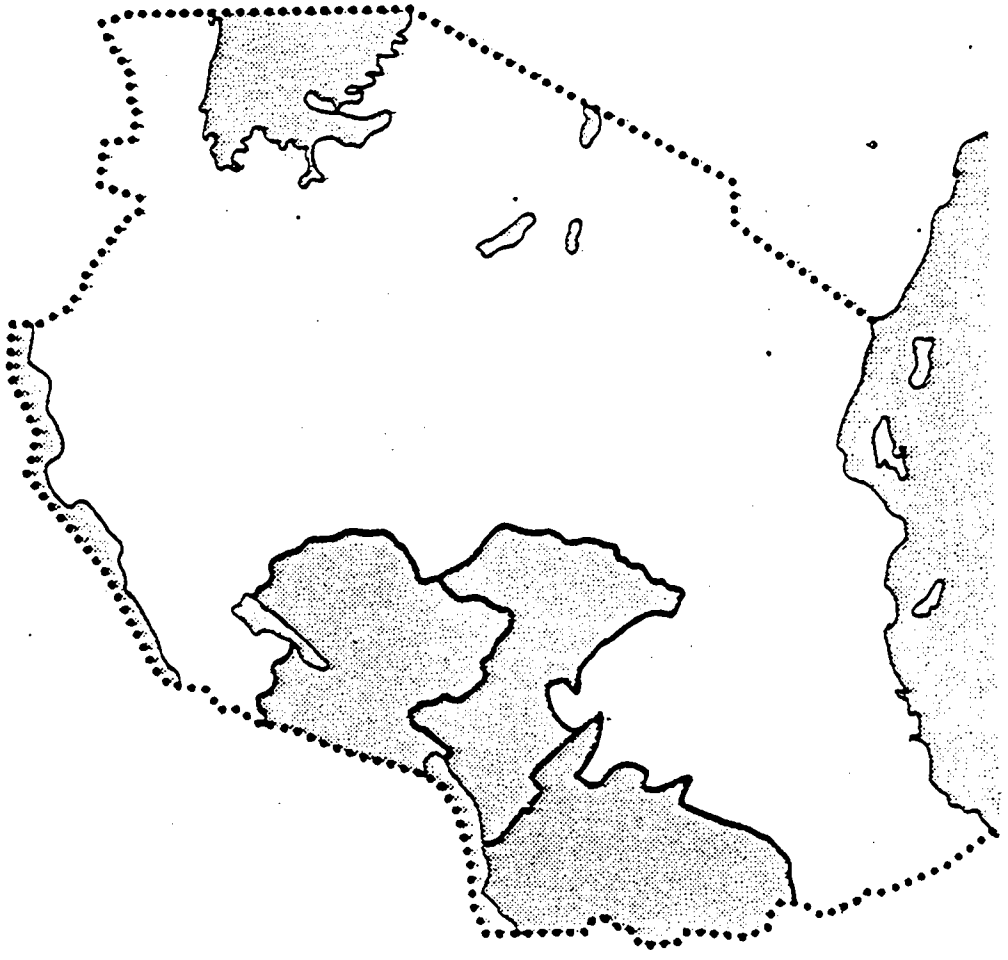
UNITED REPUBLIC OF TANZANIA

REPORT ON SHORT TERM CONSULTANCY

ON

"HEALTH EDUCATION & IMPROVEMENT OF SANITATION"

SEPTEMBER 1985



DANIDA STEERING UNIT
FOR WATER PROJECT
MAJI UBUNGO ;

DAR ES SALAAM

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APPENDICES

LIST OF ABBREVIATIONS

AFYA	-	Ministry of Health
AMREF	-	African Medical Research Foundation, Nairobi
BRALUP	-	Bureau of Resource Assessment and Land Use Planning
BSP	-	Basic Services Programme
CCKK	-	Cowiconsult.Carl Bro.Kampsax.Krüger
CCM	-	Chama cha Mapinduzi
CEDHA	-	Centre for Educational Development at Arusha
CDR	-	Centre for Development Research
DANIDA	-	Danish International Development Agency
DC	-	District Council
DED	-	District Executive Director
DFWP	-	Danida Funded Water Project
DHO	-	District Health Officer
DMO	-	District Medical Officer
DPHCC	-	District Primary Health Care Coordinator
DSU	-	Danida Steering Unit
DTT	-	District Training Team for VHW
DWE	-	District Water Engineer
HCTT	-	Health Centre Training Team for VHW
HESAWA	-	Health, Sanitation and Water Project Lake Regions
INP	-	Iringa Nutrition Programme
IRA	-	Institute of Resource Assessment
MAJI	-	Ministry of Water, Energy & Minerals
MCH	-	Maternity and Child Health
MOH	-	Ministry of Health
PHC	-	Primary Health Care

RDD	-	Regional Development Director
RHO	-	Regional Health Officer
RMA	-	Rural Medical Aid
RMO	-	Regional Medical Officer
RPHCC	-	Regional Primary Health Care Coordinator
RTT	-	Regional Training Team for VHW
RWE	-	Regional Water Engineer
SA	-	Scheme Attendant
SEC	-	Socio Economic Group
SIDA	-	Swedish International Development Agency
TOR	-	Terms of Reference
TWA	-	Tap/Well Attendant
UNICEF	-	United Nations Childrens Education Fund
USAID	-	United States Agency for International Development
VC	-	Village Council
VHW	-	Village Health Worker
VIP	-	Ventilated Improved Pit Latrine
VPC	-	Village Participation Coordinator
VWC	-	Village Water Committee
WHO	-	World Health Organisation
WMP	-	Water Master Plan

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1. INTRODUCTION

This report is the result of a consultancy carried out from 19th August to 27th September 1985. The Terms of Reference are given in Appendix A.

The consultancy was carried out by Ole Therkildsen. Two resource persons were involved in discussions and interviews in Iringa: Mr S Chizenga, Head of the Health Education Unit, Ministry of Health (6.9 to 9.9); and Professor Mark Mujwahuzi, Institute of Resource Assessment, University of Dar es Salaam (6.9 - 14.9).

The itinerary and the list of people met can be found in Appendix A and B respectively.

I would like to thank Mr Chizenga, Professor Mujwahuzi and the Danida Steering Unit for their help during my work. I would also like to thank all individuals and officials met for the support and information given.

This report contains my views. They do not necessarily correspond to the views of any of the persons mentioned above or of Danida. All proposals are subject to approval by the two governments.

2. SUMMARY

The main purpose of this consultancy is to propose how Health Education and Sanitation activities aimed at reducing water and sanitation related diseases of the beneficiaries of Danida funded water schemes in Iringa, Mbeya and Ruvuma regions can be implemented. A total of DKK 8 million/- has been allocated for such activities in the Government to Government Agreement of 10th September 1983.

2.1 Findings

Health problems caused by water and sanitation related diseases may be tackled in two ways.

Problems resulting from unhygienic conditions around tap and handpumps; non-ownership of latrines among households; and sometimes very poor sanitary conditions at schools and health facilities can be reduced by actions at the community level.

Prevailing practices on water use; personal and domestic hygiene; and use and construction of household latrines may also have detrimental effects on health. Promotion and support for changes in such practices must be done at the household level.

2.2 Recommendations

(1) If improvements in health is a major objective of DFWP, this should be explicitly stated. There is a general need to specify the objectives of the project.

(2) Village and District Councils should not be by-passed. Their commitments in cash and kind should be sought for several of the proposed activities to increase the prospect of their long-run sustainability.

(3) Declining to make such commitments should be the right of every village and District Council.

(4) Community action towards cleaner water point surroundings and full latrine coverage should be promoted.

(5) Subject to (ii) construction of public latrines at schools and health facilities should be supported.

(6) Subject to (i) and (ii) the training and supervision of Village Health Workers should be supported to promote health education and sanitary improvements at the household level.

(7) This support (6) should be limited to wards/divisions with a high concentration of DFWP villages.

(8) Selection of villages for new water schemes or rehabilitation should be done areawise to facilitate VHW-training and supervision.

(9) Initiation of recommendations 5 and 6 should start in a few districts only.

2.3 Estimated Costs

Implementation of recommendations 4, 5 and 6 from 1986 to 1990 will cost around TAS 23.8 million. They should be shared between the DFWP (TAS 13.3 million) and the 14 District Councils (TAS 10.5 million) in the three regions as shown below:

Recommendation	Implemented through	Contribution (mill.shs.) from DFWP	14 District Councils
4	DFWP	1.9	
5	DFWP	5.5	5.5
6	VHW-programme	5.9	4.9
Total		13.3	10.5

A village accepting a water scheme and employment of 2 VHWs must in addition to self-help labour be prepared to incur a yearly cash expenditure on around TAS 21,000/-

2.4 Assumption

It is assumed that willingness and capability of Village and District Councils to make resource commitments is of crucial importance for successful implementation of recommendations 5 and 6 and for their continuous viability.

A 50% District Council contribution is assumed in the yearly budgets presented in Chapter 5 and 6. Due to lack of prior experience with cost sharing arrangements a constant implementation rate is assumed in the budget to exemplify cost implications. Actual implementation rates are likely to be low in the initial period.

UNICEF plans to support the VHW-programme in Iringa and Ruvuma on a significant scale. The budget estimates assumes that this support is actually forthcoming.

It is assumed that conventional public VIP-latrines need rebuilding at intervals. District Council contributions are therefore needed. Permanent compost latrine types are assumed to be unsuitable for public use.

2.5 Major Risks

Public latrines that are not properly kept can be a health risk.

Previous experience from Tanzania and elsewhere show that without support and supervision from in-service health staff VHWs tend to stop to work or to do curative rather than preventive work.

3. ANALYSES OF HEALTH EDUCATION AND SANITATION RELATED NEEDS IN THE THREE REGIONS

Table 1 summarises the prevention of water and sanitation related diseases. The last column indicates the order of magnitude of these diseases in Tanzania. Similar health problems are likely to be found in Iringa, Mbeya and Ruvuma Regions, although the prevalence of specific diseases vary widely even within regions.

It is now generally recognised that an improved water supply within easy access of households is a necessary but not a sufficient condition for better health. Consequently improvements in sanitary conditions and in personal and domestic hygiene are needed as indicated in Table 1. Such improvements are identified below. They are based on information collected during the visits to the three regions and on information from Vol. 12 and Vol. 13 of the Water Master Plans. Interventions aimed at tackling these needs are also analysed.

3.1 Waste Water Disposal and Drainage at Water Points

A water scheme often causes some specific health problems. Around domestic points and handpumps washing and bathing, laundry activities and cattle watering frequently take place. Together with inadequate drainage this contribute to unhygienic conditions around water supply points. Mosquito breeding is extended into the dry season at these points, and the risk of disease transmission increased.

DFWP has taken a few technical measures to solve problems around water points. An improved design has reduced spillage problems significantly. Drainage is, however, still a problem in the more impermeable soils. Erosion of water point structure may also occur due to improper construction or use.

Table 1 – Prevention and Prevalence of Water & Sanitation Related Diseases

Disease[1]	Improved water	Improved excreta disposal	Personal and Domestic hygiene	Improved waste Disposal/ Drainage	Prevalence[2] (%)
Diarrhoeas	●	●	●	.	5–10
Worm-infections:					
a. roundworm	o	●	o	o	~5
b. whipworm	o	●	o	o	
c. pinworm	o	●	●	.	
d. hookworm	o	●	o	.	
e. guinea worm	●	.	.	.	
f. schistosomiasis	o	●	.	o	
Skin- and Eye-infections, and Louseborne infections	.	.	●	.	10–15
Mosquito- and Fly-borne infections:					
a. malaria	.	.	.	o	5–
b. yellow fever/ dengue	.	.	.	o	20
c. filariasis	.	●	.	●	
d. sleeping sickness	.	.	.	.	
e. river blindness	.	.	.	.	

1) Adapted from: WHO (1983)

2) Various sources on out-patient attendance BRALUP (1978); BRALUP/CDR (1982, 1.4); UNICEF (1985 a, 123–24)

● = very important to help prevent disease transmission

o = important to help prevent disease transmission

. = not important

Washing slabs present special problems:

- proper drainage can be difficult to make;
- they may discourage men from laundry work;
- their actual use is not well known;
- one slab per water point might be needed to prevent people from using traditional sources;
- cost of a slab is often about equal to the cost of a domestic point. More of the latter is known to encourage laundry at home.

Additional investigations by engineers and SEC-group are needed before these issues can be settled.

Appointment of village water committees, scheme attendants and tap/well attendants for each water point is supposed to provide a village structure within which the community may secure that a water supply operates and that water point surroundings are properly kept. Only scheme attendants are presently receiving some form of training. No systematic training of the three groups on the problems discussed above have yet been undertaken. A proposal to that effect is presented in Chapter 5.

3.2 Latrines for Households without One

Non-owners of latrines (10%) tend to be most prevalent among households that are poor ; female headed; with limited school education; or destitute. It indicates that the underlying causes of non-ownership might be socio-economic rather than cultural.

Intervention at the community level rather than at the household level may therefore be needed to encourage 100% coverage. A proposal is presented in Chapter 5.

3.3 Latrines for Public Institutions

Under present conditions many schools, dispensaries and health centres serve as channels of infection due to non-existent or poor sanitary facilities. Conditions in the three regions are probably similar to those found in Dodoma and Shinyanga regions. Here two-thirds of the Primary School children use the bushes for their toilet needs. (Ngaliwa, 1984). And, even if hand-washing is taught in schools and clinics, there is rarely any possibility of practicing it.

Schools with 200 - 600 students are now operating in almost all villages. Dispensaries and health centres are located in roughly every 3 to 4 villages. Typically they are visited by 50 to 100 patients everyday. (Not counting accompanying relatives). Poor sanitary facilities not only pose a health risk to students and patients. These will return home where they may spread diseases to other family members.

Other public institutions where people congregate in substantial numbers may pose similar risks. But local courts, prisons, training centres, etc. are comparatively few. And CCM offices do not normally attract large numbers of people on a daily basis.

The Iringa Nutrition Programme (INP) is building some latrines at dispensaries in 7 divisions. A similar activity should be initiated by DFWP at primary schools and health clinics in villages supplied with water, [1] provided District Councils are sharing the costs (see Chapter 5).

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1) Until recently USAID has supported a School Health Project which also constructed latrines. Valuable experience is therefore available. (now finished)

Barry, see also note on school sanitation Mwanza/Shinyanga with Annelie

3.4 Personal and Domestic Hygiene in Use of Water and Latrines

A majority of women in the rural areas appear to have a fair knowledge about the most common water and sanitation diseases and their prevention (BRALUP/CDR, 1982, Ch. 11). Yet people may not practice what they know, nor necessarily believe in it.

Thus, water is sometimes polluted between tap and stomach. Drinking water may be improperly stored. Increased use of water for personal and domestic hygiene could benefit health. Polluted water is often used although safer water may be available at a tap or a pump a bit further away. This problem is especially pronounced in scattered village and villages where people move to the fields during the agricultural season. The latter tendency is becoming increasingly common. This makes proper water use practices even more needed.

Usage of latrines among adults is generally high. But mothers and child-minders often do not take children to the latrine nor do they dispose properly off toddlers' excreta on the ground. This is now believed to be a significant cause of diarrhoea both among toddlers and among their family members. Furthermore, squatting plates are not always cleaned and hand-washing after latrine use is not consistently practised.

Such habits, like cigarette smoking, are difficult to change. Health education might help provided it is continuous; done by people respected and trusted by the community; and based on advice which is sound, practical and socially acceptable.

During the Water Master Planning exercise, the SEC-group experimented with such an approach. It is described in a step-wise procedure in IRA/CDR (1983, Appendix II and Ch. 9.4). To start now to implement such procedures is not recommendable. The DFWP does not have the capacity to initiate the approach in all project villages and to sustain it on a continuous basis (see Chapter 4.1).

Furthermore, the Primary Health Care Programme (PHC) introduced by Ministry of Health (1983) has made the handbook, and the approach, obsolete.

An important element in the PHC approach is the village health worker (VHW) programme. It is the intention of the Ministry that all villages in Tanzania without a dispensary should have a trained female and a male VHW by 1993. In the future they are intended to be the key health educators at village level with both curative and preventive responsibilities. The VHW programme is analysed in Appendix C. Proposals and conditions for supporting this programme in DFWP villages are detailed in Chapter 6.

3.5 Improved Latrines for Households

Latrine coverage among households in the three regions is widespread. In average around 90% of all households own some kind of latrine. This figure can be significantly lower in limited areas or particular villages.

However, many of these latrines have various structural deficiencies (BRALUP/CDR, 1982, Ch. 11). This results in two types of problems. Households must rebuild latrines every 2 to 5 years because the old one fill up or collapse. And latrines may pose a health risk by:

- discouraging use due to frequent rebuilding, collapse (or fear of it), or because of pugnant smell.
- promoting worm infections because squatting plates are unsuitable for cleaning with water.
- promoting fly and mosquito breeding.

Latrine construction is a continuous process in rural areas. Around 100,000 new latrines are built every year in the three regions without any government and donor support. Their structural quality vary. However, many households own latrines that demonstrate that local materials, used properly, can provide latrines of a reasonable quality.

In Iringa Region UNICEF is supporting the Wanging'ombe Rural Sanitation Project which promotes a double vault compost VIP-latrine in 50 villages. They are permanent if emptied. Households do all manual labour; trained fundis assist to build the latrines; and UNICEF provides cement, slabs and screen. The cost per latrine for the project is Shs. 200/- excluding training, promotion, overheads etc. Subsidies; considerable pressure on households; areal concentration; and continuous project presence and back-up in the project area over many years appear to be the key factors behind the construction of the 7,000 latrines now completed.

The INP is now promoting the same latrine in 167 villages. Subsidies to households are reduced. Villages claim it will cost Shs. 350/- to Shs. 800/- to construct one. The BSP intends to promote the VIP in the rest of the region until 1991 - with subsidies further reduced. The details are not yet worked out. The BSP in Ruvuma will also promote the VIP in three divisions in Ruvuma Region. No similar activities are ongoing or planned in Mbeya Region.

Not much is known about the likely additional health benefits of VIPs in areas where latrine coverage is almost complete (90%). Whether the VIPs improve usage, especially among toddlers, is also not known. And Users' willingness to empty the compost can only be ascertained when the Wanging'ombe latrines fill up. This is some years ahead.

The evidence to justify substantial outside inputs into household latrine improvements is therefore not yet in and is not made by Central or Local Government. In Chapter 6 it is proposed that VHWs should demonstrate and promote improvements of existing traditional latrine types.

4. ANALYSES OF INSTITUTIONAL CONTEXT

Proposals for addressing the needs identified above must be adjusted to the characteristics of the DFWP itself, the existing local administrative structures, and other ongoing projects with similar activities. The proposals should also be related to the capability and willingness of households, villages and local institutions to undertake such improvements on a sustained basis.

4.1 The Danida Funded Water Project

For a number of reasons construction and rehabilitation activities on DFWP is implemented at a slower rate than anticipated when the first five-year plan for the project was approved in 1983. It is now expected that a total of approx. 315 villages will be completed by the end of 1990 as shown in Table 2. At these rates of implementation the capacity of MAJI, Implementation Offices and the SEC-group are utilised to a large extent.

Table 2 - Village Water Supply Improvements funded by DANIDA, 1981 - 1990

Villages	Iringa	Mbeya	Ruvuma
"Completed" by end of 1984	24	34	17
Completed yearly from 1985	~15	~15	~10
Total number of villages completed by the end of 1990	~114	~124	~77

High health risks connected with traditional water sources is one of the criteria of which villages are selected for implementation (see IRA/CDR, 1983, Ch. 12). It would have been advantageous if areal concentration of villages had also been a selection criteria. This is not the case. Selected villages are quite scattered across districts and divisions. In relation to the VHW-programme this is unfortunate. It makes it difficult to establish a workable system of VHW-supervision (see Appendix C and Chapter 6).

Establishment of operation and maintenance systems in the three regions is still at the planning stage. The logistical, technical and training problems will be considerable. So will the work involved in solving them. However, continuously functioning schemes are important for many activities related to proper water and sanitation use.

The extent to which the SEC-group will assist to implement the O & M procedures has not yet been clarified within the project. The original handbook for village participation (IRA/CDR, 1983, App. I) proposed that regular follow-ups should be made. This activity has not been included in the revised handbook or in the DSU proposal for O & M of July 1985.

Present experiences with already established Village Water Committees, Scheme Attendants and Tap/Well Attendants indicate that these may slowly cease to function if left alone. This is a general experience with all activities involving community participation and paraprofessionals (Taylor and Moore, 1980). (See also Appendix C on the similar need for supervision and support of VHWs). "Maintenance" of the institutional structure established by the DFWP at village level can therefore not be ignored. This "maintenance" is crucial for certain sanitation and health education activities proposed in Chapter 5. To believe that the structure established by DFWP at village level is or will become self-sustaining is unrealistic.

As implementation proceeds the need to devote manpower resources from MAJI, the Implementation Offices (including DSU) and the SEC-groups for operation and maintenance activities will increase. At present implementation rates and staffing levels, this is likely to create capacity problems in all three regions. A balance between construction and maintenance therefore needs to be made. It should be based on a more precise specification of the short and long term objectives of the DFWP. This question warrants urgent attention.

It follows from the discussion above that the DFWP with the present level of manpower only will have limited capacity to formulate and implement health education and sanitation activities. In Chapter 5 a minimum level of activities is proposed. More extensive sanitation and health education activities are also proposed (Chapter 6) but they cannot be implemented within the present DFWP organisation and under the present project objectives.

4.2 District and Village Councils

The precise roles of District and Village Councils in sanitation, health education and water activities are rather unclear at present. Yet many of these activities cannot be sustained in the long run unless councils are involved. The consequences for the councils of donor support for these activities must therefore be analysed together.

In Chapter 3.2, it was argued that improvements of household latrines should not involve project subsidies on any significant scale. District Councils and Central Government are unlikely to make substantial resources available for this purpose either. Improvements should therefore, as hitherto, basically be made by households themselves.

The need for improving sanitary conditions at schools, dispensaries and health centres was established in Chapter 3.3. Due to heavy use such public latrines must probably be rebuilt with intervals. Both schools and health facilities fall under District Councils. To increase the possibility that rebuilding is done without donor assistance, contributions from village and District Councils should be introduced. (see Chapter 5).

Potentially, VHWs are the best health educators at the village level as argued in Chapter 3.4. However, the role of Village and District Councils in providing their drugs, in contributing to their training; and in supporting VHWs after training (supervision, allowances, etc) are not yet settled. Donors may help to initiate the process of VHW-training as is already being done by UNICEF in Iringa region. But if donors also cover the entire training costs then the VHW-programme in its present form is not replicable and sustainable. Village and District Councils should therefore contribute a significant share of the VHW-costs as suggested in Chapter 6.

At present District Councils and Central Government both contribute to the construction of locally funded rural water projects. Central Government also contributes money to operation and maintenance of recurrent expenditures. No standardised guidelines for this cost sharing have yet been worked out.

The present policy on O & M within the DFWP is that villages should pay for all spares and for the allowances of scheme attendants and mechanical fundis. To support and back up the villages, Regional Maintenance Units will be established and financed by the DFWP. Eventually District Maintenance Units will be established. Their operating costs are then gradually supposed to be paid by District Councils. However, for the time being District Councils are not involved in any decisions regarding the DFWP activities.

The introduction of District Councils represents a move to increase local governments' responsibility for administering and financing a number of activities. Many water, health and education activities are among them. This system should not be bypassed by donor projects.

4.3 Other Donor Projects in the Three Regions

Several donor projects address water, sanitation and health education related activities.

In Iringa Region the Iringa Nutrition Programme (INP), jointly supported by UNICEF/WHO, is currently supporting construction of latrines at health facilities; training of VHWs; and construction of VIP-latrines at household level. It operates in 7 divisions with 167 villages (UNICEF, 1985 b). UNICEF's Basic Services Programme (BSP) will aim at supporting VHW-training and VIP promotion in the rest of Iringa Region. It will also finance substantial water scheme construction activities. (UNICEF, 1985 c). It is scheduled to start in 1986.

Also in Ruvuma Region, VHW-training, promotion of VIP-latrines, and construction of water schemes will be supported by UNICEF through its BSP. It will operate in three divisions covering 44 villages, starting in 1986.

DANIDA support for VHW-training in these two regions (see Chapter 6), should be closely coordinated with the same activities financed through UNICEF. For example, the INP establishes Village Health Committees, while DFWP establishes Village Water Committees. These have partly overlapping responsibilities. At present they exist side by side in some villages (in Kalenga Division).

In Mbeya Region DANIDA is the only major donor for the rural water sector. There are no programmes for promotion of latrine improvements. VHW-training is scheduled to start in 1986/1987 financed initially by the Ministry of Health. No donor has committed funds for it so far.

4.4 Proposal On Strategy

On basis of the analyses of Chapter 3 and 4 two approaches for health education and sanitation improvements are proposed.

The first approach should be implemented through DFWP in all three regions. It contains activities addressed to the needs listed in Chapters 3.1 to 3.3. They are all based on community level actions for improvements. This fits the participatory approach followed by the DFWP. The approach is detailed in Chapter 5.

The second approach is based on support to the Village Health Worker Programme. These are likely to be most effective promoters of household level actions for water and sanitation related improvements (see Chapter 3.4 and 3.5). This approach cannot be implemented through DFWP. It should only be supported if Village and District Councils show financial committment to it, and if it becomes a specific objective of DFWP to improve health among beneficiaries. This support should also be adjusted to ongoing VHW-activities in the three regions. (See Chapter 6).

The two approaches are separately presented below. They may, however, be implemented together.

5. PROPOSALS FOR ACTIVITIES IMPLEMENTED THROUGH DFWP

The first set of proposed activities should mainly be carried out by AFYA staff seconded to the project (Chapter 5.1). The other set of activities should mainly be carried through MAJI's construction teams (Chapter 5.2).

5.1 Activities Implemented Through AFYA Staff Seconded to the Implementation Offices

The objectives should be to:

i) improve hygienic conditions around water points in project villages (see Chapter 3.1);

ii) encourage latrine construction for households without one in project villages (see Chapter 3.2).

5.1.1 Key Features

Principles: Activities should be integrated into the existing DFWP framework. This means that they should

- be based on the DFWP participation approach;
- fit into the procedures specified in the participation handbook.

To additional principles regarding latrines should be added:

- no subsidies to individual households will be given by DFWP (for they are unlikely to be available once DFWP construction activities move on);
- no demonstration latrines should be built (without sustained and substantial back-up they are unlikely to have any spread effects)

Manpower: The seconded AFYA staff (one health officer in each region) will be most directly involved in the activities. The VPC should guide their work.

These officers presently work after guidelines provided from the Ministry of Health that are not compatible with the activities proposed in this report. The section for Environmental Health in the Ministry is, however, willing to change these guidelines for the seconded AFYA staff.

It is important that the seconded staff is willing to and motivated for extensive work under village conditions and to engage in community participation work. More than one staff per region might be needed as the activities expand (see also Chapter 5.2).

Expertise from outside DFWP is needed to operationalise the activities in the initial phase of implementation (see below).

Target Groups: Concerning objective i) these are the Village Council (VC), the Village Water Committee (VWC), Scheme Attendants (SA) and Tap/Well Attendants (TWA). They should be trained by the AFYA staff member so that they can encourage and enforce proper water use at water points.

Concerning objective ii) the target groups are the VC and VWC. These should be encouraged to mobilise community self-help work to construct latrines for destitute and poor families without latrines. AFYA staff should also assist the VC to establish by-laws so that full coverage can be enforced.

wie VHW?

Indicators: Objective i) is achieved to the extent that

- bathing, washing, laundry and cattle watering does not take place at water point;
- traditional sources are not used for these purposes;

- water point surroundings are kept clean and dry and soak-pits are operating;
- children do not play with water at water points;
- bibcocks are operating;
- tap attendants report problems to scheme attendants or VC/VWC.

Objective ii) is achieved if

- community continuously helps destitute and poor families to construct latrines;
- VC and VWC enforce village by-laws on latrines.

Transport: One additional vehicle for each Implementation Office should be made available. The reason is that existing transport is already fully utilised. The need for transport will increase in proportion to the schemes completed (see Table 2). The activities proposed here will add to this need.

Equipment: Camping equipment for each seconded AFYA staff is needed.

Educational material might be needed. This should be defined during the development of the activities (see below).

Follow-Up: The activities proposed above depends to a large extent on community action by the VC, VWC, SAs and TWAs. They are likely to need fairly regular support and supervision visits. These should be a part of regular institutional "maintenance" as argued in Chapter 4.1. However, maintenance is outside the scope of this consultancy. But, there is a need to address it in connection with the establishment of the whole O & M system.

5.1.2 Implementation

Given the heavy workload of the SEC-groups (Chapter 4.1), the VPCs themselves cannot be expected to design and develop the procedures that are necessary to implement the activities needed. The Health Officers presently seconded to DFWP cannot do so either without outside support.

The following actions are proposed to get implementation on the way:

1. Form a team consisting of one suitable qualified Tanzanian appointed by the Ministry of Health (Team Leader) plus the three seconded AFYA-officers. Provide resources for three months of field work.

2. Send the team to Ruvuma to do field work in villages with DFWP activities.

3. The team, assisted by the VPC, Ruvuma on a part time basis, develops procedures and write them into the participation handbook.

4. Implement the procedures in each region through the seconded AFYA-staff guided by the VPC.

5. After one year the team leader should be assigned to do revisions based on experiences from implementation

More detailed guidelines for the implementation of the first three steps are given in Appendix D.

5.1.3 Budget

The estimated cost is TAS 1.9 million for the five-year period. Details are given in Table 3.

Table 3 - Estimated Costs for Health Education and Sanitation Activities Implemented through AFYA Staff (x 1000 Shs), 1986 - 1990

	1986	1987	1988	1989	1990
Develop Procedures:					
1 Team leader, 3 months[1]	60				
3 AFYA seconded staff, 3 months[2]	20				
Transport	20				
Equipment	15				
Test Procedures:					
1 Team leader, 1 month[1]	20				
3 AFYA seconded staff[2]	5				
Transport	5				
Implement. Procedures:					
3 AFYA staff[2]	25	50	50	50	50
Educational Material	30	30	30	30	30
Recurrent transport	100	210	210	210	210
3 Vehicles	420				
	720	290	290	290	290

1) Allowances and Honorarium

2) Allowances

5.2 Activities Implemented Through MAJI's Construction Teams

The objective should be to construct public latrines at primary schools, dispensaries and health centres in the project villages which do not have adequate facilities.

5.2.1 Key Features

Principles: The DFWP should construct such public latrines provided

- they are requested by village;
- village provides all self-help labour for digging, brick production, etc.;
- District Council shares in the construction cost.

These principles are needed because the DFWP (and the MAJI construction teams) will not be present in the village when new latrines are needed as the old ones fill up. This argument does not hold if permanent compost latrines are found to be suitable for public use.

Procedures for village requests should be included in the participation handbook.

Manpower: It is assumed that the MAJI construction teams both have the capacity and the skills to build public latrines provided construction drawings are prepared.

Village requests for public latrines should be channelled through the SEC-group (the AFYA - seconded staff).

Transport and Equipment: No additional needs are foreseen.

Follow-Up: The follow-up by AFYA-seconded staff proposed in Chapter 5.1 should also include visits to schools and health clinics to inspect sanitary conditions of public latrines. This should be included in the participation handbook.

5.2.2 Implementation

Suggestions for suitable types of public VIP-latrines can be found in Kilama and Winblad (1985, app. IV) and in Mara (1983). The Tanzania School Health Project in the Ministry of Health may have relevant experience with appropriate designs. The Iringa Nutrition Programme is also constructing public latrines and should be contacted.

It may be assumed that around one-third of the institutions in the project villages already have adequate latrine facilities (see Ngaliwa, 1984). A total of 315 villages will be covered by DFWP by 1990 (Table 2). Approximately each village has a primary school. There is one health facility per every 4 villages. Thus the needed number of latrines is 260:

- 210 latrines for primary schools;
- 50 latrines for health facilities.

Based on the Kilama and Winblad (1985, 14) the construction costs are as follows:

- TAS 48,000/- for each school latrine of 12 units;
- TAS 16,000/- for each Health facility latrine of 4 units.

The total construction cost is therefore approximately TAS 10.9 million. The actual cost to the project depends on the cost sharing with District Councils.

5.2.3 Budget

Only direct construction costs are included in the budget. It is assumed that District Councils cover 50% of these costs; that all 260 institutions will be provided with latrines; and that construction speed will be constant from 1986 to 1990. Table 4 indicates how the total cost of TAS 10.9 million is shared between DFWP and District Councils.

Table 4 – Estimated Costs for Public Latrines at Schools and Health Facilities (x 1000 shs), 1986 - 1990

Cost To	1986	1987	1988	1989	1990
DFWP	1100	1100	1100	1100	1100
District Councils	1100	1100	1100	1100	1100

The actual implementation rate and costs will depend on the arrangements made with District Councils and the interest of villages and District Councils for this activity.

6. PROPOSAL FOR ACTIVITIES IMPLEMENTED THROUGH THE VILLAGE HEALTH WORKER PROGRAMME

The "Guidelines for the Implementation of the Primary Health Care Programme in Tanzania" issued by MOH in 1983 sets out the approach of the VHW-programme. (see Appendix C). From the point of view of the DFWP two aspects of this programme are especially relevant.

- it is based on community participation principles similar to those used by DFWP;
- VHWs are trained to do preventive work and health education relevant to water and sanitation related diseases (see Chapters 3.4 and 3.5).

However, the Guidelines do not make clear how the financial responsibilities for the programme should be divided between the village, DC and MOH. Nor is the financial role of donors in various activities made clear. These issues should be settled before DFWP proceeds to support the VHW-programme in the three regions.

Moreover, the improvement of the health of the beneficiaries of water supplies should be explicitly stated as an objective of DANIDA support to the rural water sector before assistance to the VHW-programme is embarked upon. No clear statement to that effect can be found in the project papers.

6.1 Support for the VHW-programme

The main objectives are to

- support training of VHWs from villages where water projects are completed
- support establishment of a supervision system for VHWs in areas where water projects are completed.

6.2 Key Features

Principles: Support should be based on the following

- village commitment to support VHWs during and after training.
- village right to refuse to provide support for the VHW programme; a proposed water supply; a proposed public latrine or all three.
- District Council financial commitment to support VHW training, supervision and drug supply on a regular basis.
- Central government financial commitment to support training of trainers.
- donor commitment to support District Councils and Central Government on a cost-sharing basis.

The reason for the cost-sharing principle is that the sustainability of VHWs after completion of training will depend on the willingness and ability of village and District Councils to support (maintain) the VHWs with monthly allowance, drugs and supervision. If such support is not forthcoming the VHWs will eventually cease to work as happened in earlier Tanzanian attempts to establish this cadre (see Appendix C).

In Iringa and Ruvuma Regions the support should be coordinated with that given through UNICEF's Basic Services Programmes. (see below).

The principles for the VHW-programme itself, as formulated by MOH (1983), are sound if implemented properly (see Appendix C). They should be followed.

Sequence of Activities: The order in which a village receives a water scheme or a VHW or both is not very important. What is important is that a village refusal should be respected so that these activities are neither imposed on the village nor implemented without its consent. It is therefore absolutely crucial that a village is made aware of its responsibilities for financial and material contributions, especially with respect to recurrent commitments, before any activity is initiated.

Manpower: The VHW-training is implemented by AFYA teams of 3 to 4 people specifically trained and assigned for this work. It is planned by Regional and District PHC-Coordinators at their respective levels (see Appendix C).

Donor support to short-term consultant is needed in Mbeya Region for strengthening the training of trainers (see below).

AFYA staff seconded to DFWP should participate (for less than a week) in the training of VHWs from project villages. This might eventually necessitate secondment of 3 additional AFYA staff to the DFWP.

Areal Concentration: To make training and supervision manageable, and to reduce training costs, each group of VHW-trainees should be selected from the catchment area of one or more dispensaries under one health centre. Concentration will therefore also make administration of the DFWP support to the VHW-programme easier. It is recommended that areal concentration should be a key criteria in future selections of villages for water schemes.

The implication of this areal concentration approach is that some trainees will come from non-DFWP villages. And some DFWP villages will not be supported for VHW-training by the DFWP. (see also below).

Training Material: No suitable training material for VHW-training exists in Kiswahili. AMREF is assisting the HESAWA programme in preparing material specifically geared to water and sanitation. When available it should be used. Among other things it will emphasise improving traditional latrine types; proper storage and use of water; problems with traditional sources.

Organisational Arrangements: Appendix C describes the organisational set-up of the VHW programme within AFYA.

There is a need to coordinate the work of the DFWP and the Regional and District PHC-Coordinators by

(i) regular meetings with the Implementation Offices (see below);

(ii) membership of Regional and District PHC-Coordinators in the Regional Steering Committee.

The composition of the Review Mission for the DFWP should include one member from the PHC-Unit in MOH.

Furthermore, there is a need to coordinate VHW-support with the UNICEF supported programmes in Iringa (INP and BSP) and Ruvuma (BSP) regions.

At village level there will be partly overlapping membership and responsibilities between the Village Health Committee established by the VHW-programme (MOH, 1983, 41 and 58) and the Village Water Committee established by the DFWP. (Revised Handbook, Form 4) One committee would suffice.

Sevaral parts of the present participation handbook for water supplies will have to be revised if the proposal in Chapter 6 is implemented.

Administrative Arrangements: DFWP has already established procedures for transfer and accounting of funds to RWEs. A similar arrangement could be made vis-a-vis the Regional and District PHC-Coordinators. Transfer of funds should be based on Implementation Office approval of VHW-training plans.

Supervision: This crucial issue is generally neglected in the VHW-programme (see Appendix C). This needs urgent attention by the MOH. The proposed budgets reflect this.

6.3 Implementation

The VHW-programme has reached different stages of implementation in the three regions. DFWP support should be adjusted to these differences.

Iringa Region: No support should be given for VHW-training in the divisions where INP operates (Kalenga, Pawaga, Wanging'ombe, Mlolo, Ifwagi, Kupalilo and Mlangali). Here the programme has made funds available for complete coverage.

In the rest of the region support should be given for divisions/wards with the highest concentration of DFWP-villages. The areal concentration should be worked out in cooperation with the Regional and respective district PHCCs; District Councils; and UNICEF's BSP which supports VHW-training in the entire region outside the INP-area. Support through BSP will be given from 1986 to 1991.

UNICEF is supporting training of trainers and is considering to provide vehicles for these teams for the whole region through INP and BSP.

The VHW programme in Iringa is running well and there is no need of additional manpower support.

The present budget proposal from the BSP is based on the assumption that District Councils will cover approximately 50% of training costs. This issue is, however, not within UNICEF and with District Councils settled.

Budget estimates for DFWP support are presented in Chapter 6.4.

Ruvuma Region: No support should be given for VHW-training in the divisions where BSP (UNICEF) support is provided (Nasala, Mkongo, Minga). Here the programme will make funds available for complete coverage during the period 1986 to 1991.

In the rest of the region support should be given for divisions/wards with the highest concentration of DFWP villages. The areal concentration should be worked out in cooperation with the Regional and the respective district PHCCs and District Councils.

UNICEF is supporting training of regional and district trainers. It is considering to provide these teams with vehicles.

The teams are ready to start VHW-training in 1986. Based on observation of training seminars in Songea in September this year it is apparent that the teams do not yet have the competence of trainers observed in Iringa. Both UNICEF staff, and the PHC-Unit in MOH have expressed willingness to arrange and finance that the Ruvuma teams can receive on-the-job training from the Iringa regional team. The Regional PHCC, Iringa is willing to participate in this. Assuming that such arrangements will be made there is no need for additional outside manpower support.

The BSP budget proposal for VHW-training is based on full cost coverage of VHW-training in the three divisions.

Budget estimates for DFWP support are presented in Chapter 6.4.

Mbeya Region: The VHW-programme has not yet started. MOH intends to finance training of a regional training team in 1986/1987. Training of district training teams will follow subsequently.

No support should be given for VHW-training in Ileje, Chunya and Rungwe Districts. Only few villages have and will be covered by the DFWP here.

In Mbeya rural, Kyela and Mbozi districts support should be given to training of district training teams and to their vehicles. Furthermore, in these districts support should be given for training of VHW-training in divisions/wards with the highest concentration of DFWP villages. The areal concentration should be worked out in cooperation with the Regional PHCC and respective district PHCCs and District Councils.

A short-term consultancy to support the training teams in the initial phase of VHW-training is needed. AMREF is already providing such assistance in the Lake Regions through funds from SIDA. This institution should be requested to provide similar support to Mbeya Region (12 man-months over two years).

Budget estimates for DFWP support are presented in Chapter 6.4.

6.4 Budgets and Assumptions

The estimates are based on the following general assumptions: [1)]

(i) Village Councils agrees to pay each VHW a regular monthly allowance

(ii) District Councils provide 50% of the cost of training and all costs of drugs

(iii) UNICEF and MOH provides the assistance to training of trainers indicated above.

(iv) District training teams can train 24 VHWs per year so that training of Health Centre Training Teams is not needed in Mbeya and Ruvuma Regions.

(v) Training one district training team: TAS 51,000/- (Appendix Table C.1).

(vi) Training one VHW: TAS 12,000/- (Appendix Table C.1).

(vii) Training of in-service health staff in supervision: TAS 40,000/- per division supported (Appendix Table C.1).

(viii) VHW kits: TAS 1,500/- per village.

The resulting cost estimates are shown in Table 5. It should be noted that the total number of VHWs trained in DFWP villages cannot be estimated without detailed information from each selected ward/division. For the same reason the number of DFWP villages for which no VHW will be trained is not known.

Table 5 indicates that the total cost of supporting the VHW programme is TAS 10.8 million/-. The cost to DFWP is TAS 5.9 million/-. The cost to be shared among 11 District Councils is TAS 4.9 million/- over the five year period.

The actual implementation rate and costs will depend on the arrangements made with MOH, UNICEF and the District Councils. And on the interest of villages and District Councils for the activities carried out by the VHWs.

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1) The estimated training costs include transport costs for trainers. Cost of drugs to District Council is limited, and unknown.

Table 5 - Estimated Costs for Support to VHW-Programme (x 1000 Shs)

	1986	1987	1988	1989	1990
Iringa Region:					
. Training of 250 VHWs	600	600	600	600	600
. Training of in-service health staff for supervision	80	80	80	80	80
. Bicycles for supervision	20	20	20	20	20
. VHW kits for 125 villages	40	40	40	40	40
Total	740	740	740	740	740
DFWP Contribution	370	370	370	370	370
Contributions from 5 District Councils	370	370	370	370	370
Ruvuma Region:					
. Training of 160 VHWs	380	380	380	380	380
. Training of in-service health staff for supervision	30	30	30	30	30
. Bicycles for supervision	10	10	10	10	10
. VHW kits for 80 villages	20	20	20	20	20
Total	440	440	440	440	440
DFWP Contribution	220	220	220	220	220
Contributions from 3 District Councils	220	220	220	220	220
Mbeya Region:					
. Training of 3 District Teams	150				
. Vehicles for 3 Teams [1]	420				
. AMREF Consultant [1]	300	300			
. Training of 250 VHWs (as for Iringa)	740	740	740	740	740
Total	1610	1040	740	740	740
DFWP Contributions	1165	670	370	370	370
Contributions from 3 District Councils	445	370	370	370	370
All Three Regions:					
. Total Costs	2790	2220	1920	1920	1920
. DFWP Contributions	1755	1260	960	960	960
. Contributions from 11 District Counils	1035	960	960	960	960

[1] Fully covered by DFWP

7. SUMMARY OF COSTS OF ALL PROPOSALS

Consolidated costs for all proposals are presented in Table 6. They amount to TAS 23.7 million/-. The cost to DFWP is TAS 13.3 million/- (approx. DKK 8 million-). The cost to be shared by the 11 District Councils is TAS 10.4 million/- over the five year period.

The actual implementation rates and costs will depend on arrangements made with the various institutions involved (MOH, UNICEF and the District Councils) and on the interests of villages for the proposed activities.

Table 6 - Estimated Costs of All Proposals 1986 - 1990 (x 1000)

	1986	1987	1988	1989	1990	Total
Contributions from DFWP:						
Activities implemented by DFWP through AFYA seconded staff (Chapter 5.1)	720	290	290	290	290	1880
Activities implemented by DFWP through MAJI's construction teams (Chapter 5.2)	1100	1100	1100	1100	1100	5500
Activities implemented through the VHW-programme (Chapter 6)	1755	1260	960	960	960	5895
Total Cost to DFWP	3575	2650	2350	2350	2350	13275
Contributions from 11 District Councils						
Activities implemented by DFWP through AFYA seconded staff (Chapter 5)	0	0	0	0	0	0
Activities implemented by DFWP through MAJI's construction teams (Chapter 5.2)	1100	1100	1100	1100	1100	5500
Activities implemented through the VHW-programme (Chapter 6)	1035	960	960	960	960	4875
Total Cost to District Councils	2135	2060	2060	2060	2060	10375

APPENDIX A

SHORT TERM CONSULTANCY ON "HEALTH EDUCATION & IMPROVEMENT OF SANITATION"

List of References:

(a) Review Mission's Report of November 1984, para. 3.5.6;

(b) DSU letter to Danida Mission dated 12th March 1985;

(c) D7 letter to Danida Mission, ref.no. AA 8991 dated 5th July 1985;

(d) Guidelines for the Implementation of the Primary Health Care Programme in Tanzania, Ministry of Health, October 1983.

Background:

In the Government to Government Agreement of 10th September 1983, a total of DKK 8 mio. was allocated for "Health Education and Improvement of Sanitation" for the period from 1983 to 1988. Ref (a) recommended a short term consultant to evaluate the sanitation component of the project. Ref (b) proposed that health and sanitation aspects be considered together by a short term consultant. A "TOR" was also suggested. Ref (c) proposed that the consultancy should take place during the period from 19.8.1985 to 28.9.1985.

The Tanzanian policies with respect to health education and sanitation activities are outlined in Ref (d). They form an important component of the country's Primary Health Care Programme, which is currently being implemented.

Terms of Reference:

The "TOR" below are based on suggestions in Ref (b) and by the short term consultant. They were finalised after discussions with the DSU in Iringa on 23rd August 1985.

1. Assess the need for health education and sanitation in relation to the DANIDA funded water projects in Iringa, Mbeya and Ruvuma Regions.

2. Assess current health education and sanitation activities in the three regions, especially those carried out through the Village Health Worker Programme which is being implemented under Tanzania's Primary Health Care Programme.

3. Assess to which extent it is possible to expand and support these activities to cover past, present and future DANIDA funded water schemes.

4. Propose, on basis of 1, 2 and 3, a strategy for such health education and sanitation activities for the period 1986 to 1990.

.../ 2

5. Prepare a phased 5-year plan for the implementation of this strategy within a budget limit of DKK 8 mio. The plan should indicate the institutional framework for implementing the plan; the main contents of health education and sanitation activities; manpower needs; training material; transport; office space; etc.

Resource Persons:

Two resource persons have been appointed to assist the short term consultant Mr Ole Therkildsen, during part of the consultancy period. Mr Chinzenga is Head of the Health Education Unit, the Ministry of Health and Professor Mark Mujwahuzi is from the Institute of Resources Assessment, University of Dar es Salaam.

Tentative Itinerary:

19.8.85	:	Arrival in Dar es Salaam
20.8.85	:	Meeting in Ministry of Health, DSM
21.8.85	:	Travel to Iringa
22.8.85	:	Meeting with VPC, Implementation Office (Iringa) and DSU
23.8.85	:	Preliminary discussions with authorities, Iringa
25.8.85	:	Travel to Mbeya
26.8.85 - 28.8.85	:	Work in Mbeya
29.8.85	:	Travel to Songea
30.8.85 - 4.9.85	:	Work in Songea
5.9.85	:	Travel to Iringa; Mr Chinzenga & Prof. Mujwahuzi travelling to Iringa.
6.9.85 - 13.9.85	:	Work in Iringa. Field visits to VHW villages. Resource persons from Dar es Salaam join short term consultant.
13.9.85	:	Travel to Dar es Salaam
14.9.85	:	Meeting with Programme Officer, SIDA
15.9.85 - 27.9.85	:	Meetings with Central Authorities, Donors supporting Health Education and Sanitation activities.
		Report writing.
28.9.85	:	Departure from Dar es Salaam

Danida Steering Unit
DAR ES SALAAM

23rd August 1985

APPENDIX B - PEOPLE MET

Ministry of Health

Dr F M Magari	-	National Primary Health Care Coordinator
Mr E S Assey	-	Health Planner
Dr S J Ngaliwa	-	Senior Health Officer
Mr E K Simbaye	-	Senior Health Officer

National Institute of Medical Research, Dar es Salaam

Prof W Kilama	-	Director

UNICEF, Dar es Salaam

Dr U Johnsson	-	Representative
Mr T Shinrshaw	-	Programme Officer, Health
Mr R Majombe	-	Programme Officer, Iringa BSP
Mr E Madinger	-	Programme Officer, Ruvuma BSP
Mr B Lungquist	-	Iringa Nutrition Programme
Mr R Anderson	-	Programme Officer, Water
Mr I Blakely	-	Project Officer, Wanging'ombe

WHO, Dar es Salaam

Dr H Wulffsberg	-	Diarrhoea Control Programme

Faculty of Engineering, University of DSM

Mr T S A Mbwette	-	Engineer, Public Health & Sanitation

Local Government Secretariat, Dar es Salaam

Mr D H Mwinitete	-	Member

Regional Office, Iringa

Mr E J Mudogo	-	RDD
Mr C Rutaihwa	-	Regional Planning Officer

Iringa Rural District

Mr Majaliwa	-	DED

AFYA, Iringa

Dr M Mwakajila	-	Regional Medical Officer
Mr F P Mhomisoli	-	Medical Assistant (Regional VHW Training Team)
Ms Mariam K Mohamed	-	Assistant Nursing Officer/Regional PHC Coordinator (Regional VHW Training Team)
Mr A A Bichibuye	-	Health Officer seconded to DFWP

Iringa Nutrition Programme

Ms C N Mtalo	-	Project Coordinator
Dr Z M Mkumbwa	-	Member of Management Team, Health Activities
Mr J B Kahatano	-	Member of Management Team, Monitoring and Evaluation

Health Assistant School, Iringa

Mr J R Challange	-	Principal
Mr Magohagasenga	-	Teacher

MAJI, Iringa Region

Mr S J Rwakatare	-	RWE
Mr T R Sheuya	-	Senior Assistant Executive Engineer
Mr H J Tesha	-	Assistant Hydrogeologist, In-Charge of Shallow Well Team
Mr H E Haule	-	Senior Assistant Executive Engineer, Construction

Implementation Office, Iringa

Mr L Dahl	-	Village Participation Coordinator
Mr H Egerrup	-	Implementation Engineer, CCKK
Mr E Itumbili	-	Implementation Engineer, Counterpart

Nzihi Village, Iringa

Ms R Mkumbwike	-	RMA, VHW Trainer
Ms O Mbeyale	-	MCH-aid, VHW Trainer
Mr I C Mungongolwa	-	Ward Secretary

Nyamihuhu Village, Iringa

Mr J D Daniel	-	VHW
Ms M E Milimo	-	VHW
Mr L S Mbembe	-	Village Chairman
Mr M J Luvengo	-	Village Secretary

Itagutwa Village, Iringa

Ms R Mgohwe	-	VHW
Mr E Mtati	-	VHW
Mr J M Msambusi	-	Village Secretary
Mr A G Matega	-	Village Chairman

Kitapilimwa Village, Iringa

Mr G Lawa	-	VHW
Mr J V Mwano	-	Village Chairman

Kiwere Dispensary, Iringa

Mr B P Mchindizi	-	RMA
Mr B Ngakonda	-	Dispensing Aid
Ms C Ngakonda	-	MCH-Aid

Implementation Office, Mbeya

Ms I Benz	-	Village Participation Coordinator
Mr L F McCarry	-	Implementation Engineer
Mr F Sørensen	-	Mechanical Engineer

MAJI, Mbeya

Mr M O Ngalisoni	-	RWE
Mr H Mwankenja	-	DWE, Kyela
Mr S K Babala	-	Engineer, seconded to Implementation Office
Mr C K Lwakiromba	-	Engineer, seconded to Implementation Office
Mr J Gwimile	-	Engineer, seconded to Implementation Office

AFYA, Mbeya

Dr Nduma	-	RMO
Mr A Mwaigomole	-	RHO and acting DHO & DMO Mbeya
Mr P L Meleki	-	Health Officer, attached to DANIDA Water Project

District Council, Mbeya Rural

Mr R S Kapongo	-	Planning & Control Officer
Mr J Matata	-	DED

RDD Office, Ruvuma

Mr E Mjwanga	-	Regional Local Government Officer

MAJI, Ruvuma

Mr J T Kababi	-	RWE
Mr A Lyimo	-	Design Engineer, seconded to Implementation Office

MAJI, Songea Rural

Mr W Mandia	-	DWE

Implementation Office, Ruvuma

Mr H W Jakobsen	-	Implementation Engineer
Mr B Kapinga	-	Village Participation Coordinator
Mr S Salobir	-	Mechanical Engineer
Mr Z N Chipile	-	Health Officer, seconded to Implementation Office

AFYA, Ruvuma

Mr A J Haule	-	RMO
Mr A J Masumba	-	RHO, RPHCC

District Trainers of VHWs, Songea Rural

Mr J F Chale	-	Nurse
Mr S T Kessy	-	Medical Assistant
Mr O L Hyera	-	Health Officer

Regional Training of Trainers Team, Ruvuma

Mr S Mbughuni	-	Medical Assistant
Mr A Kihaule	-	Nursing Officer
Ms J Kapinga	-	Public Health Nurse

District Trainers of VHWs, Mbinga

Mr E P Shaba	-	Health Officer
Mr M P Mangweha	-	Medical Assistant
Ms B D Singinika	-	Nurse Midwife

District Trainers of VHWs, Tunduru

Ms I Lukanga	-	Public Health Nurse
Mr E Njawa	-	Health Officer
Mr M B Sinje	-	Medical Assistant

RMA-School, Songea

Dr R S Mwampambe	-	Principal

Mpitimbi Dispensary, Songea Rural

Ms P Filipa	-	MCH-Nurse

APPENDIX C

THE VILLAGE HEALTH WORKER PROGRAMME

The VHW Programme was initiated in 1983. Activities are now going on in 16 regions. Iringa and Ruvuma are among these. Mbeya will be included in 1986/1987. The programme is an important element in the Primary Health Care (PHC) approach formulated by MOH but not yet approved by the Cabinet.

C.1 General Description

The description is mainly based on MOH (1983) and interviews in the three regions.

Objectives

Each village without a health facility should have a male and female VHW by 1993.

The VHW should be trained to do both curative and preventive work.

Job Description for VHWs

Among the responsibilities of VHWs are

- to provide education and guidance to villagers regarding health inducing practices to villagers
- to demonstrate better food production, storage, etc. to villagers
- to provide basic services to mothers and children
- to provide basic curative and preventive services
- to encourage changes in culturally rooted behaviour that is detrimental to health
- home visiting.

Selection of VHWs

VHWs are selected by the village and should be married, permanent resident of village and literate.

The District PHC-Coordinator (or the DMO) supposedly selects the villages.

Training of VHWs

VHWs get a total of 6 months training (2 month school, 3 month supervised practice, 1 month at school). Training at school takes place at existing training centres, Folk Development Colleges, Health Centres, etc. VHWs return to village to work there during practicals. Groups of 12 VHWs (from 6 villages) are trained together.

A Health Centre Training Team (see below) conducts the training.

The Curriculum varies from place to place depending on local conditions. Eighty percentage (310 hours) of total training time of VHWs at Nzihi village in Iringa regions was spent on the following topics listed in order of importance:

- environmental health (latrines, waste disposal)
- Mother and Child Care
- Common diseases in village
- Health Education
- Nutrition and food preparation

Adult education training methods are used. Practical activities (discussions, role play, group work, etc.) rather than lectures are supposed to be favoured.

There is no standardised training material, nor do the VHWs normally get books for study and reference. There is a shortage of suitable material and funds for this.

Appendix Table C.1 gives various cost estimates for the six months of training. It varies from Shs. 8,400/- to Shs. 15,000/- per trained VHW.

Appendix Table C.1 - Various Cost Estimates for Village Health Workers

	Item	Lake Regions (1984)	Iringa Region (1985)	Ruvuma Region (1986)
	Training of Regional and District Teams			
1.	Training of 3 regional trainers at CEDHA for 12 weeks	55,000		
2.	Training of 1 district trainer team (3 persons) at regional level			51,000
3.	Seminar for national, regional, district, divisional, ward and village level leaders for one region.	86,000		
	Training of VHW-Workers			
4.	Selection of VHWs (groups of 12)	36,400	3,600	
5.	Seminar for ward and village leaders	see 3	1,200	
6.	Transport for trainers	131,600	10,000	10,000
7.	Daily allowance for outside trainers		7,200[1]	45,000[2]
8.	Pocket money for VHWs (groups of 12)		8,640	
9.	Board & Lodging for VHWs (groups of 12)		64,800	64,800
10.	Cooks			10,800
11.	Books (for 12 VHWs)	9,300	3,360	
12.	Stationery		2,000	15,000
	Set-up of Supervision			
13.	Seminar for in-service health staff	39,000		
	Direct Cost of Training 12 VHWs (items 4 to 9)[3]	177,300	100,800	145,600
	Direct Cost per one trained VHW	~15,000	~8,400	~12,000

Sources: Lakes Regions - Ministry of Health Proposal of 1984; Iringa Region - Interview with RPHCC; Ruvuma Region - RPHCC and Regional Training Team

1) Most trainers are residents at the multi-purpose training centres
2) Trainers assumed not to be residents at training location
3) 3 months residential & 3 months practicals

Training of Trainers

The VHW-programme in a regions starts by training of trainers. This proceeds in three stages:

(i) A Regional Training Team (RTT) consisting of three to four persons are trained at CEDHA, Arusha for 6 weeks. The RTT then trains the District training teams of 3 to 4 persons (DTTs) for 5 - 6 weeks. Together these team trains 12 VHWs;

(ii) Each DTT now trains Health Centre Training Teams (HCTT);

(iii) The HCTT trains VHWs.

It is part of the start up of the VHW-programme in a region and a district that government and Party leaders are attending a seminar on PHC activities.

At the respective levels trainers are selected among the following: Medical Assistants; Rural Medical Aids; Public Health Nurses or MCH-aids; Health Officers and Health Assistants.

Funds and Responsibilities

The table on the following page indicates the major responsibilities and sources of funds. At the Ministry a total of Shs. 1.6 million is available for VHW-training in 1985/1986. The PHC unit does not have information on the funds available at regional level and in the District Councils. Iringa rural District Council, where VHW training is ongoing, is not contributing to it. The Iringa Nutrition Project provides the funds.

Appendix Table C.2 - Major Responsibilities and Sources of Funds

	Responsible	Funds From
Selection of VHW	Village Council assisted by RHTT	District Council
Training of VHW	RHTT supervised by DTT	District Council. Village may take care of Shambas etc. while VHW is on training.
Payment of VHW allowance	Village Council	Village Government (Perhaps District Council in future)
Drugs for VHW	DMO ?	District Council
Bicycles for VHW	District PHC-Coordinator	District Council
Supplies of kits	MOH?	MOH ?
Supervision of VHW	Village Health Committee Dispensary Staff, Health Centre Staff, District PHC-Coordinator	District Council
	Reg. PHC-Coordinator	Central Government
Vehicles for supervision and training	MOH?	District Council/ Central Government
Training of regional trainers	MOH	Central Government
Training of district trainers	RTT	Central Government/ District Councils
Training of Health Centre trainers	DTT	District Council

Organisational Structure

At the national level, VHW-activities are coordinated by the PHC-Coordinating Unit in the Ministry of Health.

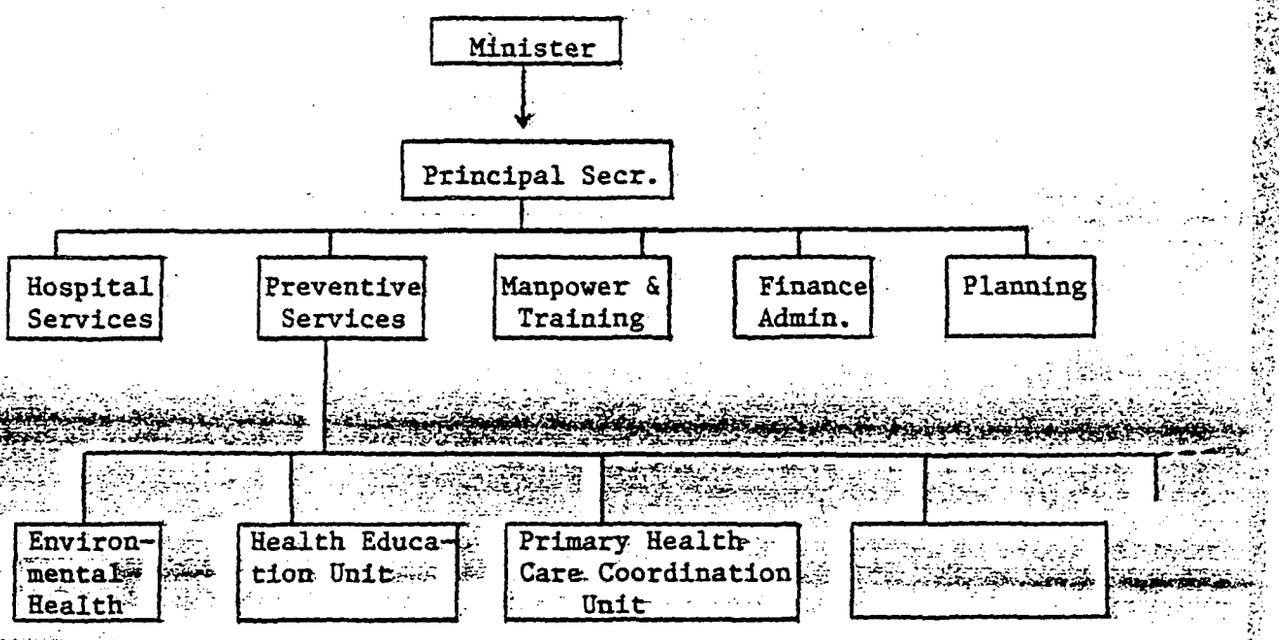

Fig. I.: Present Structure of Ministry of Health

The figure shows that the PHC Unit has a rather modest position in the structure, given the integrated approach that the PHC guidelines advocate. The whole structure is under revision but the details of the future organisation is unknown.

At the regional and district level a PHC-Coordinator is appointed to be responsible for planning, implementation and supervision of the VHW-programme. These Coordinators report to the RMO and DMO respectively. However, the organisational structure of AFYA at District level is also changing as a result of the reintroduction of District Councils. It is not yet completed.

A number of PHC Coordination Committees are supposed to guide the VHW-programme. They are supposed to be established at national, regional and district level (on membership see MOH (1983, 40-49).

At ward and village levels Health Committees are established.

C.2 Major Problems

The VHW-programme represents a renewed attempt to establish this cadre of paraprofessionals at the village level. Previous attempts at this have been made. The official view on these attempts is that they failed (MOH, 1983). The reasons have been described by Therkildsen (1984, Chapter 2.5). The present VHW-programme faces many of the same problems. Among them are:

- The PHC Coordination Unit in the Ministry is severy under-staffed to shape and coordinate the VHW-programme.
- Direct training costs range between 10 - 15,000 Shs. per VHW. This may prohibit implementation on a larger scale.
- Suitable training material in Kiswahili does not exist.
- A system for supervision of VHW by AFYA staff is not worked out yet. Currently many of the different programmes already implemented through the Ministry add significantly to the workload of key staff members from regional level and down.
- Regular payment of VHWs is crucial for their continuous service. The role of District Councils in this (and in payment for drugs) has not yet been settled. The same holds for the Village Council.

APPENDIX D

PREPARING PROCEDURES FOR IMPROVED HYGIENE AROUND WATER POINTS AND FULL LATRINE COVERAGE AND PUBLIC LATRINES AT SCHOOLS AND HEALTH FACILITIES

The main purposes of the 3 months' work in Ruvuma Region is for the three seconded AFYA staff and team leader to

- get acquainted with the village participation procedures used by DFWP as stated in the participation handbook.
- prepare additional procedures for the above activities following the same approach.
- writing these procedures into the handbook.

Tasks

1. Work with the SEC-assistants in two DFWP villages (handpump and gravity)
2. Study the causes of dirtyness around water points in completed DFWP villages
3. Talk with villagers about the problem of non-ownership of latrines. (the poor, the destitutes, the refusers)
4. Suggest how Village Water Committees, Scheme Attendants and Tap/ Well Attendants could be trained to promote cleanliness around water points
5. Suggest how village can help the poor and destitutes to build latrines
6. Suggest by-laws that will enable village to enforce full coverage (how to deal with refusers)
7. Discuss the suggestions with the VPC, Ruvuma
8. Write the suggestions into the Participation Handbook together with the VPC
9. Present the revised handbook for all VPCs and maked needed changes.
10. The seconded AFYA staff starts to implement the procedures in their respective regions.

Suggestions

In the Participation Handbook the following steps should probably be amended and two new steps added.

Amend: Steps 1, 2, 3, 4, 8, 13 (See Chapter 3.1), 15, 17, 18, 21

Add : Step between 9 and 10 to include village action to achieve full latrine coverage

Add : Step 22, return to village to follow up on hygienic conditions and latrine coverage.

Work on public latrines requires that DFWP has made prior arrangement with District Councils.

Perhaps 2 out of the 3 months should be spent in a few villages. This is not a desk study.

No detailed report on the field investigations themselves should be made.