

6210093  
PP-APU-819  
ISN=44676

**Lessons Learned  
Maasai Health Services Project  
Tanzania**

The Maasai Health Services (MHS) Project is one of several Operations Research projects in Africa being carried out by the Center for Population and Family Health with financial assistance from AID. The project, based in the Arusha Region of northern Tanzania, aims to train approximately 72 Community Health Workers (CHWs) to provide selected curative and preventive services in their communities over a period of 3 years. The CHWs are selected by their communities, trained by a team consisting of project staff, Lutheran Synod dispensary workers, and community members, and ultimately supported and supervised by their communities.

Following is a brief description of lessons we have learned in the Maasai Health Services (MHS) Project. These lessons fall into four broad categories: Community Participation, Training, Service Delivery, and Methodology.

**Lessons Learned in Community Participation**

- A community based project begun with intensive outside input oriented towards skills transfer can become self-sustaining over time.

After an initial reliance on substantial outside resources, MHS project activities can be sustained with minimal outside assistance. Over time the community provides an increasing amount of financial and human resources to carry out the management, training, and supervision functions required for continuation of the project. This has occurred in the project pilot area of Orkesmet in 1 1/2 years and is in process in 4 other sites.

- Frequent meetings in the community with elders, elected leaders, and the general public contribute to community involvement in project activities.

In those villages where few meetings were held, community participation, as measured by 1) active participation in the decision-making process affecting the project, 2) provision of food and/or stipends to the Community Health Workers (CHWs), 3) provision of kerosene for vaccine refrigerators and other supplies, and 4) utilization of CHW services, is less evident than in communities where meetings are held regularly and frequently.

- Community involvement and support is more difficult to attain in the more urban settings than in the traditional Maasai Communities.

With greater demands on their time, less felt need for health services, and a rapidly changing social structure, the settled, semi-urban Waarusha present difficulties in conducting well-attended meetings, and achieving consensus on project issues.

- Maasai communities are willing and able to provide regular financial and in-kind support to CHWs.

In 2 of the 5 sites which have functioning CHWs, the community has organized to provide them with monthly stipends. In 1 other site, food and assistance with domestic responsibilities has been provided while CHWs are in training or on home visits. The process through which this tangible support has been achieved requires time and patience. To facilitate the process, the issue of whether and how support will be forthcoming must be thoroughly discussed within the community and CHWs must be prepared to work without support until the community witnesses the benefits they bring.

- Once convinced that a particular service is worthwhile and that they are responsible for making it available, Maasai communities will take the steps necessary to assure the availability of the service.

When kerosene for the vaccine refrigerators runs out,

community members in Orkesmet, Ketumbeine, and Gelai have taken it upon themselves to obtain supplies from the District Medical Office or, in most cases, to purchase it at prevailing black market rates.

- The project must use a broad definition of health development in order to respond to the felt needs of a community and to gain their trust.

When a community's felt needs fall outside the expertise and declared purpose of the project, staff must be willing to assist insofar as possible or facilitate referral to a more appropriate source of assistance.

### Training

- Training conducted in the CHWs' own communities is both feasible and desirable.

Training of 40 CHWs has been carried out in 5 sites of the MHS project. The benefits associated with localized training include:

- CHWs need not neglect their domestic and community responsibilities
- visibility of CHWs and trainers is increased
- informal discussions with community members about the project are encouraged leading to a better informed community
- field work during training is directly relevant to CHWs' work and provides needed assistance to this underserved population
- community leaders are able to participate as trainers and resource people
- sessions are open to any community members who would like to attend
- community meetings held during training increase CHWs' facilitation skills and promote community participation
- CHWs gain credibility from their visible association with respected and trusted trainers

An exception to localized training is made when the CHWs are brought to the central dispensary for training in some clinical skills because the number of cases in their smaller home dispensaries would otherwise be insufficient to ensure competency in their smaller home dispensaries.

- Full time dispensary workers are a valuable training and supervision resource for the CHWs.

After attending Training of Trainers workshops conducted by project staff, dispensary workers and project staff become co-trainers of CHWs. The dispensary workers gradually assume all training responsibilities. Currently, dispensary workers in 3 sites have primary responsibility for CHW training and in 2 sites are well on their way towards the same level of competence.

- The Competency Based Training (CBT) approach is appropriate and effective in training CHWs in the performance of specific skills.

Training was evaluated in the pilot area of Orkesmet in April 1983 according to CHW performance of specific tasks which had been targetted during training. Clinical skills, which easily lend themselves to the CBT approach, were uniformly well performed, while education and counselling skills needed more attention.

- The content of training must be based on a thorough needs and resources assessment of the project area but must remain flexible in order to respond to specific needs of each community and each group of CHWs.

For example, conjunctivitis treatment and prevention must be highlighted in the arid parts of Maasailand but need not be in the areas with greater water availability.

- Phased training is an appropriate response to:

- 1) the community's immediate need for services
- 2) the CHWs' need to apply skills to cement learning before new skills are learned

- 3) the CHWs' inability to leave their domestic responsibilities for extended periods
  - 4) the logistics problems of organizing field trips of more than 2-3 weeks duration, given the scarcity of goods in Tanzania.
- Documentation of objective and subjective results of training must be maintained for continual feedback and for the improvement of training.

Training evaluation tools include pre- and post-tests, skills records kept by the CHWs, written daily feedback from CHWs to trainers, community mini-surveys on coverage by CHWs and reaction to CHWs and their role, team training with daily critique meetings, and extensive guided observation of trainers and CHWs.

### **Lessons Learning in Service Delivery and Supervision**

- The provision of MCH services by CHWs on an outreach basis increases clinic attendance and improves MCH coverage.

On the basis of the baseline and post-training surveys in the pilot region, it was found that:

- MCH clinic attendance increased from 20% of mothers bringing their pre-school children irregularly to 86% of mothers attending monthly
- ORT awareness increased from 10% of women to 90%
- 87% of pre-school children were in the process of receiving the full immunization series compared to virtually no children prior to the project since those services were unavailable
- No measles deaths occurred in the pilot area after vaccination services commenced though several such deaths were reported in neighboring areas
- 75% of children under 5 had up-to-date and accurate growth charts at the end of CHW training vs. no children prior to the project
- Over half of the women interviewed had been taught about

and practiced eye-washing to prevent conjunctivitis

- Traditional Birth Attendants with limited training in family planning and MCH services are effective in referring women to the dispensary for those services. This aspect of the program is just being implemented in Selian, a settled Waarusha community. Referrals for family planning services have increased significantly since the start of this effort. The program will be expanded into other areas.
- Local dispensary workers can carry out effective technical supervision of the CHWs in their areas.

In one project site, the dispensary workers have assumed total responsibility for all CHW technical supervision needs. In the remaining sites, project staff still share that responsibility as the process of skills transfer is not complete.

#### **Lessons Learned in Research Methodology**

- The initiation of services in a pilot area is an efficient use of scarce resources and a valuable method with which to investigate operations research questions.

The needs and resources assessment, baseline survey, training materials development, training program, service delivery, and evaluation carried out in the pilot area in Orkesmet provided valuable information for expanding activities to other project sites.

- The extensive time spent by the project staff in the field improves the effectiveness of project activities.

The staff's impressive and increasing familiarity with the various project sites improves the quality of data, particularly qualitative data, collected. This familiarity also has a positive impact on community participation and training.

- Contrary to widely held opinion, it is, in fact, possible to conduct both large scale and sample surveys among the semi-nomadic, traditional Maasai people.
- Small scale surveys and service statistics hold great potential for improving service delivery but only if they can be immediately analyzed and modifications made based on the results.

Access to a mini-computer would speed up the feedback process and permit pertinent revision on project planning.

- Focus groups can provide valuable information for guidance in the further investigation of selected topics.

Focus groups on the topic of family planning/child spacing were recently held on one semi-urban project site. We were pleased to find that the women were quite open in the discussion and provided important insights into their perceptions of traditional and modern contraceptives and child spacing practices.

MAASAI  
6/18/84  
EW:rm