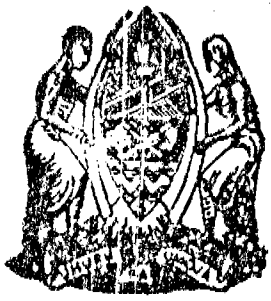

THE UNITED REPUBLIC OF TANZANIA

Facts for Life

Health Education Initiative

SECOND

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PLAN OF ACTION 1991

With support from

UNICEF

UNESCO

WHO

1: INTRODUCTION

1. BACKGROUND:

Facts for Life (FFL) was a joint WHO/UNICEF/UNESCO initiative with the purpose of making the most important life saving messages available to a larger audience worldwide. The first copies of the English version of FFL were distributed to some key ministries and institutions to study it. The response was that this book be translated into Swahili and adopted to the local conditions in the country. The Book would be an extremely valuable guide to the people in their efforts to improve their health situation and that of their families. The work was initiated and completed by a Task Force composed of Government officials and communication experts.

At the same time, the Ministry of Health recognized the urgent need to communicate with PHC committees at all levels including health and other extension workers in general, on how to conduct Health Education in the communities. It was agreed to launch a comprehensive and integrated training of PHC committees at all level rather than conducting a series of individual vertical seminars. This efforts came to be called Health Education Initiative (HEI).

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, Immunisable Diseases (measles, polio, whooping cough, diphtheria, 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 literature from the Task Forces was then put together into two manuals. One to be used by the District and Ward PHC committees and the second one for the communities. Posters were also developed to support health education activities at the community level.

Since Facts for Life and Health Education Initiative compliment each other, it was deemed necessary to integrate the two fully. An intersectoral coordinating committee was thus set up comprising of the ministries of Health, Education and Information, the department of Community Development of the Ministry of the Local Government and the secretariat of Social Services of the Party. This committee developed the FFL/HEI Plan of Action for 1990. The objective of this Plan was to facilitate the smooth implementation, supervision,

monitoring and evaluation of the programme.

GOAL

The overall goal of the FFL/HEI is to make sure that communities are capable of assessing, analysing and taking action on common disease factors affecting their well-being.

2. OBJECTIVES

The main objectives of the 1990 action plan was 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 all 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 within the specified period.

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

3. EXPERIENCE

The FFL/HEI is an ongoing activity and permanent in nature. It is far from being a campaign and has to be sustained by the people themselves. It is aimed at changing people's attitude and behaviour for positive healthful living through solving their health problems in their own localities.

During 1990 FFL/HEI revived most of the dormant and non-functional Primary Health Care Committees at all levels. This was done through advocacy meeting to regional and district leaders, training workshops for training of trainers (TOTs) at National, District, and Ward levels. Other activities included distribution of FFL/HEI booklets and posters, print and traditional media activities.

By December 1990, 84% of wards and 78% of villages

had been covered during the training. Few regions had some administrative and implementation problems i.e. transport, lack of accountability which led to unfinished training activities. The multisectoral nature of the programme with community participation and commitment of Party and Government leaders in most of the region contributed a lot towards the success of the planned activities.

The 1991 Plan of Action aims at:

(a) Strengthening and sustaining the programme in the whole country.

(b) Promote Village Health Days (VHDs)for communities to undertake health promotional activities, including Child Survival and Development.

(c) Strengthening Primary Health Care committees at all levels to ensure that they hold regular meetings and discuss issues relevant for their social development.

(d) Strengthening capacity of extension workers in communication skills for health programme.

(e) Facilitate community participation , monitoring and evaluation of activities.

4. IMPLEMENTATION STRATEGY

The FFL/HEI strategy insists on utilizing our limited resources (i.e. manpower, money and material) available in an economical and effective way by integrating and coordinating the ongoing activities financed by the Government, donor agencies, and NGOs within the region/districts. In areas currently implementing CSD programmes, for example, it is suggested that the FFL/HEI continued to be coordinated with planned training of ward and village health committees.

4.1 TRAINING

The already established national training team will be equipped with:

- Communication techniques on control of diarrhoea disease.

- Knowledge on how to organize and implement Village

Health Days aimed at promoting community based health initiatives and actions.

- Knowledge on how to facilitate and assist in evaluation of FFL/HEI activities (KAP study).

- Knowledge on how to facilitate community participation and monitoring on water and sanitation activities.

Specialist from these areas will join the national training team (NTT) in passing knowledge acquired to other training teams at regional to ward levels, ultimately train the PHC committees at all levels.

4.1.1 PARTICIPANTS

National Trainers (NTT):	11 ESTC trainers 3 communication exp. on CDD. 6 Zonal Continuing Education Coordinators for Health Staff. 3 Party Members 3 Education 3 Information 3 Health (MOH) Total to be divided into 6 teams of 5 members each.
Regional Trainers (RTT)	3 Health (RMO and 2 other medical personnel). 1 Party 1 Education (REO, etc.) 1 Information 1 Statistics 1 Community Development Total 8 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 to whom majority are extension workers.

4.2 OPERATIONS

4.2.1 At National Level:

Followup and retraining of the (NTT) will be conducted in Dar es Salaam. This will include 11 new members from the East African Statistical Training Centre (EASTC), 3 others from the Control of Diarrhoea Diseases (CDD) programme and 1 or 2 experts on Water and Environmental Sanitation (WES). This is expected to be done on 25th and 26th October, 1991.

- There will be one day Mass media seminar on FFL/HEI main objectives and plans for 1991, to continue solicit support and participation in the implementation.

- A one day parliamentary workshop will be organized this year so as to solicity full support of political leaders who will advocate and promote FFL/HEI in their respective constituencies: Regional Development Committee Metings (RDC's), District Development Committee Meeting (WDCs), Ward Development Committee Meetings (WDCs), and Village Development Committee Meetings (VDCs).

4.2.2 At Zonal Level

Six groups of NTT will conduct training of the 20 regional training teams at six designated zonal headquarters. Media representatives who are also members of the training team will cover not only contents of the FFL/HEI, but also discuss how to establish implementation plans for the regions and districts within the zone. Training will take place as follows:

6/11/91 - The Northern Zone: Arusha, Singida, Kilimanjaro and Tanga.

6/11/91 - The Southern Zone: Mtwara and Lindi. (Might be postoponed due to the floods).

6/11/91 - The Eastern Zone: Morogoro, Coast, Dar es Salaam and Dodoma.

6/11/91 - The Western Zone: Kigoma, Tabora

and Mpanda.

6/11/91 - The Lake Zone: Mwanza, Kagera, Mara and Shinyanga.

6/11/91 - The Southern Highlands Zone: Mbeya, Iringa, Ruvuma and Rukwa.

Note: Underlined towns will host the zonal workshops.

4.2.3 At Regional Level

As usual the RTT will organize regional advocacy/information meting involving regional leaders. Regional Commissioners (RCS) who are chairman of the RPHC committees and members of the Parliament (MPs) who are members of the RDC's, DDC's and DPHC committee will brief other leaders on the followup and implementation of the 1991 FFL/HEI activities. 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 time-table, budget and distribution plan for the additional training materials. In addition, they will also identify specific roles for themselves including allocation of districts in which each member will be responsible for support and followup. The Regional FFL/HEI Coordinator on behalf of the RMO, will be responsible for coordination, supervision, monitoring and accounting of the activities in the region.

Training of the District Training Teams may be at regional headquarters or any other location depending on the convenience of each region. This training session should be completed by end of October 1991.

4.2.4 At District Level

After the training of the DTT, each district team together with the RTT member(s) responsible for the followup in that district will conduct an advocacy/information meeting. The MPs will brief

the district leaders on the followup and implementation of the 1991 FFL/HEI activities.

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. Logistics and distribution lists for the Health Education 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 of eight people, which means that only 3-4 wards can be trained at one time. If a district has about 25 wards, 7-8 seminars of one day each 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 institutions in the district (including non-governmental organizations) could be involved in the FFL/HEI and in the continued health education activities. The district FFL/HEI Coordinator will

4.2.5. At Ward Level

The seminars for ward staff will continue to be combined with advocacy/information, 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 are the change agents within the communities. It is therefore extremely important that these seminars for ward staff be carefully executed, ensure they 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 retraining of FFL/HEI will continue to strengthen and emphasize the role of these committees. It is further suggested that during the ward seminars, members of the WTT continue with their individual assigned villages within the ward with a clear responsibilities and continuous followup of the health development.

The District teams should try to complete the training of ward staff by end of

4.2.6 At Village Level

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 propose of the 1991 FFL/HEI plans and propose regular VHD be held from that day onwards. Besides health education, these village health days should include other health services like immunizations, growth monitoring, sanitation activities and nutrition. Additional copies of FFL/HEI booklets should also be handed to the village.

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.

4.3 INSTITUTE OF ADULT EDUCATION

4.3.1 a) Ward Adult Education Coordinators Training Programmes:

The Institute of Adult Education has ongoing programmes of training Ward Adult Education Coordinators. For 1990 , such training programmes were conductged in Kagera, Tanga and Morogoro Regions. In 1991, Ward Adult Education Coordinators training programmes were planned for Mara, Mwanza and Arusha Regions.

For next year 1992 training programmes for Ward Adult Education Coordinators are planned for three regions namely Pwani, Kigoma and Mtwara.

The objective of these training programmes has been to include elements and concerns of FFL/HEI in such programmes.

4.3.2 Women and Development Educational Seminars

The IAE has also been conducting education seminars for women at village level which included FFL/HEI aspects. For 1990, such seminars were conducted in Singida, Mwanza and Mbeya Regions.

This year 1991 these seminars were planned to be conducted in Musoma, Iringa and Tanga depending on availability of funds.

They will also be conducted in three more regions next year (1992).

The objective is to reach target group women at village level with FFL/HEI messages as they are the ones who care for children's lives and whose lives are danger. The training in the past has mostly focused extension staff with expectations that they will deliver the messages to the target. However, these expectations have not been met for various reasons.

4.3.3 Production and distribution for Post Literacy Materials:

The IAE has been producing and distributing post-literacy materials such as books. The plan for 1991 is to print and distribute a book 'MATUNZO YA MAMA MJAMZITO' (25,000 copies) to be used in literacy classes and other post literacy followup programmes.

The plan for 1992 is to print and distribute a book titled 'JINSI YA KUTENGENEZA CHAKULA CHA MTOTO' (25,000).

In addition the IAE plans to organize a writer's workshop in Morogoro so as to get another manuscript with more FFL/HEI messages.

4.4. COMMUNITY DEVELOPMENT

The Ministry of Community Development Women Affairs and Children has several programmes at community level through which FFL/HEI messages could reach communities. The following programmes can be conveniently used to that effect.

4.4.1 Training for Rural Development Centres (TRDCs). These carry out training of villagers in issues that concern particular problems in their day to day chores particularly in areas of production, project management and leadership. These centres are Ruaha, Uyole, Mlale, Monduli and Mabughai.

4.4.2 Folk Development Colleges (FDC)

These are 52 in number. They are responsible for

the training of villagers in carpentary, masonry, agriculture, home economics and animal husbandry among others. They have short courses and also long courses of up to two years.

4.4.3 Community Development Training Institute

These train community development extension staff at certificate and advanced diploma levels. They are trained in order to take positions at District and Village Levels where they can work directly with communities. They are Tengeru, Buhare, Misungwi, and Rugemba.

Since the target group/audience of FFL/HEI is the community it is obvious that all these training institutions in the Ministry of Community Development, Women Affairs and Children can be very instrumental in promoting health education through the propagation of FFL/HEI messages.

4.4.4 Radio Programme

The Ministerial Radio Programmes are intended basically for rural people and several FFL/HEI messages have been disseminated through this channel in the past. The main participants in the programmes are villagers who explain their experiences and experts participate in giving expert explanations to issues. These radio programmes will still be used in FFL/HEI messages dissemination.

4.4.5 Implementors

Implementors of FFL/HEI in the institution will be the tutors who are teaching home economics. For effective implementation there is a need to orient these tutors (61 in total) in FFL/HEI programme.

4.5 EDUCATION

4.5.1 The Ministry of Education and Culture trained 42 I.T.Es and 24 Inspectors who have already trained 1000 teachers from 20 districts.

The trained teachers are School Health Coordinators, and parto fo 10,431 teachers who have to be trained.

This year the Teacher and Primary Departments will

continue conducting the training of the teachers to the ward level to allow a health coordinator at each primary school.

4.5.2 The Ministry of Education and Culture especially the Primary Department will distribute the FFL/HEI books 52,000 which have been allocated to:

i) all Primary Schools - at least each school will get 5 books of each title.

ii) All public libraries and one private library will receive 10 books of each title.

iii) Production of teaching materials apart from the distributed books, then should be workshops to involve teachers themselves in preparing their own materials.

5. FUNDING

Funds for followup and retraining of FFL/HEI will be provided by UNICEF. These activity are standardized according to Annex 5. 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.

5.1 ACCOUNTING

The RMO's will continue to be accountable for these funds and they will only be advanced if the region does not have outstanding advances. It is proposed that these funds be entered into the AIDS control account of the RMO to facilitate utilization and accounting. The RMO will advance the funds needed in each of the districts to the respective DMO according to the requirement of each district. After completing district implementations the DMO's will then account back to the RMO, who in turn will submit the total accounts for the region to UNICEF. Certificate of expenditure should indicate how funds were spent and not how funds were distributed to districts.

5.2 DEAD-LINES

Dead-lines have been established for completing the

1991 activities of the FFL/HEI at regional, district , ward and village level. It is emphasized that these dealines be folowed not only to ensure that the important messages r eaches out as quickly as possible, but also for monitoring and accounting purposes. Some districts and regions delayed implementation, and it was not possible to initiate followup activities as required. If regions or districts face implementation constraints, and not able to complete all planned activities on time, the DMO or the RMO should close the accounts for the a ctivities actually carried out, return any remaining funds, and submit a new implementation plan with a budget indicating how the remaining activities going to be covered. Provided that all previous activities have been performed satisfactorily, all such requests will be honoured.

6. MATERIALS

Additional materials of FFL/HEI have been reproduced according to the demand raised during the 1990 training activities. These materials will be at the regional level in time and the RTT will then be responsible for distribution to the districts, DTT to the wards and WTT, to the villages following the distribution plan given in Annex 6.

7. 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 achievement gained during the initiative as fully as possible, the coordinators at each level (down to the districts) will be requested to write 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 followup.

- views on how to establish effective and continuous health education actions in the communities and what support that would be crucial for such action to be sustained in his/her area.

8. IMPACT MONITORING

The second survey will 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 promptly by the East African Statistical Training Centre and the Training teams at all levels who will assist in supervising and providing other logistics to ensure smooth implementation of the KAP study.

9. LONG-TERM DEVELOPMENTS

The Health Education Initiative as described in the background is not a 'campaign', but it is intended as a starting point rather than an end in itself. The idea is to put updated, relevant materials and new ideas into the hands of potential health educators at all administrative levels as effectively as possible. The success of this effort, however, will wholly depend on what these health educators, themselves actually do with the new knowledge 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 ward 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 followup action 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 still being prepared with much more emphasis than before on decentralized, local level actions within the emerging primary health care structures and procedures. This new

FACTS FOR LIFE AND HEALTH EDUCATION INITIATIVE ACTIVITIES

NO	ACTIVITY	PERIOD	WEEKS 1	2	3	4	COMMENTS
1	Completion of 1990 training activities DSM, Mara, Coast, Mbeya, Rukwa, Ruvuma and Arusha.	May-November 1991	--	--	--	--	
2	Media briefing						
3	Parliamentarian workshop	Nov. 1991	--		--		
4	National Level w/shop NTT	Oct. 1991			--		
5	Zonal Level w/shop RTT	Nov. 1991	--				
6	Regional Level w/shop DTT	Nov. 1991			--	--	
7	District Level w/shop WTT	Dec. 1991				--	
8	Conducting Community Based h/ed. acti.	Dec. 1991 Jan-Dec.1992	--	--	--	--	
9	Multi-media activities (traditional, print and radio)	Dec. 1991 Jan-Dec.1992	--	--	--	--	
10	Establishing VHDs	Nov-Dec.1991	--	--	--	--	
11	National feedback meeting at:	Jan.1992	--	--	--	--	
12	Compilation of implementation report (by national secretariat). Preparation Action Plan 1992	Jan.1992	--	--	--	--	
13	Submission of the final report	Jan.1992				--	
14	Media Briefing	March.1992		--		--	
15	Distribution of the FFL/HEI report	March, 1992		--	--	--	

programme will help to facilitate health education initiatives and also production of education materials according to local situations and felt priorities. This programme 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 effctive 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 imporrtant factors that need to be addressed in order to achieve 'Health for All by the Year 2000'.

10. PHASING

The specific activities described above are listed below in their chronological order in which they are expected to be implemented.

1. Completing 1990 training activities in DSM, Mara, Coast, Mbeya, Rukwa, Ruvuma , Kigoma and Arusha.

2. Briefing of national mass media regarding followup of FFL/HEI.

3. Parliamentarian seminar on FFL/HEI strategies.

4. National seminar and trining of NTT on WES monitoring, communication on CDD, KAP study and formation of VHD.

5. Followup and training of RTT on WES, CDD, KAP and VHD's. This will take place at zona level by the NTT.

6. Regional Advocacy/Information meetings. To be carried out by the RTT in all regions on half to one day. MPs are also expected to brief other regiona leaders.

7. Followup and training of DTT on WES, CDD, KAP nd VHDs to be done by RTT. This will be done at regional level covering all the expected DTT's by November.

8. Followup and training of ward PHC members on CDD, WES, KAP and VHD. This will be done by DTT at divisional level covering 3-4 wards in each seminar. This is expected to be completed by end of October.

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

10 Evaluation

11. National feedback meeting.

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	Question/ Answer/feedback

	-Sustainability	
(ii) *Information gathering*	-Language to be -used -Mass Media -Communication agents. -Communication resource available	Question/ Answer/feed back
(iii) Communication Channels	-Horizontal -Vertical -Parallel	Group Observation
(iv) Media and non-media communication activities	-Mass media -People based -Other media, materials.	Production examples
(v) Message design and dissemination	-Service strategy -User audience needs. -Programme communication strategies.	Executes 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 healthy education.

(ii) 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 - Multisectoral committee formation. - Health delivery systems.	Question/ Answer/ feedback mechanism.
(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. Identification of a focal point for H/Ed.	Committment by individual sectors to carry out these roles.
(iii) Information, Education and Communication	30 mins	- Methods used in information dissemination, educating communities, communicating with target audience. - Use of change agents in the community.	Attitudinal change in society
(iv) Decentralization of Health/Ed.	30 mins	- Centralization vs decentralization	Organizational structure for H/Ed.

			- Health Education structures at national, zonal regional, district, ward, and village levels. - Focal point at these levels.
(v)	Role of women	30 mins	-Household level -Communsity level -Institutional level

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KEY LEARNING POINTS

1. Health Education is a dialogue between two parties, an information exchange on health issues whereby 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) Organise 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 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) Sentitization 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 eg	Analysis of conceptual framework

		- Maternity fertility - Excessive fertility - High risk pregn. Maternity services - Socio-economic development - Political and ideological factors.	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	- Organization of family planning delivery system - Types of contraceptives. - Indications and contradictions - 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 neglecting 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) Organize 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 quantities 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 will have 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 assessment, analysis and action on problems identified.	Analysis of actions
(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 followup

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 section 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 entify roles of each sector, institution in the immunization programme as well as come up with an organization of a Health Day.

Reference:
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 & - its organization - Major activities - Report writing	Exercises

- Followup

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 community's 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. 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 infestation 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
b) Health Education Initiative Manual
c) Posters
d) Handouts

Detailed Content:

Subject	Duration	Content	Evaluation
i) Diarrhoea		- Causes - Epidemiology in country - Symptoms and signs control measures - Design of effective communication message to the public on control of the disease	Experimental feedback in a session
ii) Malaria		- do -	
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) Appropriate 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

CDD PROGRAMME

Diarrhoea is a threat to every individual in the community and especially to the underfives. To reduce the mortality rate caused by diarrhoeal diseases, the Ministry of Health has established a programme for the control of Diarrhoeal Diseases. Through the programme the Ministry has already trained a number of supervisory staff in clinical management and in supervision skills. However through some of the ORT corner health personnel have received trainings in clinical management, they lack skills in communication which are vital for promotion of home case management. The programme has started training facilitators in communication skills who will train the ORT corner health personnel throughout the country.

The FFL/HEI is now entering the second phase, with one day national, zonal, regional, district and ward meeting scheduled to begin in October. The purpose of these meetings will be to reinforce key message areas and to present new printed materials. It is adopted that the new CDD pictorial materials be presented at these meetings, and that the FFL/HEI trainers at all levels be oriented to their effective use. The integration of CDD communication activities with Facts for Life and Health Education Initiative will enable the extension workers conduct effectively trainings to target groups

(mothers/caretakers) in CDD case management at home and prevention of diarrhoea diseases to the community.

MALARIA

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

2. Control measures must include the following:

   - Appropriate treatment of diagnosed cases;
   - Chemoprophylaxis of pregnant women with the recommended antimalarial;
   - Use of personal protection measures, e.g. impregnated 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)
   - Sulphametophyrazine/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 phenumonia, 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 contrimoxazole 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).

Appendix 2.

FORMAT 1

WATER AND SANITATION MONITORING SYSTEM (WASAMS) QUESTIONNAIRE

CORE INDICATORS FOR MONITORING THE WATER AND SANITATION SECTOR

REGION:.....TOWN:.....DISTRICT:.....VILLAGE:.....

1. A. ESTIMATED POPULATION:

1. Urban (Total, Obsolute numbers) .....
   As a percentage of total population .....

   (a) High Income, planned areas
   (absolutenumbers).....
   As a percent of total urban .....

   (b) Low Income, unplanned areas
   (absolute numbers) .....
   As a percent of total urban .....

2. Rural, (in absolute numbers) .....
   As a percent of total urban .....

3. Total population, absolute numbers 100%

3 togo 11x

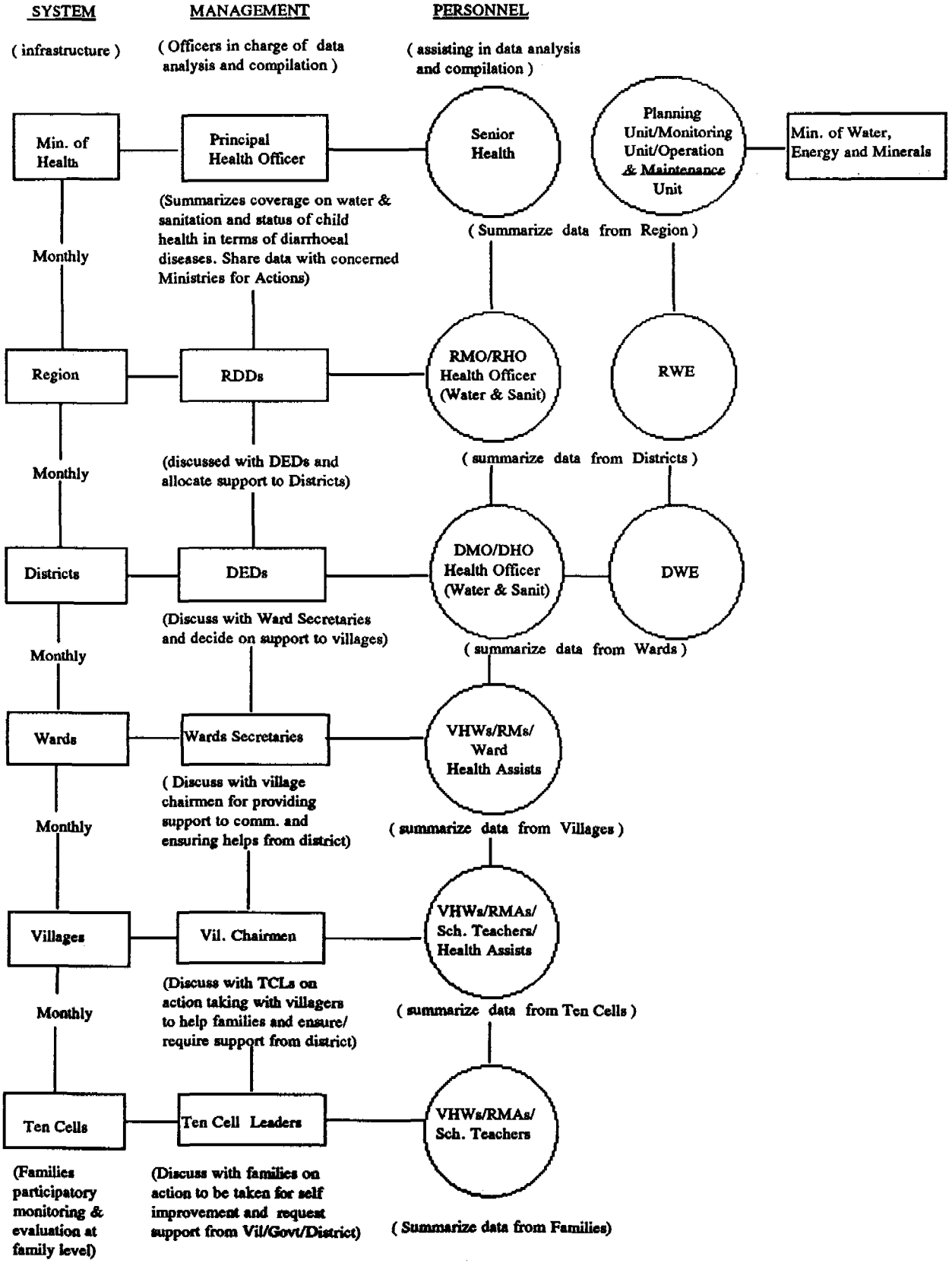
WATER AND SANITATION MONITORING SYSTEM (WASAMS) QUESTIONAIRE

CORE INDICATORS FOR MONITORING THE WATER AND SANITATION SECTOR; DATE: .....

REGION: ..... TOWN: ..... DISTRICT: ..... VILLAGE: .....

WATER SUPPLY 1. Urban High - Income Population with access to following facilities:								SANITATION Urban High - Income Population with access to the following facilities:						
NAME OF HEAD OF HOUSEHOLD	HOUSE CONN.	YARD TAP	PUBLIC S/PIPE	BORE HOLE I/C HAND PUMP	PROTECTED WELLS	RAIN WATER COL. SYS	OTHER SPECIFY	CONN. TO PUBLIC SEWER	SEPTIC TANK	SHALLOW SMALLBORE P/SEWER	POURFLUSH LATRINE	VIP LATRINE	SIMPLE P/LATR.	OTHER SPECIFY

FIGURE 1. COMMUNITY PARTICIPATORY WATER AND SANITATION MONITORING SYSTEM



NOTE: AAA cycle is applied at all levels from family to Ministry

ANNEX 3

A KNOWLEDGE, ATTITUDES AND PRACTICES SURVEY (KAPS) OF HEALTH ISSUES - 1991

As a follow-up to the 1990 Health Education Initiative/Facts for Life (KAP) Survey, the 1991 survey is planned to cover, on sample basis, all 20 regions in Tanzania mainland. Villages/Enumeration areas (District-towns), representing Rural and Urban Areas respectively, to be included in the sample will be obtained from the National Master Samples (NMS) constructed by the central statistical office, Dar es Salaam.

In the 1990 survey, 50 villages and 40 enumeration areas (EAS) were canvassed. In like manner, the 1991 survey is planned to cover the same villages and EAS. These villages and EAS (District-towns) are listed here-below:-

REGION	DISTRICT-TOWN	WARD/BRANCH	VILLAGE
Arusha	Arusha (U)	Unga Ltd	-
	Monduli (U)	Komoko/ Namanga	-
	-	Longido	Longido
	-	Singa	Himiti
	-	Karatu	Gerkum Lambo
Singida	Singida (U)	Kibaoni	-
	Manyoni (U)	Kipondoda	-
	-	Mgandu	Mitundu
	-	Dung'unyi	Samaka
Kilimanjaro	Moshi (U)	Mjimpya	-
	Rombo (U)	Makala	-
	-	Kibosho-Kindi	Kindi
	-	Mrao/Karyo	Mrao
	-	Mahida-Halili	Mahinda-Ngunduri
Tanga	Tanga (U)	Ngamiani Kaskazini	-
	Korogwe	Manundu	-
	-	Mng'ara	Mng'ara
	-	Makuyuni	Makuyuni
Mtwara	Mtwara (U)	Magengeni	-
	Masasi (U)	Mkuti	Chiunguta
		Kitaya	Mayembe
	-	Nakingu	Msimbati
Lindi	Lindi (U)	Mtanda	-
	Liwale	Nangondo	-

		Mbaya	Nduruka
Morogoro	Morogoro (U)	Mwembe Songo	-
	-	Humbati	Mkindo
	-	Kikao	Luale
Dodoma	Dodoma (U)	K/cha Ndege	-
	-	Nzunguni	Nzunguni
	-	Zauka	Mkondai
	-	Mauchali	Mauchali
Coast	Kibaha	Mailimoja	-
	Rufiji	Ikwiriri(K)	-
		Mchukwi	
	Kisarawe	Kisarawe Mjini	-
	-	Mzenga	Vilabwa
D'Salaam	Temeke	Kizuiani	-
	-	Tuangoma	M/Sekwa
	Ilala	Upanga M'riki	-
	Kinondoni	Mabibo	-
Mbeya	Mbeya (U)	Mapambano	-
	-	Tembera	Ngoka
	-	Matwiga	Matwiga
	-	Makongolosi	Makongolosi
	-	Ndulambo	Ndulambo
	-	Kinyala	Igambe
	Mbozi	Tunduma	-
	Rungwe	Bulyaga	-
Rukwa	Sumbawanga	Kitandula	-
		Kipeta	Kilangawana
Iringa	Iringa (U)	Ngangibuga	-
	Mufindi	Wambi	-
		Twawa	Ivilikinge
		Sadani	Utosi
Ruvuma	Songea (U)	Lizaboni	-
		Mpitimbi	Nametili
		Nyoni	Nyoni
Tabora	Tabora (U)	Ng'ambo	-
	Nzega	Nzega (U)	-
		Itobo	Chamwabo
		Igowero	Usway
Kigoma	Kigoma (U)	Mwanga-Kusini	-
	Kasulu	Kumsenga	-
		Msambara	Kabanga
		Mukinda	Mweyaya

Mwanza	Mwanza (U)	Pamba	-
	Kwimba	Kakosa	-
		Malya	Talaga
		Kanyelele	Kanyelele
	Sengerema (U)	Nyatukara	-
		Nyamatongo	Irunda
		Kagunga	Kagunga
Mara	Musoma (U)	Kitaji	-
	Bunda	Bunda (U)	
		Nyaukanga	Nyaukanga
		Mugera	Mgeta
Shinyanga	Shinyanga (U)	Kambarage	-
		Mwawaza	Mwawaza
		Muliunze	Muliunze
		Somanda	Ng'wang'wali
		Mwadoya	Uwakakuba
	Kahama	Itogwanholo	-
		Isaka	Isaka
Kagera	Bukoba (U)	Hamgembe	
	Biharamulo	Ibuga	Bunywambale
		Itundu	Itundu
		B'mulo (U)	
		Bwanga	Bwanga
Total	40		50

ANNEX 4

PRIMARY HEALTH CARE COMMITTEES

1. REGIONAL PHC COMMITTEE MEMBERS

1.	Regional Commissioner	-	Chairman
2.	Regional Development Director	-	Member
3.	Regional Medical Officer	-	Secretary
4.	Regional Planning Officer	-	Member
5.	Regional Community Development Officer	-	"
6.	Regional Local Government Officer	-	"
7.	Regional Education Officer	-	"
8.	Regional Agriculture Officer	-	"
9.	Party Leader (Huduma za Umma)	-	"
10.	Regional Livestock Officer	-	"
11.	Regional Water Engineer	-	"
12.	Regional Health Officer	-	"
13.	MCH Coordinator (R)	-	"
14.	Representatives of NGOs	-	"
15.	UWT Secretary (R)	-	"
16.	RVHW Programme Coordinator	-	"

Function of the Committee:

1. Plan, supervise and coordinate health related projects
2. To coordinate and advice on implementation of health project run by NGOs.
3. To reserve implementation reports from the district
4. To report quarterly yearly (report of implementation)
5. To evaluate programmes once after 3 years

2. District PHC Committees

1.	District Commissioner	-	Chairman
2.	District Medical Officer	-	Sec
3.	District Executive Director	-	Member
4.	District Cultural Officer	-	"
5.	District Education Officer	-	"
6.	District Community Dev. Officer	-	"
7.	District Agriculture Officer & Livestock Officer	-	"
8.	District Water Engineer	-	"
9.	Secretary Social Services Committee of CCM	-	"
10.	Chairman, Social Services Committee of District Council.	-	"
11.	Representative NGOs	-	"
12.	UWT Secretary	-	"
13.	VHW Coordinator	-	"

Function of the Committees:

3. WARD HEALTH COMMITTEES:

1.	Ward Secretary	-	Chairman
2.	M.A. Incharge HC/Dispensary	-	Secretary
3.	Ward Education Coordinator	-	Member
4.	Community Development Assistant	-	"
5.	Agriculture Assistant	-	"
6.	Livestock Assistant	-	"
7.	Councellor (ward)	-	"
8.	Nurse 'B'	-	"
9.	Representative of NGOs	-	"
10.	Health Assistant	-	"
11.	Ward Executive Secretary	-	"
12.	Water Attendant	-	"

Function of the Committee

Plan, supervise and coordinate health in the ward

- To identify major health problems and try to find solutions
- To advise village government on appropriate method on promotion of health status of the people.
- To receive implementation report form the village government
- To provide implementation reports
- To evaluate programme once after every three years

4. Village Primary Health Care Committee

1.	Village Chairman	-	Chairman
2.	RMA/VHW/Head Teacher	-	Secretary
3.	Village Health Worker	-	Member
4.	Agriculture Assistant	-	"
5.	Livestock Assistant	-	"
6.	Water Attendant	-	"
7.	Community Development Asst.	-	"
8.	Village Manager	-	"
9.	Influential Person in the Village	-	Member
10.	Representative of NGO's	-	"
11.	UWT Secretary	-	"

Function of the Committees:

1. To identify health problems on their representative village and ways of solving them.
2. To plan and supervise health implementation of their villages

by using local facilities available in their villages.

3. To inform the village government on major decisions and resolutions of the village PHC Committees and to give appropriate advise on health issues.

To mobilize the committees to implement the solution laid by village health committee and give moral and physical contribution.

To supervise village health post plus the essential drugs use and facilities.

To evaluate the programme every 3 years.

Generally the VHC has the following roles:

- To play the main leadership role for health promotion in the Community.
- Mobilization of local resources for development activities
- Make requisitions for possible assistance from higher levels
- Management/supervision of inputs e.g. drug kits, sustainability of development work including remuneration of VHWs.
- Review progress of community development workplan in monthly meetings.

ANNEX 5

BUDGET

1. GENERAL COMPUTATION

LEVEL	ACTIVITY	NO. OF PEOPLE	DURATION	COST	TSHS
National Level	Followup	18	1	L/all. 18 part.x1500/=/pxlday=	27,000
				Tea/coffee 24 partx200/=px1day=	7,200
				Stationery 18 partx200/=/p=	3,600
				Hall 10,000/=/dayx1day=	1,000
					38,800
	Travels NIHP			DSA=18x5,200/=/dx4days=	374,400
				Transport 18x40,000/=/p=	720,000
					1,094,400
Zonal level		18 national	1	Host Reg.L/allow=8partx6regx1500/=pxlday=	72,000
				Visiting Reg.DSA=8x14reg.x52/=/2day	1,164,800
				Travels=112part.x3000/=/p=	336,000
				Tea/coffee=trainers18x300/=/px2d=	10,800
				Tea/coffee=160part.x300/=/p.	48,000
				Stationary=160part.x200/=/p=	32,000
				Hall-5000/=/dx1dayx6zones=	30,000
				Petrol-30ltsx6zonesx150/=/lt.	45,000
					1,738,600
Regional level		160 reg.		Host:L/all-160facilx1500/=xiday=	240,000
				L/all=160part.x15000/=x1day=	240,000
				Visiting dist.=DSA=664partx4800/=x2	6,374,400
				Travels=664x1000/=/p=	664,000
				Tea/coffee=984x300/=/dx1=	295,200
				Stationery=824part.x200/=/p=	164,800
				Petrol=50ltsx20reg.x1500/=/lt.	150,000
					8,128,400
District level		824 district		Host- Lunch allow.17192x1200/=x1d	20,630,400
				DSA facil.=824x1200/=x3sessions	2,966,400
				Tea/coffee=824fac.x100/=/px3sess.	247,200
				Tea/coffee=17192x100/=/px1day	1,719,200
				Stationary=17192x100/=/p	1,719,200
				Petrol=20lts/wardx180/=/1tx2149w=	7,736,400
				Travel=200/=/px17192=	3,438,400
					38,457,200

2. ZONAL FOLLOWUP BUDGET

ZONE	REGIONS	COSTS	TSH
Northern	Arusha Singida Kilimanjaro Tanga	L/All Host Reg. 8 part.xTsh.1500x1day= DSA - 24 partxTsh.5200x2days= Tea/coffee - 38 partxTsh.300/px1day= Hall - Tsh.5000/dayx1day= Stat. - 32part.xTsh.200/p= Petrol - 50ltxTsh.150/lt.= Sub-total	12,000 249,600 72,000 5,000 6,400 7,500 --- 363,900
Southern	Mtwara Lindi	L/all. host reg. 8 part.xTsh.1500x1day DSA - 8 part.xTsh.5200x2days= Travel - 8 part.xTsh.3000/p.= Tea/coffee - 22 part.xTsh.300/px1day= Hall - Tsh.5000/dx1d= Stationery - 16 part.xTsh.200/p.= Petrol - 50lt.xTsh.150/lt.= Sub-total	12,000 83,200 24,000 6,600 5,000 3,200 7,500 --- 141,500
Eastern	Morogoro Coast Dar-es-Salaam Dodoma	L/all. 8 part.xTsh.1500x1d= DSA - 24part.xTsh.5200x2d= Travel - 24part.xTsh.3000/p.= Tea/coffee-38part.xTsh.200/px1d.= Hall - Tsh.5000/dx1d.= Stationery - 32part.xTsh.200/p.= Petrol - 50lt.xTsh.150/lt.= Sub-total	12,000 249,600 72,000 11,400 5,000 6,400 7,500 --- 363,900
Southern Highland	Mbeya Iringa Ruvuma Rukwa	L/all - 8part.xTsh.1500x1day= DSA - 24part.xTsh.5200x2d= Travel - 24part.xTsh.3000/p.= Tea/coffee - 38part.xTsh.300/px1d= Hall - Tsh.500/dx1day= Stationery - 32part.xTsh.200/p= Petrol - 50lts.xTsh.1500/lt= Sub-total	12,000 249,600 72,000 11,400 5,000 6,400 7,500 --- 363,900
Western	Kigoma Tabora	L/all - 8part.xTsh.1500x1d= DSA - 8part.xTsh.5200x2d= Travel - 8part.xTsh.3000/p= Tea/coffee - 22part.xTsh.300/px1d= Hall - Tsh.5000/dx1d= Stationery - 16part.xTsh.200/p. = Petrol - 50lts.xTsh.150/lt.= Sub-total	12,000 83,200 24,000 6,600 5,000 3,200 7,500 --- 141,500

ZONE	REGIONS	COSTS	TSH
Lake	Mwanza	L/all - 8part.xTsh.1500x1d.=	12,000
	Kagera	DSA - 24part.xTsh.5200x2d=	249,600
	Shinyanga	Travel - 24part.xTsh.3000/p.=	72,000
	Mara	Tea/coffee - 38part.xTsh.300/pxid=	11,000
		Hall - Tsh.5000/d.x1d.=	5,000
		Stationery - 32part.xTsh.200/p.=	6,400
		Petrol - 50lts.xTsh.150/lt.=	7,500
		Sub-total	363,700
		Zonal Grand Total	1,738,600

3. GUIDELINE FOR BUDGET COMPUTATION AT REGIONAL DISTRICT/WARD LEVEL

LEVEL	COSTS	TSHS
Regional Level	Hosts	
	L/all Reg.trainers 8xTsh.1500/dx1d=	12,000
	L/all host dist.8xTsh.1500/dx1d=	12,000
	Tea/coffee- 16xTsh.300/dx1day=	4,800
	Stat. - 8xTsh.200/p=	1,600
	Petrol - 50ltxTsh.150/lt.=	7,500
		37,900
	Visiting Dist.	
	DSA - 8part.xTsh.4,800x2d=	76,800
	Tea/coffee - 8part.xTsh.300/p=	2,400
	Stationery - 8part.xTsh.200/p.=	1,600
	Travel - 8part.xTsh.1000/p=	8,000
		88,800
District Ward level	Trainers Dist.	
	DSA - 8fac.xTsh.1200/px1dx3ses.	28,800
	Tea/coffee 8fac.xTsh.100/px1x3sess.	2,400
		31,200
	Ward Trainers (1 ward)	
	L/all - 8part.xTsh.1200x1day=	9,600
	Tea/coffee- 8part.xTsh.100/px1d.=	800
	Stationery - 8part.xTsh.100/p.=	800
	Petrol - 20lts./wardxTsh.180/lt=	3,600
	Travel - 8part.xTsh.200/p.=	1,600
		16,400

4. REGIONAL BUDGET ALLOCATION

Region	District	Wards	Coast Regional Followup	Cost Dist. Trainers	Cost Ward Trainers	Total Tshs
Dodoma	4	121	304,300	124,800	1,984,400	2,413,500
Arusha	8	141	659,500	249,600	2,312,400	3,221,500
Kilimanjaro	6	113	481,900	187,200	1,853,200	2,522,300
Tanga	6	138	481,900	187,200	2,263,200	2,932,300
Morogoro	5	134	393,100	156,000	2,197,600	2,746,700
Coast	5	70	393,100	156,000	1,148,000	1,697,100
Dar es Salaam	3	52	215,500	93,600	852,800	1,161,900
Lindi	5	114	393,100	156,000	1,869,600	2,418,700
Mtwara	4	97	304,300	124,800	1,590,800	2,019,900
Ruvuma	4	84	304,300	124,800	1,377,600	1,806,700
Iringa	6	113	481,900	187,200	1,853,200	2,522,300
Mbeya	7	135	570,700	218,400	2,214,000	3,003,100
Singida	4	86	304,300	124,800	1,410,400	1,839,500
Tabora	5	134	393,100	156,000	2,197,600	2,746,700
Rukwa	4	68	304,300	124,800	1,115,200	1,544,300
Kigoma	4	81	304,300	124,800	1,328,400	1,757,500
Shinyanga	6	118	481,900	187,200	1,935,200	2,604,300
Kagera	6	111	481,900	187,200	1,820,400	2,489,500
Mwanza	6	159	481,900	187,200	2,607,600	3,276,700
Mara	5	80	393,100	156,000	1,312,000	1,861,100
Totals	103		8,128,400	3,213,600	35,243,600	46,585,600

ANNEX 7

Monitoring and Evaluation

Reporting form for Regional Medical Officer

REGION.....(To be submitted to National Coordinator .

1. Activities performed

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

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

Training of District Training Teams: Materials Distributed to Districts:

District	Date	No of Part.	FFL	HEI(Y)	HEI(B)
.....	....	.....	...	.....	.....
.....	.....		...	.....	.....
.....	.....		...	.....	.....
.....	.....		...	.....	.....
.....	.....		...	.....	.....
.....	.....		...	.....	.....
.....	.....		...	.....	.....

Tools:

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

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

ANNEX 8

Monitoring and Evaluation

Reporting Form for District Medical Officer

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

Note: This report should be submitted to the RMO latest

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..... 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: .....

Ward PHC seminars .....

Total Costs .....

Advance received ----------

Balance (to be retured to RMO) ==========

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

ANNEX 9

TUMEELIMIKA KIAFYA

Jina la Kijiji:---------- Waliohusika kutoa Elimu:

Kata---------- 1.

Wilaya--------- 2.

Mkoa---------- 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 mktaba/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.

6.2 MGAWANYO WA VITABU VYA ELIMU YA AFYA KATIKA SHULE ZA MSINGI TANZANIA BARA

	Mkoa	Idadi ya shule		Ukweli kuhusu maisha	Ujumbe muhimu kwa Jamii (blue)
		Pub.	Private		
1	Arusha	519	1	2595	2595
2	Dar es Salaam	156	-	780	780
3	Dodoma	487	1	2435	2435
4	Iringa	677	-	3385	3385
5	Kagera	628	2	3140	3140
6	Kigoma	236	-	1180	1180
7	Kilimanjaro	696	1	3480	3480
8	Lindi	320	-	1600	1600
9	Mara	628	2	3140	3140
10	Mbeya	769	-	3845	3845
11	Morogoro	578	2	2890	2890
12	Mtwara	471	1	2355	2355
13	Mwanza	798	2	3990	3990
14	Pwani	384	-	1920	1920
15	Rukwa	339	2	2695	2695
16	Ruvuma	439	2	2195	2195
17	Shinyanga	823	5	4115	4115
18	Singida	324	1620	1620	1620
19	Tabora	488	2440	2440	2440
20	Tanga	643	4	3215	3215
	Total	10403	25	53015	