THE UNITED REPUBLIC OF TANZANIA

Facts for Life

Health Education Initiative

PLAN OF ACTION 1990

With support from

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WHO

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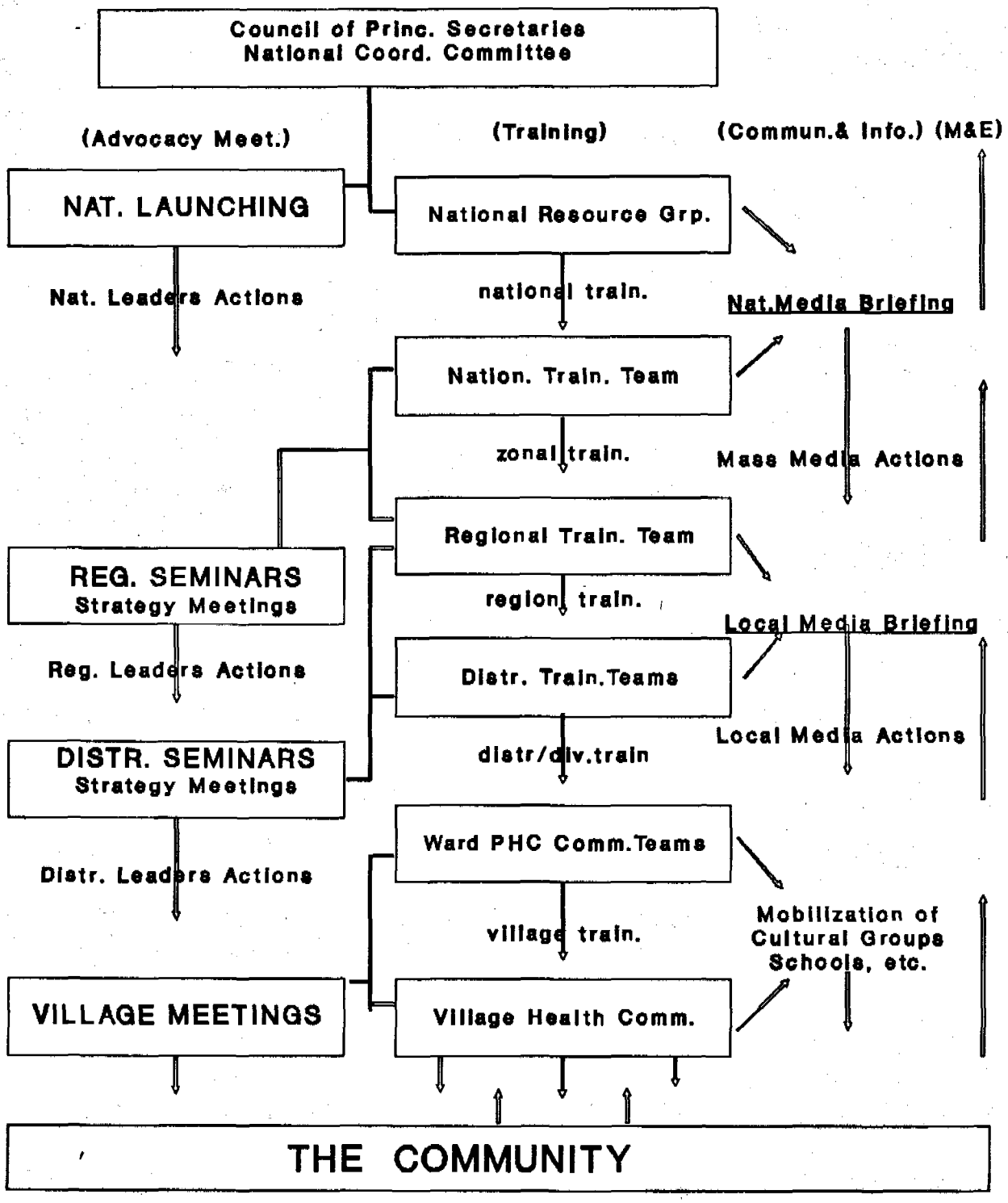

FACTS FOR LIFE/HEALTH EDUCATION INITIATIVE

IMPLEMENTATION PLAN

1. BACKGROUND

Facts for Life was a joint WHO/UNICEF/UNESCO initiative with the purpose of making the most important, life-saving messages available to a large audience worldwide. It called a 'Communication Challenge' meaning that it should be a challenge to all countries to find the most effective ways and means to communicate these messages to their populations.

The first copies of the English version of Facts for Life reaching Tanzania were distributed to some key ministries and institutions for comment. The response was immediate and unison: this booklet, translated to Swahili and adapted to the conditions in the country, would be an extremely valuable guide to the people in their efforts to improve their own situation and that of their families. The work to translate and to adapt the booklet was thus initiated and completed by a Task Force of Government health and communication experts.

At about the same time as the Facts for Life booklet was being reviewed and translated, the Ministry of Health recognized that there was an urgent need to communicate to the Primary Health Care (PHC) committees, to health staff and to extension workers in general how they should go about organizing health services and conducting health education in the communities. The control strategies for a number of the most important disease factors had been revised and even the PHC policies and health education approaches had been reviewed on basis of experiences gained. All this information needed to be communicated to the groups mentioned, and it was agreed to try to launch a comprehensive and integrated retraining exercise rather than to conduct a series of individual vertical seminars. This effort came to be called the Health Education Initiative.

In order to prepare for the Health Education Initiative, the first step was to identify the problem areas, i.e. disease factors, to be included in the training package. The following were selected: Safe Motherhood issues, Family Planning, Nutrition, Immunicable diseases (Measles, Polio, Whooping Cough, Diptheria, Tetanus, Tuberculosis) Diarrhoeal diseases, AIDS and Hygiene/Sanitation issues, Malaria and ARI. For each of these problem areas, a Task Force developed the necessary background information and guidelines for control. All the materials from the Task Forces was then put together into two manuals: one for district and ward PHC committees and one for extension workers and community as well. These manuals were pre-tested and modified before final printing. It was also agreed that a few new posters were needed to be produced to support the health education activities at community level.

Approaching the final implementation of the Facts for Life and the Health Education Initiative, it became clear that these two should be integrated fully. An Intersectoral Coordinating Committee (ICC) was thus set up comprising Ministries of Health, Education and Information, the Department

of Community Development and the Social Services Secretariat of the Party. This implementaton plan is a result of the work of the ICC.

2. OBJECTIVES

The Facts for Life/Health Education initiative is an attempt to assure that the most recent and relevant knowledge and experiences are being applied in peoples' efforts to control some of the most serious public health problems in Tanzania. These include maternal health problems, family planning, immunicable diseases, AIDS, malnutrition and diseases related to water and environmental sanitation.

The strategy to reach this overall objective is to:

- Ensure that all people have access to the most important information and advice on how to protect themselves and their children against these disease factors.

  Ensure that extension staff from various sectors, political cadres and primary health care committee members are able to effectively communicate such information and advice and also able to recognise their role in reinforcing and supporting efforts by people and communities.

  Ensure that Party, Government, Religious and other leaders are fully in support of the initiative and provide leadership and guidance as required.

3. METHODOLOGY

The existing Party and Government systems for mass mobilisation, education and information have proved in the past to be very effective and will be utilized as fully as possible for the FFL/HEI. This means that apart from 'professional' health educators, the Party (particularly Social Service Secretariat), the Education Sector, Community Development Workers and Media representatives will play a leading role in its implementation.

At the same time, the initiative aims at strengthening the multisectoral collaboration at all administrative levels within a PHC framework. It will thus constitute a first major attempt to establishing District Training Teams (DTT) and to support decentralised health education actions - albeit this first time with centrally produced learning materials and guidelines.

To pursue these general principles, it has been recognised that four major types of activities need to be carried out at relevant administrative levels:

Establishment of Training Teams;

Advocacy meetings;

. Communication and Information;

. Education.

3.1 **ESTABLISHMENT OF TRAINING TEAMS** These teams should be able to:

- Train PHC committee members on their duties in general and regarding the FFL/EHI in particular.

- Guide potential 'health educators on communication/mobilisation techniques and how to organise and implement the FFL/HEI in their respective areas of responsibility.

- Assist in advocacy/information meetings for Party/Government leaders.

- Train Training Teams who shall be able to carry out the above assignments at lower administrative levels.

It has been proposed that these types of Teams need to be established at the following levels:

National (NTT)
Regional (RTT)
District (DTT)
Ward (W/PHC)

3.1.1 PARTICIPANTS

National Trainers (NTT): 6 Zonal Continuing Education Coordinators for Health Staff;
3 Party Members;
3 Education;
3 Information;
3 Health (MOH);
Total = 18. To be divided into 3 teams of 6 each.

Regional Trainers (RTT): 3 Health (RMO and 2 other medical personnel);
1 Party;
1 Education (REO, etc.);
1 Information;
1 Community Development;
Total 7 per region.

District Trainers (DTT): 1 DMOs;
1 DHO/MCHC;
1 Party;
1 Education;

1 Community Development;
Total approx. 5 from each district.

Ward Trainers (WTT): Ward Primary Health Care Committee Members (about 12 from each ward).

3.1.2 TRAINING OPERATIONS

National Level: Training of three National Training Teams (NTT) will be conducted in Dar es Salaam. (This has already been done in March, 1990.)

Zonal Level: The NTT will then proceed to 6 Zonal Continuing Education Centres where the training of 20 Regional Training Teams (involving 140 Regional Trainees) will take place as follows:

14/5 The Northern Zone: Arusha, Singida, Kilimanjaro and Tanga.

21/5 The Southern Zone: Mtwara and Lindi. (Might be postponed due to the floods).

14/5 The Eastern Zone: Morogoro, Coast, Dar es Salaam and Dodoma.

21/5 The Western Zone: Kigoma, Tabora and Mpanda.

14/5 The Lake Zone: Mwanza, Kagera, Mara and Shinyanga.

21/5 The Southern Highlands Zone: Mbeya, Iringa, Ruvuma and Rukwa.

Note: Underlined towns will host the zonal workshops.

Regional Level: The RTT's will conduct training of the District Training Teams at each regional headquarter or other location depending on the convenience of each region. This training session should be completed before end of June 1990.

District Level: Training of 17,192 Ward PHC committee members, who are the key changing agents will be conducted gathering 3-5 wards at a time depending on geographical convenience. The training will be conducted by the DTT and completed before end of July 1990.

Village Level: This final stage will be carried out by ward PHC committee teams in each of the villages in their

ward. It will start by educating village P.H.C. committees, followed by Village Health Education meeting starting with the most pressing problem at that particular area. By the end of August, 1990, each village in the ward should have been visited at least once and the FFL/HEI materials submitted to the village health committee.

3.1.4 PRIORITY TOPICS

- Advocacy
- Strategy for Health Education
- Educational Methodology
- Safe Motherhood Initiative
- Nutrition
- Immunization
- Water and Environmental Sanitation
- Specific disease factors:

  . Diarrhoea
  . Malaria
  . AIDS
  . Acute Respiratory Infection (ARI)

This topics were discussed in detail during the training of the National Training Team (NTT). The NTT came up with a number of recommendations regarding key issues to be emphasized, communication methodologies, time plan for training sessions, etc. These recommendations are included in this plan as Annex 1.

3.2 ADVOCACY MEETINGS

3.2.1 Strategy

There will be advocacy/information meetings organized at National, Regional, District and Village levels. These meetings will be organized by the NTT, the DTT and Ward PHC teams respectively, but it is strongly recommended that resource persons from higher levels participates in these meetings.

3.2.2 National Level

On the National Advocacy occasion day (date to be fixed), the guest of honour will be a national leader (to be known later). This leader will launch the book 'UKWELI KUHUSU MAISHA', and the HEI.

3.2.3 Regional and District Levels

At Regional and District levels, the advocacy meetings will be conducted as seminars for high Party and Government officials and relevant NGOs. They may then leave the seminar to the technical

staff to finalize or they may remain to provide their recommendations to the implementation planning.

Guests of honour at these seminars will be Party distinguished and Government officials of the specific levels and they will open and close the seminars alternately.

3.2.4 Village Level

The meetings at village level will have a duration of up to four hours, except when they take the form of Village Health week/day whereby various health activities are undertaken. At these meetings a call for popular participation will be made. The first meeting in each village will be supported by HEI funds, but it is anticipated that similar meetings should be organized regularly using FFL/HEI materials as inputs.

3.2.5 Methodology

- At the National level, the programme shall accomodate space for inaugural speech of the Guest of Honour and distribution of a few copies of UKWELI KUHUSU MAISHA to some special guests immediately. Later, more copies may be available for distribution to people identified as suitable communicators for the purpose of Fact for Life/Health Education Initiative. There will be other education materials such as posters and brochures for display and distribution.

- The launching of the book will be celebrated in the regions to fit the national programme (date to be announced).

- The one day advocacy/information meeting at village level shall be action oriented.

3.3 COMMUNICATION/INFORMATION

Facts for Life - Health Education Initiative is basically a Communication/Information undertaking. Information which has world-wide scientific consensus is presented in simple language for everyone to understand. Secondly the materials and information is basically practical, low-cost and promotes a family based approach of solving day to day health issues. With this in mind, communication and information will therefore strive to meet the following challenges:

- To build alliances for children and women through the promotion of FFL and HEI.

- To disseminate messages on sustainable basis using a multimedia approach.

To transform the messages using conventional as well as traditional methods of communication into practical actions.

The immediate need therefore is to strengthen the existing channels of communication and information by promoting the alliances which exist within the Government, Part, Private Voluntary Organisations and the Masses.

These alliances might be specific as in the case of working with the Media Institutions. Or looser and more general as in attempts to mobilise diverse channels through traditional media, songs, ngonjeras

or through meetings, public rallies or in more conventional means of using the Press and the electronic media.

In order to initiate action the following activities are proposed for the promotion of Facts for Life/Health Education Initiative.

- Media Briefings.
- Traditional Media.
- Feature Articles and other Support Publications.
- Radio and TV spots.

3.3.1 Media Briefings

There will be briefings by Media personnel at National level to go hand in hand with FFL/HEI training programme.

The first National Media brieting (date to be accounced) will act as a coordinating forum for Media personnel and incorporate other traditional and alternative media.

3.3.2 Traditional Media

Support to traditional media will take the form of competitions in established institutions such as schools and Teacher Colleges. Adult participants will be encouraged to form Health Brigades and Primary Health Care committee Drama Groups and story tellers. Traditional Birth Attendants can form themselves into folk groups. Support will be in the form of emoluments for awards to best groups, transport support to ferry groups, funds for recording songs and for video shooting and presentations.

3.3.3 Feature Articles and Other Support Publications

Feature articles and other support communications will be based upon "what is working in the field" and studies of actions undertaken. Articles will appear in both the major dailies and weklies and also in Rural Press newspapers. Support will be extended to journalists

who will show interest and dedication in documenting efforts taken by committees in taking care of their health. Village correspondences will be encouraged to contribute in their respective area based newsletters where available. Other support publications will include promotional leaflets to go with the Kiswahili version of Facts for Life brochures on specific themes which were otherwise lacking in Facts for Life such as Iodine Deficiency Disorders, Vitamin A Deficiency and other specific themes which will come to light in later days.

3.3.4 Radio Programmes and TV Spots

Journaslists from the Electronic Media such as Radio and Television will be encouraged to record and document programmes related to children and women's wellbeing. Support will be extended to realise the said programmes. Radio spots will also be utilised during the World Health Day for promotional purposes of the FFL and HEI publications. TV spots for TV Zanzibar can also be arranged. Journalists will be supported to take these undertakings.

3.4 EDUCATION

The Ministry of Education has several programmes being implemented and which can be explored further in supporting this initiative.

3.4.1 Teacher Education Department

Through its unit of MTUU (Special programme - URT, UNESCO and UNICEF collaboration). The unit has trained 42 itenary Teacher Educators, 20 inspectors and other educationists who in turn trained 1000 teachers from 1000 schools in twenty districts in Tanzania.

Teachers are potential multipliers to knowledge and information and will act as facilitators of FFL and HEI.

The planned itenary teacher training programme in June and December 1990 will utilize FFL and the two health education booklets.

3.4.2 Adult Education

Informal and non-formal educational channels with the Adult Education programme has prepared 3 books:-

(1) Jiandae kupata mtoto.
(2) Malezi ya mtoto.
(3) Haki za mtoto.

Literacy classes and post literacy follow of programmes will need to utilize FFL and HEI materials.

3.4.3 The Institute of Curriculum Development

The Institute could explore HEI/FFL contents and seek possibilities of incorporating it in the primary school curriculum.

The Institute is also involved in preparing a programme for introducing the teaching of AIDS in schools.

3.4.4 The Office of the Commissioner

The office of the commissioner at present is conducting the following programmes:-

The Family Life Education:

This programme is run on a pilot project basis. The general aim of the whole project is to try to bring about better quality of life to the learners and ultimately to the whole society when the project takes off. Some of the topics included in the syllabuses are topics which are related to Facts for life Education.

The AIDS Programme:

AIDS is a threat to everybody. It is particularly a threat to pupils in schools. In an attempt to fight this problem; the minitry of education in collaboration with minitry of health is conducting a special programme whereby booklets will be prepared and teachers will be trained to help conduct a campaign to enlighted pupils on the dangers and spread of AIDS. Such programmes are relevant on the implementation of the FFL/HEI and can be strengthened.

Over and above the activities mentioned, the Ministry for a long time has been using a curriculum which is somehow related to Facts for Life Issues. The Home Economics curriculum provides most of the issues raised in Facts for Life at all education cycles.

4. MATERIALS

The training and learning materials to be used during the FFL/HEI are the following:

Ukweli Kuhusu Maisha (Facts for Life, Swahili translation). 80,000 copies of this booklet is being printed and will be distributed to training teams, extension staff and other potential 'health educators'. It is planned that about half of these copies will be distributed at village level (5 per village).

Health Education Manual for District PHC members. 20,000 copies produced primarily for use by District PHC committee members.

Health Education Manual for Extension staff. 40,000 copies to be produced and will be given to extension staff to enable them to effectively communicate key health messages and to provide other necessary support to key disease control strategies.

Posters, 20,000 copies of 8 types of posters will be printed to support health education activities primarily at village level. (Distribution list for these materials is given in Annex 3).

All these materials will be used in the training process as resource materials for trainers and trainees including consolidation and reinforcement of the main important messages to the communities. They have been produced and will be made available to all regions and districts according to the distribution plan inclosed as Annex 3.

5. IMPLEMENTATION STRATEGY

In order to maximize the utilization of the limited resources available in an effective way, it is necessary to integrate and to coordinate all four major activities at all levels. All these activities should again be integrated to other ongoing activities financed by the Government, donor agencies and non-governmental organizations in the regions and in the districts. In the areas currently implementing CSD programmes, for example, it is suggested that the FFL/HEI is coordinated with planned training of ward and village health committees.

The general outline and principles for the integrated implementation plan of the FFL/HEI are summarized in the chart of page 2 of this document, and the detailed guidelines for each consecutive step are described below.

At National Level

- Training of three national training teams, who will then be responsible for training regional teams on zonal basis.

- One day mass media seminar on FFL/HEI objectives and plans to solicit full media support and participation in implementation.

- Launching of the FFL/HEI is expected to take place around June 1, 1990.
  This will mark the beginning of a major advocacy undertaking which is expected to be picked up by most leaders media institutions in the country.

At Zonal Level

The three National Training Teams will conduct the training of the 20 Regional Training Teams at six designated zonal headquarters. Media representatives will also be invited to participate in these sessions, which will not only cover the contents of the FFL/HEI, but also discuss how to establish implementation plans for the regions and districts within the zone.

At Regional Level

Just after the National launching of the FFL/HEI (preferably the day after), regional advocacy/information meetings should be held involving regional leaders in order to inform them about the purpose and the content of the FFL/HEI and to solicit their full support and their recommendations for the implementation in the region. These will be half to one day meetings.
Regional strategy meetings: Immediately after the advocacy meeting, a smaller group should sit down and work out an implementation strategy for the region. This group should comprise the RTT headed by the RMO with a few additional, selected members from the regional PHC committee, from the Party and from the other key sectors identified as crucial in the implementation of the training and advocacy process. This group will develop the detailed plan for the

training, including identification of District Training Team members, sites for training and time-table and budget, logistics and distribution plan for training materials. In addition, the group should carefully plan how the Party organization, the Education sector, the Community Development staff and local media should participate in the further planning and implementation of the FFL/HEI activities in the region. They will also identify specific roles for themselves including allocation of districts in which each member will be responsible for support and follow up. The RMO may appoint one member of the RTT to act as a focal point for supervision, monitoring and accounting of the activities in the region on his/her behalf.

Training of the District Training Teams. This should be done as soon as possible (before the end of June) at one or two training sites depending on convenience and number of DTT members to be trained.

At District Level

After the training of the DTT, each district team together with the RTT member(s) responsible for the follow up in that district will conduct an advocacy/information meeting for district leaders to inform them about the purpose and contents of the FFL/HEI and to solicit their support and participation. This will be a half day or one day meeting.

Just like for the regional level, the next step is to conduct a district strategy meeting where the specific implementation plan for the district is established. This plan should include a careful listing of how many persons per ward that should be trained, which wards that could be trained together and where this can be done. Logistics and distribution lists for the training materials need to be worked out, and all activities matched against the funds allocated to the district. It should be noted that the number of persons to be trained in each ward is estimated to be on average eight, which means that only 3-4 wards can be trained during one 3-day seminar. If a district has about 25 wards, 7-8 seminars need to be conducted by the DTT. It is thus suggested that the DTT divide themselves into two groups to cover the whole district as quickly as possible. The district strategy meeting also needs to consider how various resource persons and institution in the district (including non-governmental organizations) could be involved in the FFL/HEI and in the continued health education activities. The DMO may also appoint one member of the DTT to act as a focal point for the coordination, monitoring and accounting of the FFL/HEI in the district on his/her behalf.

At Ward Level

The seminars for ward staff will in practice be a combination of advocacy/information and strategy meetings and training of a Ward Training Teams. This is in many respects the most important step of all within the FFL/HEI. These WTT s, together with the Village Health

Workers who they supervise, are the ultimate change agents with a direct access to the communities. It is thus extremely important that these seminars for ward staff are very carefully executed, ensuring that these staff afterwards are not only able to communicate certain messages, but also able to mobilize, to guide and to support the communities in their efforts to improve their health situation. These WTT s are indeed the proper PHC committees at ward level and it is anticipated that the FFL/HEI will help to better establish the role of these committees for the important work that they have to carry out in the future if the goal of 'health for all' is to be achieved. It is further suggested that during the ward seminars, members of the WTT are assigned to individual villages within the ward with a clear responsibility to initiate the FFL/HEI in these villages as well as for continued follow up of the health developments.

The District Teams should try to complete the training of ward staff by end of July in order to allow these to able to initiate the FFL/HEI in all their villages before the end of August.

At Village Level

On the day when the FFL/HEI is introduced in the village, it is suggested that the WTT members first hold a half-day meeting with the village PHC committee plus selected community leaders to explain the purpose and the contents of the initiative, and to hand over the teaching materials. They then select one of the topics and jointly conduct a village health education meeting on this topic for the whole community. They then inform the community about the health education resource materials now available in their village, and propose that regular village health days be held from that day onwards. Besides health education, these village health days should in the future include certain health services like immunizations, growth monitoring, etc, if practical and possible.

The WTT member(s) responsible for each village should then come back to their village as often as possible, but definitely on the regular health days (once per month).

The village level activities should also be supported by various local advocacy actions such as choirs, ngoma, ngonjera, etc.

Funding

Special funds for initiating the FFL/HEI will be provided by UNICEF. The funds for each activity have been standardized according to Annex 2. Individual regions and districts or villages may decide to add to the activities proposed by soliciting or contributing funds from other sources, but these UNICEF funds have to be used for the purpose defined in the Annex.

The RMO s will be accountable for these funds and they will be advanced after completing the training of the RTT. It is proposed that these funds be entered into the 'AIDS Control Account' of the RMO to facilitate utilization and accounting. The RMO will then advance the funds needed in each of the districts to the respective DMO according to the requirement of each district. After completing district implementation and before the dead-line (see below), the DMO's will then account back to the RMO, who in turn will submit the total accounts for the region to UNICEF.

Materials

All materials prepared for the FFL/HEI will be distributed to the regional headquarters to be in place at the time of initiating the regional activities, i.e. by the end of June. The RTT will then be responsible for distribution to the districts, the DTT for distribution to the wards and the WTT, finally, for distribution to the villages; at every step according to the distribution plan given in Annex 3.

Dead-lines

Dead-lines have been established for completing the introduction of the FFL/HEI initiative at regional, district, ward and village level according to this implementation plan. It is of utmost importance that these dead-lines are kept,not only to ensure that the important messages reaches out as quickly as possible, but also for monitoring and accounting purposes. If some districts or regions delay implementation, it will not be possible to evaluate and to initiate follow up activities as required. It is understood that some regions or districts may face implementation constraints and not be able to complete all planned activities on time. In such cases, the DMO or the RMO should complete the accounts for the activities actually carried out, return any remaining funds, and submit a new implementation plan with a budget for how to cover remaining activities. Provided that all previous activities have been performed satisfactory, all such requests will be honoured.

6. MONITORING AND EVALUATION

In order to ensure effective implementation and follow-up of the FFL/HEI, and also to provide a firm foundation for future health education actions, it is essential to establish a clear monitoring and evaluation system for the whole exercise. The proposed system has four main components:

1. Implementation monitoring. Special forms have been designed (Annex 4 - 6) for reporting by the RMO, the DMO and the WTT (on village implementation), respectively, covering the most important activities that are planned to be performed at each of these administrative levels. This form should be completed by the person who has been assigned to carry out the activity concerned and then submitted to the person coordinating the HEI at that level. The coordinator is normally the Regional or the District Medical Officer, but he/she may assign one staff member to coordinate the HEI on his/her behalf. The DMO thus ensures that the district advocacy and the district strategy meetings take place and the training of all the ward PHC committees are carried out and that the forms are filled out accordingly. The DMO then waits for the ward PHC committees to complete their introductory training and advocacy meetings in all their villages and ensures that the forms are collected before the final payments to the ward staff is done. The DMO shall then compile a final report from the district with all the forms filled out and with full accounts of the expenditures completed (see below). This report is then submitted to the RMO, who compiles the reports from the individual districts, and adds the reports and accounts for the activities carried out at the regional level. This final and complete report from the region is then submitted to the zonal coordinator, who compiles the reports from the regions in that zone and submits it to the national coordinator, i.e. the Ministry of Health.

It will be extremely important that the implementation plan and dead-lines are followed at all levels to avoid lengthy delays in the reporting and accounting. If any of the planned activities have not been carried out before the dead-line, the coordinating officer should report and account for everything implemented and return the balance of the advances received. A special plan for how to complete the remaining activities within the region or district shall then be prepared and funded through a new advance as explained in section 5.

2. Accounting. Funds to carry out all activities as defined in this plan will be forwarded to the Regional Medical Officers through their special AIDS Control accounts. The RMO s will then issue similar advances to the DMO s in the region according to the estimates done based on Annex 2 . The RMO then receives the accounts from the DMO s and prepare a final account from the region as a statement of accounts using the form in Annex 7. The RMO thus do not need to submit all the particulars of the expenditures but only this form. The particulars remain in the RMO s accounts section for future verification if required. The zonal coordinators, finally, receive thee accounts from the RMO s and submits these to the Ministry of Health.

3. Impact monitoring. An attempt will be made to assess the direct impact of the HEI/FtL on people s knowledge, attitude and practices (KAP). This will be done by conducting a baseline survey in statistically selected

areas in May/June, and then to do a follow-up survey later in the year and try to measure changes in KAP and the extent to which these are related to activities carried out by the HEI or local actions initiated from it. This evaluation will be carried by a separate national institution.

4. Internal evaluation. The importance of the FFL/HEI for the future development of health education actions in the country is emphasized in section 7 below. In order to try to document the experiences gained during the initiative as fully as possible, the coordinators at each level (down to the districts) will be requested to wright a report and submit it to the national coordinator. This report shall not only include a report of how the specific HEI activities were carried out, but also, and more importantly, how the coordinator view the effectiveness and appropriateness of factors such as:

- the teaching materials
- the teaching methodologies
- appropriateness of priority topics included in the HEI
- appropriateness of messages
- problems of planning, implementation and follow up
- views on how to establish effective and continuous health education actions in the communities and what support that would be crucial for such actions to be sustained in his/her area.

7. LONG-TERM DEVELOPMENTS

The Health Education Initiative as described above is planned not as a "Campaign", but it is intended as a starting point rather than an end in itself. The idea is to put up-dated, relevant materials into the hands of potential health educators at all administrative levels as quickly and as effectively as possible. The success of this effort, however, will wholly depend on what these health educators, themselves, actually do with the material that they receive. This has to be carefully considered in the planning and in the implementation of the initiative at all levels, but most importantly at the district and sub-district levels.

The planning of how to implement the HEI in the districts and in the wards should thus not only cover details on how to conduct the various training and advocacy activities described above, but it should also clarify the supervisory, supportive and follow-up actions that will be necessary to ensure that health education becomes a permanent action in all the communities.

It should also be known that a new national Health Education Programme is being prepared with much more emphasis than before on decentralized, local level actions within the emerging primary ehalth care structures and procedures. This new programme will help to facilitate health education initiatives and also production of education materials according to local situations and felt priorities. This programme will be put into place towards the end of 1990 and early 1991, and will thus provide an opportunity for support for extension and further development of activities established by the current HEI.

For the purpose of long-term planning and development of health education activities in Tanzania, it is thus important to ensure that there is an effective feed-back from the Health Education Initiative, not only regarding the extent to which the messages promoted by the HEI and the Facts for Life are properly understood and applicable, but also regarding other important factors that need to be addressed in order to achieve 'Health for All by the Year 2000'.

8. PHASING

The specific activities arising from the methodology described above are listed below in the chronological order they are expected to be implemented.

8.1 National seminar and training of NTT.

8.2 Briefing of national mass media regarding FFL/HEI.

8.3 Training of RTT. This will take place at zonal level by the NTT and other important zonal coordinators and media staff will also be invited. This is expected to be completed by 18th May.

8.4 National Launching. This is expected to be on 30th May, 1990.

8.5 Regional Advocacy/Information Meetings. To be carried out by the RTT in all regions on half to one day.

8.6 Regional Strategy Meetings. To be done by RTT in conjunction with 8.5.

8.7 Training of DTT. To be done by RTT for selected DTT members. This will be done at regional level covering all the expected DTT's by the end of June.

8.8 District Advocacy/Information Meeting. To be done by DTT with support individuals from RTT.

8.9 District Strategy Meetings. To be done in conjunction with 8.8.

8.10 Training of Ward PHC members. This will be done by DTT at divisional level covering 4-5 wards in each seminar. This is expected to be completed by July 1990.

8.11 Advocacy/Information Meeting at village level. To be done by ward PHC team.

8.12 Training of Village PHC members. To be done by W/PHC team in conjunction with 8.11. By the end of August, all villages need to be contacted in the first round.

8.13 Monitoring and recovery of advances from regional and district medical officers. To be done by National trainers.

8.14 1st Evaluation on the FFL/HEI materials and its initial impact.

9. TIME FRAME FOR PHASING

	M	A	M	J	J	A	S	O	N	D
1. NATIONAL TRAINING	-									
2. NATIONAL MASS MEDIA MEETING										
3. REGIONAL TRAINING OF TOT										
(a) NORTHERN ZONE 4 REGS.			-							
(b) SOUTHERN ZONE 2 REGS.			-							
(c) EASTERN ZONE 4 REGS.			-							
(d) WESTERN ZONE 2 REGS.			-							
(e) LAKE ZONE 4 REGS.			-							
(f) SOUTHERN H'LANDS 4 REGS.			-							
4. NATIONAL LAUNCHING			-							
5. REIGONAL ADVOCACY/INFORMATION				--						
6. REGIONAL STRATEGY MEETINGS				--						
7. DISTRICT TRAINING OF TOT'S				--	-					
8. DISTRICT ADVOCACY/INFORMATION				---						
9. DISTRICT STRATEGY MEETINGS				---						
10. TRAINING WARD PHC MEMBERS				--	---					
11. VILLAGE ADVOCACY				-	---					
12. VILLAGE HEALTH ED. MEETINGS				-	---	---				
13. MONITORING AND RECOVERY OF ADVANCES					---	---	---				
14. EVALUATIONS (1ST)										---|

10. BUDGET SUMMARY

10.1 TRAINING/ADVOCACY

(a)	National trainers	489,000
(b)	Regional trainers	4,471,200
(c)	District trainers	14,049,200
(d)	Ward trainers	50,161,550
(e)	Village health education meetings	8,978,000
10.2	COMMUNICATION	1,431,700
10.3	EDUCATION	2,000,000
10.4	MONITORING AND EVALUATION	1,000,000
		81,378,250

Further details of the budget are given in Annex 2(A-C).

11. ZANZIBAR

The implementation of the Health Education Initiative/Fact for Life in Zanzibar will be organized as a follow up to the country-wide nutrition programme campaign that was conducted January - April 1990. It is planned that the community level seminars will concide with the next round of Community Health Days scheduled for June 1990. A separate implementation plan for Zanzibar is being prepared.

ANNEX 1

TEACHER/LEARNER INSTRUCTIONS

The Teachers/Learners Instruction is aimed at guiding or suggesting to the user on what is expected to be covered in each subject. This guide may be expanded or modified to suit particular type of audience provided that the main objective is covered.

1. ADVOCACY

Objective:

At the end of this session the participants should be able to:

(i) Describe the role of advocacy as a key to programme acceleration.

(ii) Identify specific ways and means of obtaining the necessary information.

(iii) Describe communication channels which can make an impact on health education.

(iv) List a range of media and non-media communication activities that can be used for advocacy on good health.

(v) Draw basic factors to be used in designing messages and disseminating them.

Teaching/Learning Methodology

Participants should be exposed to various communication channels, social mobilization strategies for them to design appropriate messages that can be effectively disseminated to the target audience.

References: a) Facts for Life
b) Social Mobilization Training Manual
c) Handouts

Detailed Content:

Subject	Duration	Content	Evaluation
(i) Programme acceleration		- Basic product - Political will - Multisectoral approach - Sustainability	Question/ Answer/feedback

Subject	Duration	Content	Evaluation
(ii) Information gathering		- Language to be used - Mass media - Communication agents - Communication resource available	Question/ Answer/feedback
(iii) Communication Channels		- Horizontal - Vertical - Parallel	Group Observation
(iv) Media and non-media communication activities		- Mass media - People based - Other media, materials	Production of examples
(v) Message design and dissemination		- Service strategy - User audience needs - Programme communication strategies	Exercutes and presentation

2. STRATEGY FOR HEALTH EDUCATION

Objectives:

Participants should, by the end of this session, be able to:

(i) Draw out points in favour of inter-sectoral coordination in health education.

Identify roles of various sectors and institutions.

(iii) List health education methodologies used in disseminating information, educating the community and communicating with target audience.

(iv) List advantages and disadvantages of decentralization of health education activities.

Teaching/Learning Methodologies

Participants must be told new strategies for health education delivery, organizational set up, counselling, health education in PHC context, roles of various sectors and institutions and health education material production, storage and distribution.

References: a) Health Education Initiative manuals
b) The National PHC Strategy
c) Handouts

Detailed Content:

Subject		Duration	Content	Evaluation
(i)	Intersectoral coordination	30 mins	- Integrated training programmes	Question/ Answer/ feedback mechanism.
			- Multisectoral committee formation	
			- Health delivery systems	
(ii)	Roles of key sectors and institutions dealing with H/Ed.	30 mins	- A clear definition of these roles for health, community development, education, Party, Information, etc.	Committment by individual sector/inst. to carry out these roles.
			- Identification of a focal point for H/Ed.	
(iii)	Information, Education and Communication	30 mins	- Methods used in information dissemination, educating communities, communicating with target audience.	Attitudinal change in society.
			- Use of change agents in the community	
(iv)	Decentralization of Health Educ.	30 mins	- Centralization vs decentralization	Organizational structure for H/Education
			- Health Education structures at national, zonal, regional, district, ward and village levels.	
			- Focal point at these levels	

Subject		Duration	Content	Evaluation
(v)	Role of women	30 mins	- Household level - Community level - Institutional level	

KEY LEARNING POINTS

1. Health Education is a dialogue between two parties, an information exchange on health issues wheregy each of the parties has a say.

2. The intension of the Ministry of Health is to decentralize health education activities in terms of personnel and establishing minature Health Education Units at Regional and District Levels.

3. The present health education strategy emphasizes on a multisectoral approach, community oriented in solving health problems e.g. Involvement of the Party, Ministry of Education, Health, Information, Community Development, etc.

4. The role of women in health education must be clearly reflected at both decision making level as well as the implementation level e.g. in committee formation there should be a deliberate effort to have higher women representations.

3. EDUCATIONAL METHODOLOGY

Objectives:

By the end of this session, participants should be able to:

(i) Organize a training programme.

(ii) Demonstrate willingness to train others with the knowledge and skills gained in this session.

(iii) Be a good example of the methods on health education that are demonstrated to the audience.

(iv) Monitor and evaluate health education programmes effectively.

Teaching/Learning Methodologies

Participants will be exposed to principles of curriculum development, lesson planning, monitoring and evaluation. They will further be given topics of their own interest related to health to work on and present to fellow participants evaluation of this presentation will modify the behaviour of individual participants.

References: a) Training curricula
b) Handouts

Detailed Content:

Subject	Duration	Content	Evaluation
(i) Organization of a training progr.		- Audience needs and the environment - Objective setting - Training strategies	Group exercises and presentation
(ii) Knowledge, skills and attitudes		- Knowledge - Skills - Attitude	Examples
(iii) Health Education activities		- Continuous assessment - Examinations - Motivation - Certification - Career prospects	Examples

KEY LEARNING POINTS

1. The techniques using a wide range of teaching/learning methodologies make a great difference in participants' comprehension of a topic/issue if we compare one presenter from the other.

2. Trainers should as much as possible be a model of what they are advocating for participants to initiate such examples.

3. A curriculum must aim at transforming theoretical information into practice with a change in behaviour of the individual under training.

4. It is important to evaluate a participant according to the originally stated objectives of the training.

4. SAFE MOTHERHOOD INITIATIVE AND FAMILY PLANNING

Objectives:

At the end of this session the participants will be able to:

(i) Sensitize a number of key people on safe motherhood issues during formal and informal meetings.

(ii) Explain the magnitude of maternal health problems in the country to the community.

(iii) Identify roles of sectors and other organizations on safe motherhood initiative.

(iv) Analyse contraceptive methods available in the country with a view of increasing the use rate.

(v) Make plans of action at their respective areas to reduce maternal deaths.

Educational Methodology

Participants will use their experience in analysing maternal mortality, maternity complications, exessive fertility, high risk pregnancy, socio-economic and political structures using the conceptual framework for situation analysis of maternal health.

References: a) Facts for Life
b) Health Education manuals
c) Handouts

Detailed Content:

Subject	Duration	Content	Evaluation
(i) Sensitization of decision makers		- Situation analysis on SMI - Policies on SMI - Their role in mass mobilization	Question/ Answers/ responses
(ii) Maternal health problems in the country		- Maternal mortality rate (MMR) - Morbidity factors e.g - Maternity fertility - Excessive fertility - High risk pregn. Maternity services - Socio-economic development - Political and ideological factors	Analysis of conceptual framework for for maternal health
(iii) Roles of Sectors and other organizations		- Sectors and their roles - Organizations and their roles	Group exercises and presentation
(iv) Contraceptive methods		- Organizaiton of family planning delivery system - Types of contraceptives	

Subject	Duration	Content	Evaluation
		- Indications and contraditions - Potential users - Use rate	
(v) Reduction of maternal deaths		- Plan of Action - Integration with other PHC activities	Exercises and presentations

KEY LEARNING POINTS

1. A lot has been done in improving the health services of children through MCH Services at an extent of neglectting mothers who take care of those children.

2. Maternal mortality in Tanzania is increasing. It is estimated to be in the order of 2 to 4 deaths per 1000 live births.

3. Maternal death is defined as death of a woman while pregnant or within 42 days of termination of pregnancy, inrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from incidental or incidental causes.

4. Maternal mortality is a result of maternal complications due to:

   - Excessive fertility;
   - High risk pregnancy;
   - Traditions and customs e.g. early marriage; food taboos; gender roles (heavy workload); traditional birth practices;

5. Safe motherhood therefore must comprise of:

   - Raising of the status of women to have an economic power and power of decision;

   - Family health education and service provision e.g. family planning.

   - Strengthening community based care with good referral system e.g. training TBAs; pregnancy monitoring;

   - Strengthening district hospitals to enable them to perform all essential maternity functions.

5. NUTRITION

Objectives:

Participants should, at the end of this session, be able to:

(i) Describe the main causes of child deaths associated with nutrition.

(ii) Draw attention to the importance of frequency of feeding a child at least 5 times per day using locally available foods.

(iii) Describe the 6 rules of thumb for feeding a child.

(iv) Orgnaize a village based nutrition rehabilitation scheme together with the community.

(v) Monitor the nutritional status of children in a given area.

(vi) Use the available information to take action on problems identified.

Educational Methodology

Participants will be exposed to the new concept of nutrition and its application at all levels especially the household level using a 'triple A' cycle. Emphasis must be made on the need for frequent feeding of a child more than 5 times a day with the locally available food. The use of germinated power flour to reduce dietary bulk will need to be demonstrated to participants. Emphasis also on hygiene, continued breastfeeding, enough quantitities with the required nutrients will have to be made. Finally exercises on the organization of a village based nutrition rehabilitation scheme with a monthly monitoring of the nutritional status of children willhave to be demonstrated.

References: a) Health Education
b) Facts for Life
c) MCH growth cards
d) Handouts

Detailed Content:

Subject	Duration	Content	Evaluation
(i) Causes of child deaths associated with nutrition		- Child deaths due to immediate, underlying basic causes.	Analysis of causes
(ii) Information utilization		- In assessement, analysis and action on problems identified.	Analysis of actions

Subject	Duration	Content	Evaluation
(iii) 6 rules of thumb		- Feeding frequency of more than 5 times. - Adequate nutrient content - Hygiene - Adequate amount - Food free from dietary bulk - Continued breast feeding	Question/ Answer response
(iv) Village based nutrition rehabilitation scheme		- Community mobilization for food availability - Day care systems - Day care attendants - Nutritional status monitoring system	Exercises and responses
(v) Nutrition Status of children		- Monitoring system - Village registers - Health Days - Report writing - Feedback, followup and supervision	Exercise and responses.
(vi) Nutrition and Health Campaign		- Pre-requisite to the Campaign - Campaign day - Post campaign followups	

KEY LEARNING POINTS

1. We have to change from the traditional description of nutrition using food tables to the importance of stressing for the frequency of feeding a child 5 times a day with the locally available food. Eating more of what is available is the principle.

2. Health factors associated with food deficiencies are:

   2.1 Protein Energy Malnutrition (PEM)
   2.2 Anaemia
   2.3 IDD
   2.4 Vitamin A deficiency

3. Because a child has to eat half of the adult food with a frequency of 5 times per day in order to grow well, this is not an easy task. Therefore in reality practically all children are affected with PEM.

4. Proteins are important but they are being emphasized too much at an expense of other foods.

5. The growth of a child can be effectively monitored using a growth card.

6. The 6 rules of thumb on child feeding are:

   6.1 Frequency of feeding a child 5 times per day with locally available food
   6.2 Adequate amounts of food e.g. half the adult food per day
   6.3 Observe hygiene
   6.4 Food must be nutritious
   6.5 Food must be free from dietary bulk e.g. use power flour to reduce dietary bulk
   6.6 Continue breastfeeding even when the child has diarrhoea.

6. IMMUNIZATION

Objectives:

Participants must be able, at the end of this session, to:

(i) Describe symptoms and signs of 6 immunizable diseases.

(ii) Describe the immunization schedule for these diseases.

(iii) Identify roles of each sector on sustainability of the immunization programme.

(iv) Organize effective Health Days in their respective areas.

Educational Methodology

Participants will have to be exposed to MCH clinics/wards for a practical exercise on immunization. They will also work in groups to identify roles of each sector, institution in the immunization programme as well as come up with an organization of a 'Health Day'.

References: a) Facts for Life
b) Health Education manual
c) MCH cards
d) Handouts

Detailed Content:

Subject	Duration	Content	Evaluation
(i) 6 Immunizable diseases		- Tuberculosis - Measles - Diphtheria - Polio	Question/ Answer/ responses

Subject	Duration	Content	Evaluation
		- Tetanus - Pertussis	
(ii) Immunization Schedule		- Immunization schedule	Exercises
(iii) Roles of each Sector		- Individual roles - Multisectoral collaboration - Coordinating committees - Sustainability	Exercises
(iv) Health Days		- Village register and its organization - Major activities - Report writing - Followu-up	Exercises

KEY LEARNING POINTS

1. The 6 immunizable diseases are:

   - Tuberculosis
   - Polio
   - Pertussis
   - Diptheria
   - Tetanus and
   - Measles

2. Immunization Schedule for children

Age	Antigen
At birth	BCG, Polio
4 weeks	DPT, Polio
8 weeks	DPT, Polio
12 weeks	DPT, Polio
9 months	Measles

Immunization against tetanus for women:

Doses	Period	Protection
First	Any time	None
Second	After 4 weeks	3 Years
Third	After 6 months or another pregnancy	5 years

Fourth	After a year or another pregnancy	10 years
Fifth	After a year or another pregnancy	20 years

3. Effective health days must include:

- Effective outreach programme
- Demarkated catchment area/health facility
- Community mobilization
- Integrated activities e.g. weight taking, immunization, health and nutrition promotion, feeding demonstration, family planning, etc.

7. WATER AND ENVIRONMENTAL SANITATION

Objectives:

At the end of this session, participants will be able to:

(i) Analyse various sources of water pollution and poor environmental sanitation and their outcome.

(ii) Describe advantages of a Ventilated Improved Pit Latrine (VIP).

(iii) Mention factors to be observed in order to ensure the availability of safe water supply.

(iv) Identify the responsibilities of a community in ensuring a clean water supply and the environment.

Educational Methodology

Participants will have to visit a number of water sources and observe the environment in that area. A description of a VIP will have to be made and the communitys' responsibility on cleanliness will be analyzed.

Detailed Content:

Subject	Duration	Content	Evaluation
(i) Sources of Water		- Sources - Relationship with diseases - Control measures	
(ii) Ventilated Improved Pit Latrine (VIP)		- Advantages e.g. permanent, fly free, smell free, appropriate technology,	

Subject	Duration	Content	Evaluation
		reasonable cost. - Construction of a low-cost VIP.	
(iii) Safe Water Supply		- Factors for consideration - Relationship with Nutrition	
(iv) Community involvement in safe water supply		- Mass Mobilization - Water Committee formation with domination of potential users. - Self reliance for income generation/ human above	

KEY LEARNING POINTS

1. Water borne and faecal oral diarrhoeas, cholera, typhoid, biacillary dysentry, amoebic dysentry, poliomyelitis, hepatitis A, worm infestations e.g. ascariasis, trichuriasis.

2. Amount of water required for domestic purposes per individual is 25 litres per day.

3. Preventive measures include:

   3.1 Proper disposal of human excreta using latrines (VIP)
   3.2 Safe water supply
   3.3 Washing hand with soap/ash before food handling and after latrine use

   3.4 Simple soakage pits, garbage pits or domestic wastewater and garbage disposal
   3.5 Proper housing
   3.6 Proper animal husbandry
   3.7 Health education on personal and food hygiene, home and environmental cleanliness, etc.

8. **SPECIFIC DISEASE FACTORS**

Objectives:

At the end of this session, participants will be able to:

(i) Describe control measures of the top endemic diseases of public health importance such as:

a) Diarrhoea
b) Malaria
c) AIDS
d) Acute Respiratory Infections (ARI)

(ii) Design communication messages suitable to target audience on control of these diseases.

(iii) Describe symptoms and signs of manifestations of these patients.

(iv) Assess the magnitude of these diseases in the country epidemiologically.

Educational Methodology

An exposure to patients suffering from these diseases will be vital for an on the spot glance of symptoms and signs. Detailed description of control measures and the epidemiology of these diseases will have to be provided by the resource persons.

References: a) Facts for Life manual
b) Health Education Initiative manual
c) Posters
d) Handouts

Detailed Content:

Subject	Duration	Content	Evaluation
(i) Diarrhoea		- Causes - Epidemiology in country - Symptons and signs Control measures - Design of effective communication message to the public on control of the disease	Experimental feedback in a session
(ii) Malaria			
(iii) AIDS		- do -	
(iv) Acute Respiratory Infections (ARI)		- do -	

KEY LEARNING POINTS

DIARRHOEA

1. **Correct Case Management at health facility includes:**

   - **Correct assessment of child**
   - **Correct rehydration therapy using ORS or under critical conditions I.V. fluids**
   - **Feed children staying over 4 - 6 hours**
   - **Correct use of antibiotics**
   - **Correct advice on home case management**

2. **Correct Home Case Management includes:**

   - **Timely ORT**
     a) **Correctly prepared**
     b) **In increased volumes**

   - **Continued feeding**
     a) **Quantity**
     b) **Apprioriate foods**

   - **Know when to refer**

3. **Prevention of diarrhoea includes:**

   - **Breast feeding**
   - **Improved weaning practices**
   - **Clean water**
   - **Hand washing**
   - **Latrine use preferrably a VIP**
   - **Stool disposal**
   - **Measles immunization**

MALARIA

1. Malaria is a number one killer of under-fives in Tanzania.

2. Control measures must include the following:

   - Appppropriate treatment of diagnosed cases;

   - Chemoprophylaxis of pregnant women with the recommended antimalarial;

   - Use of personal protection measures, e.g. empregnated mosquito bed-nets;

   - Microscopic diagnosis of the infection particularly in pregnancy;

- Proper environmental sanitation to minimise breeding sites for mosquitoes.

3. Recommended anti-malarial drugs are:-

- Chloroquine (with a lot of resistant cases);
- Quinine;
- Sulfadoxine/pyrimethamine (fansidar);
- Sulphametopyrazine/pyrimethamine (metakelfin);
- Mefloquine.

4. It is essential to reduce the temperature to below 39C degrees before giving any injectable antimalarial by tepid sponging or use of antipiretics e.g. Acetyl salicylic acid.

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

1. The first AIDS suspects in Tanzania were reported in 1983 in one region (Kagera) and the condition has spread to involve all the mainland regions by 1986.

2. The number of AIDS cases has doubled each year except for 1989.

3. Infections among blood donors and pregnant mothers indicate an upward trend.

4. The main mode of transmission of HIV in Tanzania is heterosexual contact.

5. The number of children without parents (orphans) is rapidly growing. A concern on their care is becoming crucial.

6. Preventive measures for AIDS are mainly:

- Change of behaviour towards sexual intercourse.
- Screening blood for transfusion.

- Avoid trans-placental transmission of HIV.
- Use of condoms when necessary.

ACUTE RESPIRATORY INFECTIONS (ARI)

1. Acute Respiratory Infection is one of the 4 common cause of morbidity and mortality among under-five children in Tanzania. Other diseases are diarrhoea, malaria and malnutrition.

2. ARI consists of a group of diseases/conditions such as Pneumonia, coughs, colds, diptheria, pertusis, measles, tuberculosis.

3. **Effective control measures require:**

3.1 Recognition and treatment of pneumonia
3.2 Immunization against diptheria
3.3 Use of appropriate drugs
Antimicrobal drugs of choice are:
3.3.1 Co-trimoxazole
Procaine benzylpenicillin
Amoxycillin
Ampicillin

A community health worker can be allowed to use co-trimoxazole which is the cheapest of them all.

3.4 Prenatal care for encouraging breastfeeding, proper nutrition, increase in birth weight, protection against chills and reduction indoor air pollution (including smoking).

PROPOSED 3 DAY-TRAINING TIME TABLE

Day	Time	Topic	Responsible
	08.30 - 09.30	Opening Ceremony	Guest of honor
FIRST	09.30 - 10.00	Advocacy	IEC/CCM/Comm Dev.
	10.00 - 10.30	Nutrition Break	Secretary
	10.30 - 11.00	Discussions	
	11.00 - 12.00	Facts for Life	IEC Person
	12.00 - 13.00	Discussions	
	13.00 - 14.00	Lunch Break	
	14.00 - 15.00	Health Education Strategy	Health Ed. Person
	15.00 - 16.00	Discussions and exercises	
	16.00 - 16.30	Nutritional break	
	16.30 - 17.00	Administrative procedures	
SECOND	08.00 - 08.30	Educational Methodology	Education Person
	08.30 - 09.30	Exercises and discussions	
	09.30 - 10.00	Safe Motherhood Initiative	Health Person
	10.00 - 10.30	Nutrition Break	
	10.30 - 11.30	Discussions	
	11.30 - 12.00	Immunization	EPI Person
	12.00 - 13.00	Discussion	
	13.00 - 14.00	Lunch Break	
	14.00 - 15.00	Specific disease factors e.g. Diarrhoea, Malaria, AIR, AIDS	Health Person/IEC
	15.00 - 16.00	Discussions and Demonstrations	
	16.00 - 16.30	Nutritional break	
	16.30 - 17.00	Administrative Procedures	
THIRD	08.00 - 08.30	Water and Evironmental Sanitation	Water/Health Person
	08.30 - 09.30	Discussions and Exercises	
	09.30 - 10.00	Nutrition	Agric./Health person
	10.00 - 10.30	Nutritional break	
	10.30 - 11.30	Discussions and exercise	
	11.30 - 13.00	Zonal/Regional/District/Ward Village training workshop Organization	Participants
	13.00 - 14.00	Lunch break	
	14.00 - 16.00	Presentations/discussions	
	16.00 - 16.30	Nutritional break	
	16.30 - 17.00	Addresses by Party/Govt. Leaders	

NOTE: This is a proposed 3 day training timetable. The Training team can draw a programme to be used locally depending on the proposed number of days and trainers available.

ANNEX 2

TRAINING BUDGET

LEVEL	ACTIVITY	NO. OF PEOPLE INVOLVED	DAYS	COSTS	TSHS
NATIONAL	TRAINING NATIONAL TRAINERS	11 FACILITATORS	3 days	Lunch allw. 15 x Tshs. 900 x 3d	40,500
				Lunch allw. 3 drivers x 900 x 3d	8,100
		18 NATIONAL TRAINERS		DSA - 8 people x 5,800 x 5 d	232,000
				Travels - 8 x Tshs. 10,000	80,000
				Transp. - 50l/d x 3 cars x 3d x Tshs. 120	54,000
				Hall - Tshs. 10,000/d x 3d	30,000
				Stationary - Tshs. 200/p x 12	2,400
				Tea/Coffee Tshs. 300/person x 23 x 3d x 2	42,000
				NATIONAL TOTAL	489,000
ZONAL	TRAINING REGIONAL TRAINERS ON ZONAL BASIS	18 FACILITATORS	4 days	Lunch allw. Host Rg.	
				8p x 6Rg. x Tshs. 600 x 4d	115,200
		160 REG. TRAINERS		DSA - 8p x 14Rg. x Tshs. 3,900/p x 6d	2,620,800
				Travels - Tshs. 7 000/p x 112	224,000
				Halls - Tshs. 5,[illegible]d x 4d x 6	120,000
				Tea/Coffee - particip. Tshs. 200/p x 160p x 4d	128,000
				Tea/Coffee - facilit. Tshs. 200/p x 12p x 6 sess. x 4d	57,600
				Stationary - Tshs. 200/p x 160p	3,200
	TRAVELLING	18 NAT. FACILITATORS		DSA 18 fac. x 12/d x 15hs. 3,900	842,400
				Transport approx. 15hs. 20,000/d x 18	360,000
				ZONAL TOTAL	4,471,200
REGIONAL			4 days	Advocacy - 17 PHC x 20Rg. x 500	170,000
	TRAINING DISTRICT TRAINERS (8 PER DISTRICT)	160 FACILITATORS		Lunch allw. - 160 fac. & 160 people from Host district in the Reg.	
				320p x Tshs. 600 x 4d	768,000
		824 DISTRICT TRAINERS		DSA - 664 x Tshs. 3,100 x 5d	10,292,000
				Travel - 664 x Tshs. 1,000/p	624,00
				Hall - Tshs. 2,000 x 7 reg. x 4d	56,000
				Tea/Coffee - Tshs. 200/p x 984 x 2	1,574,400
				Tshs. 2,000 x 13 reg. x 4d x 2	208,000
				Stationary - Tshs. 200/p x 824	164,800
				Petrol - Tshs. 120/l x 80l x 20	192,000
				REGIONAL TOTAL	14,049,200
WARD	TRAINING WARD PHC COMMITTEE MEMBERS	824 FACILITATORS	3 days	Advocacy to distr. leaders - 15 RHC x 103d x Tshs. 350/p	540,750
				Lunch allw. for host ward - 4,944p x 150/p x 3d	2,224,800
	TRAINERS IN THE DISTRICT CAN SPLIT IN TWO GROUPS			DSA - 12,248p x Tshs. 800 x 3d	29,395,200
				DSA - 824 fac. x Tshs. 1,300 x 3d x 3 sess.	9,640,800
				DSA - 2 drivers/d x 103 x Tshs. 800 x 9d	1,483,200
				Petrol - 20lt/ward x Tshs. 120 x 2,149	5,157,600
				Stationary - Tshs. 100/p x 17,192	1,719,200
				WARD TOTAL	50,161,550

LEVEL	ACTIVITY	NO. OF PEOPLE INVOLVED	DAYS	COSTS	TSHS
VILLAGE	CONDUCTING HEALTH EDUCATION SESSIONS IN EACH VILLAGE	17,192 EDUCATORS 1-2 EDUCATORS TO BE ALLOCATED ONE VILLAGE		Expenses for each village tshs. 1,000 x 8,978	8,978,000
				GRAND TOTAL	78,148,950

ANNEX 2A

ZONAL BUDGET ALLOCATION

ZONES	REGIONS	COST		TSHS.
NORTHERN	ARUSHA	Lunch Host Rg.	8p x Ishs. 600 x 4d	19,200
		DSA	24p x Ishs. 3,900 x 6d	561,600
	SINGIDA	Travels	Ishs. 2,000/p x 24p	48,000
		Tea/Coffee	Ishs. 200/pd x 38p x 4d	30,400
	KILIMANJARO	Hall	Ishs. 5,000/d x 4d	20,000
		Stationary	Ishs. 200/p x 22p	6,400
	TANGA			
				685,600
SOUTHERN		Lunch Host Rg.	8p x Ishs. 600 x 4d	19,200
	MTWARA	DSA	8p x Ishs. 3,900 x 6d	187,200
		Travels	Ishs. 2,000/p x 8p	16,000
		Tea/Coffee	Ishs. 200/pd x 22p x 4d	17,600
	LINDI	Hall	Ishs. 5,000/d x 4d	20,000
		Stationary	Ishs. 200/p x 16p	3,200
				263,200
EASTERN	MOROGORO	Lunch Host Rg.	8p x Ishs. 600 x 4d	19,200
		DSA	24p x Ishs. 3,900 x 6d	561,600
	COAST	Travels	Ishs. 2,000/p x 24p	48,000
		Tea/Coffee	Ishs. 200/pd x 38p x 4d	30,400
	DAR ES SALAAM	Hall	Ishs. 5,000/d x 4d	20,000
		Stationary	Ishs. 200/p x 22p	6,400
	DODOMA			
				685,600
SOUTHERN HIGHLANDS	MBEYA	Lunch Host Rg.	8p x Ishs. 600 x 4d	19,200
		DSA	24p x Ishs. 3,900 x 6d	561,600
	IRINGA	Travels	Ishs. 2,000/p x 24p	48,000
		Tea/Coffee	Ishs. 200/pd x 38p x 4d	30,400
	RUVUMA	Hall	Ishs. 5,000/d x 4d	20,000
		Stationary	Ishs. 200/p x 22p	6,400
	RUKWA			
				685,600
WESTERN		Lunch Host Rg.	8p x Ishs. 600 x 4d	19,200
	KIGOMA	DSA	8p x Ishs. 3,900 x 6d	187,200
		Travels	Ishs. 2,000/p x 8p	16,000
	TABORA	Tea/Coffee	Ishs. 200/pd x 22p x 4d	17,600
		Hall	Ishs. 5,000/d x 4d	20,000
		Stationary	Ishs. 200/p x 16p	3,200
				263,200

ZONES	REGIONS	COST		ISHS.
LAKE	MWANZA	Lunch Host Rg.	8p x Ishs. 600 x 4d	19,200
		USA	24p x Ishs. 3,900 x 6d	561,600
	KAGERA	Travels	Ishs. 2,000/p x 24p	48,000
		Tea/Coffee	Ishs. 200/pd x 38p x 4d	30,400
	SHINYANGA	Hall	Ishs. 5,000/d x 4d	20,000
		Stationary	Ishs. 200/p x 22p	6,400
	MARA			
				685,600
GRAND TOTAL				3,268,800

ANNEX 2B

REGIONAL BUDGET ALLOCATION

REGIONS	DIST.	WARD	VILL.	COSTS DIOT	COST TRAINING WARD PHC	COST VILLAGE MEETINGS	TSHS
DODOMA	4	121	451	545,600	2,824,000	451,000	3,820,600
ARUSHA	8	141	512	1,091,200	3,291,000	512,000	4,894,200
KILIMANJARO	6	113	398	818,400	2,638,000	398,000	3,854,400
TANGA	6	138	665	818,400	3,221,000	665,000	4,704,400
MOROGORO	5	134	489	682,000	3,128,000	489,000	4,299,000
COAST	5	70	301	682,000	1,634,000	301,000	2,617,000
DAR ES SALAAM	3	52	51	409,200	1,214,000	51,000	1,674,200
LINDI	5	114	361	682,000	2,661,000	361,000	3,704,000
MTWARA	4	97	483	545,600	2,264,000	483,000	3,292,600
RUVUMA	4	84	324	545,600	1,961,000	324,000	2,830,600
IRINGA	6	113	636	818,400	2,638,000	636,000	4,092,400
MBEYA	7	135	639	954,800	3,151,000	639,000	4,744,800
SINGIDA	4	86	346	545,600	2,007,000	346,000	2,898,600
TABORA	5	134	410	682,000	3,128,000	410,000	4,220,000
RUKWA	4	68	364	545,600	1,587,000	364,000	2,496,600
KIGOMA	4	81	227	54,600	1,891,000	227,000	2,172,600
SHINYANGA	6	118	756	818,400	2,754,000	756,000	4,328,400
KAGERA	6	111	528	818,400	2,591,000	528,000	3,937,400
MWANZA	6	159	664	818,400	3,711,000	664,000	5,193,400
MARA	5	80	333	682,000	1,867,000	333,000	2,882,000
TOTALS	103	2,149	8,938	13,558,200	50,161,000	8,938,000	72,657,200

ANNEX 2C

COMMUNICATION/INFORMATION BUDGET

1. MEDIA BRIEFINGS

National

Two National Briefings will be held in 1990 - one during the NTT workshop on 15th march, 1990 and one in December 1990 for appraisal and continuity in advocacy.

Lunch allowance 22 participants	19,800
900 x 22	19,800
Soft drinks and bites 180 x 22	3,300
Transport and incidentals	5,000
	28,100
Two meetings 28,100 x 2	
Sub total	56,200

2. SUPPORT TO TRADITIONAL MEDIA

- DSA and Honoraria to groups	200,000
- Certificate or Awards to performing Artists	100,000
- Recordings and Studio Charges	50,000
- Travel	200,000
Sub total	550,000

3. FEATURE ARTICLES AND OTHER SUPPORT PUBLICATIONS

1. Production of Promotional Brochures	
50 x 10,000 brochures	500,000
2. Travel for 3 Journalists 5,000 x 3	45,000
3. 3 Journalists x 3 days x 3,100 x 3 trips	83,700
Sub total	620,000

4. RADIO AND TV SPOTS

1. Radio and TV, Studio & Production charges	70,000
2. DSA and Travel for 2 Journalists DSA - 3,100 x 2 x 4	24,800
Travel - 5,000 x 2	10,000
3. Video Production	100,000
Sub total	204,800

SUMMARY OF BUDGET

1.	Media	56,200
2.	Traditional Media Support	550,000
3.	Feature Articles and Publications	620,700
4.	Radio and TV Production	204,800
	Grand total	1,431,700

ANNEX 3

TRAINING MATERIALS DISTRIBUTION

	REGIONS PHC MEMBERS 17	DISTRICTS (D) 15	WARDS (W) 8	VILLAGES (V)	FFL	HEALTH EDUC. PHC (YELLOW) (17XR)+(15XD)+(8XW)	HEALTH EDUC. COMM (BLUE) (2XV)+(10XW)	POSTERS (EACH) (2XV)
DODOMA	1	4	121	451	3,160	1,050	2,120	910
ARUSHA	1	8	141	512	3,590	1,270	2,446	1,030
KILIMANJARO	1	6	113	398	2,970	1,020	1,930	800
TANGA	1	6	138	665	4,660	1,000	2,710	1,330
MOROGORO	1	5	134	489	3,430	1,170	2,320	980
COAST	1	5	70	301	2,110	650	1,310	310
DAR ES SALAAM	1	3	52	51	350	500	630	110
LINDI	1	5	114	361	2,530	1,000	1,870	730
MTWARA	1	4	97	483	3,390	850	1,940	910
RUVUMA	1	4	84	324	2,270	750	1,490	650
IRINGA	1	6	113	636	4,450	1,010	2,410	1,280
MBEYA	1	7	135	636	4,480	1,200	2,630	1,280
SINGIDA	1	4	86	346	2,430	110	1,560	100
TABORA	1	5	134	410	2,870	1,180	1,410	820
RUKWA	1	4	68	364	2,550	650	1,410	730
KIGOMA	1	4	81	227	1,590	730	1,270	460
SHINYANGA	1	6	118	745	5,230	1,050	2,680	1,500
KAGERA	1	6	111	528	3,700	1,000	2,170	1,050
MWANZA	1	6	159	664	4,680	1,380	2,920	1,330
MARA	1	5	80	333	2,340	740	1,470	670
	20	103	2,149	8,924	62,780	18,310	38,696	16,980

ANNEX 4

Monitoring and Evaluation

Reporting form for Regional Medical officer.

REGION.....(To be submitted to Zonal Coordinator latest 20/9/90)

1. Activities performed.

Regional Advocacy Meeting: Date..... No of participants.....

Regional Strategy Meeting: Date..... No of participants.....

Training of District Training Teams: Materials Distributed:

District	Date	No of Part.	FtL	HEI(Y)	HEI(B)	Post.
.....	....	.....	....	....	....	....
.....	....	.....	....	....	....	....
.....	....	.....	....	....	....	....
.....	....	.....	....	....	....	....
.....	....	.....	....	....	....	....
.....	....	.....	....	....	....	....

2. District Reports Received by 10/9/90.

District Name	No of wards Covered	No of wards Not Cov.	No of villages Covered	No of villages Not Cov.	Funds (T.Sh) Advanced	Funds (T.Sh) Returned
.....	....	....	....	....	.....	.....
.....	....	....	....	....	.....	.....
.....	....	....	....	....	.....	.....
.....	....	....	....	....	.....	.....
.....	....	....	....	....	.....	.....
.....	....	....	....	....	.....	.....
Totals:	____	____	____	____	_____	_____

Signed;..... Date:.....

(UNICEF statement of account form plus follow up plan for the region to be attached)

Monitoring and Evaluation ANNEX 5

Reporting Form for District Medical Officer.

DISTRICT..... REGION.....

Note: This report should be submitted to the RMO latest 10/9/90

1. Activities Performed

1.1 Advocacy Meeting: Date..... No of participants.....

1.2 Strategy Meeting: Date..... No of participants.....

1.3 Training of Ward PHC Committees:

Training site 1..... date..... No of wards.... No of part....

Training site 2..... date..... No of wards.... No of part....

Training site 3..... date..... No of wards.... No of part....

Training site 4..... date..... No of wards.... No of part....

Training site 5..... date..... No of wards.... No of part....

Training site 6..... date..... No of wards.... No of part....

Summary: Number of wards covered by 31/8..... Not covered.....

1.4 Village Meetings/Training:
Number of village return forms received.....

Number of villages still to be covered.....

2. Summary of Accounts.

Costs incurred: District advocacy meeting .....

District strategy meeting .....

Ward PHC seminars .....

Village meetings/training _____

Total costs .....

Advance received _____

Balance (to be returned to RMO) ==========

Signed:..... Date:.....

ANNEX 6

TUMEELIMIKA KIAFYA

Jina la Kijiji: _____ Waliohusika kutoa Elimu:

1.

2.

3.

Uongozi wa kijiji unathibitisha kwamba, mafunzo kuhusu Elimu ya Afya na Ukweli kuhusu Maisha yametolewa kwa Kamati ya HAM ya kijiji tarehe ..... mwezi ..... 1990 na wanakijiji wote katika mkutano wa hadhara tarehe ..... mwezi ..... 1990.

Pia tumethibitisha kupokea vitabu vifuatavyo kwa ajili ya maktaba/ofisi ya CCM ya kijiji.

Ukweli kuhusu Maisha - Jumla ya vitabu ( )

Ujumbe Muhimu kwa jamii - Jumla ya vitabu ( )

Mwenyekiti wa kijiji: .....
sahihi

Katibu wa kijiji: .....
sahihi

Mwalimu Mkuu: .....
sahihi

Nakala:

Mwenyekiti wa kijiji ( )

Katibu kata ( )

Mganga Mkuu wa wilaya ( )

Ikiwa kazi imefanyika vizuri na kuthibitishwa ipasavyo fomu hii itakuwa ni ushahidi wa kutoa malipo kwa wale waliohusika kutoa elimu hiyo.

ANNEX 7

UNICEF Representative
P.O. Box 4076,
DAR ES SALAAM.

Date:
Ref:

CERTIFICATE OF EXPENDITURE

This is certify that the advance of Tshs. ..... provided by UNICEF for ..... vide your letter Ref No. ..... dated ..... has been expended as follows:

.....	Tshs	.....
.....	Tshs	.....
.....	Tshs	.....
.....	Tshs	.....
.....	Tshs	.....
Total	Tshs	.....
Less: Advanced as above	Tshs	.....
Overexpenditure/Balance due UNICEF	Tshs	.....

We hereby certify the expenditures have been in accordance with Government financial rules and régulations and that all supporting documentation (vouchers, receipts, payrolls, etc) are available at ..... for scrutiny by UNICEF as/if required.

Signed: ..... Signed: .....
Head of Dept. (Responsible Officer) Accountant