td>d) Data Processing</td> <td>81,000</td> </tr> <tr> <td><b>Total</b></td> <td><b>\$348,944</b></td> </tr> </table>	a) Planning Phase	\$ 11,050	b) Pilot Phase	40,444	c) Two-year Project	216,450	d) Data Processing	81,000	<b>Total</b>	<b>\$348,944</b>	<p>Identification by villagers of priority needs. Village requests for project assistance.</p> <p><u>Purpose:</u></p> <ol style="list-style-type: none"> <li>Hanang District records</li> <li>Project evaluation</li> <li>Village health records</li> <li>Observation</li> <li>Project reports</li> </ol> <p><u>Outputs:</u></p> <ol style="list-style-type: none"> <li>Hanang District records</li> <li>Project evaluation</li> <li>Village health records</li> <li>Observation</li> <li>Project reports</li> </ol> <p><u>Inputs:</u> Project reports</p>	<p>Assumptions for achieving goal targets:</p> <p>Continuity in collaboration and coordination by all interested parties.</p> <p><u>Purpose:</u></p> <ol style="list-style-type: none"> <li>Tanzanian Government continues support for the project;</li> <li>Village support adequate and consistent.</li> </ol> <p><u>Outputs:</u></p> <ol style="list-style-type: none"> <li>Adequate number of trainees available;</li> <li>Data processed on timely basis;</li> <li>Villages cooperative in both health delivery work and data collection.</li> </ol> <p><u>Inputs:</u> Funds available on timely basis and Tanzanian Government inputs adequate.</p>
a) Planning Phase	\$ 11,050												
b) Pilot Phase	40,444												
c) Two-year Project	216,450												
d) Data Processing	81,000												
<b>Total</b>	<b>\$348,944</b>												

OFFICE OF THE PRIME MINISTER AND SECOND VICE-PRESIDENT  
Regional Development Director, Arusha

HO/AR/D.3/60/44

3rd April, 1976

Patrick Cullen  
African Representative,  
MODEL Inc.,  
New York, N.Y.

Sir,

RWA BANANG DISTRICT UJANGA VILLAGE

PUBLIC HEALTH SCHEME

Reference is made to your discussion with the Regional Development Director Arusha, Tanzania, about your project plan submitted to the region.

I am glad to inform you that the above mentioned scheme of which your organisation intends to undertake in Arusha Reg. Dist, Banang District for a period of two (2) years, starting from May, 1976, has been accepted in principle at all district and regional levels.

However, it should be noted that the region is conducting a study of this project regarding its implementation before it is ready for execution.

For the success of the project it is recommended that there should be exchange of communication from time to time on the same whenever necessary.

Yours sincerely,



G. P. Mwakanga  
for: REGIONAL DEVELOPMENT DIRECTOR,  
ARUSHA REGION.

c.c.-

Principal Secretary  
Prime Minister and Second Vice-President's Office,  
P.O. Box 980,  
DOUMA. (This project has been incorporated in  
the 1976/77 Arusha Regional Plan)

Sister Jean Lynch M.R.N.,  
Dareda Hospital,  
P.O. Box 314,  
ARUSHA.

District Development Director,  
Banang.

WIZARA YA AFYA ~~WA TANZANIA~~

Akwazi wa Siku "Afya" Dar es Salaam

Siku ya Mhimo: 20/01.

Huru zote riadikwa kwa Kithu Mkuu.

Uajuzi wa afadhali taji:

Pambuzi Namba: **NSD/40/13/**SANDHUU LA POSTA ~~9083~~  
DAR ES SALAAM.

3 January, 1976

Sister Jeane Lynch,  
Dareda Hospital, Box 3124  
ARUSHA.

Dear Sister Lynch,

Please refer to the document entitled "The Hanang Ujamaa Village Health Scheme and Rural Health Instructors Program" which you gave to our Minister of Health Ndugu Stirling and the discussions which we had in my office on 2/1/76.

2. This is to confirm what I said that in general the proposed programme is in line with the policies of this Ministry which aim at the provision of health care for everyone and not just the few people who live in the neighbourhood of our existing health units. As to the details of the programme you will remember I suggested that existing cadres should be used as much as possible and if necessary their numbers can be increased. Creation of yet new cadres, for whom there is no scheme of service is bound to lead to a number of problems in the near future. You will remember I also made a number of suggestions on the organization of the programme. I would suggest that you discuss these and other suggestions you may have received on the programme with the local leaders to ensure that the programme is part and parcel of the general rural development in the District.

Yours sincerely.

*E. Tarimo*  
(Dr. E. Tarimo)  
for PRINCIPAL SECRETARY

The original "Schedule D"  
(Project budget) attached  
to the initial submission  
has been superseded by the  
update which appears as  
Attachment 3-c

Harang  
Attachment 1-b



Budget, Pilot Program (exclusive of Data Program)

Salaries & Wages

Doctor	\$ 3,000 (DPG)	
Dr. Jeane	2,500 (DPG)	
Sr. J. Anthony	1,500 (DPG)	
Liaison Officer	2,450 (DPG)	
Executive Secretary	900 (DPG)	
Clerk	400 (DPG)	
8 Trainees (training per diem)	1,520 (DPG)	
2 Drivers	1,200 (DPG)	
Allowance, Health Officer	200	
Allowance, Div. Leaders	500	
Teacher	750	
Gratuities	800	
		\$ 15,720
		<u>3,500</u> 2-2-77
		\$ 19,220

Transport

Maintenance & Petrol	\$ 6,375*	
Camper - land & license	1,500	
Mechanic	1,000	
		<u>8,875</u>

Equipment

School Lab & Teaching:		
Microscope	\$ 750	
16 MM movie projector	1,250	
Generator dolly (gen. donated)	600	
Duplicator	400	
Tape recorders (3)	400	
Furniture	500	
		<u>3,900</u>
Office Supplies & Equipment		
2 Typewriters	800	
Safe	1,000	
Furniture & Desks	600	
Paper, supplies, etc.	400	
		<u>2,800</u>

<u>Medical Equipment &amp; Medicine</u>	<u>3,650</u>	<u>3,650</u>
<u>Consultants Fees</u>	<u>1,000</u>	<u>1,000</u>
<u>Data Processing</u>	<u>29,596 (DPG)</u>	<u>29,596</u>
<u>Administrative Costs to CODEL</u>	<u>5,390</u>	<u>5,390</u>
<u>TOTAL COST OF PILOT PROGRAM</u>		<u>74,431</u>

\* Based upon ½ vehicle cost per year.

Ø Construction not to begin until interim evaluation of pilot program is available. Must be ready in time for full operational program.

‡ All salaries paid in accordance with government standards for occupants of each position.

Budget - Two Year Operational Program (exclusive of Data Program)

Salaries and Wages

Doctor	\$ 12,000	
Dr. Jeane	10,000	
Sr. J. Anthony	6,000	
Liaison Officer	9,800	
Executive Secretary	4,500	
Teacher	3,700	
Clerk	1,500	
2 RN Midwives - Grad A	7,200 #	
2 Comm. Dev. & Nutrition	6,000 #	
Drivers (4)	9,600	
Allowance, Health Officer	900	
Allowance, Dev. Leaders	500	
Allowance, Medical Officer	3,000	
Night Watchman	1,800	
Mechanic	3,000	\$ 79,500
Payroll Taxes of employees (estimated 5%)		3,975
Trainees (per diem allowances during training)		20,266 **
Gratuities		17,500
Travel & Per Diem (supervisory staff)		10,000 2-2-77

Transportation

Petrol & Maintenance 70,000 \*

Communications T

Shortwave & 11 meter band radio network 7,500

Field Equipment

8 Screen tents	1,000	
8 Sleep tents	1,000	
Supplies incl. stoves, bags etc.	500	2,500

Building Construction, Rent & Maintenance

Rent (4 rooms) from Lutherans	150	
Classroom Building	7,500 Ø	
Attached garage & pit	2,000 Ø	
Water piping & maintenance	1,000 Ø	
Night watchman	400 Ø	
Staff housing	11,500 Ø	22,550

School Lab & Teaching Equipment

Microscope	750	
5 Recorders, maint & new	1,000	
School furniture - plain	1,500	
Paper, pencils & supplies	2,000	
		<u>5,250</u>

Office Equipment & Supplies

File cabinet	250	
2 Typewriters	600	
File folders, paper & consumables	2,200	
		<u>3,050</u>

Medical Equipment & Supplies

Refrigerators & cold boxes #	2,500	
Medicines (or airpost for free vaccines) @@	20,000	
		<u>22,500</u>

Consulting Fees 6,000

Data Processing 38,150

Administrative Costs to CODEL 6,059

TOTAL OPERATIONAL BUDGET 314,800

# May be secured from/supplied by government.

++ Based upon no salaries when health worker returns to village.

\* Based upon ½ of cost of auto per year.

T Pending discussions with organizations which have attempted a system.

@@ Based upon supply necessary to avoid shortages of necessary vaccines commencement of operational program. Government to supply all other medical needs.

# DEVELOPMENT ALTERNATIVES, INC.

1823 JEFFERSON PLACE, N.W.  
WASHINGTON, D.C. 20036

TELEPHONE:  
202 833-8140

May 16, 1977

CABLE ADDRESS:  
DEVALT

## HANANG DISTRICT VILLAGE HEALTH PROJECT

### A SYSTEM FOR PROJECT MONITORING AND EVALUATION

#### Introduction

The Hanang Village Health Project is designed to develop a process for improving the health of villagers in Hanang District which builds upon the political, administrative and social structure found in Tanzania -- utilizing the village and ten-house groups as the basic planning and implementation units, supported by the administrative and political structure on each level from the Ward to the Division through the central Ministry of Health and the Office of the Prime Minister. The principal thrust of the project is the improvement of health through preventive medicine and includes village health education related to nutrition, sanitation and hygiene, as well as the promotion of health related activities, e.g., developing vegetable plots aimed at providing more nutritional diets. In addition, clinics will be held in each village which will provide vaccinations, offer maternal and child

health care and give some general curative medical services.

The organization and initial implementation of these activities will be the responsibility of village health trainees, two of whom will be chosen by each village from village residents. The main objective of their work will be to help villagers define health related problems and find approaches to their solution; the long-run aim is to develop the capability within villages to identify problems and mobilize the resources needed for their solution. The approaches used by trainees in carrying out their work will vary widely depending upon the characteristics and needs of particular villages; in some the Village Development Committees will likely be the bodies with which the trainees most actively work in organizing and carrying out specific health activities, while in others individuals -- such as chairmen of ten-house units -- may be designated to work with the trainees in seeing that the project activities get carried forward.

Project staff to support the village activities will include Division Health Leaders, one per Division, as well as a complement of health/administrative/data collection staff located at the District Headquarters and responsible for the support of activities throughout the District.

While this project design is based on the best presently available knowledge of local conditions, there still remain

uncertainties concerning the most efficacious approaches to affecting improvements in health at the village level. Efforts at improving health through preventive practices are relatively new and much is yet to be learned concerning the difficulty of changing, for example, household nutrition and hygiene practices. This, coupled with the fact that approaches to project implementation will vary between villages, punctuates the importance of incorporating in the project a system to monitor and evaluate implementation approaches and impact on village health. The monitoring and evaluation system developed for Hanang, described in detail below, is intended to be a low-cost approach which has the potential both for being sustained in the project area subsequent to the termination of external project funds and of being replicated in other districts in Tanzania.

#### Objectives of the Monitoring and Evaluation System

The specific objectives of the project monitoring and evaluation system are as follows:

- (1) To gain an overview of village health conditions and problems. The principal need for this information is to assist 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.
- (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 the behavioral patterns of villagers, and the effectiveness of alternative approaches (or treatments to project implementation). The information will be used largely for project management

purposes, i.e., to track activities in order to determine whether what is scheduled to be carried out is in fact accomplished and to identify problems and assess their causes. Monitoring information will be used to signal needed actions on the part of the project staff both with regard to implementation and to possible modifications in project design.

- (3) To evaluate the impact of the project on the health of villagers. This component of the information system will look at both behavioral change related to, for example, nutrition and hygiene practices as well as changes in the incidence of selected diseases in the villages. The analysis will focus on the impact of alternative project approaches on village health.

### Approach to Monitoring and Evaluation in Hanang

The development of a monitoring and evaluation system for Hanang requires several steps:

- Specification of data requirements;
- Selection of a research methodology, including data sources, collectors and appropriate analytical techniques to be utilized; and
- determination of the best information dissemination approach.

The point of departure for specifying data requirements is to understand the information needs of decision makers from the village through the national level. Information needs will, in effect, define the parameters of the data most essential to collect. In the case of the Hanang project, information is needed for a variety of purposes by a large number of groups and individuals:

- (1) On the village level information on health problems and conditions is needed for both planning and project implementation purposes by the village trainees

and the Village Health Leaders as well as by a series of other local party and government officials: the Village Chairmen and Secretaries, Village Development Committees and the leaders of ten-house unites. In addition, the villagers themselves need information on improved nutrition and hygiene practices and how such practices relate to the incidence of various diseases prevalent in the village;

- (2) The Ward Party Secretary, Division Party Secretary and Division Health Leaders should know the progress of project activities and problems being encountered in order to make management decisions designed to facilitate implementation. Health Center personnel on the Division level must have data on disease incidence broken out by area and a good notion of the nature of and reasons for various nutrition and hygiene practices being followed;
- (3) On the District level numerous decision makers have need for various types of monitoring and evaluation information. The District Medical Officer and project staff will be concerned that project implementation is proceeding smoothly -- that village clinics are being undertaken, that training of village trainees and Village Health Leaders is progressing as planned. Further, the District Development Director along with party officials and several district level planning committees -- the District Development and Planning Committee, the District Development Council and the District Executive Committee -- will be concerned with both project progress and impact; they will need to make decisions concerning the level and types of support needed for the project as well as decisions concerning project redesign and strategy.
- (4) Regional and national officials, both party and government, are responsible for planning and project design decisions and will make the determination as to the efficacy of replicating the project. They must be kept informed of project impact on health problems and have a good understanding of the strengths and weaknesses of alternative project implementation strategies.

Utilizing this approach of defining data requirements of various sets of decision makers, the project staff, in collaboration with local officials, developed an initial set of data points for collection. Discussion of these data, along with the specification of the research methodologies which will be used and the most effective methods of information dissemination can best be done in the context of the objectives of the monitoring and evaluation system spelled out earlier.

*To Gain an Overview of Village Health Conditions and Problems.*

The first task of the village trainees will be to gain a basic understanding of the conditions and health problems facing the villages in which they work. Because of the diversity in conditions that exists between villages, such an understanding is a prerequisite to determining the most appropriate approaches to designing and initiating health activities. The data to be collected in this category fall under two general headings: descriptive village data intended to provide an overview of village conditions and baseline data which will be used both to provide the trainee with an understanding of village health conditions and to measure project impact over time (data for evaluation purposes). Note: Since the trainee will begin collecting the baseline data as soon as his/her work commences, it will provide a valuable source from which an initial understanding of village health

problems can be gained. More importantly, however, these data will be used to measure change in health conditions over time. The baseline data given on the following pages are a partial listing which includes those which the project staff have preliminarily defined as most useful to the trainee in gaining an overview of conditions in the village; the balance of the baseline data are spelled out and discussed in the section on project evaluation.

All of these data will be collected by the health trainee and recorded on precoded forms. Most immediately they must be summarized for use by trainees and project staff in making decisions concerning what project activities need to be stressed and/or initiated and for use in discussing health issues with villagers. Initial tabulation will be carried out by hand by the trainees and Division Health Leaders and passed on for review by the central project staff. For presentation back to villagers, the trainees in collaboration with staff will decide the most useful form in which to display the information, e.g., graphically displayed, health problems portrayed through diagrams. The data will subsequently be punched on cards by the project staff for use in summarizing health conditions and practices found in the villages and for later use in project evaluation.<sup>1</sup>

<sup>1</sup> Information flows -- what information flows to whom -- are depicted diagrammatically in Appendix A.

DATA	COLLECTOR	DATA SOURCE	COLLECTION METHOD
<b>I. Descriptive Village Data</b>			
1. Name of village, division, ward.	Trainee	Village Informant	Discussion
2. Number of families in village	Trainee	Village Informant/ Village Observation	Discussion, house count
3. Number of ten-house units in village	Trainee	Village Informant	Discussion
4. Stretch of village	Trainee	Village Informant	Discussion, walking village diameter
5. Miles from administrative center, market center, and dispensary/hospital	Trainee	Village Informant	Discussion
6. Services being provided in village (including health services)	Trainee	Village Informant	Discussion
7. Main agricultural activities (crops and livestock)	Trainee	Village Informant	Discussion
8. <i>Hali ya lishe</i> <sup>1</sup>	Trainee	Village Informant	Discussion

<sup>1</sup> This Kiswahili phrase has no direct English translation. It refers to conditions in the village important to nutrition and health and might include observations on nutritional levels, feeding habits, and conditions for growing crops. The project staff specified this as important to give the trainee an idea of health related village conditions and problems; the type of response given to this question will vary depending on the particular characteristics of a village and the data are non-comparable across villages.

DATA	COLLECTOR	DATA SOURCE	COLLECTION METHOD
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II. BASELINE DATA <sup>1</sup>

A. General

1. Tribe	Trainee	Household Sample	Discussion
2. Number of years of formal education	Trainee	Household Sample	Discussion
3. Indicator of economic well-being (to be specified)	Trainee	Household Sample	To be specified.

B. Health Indicators

1. Nutrition

a. Number of times children fed per day	Trainee	Household Sample	Observation
b. Whether children are breast fed and at what age breast feeding is discontinued	Trainee	Household Sample-Children ages 0-5	Discussion

<sup>1</sup> Collection instruments for a portion of these data have been developed and are given in Appendix B. The balance of the instruments needed are presently being constructed and coded by the project staff.

DATA	COLLECTOR	DATA SOURCE	COLLECTION METHOD
c. What food is consumed in household (broken down by meal)	Trainee	Household Sample	Observation, discussion
2. Sanitation.			
a. Whether the house has a latrine	Trainee	Household Sample	Observation
b. Whether latrine is kept clean	Trainee	Household Sample	Observation
c. Whether latrine is used	Trainee	Household Sample	Observation
d. Whether the house has a rubbish pit	Trainee	Household Sample	Observation
3. Hygiene			
a. How food in the household is stored (covered, off floor)	Trainee	Household Sample	Observation
b. Indicator of cleanliness of clothing	Trainee	Household Sample	Observation
c. Whether household members wear shoes	Trainee	Household Sample	Observation

DATA	COLLECTOR	DATA SOURCE	COLLECTION METHOD
4. Adequacy of supply of portable water.			
a. Source of water for humans/animals	Trainee	Household Sample	Discussion
b. Distance to water source	Trainee	Household Sample	Discussion
c. Sufficiency and cleanliness of water	Trainee	Household Sample	Observation, discussion
5. Vaccinations received by type.	Trainee	Household Sample	Discussion, clinic records.
6. Social/Cultural Problems and Beliefs that are Detrimental to Health.			

Data points must be defined with trainees who represent different villages and tribes. The data collector will be, as above, the village trainee and the source the household sample.

Though at first glance the listing of data appears long and by implication perhaps overly ambitious, in fact they are easily obtainable through either direct questioning or observation. The intent is that the nature of the data and their method of collection and analysis be such that, instead of implementation of the information system being an extra piece of work which trainees are required to undertake, it will merely make more systematic an activity which trainees would carry out anyway and which is an integral part of their work, i.e., gaining a minimum knowledge of health related issues which will allow them to implement their activities in a sensible manner.

Finally, it must be stressed that this specification of data points, as is the case with those listed for project management and evaluation purposes below, is preliminary. As noted, they were settled upon by project staff through initially examining data needs by various decision makers. A similar procedure will be carried out with village trainees which will likely result in further modification/changing of data to be collected.

*To Monitor Project Implementation in Terms of the Financial, Commodity and Extension Inputs into the Project, the Direct Project Results or Outputs and the Initial Effects of Project Activities on the Behavioral Patterns of Villagers*

As noted earlier, information is needed by the project staff for purposes of project management. It is necessary,

in effect, for the staff to know what is happening when and where, and be able to detect problems and formulate solutions.

In the Hanang project, management information will be collected and compiled by the central project staff, the Division Health Leaders and the village trainees. The data identified by the central project staff as most critical for their purposes include, broadly, financial data and data on the progress of specified project activities. The project financial administrator will keep a running log of amounts spent, broken out by the type of expenditure, and will track these amounts against total monies available. The information which will be collected on the progress of project activities is illustrated by Form I. In developing this format, project staff initially considered listing project inputs as against outputs. The alternative notion of specifying project "activities" (see Column 1 on Form I) resulted from the realization that this is how most implementing officers perceive their projects -- they normally do not think in terms of inputs and outputs (and, in fact, frequently find that the distinction between the two is not clear), but rather of a series of discreet activities that must be completed in the course of project implementation. For each activity the staff will note the officer responsible (Column 2), the expected results and planned timing (Columns 3 and 4) and the actual results along with the time when each activity was accomplished (Columns 5 and 6). Finally, reasons for any differences



between expected and actual results will be recorded in Column 7. This approach will capture input and output data as well as provide other management information; with it project staff will be able to track, on a monthly basis, which activities are moving ahead as planned, which are stalled, what appear to be the primary problems facing activity implementation and who is responsible for solving the problems and seeing that implementation proceeds. They will have, in effect, the basic information needed with which to make management decisions.

A similar record of activity progress will be kept by Division Health Leaders for each project village in their respective Divisions. The format for recording the information which they need differs from that which will be used by the central project staff and is illustrated by Form II. Whereas the central staff is concerned with all activities undertaken by the project -- from building construction at District Headquarters to staff training to seeing that adequate medical supplies are provided to village clinics -- Division Health Leaders are responsible to help implement village-level activities alone. They will record, in Column 1, the various village activities to be undertaken broken out by health education, health clinics and health related projects. Columns 2-5 -- for specifying results and reasons for failing to meet initial expectations -- are similar but less comprehensive than the comparable information recorded by the central project staff discussed above.

MONITORING DATA  
DIVISION HEALTH LEADERS

Village: \_\_\_\_\_

Month: \_\_\_\_\_

(1) List Steps Undertaken in the Village Aimed at Making Progress in the Following Areas:	(2) Initiated by	(3) Expected Results	(4) Actual Results	(5) Reasons for Difference Between Expected and Actual Results
1. Health Education				
2. Health Clinics				
3. Health Related Activities				

The village trainees will likewise keep a record of project activities taking place in the village and will record them in monthly progress reports, reports which are required under the terms of the project. The format of this report, given in Appendix C, calls for observations of the trainee on developments related to the general categories of activities which the project supports -- health education, health related activities, etc. The report is intended to indicate both actual progress made as well as perceptions by trainees of approaches to and problems confronting the village health activities. It will provide both Division Health Leaders and central project staff with some indication of support needed by trainees in each village.

A final category of monitoring information which will be collected by the project staff relates to initial project effects. Throughout the project and before impact data are collected and project evaluation undertaken, it will be possible to begin to examine the effects of the project. It is, in effect, possible to begin an assessment of the strengths and weaknesses of the innovations being tried. This information will be gathered by the Division Health Leaders and the Health Information Supervisor<sup>1</sup> through group meetings and

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<sup>1</sup> The Health Information Supervisor is one of the project monitoring and evaluation staff. The composition and responsibilities of this staff are discussed in the section below on Organization of Monitoring Evaluation Activity.

individual discussions with villagers; the appropriate approach will vary by village and will be settled upon by the Health Information Supervisor in collaboration with the Division Health Leaders. In these discussions the staff will be interested in initial indications that the project is affecting village health. For this purpose the staff will use, as a check list, the data points spelled out elsewhere in this paper for measuring project impact. The collection of this information will be ongoing throughout the implementation of the project.

An important issue in developing a system for project monitoring relates to insuring objective reporting by those collecting the data. This consideration becomes particularly important when the collection is done by project staff who have a stake in project success. The objectivity of reporting in this project will be helped by several factors: First, the monitoring and evaluation staff -- the Statistical Analyst, Data Coordinator and the Health Information Supervisor -- will spot check project monitoring data for reliability and consistency. The first two will be responsible for checking the monitoring data collected by the central project staff. The latter will do the same with regard to the project progress information collected by the Division Health Leaders and village trainees. These staff will be hired as communicators whose personal gain does not depend upon project success but upon discovering successful project

approaches; as a result, they will have an incentive to see that reporting is done objectively.

Secondly, the Division Health Leaders and village trainees will be involved in project problem solving through frequent meetings with central staff. The emphasis will be upon identifying alternative approaches which work best as opposed to "proving" that the approach being tried in one particular Division or village is successful. This process will relieve pressure upon the Division and village staff to show that everything is progressing smoothly and will encourage objectivity.

Data sources for monitoring information, collection techniques and analysis to be undertaken can be summarized as follows:

Monitoring data needed by the central project staff (Form I) will be collected on a continuing basis from the officers responsible for implementing each project activity. An example will help clarify this approach. The curriculum for the training course for village trainees must be prepared and ready for review one week prior to the commencement of training. The Project Director will utilize the monitoring form as a reminder that this activity must be completed in sufficient time and will check with the person responsible for curriculum preparation. If problems have arisen resulting in delays, the Director must make decisions aimed at overcoming the difficulties. If the causes of the problems are not clear, it might require the monitoring and evaluation staff to make a special inquiry as to the nature of the difficulties and pass the information on to the Director before a decision can be made. Note: The use of one or more persons to do a "special study" of an implementation problem

or other project related issue is a useful and effective research approach; when necessary, the monitoring and evaluation staff will be used in that capacity.

While the primary purpose of this monitoring data is to allow the staff to track financial flows and activity progress on a continuous basis, the data also provide the basis for summarizing overall project progress and problems for use by District and Regional planning committees and designated government and party officials. These data will be collected from the Project Director and summarized every three months by the Data Coordinator for that purpose.

Sources for monitoring data collected by Division Health Leaders (Form II) will include trainees, Village Chairmen and Village Secretaries. The data will be collected on a continuing basis as project implementation proceeds and a separate form will be kept for each village. Aside from the use of these data for identifying implementation progress and problems, they will provide a partial basis for analyzing the effectiveness of varying implementation approaches being tried in different villages (the importance of this aspect of project analysis is noted below). The approach pursued by a single village will be reflected in the set of activities listed to be accomplished by that village. These data will be compiled quarterly by the Health Information Supervisor as he works with the Division Health Leaders; he will pass them to the Data Coordinator at the Project Headquarters for summarizing progress and problems categorized by implementation approach. These data will be summarized for two purposes: to allow central project staff to make management decisions and to track progress in villages utilizing differing approaches; this latter information will be used by staff both to evaluate the effectiveness of the approaches used and to disseminate back to villagers to indicate the progress being made.

Sources for and methods of collection of data on initial project effects are discussed above. The Data Coordinator will compile the data by hand every three months categorized by village and will do simple cross-tabulations comparing progress on health indicators with differing approaches to project implementation, e.g., Approach A to health education with observed sanitation behavior. This analysis will be very preliminary but will provide a useful indication of initial progress.

*To Evaluate the Impact of the Project on the Health of Villagers*

The evaluation of project impact is at the heart of the Hanang information system. A primary purpose of the project is to provide information on the best approaches to effect improvements in village health. To do this approaches must be evaluated against indicators of change in the levels of health through the collection and analysis of selected base-line or impact data over time. In addition to this is the need to evaluate whether, as the project progresses, there is an increased capability at the village level to identify and solve local health problems.<sup>1</sup>

A partial listing of the impact data identified by project staff as important has already been given. Added to this will be the following (again, this listing of data requirements will be modified by the input of trainees and over time as collection problems become known and as different data emerge as important). All of these data, save that listed under Section D, will be collected from a random sample of village households and will be comparable. Collection will be done once every six months on all variables except various of those measuring disease incidence; on these variables collection will be more frequent. Each village will be considered

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<sup>1</sup> A separate evaluation will be carried out of the pilot phase of the project in August 1977. The components of this evaluation are discussed in Appendix D.

<u>Data</u>	<u>Collector</u>	<u>Date Source</u>	<u>Collection Method</u>
II. BASELINE DATA (Continued from page 11)			
C. Mortality/Disease Incidence			
1. Mortality			
a. Births	Trainee	Household sample	Discussion
b. Deaths			
2. Disease Incidence			
a. Measles	Village Health Leaders	Household sample - children ages 0-5	Collected monthly through discussion. Trainees record in journals monthly from Village Health Leaders.
b. Whooping Cough			
c. Gastroenteritis			
d. Round worms			
e. Eye Diseases (sore eyes)	Clinic staff		Collected monthly through observation/examination. Trainees record in journals monthly from clinic records
f. Kwashiorkor			
g. Marasmus			
h. Anemia	Household sample		
i. F.B.			
j. Leprosy			
k. Bilharzia			
l. Hookworm			
m. Malaria (spleen count)			

<u>Data</u>	<u>Collector</u>	<u>Data Source</u>	<u>Collection Method</u>
<b>D. Village Capability to Identify and Solve Local Health Problems<sup>1</sup></b>			
1. Number of ten-house units with which Village Health Leaders are actively working	Division Health Leader	Village Informants	Discussion
2. Number and type of health education activities organized by village over past six months and number participating	Division Health Leader	Village Informants	Discussion
3. Number of health clinics in past six months in which village representative actively worked	Division Health Leader	Clinic Staff	Discussion
4. Number of residents using services of health clinics held over past six months	Division Health Leader	Clinic records	Examine clinic records
5. Health related activities initiated by village over past six months	Division Health Leader	Village Informants	Discussion

<sup>1</sup> The five data points listed here are indicators of the capability to identify and solve local health problems through measuring (a) the extent of activities organized by the village and (b) the degree of participation of villagers in the activities.

as a separate population and a sample selected from each as follows:

- A single house will be chosen at random in each village;
- A pattern of selecting subsequent houses moving in one direction from the first will be pre-determined by the Statistical Analyst using a table of random numbers, e.g., from the first skip two houses, selecting the third, then skip four, selecting the fifth, etc. The pattern will be repeated in a single village until the predetermined sample size is reached.

The required sample size will be determined by the monitoring and evaluation staff only after the questionnaire is tested by the trainees in their villages. On the weekends during the two-month training course, trainees will spend time in villages during which data requirements and instruments will be modified and tested. Data collected on the impact variables from a stratified sample of villages during this testing period will be used to estimate the variance of the sample values. This statistic will in turn be utilized in settling on the sample sizes for the collection of the impact data.

Data processing and analysis will be carried out by the monitoring and evaluation staff and will be relatively simple. The data will be punched on cards and cross tabulations of selected data made utilizing a sorter.<sup>1</sup> The analysis will

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<sup>1</sup> More sophisticated techniques such as multivariate analysis will not be carried out because of lack of available local computer time and the fact that such techniques could not be replicated should the approach be undertaken in other districts.

focus on singling out effects on health behavior attributable to the project and examining the relationships between health behavior and disease incidence. Three categories of comparisons will be made utilizing the baseline data: tribe, years of formal education and economic well being with the health indicators (indicators of behavior related to nutrition, hygiene and sanitation which will be measured over time for change), varying approaches (or treatments) used in villages for influencing behavior related to nutrition, hygiene and sanitation with the health indicators, and health indicators with disease incidence. Tests of statistical significance will be used to infer whether observed changes can be reasonably attributed to the project (are significant) or are due to non-project related influences.

The analysis will of necessity be confined to a longitudinal study with data in period one collected at the time of project commencement. At the least it would be useful to have time series data for a period prior to the beginning of the project activity. Such data are not available. Ideally one would like to have available data from a randomized control group with which to make comparisons; the conclusions from the study would be immeasurably more powerful through such analysis. In order to do this, data would have to be collected from additional non-treatment villages. Such is not possible within the financial and manpower constraints of the project.

The analyzed impact data will have multiple uses. They will be disseminated from project staff back to villages for use in demonstrating relationships between approaches and health behavior indicators on the one hand and health behavior indicators and disease incidence on the other. Project and district staff will utilize the findings to modify project strategies, and regional and national officials will require the information for decisions relating to the design of health projects for replicability in other areas.

#### Organization of the Monitoring and Evaluation Activity

As indicated throughout this paper, the implementation of the monitoring and evaluation system for the Hanang Project will be carried out by a host of staff and involved residents from the village level upwards. In their capacity as the primary persons responsible for organization and initial implementation of the project, the village health trainees will carry out the bulk of the data collection activity; this activity will be an integral part of their work in planning and implementing village activities. They, likewise, will involve Village Health Leaders and other village officials in the data collection work. This village activity will be supported most directly by the Division Health Leaders, who will help village trainees sort out data collection problems, determine approaches most effective for a given village, and be involved in limited initial analysis

of data that will be summarized and returned to the village for use by trainees.

On the District level a project staff of four will organize and coordinate the data work. A Statistical Analyst will be employed half time and will be responsible for overall supervision of the data collection and analysis activity. In conjunction with the Project Director he will settle on the design of the information system including data to be collected, collection methodology and analytical techniques to use. In addition, he will settle on the most useful dissemination of information and be the principal person who decides on modifications to the information system over time. A Data Coordinator will do the bulk of the data tabulation and summarization along with limited field work in coordinating data tabulation with the Division Health Leaders and village trainees. The bulk of the work in the field will be carried out by a Health Information Supervisor; he will work closely with Division Health Leaders in reviewing village data collection problems and procedures, will assist trainees who are facing particularly difficult situations, and supervise the data tabulation which is undertaken in the field. Finally, a clerk will work in the project headquarters and assist the Data Coordinator with tabulation and summarization of data.

As is stressed repeatedly above, to be effective the monitoring and evaluation system for this project must be

built from the bottom, i.e., data requirements built on the needs of decision makers from the village through the national level, collection techniques shaped to a large extent by the data collectors to take account of local conditions, and analytical approaches defined around the capabilities of staff and residents on each level. The data requirements and methodology described in this paper have been developed largely by the project staff. As the project progresses, additional modifications will be made in the system as more is learned principally through the work of the Division Health Leaders and the village trainees. Most immediately, during the training of the village trainees and for the balance of the pilot phase of the project, an important task is to involve the village trainees and Division Health Leaders in the further development/modification of the system.

### Training Village Health Trainees

The objectives of the initial training in data collection and analysis for the village health trainees will be twofold:

- (1) Develop among the trainees an understanding and appreciation of the types of information needed for them to effectively help in their villages; and
- (2) Involve the trainees in the development of the instruments for data collection, with a special emphasis on how these instruments can help them develop good communication with the people in their villages.

These objectives will be accomplished through a training/communication process that will continue throughout the course of the project.

One important lesson for the trainees is that they have much to learn from the villagers; frequently individuals with some technical training perceive their role only as providing information rather than as exchanging information. Rural people have very good reasons for carrying out certain production, health care and other types of practices; an understanding of what people are currently doing provides a sound basis for identifying possible changes that may help them to improve their social well being.

To develop the above awareness several techniques will be used. Prior to the intensive two month course, the trainees will have a one-week orientation in techniques of communication. They will then return to their villages to observe and discuss with villagers village health problems. When the two-month training course commences, the observations will be discussed among the trainees and they will attempt to list them in order of priority. During this period, the trainees will begin a process of visiting villages weekly and will carry their perceived problems back to villagers for discussion. Through this procedure the trainees will develop an understanding of village problems, the result of which will be the identification by them of data requirements most important to collect and collection procedures which are effective in the village environment. A similar procedure will later be carried out by village trainees with Village

Health Leaders in attempting to make the latter aware of the most pressing village concerns.

Throughout the project the trainees will be brought to the District Headquarters for a one-week session once approximately every six weeks. The objective will be to modify and change the information system as necessary over time to adapt it to the realities of the villages.

### Budget

Detailed below is an itemized budget for monitoring and evaluation during both the pilot and operational phases of the project.

## BUDGET FOR MONITORING AND EVALUATION

## HANANG HEALTH PROJECT

	<u>Pilot</u>	<u>Two Year</u>	<u>Total</u>
<u>Salaries &amp; Wages</u>			
Statistical Analyst	1,500	6,000	7,500
Data Coordinator	750	3,000	3,750
Health Information Supervisor	750	3,000	3,750
Clerk	450	1,800	2,250
Gratuity (25% of salaries)	<u>863</u>	<u>3,450</u>	<u>4,313</u>
SUBTOTAL	\$4,313	\$17,250	\$21,563
<u>Travel/Per Diem</u>			
Statistical Analyst	1,175	4,900	6,075
Data Coordinator	450	1,800	2,250
Health Information Supervisor	<u>900</u>	<u>3,100</u>	<u>4,000</u>
SUBTOTAL	\$2,525	\$9,800	\$12,325
<u>Data Processing</u>			
Cards	100	500	600
Processing	<u>100</u>	<u>2,500</u>	<u>2,600</u>
SUBTOTAL	\$200	\$3,000	\$3,200
<u>Office/Field Materials</u>	\$700	\$4,100	\$4,800
<u>Equipment</u>			
Filing Cabinet	250	-	250
Typewriter	480	-	480
Calculator	<u>300</u>	-	<u>300</u>
SUBTOTAL	\$1,030		\$1,030
Training	300	2,000	2,300
Miscellaneous, Including Telephone, Postage	<u>500</u>	<u>2,000</u>	<u>2,500</u>
	\$9,568	\$38,150	\$47,718
TOTAL DAI CONSULTING BUDGET (Detailed on following page)			<u>\$20,027.75</u> <u>\$67,745.75</u>

## DAI CONSULTING BUDGET

## PHASE I : FIRST TRIP TO TANZANIA BY DAI

Senior Evaluation and Design Specialist (Three man-days in Washington and 21 man-days in Tanzania) \$112.80 x 24	\$2,707.20
Overhead @ 85%	2,301.12
Travel:	
Excursion Ticket: Washington/Dar Es Salaam/ Washington (14-45 days)	1,386.00
Per Diem: 26 days x \$36	936.00
Miscellaneous Expenses Including In-Country Travel, Telephone, Local Hire	<u>550.00</u>
SUBTOTAL PHASE I	\$7,880.32

## PHASE II: PREPARING OF INFORMATION SYSTEM - WASHINGTON, D.C.

Senior Evaluation and Design Specialist Three Man-days x \$154.68 =	\$464.04	
Senior Evaluation and Design Specialist Seven Man-days x \$122.80 =	<u>\$789.60</u>	\$1,253.64
Overhead @ 85%		\$1,065.59
Travel:		
Two round trip tickets to New York (one day trip) \$100 x 2 =		200.00
Reproduction/Materials (\$50)		<u>50.00</u>
SUBTOTAL PHASE II		\$2,569.23

## PHASE III: SECOND TRIP TO TANZANIA BY DAI

Senior Evaluation and Design Specialist Three Man-days x \$154.68 =	\$464.04	
Senior Evaluation and Design Specialist 19 Man-days x \$122.80 =	\$2,143.20	\$2,607.24
Overhead @ 85%		\$2,216.15

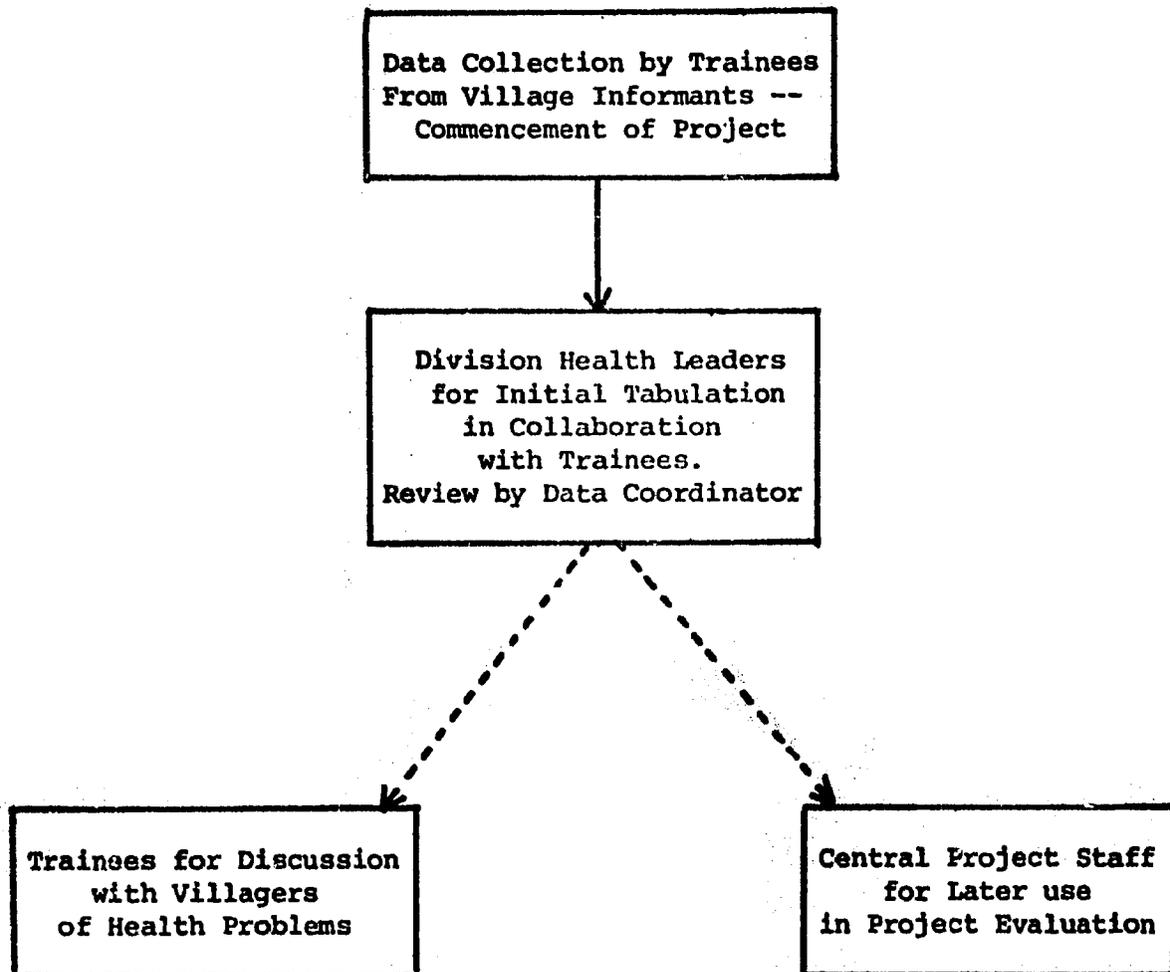
## (PHASE III (Continued))

<b>Travel:</b>	
One Excursion ticket: Washington/Dar Es Salaam/ Washington	
Two round trip tickets to New York (one day)	\$1,218.00
Per Diem: 22 days x \$36	792.00
Expenses Including In-Country Travel, Telephone, Local Hire.	<u>500.00</u>
<b>Subtotal Phase III</b>	<b>\$7,333.39</b>
 <b>SUBTOTAL</b>	 <b>17,782.94</b>
<b>Fee @ 7%</b>	<u><b>1,244.81</b></u>
	<b>\$19,027.75</b>
 <b>Project Local Expenses</b>	 <u><b>1,000.00</b></u>
	<u><u>                    </u></u>
 <b>TOTAL</b>	 <b>\$20,027.75</b>

APPENDIX A

The flow chart below will help clarify the flow and use of data in the Hanang Project.

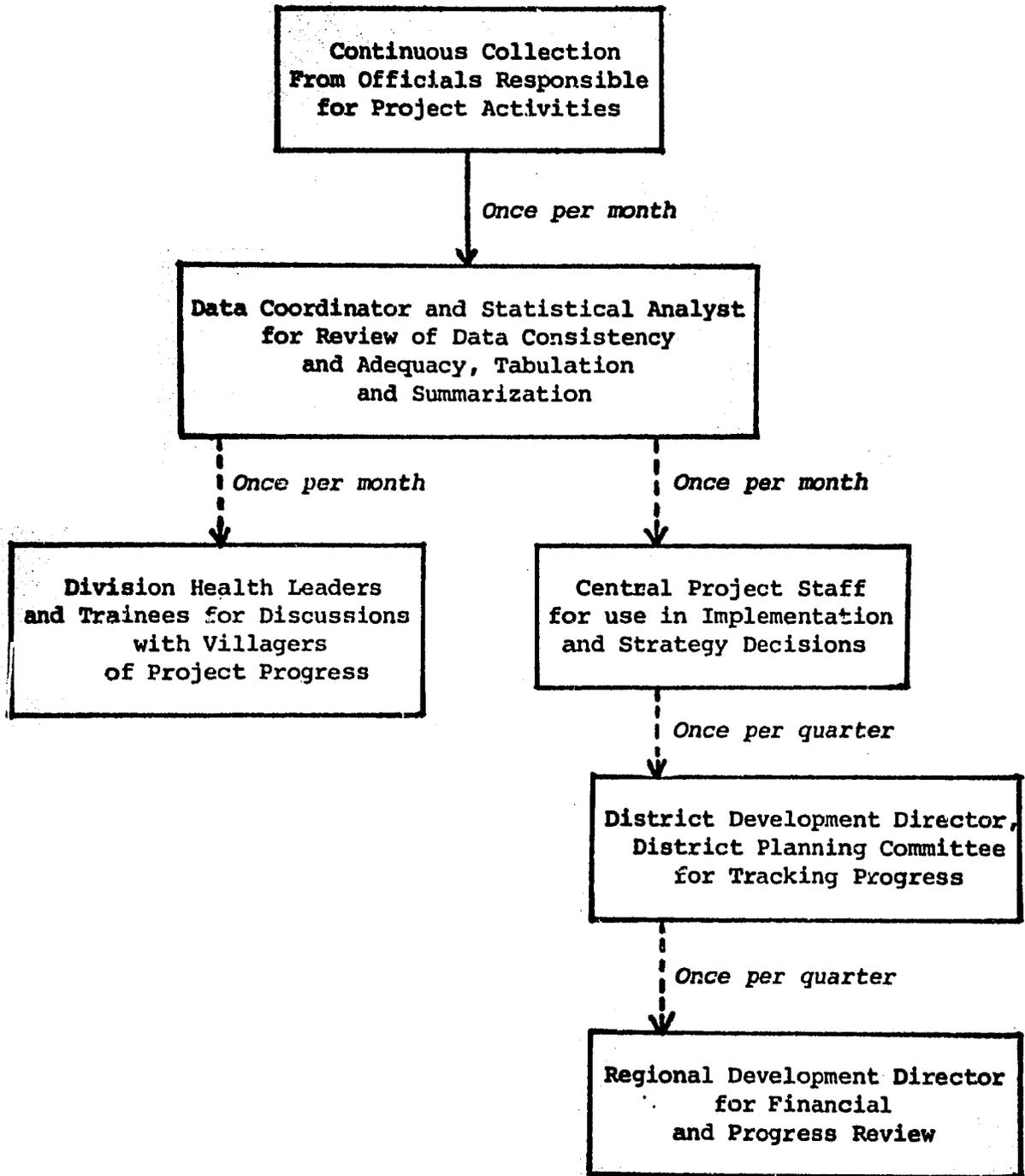
I. Descriptive Data



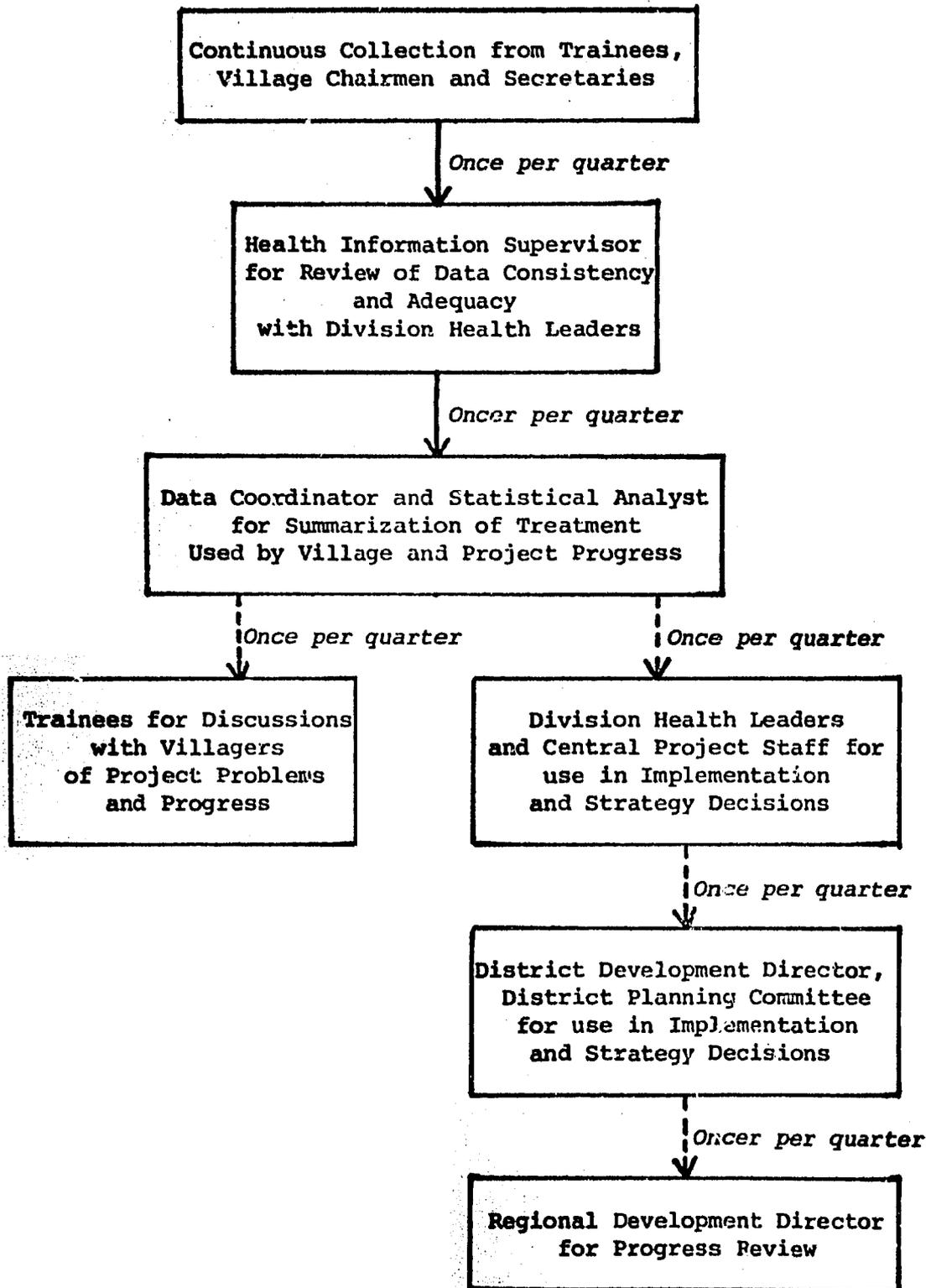
—————> Flow of Data  
- - - - -> Flow of Information

II. Monitoring Data

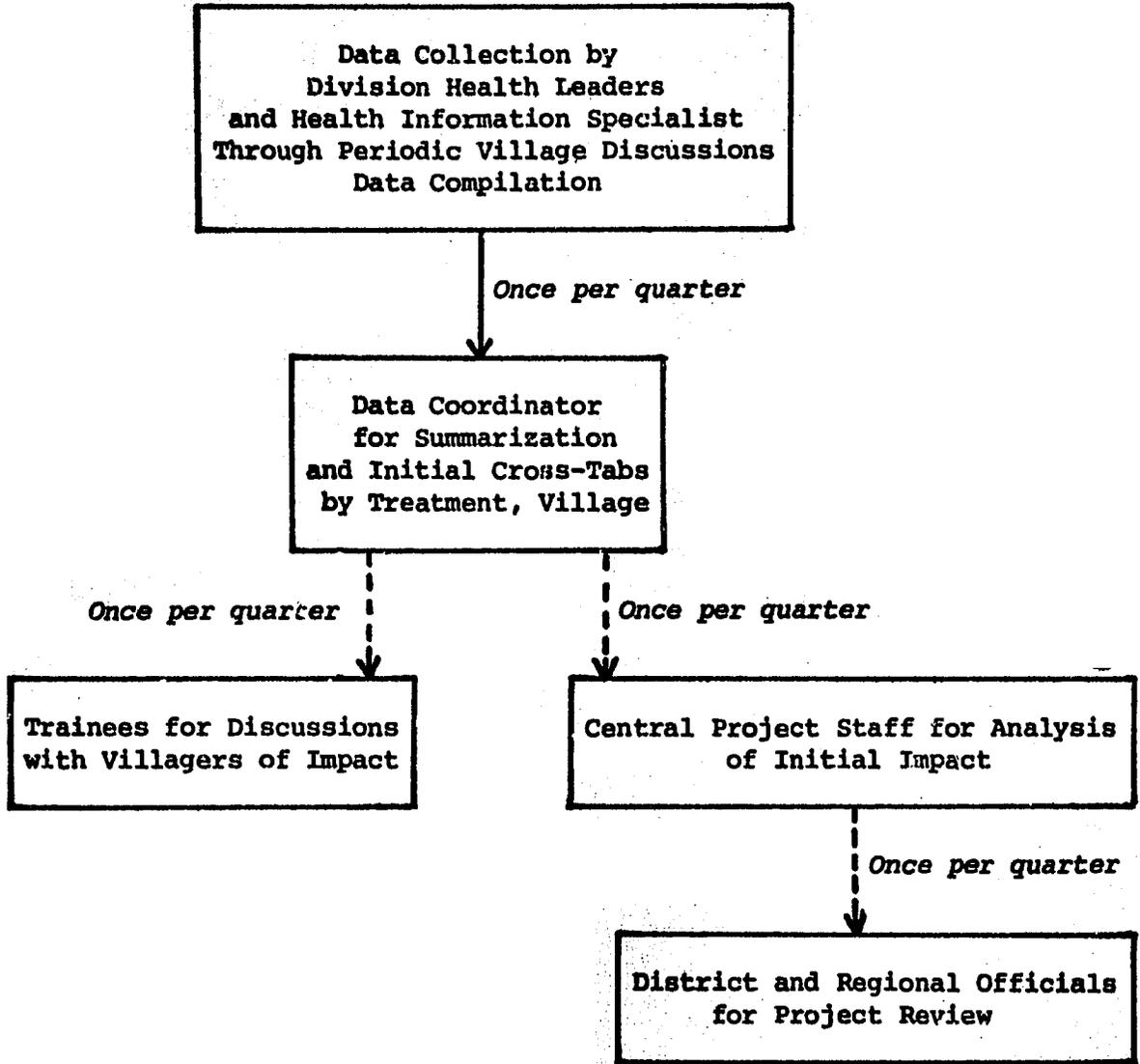
A. Monitoring data collected by central project staff



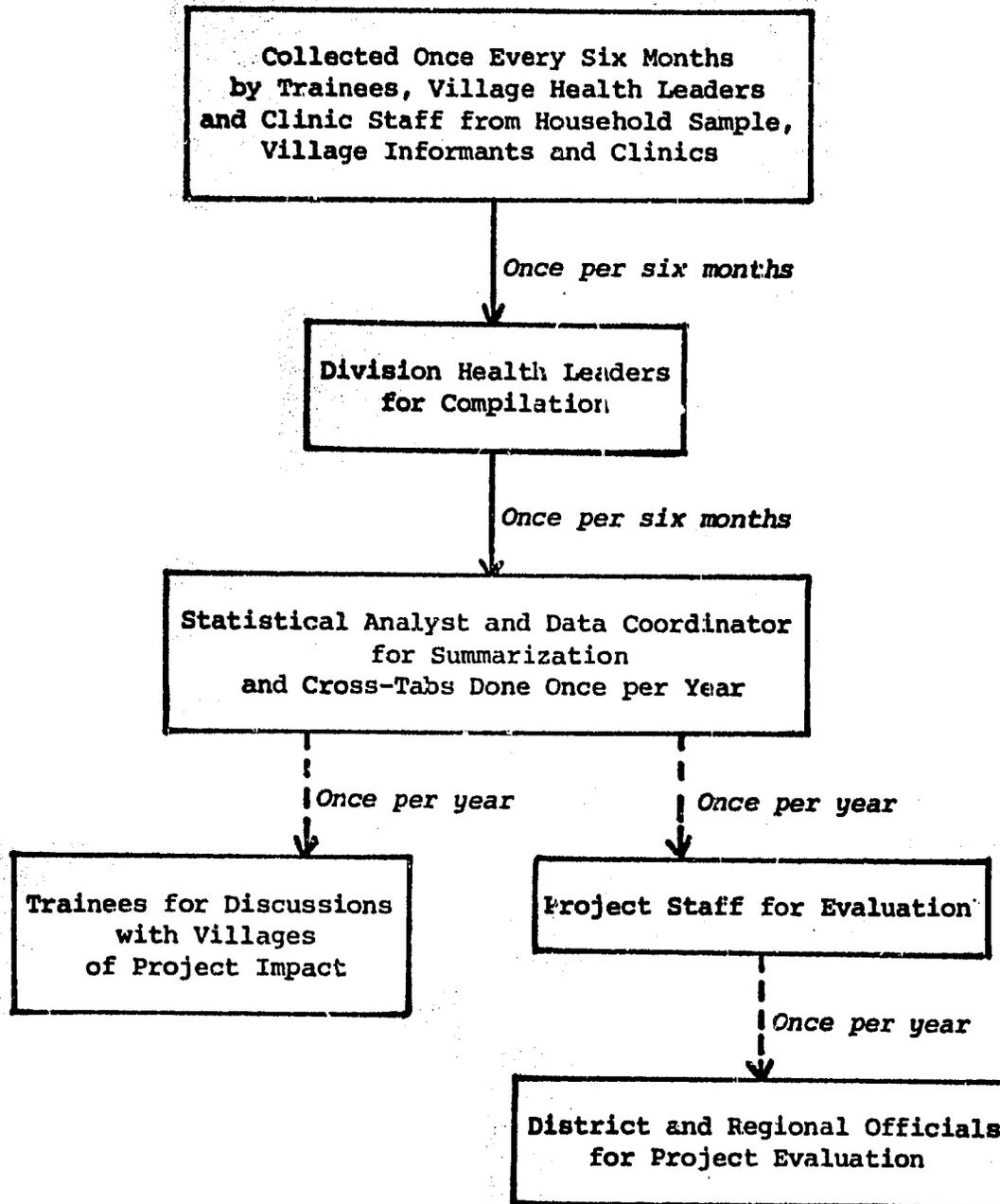
**B. Monitoring data collected by Division Health Leaders**



C. Initial effects data



III. Evaluation/Impact Data



APPENDIX B

Data Collection Instruments for Descriptive Village Data and Baseline Data  
Broken out by Data Source. (Instruments for the collection of mortality/disease  
incidence are being developed by the project staff.)

DESCRIPTIVE VILLAGE DATA

Date Completed \_\_\_\_\_

Data Collector: Village Trainee

Name of Trainee \_\_\_\_\_

1. Name of village \_\_\_\_\_

2. Ward \_\_\_\_\_

3. Division \_\_\_\_\_

4. Number of families in village \_\_\_\_\_

5. Number of ten-house units in village \_\_\_\_\_

6. Stretch of village \_\_\_\_\_

7. Miles from: Dispensary/hospital (specify which) \_\_\_\_\_

Administrative center (specify) \_\_\_\_\_

Market center (specify) \_\_\_\_\_

8. Services provided in village (list by type, who provides service, and quantity where applicable):

<u>Health Services</u>	<u>Education</u>	<u>Agricultural Related Services e.g. Extension</u>	<u>Community Social Services</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

9. Principal agricultural activities of village (list by type):

<u>Crops</u>	<u>Livestock</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

10. *Hali ya lishe.*

BASELINE DATA

Data Collector: Trainees, Village Health Leaders, Clinic Staff

Name of Household Head \_\_\_\_\_

Name(s) of wives: 1 \_\_\_\_\_  
(Where wife is not household head) 2 \_\_\_\_\_

3 \_\_\_\_\_

Name of Trainee: \_\_\_\_\_

Date Completed: \_\_\_\_\_

I. GENERAL

1. Tribe: \_\_\_\_\_

2. Number of years of formal education: Household Head: \_\_\_\_\_

Wives: 1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

3. Income/economic well-being (data points yet to be specified with project staff):

II. HEALTH INDICATORS (check response)

A. Nutrition

1. How many times each day are children in this household fed: 1

2
3
4
5

2. Did you/are you breast feeding your baby? (Specify for children 0-5 for each wife)

Wife \_\_\_\_\_

Child		
1	2	3

Yes

No

Wife \_\_\_\_\_

Child		
1	2	3

Wife \_\_\_\_\_

Child		
1	2	3

3. When was breast feeding stopped? (Estimate age of child)

Wife \_\_\_\_\_

Child		
1	2	3

6 months

9 months

12 months

15 months

18 months

Wife \_\_\_\_\_

Child		
1	2	3

Wife \_\_\_\_\_

Child		
1	2	3

5. What is daily diet of household?

Meal 1	Tea	<input type="checkbox"/>
	Ugali	<input type="checkbox"/>
	Uji	<input type="checkbox"/>
Other	<hr/> <hr/> <hr/>	

Meal 2	Ugali	<input type="checkbox"/>
	Rice	<input type="checkbox"/>
	Beans	<input type="checkbox"/>
	Vegetables	<input type="checkbox"/>
Other	<hr/> <hr/> <hr/>	

Meal 3	Ugali	<input type="checkbox"/>
	Rice	<input type="checkbox"/>
	Maboga	<input type="checkbox"/>
	Meat	<input type="checkbox"/>
	Maize	<input type="checkbox"/>
	Beans	<input type="checkbox"/>
Other	<hr/> <hr/> <hr/>	

**B. Sanitation**

1. Does the house have a latrine?

Yes

No

2. Is the latrine used?

Used

Not used

3. Condition of the latrine?

Dirty

Clean

4. Does the house have a rubbish pit?

Yes

No

**C. Hygiene**

1. How is food in the house stored?

Food covered

Food off floor

Food uncovered

Food on floor

2. Are the clothes of household members clean?

	Adult Males	Adult Females	Children
Clean			
Partly Clean			
Dirty			

3. Do household members wear shoes?

	Adult Males		Adult Females		Children	
	Yes	No	Yes	No	Yes	No
Near House						
In Village						

D. Adequacy of portable water

1. What is the source of water for household use?

	Rains	Dry Season
Stream		
Spring		
Pipe		
Rain Catchment		

Other (Specify)

2. Distance to primary water source (minutes from house):

Rains \_\_\_\_\_ Dry Season \_\_\_\_\_

3. Is water for household use sufficient?

	Rains	Dry Season
Sufficient		
Insufficient		

4. Is water for household use clean?

	Rains	Dry Season
Clean		
Muddy		

5. Is the water source for the household and livestock the same?

	Rains	Dry Season
Same		
Different		

BASELINE DATA

Data Collector: Division Health Leaders

I. Village capability to identify and solve local health problems

1. Number of ten-house units with which village health leaders are actively working: \_\_\_\_\_

2. Health education activities organized by village over past six months:

Type	Number Held	Number of Villagers Participating
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Health related activities initiated by village over past six months (list by type):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

BASELINE DATA

Data Collector: Division Health Leaders

I. Village capability to identify and solve local health problems:

1. Number of health clinics in past six months in which village representative actively worked: \_\_\_\_\_

2. Number of residents using services of health clinics held over past six months:

<u>Type of Service</u>	<u>Date</u>	<u>Number Using Service</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

APPENDIX C

MONTHLY PROGRESS REPORT OF VILLAGE TRAINEE

Name .....

Village .....

Ward .....

Division .....

Date \_\_\_\_\_

Since last month's report what developments have there been with regard to:

Health Education

Health Related Activities

Collaborative Efforts with Various Leaders

Clinic Activities

Problems

Signature

## APPENDIX D

EVALUATION OF THE PILOT PHASE  
OF THE HANANG VILLAGE HEALTH PROJECT

The Hanang Village Health Project will operate under two different funding mechanisms -- a DPG allotment for a pilot phase and OPG commitment for the implementation phase. One complicating factor is the need to sign the OPG contract and begin construction of certain necessary facilities prior to the actual beginning of the implementation phase.

The pilot phase of the project will commence in May 1977 with the selection of eight trainees, the establishment of the training curriculum and the initiation of eight weeks of specialized instruction for the trainees. At the conclusion of this phase the trainees will return to their villages to assist in a preventative and curative health/nutrition improvement program in conjunction with government-sponsored clinics and other related health services. The pilot phase of the project will conclude in September at which time an evaluation will be necessary before extending the activity to a greater number of villages in the implementation phase. This evaluation will be used primarily to modify procedures/approaches used in the pilot in order to avoid problems and improve on implementation as the project moves into more villages.

Specifically, the evaluation will assess the adequacy of the village trainees' training course, the initial performance of the trainees in the four pilot villages, the adequacy of the information system, and a general project performance. Information to be collected in each of these categories includes the following:

Data

Data Source

1. Trainee Performance Indicators:

- Successfully initiated meetings with village development committees and the CCM (party officials) to discuss alternatives to organizing the village health program, including the training of selected village health leaders.
- Helped to organize and carry out an initial health clinic in their villages.
- Number of villagers attending first village health clinic.
- Taken initiative in identifying the most effective methods of organizing residents for carrying out health education.
- Data gathering completed by the trainees, including:
  - Initial survey of village health conditions and problems;
  - Initial meeting held in villages at which some of these data are used in discussions of problems (utilization of analyzed data on the village flowing back from project staff).

Division Health Leaders' monitoring data

Division Health Leaders' monitoring data

Clinic records

Division Health Leaders' monitoring data

Division Health Leaders' monitoring data

2. Assessment of Training Program:

- Analysis of (a) the above indicators and (b) the first monthly report of trainees as proxies for the extent to which trainees grasp basic village health issues and approaches to the solution of health problems.
- Assessment by trainees of the strengths and weaknesses of the course (based upon their first month of field experience in the villages).

Trainees' monthly reports, data listed above.

Trainees

Data

Data Source

3. Assessment of Informatic System:

- Review appropriateness/adequacy of initial data points selected for collection, collection methodology, e.g., evaluation forms, and preliminary analysis performed on the data.

Informal discussions with project monitoring and evaluation staff, Division Health Leaders and trainees

4. General Project Evaluation

- Areas of greatest progress and problems in project implementation, principle reasons for both progress and problems, and suggested alternative actions.
- Project aims, how they perceive them, how the aims might best be achieved, and approaches for their achievement which the project is currently taking.

Informal discussions with trainees, village health leaders and other selected village leaders

Much of these data will be collected under the ongoing project monitoring and evaluation system designed for the project and will merely be compiled for purposes of this evaluation (data listed under items 1 and 2 above). The project Data Coordinator will be responsible for this compilation. The informal discussions to be held to gather the data listed in items 3 and 4 will be carried out by project staff, a representative of USAID Dar es Salaam (if requested), and Hanang District officials. The evaluation will be used for purposes of improving the training curriculum and approaches and implementation procedures of the project and information system.

AN EVALUATION PLAN FOR THE HANANG UJAMAA VILLAGE  
PUBLIC HEALTH PROGRAM, TANZANIA PROJECT

INTRODUCTION

CODEL is presently preparing an evaluation plan to cover all supported projects. The plan calls for evaluation of the performance of the project against intent (achievement of the objectively verifiable indicators of performance), as well as an assessment of the changes in the target population contrasted to similar but unaffected control groups. The complexity of the evaluation plan, and the details to be extracted by either project management or outside CODEL or AID evaluators, will depend upon the size of the funding commitment, and the prospects that the project will offer new insights to the development community in innovative ways to involve and benefit rural or urban poor. The specific evaluation plan for the Hanang Ujamaa Village Public Health Program, Tanzania project is consistent with the overall evaluation concepts of CODEL.

THE PILOT PHASE OF THE HANANG UJAMAA VILLAGE  
PUBLIC HEALTH PROGRAM PROJECT

The Hanang Ujamaa Villag- Public Health Program project will operate under two different funding mechanisms--a DPG allotment for a pilot phase and an OPG commitment for the implementation phase.

One complicating factor is the need to sign the OPG contract and begin construction of certain necessary facilities prior to the actual beginning of the implementation phase.

The pilot phase of the project is presently underway with the selection of eight trainees, the establishment of the training curriculum and the initiation of seven weeks of specialized instruction for the trainees. At conclusion of this phase, the trainees will return to their villages, (from which they were chosen by the community) to assist in a prevent preventative and curative health/nutrition improvement program in conjunction with government-sponsored clinics and other related health services.

At the conclusion of the first training cycle a decision point is reached which calls for an evaluation by the project director of the effectiveness of the training program. Specifically, the project directors must certify that at least four of the trainees have demonstrated the ability to extend their newly acquired knowledge to villagers, and to assist them to undertake preventative health measures, as well as to make use of existing government services to standards which will be set by the directors of the project. In the event that training has not produced at least four well-qualified parastatals, funding for the implementation phase of the project will not go forward until the training curriculum has been revised, and the selection process reviewed to insure that qualified students can be found who will be able to extend the health knowledge necessary to make the project work. The certification of successful completion of training of 50 percent of the trainees, based upon fields observation and classroom performance, is expected by 1 April 1977.

The second half of the pilot program will consist of the work of the trainees in their home villages. During this phase, a set of records will be maintained which will allow an end-of-pilot-phase evaluation which will consist of:

- The adequacy of the curriculum to the actual work performed by the trainees;
- The ratio of trainees to the population to be served--specifically, is the designated ratio of two per village, the appropriate ratio to be continued in the implementation phase;

- The influence of the trainees on the medical and nutritional behavior of the target population in the villages, insofar as this can be determined during a few short months. This would include the recapitulation of the elder women to suggestions of the trainees, and the willingness to grant audiences and, most significantly, to change behavior in ways recommended by the trainees.

The trainees would also collect documentation on those phases of the government's medical health and nutrition services which their efforts support--that is, the adequacy and availability of medicines distributed through the government centers (to allow the project's backup distribution system to be activated if necessary), the availability of clinics and trained medical personnel, the need for improved sources of potable water waste disposal, mother and child nutritional supplements, etc.

The actual data to be collected, and the instruments, will be designed by consultant of J.L. Systems working in conjunction with the project officers Dr. Martha Collins and Dr. Jeane Lynch. This is a separate contract and important project component. The output of the data collection system will be used to judge not only the performance of the trainees in the field, but the adequacy of the data collection and analysis methods recommended by the consultant.

A final evaluation of the pilot phase of the project will be scheduled for June 1977, and be performed by project management, CODEL coordinator Rev. Patrick Cullen, and a representative of USAID/Dar-es-Salaam, with the purpose of improving the design of the selection, training and village activity plan prior to the implementation phase.

THE IMPLEMENTATION PHASE OF THE HANANG UJAMAA VILLAGE  
PUBLIC HEALTH PROGRAM PROJECT

Due to the necessity of housing/building installation to be ready at the start of the implementation phase in July, (and the constraints of the rainy season) a decision to sign the OPG and initiate construction must be made in early April, 1977. The "go" decision will be based upon a written certification by project instructors of a 50 percent successful completion of training, as mentioned above. In addition, the decision to proceed will depend upon:

- The donation of a site for construction deemed suitable by the project director;
- Approval by the District Development Officer (or other appropriate local official) that the plans for the buildings and housing are of an acceptable quality (neither too plain or too fancy).

Based upon the successful fulfillment of these three criteria, the OPG will be signed, and construction work will proceed on the buildings as specified in the project description.

Ongoing evaluation of the implementation phase will be possible from the data collection and analysis which has been made a permanent component of the project, under contract to J.L. Systems. This data will allow the following comparisons:

- Progress of the improvement of health indicators in the area of the project, measured in terms of deaths per live births among children, death rates in the 1-5 years old categories, improved nutritional status of children as established by anthropomorphic measurements (set against Tanzania standards) and blood examinations as proposed by the project.
- Improvement of the use of available government facilities and services by comparing the use rates for the government medical clinics in the areas served by the project to use prior to project initiation as well as with the outreach ability of government clinics in similar adjoining areas not served by the paramedical personnel. Since centers are likely to have records of treatments and attendance, this should be a fairly uncomplicated evaluation comparison.
- Comparison of the prevalence of communicable disease outbreak between villages served by the paramedical to a history of previous disease outbreaks and outbreaks in comparable but non-program villages in adjoining areas;

- Improvement in a set of preventative measures (behavior changes) to be identified by the project (the object of the training course) which would show the impact of the village trainees on the behavior of villagers--changes in methods used to feed children, accept immunization, sterilize water and related eating utensils, dispose of human and animal waste, etc.

Since the project has a significant data collection component, the ongoing data analysis will allow improvements in the project overtime, as insights are gained from variations in response among villages in the program. In addition, specific evaluations, utilizing this data and direct field observation, will be conducted annually, utilizing staff of the project, CODEL, Inc. and USAID/Dar-es-Salaam beginning in June 1978.